CASE 5

Can This Relationship Be Saved? The Midwestern Medical Group’s Integration Journey

Introduction

On a snowy January evening, the Midwestern Medical Group (MMG) management team held a retirement party for Judith Olsen, MMG president. During the evening, Olsen reflected back on the years she had worked for MMG with mixed feelings about her experience. Over the course of their eight-year integration journey, both she and the organization had learned valuable lessons about collaboration, communication, and leadership.

This case was written by Rhonda Engleman and Jisun Yu under the supervision of Professor Andrew H. Van de Ven of the Carlson School of Management at the University of Minnesota. We also appreciate the editorial assistance of Julie Trupke and useful comments of Gyewan Moon and Margaret Schomaker. We gratefully acknowledge Stuart Bunderson, Shawn Lofstrom, Russel Rogers, Frank Schultz, and Jeffery Thompson who assisted in collecting data during this eight-year longitudinal study of MMG’s integration journey. The case was prepared to promote class discussion and learning. It was not designed to illustrate either effective or ineffective management. Used with permission from Rhonda Engleman.
journey within the Midwestern Health System (Midwestern), the MMG management team experienced many encouraging moments, achievements, and successes as well as many struggles, disappointments, and conflicts. She was scheduled to meet with the board chair the next day to talk about the major issues her successor would need to address as president of MMG. Knowing this might be her last contribution to MMG before she retired, Olsen wanted to provide the board chair with helpful advice to pass on to her successor.

Olsen pondered the historical events in MMG’s integration journey as she thought about what to say in that meeting. (See Exhibit 5/1 for major Midwestern and MMG events.)

Exhibit 5/1: Major Midwestern Health System and MMG Events

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<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>1994</td>
<td>Health Systems Corporation and Midwest Health Plan merged to become Midwestern Health System (Midwestern)</td>
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<td>1994</td>
<td>Midwestern established three divisions – Delivery Services, Professional Services, and Health Plan</td>
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<td>1994</td>
<td>Midwestern established the Midwestern Medical Group (MMG), with 20 primary care clinics</td>
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<td>1995–1996</td>
<td>MMG expanded by acquiring 30 additional primary care clinics</td>
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<td>July 1997</td>
<td>Patrick, the original MMG president, was promoted to System vice president of Clinical Services, and Erickson was appointed the new MMG president</td>
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<td>Fall 1998</td>
<td>MMG decided to hire an ophthalmologist to expand clinic services; Midwestern protested decision; MMG ordered to cancel hiring negotiations</td>
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<td>February 1999</td>
<td>Johanson, Midwestern CEO, announced a new organizational structure, moving from three divisions to two, the Hospitals &amp; Clinics division and the Health Plan division; the new divisions were charged to select and organize around market business segments (MBSs), focusing on specific customer groups to be determined by the divisions</td>
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<td>Spring 1999</td>
<td>MMG decided to hire a spine surgeon; Midwestern hospital protested decision; MMG ordered to cancel hiring negotiations</td>
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<tr>
<td>Mid-1999</td>
<td>Hospital &amp; Clinics division selected six market business segments – three metropolitan hospitals, regional hospitals, MMG, and home care</td>
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<tr>
<td>Summer 1999</td>
<td>Johanson commissioned a benchmarking study to compare MMG with benchmark medical groups; MMG compared favorably to benchmark group performance standards</td>
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<tr>
<td>Fall 1999</td>
<td>MMG decided to hire a general surgeon; Midwestern hospital protested decision; MMG ordered to cancel hiring negotiations</td>
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<tr>
<td>Spring 2000</td>
<td>Midwestern System board commissioned a study to evaluate the appropriateness and value of MMG referrals to Midwestern hospitals; the study demonstrated appropriateness and significant financial value of MMG referrals to Midwestern hospitals</td>
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<tr>
<td>Spring 2000</td>
<td>Johanson announced planned retirement in summer 2001; Novak promoted from president of Midwest Health Plan to Midwestern COO to prepare to take over System CEO position</td>
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Background

Midwestern Health System (Midwestern) was established in July 1994 through the merger of Health Systems Corporation and Midwest Health Plan, making it the largest health care organization in its region. Health Systems contributed hospitals, clinics, nursing homes, a home health agency, and other health care services while Midwest Health Plan contributed health insurance products and relationships with physician groups. The vision guiding Midwestern’s development was to “offer an integrated health care system to affordably enhance the health
of people living and working in communities we serve.” This vision implied two priorities: the commitment to build an integrated health care system and the goal to improve community health.

MMG was founded in 1994 with an initial network of 340 employed physicians working in 20 clinics previously owned by Health Systems Corporation hospitals at the time of the merger with Midwest Health Plan. Hal Patrick was selected as the first MMG president. Under Patrick’s leadership, MMG grew rapidly during its first two years, acquiring 30 additional primary care clinics in strategic locations across Midwestern’s geographic market. By mid-1996, MMG’s management attention shifted from growth by acquisition to management and organizational development of its 50 clinics with 450 physicians and over 3,000 employees. MMG experienced many challenges during these formation and establishment periods within the Midwestern Health System. System integration processes proved complex, involving many interdependent change initiatives. The initiatives included: (1) creating a large integrated group medical practice from formerly small independent physician clinics; (2) transitioning the identities and roles of physicians from being principals of private clinical practices to becoming agents and employees of health care companies; (3) building an organizational culture that aligned incentives and strengthened the commitment of clinicians with MMG and Midwestern while maintaining their commitment to the medical profession; and (4) developing an integrated system of health care for patients by linking MMG’s clinical and business services with other Midwestern units, including the hospitals and the Midwestern Health Plan.

In July 1997, Patrick was promoted to system vice president of clinical services for Midwestern. Midwestern leaders appointed Lief Erickson as the new MMG president. Erickson represented a strong voice for MMG physicians and patient care and had worked as an MMG manager since its formation. Despite continuous hardships in both finances and operations, Erickson led MMG as the group rebounded from a record loss of $41 million in 1996, decreasing losses to $22 million in 1997 and $20 million in 1998. MMG was on track to improve its financial performance in 1999 by decreasing its losses to $17 million; still far from ideal but movement in the right direction (see Exhibit 5/2). Under Erickson’s leadership, MMG developed a solid management team of administrative and physician leaders as the group shifted from a culture of survival to a culture of performance. MMG had faced many challenges since its formation in 1994, but Erickson and his management team weathered the storm to establish MMG as an integral part of the Midwestern Health System. The MMG management team still faced many tensions in their relationships with others in the Midwestern system, but Erickson was confident that his team had demonstrated MMG’s value to Midwestern and would continue their journey to lead MMG to even better results in the future.

Arranged Marriage of Equals

The Midwestern Health System experienced escalating financial pressures in 1998 and 1999. Since Midwestern’s formation, the system had not achieved its overall financial performance goals. Johanson, CEO of Midwestern, anticipated that the
Exhibit 5/2: MMG Annual Operating and Financial Performance, 1994–2002

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<td>Gross Charges</td>
<td>119,380</td>
<td>164,524</td>
<td>204,739</td>
<td>204,491</td>
<td>218,612</td>
<td>259,454</td>
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<td>Discounts</td>
<td>24,393</td>
<td>38,732</td>
<td>58,346</td>
<td>63,779</td>
<td>77,181</td>
<td>74,041</td>
<td>116,135</td>
<td>150,596</td>
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<td>Net Patient Revenue</td>
<td>94,987</td>
<td>125,792</td>
<td>146,393</td>
<td>150,735</td>
<td>154,833</td>
<td>182,273</td>
<td>197,429</td>
<td>215,686</td>
<td>230,570</td>
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<td>Other Income</td>
<td>4,277</td>
<td>5,310</td>
<td>4,642</td>
<td>5,913</td>
<td>7,508</td>
<td>10,478</td>
<td>13,255</td>
<td>14,772</td>
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<td>Net Revenue</td>
<td>99,264</td>
<td>131,102</td>
<td>151,035</td>
<td>156,648</td>
<td>162,341</td>
<td>192,751</td>
<td>210,884</td>
<td>230,658</td>
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<td><strong>Expenses</strong></td>
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<td>Physician Comp. &amp; Benefits</td>
<td>43,210</td>
<td>54,943</td>
<td>71,533</td>
<td>66,086</td>
<td>62,688</td>
<td>72,939</td>
<td>68,776</td>
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<td>Other Comp. &amp; Benefits</td>
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<td>52,406</td>
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<td>77,254</td>
<td>97,082</td>
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<td>All Other Expense</td>
<td>41,794</td>
<td>52,633</td>
<td>60,769</td>
<td>51,733</td>
<td>51,732</td>
<td>59,089</td>
<td>87,936</td>
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<td>Total Expenses</td>
<td>122,685</td>
<td>159,982</td>
<td>192,482</td>
<td>178,997</td>
<td>180,071</td>
<td>209,282</td>
<td>253,794</td>
<td>278,523</td>
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<td><strong>Net Income (Loss)</strong>*</td>
<td>(23,421)</td>
<td>(28,880)</td>
<td>(41,447)</td>
<td>(22,349)</td>
<td>(17,730)</td>
<td>(16,531)</td>
<td>(43,110)</td>
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**Key Statistics**

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<td>103.89</td>
<td>95.80</td>
<td>104.74</td>
<td>108.07</td>
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<td>121.41</td>
<td>125.17</td>
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<td>Charges per Visit ($)</td>
<td>20.43</td>
<td>23.54</td>
<td>26.50</td>
<td>26.29</td>
<td>29.17</td>
<td>29.75</td>
<td>27.27</td>
<td>35.00</td>
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<td>Discount Rate (%)</td>
<td>86.38</td>
<td>76.34</td>
<td>77.27</td>
<td>82.79</td>
<td>87.04</td>
<td>90.20</td>
<td>97.14</td>
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<td>Physician FTEs</td>
<td>313</td>
<td>324</td>
<td>380</td>
<td>356</td>
<td>327</td>
<td>374</td>
<td>387</td>
<td>385</td>
<td>382</td>
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<tr>
<td>Support FTEs</td>
<td>1,107</td>
<td>1,573</td>
<td>1,913</td>
<td>1,913</td>
<td>1,898</td>
<td>1,895</td>
<td>2,156</td>
<td>2,207</td>
<td>2,170</td>
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system would experience reductions of $50 million in Medicare reimbursement over the next five years because of changes in the program made by the Balanced Budget Act of 1997. Reimbursement rates from other commercial payors were also declining. Johanson feared that Midwestern could not survive without major system-wide changes to improve the organization’s financial performance in patient care services.

Meanwhile, Midwest Health Plan had achieved stellar results with the Market Business Segment (MBS) business model. In 1997, Midwest Health Plan experienced significant financial losses, but then it adopted the MBS business model, moving from a structure with staff organized by major functions (such as marketing, member relations, and product development) to a structure with staff organized around Midwest Health Plan’s major customer segments (such as government payors, small business, and other commercial payor groups). The move to the MBS business model allowed Midwest Health Plan leaders to streamline the organizational structure and develop products and pricing systems tailored to customer needs in each business segment. As a result, Midwest Health Plan improved its financial performance, moving from a significant financial loss before the MBS restructuring to a sound financial gain after its implementation. Johanson decided to extend the MBS business model to the rest of the Midwestern system, anticipating that the hospitals and MMG could achieve financial results similar to Midwest Health Plan’s and enable Midwestern to improve the performance of all its individual units.

In February 1999, Johanson officially unveiled the plan to implement the MBS business model in the Midwestern hospitals and MMG. Johanson announced that in the MBS business model, Midwestern would move from three divisions – Hospitals, MMG, and Health Plan – and reorganize as two divisions – the Health Plan division and the Hospitals & Clinics division (see Exhibits 5/3 and 5/4). Midwest Health Plan would continue with the MBS business model as previously defined and implemented. The Hospitals & Clinics division, including the Midwestern hospitals and MMG, would define and organize around its own market business segments. These two divisions would be assigned accountability and responsibility to become the leader in their chosen market business segments.

Johanson stated that the MBS model signaled a short-term move away from system-wide integration. The old Midwestern business model assumed that individual units shared one customer and attempted to provide a single “Midwestern experience.” The MBS model acknowledged that the old view was inadequate because each division served unique customer groups. Midwest Health Plan’s customers were health plan members, corporations, other purchasers, and insurance brokers. MMG’s primary customers were patients. The Midwestern hospitals’ primary customers were physician specialists. Although the mission and vision of Midwestern would remain the same, the system would back off from tight integration and pursue high-impact integration in a few selected areas to meet the unique customer needs of each division. Johanson charged each division to maximize financial and patient care performance within certain “rules of the game,” including open communication between divisions and “no tolerance for badmouthing other parts of the organization.” Johanson declared 1999 as the year
of “freedom to act.” He expected the units within each division to coordinate their activities, but each division would be free to define and manage its own unique set of market business segments.

Johanson purposely designed the MBS business model to force the hospitals and the MMG to resolve their tensions and conflicts by combining them into a single division. According to Johanson, “We’re learning more about integration. We used to assume that if we put them all together, they’d see the need to talk and automatically coordinate. They don’t; it’s not natural. Our new model acknowledges that and encourages integration more directly.” Johanson expected and looked forward to watching these tensions unfold and play out between the hospitals and MMG in the move to the MBS model.
After the announced restructuring, Erickson expressed mixed feelings about the MBS model when he discussed the change with his MMG management team. Erickson expected that MMG would have an equal voice in the MBS implementation process, with representation on a new board established to govern the Hospitals & Clinics division. He welcomed the freedom to act that Johanson had given to the hospitals and to MMG to establish their own business market segments. Johanson promised that if MMG decided that improving patient care was one of their most important goals, then his expectation would be that MMG would outperform their competitors in that area. Erickson reported, “Then he will go away, and wait for me to come back and tell him how MMG did. That’s different, isn’t it! They’re not going to tell us how to do it.” Erickson hoped that the MBS model would help to improve relationships between MMG and the Midwestern hospitals. He felt that this really would be the first time that the hospitals and MMG had a chance to test integration. The hospitals and the MMG had not yet been able to work together to prove what they could achieve in combination to improve patient care. Erickson reassured his MMG management team, “There is a lot of instability and uncertainty. I’m convinced, though, that the strategy is right to focus more on customers and relationships.”

At the same time, Erickson wondered if MMG and the hospitals could resolve the differences in their customer groups and approaches to health care delivery. “The structure by itself will not do away with those fundamental market activities that make us see the world differently and to be different. When they think of a customer, they look out the window and see the specialist building; my customer is this region because at some time those people will eventually wind up in the hospital. For MMG, the customer is across the table. They simply have a different customer set. It’s funny how you won’t face what you have to face. Hospitals say they have patients and referring doctors, as on an equal plane. When you really look at it, though, the referring doctor is on the top of the priority list. . . . In MMG, the patient is center, and it’s relationship based. We see customers and markets differently. And now you say you’ve got to get together in a ‘market-based segment?’ Hang on! It will be OK, but it will be another game; all those market dynamics are still in place. If we can survive it, it will be good. No matter how good a new model is, if you make a change like this, the bridge in between is tough. I don’t think we’ve got many more shots at this thing.”

Erickson went on to note, “If you’re the CEO and you say, ‘I expect you to outperform your competition at all costs’ – which is a part of this market segment idea – but then I put you in a box with these other groups, who have the ability to impede you, you’re sending a very complex message. Every day, the clinics are compromised by the hospitals’ needs. . . . They have a good theory, but if it’s not carried out well, it’s not a good theory. But, anyway, we’re going to try.” Erickson urged his MMG management team to send a positive message about
the new MBS business model to the staff and physicians working in their clinics: “No matter which way we go, we’re partners with the hospitals; we’ve got to coordinate, and the future’s about relationships... As we sell this to our clinics and our partners, we want to make it positive and build hope.”

The Children Get Separate Rooms

Johanson appointed Frank Henry as senior vice president of the Hospitals & Clinics division. Henry formed a division management team of representatives from each unit to review options for selecting market business segments. The team explored three options. First, the group considered the status quo option, with MMG as one business segment and each of the three hospitals as a separate business segment. Second, the group explored the implications of establishing two business segments – hospital services and ambulatory care services. Finally, the group considered creating a regional model, with each metro hospital forming the anchor of three separate MBSs and the clinics organized geographically around these hospitals. After discussing the pros and cons of each option, the team decided to maintain the status quo, with a few additions by selecting six market business segments for the Hospitals & Clinics division: three metropolitan hospitals, regional hospitals, MMG, and home care.

MMG as the Problem Child

In early 1999, Johanson asked the Midwestern financial management staff to compare MMG’s performance to a best-practice model developed by a national consulting group. In a study of seven health system-sponsored primary care groups, the consulting group concluded that financial losses were inevitable in such groups because of costs associated with system membership, including high practice acquisition costs, additional system overhead, increased employee benefit costs, new information systems expenses, and loss of ancillary revenues to hospital affiliates. The consulting group developed a model of realistic performance expectations for health system-sponsored primary care groups given such limitations.

The finance staff found that MMG gross revenues were lower than the benchmark, but that MMG compared favorably in net revenue, expenses, and loss per RVU¹ when compared with the best-practice standards. MMG also compared favorably in productivity, producing 6,428 RVUs per physician in 1998 compared with best-practice benchmarks of only 6,100. Erickson summarized the significance of these findings, “What’s important is that it should eliminate the notion that MMG can gradually move to a zero loss.”

Erickson presented MMG’s favorable benchmark comparisons to the Midwestern board. The board expressed a new appreciation for MMG, its performance, and its value to the larger Midwestern system. They reported that this study gave them a better understanding of how to measure MMG’s financial and operational performance, how to set benchmarks for its performance, and the need to recognize the value that MMG contributed to the Midwestern system.
Despite the board’s affirmation of MMG’s value to Midwestern and recognition that its financial performance exceeded expectations, MMG leaders heard repeated comments by other Midwestern leaders that there must be something wrong with the management team of a unit that consistently lost money. For example, when an MMG vice president presented an analysis of MMG’s financial losses to a group of other Midwestern leaders, one of the hospital vice presidents in the audience taunted her, saying: “It pretty much sucks to be you, doesn’t it?” When she made the same presentation to MMG’s own physician advisory group members, many of whom had sold their practices to MMG, “They went off the deep end on it. Their mindset was, ‘No, we used to at least break even. Something’s wrong if we lose $17 million!’”

One Midwestern hospital administrator summarized the hospital leaders’ views on the “MMG problem” this way: “Looking at MMG’s bottom-line losses, the hospital leaders started thinking that they must not be very good managers and resented having to subsidize MMG. . . . They were making money before they became part of Midwestern and now they were getting fat and lazy. . . . The move to the MBS only reinforced that ‘what’s your problem?’ mentality, regardless of the data that showed MMG being set up to lose money. The data became almost irrelevant. There was no view that we were in this together.”

These negative reactions affected the MMG management team morale. The perception by other Midwestern leaders that MMG was a financial drain on the system was clearly felt by MMG leaders. The MMG financial manager acknowledged the view that, “MMG’s been looked down on – if it weren’t for us, the hospitals would have more capital to spend.” In one MMG leadership meeting when the group reviewed a report showing that MMG’s losses were far lower than budget, one MMG manager lamented, “If we’re doing so great, how come we are not feeling better?” Another manager replied, “It’s because we’re in a lousy business. No matter what we do, we lose money.” In another meeting, one MMG physician manager urged, “We need to stop presenting that awful $20 million loss figure. That turns us into the no-joy club. We should be talking instead about how we compare to best practice clinic groups.” Searching to bolster his team’s morale, Erickson asserted that, “MMG is a very important piece of the Midwestern Health System, and we are not underperformers.”

In addition to concerns about MMG’s financial losses, some Midwestern hospital administrators expressed concern that MMG failed to honor its responsibility to other system members by inappropriately referring patients to non-Midwestern hospitals. In Spring 2000, the Midwestern board commissioned another study to quantify the value and appropriateness of MMG referrals to Midwestern hospitals. Erickson felt that this new study was another example of, “. . . some guys in the board room occasionally waking up and wondering, ‘why do we have this clinic, again?’” This MMG valuation study provided evidence that MMG stabilized and increased referrals to Midwestern-owned facilities plus affiliated specialists, and provided a large and geographically well-located clinic group to strengthen Midwestern’s position in contract negotiations with payors. In addition, this study showed that MMG clinics contributed more than $500 million in net revenue and about $250 million in contribution margin to the Midwestern hospitals annually. Overall, the MMG valuation study once again
affirmed MMG’s value to the larger Midwestern system, despite its individual unit losses.

The Midwestern system and hospital leaders were not entirely impressed by the results of the MMG valuation study. When the MMG leaders presented the MMG valuation study findings to the Midwestern executive committee, members initially responded that the results “couldn’t be this good.” They sent MMG back to check their numbers and review their findings with Midwestern’s chief financial officer. This additional review confirmed the original results. The MMG leadership team found the hospital administrators’ interpretations of the MMG valuation study results interesting. While the study showed that MMG contributed $250 million to the hospitals, Olsen summarized the hospital leaders’ attitudes toward this news as, “We would have gotten those referrals anyway, so sit down and shut up.”

Family Squabbles in the Hospitals & Clinics Division

Midwestern held the individual market business segments accountable for their individual revenue and expense statements. As its own MBS within the Hospitals & Clinics division, MMG continued to experience significant financial losses. MMG attempted several strategies to improve its financial performance. One promising strategy was to expand MMG services to the community by hiring specialists because their services are typically reimbursed at a higher rate than primary care services. The MMG leaders engaged in their “freedom to act” within the general guidelines set out for them by Johanson in the MBS rollout. They committed to hire outside specialists only if Midwestern hospital-affiliated specialists could not meet their needs. However, MMG’s efforts to hire specialists led to several squabbles with other members of the Hospital & Clinics division.

In late 1998, MMG decided to hire an ophthalmologist to provide outpatient laser surgery in an MMG clinic near one of Midwestern’s hospitals. The ophthalmologists practicing at that hospital perceived this MMG decision as promoting unfair competition within their service area. According to the hospital administrator, MMG made the decision to hire an ophthalmologist unilaterally without consulting with him or his ophthalmologist group. The ophthalmologists affiliated with this Midwestern hospital said, “To heck with that. We’ve been taking ER calls in the middle of the night and MMG doesn’t do that.” This group of ophthalmologists resigned and established a new independent practice. Midwestern hospital lost patient volume to this new competitor and had to find another group to provide emergency room coverage for ophthalmology services. According to the hospital administrator, “It was a good business decision for MMG, but it was a dumb decision for Midwestern.”

In early 1999, MMG learned that Midwestern had developed a formal specialty strategy. In a strategy presentation to a management group, a Midwestern leader cited MMG’s plan to recruit an independent spine surgeon as a prime example of this strategy in practice. MMG leaders were excited to see their strategy moving
forward and receiving acceptance and support from the Midwestern leadership group. A week later, MMG learned that Midwestern system leaders had made a commitment to a group practicing at one of the Midwestern hospitals and decided that all Midwestern business related to spine surgery should go to them. MMG was forced to comply with this new contract by working with the Midwestern hospital group to provide spine surgery services and had to retract their previous employment offer to the independent surgeon.

Later in 1999, MMG hired a general surgeon to practice at another of its clinics. According to Erickson, “It’s got the whole damn city up in arms. The official policy, though, is that we, when we can, should work with existing specialists. If they can’t meet your needs to out-compete the market, then you can get your own. In this clinic, there’s a stodgy old surgeon group who won’t meet our needs in our new great facility, so we’re going outside to hire.” Once again, Midwestern system leaders had other ideas. They demanded that the MMG leaders retract their plan to hire the general surgeon originally selected and instead work with the local Midwestern hospital’s surgeon group.

Johanson blamed Erickson for these conflicts with Midwestern hospital-affiliated specialists. According to Johanson, “It was so painfully obvious to me that Erickson needed to get key players together to hash out issues, but he simply wasn’t getting to the issues.” Johanson went on to note that, “Erickson falls into the trap of seeing our need for information and coordination as questioning respect; he refuses at times to admit he needs help and discussion. . . . On this specialty issue, he didn’t get the big picture about implications for the whole organization and the ripple effects he might be creating. There’s a ‘lack of learning’ problem.”

Erickson viewed these conflicts as evidence to support his suspicion that the Midwestern hospitals wanted to regionalize MMG. His management team tried to follow the expectation that MMG would work with Midwestern hospital-affiliated specialists and only go outside the system when they could not meet MMG’s needs. Even so, the MMG leaders were handcuffed in their attempts to improve MMG financials and expand services by hiring specialists. Erickson and the MMG management group were discouraged by the lack of a coherent specialty strategy at the Midwestern system level. One MMG manager expressed frustration “because you start going down a path, and then it gets pulled out from under you. And then you find out that there was never really a strategy to begin with.”

MMG Moves Along With Its Work

Despite difficulties implementing the MBS business model in the Hospitals & Clinics division, MMG continued to move on with its work in 1999. The MMG management team focused on fine-tuning their systems, structures, and working procedures across clinics as well as developing patient-focused quality improvement initiatives. A 1998 billing practices audit report showed that MMG billing practices were often inaccurate and patient care documentation was sometimes incomplete.
CASE 5: MIDWESTERN MEDICAL GROUP’S INTEGRATION JOURNEY

MMG leaders worked hard in 1999 to implement standardized patient care documentation and billing practices to assure that MMG was in compliance with the government’s billing and documentation standards. Improving these systems also provided an excellent opportunity to increase revenues by collecting payments for previously unbilled and underbilled services.

While they were trying to improve such administrative issues, the MMG management team also initiated several programs to enhance their patient care quality. One program of focus was the Clinical Care Improvement (CCI) initiative. The MMG management team believed that MMG could produce measurable improvement in clinical care and transfer successful experience from one clinic to another. Thus, the MMG managers established a CCI cross-functional team to lead MMG on clinical care improvement initiatives. The CCI cross-functional team set out to prioritize health care services where MMG could have a strong impact on community health improvement such as diabetes care, elderly care, and smoking cessation. The team identified methods that MMG clinics could use to improve their services and established incentives to motivate clinics to improve their patient care outcomes in these areas. The MMG leaders hoped that their work would provide an example to other Midwestern system units by demonstrating the benefits of continuous care improvement in action. These continuous improvement efforts paid off. Early in 1999, at an executive leadership retreat, one of Midwestern’s executive officers stated that, “MMG really is the cornerstone of any meaningful changes we make.” He explained that MMG could demonstrate best practices and clinical care improvements and urged the other units to follow their example.

Is the Family Going to Stay Together?

Despite the positive results of the benchmarking study, the MMG valuation study, and improvements within the MMG, the Midwestern executive council began to reconsider MMG’s future in the Midwestern system. Concerns about MMG’s financial losses continued, and squabbles with Midwestern hospitals and specialists indicated to the executive group that some change was needed. In their June 2000 meeting, the executive council reviewed seven options for restructuring MMG’s role in the Midwestern system:

1. Status quo, with MMG as one MBS within Hospitals & Clinics division;
2. Separate MMG as its own division;
3. Regionalize MMG by placing clinics under Midwestern hospital management;
4. Divest MMG;
5. Partial sale of selected MMG clinics or programs;
6. Hire an outside group to manage MMG; and
7. Transfer ownership of MMG to a community trust.

The executive council decided to keep MMG within the Midwestern system and rejected the divestiture option. The group also rejected the option to regionalize
MMG or establish it as a separate division but deferred a decision on any of the other options, fearing that any decision would be premature.

Erickson expressed frustration with the executive council’s decision-making process to determine MMG’s future status in the Midwestern system. When asked by his MMG management team about his sense of Midwestern’s direction, he replied, “I should know, but I don’t. MMG is not at the table. Johanson doesn’t meet with me, and Henry’s met with me twice in six months. . . . We’ve been systematically excluded from all that activity. The experience we’ve had in this division is the most ridiculous thing we’ve gone through. Midwest Health Plan and the hospitals have come up with a grand scheme, perhaps, on delivery, and they’re keeping it from us. . . . I don’t have an answer.” Erickson went on to note that, “On the down side, there is apparently no willingness, no openness to think about an MBS structure where we’re cut loose from the division, which is where I think we need to go. People in the organization are saying that the two divisions are constantly fighting, so why would we want three? I’m saying that we had far less turmoil with three.”

While Midwestern leaders and MMG were trying to clarify MMG’s future in the Midwestern system, some of the MMG clinics began to make their own decisions about their future. A Midwestern competitor approached the physician leaders of one MMG clinic with an offer to expand the facility if they would associate with the competitor’s system. If they chose not to, then the competitor warned the MMG clinic physicians that they would build new clinics in the area to compete with MMG. The Midwestern system executives conceded to the sale, believing that this MMG clinic was not large enough to withstand the potential competition. They decided that it was better to cut their losses and negotiated the sale of that clinic to the competitor. After watching this sale transpire and wondering about their own future in the Midwestern system, other MMG clinics also threatened to defect. According to Erickson, the executive council wanted much more clarity about its direction on some of the MMG clinics that could try to leave the system. “They’re realizing that when a medical group wants to leave, it leaves. . . . It took one clinic to get their attention, but I think it will get bigger with other clinics.”

Maybe Uncle Novak Will Take Care of Us

In Spring 2000, Johanson announced his plan to retire in Summer 2001. Johanson selected Michael Novak as his heir apparent. Novak had led Midwest Health Plan’s turnaround effort. In preparation for taking over the reins, Novak changed his role as president of the Midwest Health Plan to the Midwestern chief operating officer. Olsen summarized the MMG’s reactions to Novak’s appointment, saying: “. . . he’s my hope. What he says about his values is encouraging. Two things about him give me hope. First, he’s visiting the facilities, using his time as an understudy to get to know the organization from a front-line perspective. Second, he’ll be very clear about the direction of the organization. He’ll be clear, and follow through on what he will and will not tolerate.”
Olsen was heartened by a statement that Novak made in a meeting with the MMG leaders. “We asked you to pull together 50 clinics and make them into one. You actually did it, and we never said thanks. Now we’ve tried to make you the scapegoat for the fact that we don’t know what to do with it now that you’ve succeeded.” Olsen was impressed with the changes Novak had implemented in Midwest Health Plan. Although some described how Novak handled Midwest Health Plan’s turnaround as “scorching the earth” because he had let many of the original management staff go, Olsen believed that many who left Midwest Health Plan really did need to go. “Midwestern needs somebody who can see that and act on it.” Novak confirmed with the MMG managers that he would be very clear in his expectations for Midwestern managers, using phrases like, “I won’t drag anyone along.” At the same time, Olsen was confident that Novak would emphasize paired physician–executive leadership. “Novak doesn’t think anyone can be everything to everyone, and he’ll put strong physicians with strong managers.”

**Erickson Shunned For Misbehaving One Too Many Times**

In May 2000, another contentious conflict exploded between MMG and Midwestern hospital-affiliated specialists. Erickson asked the pulmonary specialist group associated with Midwestern’s City Hospital for help in implementing a Healthy Lung program at the Wellview Clinic by extending the clinic’s smoking cessation and early heart disease detection services. The City Hospital pulmonary group declined the invitation to work with this program. When he learned of MMG’s difficulties in working with City Hospital, the chief medical officer from Midwestern’s General Hospital facilitated a relationship with MMG so it could provide the program and contract negotiations began. The chief medical officer at City Hospital heard of these plans and demanded that Erickson stop MMG negotiations with the General Hospital group well after they had begun. The pulmonary group based at City Hospital also had an office at General Hospital. They were angered by the proposed relationship between General Hospital and MMG and closed their General Hospital office after this conflict erupted. They also threatened to leave City Hospital and set up an independent practice to compete with the Midwestern system if Erickson did not agree to work with them on the Healthy Lung program at Wellview. The City Hospital pulmonary group sent a letter to Johanson and the Midwestern board demanding Erickson’s resignation for causing this conflict.

The conflict culminated in Johanson conceding to the City Hospital pulmonary group’s demands by asking for Erickson’s resignation. Reflecting on the events leading to this decision, Johanson acknowledged Erickson’s success in providing internal leadership of MMG. “The problem is when you get out of the sandbox in managing relationships with other parts of the system. I am not saying that Erickson was wrong; only that he has not been able to handle them well and prevent problems from growing to high visibility crisis situations.” Johanson went on to say that Erickson’s “building of the MMG silo may be at the expense
of the undoing of the Midwestern system. Erickson has not been willing to bring the Midwestern mission into MMG.” Johanson suggested that Erickson had taken MMG as far as he could and should retire while he was at the peak of his career. “I have known Erickson for a long time; he came from a primary care clinic, and he has been in front of the business in the development of primary care. Now he is in the middle of managing relationships with specialists, which is causing him trouble.” Johanson initially suggested to Erickson that he resign in July 2001. Johanson later decided to move up the timetable for Erickson to transition out of MMG by the end of 2000. Johanson reported that he had talked with the MMG board and district medical directors, who said they recognized Erickson’s strengths and weaknesses, and they wanted to make sure there was an orderly transition in leadership and the right leadership for MMG.

Henry agreed with Johanson’s view that Erickson had made great strides in molding MMG into one entity. “Now we need to put MMG into better alignment with the Midwestern hospitals. Erickson has not agreed with this strategy; nor is it part of his skill set.” Henry cited concern that Erickson participated in senior management team meetings only to pull back later and do his own thing on billing and other simple things. Henry supported the call for Erickson’s resignation saying, “We need to stop working at cross-purposes. Erickson has simply not bought into our strategy and has been unwilling to work toward consensus with a division team.”

The Midwestern hospital administrators supported the call for Erickson’s resignation. One administrator summarized her views on Erickson and MMG’s role within Midwestern: “We act like a classic dysfunctional family. In a dysfunctional family, there is always a problem child. MMG is the classic child that acts out in the Midwestern family. Erickson played that part well; in fact, he seemed to be born to it. One way to act out is to take money from the specialists and that starts a lot of conflict.” Another Midwestern hospital administrator agreed, saying: “Erickson just loved to mix it up. He was their guy, take out the word ophthalmology and insert any number of other specialties. If I’m never disciplined for stepping over an organizational line, then I’m doing the right thing. . . . We ought to be Midwestern leaders first and work this out. We’ve got to always think of the big picture.”

Erickson acknowledged two reasons for his forthcoming resignation. First, he cited Johanson’s response to a “group of thugs . . . who are writing letters to the board and Johanson, and being successful at it.” Erickson stated that a second and deeper issue was the MBS business model. “I don’t believe in it and do not want to put MMG in with the hospitals. The more I challenged this issue the more peripheral I became. The vertical structure and hierarchy of the company does not permit conflict, and this is foreign to my horizontal conflict management approach.” Later in the year, he appeared to have come to terms with his pending resignation, saying: “I am happy to be leaving because I no longer trust the values of top management. I recognize I do not fit in this organization.” Erickson ultimately attributed his demise to a classic case of failed leadership. Erickson believed that Midwestern executives failed to implement the MBS strategy because power and control stayed in the hands of a few people who were unwilling to
CASE 5: MIDWESTERN MEDICAL GROUP’S INTEGRATION JOURNEY

leave their power and allow the system to establish market business segments. Instead, the Midwestern leaders tried to regionalize the system around the three metro hospitals. “The strategy was to have a collaborating set of divisions, each of which would compete fiercely in the market for their customers. They turned around and said that’s not what they meant; instead, they said be subservient to the hospitals. The soul has gone out of the company.” Erickson summarized his sense of betrayal, saying: “When introducing the market business segments strategy, the company told us that we would be judged by our ability to implement the strategy. They left unspoken that if you get others upset, we will kill you.”

MMG Leaders Rally to Defend Their Rights

The MMG management team was alarmed at the potential implications of Erickson’s ousting to the future of MMG. They felt that Johanson had violated his previous assertions that Erickson would be evaluated based on MMG’s financial and clinical performance, reflecting a lack of integrity in the Midwestern system leadership. One MMG physician manager noted, “If the company treats Erickson this way, then it may happen to the next person or yourself.” The MMG management team feared that the call for Erickson’s resignation was a sign that the system intended to break up or sell MMG.

During his transition period, Erickson urged the MMG management team to step up to the plate to keep Midwestern from tearing MMG apart. Working with Erickson, the MMG management team generated a list of demands for the Midwestern board to clarify MMG’s future role in the Midwestern system:

1. Maintain a single MMG with physician executive leadership;
2. Give MMG increased representation at the division and system tables;
3. Acknowledge the contributions of MMG to the system;
4. Develop a realistic plan to attract and retain physician leaders; and
5. Expectations, accountabilities, and roles must be clarified.

The MMG management team presented these demands to the Midwestern board in August 2000. The board listened to their presentation, and Novak said he would get back to them on the issues they presented. Novak came to an MMG management team meeting in October 2000 to respond to the demands. He hedged on the demand to have a single MMG. “I have no idea how this will play out, but whatever we decide to do, it will be to improve patient care. I think there is value in having MMG together, but there is also value in regional efforts.” He affirmed that Midwestern was searching for a physician executive as the future MMG leader, a person with 15 years of clinical and operational experience. “I don’t need to tell you that that’s a lot to ask. That makes for a very small pool of candidates; finding someone with a career combining both is rare. We don’t want to put that person in position to fail. We need to find someone who fits the profile. We are looking for a physician right now; we’ll see how we do.”
Regarding MMG presence on the executive council, Novak stated that until the new MMG president was selected, Henry would represent MMG in operational matters and the Midwestern chief medical officer would represent MMG physician interests on the executive council. He stated that he was not ready to include the MMG president as part of the executive council. When the MMG management team noted concern about their lack of involvement at the executive council level, Novak replied that it was a temporary arrangement, and “What I can tell you is that the only constant for MMG and Midwestern overall will be change. I’m not sure what the ultimate structure will be.”

Novak expressed confusion about the MMG demand to have a representative on the Midwestern board because he believed that MMG had a representative. Olsen noted that people do not see the person appointed to represent MMG as a true MMG representative. She added, “I think our major concern is about being consumed by hospitals; that’s not the best way to take care of patients. I think what we are saying is that we want to have a voice in whatever strategy is decided for how to organize MMG and how it relates to the rest of Midwestern.” Novak acknowledged this concern and committed to maintaining a continued dialogue with MMG involvement in such decisions, whether through the board, the executive council, or other channels.

When the discussion turned to how to better reflect the value of MMG to Midwestern, Novak stressed that, “What I want to get to is the role for MMG; how we account for it in the books is not really important to me. I think that it’s more important how we decide where we’re going. I will be working with the board on the strategic planning process.” One manager pointed out that Novak should understand that MMG had been “put under the gun about our numbers and that’s why we are so sensitive about that.” Novak replied, “I’m not saying that the numbers are not important, but that discussion won’t take us anywhere.” He framed the problem as finding an economic model that fits the current economic realities facing Midwestern and MMG. “I want you to know that the numbers are not important to me. The more time I spend in MMG, the more I believe that this is Midwestern’s crown jewel.”

Novak went on to acknowledge that recruiting and retaining physician leaders were major challenges for Midwestern. The system had lost many talented physician leaders, and many who remained expressed frustration with their limited ability to impact the organization. Novak informed MMG that the physician resources committee of the board was taking this issue seriously, making it their top priority.

Novak heartedly agreed with the MMG demand to clarify roles and accountabilities in the Midwestern system. “We can be about financials, but I think for our employees it’s more about feeling valued than the bottom line. I believe that organizations that have clarity around purpose and values do better than organizations that are focused on the bottom line. The number one thing we can do to improve bottom line is to have clarity of purpose. The other is to take responsibility. Having those two things is essential to having a healthy organization.” Olsen noted that she and other MMG leaders had often been confused about decision-making authority. “We get very confused with knowing whether
we have the ability to make decisions or whether someone else has the power to make our decisions for us.” Novak agreed with this concern. “Who’s on first, who is in charge, that’s a problem. We have a lot of people working on committees and no one knows who is in charge; it’s wasted time. We need to be willing to let someone be in charge. That person needs to understand the organization’s needs. I’m working to try to get a handle on these things; we need to keep having conversations about this issue.”

Who Is Going to Lead Us Now?

With Erickson’s resignation imminent, Johanson appointed Henry to lead a national search for a new president of MMG. Henry explained the search process to the MMG management group in June 2000. A selection committee of Midwestern system leaders was appointed to make the hiring decision. The committee would include one MMG representative, yet to be determined. The committee planned to develop a new MMG president job description and would have better-defined position requirements in 30 days. He stated that the committee would like to have a candidate in place by the end of 2000, but a national search could take longer to complete.

One MMG manager pointed out that, “It sounds like you have a good process in place, but I think it’s important to do a good bit of soul searching to figure out what failed this time and how to make it work the next time.” Olsen added, “I think you have to understand that we are mourning a loss here. Many of us are feeling that there is a certain disconnect here. We have an excellent leader, and it’s not clear to us what exactly went wrong.” Another manager added, “There are many things about Erickson that have been very successful, and we need to keep those things and build on the others. If we don’t do that, the environment and relationship pieces won’t be successful.” Henry agreed and expressed openness to feedback from the entire group on how to improve the success of the new MMG president. “It’s no secret that we have a poor track record with physician leaders. Is it preparation, culture, fit, selection?” Henry assured the group that the search committee would consider this issue seriously in the recruitment process.

The MMG management team assumed that Olsen was the most logical choice to lead MMG in the interim following Erickson’s resignation. Olsen had served as senior vice president of MMG since 1997. In that role, she had provided leadership on several major initiatives. However, weeks passed after Johanson’s call for Erickson’s resignation in May 2000 and Olsen was bewildered by Henry’s silence regarding a plan to manage the MMG leadership transition. The absence of any contact about this made Olsen wonder if she would not be invited to stay on with MMG. Olsen also wondered if this lack of succession planning communication was a further indication that the Midwestern leaders intended to sell MMG or split it up by regionalizing clinics with the hospitals. She felt that the option to replace Erickson and keep MMG intact was not behaviorally apparent since no efforts had been made to communicate with the MMG top management team to keep it intact.
In July 2000, Olsen talked briefly with Henry after a large management meeting. Olsen told Henry that she had heard a rumor that Erickson was leaving on September 1st. She asked if that was true and could people begin talking about it and making plans? Henry was shocked and shushed Olsen saying that people weren’t supposed to know; he had only told one or two people. Olsen asked, “Well, if it’s true, who will run MMG with Erickson gone?” This question appeared to catch Henry off guard. “Um, well, you are doing a good job right now,” he replied. Olsen informed him that she did not want to do the job just by default. Olsen was disturbed by Henry’s lack of communication with her and other MMG management staff on the MMG leadership transition outside of sidebar conversations. Henry assured her that he would set up a time very soon to talk with her formally.

Weeks went by again until Henry finally called Olsen to ask if Erickson had told people about his leaving in September. Olsen replied that of course, many people knew by then. Henry was flustered and said that he needed to send out a memo announcing Erickson leaving, Olsen taking over, and other management changes. Olsen replied, “Wait. Hold on. You need to talk to me about this first. The memo can’t go out today; you need to talk to me and not just take this as a natural default move.”

Henry finally set up a meeting with Olsen in mid-August 2000. Olsen asked him to describe exactly what the MMG interim president position entailed. Henry replied, “Well, it’s just running MMG, you know.” Olsen asked for clarification of her role within Midwestern, such as what decision-making authority she would have in MMG versus decisions that would be made by Henry and other system executives. Henry hadn’t thought about those issues. By October 2000, when asked about how the transition from Erickson was working, Olsen reported that the transition was going well by that time. At first people were sad to see Erickson go but, after a time, the grieving subsided. However, Olsen and the rest of the MMG management team remained concerned that this interim MMG leadership period might be used to justify breaking up and parceling out MMG clinics. Olsen’s role and MMG’s role within Midwestern had not yet been clarified, but Olsen was determined to hold the MMG management team together despite this.

**MMG Continues to Move Along With Its Work**

Despite leadership transitions at the system and MMG levels, MMG continued to move on with its work in 2000. MMG leaders pushed forward with their clinical quality improvement initiatives. In addition, they established a new initiative focusing on patient safety and drug interactions. They established a safety committee to implement a mechanism for reporting safety issues and medical errors in MMG clinics. To support this effort, they emphasized the need to create a “blameless culture” in which clinic staff and physicians could feel safe to report issues without fear of reprisal. The MMG management team initiated a project to implement same-day scheduling in MMG clinics. This initiative improved
patient satisfaction with the scheduling process and allowed the MMG clinics to improve quality of care by addressing patient needs on a more timely basis. The MMG management team also improved patient care by implementing new patient education programs. The MMG medical leaders established a Council of Evidence-Based Medicine to set priorities for evaluating and implementing clinical best-practice standards in MMG clinics.

The MMG management team implemented changes in its employee recruitment and compensation systems as well. MMG was suffering from increased employee turnover rates as staff left MMG for better-paying positions with other organizations. MMG’s compensation rates had been kept lower than market rates for many positions, and annual salary increases had not kept pace with inflation. Also, some MMG clinics found that to recruit new staff, they had to offer higher compensation to new employees than more tenured employees, creating an equity problem in staff compensation. MMG needed to address these issues to retain its workforce. The MMG management team successfully lobbied for the approval and additional funding needed from Midwestern to address these recruitment and compensation issues.

Continued Family Squabbles

In her interim MMG president position, Olsen experienced continued conflicts with hospital-affiliated specialists. In April 2000, MMG had sent out a request for proposals for radiology services in MMG clinics when the contracts with the groups providing these services were about to expire. In September 2000, MMG reviewed the proposals received, chose to offer the groups currently providing services first right of refusal for new contracts, and sent them all a letter verifying this decision. These new contracts established service and quality expectations and clarified the MMG–radiology group relationship overall.

After the fact, some of the Midwestern hospital leaders protested MMG’s decision. For example, under MMG’s decision, the Wellview Clinic would retain its current radiology provider, Central Radiology. The chief medical officer at Midwestern’s City Hospital demanded that Wellview replace Central Radiology with City Hospital’s radiology provider, Allied Radiology. Responding to such complaints by Midwestern hospital leaders, Henry informed Olsen that MMG should be following “the guiding principle” in their contracting. Olsen replied that she had no idea what this guiding principle was, or when it was decided that MMG was supposed to be following it. Henry explained that the guiding principle referred to a decision made by the executive team that MMG should give preference to specialist relationships that had been established in the local Midwestern hospital when contracting for specialist services. He explained that if a Midwestern hospital used a certain radiology group, the local MMG clinic should give their radiology contract to the same group. In the Wellview Clinic, this would mean replacing the current provider, Central Radiology, with the City Hospital provider, Allied Radiology.
Olsen explained to Henry that following this “guiding principle” could wreak havoc in MMG. MMG had contracts with various specialists where, in return for covering some of the rural, less desirable clinics, a specialist group was given some of the urban, more desirable sites, like Wellview. Olsen explained that following this new “guiding principle” might accomplish the hospitals’ objectives of giving their specialists the MMG sites they wanted, but that this would mean severing relationships with providers that had established, long-standing relationships with a given site. She pointed out that if a specialist group loses one of the urban sites to a Midwestern hospital-affiliated group, they would have no incentive to cover MMG’s rural sites. Olsen feared that implementing the “guiding principle” could result in some MMG clinics losing specialist services entirely, which could, in turn, compromise patient care quality.

Henry ignored Olsen’s concerns, negated MMG’s radiology vendor decision, and forced MMG to use the local Midwestern hospital radiologists. Henry’s plan was more expensive than the plan MMG had originally developed. As vendors were moved out of MMG clinics, they took their equipment with them, forcing MMG to purchase replacement equipment. Technical support staff also transitioned, and MMG incurred additional recruitment and training costs to hire replacement staff. In addition, Henry’s plan put the organization at risk of legal action for breach of contract from the radiologists originally selected to provide services to the MMG clinics.

Tell Me Again, Why Is MMG Such a Problem Child?

In late 2000, Novak hired Deloitte & Touche to conduct a benchmarking study of the individual MBS units in the Hospital & Clinics division. Deloitte & Touche reviewed MMG’s performance in the areas where they had typically found opportunities for improvement in other primary care physician networks. They found that MMG compared favorably to other groups in productivity, compensation, number of support staff, ancillary revenues, billing practices, and referrals provided to other system members. Deloitte & Touche found that the most significant factor contributing to MMG’s financial losses was excessive system overhead costs assigned to the group by the Midwestern system. MMG was carrying far more system overhead than the average medical group – $110,000 per physician compared to a Deloitte & Touche benchmark of $50,000 per physician. Further, MMG was forced to provide staff benefits to match benefits provided by the hospitals, benefits that most independent groups did not provide. In addition, MMG had incurred technology costs that did not create operational improvements, technology imposed on the group by other Midwestern system members. Just like the earlier benchmarking analysis and the MMG valuation project, the Deloitte & Touche analysis once again reaffirmed that MMG did provide value to the Midwestern system and was performing as best it could given the constraints placed on it by the Midwestern system.
Is the Family Going to Stay Together? – Round Two

In Spring 2001, despite Deloitte & Touche’s findings and reaffirmation of MMG’s value to Midwestern, Novak commissioned a group to investigate how to retain the benefits of MMG while minimizing its financial losses. This group analyzed the potential of eight models to achieve this objective:

1. Sell MMG to an outside party;
2. Spin off MMG by selling the clinics back to the physicians;
3. Form a holding company in which MMG would become its own separate Midwestern division;
4. Use a hospital-centered approach, with MMG clinics managed to maximize hospital benefit;
5. Move to a regional model, with the hospitals and clinics reporting to a regional executive;
6. Merge MMG and Midwest Health Plan;
7. Form a Midwestern ambulatory company with all ambulatory services across Midwestern managed under one umbrella; and
8. Maintain status quo, with MMG as one MBS within the Hospitals & Clinics division.

The group rejected the option to merge MMG and Midwest Health Plan, fearing that this could have negative financial effects on the Midwestern hospitals. The group rejected the option to form a Midwestern ambulatory company as an essentially unmanageable change. Novak decided to present the status quo, sell, spin off, holding company, and a combination of the hospital-centered/regional models to the board to make a final decision. According to Olsen, selling MMG seemed unlikely since this would likely result in significant loss in hospital volumes, although it would bring Midwestern an immediate $75 to $100 million in capital from the sale. Spinning off MMG via selling it back to the physicians seemed unlikely to Olsen because MMG physicians were hesitant to assume the financial management responsibility. Forming a holding company seemed unlikely because this would require significant changes in current leadership and high transition costs. Some combination of the hospital-centered/regional models seemed the most likely board choice of the change options, but it would require transition costs and probably additional layers of management. Olsen felt that the current state was adequate, and “if the loss bothers you, restate the financials.”

Olsen Remains at the MMG Helm by Default

In March 2001, the MMG president search committee interviewed two candidates for the permanent MMG president position. However, the search committee
determined that neither candidate fitted the needs of the position and extended the search process. Olsen had been evaluating her role and was not interested in being a perpetual interim. Olsen wondered if she laid low and stayed quiet, she just might end up getting the job by default.

In June 2001, Novak officially suspended the search for an MMG president. He made an announcement at the Midwestern leadership council saying that, given the strategic planning work the board was doing that would likely alter the MMG role in Midwestern, recruiting top talent would be difficult. Because of these issues, Novak announced that Olsen would remain the MMG interim president through the end of 2001 or early 2002. Olsen was surprised by this announcement and found it demeaning – it was as if they were saying they had to scrape the bottom of the barrel and had no choice but to leave her in the position. Olsen spoke to Novak before the next board meeting and discussed the tone of the message with him. The message Novak gave the board was much more positive. Overall, Olsen felt like the top leaders were “patting her on the head.” She found the way Novak and other leaders were communicating about her role as strange. Novak was including her now in top leadership meetings and the executive council. But, the other Midwestern leaders talked about her participation as if she was merely sitting in on the meetings, not like she was a true participant.

Changes at the Top

Although Novak had intended to take the remaining options to restructure the MMG to the Midwestern board in July 2001, these plans were placed on hold indefinitely when the system leadership fell apart. Novak left the organization unexpectedly in July 2001. Johanson retired in October 2001. Henry also retired and several other Midwestern executives left the organization. Timothy Norton was appointed chair of the Midwestern board and interim CEO of Midwestern when Johanson retired. Midwestern initiated a national search for a new CEO. In March 2002, Norton formed the “Office of the Chief Executive Officer” with Norton as interim CEO, Mark Jepson as chief operating officer of Midwestern’s hospitals and MMG, and Steven Flander as chief administrative officer supervising system support functions, including accounting, finance, human resources, and legal services. Norton decided that the hospitals and clinics would continue to be managed as a single division.

During this interim system leadership period, Norton and the remaining Midwestern leadership team focused on addressing Midwestern’s financial performance. Midwestern had experienced record losses in 2001. While restructuring MMG was still on the table, the system needed to take immediate short-term actions to bolster Midwestern’s bottom line. What to do with the “MMG problem” slipped off the top management team priority list while the system leaders focused on other issues of more immediate concern.
And MMG Continues to Move Along in Its Work

Despite the distractions from these new leadership transitions, system performance issues, Olsen’s interim status, and continued questions about MMG’s role in Midwestern, the MMG management team continued to move on with its work in 2001. The group continued implementing the same-day scheduling system in MMG clinics. The Council of Evidence-Based Medicine continued by developing a formal charter and appointing MMG medical leaders to the group. The CCI program expanded its quality improvement initiatives, including a project to improve congestive heart failure services and a tobacco cessation counseling initiative. MMG established a new service endeavor to improve the physician–patient relationship, developing a service resource manual and holding an MMG conference focused on educating physicians on how to improve their communications with patients, including improving courteousness, listening skills, and involving patients in their treatment decisions. The MMG management team also developed strategies to improve physician productivity by developing mentoring relationships for new physicians and addressing other organizational barriers that constrained physician productivity. MMG conducted a clinic benchmarking study to better understand the variance in financial and clinical performance across MMG clinics and develop strategies for implementing best practices in low-performing clinics.

MMG Exercises Its Right to Self-Determination

While the Midwestern system leaders struggled to decide about MMG’s future in the system, several more clinics left MMG and others were threatening to leave. Olsen and her team decided not to sit still and be “plucked to death like a duck.” They felt that before they lost all of their clinics by default, they needed to do something to establish a sense of direction for MMG in the absence of a system strategy. Olsen pulled together an MMG team in Fall 2001 to develop a vision for MMG’s future. The team focused on three main scenarios. First was complete divestiture of MMG. The group determined that it would cost Midwestern about $86.4 million to close down MMG. They estimated an approximate 50 percent downstream loss to Midwestern hospitals depending on who bought MMG. Second was the enterprise model. In this model, MMG would go to the Midwestern hospitals and ask which clinics they wanted and which they wanted to close. If a Midwestern hospital wanted to keep a clinic because it generated substantial referrals to the hospital, then the hospital would be charged with supporting the clinic’s financial losses. The third option Olsen’s team explored was the multispecialty practice model. This would involve developing a hub-and-spoke clinic system, with large multispecialty clinics such as Wellview in the center and other primary care clinics as spokes that would refer to those hubs. Clinics that could not generate enough contribution to the hubs would be closed.

In addition, Olsen and her group developed a plan to address the needs of clinics in rural areas of Minnesota, referred to by the team as the “Greater Midwest...
strategy.” In some areas, a local non-Midwestern hospital received the majority of referrals generated by these clinics. In those areas, MMG planned to negotiate joint venture relationships with the local hospitals to share support of those clinics. Olsen envisioned that her team would pursue the Greater Midwest strategy in conjunction with the restructuring model ultimately selected.

While Olsen and her management team were moving along with their MMG visioning process, Norton contacted Olsen and instructed her to develop an additional plan for MMG. He instructed Olsen to not worry about politics but to put together a plan to bring MMG to a break-even position or better in three years. He gave Olsen three weeks to complete this plan, which she did. This plan included elements that would allow MMG to hire specialists in direct competition with some of the Midwestern hospital-affiliated specialists, develop ancillary services within MMG (such as laboratory services, which previously had been directed to the hospitals), and carry out other potentially controversial strategies. But, the plan clearly demonstrated that, if allowed to engage in practices that made sense for MMG from a business perspective, MMG could clearly break even or even make a profit within three years.

In May 2002, Olsen presented the results of her team’s MMG visioning process and the break-even plan to Norton, Jepson, and Flander. Jepson and Flander were uneasy with some of the elements of the break-even plan, particularly those that would allow MMG to compete with the Midwestern hospitals and affiliated specialists. Nonetheless, Norton supported the break-even plan, and Olsen presented it to the Midwestern board in July 2002. The board unanimously approved the plan.

Several issues surfaced as Olsen moved forward to implement the approved MMG break-even plan. Some Midwestern board members later said that they did not really intend to pass the plan, but felt that they could not speak up in the meeting to voice their objections. In subsequent board meetings, Olsen noted that MMG budget projections her team had calculated based on the break-even plan were not reflected in 2003 to 2005 budget figures presented to the board’s finance committee. Figures presented in these meetings reflected the previous projections, showing sustained MMG losses according to budget assumptions made before the break-even plan was approved. Olsen voiced concern about this to the board’s finance committee and asked that the MMG budget figures presented be changed to reflect the new MMG plan. One Midwestern executive told Olsen, “You couldn’t really think that you would be allowed to move ahead with the plan.” She was hearing the same old message, to shut up and stop making trouble.

Outside the boardroom, some Midwestern executives questioned whether Olsen was “playing fair” with this new break-even MMG plan. One Midwestern executive felt that Olsen was being disingenuous in “pushing” her break-even plan through with Norton. Jepson, Flander, and other members of the Midwestern executive team saw Norton as the type of person who often failed to follow chain of command. In their perspective, Olsen took unfair advantage of Norton’s management style. Since Norton asked Olsen to develop a break-even plan for the MMG and she included tactics that would reignite old conflicts with Midwestern hospitals, some Midwestern executives felt that Olsen was wrong to take Norton’s
approval at face value and proceed. They felt that Olsen should have discussed these strategies with them before including them in her plan for the MMG.

Olsen seemed undeterred by these criticisms. She and the MMG management team proceeded to implement the MMG break-even plan. Olsen and her team broke the plan into three phases. Phase One involved moving forward with the Greater Midwest strategy to develop joint venture relationships with non-Midwestern hospitals to share support for MMG clinics that provided them substantial referrals. This phase involved developing partnerships to share financial and management support of some MMG clinics with Midwestern hospitals and negotiating improved contracts with various payors. Phase One projects were expected to have immediate impact on improving MMG financials. Phase Two involved projects that would be implemented with impact from 2003 to 2005. Phase Two projects included the expansion of laboratory services and additional hospital–MMG clinic partnerships. Phase Three involved strategic planning to expand MMG services in promising outpatient markets. By October 2002, the MMG management team had met most of its Phase One goals and was developing detailed action plans to move into Phase Two.

Olsen Says Goodbye

In mid-October 2002, Olsen announced her plan to retire in January 2003. Olsen felt that she could say goodbye knowing that she was leaving MMG in good hands and headed in the right direction. But, she still had to decide what to tell the board chair the following day. How could she summarize the key issues that her successor would face in managing MMG? What actions should she recommend to address these issues?

NOTE

1. RVU stood for relative value unit. An RVU was a physician productivity measure calculated by using a multilevel factor system to assign a set value to each clinical service based on the complexity of the patient visit. More complex services were assigned higher RVUs than less complex services to reflect the additional work performed in providing these services.