

Driving Performance Improvement for Hospital-Owned Medical Practices



Live teleseminar with Marc Halley
President and CEO of Halley Consulting Group
and author of
*The Primary Care-Market Share Connection: How Hospitals
Achieve Competitive Advantage*

KEY POINTS:

- 1) Identifying common mistakes hospitals make when acquiring medical practices and employing physicians.
- 2) Learning from the past and avoiding the repetition of these mistakes.
- 3) Developing the strategies and tactics to position medical practices for success.
- 4) Employing the processes and tools for medical practice financial viability.

***Medical practice financial viability
is dependant upon physicians being
engaged at the practice level and at
the network level.***



**Ralph
Harding:**

Good afternoon, everyone. This is Ralph Harding, your host for this exciting one-hour seminar with our guest, Marc Halley, who is one of the leading authorities in the nation on strategy and performance improvement for physician networks.

Today we will be visiting with Marc about driving performance improvement in hospital-owned medical practices. As a result of attending this seminar, you will learn the common mistakes hospitals make when they acquire medical practices and employ physicians.

You'll learn how to avoid these errors and how to develop the strategies, tactics, and tools to position and operate your owned and affiliated medical practices to achieve financial viability. This subject has dramatic implications because, as hospitals and physicians integrate more closely, markets are increasingly competitive.

Today we will be discussing a number of critical factors that affect the viability of a medical practice, based on the dozens of thoughtful questions that you, as healthcare professionals, posed to Marc during our Ask Campaign. We will be addressing just as many of your questions as we possibly can during this 60-minute broadcast.

However, all of the questions submitted during our Ask Campaign that we do not answer during the broadcast will be answered by Marc either by phone or e-mail.

First of all, let me call your attention to the blue handout link on the left-hand side of your screen, just below the Welcome to the Seminar heading. Please print the handout and be prepared to take copious notes on the sage counsel that we will be receiving from Marc today on this most important topic.

Before we begin the interview with Marc, let me provide you with a view of his rich background in healthcare. Marc D. Halley is President and Chief Executive Officer of Halley Consulting. Marc has provided management and consulting services to medical practices for more than 20 years, and has worked with a variety of specialties, including hospital-owned practice networks across the United States.



He has negotiated numerous contracts to acquire medical practices on behalf of hospitals in highly competitive environments, served as Senior Operating Officer of primary care networks, facilitated the financial turnarounds of hospital-owned medical practice networks, and worked with physicians to take primary care networks into risk-sharing arrangements, including carrier contract negotiations for a 100-physician primary care panel.

He also developed and implemented numerous models and tools to assist physicians and managers to track and improve medical practice operations. His supervisory training program has been taught to medical office managers around the country.

Marc is a frequently requested speaker addressing governing boards, senior executives, physician groups, and management teams, as well as national organizations.

Marc's first book, The Primary Care - Market Share Connection: How Hospitals Achieve Competitive Advantage, was released by Health Administration Press in March 2007.

In December 2007, Marc contributed to a three-volume set, titled The Business of Health Care. Marc was also a contributor and co-editor of The Medical Practice Start-Up Guide, released by Greenbranch Publishing in August 2008.

He received his Bachelor of Science degree from Weber State University in Business Administration Management, and his Master of Business Administration degree from Utah State University.

Marc, we're delighted to have you on the call. You will be interested to know that over 100 healthcare professionals from across the country have joined us today for this most valuable seminar.

Let's talk for just a few minutes, if we could, about some of your experiences in assessing what drives medical practice financial viability. Was there a specific practice you worked with early on in your career that served as a catalyst for your passion in this area?



**Marc
Halley:**

Ralph, thank you. Actually, it was my experience working with a hospital-owned medical practice network of several practices that motivated my search for best practices.

Early in my work with this particular network, I made the fundamental error of assuming that the losses apparent on the income statement were a function of expenses being out of line - not an uncommon mistake - and labor, of course, being among the most significant of those expenses.

However, over the next few months, as we reduced labor costs, performance actually worsened. I was embarrassed and confused, and I went back to the drawing board.

Using simple ratio analysis, I soon discovered that the root problem was actually on the revenue side of the income statement. That low revenue was driven by a variety of issues, not the least of which was low physician productivity.

By focusing on the many of the eight revenue factors that we will discuss today - and in some cases, actually increasing labor costs - we drove additional revenue and improved the performance of that network markedly.

Ralph:

Most interesting. That is such a perfect background to provide context for our seminar today. I'm very excited to pose to you just as many of the very insightful and, actually, very perceptive questions that we've received as possible.

Let's begin with this first question: "What are the common mistakes hospitals make when they acquire medical practices and employ physicians?"

Marc:

Ralph, this - like all of the questions that were submitted - is a great question. This one, in particular, though, is a wonderful question to start the session because the answers lead to so many of the questions we received from those who registered.



As we speak around the country, we often use a slide titled “Where Did Hospitals Go Wrong Last Time?” That slide includes 12 key factors that describe the common mistakes hospitals are making today as they acquire, start, or expand medical practices they own and operate.

Sadly, this slide is virtually the same slide I was using in 1994 during the first round of physician employment by hospitals. In fact, those 12 factors were the basis for our 12 Mistakes Self-Evaluation Questionnaire that we use with our new hospital clients.

Ralph: During our April teleseminar, you agreed to provide some tools for our listeners. How would you feel about making the 12 Mistakes Self-Evaluation Questionnaire available for our listeners on this call?

Marc: We planned on doing that, so we’ll be happy to make that available.

Ralph: Excellent. The next question we received used to be posed quite often, and can be very perplexing, I think: “When structuring the acquisition of a medical practice, how do we determine the balance between fair market value and good will?”

Marc: Ralph, during the first cycle of physician employment, which started in the mid-1980s and lasted until the late 1990s, hospitals frequently got into bidding wars for largely primary care practices. They paid significant amounts of money for “goodwill,” the goodwill value of those primary care practices.

This goodwill was usually amortized over a few years, wreaking havoc on medical practice income statements, of course, and contributing to the frustration of physicians, management, and board members alike.



During Round 2 of physician employment by hospitals, which started in late 2002 or early 2003, hospitals had so far avoided paying much - if anything - in terms of goodwill. They're paying for tangible assets only.

Some hospitals, however, are committing an even more insidious error by paying specialty physicians unsustainable salaries in order to protect hospital service lines. I say "more insidious" because the goodwill of the first cycle could be amortized over a few years; whereas compensation stays with us, potentially, for the long term.

Ralph:

Thank you, Marc, for that excellent background and clarification about market value and goodwill in practice acquisitions.

Listeners, if you will refer to your handout, on Page 2 and Page 3 there are some blanks there that we will guide you to fill in. In the box on the bottom of Page 2, the blanks should be filled in "medical practice income statements," "physicians," and "board members."

That box should read, "Paying significant amounts for goodwill in a practice acquisition has a negative impact on medical practice income statements and frustrates both physicians and board members."

In the second box, which is at the top of Page 3, the blanks are "unsustainable salaries." "In the second cycle of physician employment, some hospitals are committing an even more insidious error by paying specialty physicians unsustainable salaries in order to protect hospital service lines."

Interestingly, the next question deals with the insidious error you just mentioned. Our listener asks, "From a strategic point of view, what are the most important factors we should consider in our primary care and specialty care physician recruitment efforts?"

Marc:

Performance expectations, combined with a realistic understanding of the commitment the hospitals are making, are two of the most important factors. What do we expect out of the practice and what will it cost for us to be in this business?



First, let's focus on performance expectations. The hiring, coaching, and keeping the very best providers and staff require an investment which inevitably provides an excellent return in physician productivity, as well as clinical quality care.

The system we utilize to help our clients recruit physicians that are an optimum match for their hospital or owned medical practices is based on the insight we've gained from years of experience. It includes things like correlating personality, core competencies, culture, the types of procedures that the candidate is interested in, expected volume and productivity preferred volume of the candidate, and the candidate's personal values to make the best possible match.

In our experience, employed physicians are just as smart and just as capable of achieving financial viability as are their successful private practice counterparts.

Most private medical practices, of course, break even. There's a goose egg on the bottom line at the end of the year. They pay all their bills, they service their debt - which, of course, is the most common source of private practice capital -, they fund their retirement, and they pay their physicians a market rate of compensation.

If we employ the right physicians and treat them like partners, and follow the correct operating principles for medical practice success, we can usually create a viable, hospital-owned physician entity.

Now, as to "the commitment the hospital is making." When we help our clients purchase and establish a practice, we expect that practice and the employed physicians to remain financially viable right from the start.

When we help our clients start a new physician practice or add a new physician to an existing practice, we anticipate that that practice will experience some operating losses for anywhere between six and as many as twenty-four months, depending on the specialty and the market circumstances.



We call these new practices “investment practices,” whether they’re a cold start - by that, we mean starting a physician from scratch in a new location - or warm starts, meaning adding a new physician to an established practice.

However, investment practices require operating capital to cover those losses during that start-up period, and that operating capital for a cold start in a competitive market may be as high as a half-million dollars. So this is a real investment that board members, managers, and hospital executives, as well as the physicians themselves, need to appreciate and understand.

Ralph:

Thank you for providing some very excellent criteria for successful physician recruitment.

For those of you who are following along on your handout, on the bottom of Page 3 the blanks in that box should read, “Hiring, coaching, and keeping the very best providers and staff require an investment, which inevitably provides an excellent return in physician productivity and clinical care quality.”

Then, on the bottom of Page 4, the blanks are “Cold start refers to a practice started from scratch. Warm start refers to adding a physician to an established practice. We call these new practices investment practices.”

Marc, listen to this next very challenging question. “When developing our market penetration strategy, what tools are available to accurately determine if physician capacity already exceeds the demand for services in a given community?”

Marc:

Ralph, this is a very legitimate question, and helps determine whether we need to add capacity or try and acquire existing practices in particular neighborhoods or communities.

Oftentimes, hospital competitors see the same community-need data, and simultaneously add new physician capacity to the same markets or neighborhoods.



In some metropolitan areas, this flurry of new physician capacity already exceeds the demand for services, particularly in choice, targeted neighborhoods, making it very difficult - if not impossible - for these new practices to ever reach financial viability.

In some markets, big boxes - which are basically off-campus MOBs - are being built, new practices are being opened, and new physicians are being recruited to neighborhoods with only limited understanding of how primary care practices attract patients and keep them, and with precious little analysis of local market segments and available market share.

This is an astute question, because we rarely hear hospital executives being concerned about market saturation. The tools and the process we use to evaluate the potential market for services are described in detail in my first book, The Primary Care - Market Share Connection, in Chapter 7, pages 100-105.

Let me very briefly provide a description of the process and tools we employ to make the determination our listener is asking about. As our hospital clients have learned, the process of retail analysis and strategy development is not conceptually complex, but it does take a different mindset than has been traditionally employed by hospitals and hospital executives.

Retail analysis requires not only an understanding of the population within our targeted market, but also analyzing our competitors' retail penetration, as well as supply-and-demand data for each primary care specialty.

Once this information is collected, the capacity needs for my specialty will surface, strategic needs will surface, and the number of locations where there are plenty of PCPs already practicing in competition with us will become apparent.

The objective of, then, retail analysis in the targeted area - which is usually identified by various zip codes - includes whether additional PCPs are needed, what type and how many are needed, where the additional PCPs are needed, when they will be needed - if there are



retiring physicians or physicians over age 55, we start worrying about that - and the development of tactics, then, to address the identified opportunities for additional services.

This analysis process will involve, also, a very clear market definition, certainly demographic analysis, then competitor analysis, and geographic location of your existing hospitals, ambulatory service settings, and so on, as well as each hospital's affiliated and employed physicians.

In addition to those factors, provider capacity within those practices, payer analysis, drive-time analysis, capacity opportunity analysis, as we call it, and so forth, are all used along with other tools to develop a sound strategy. We load all those factors into a mathematical matrix that helps us prioritize, then, which zip codes we should go after first, second, third, and so forth.

Ralph: Listeners, you can obtain The Primary Care - Market Share Connection by visiting www.HalleyConsulting.com and clicking on 'Publications.' Then you'll be able to obtain all of this valuable information that Marc has just provided, in written form.

Marc, I believe you'll enjoy this next very excellent question. The listener asks, "We have had some differences of opinion and vigorous debate within our leadership team about whether we should allow our hospital-owned medical practices to maintain ancillary services. What are your thoughts, based on your experience?"

Marc: Let me first say to the listener that you're not alone. Hospitals routinely strip out existing ancillary services or fail to add ancillary services usually found in small primary care and specialty group practices.

This blunder creates two significant problems. First, when we strip out ancillaries, diagnostic, or even procedural services from primary care and specialty practices, we disappoint our customer, who expects, certainly, basic laboratory, radiology services, and procedures common to the specialty in a convenient and accessible one-stop shop. I'm not even talking about down the hall, down two stairwells, and so on and so forth, but literally in the practice itself. So, first, we disappoint our customer.



Second, by eliminating ancillaries, we remove anywhere from 15-30% or more of traditional net revenue found in successful private primary care practices, in particular.

In fact, when we work with private cognitive practices, a rule of thumb we use is the fact that they must generate 20% of their net revenue through ancillary services if they're going to remain viable.

When these capabilities are removed or withheld from already full practices, physicians are unable to compensate for that lost net revenue through additional cognitive services alone.

The rationale for this common hospital tactic is some potential for improved reimbursement at the hospital level, and additional revenue to the hospital bottom line; but at what cost? Our patients are disappointed and our practices lose even more money, requiring additional infusions of capital from the hospital.

The practices are going to get the money, one way or the other. Why not invest it in terms of capital up front in additional services, where it will please our customers and do some good in terms of practice performance?

Ralph: Thank you.

Listeners, if you'll look on the bottom of Page 6, the box should read as follows: "We disappoint our customer who expects these services," and "We remove 15-30% of the net revenue coming in from procedures and ancillary services."

Then, over on Page 7, be prepared for the next blanks that we'll be filling in after this question that we now present to Marc: "Over the years, physician productivity levels in many of our hospital-owned medical practices have jeopardized their financial viability. What understanding can you provide on this subject, particularly as it relates to productivity incentives and compensation models?"



Marc:

Ralph, frequently physicians are looking for hospital employment to secure their incomes. Some hospital executives accommodate this desire by offering high-based salaries with very limited incentives. Many of these salary offers are actually more lucrative than the incomes physicians were experiencing in private practice, not to mention the additional benefit packages and the costs associated with those.

Often, the incentive thresholds in these high-based salary models are set so high as to be impractical. As many physicians move from the traditional private practice, eat-what-you-treat compensation approach to a high-based salary model, their incentive to work declines. In addition, some physicians leave private practice for employment so they can “slow down” and enjoy a more palatable lifestyle.

Also, many younger physicians have a different work ethic. Some want part-time employment. There are more women physicians trying to balance both work and family; a huge challenge. As a result of these and many other factors, employed physician productivity usually falls significantly.

As this insightful question indicates, physician productivity is the key driver of revenue and, ultimately, success in a medical practice. The main driver of physician productivity is the compensation model, which we’ll discuss in a minute.

Physician productivity is also heavily influenced by what happens in what we call “the productivity zone.” The productivity zone includes the examination rooms, the nurses’ station, and the physicians’ workstation. A crucial key to productivity is to remove everything that does not enhance physician and nurse productivity from that productivity zone.

Physicians should do what only physicians can do. As their first priority, clinical assistants should ensure that patients feel well cared for. As their second priority, the clinical assistants should focus on driving physician productivity; in other words, keeping the doctor moving and on schedule. The clinical assistant can’t fulfill those obligations if he or she is on the phone, making referral calls or whatever the case may be.



So, all other duties that don't involve the particular physician and the clinical assistant/nurse seeing their patient population during that day should be removed from that productivity zone and assigned to others.

As to the compensation model, we have implemented our best practice compensation approach in a variety of settings and specialties around the country. Those who have followed our recommendations for best practice have been successful in motivating their physicians to higher levels of productivity and income.

In order to be an effective motivator, we have learned that physician compensation needs to include four very important factors. First, there needs to be significant financial risk involved. Private practicing physicians have to meet a payroll every other week. That's great motivation to see that patient who calls this afternoon at 4:45, 15 minutes before I want to close.

Second, productive behavior needs to be rewarded quickly, as opposed to even quarterly bonus payouts, which can occur as much as four months after the productive behavior.

Third, the model has to emphasize productivity, and not be diluted by other factors.

Fourth, the model must be sustainable, meaning we can't pay out more than the physician earns and the practice can afford.

Our approach uses work relative value units (RVUs) as the basis for measuring productivity. Work RVUs allow the physician to be payer blind in the exam room. RVUs also promote improved coding, which of course, must be supported by adequate documentation, which we can check.

The rate paid per work RVU is a function of a market rate of pay for the specialty and what the practice can afford. Base pay is usually about 50% of what we anticipate the compensation will be for the physician, and is determined by taking 50% of the last 12 months' work RVUs, multiplied by the rate per RVU. That's the base pay, and that base amount is paid out over 24 or 26 pay periods, depending on the payroll schedule.



The production component is determined by taking 50% of the average work RVUs generated during the most recent three months - a three-month moving average - and applying that same rate per RVU. So, taking half of each and bringing that together gives us the production pay amount and the base.

The production pay is distributed, then, on the second payday of the following month. So, there can be as few as 10 or 15 days - or even fewer days - between my behavior and what I see in my paycheck.

Many have asked us about the value of attaching expense management, bottom line performance, clinical quality measures, and patient satisfaction to the compensation model. Although we've done so in the past, I'll share a personal bias, and I think it's based on some valid experience.

Again, we remember the most important driver of practice success is revenue, and productivity is the key to that revenue; and compensation is the key to productivity.

I prefer not to dilute the productivity pay with any other factors. Besides that, expense management, bottom line performance, clinical quality, and patient satisfaction are better dealt with as operational governance and management issues.

Ralph:

Listeners, if you will look on Page 7, fill in the box there with “Physician productivity is the key driver of revenue and ultimate success in a medical practice. The compensation model is the main driver of physician productivity.”

Then, on the following page, “The most important driver of medical practice success is revenue. Productivity is the key to revenue. Compensation is the key to productivity.”

Marc, here's another great question: “What should we be sensitive to in regards to driving performance improvement in our hospital departments versus driving performance improvement in our owned medical practices?”



Marc:

Thank you, Ralph. That's a great question. When I was a hospital and a health system executive I learned that correcting budget shortfalls in a hospital department usually required focused attention on the expense side of the income statement.

Of course, variable expenses accounted for as much as 50% of our cost structure in the hospital business. We could usually cost-cut our way out of short-term financial performance problems. Such is not the case in a medical practice.

Seventy percent or more of a medical practice cost structure consists of the physician and support staff: labor costs. These human resource costs are largely fixed in the short term. We don't lay off a receptionist because the doctor takes a week's vacation.

Add to that labor cost the cost of occupying a building which is again, another fixed cost, and the cost of clinical supplies, the fourth factor, and you've identified as much as 85% of your cost structure in a medical practice setting; clinical supplies obviously being the only variable cost in that list.

Some hospitals found out the hard way, as I did early in my consulting career, that cutting labor costs in a medical practice will frequently decrease performance in terms of physician productivity, service quality including access, and clinical quality, ultimately making poor financial performance even worse.

Ralph:

Most valuable information. Listeners, we're now on page nine of our handout where you will find a summation of those very important factors that Marc just discussed.

Marc, here is a great question from one of our hospital executives that has attended some of your public speaking engagements. She asks, "What are some of the less obvious pitfalls that we should be aware of in our hospital-owned medical practice performance improvement initiatives?"



Marc:

Ralph, this is a great question. Let me speak just momentarily about several of the mistakes that seem to fly under the radar when we as hospital executives get into this new business.

First of all, sometimes a major motivator for physicians to seek hospital employment is to provide improved employee benefits for themselves and for their support staff members.

Now, while some hospitals do indeed develop different - to be interpreted as lesser - benefit packages for their owned medical practices, most treat their practices like any other department of the hospital and offer full hospital benefits to all employees.

Ethical considerations, perceived fairness, ease of administration, and other reasons are an easy sell, and there is no question that the practice employees benefit from this generous offer, at least in the short term.

Unfortunately, the medical practice business model cannot support the benefit levels routinely provided to hospital employees, and so such generosity guarantees financial losses.

Second, hospitals frequently agree to provide new or remodeled physical space for a medical practice they purchase or practices they start from scratch. Soon, practices that are or were viable in space costing \$10 or \$15 per square foot per year are located in new or remodeled space that costs \$20, \$25, or more per square foot.

So, occupancy costs, which previously totaled four to eight percent of net patient revenue depending on the specialty, now consume as much as ten or 15% of net patient revenue.

In addition, while private medical practices because of the way they attract capital are usually forced to add space incrementally, many hospitals continue to pursue our traditional “build it and they will come” mental model by building or leasing space to accommodate planned growth over the next several years, and then leaving that space empty.



Placing two employees in 10,000 square feet of space, which is enough for six or eight depending on the specialty and the office schedule, and charging the full lease cost to that cost center, is not an uncommon practice.

Third, instead of hiring an experienced medical practice network executive, many hospitals assign a bright, assistant administrator to lead the practices. These young executives learn the hard way the differences between the hospital and medical practice network administration. This on-the-job training process creates frustration for everybody involved.

A few hospitals do seek and hire an experienced group practice administrator to manage their networks. Some of these experienced administrators fail to make the transition from group practice administration, from its common single culture and single physician governance, to a network with multiple sides, multiple cultures, and operating within a hospital bureaucracy.

A fourth common mistake that sometimes is ignored, since there is only limited appreciation for the differences between medical practice and hospital businesses, many hospital centric organizations focus their energies on financial reporting to hospital boards rather than on managerial accounting to improve performance.

Medical practice income statements are developed using a hospital footprint rather than being comparable to medical practice benchmarks. Additionally, practice management software decisions are sometimes limited to the hospital software vendor who happens to have a practice management system as a sideline rather than making the best decision for this unique medical practice business, and potentially sacrificing service and efficiency for the entire medical practice network.

A fifth problem, most hospital executives enter the medical practice business without understanding the basics of successful physician integration. We don't invest the same effort to understand and implement critical success factors in this new business as we do in the hospital business.

Most hospitals have no primary care retail strategy guiding the placement of their primary care practices, or where they acquire practices. Even fewer hospital executives place any emphasis on actively managing



referral relationships between primary care physicians and affiliated specialists or hospital services. These relationships are largely left to chance.

A sixth mistake, in the early days of physician employment we thought that we would make up any losses we experienced in our hospital-owned medical practices by driving additional volume through our capital generating engine, the hospital.

While this theory seems logical, two key factors get in the way of our success. First, many of the practices we purchase are at capacity and already admit their patients to our hospital directly or through referrals to our affiliated specialists. We're buying market share we're already receiving rather than incremental business, and sometimes we're paying too much for it to boot.

Secondly, hospital executives usually fail to anticipate the capital required to cover the significant losses we create by fouling up the established medical practices we do purchase. We fail to recognize the capital needed to start new practices and to capture incremental volume.

It's interesting, we often hear physicians say, "Think of my downstream revenue." We hear executives say, "Think of my downstream revenue." Remember, \$1.5 million in patient revenue on the top line at three percent yields a margin of \$45,000 when it hits that bottom line. That's not much if we're losing a lot on our practices.

Finally in this list, hospital executives have a difficult time holding employed physicians accountable for their performance and their behavior. The traditional medical staff models have usually failed to create any level of accountability, and our high-base salary compensation models fail to set the stage for that accountability.

Importantly, most hospital executives establish very few, if any, performance expectations, and many employed physicians are very unaware of the losses being generated by what were previously financially viable medical practices.



As I mentioned, these same mistakes are being made today by many hospitals that are, or have been, in the medical practice business. Now we're making the mistakes, however, in both primary care and specialty practices, and the losses per physician per year are climbing rapidly in many organizations.

Ralph:

That was an excellent answer to a great question. Listeners, the seven less obvious mistakes are summarized on page ten of the handout.

Marc, this next question strikes at the very heart of one of the most powerful ways hospitals can drive performance improvement in medical practices. Our listener asks, "What specific recommendations can you provide for structuring operational governance of hospital-owned medical practices?"

Marc:

This is a great question. It's a great question because it is the foundation, in our experience, for turning around performance of established medical practice networks and of course, the foundation for properly establishing a network in the first place.

Some hospital executives view physicians as employees rather than as business partners. They disengage these valuable human resources from business decision making in the practice setting. They fail to include employed physicians in the development of medical practice network strategy or in forming policies that affect the physicians' work lives.

Consequently, employed physicians do disengage and become technicians working for a paycheck rather than feeling ownership in the success of the enterprise, whether it's the individual practice or the network as a whole.

Ralph, we've discussed a number of things today, but without physicians being engaged at the practice level and at the network level, none of the principles and tactics we've discussed can be fully implemented.



We can make a few improvements here and there but without governance, without engaging the physician, we have a very difficult time getting to any type of full implementation.

What we call operational governance occurs at both levels. For our purposes here, operational governance has many of the same characteristics seen on fiduciary boards; however, most operational governance models do not have formal authority in the traditional board sense. They're not authorized.

Some are formed with formal board approval but they lack that same authority. They derive their authority from an officer of the organization - we usually recommend the CEO - who participates as a member and who has ultimate veto authority.

Operational governing bodies are subject to the same board-approved strategies and policies as every other council or committee or department of the integrated organization, but operational governance includes the responsibility to ensure the development of strategies in support of the larger organizations mission and strategic and performance objectives.

Operational governance also includes the development of performance standards, the establishment of performance improvement initiatives, and the review of financial and operating performance throughout the medical practice network.

Such governance holds a management team accountable for implementation of both network-wide and site-specific policies and tactics and initiatives. Operational governance involves the approval of operating policies and procedures affecting the business and the clinical sides of the affiliated practices.

It also includes recommendations to the board-appointed fiduciary, and/or to the board itself on such issues as budget and physician compensation which cannot be approved by the physician group itself.

The operational governing body cannot hire or fire or sanction employed physicians, although members will usually review performance and make recommendations to the hospital or integrated systems CEO who does sign the physician employment contract.



Operational governance is best provided, in our experience, through what we call a “council model.” A true council model is not a rubber stamp organization or an information disseminating vehicle. Just ask a network executive or practice manager who reports to properly functioning councils.

A council combines the expertise of knowledge workers, usually half a dozen employed physicians, with the line management authority of the CEO and the business expertise of one or two others to ensure the success of the physician network.

Council members provide line managers with counsel based on their content expertise which usually results in improved group decision making. A full-time practicing employed physician usually chairs what we call a Network Operations Council and works hand-in-hand with the hospital or integrated systems CEO on network-wide business.

Now, because council members participate in the decision making process they’re in a perfect position to become what Darrell Connor calls “sustaining sponsors” as the CEO and other implementers manage change within their areas of responsibility.

Because employed physician leaders participate in the decision making process they understand the factors affecting important decisions and they’re more likely to take ownership of those decisions.

Again, we use the term Network Operations Council to describe the physicians and executives who make network-wide decisions, who establish network-wide policies, and hold what we call a network executive accountable.

While employed physicians cannot be supervised in the traditional sense, they can be effectively held accountable by the integrated CEO, or hospital CEO, with the council of Network Operations Council experts who are also physicians.

For example, it’s not uncommon for a physician with behavioral problems to receive a visit from the CEO who signs the physician’s employment contract accompanied by the chairperson of the Network Operations Council, a full-time practicing physician as well.



This combination of clinical expertise and legal authority is perfect for the types of crucial conversations that are sometimes necessary in such sessions.

Importantly, the council model also includes a Practice Operations Council, or POC, at every practice site. The POC includes the physicians and other providers assigned to the location and the network executive.

Each POC is responsible for the successful operation of that medical practice location and holds the practice manager accountable for successful implementation of approved policies, procedures, and practice performance tactics.

The POC meets monthly and is responsible to ensure that the practice achieves its financial performance target within the timeline. The POC also approves practice staffing, reviews customer service performance, and works with the practice manager to improve processes that will enhance customer service, increase productivity, control expenses, and facilitate improved quality.

The practice manager is not a member of the POC but attends the meetings and is accountable to the POC and to the network executive for practice improvement.

Ralph:

That's a great description of operational governance. Listeners, if you will, refer to the box on page 11 of your handout and fill in the blanks with "practice" and "network."

On the following page, page 12, the box should read, "Operational governance is best provided through a council model."

Marc, you mentioned in your description a few moments ago, a network executive and practice managers. Can you describe your best practice management infrastructure for us?



Marc:

Yes, I'd be pleased to do that because it relates very closely to that prior topic.

Managers in our business are implementers. They support the council model we discussed just a few minutes ago, as I mentioned. Management infrastructure, therefore, needs to match operational governance.

Let's talk first about what we call a network executive. The network executive is responsible to ensure the effective implementation of what we call, network-wide initiatives - that is his/her job - that are approved by the network operations council and communicated to all physicians through the NOC meeting minutes.

Such initiatives will include policies and procedures that affect every practice, or at least multiple practices, within the network. For example, most practices have standard policies for revenue cycle management and to govern human resource issues.

Software decisions involving practice management and medical records are usually network-wide initiatives, so we have a single EMR and a single practice management system for the network.

Network development strategies, capital allocation, and quality assurance are also common Network Operations Council matters.

A critical role of the network executive is to ensure that every practice location is assigned a competent practice manager. Small group practice managers are rarely master prepared or even college trained. In fact, many of them started out as practice receptionists and lasted longer than anyone else.

They're often very bright, daily operations experts who have learned management on the job. They are like sponges when given the opportunity to learn the theories and principles about professional management.

They need to be provided with the tools, they need to be taught correct principles, and coached in their implementation in order to become management professionals.



These tools and training and coaching are provided at the network level through the network executive and others. Such support ensures that practice managers are prepared to work with physicians and other providers in Practice Operations Councils to successfully implement what we call “site-specific initiatives” that will drive performance both on the revenue and expense side in a particular site.

As implementers, the management team, the executive, and managers, work for councils and supervise support staff, both clinical and non-clinical, to achieve the organizations objectives as they are defined by those councils.

The physicians and other providers are accountable to those same councils.

Ralph: Listeners, if you look again on page 13 of your handout, the key point in that box is, “Managers are implementers and should support the council model.”

Marc, you’ve provided us with some wonderful information today. Talk to our listeners about the results that Halley Consulting Group clients are experiencing from implementing the counsel you’ve provided us today.

Marc: Ralph, we are typically engaged to assist hospitals and health systems that own medical practices and are sustaining substantial losses each month.

Oftentimes there are scores of providers who are working in multiple sites. Productivity is low and physicians have no direct control over their income and little influence in the decision making process of the network.

As we work with these networks to implement the compensation model we’ve described today, as well as the governance model based on operating councils, we’ve seen many positive effects including significant improvements in physician productivity and physician income,



improvements in physician morale and quality of care and caring along with the corresponding financial performance improvements, including collective cash, which of course leads to financial viability of all of these owned medical practices.

In fact, we encourage our governing bodies to base all decisions on four key filters:

1. Does the decision maintain or enhance clinical quality?
2. Does it maintain or enhance service quality?
3. Does it maintain or enhance physician productivity?
4. Does the decision, policy, or procedure maintain or enhance operational and financial viability?

Ralph: Excellent. Thank you.

This has been a most informative and valuable hour. Thank you for teaching us about driving performance improvement in hospital owned medical practices. It's been so helpful to review with you the critical issues regarding this important subject raised by our listeners.

Marc, what is the best way for our listeners to contact your company to arrange for an organizationally specific analysis of their health system, hospital, or group practice?

Marc: Ralph, whether our listeners are just getting into the business and needing to develop a business plan based on correct operating principles, whether they need their established networks examined and a path developed, a plan developed, to move them from where they are today to financial viability, or whether they need a subset of one of the tools and models that we've dealt with, they can reach us very easily in one of two ways.

One, of course, we have our Web site www.HalleyConsulting.com, and also an 800# which is 1-866-706-5373 and they'll be talking with one of our fine business development executives. We'll look forward to hearing from those who are interested.



Ralph: Thank you, Marc, for joining us today and providing tremendous insight which I know will be so valuable to our listening healthcare professionals.

Is there any parting thought that you would like to convey prior to the conclusion of this event?

Marc: Let me just say, Ralph, that we wander into a number of settings in many states where managers and board members have given up on reaching financial viability in the practices that they own and operate. That's not a good place to be.

Given our experience in multiple settings and multiple markets, I'm confident that working with the board members, management teams, and physician leaders, every organization can ultimately be brought to financial and strategic viability.

Ralph: That is a very encouraging prospect I'm sure, for most, if not all, of our listeners.

A special thanks to all of you who invested your time today to join this seminar. For your convenience and the convenience of your colleagues who may not have been able to attend, a recording of this seminar will be available on the Halley Consulting Group Web site along with a written transcript of the entire interview for your use.

We will give you notice within the next few days so you can visit the Halley site at www.HalleyConsulting.com and access this most valuable information.

Until then, our most kind regards and appreciation for the opportunity to be with you today.