Preparing Two Distinctly Different Family Medicine Practices for Merger

Case Study

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Statement of Problem

A small rural hospital with a hospital owned family medicine practice purchased a second family medicine practice that had been privately owned for thirty six years. The physicians in the practices had been in the same coverage group for more than twenty years, but that was the extent of their relationship. While the practices were owned by the same entity, they were competing for the same patient population, under the same discipline (family medicine). They were located across the street from each other, and their practice systems and workflows were not aligned.

Two years after the purchase of the private practice the hospital engaged the practice manager, who had been with the private practice for more than twenty five years, to assume the management responsibilities for both practices. The intent of this management configuration was to prepare for the eventual merging of the two practices. If the systems and workflows were going to be conducive to merger, they would need to be standardized between the practices. If these differences could not be resolved, a merger would not be successful.

Arriving at Alternate Solutions

In 2013, following an evaluation of the hospital owned practices, their space needs, and access to care expectations, the hospital board of trustees directed the organization to begin investigating the prospect of a new medical office building. The process led to approval by the board to begin construction. As the plans evolved, it was decided that the two family medicine practices would merge into one when the new building was created. It was determined that this was the appropriate business decision. Creating one large family medicine practice would allow for more consistent access to care, and for standardized patient care workflows. Sharing of resources would reduce the cost of care. Physicians that already shared after hours call, would have an
opportunity for improved communication regarding the family medicine patients, and there would be improved availability for same day patient access in a larger group environment.

Not merging the practices would cultivate an environment of competition for consumers between collectively owned entities. This did not align with the mission of the organization which was, “To ensure a high quality, accessible, affordable, and appropriate integrated health care system to improve the health and well-being of the community”.  

**Alternative Decisions Considered**

The option of continuing to operate as two separate family medicine practices was considered. This would allow each practice to maintain their distinct identity. It would also allow successes and failures in quality and financial performance to remain separate and identifiable. The practices would be able to maintain independent office systems and workflows, and it would delay or even eliminate the need for providers and staff to build new relationships with competing providers and staff.

Alternately, this would also support an environment where no bond between the practices is created, patients remain unfamiliar with the after-hours coverage physicians and practice improvement work must be initiated and supported in two separate locations simultaneously. The practices would remain unprepared for a possible merger in the future.

The option of merging immediately was not considered. Space limitations in the existing practice locations prohibited this possibility.
The practice considered the implications of initiating work to prepare the practices for eventual merger. The benefits of pre-planning for merger were significant. Advanced planning would allow the practices time to identify and collaborate on differences in workflows, allow an opportunity to cross train staff and build relationships among providers and staff, and encourage alignment of financial and quality goals prior to merging the practices. This would also allow an opportunity for patients to build relationships with providers and staff from both practices. Patient and family advisors would be a valuable resource during this pre-merger planning, affording the patient perspective as decisions are made.

Drawbacks to advanced planning were few, but included the recognition that there would be some duplication of work and that the collaboration would need to be accomplished with staff and providers residing in separate locations. Consideration was given to the budget process, recognizing that the practices would continue to operate under separate budgets until the actual merger.

**Chosen Solution**

The administrative leaders, in concert with the providers and practice manager decided it was important to begin the work of transformation well in advance of the merger. Realizing how disruptive a move to a new location at the same time as a merger could be to patients and the practice; this gradual transformation would present the best outcomes for patients, staff and providers when the practices merged.

**Implementation**

The following timeline demonstrates the project progress from beginning to completion:
October, 2014 – Board approved construction for build of a new medical office building

November, 2014 – Bi-monthly building planning meetings began with architects and stakeholders

January, 2015 – Integration planning began with practice manager and practice leadership

March, 2015 – Sharing of staff between practices began

April, 2015 – Review and problem solving of variations in workflows began

August, 2015 – Introduced patient and family advisors from each practice to the other practice

September, 2015 – Began combining all staff and provider meetings

October, 2015 – Providers began sharing time between practices to support understaffed practice

November, 2015 – Combined staffing schedules were developed for the new practice

December, 2015 – Christmas party mixer, joint effort between practices

January, 2016 – Merger and move to new medical office building

February, 2016 - Patient and family advisors from each practice began working together

Following approval by the Board of Directors for the construction, bi-monthly meetings began.

The architects who designed the building were chosen for their experience in designing patient centered medical home practices. The practice managers as well as physician representation from the practices were involved in the building design from start to finish. Both staff and patient and family advisors were included in the process and contributed ideas to the success of the final building design.

The next step was to begin making plans to identify all areas that may be of concern as the practices faced the merger in the next twelve months. The practice manager and physician leadership from both practices began discussions on how best to proceed. The fact that the physicians had shared after hours call for many years was of great benefit; they were at least familiar with each other and had frequently collaborated over after hours patients.
It was decided that sharing staff between the offices would accomplish several goals. This process would permit the offices to identify existing differences in workflows and also inspire cross training, thereby allowing staff to understand the unique preferences of each provider. Simultaneously the practices began including two staff from each practice to attend the other practice’s staff meetings. This too encouraged the sharing of best practices and helped to build stronger relationships.

The staff was encouraged to engage in social opportunities. The first of these was a pot luck lunch, hosted by the larger of the two practices. This proved to be a challenge and resulted in a great deal of awkwardness and very little social interaction. But they pushed on. Over time there were numerous staff from each practice who reached out to include the other practice in planned get-togethers, such as after-hours painting events and skin care parties. Providers were engaged in mingling opportunities through the efforts of one of the newer physicians who hosted a gathering at her home. A family medicine provider retreat meeting was not as successful as anticipated and was abandoned after the first attempt. It was felt that this was just another form of a provider meeting and could be accomplished in another way.

During this time, the patient and family advisors from each practice were introduced to each other and to each other’s practice. The work of the advisors continued to remain within the practice they were associated with until the time of merger. It was felt that the advisors knew their practice well and could help everyone stay focused on the expectations of the patients from each practice during this time of transition. This proved to be the right decision for this group.

Next was the opportunity to identify areas of work that could begin blending before the merger. An inventory of systems was conducted to determine opportunities for standardization and shared resources. The two areas that emerged were quality data management and referral management.
One practice had a quality coordinator in place already. She had been with the practice for more than twenty years, and was very talented and organized in quality data management. Over time, the practice manager relied on her to begin managing the quality work for both practices. Examples included the submission of information to the National Council on Quality Assurance (NCQA) so the physicians could achieve recognition in diabetes care and heart/stroke care. She also began providing all providers with their monthly quality outcomes reports. This was very well received by the providers and helped build bridges between the practices. The second area of early integration was in referrals. Since both practices shared the same electronic medical record and all referrals were managed through the record, it was not necessary for the referral coordinator to be located at both practices. She was excellent at managing referrals and yielded a great improvement in referral management for the larger practice who had had inadequate referral coverage until then. This too was very well received by the providers in the practices and helped to build trust in management decisions surrounding staffing. Financial performance meetings that had previously been kept separate were combined. Productivity information became transparent between the practices.

Four months prior to the merger, all staff and provider meetings were combined. A conference room at the hospital large enough to accommodate the entire group was booked for these meetings. Each meeting started with everyone introducing themselves and defining their role. The practice manager requested that as they went around the room, they not identify themselves with one practice or the other, but use the name that had been established for the new practice. This built a comradery over time and helped the group identify as one. Following the departure of a nurse practitioner and a physician from the smaller practice (which occurred around this same time), providers from the larger practice offered to help out until the merger occurred. One physician began sharing her time at both practices and a new nurse practitioner that had been
hired at the larger practice, was actually established at the smaller practice. This contributed to supportive feelings among the providers in the practices.

A shared goal of expanding patient access hours was discussed. It was recognized that the new, combined practice and larger facility would be conducive to this goal. Two months prior to the merger, based on the partnerships that had evolved, provider and staff teams were defined. This was the first time either practice had been large enough to move to a true team model. Involving providers and staff in the process, the practice manager built schedules that provided for extended patient hours. Once in their new location, the practice would begin seeing patients at 7:30 AM and finish at 6:30PM, every weekday (except Friday, they would close at 5:30PM).

In December 2015, just one month before the merger, the practices collaborated to have a Christmas party mixer. The hospital allowed them to rent a facility on a Saturday afternoon for this event. Everyone signed up to bring a dish, families were included and plans were made to have team building activities during the party. This was very well received and was well attended with approximately 80% of staff and providers attending with their families.

On January 8, 2016, right on schedule, the practices moved to the new office building. Staff and providers were responsible to pack their belongings but the actual move was choreographed by an experienced moving company. In an effort to reduce the chaos of the move, only the practice manager was allowed to be on site the day of the move. In light of this, moving day for the rest of the staff and providers was set up with educational workshops. The staff attended customer service workshops and the providers attended clinical education meetings. The entire group came together for a lunch workshop on non-violent communication, something one of the nurse practitioners had attended and thought would be well received by the larger group.
Outcomes and Lessons Learned

The process produced better than expected results. Staff and providers were engaged and recognized their value in the change process. Strong, cooperative physician leaders resulted in a collaborative environment that was positive and supportive of the efforts of the practice management staff. Standardized workflows that maintained an element of individuality helped create best practices for the group. While still apprehensive, both practices felt prepared for merger and were willing to work together to create the best possible outcome.

Within two months of merger, two front desk staff chose to leave their positions. This represented 5.7% of the entire practice team. This was disappointing, but could have been anticipated. There will be team players that are unhappy with the change and will move on.

It is important to keep lines of communication open. Inform staff and providers along the way of all progress, both positive and challenging. Engaged, informed staff can promote the positive and help find solutions for the challenges. Engagement is enhanced if an environment of autonomy is fostered, while holding each participant accountable to the larger team.

Identifying individual strengths will improve the merging of duties. Celebrations render positive relationships and an overall positive attitude.

Recommendation for Other Managers

The practice manager plays an essential role in the process of change, especially during a merger of two practices. Identify and involve the most engaged staff in the integration process, this will help encourage full staff buy-in. Solicit team member ideas to help engage the larger group.
Identify staff and providers who are most reluctant, work to fully understand their concerns and solicit help as needed from the leaders of the organization to help these individuals embrace the changes.

Look for every opportunity to create a win-win, such as soliciting individual preferences when the issue allows. Work schedules are an example of this kind of opportunity. Include patient and family advisors in your work, this allows the patient perspective to be considered in every area of the process. Don’t set unattainable expectations. Expect a certain amount of disappointment but don’t let it inhibit your progress and fortitude. Celebrate accomplishments.
1. Retrieved from the Western Maine Health website; http://www.wmhcc.org/wmh_body.cfm?id=4202