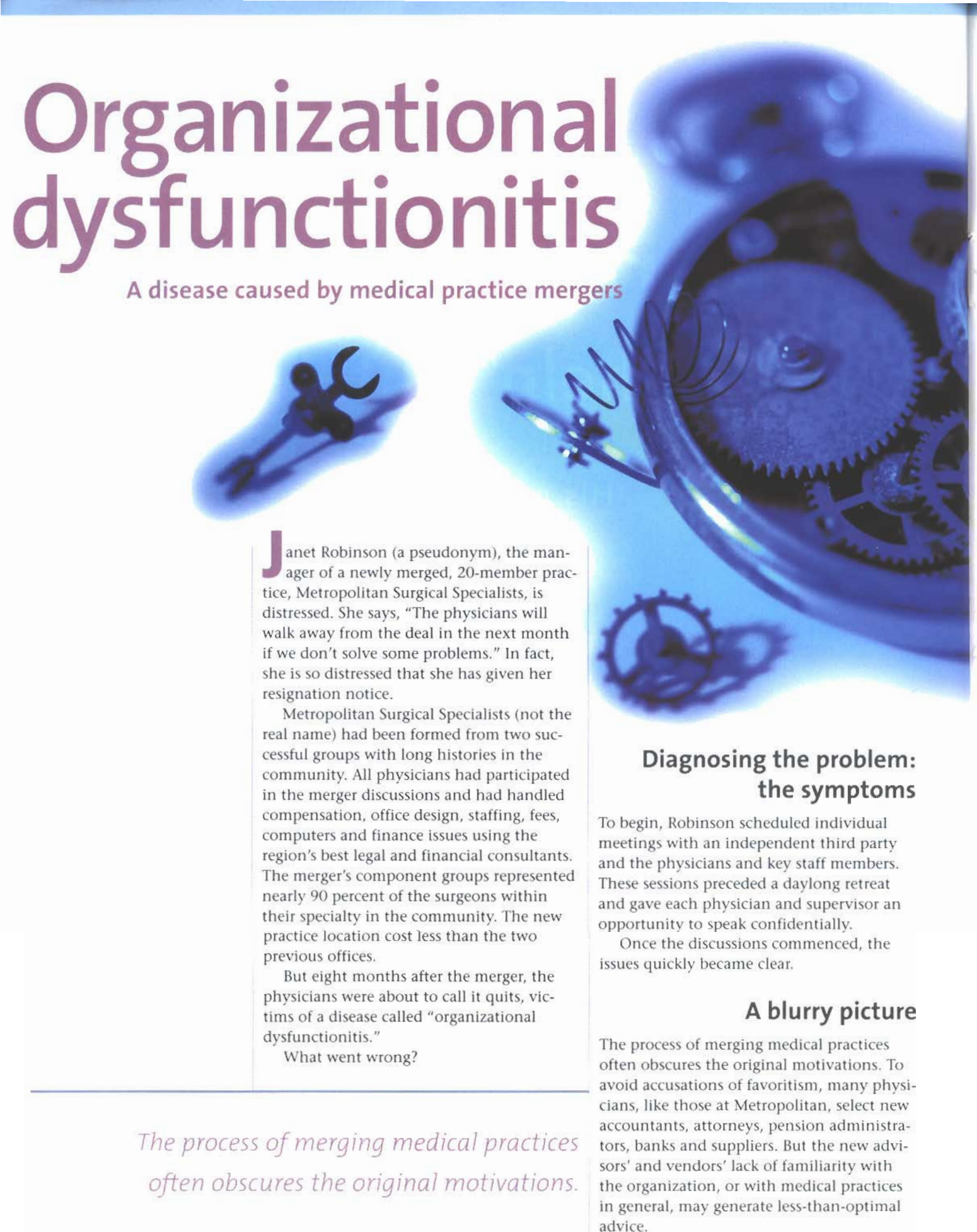


Organizational dysfunctionitis

A disease caused by medical practice mergers



Janet Robinson (a pseudonym), the manager of a newly merged, 20-member practice, Metropolitan Surgical Specialists, is distressed. She says, "The physicians will walk away from the deal in the next month if we don't solve some problems." In fact, she is so distressed that she has given her resignation notice.

Metropolitan Surgical Specialists (not the real name) had been formed from two successful groups with long histories in the community. All physicians had participated in the merger discussions and had handled compensation, office design, staffing, fees, computers and finance issues using the region's best legal and financial consultants. The merger's component groups represented nearly 90 percent of the surgeons within their specialty in the community. The new practice location cost less than the two previous offices.

But eight months after the merger, the physicians were about to call it quits, victims of a disease called "organizational dysfunctionitis."

What went wrong?

Diagnosing the problem: the symptoms

To begin, Robinson scheduled individual meetings with an independent third party and the physicians and key staff members. These sessions preceded a daylong retreat and gave each physician and supervisor an opportunity to speak confidentially.

Once the discussions commenced, the issues quickly became clear.

A blurry picture

The process of merging medical practices often obscures the original motivations. To avoid accusations of favoritism, many physicians, like those at Metropolitan, select new accountants, attorneys, pension administrators, banks and suppliers. But the new advisors' and vendors' lack of familiarity with the organization, or with medical practices in general, may generate less-than-optimal advice.

The process of merging medical practices often obscures the original motivations.

When asked why they decided to merge their practices, physicians often answer "to get bigger." They believe bigger practices can squeeze more out of each dollar collected, demand better treatment from payors, draw more patients, let physicians work less and make more. Unfortunately, few of those expectations are valid, and frustration results when the advantages don't materialize.

Practices need a clear strategic vision of the new entity. Will the merger:

- Combine clinical skills into a practice that can serve a new group of patients and generate more revenue?
- Allow for a new office to serve a new market?
- Allow staffing efficiencies to reduce overhead?
- Create financial strength to justify buying new technology to enhance human resources?

Those are valid reasons to merge. Getting bigger is not one of them.

Metropolitan envisioned an environment where the physicians could further specialize (a good plan) and work less (unrealistic). Under the pre-merger scenario, if two physicians were needed to provide call coverage for 10 busy surgeons, it probably would take four physicians to cover the patient load of 20 in the postmerger scenario. Work doesn't get easier — it just gets different.

The newly merged group's plans for subspecialization would have allowed for the development of greater clinical skills and attracted patients from the nearby teaching hospital. Unfortunately, Metropolitan's physicians never got beyond disappointment over the workload.

New problems call for new solutions

Most medical practices have essentially three job types: physicians, front-line staff and managers/supervisors. The first two jobs don't change, regardless of the size of the practice.

What does change dramatically is the role of the practice manager. The manager who could support and motivate five employees

The manager who could support and motivate five employees may not be able to handle 10; the manager who could keep his or her fingers on the pulse of 10 physicians may crumble under the challenges of 20.

may not be able to handle 10; the manager who could keep his or her fingers on the pulse of 10 physicians may crumble under the challenges of 20. Administrative complexities increase proportionately to the number of physicians.

Metropolitan's leaders faced a new environment — and were overwhelmed. They clung to the belief that "the old way was better" and communicated it to staff and physicians. Morale sagged. Employees pointed out that "their" practice never had these problems, and the problems must, therefore, be the fault of staff from the "other" practice.

No one considered that new problems called for new solutions. The physicians, trying to be fair, had split supervisory positions among staff from each practice based on tenure, not skill. Overloaded supervisors brought problems to an overwhelmed manager who brought issues to physicians who had never worked in a large practice. Since no one had experience in a bigger environment, they identified problems but could not solve them. Uncertainty resulted in caution, which caused inaction, which generated frustration, which sparked a heated confrontation between the manager and staff. Organizational chaos reigned.

Phantom management

Supervisors and staff took problems directly to the physicians. Supervisors became polarized by their physician loyalties. Employees who didn't like supervisors' instructions took complaints to physicians from "their" practice, and the physicians often sided with "their" staff. Supervisors felt impotent, staff

see **Dysfunctionitis**, page 54

By Gregory Mertz, FACMPE



about the author

Gregory Mertz, FACMPE, MGMA member and president, The Horizon Group, Virginia Beach, Va., gjm@medgroupstrategy.com

When practices finally recognize that they're sick, organizational dysfunctionitis is far advanced.

felt empowered and physicians realized things were out of control.

Many medical group physicians make decisions by consensus. Double the size of the decision-making body, add new personalities and the decision process grinds to a halt. None of Metropolitan's physicians had leadership experience outside medical staff. Without a strong and effective practice manager, attempts to forge a new culture stalled. Because problems weren't getting resolved, because employees were in revolt, the physicians believed they should pull the plug on the merger.

Metropolitan had to refocus physicians' attention on the benefits of the new practice

if it was going to survive. Staff would feel less threatened if the physicians publicly supported the merger. A strong manager could develop and implement operational procedures.

The daylong retreat clarified physicians' frustration: the effort required to perform various patient care responsibilities. Compounding the problem were inefficient office scheduling, cumbersome surgery scheduling and an accounts receivable system causing cash flow problems. The circle was closing. Organizational paralysis prevented timely solutions to operational problems, political issues prevented the manager from overcoming the functional logjam, and the resulting inefficiencies demoralized the physicians.

The medicine works but tastes bad

When practices finally recognize that they're sick, organizational dysfunctionitis is

Joint Commission ACCREDITATION

■ ■ ■ ■ ■ *Short, Simple, Affordable?*

At last! A shorter, streamlined accreditation process that meets your needs.

Joint Commission Office-Based Surgery Accreditation gives you what you need accreditation for: reimbursement, contracts, recognition, and improvement, without putting you through an overly lengthy, expensive process.

To create Office-Based Surgery Accreditation, we listened to what you wanted in a small setting, and designed our offering around what really matters: the key issues that can put patients at risk. It's an accreditation process that recognizes the needs, and the limitations, of small practices.

As streamlined as it is, we're confident you'll experience the same benefits from this new accreditation process as your larger peers.

Demonstrate your commitment to your patients
Enhance community confidence in your practice
Increase your competitive edge



Joint Commission
OFFICE-BASED SURGERY ACCREDITATION

It's not what you expect.

www.jcaho.org

See the first OBS survey in action! For a copy of our free 10-minute video "The ABC's of Office Based Surgery Accreditation, call 630-792-5259 or e-mail obs@jcaho.org

far advanced. Within a month of the planning retreat, Metropolitan's physicians mulled a feature of the employment contract that allowed them to leave without penalty. During the interviews, each physician said that his/her first choice was to make a success of Metropolitan — but s/he was keeping options open.

When Robinson gave notice, the group advertised for a new manager. None of the applicants had dealt with mergers, and none had managed 20 specialists. Now was not the time to learn on the job.

Metropolitan's transition required an interventionalist practice manager (see box). It had no other option. Metropolitan hired an interim administrator who could make necessary — if unpopular — changes. A permanent administrator — an operationalist — could fine-tune practice operations.

Introspection points toward solutions

The practice needed to regain stability. Supervisors had to focus on common goals, and staff had to do their jobs and not question every instruction. Physicians had to withdraw from day-to-day decisions. Supervisors needed to understand that they should first review issues with the practice manager. And they needed to stay in touch with staff and maintain the lines of communication.

Supervisors were asked to write a brief report on:

- What they had accomplished since the merger;
- What they had tried but failed to achieve;
- What was left unfinished; and
- What they needed to be successful.

The exercise showed that people had focused on fighting fires, not preventing them; that important process-building tasks were still active; and that barriers to success were objects, such as printers, computer terminals and modems. Soon, supervisors got their requests approved so that nothing stood between them and success. The impact was dramatic. Supervisors started

bringing new ideas to their (new) weekly meetings. They began to help each other.

Next, the practice staff identified external factors that prevented efficiencies. The top three: time needed to schedule surgeries, insurance verification and surgery precertification. When the surgery scheduling supervisor was included in meetings with hospital administration, she went from a "but-we-always-did-it-this-way" mentality to a "what-if-we-try-this" attitude.

The physicians authorized tough negotiations with payors to streamline administrative requirements. Metropolitan told payors it would work on the basis of presumptive presurgery approval with retrospective auditing. The clinical supervisor devised a new approach to schedule diagnostic studies. The progress boosted staff morale, and people began to seek solutions, not more problems.

Dysfunctionitis cured

The date for physicians to leave the practice came and went. All practitioners remained — and are now recruiting new members. They even voted to replace their productivity compensation plan with an equal-share design to reap rewards of working together.

Mergers can allow practices to meet the strategic and economic challenges of the marketplace, but watch out for the early symptoms of organizational dysfunctionitis. If untreated, it can be fatal. X

@ www.mgma.com

- In the article archive in the member area, search under the subject heading "mergers"
- To purchase the book *Strategic Leadership for Medical Groups: Navigating Your Strategic Web*, go to the store and search for Item 5069

e-mail us

Is your practice suffering from a merger-induced illness? Tell us about it at connection@mgma.com

Two types of group managers

Interventionalists and operationalists represent two types of group practice managers, each effective in a particular environment.

The interventionalist thrives on chaos, focusing on key issues, offering leadership and vision. But once problems are solved, the interventionalist becomes bored.

The operationalist builds teams, encouraging employees to develop and refine skills. S/he takes time to find the best solution for each problem and gain group consensus. But during a crisis, the patient will die long before an operationalist takes corrective action.

Which type of manager a practice chooses to recruit should depend on its current situation — stable or chaotic — and the challenges accompanying each environment.