

If You Build It, Will They Come?

Growing and Sustaining Your 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) Critical components of successful physician recruitment.
- 2) Practice acquisition criteria.
- 3) Fundamentals of physician on-boarding and integration.
- 4) Positioning your owned medical practice network for market leadership.

The purpose of an integrated network is to capture and retain market share in primary care practices and to attract that market share to our specialty physicians and to our capital-generating hospital.



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 growing and sustaining your hospital-owned medical practice network. As a result of attending this seminar, you will learn the critical components of successful physician recruitment, practice acquisition, physician on-boarding and integration as foundational pillars that will position your owned medical practice network for market leadership.

The content of our discussion today is driven by 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 email.

First of all, let me call your attention to the blue handout link in the middle of your screen just below the “Welcome to the Seminar” heading. Please print the handout and be prepared to take copious notes on the clear 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, management teams and 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 Healthcare*. Marc was also a contributor and co-editor of *The Medical Practice Start-Up Guide*, released by Greenbranch Publishing in August 2008.

His newest book, *Owning Medical Practices: Best Practices for Sustainable Results* will be released by the American Hospital Association's AHA Press in January 2011.

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.



Marc Halley: Thank you very much, Ralph. My pleasure.

Ralph: You will be interested to know that over 100 healthcare professionals from across the country have joined us today for this most valuable seminar.

I'd like to begin by talking for just a few minutes about your perspective as it relates to assisting hospitals through the process of planning, growing, and sustaining hospital-owned medical practice networks by presenting the first question from one of our listening hospital executives. She asks, "Would you please define what you refer to as network development?"

Marc: Sure. Thank you for this question. Network development is the process of creating a multisite network of affiliated primary care physicians and then integrating that network with affiliated specialists and hospitals.

The purpose of an integrated network is to capture and retain market share in primary care practices and then to attract that market share to our specialty physicians and to our capital-generating hospital. Network development tactics range from the least integrated membership on a hospital medical staff or medical directorships to the increasingly integrated joint ventures, professional services arrangements, and of course, physician employment.

Our definition of network development goes well beyond the traditional medical staff development plan which is often little more than a physician recruitment list. Ideally, building an integrated network starts with a hospital's strategic and



mission objectives which are supported then by market share targets that will lead to the required admissions.

Market share targets define the required numbers of affiliated primary care physicians located throughout the targeted geography. Those market share targets then also define the required specialty physician services and the capacity required. Once these quantitative targets are clarified, the appropriate implementation tactics can be identified based on current and projected market conditions.

For example, if my competitors are buying up primary care practices around the community, I will likely need to respond in kind to protect my market share. If the competition is not as intense in my market and my affiliated physicians are not vulnerable to competitive offers, I may deploy physician liaisons to strengthen relationships between referring physicians, specialty physicians, and the hospital.

Ralph:

Very good. Thank you, Marc. Let's look, if you would, listeners, on page two of the handout. Marc has just given us the answers for both of the boxes on that page.

The first box should read: "Building an integrated network starts with a hospital's strategic and mission objectives which are supported by market share targets." So the answers there are "strategic" and "mission."

The second box on page two should read: "After clarifying market share targets, we can identify appropriate implementation tactics based on current and projected market conditions." So fill in the blanks with "current" and "projected."

Marc, our next question from one of our listeners is, "Can you elaborate on the tactics hospitals are using today to develop their integrated networks?"



Marc:

Well, Ralph, this great question could consume the entire hour. During the past five years in particular, we have worked in more than 70 cities around the country, and we've seen a variety of strategies and "deals," if you will, between physicians and hospitals.

We recommend that our clients offer their targeted physicians and medical groups multiple options or places to plug in to the integrated network. Given our time constraints, let me share six broad categories from the least integrated and the least sustainable to the most integrated and sustainable.

The first, of course, is the traditional medical staff membership supplemented by a relationship management or liaison program. Medical staff members remain independent, but the hospital CEO, who we call the "Market Manager," and other business development staff are out actively maintaining relationships, especially with primary care physicians who may no longer darken the hospital doors due to successful hospitalist programs.

The second option includes medical directorships or co-management agreements which contractually engage physicians or medical groups in service-line development or in other legitimate activities.

Again, moving toward the more integrated options, the third option includes joint ventures. Here I should mention that joint venture has sometimes meant simply giving hospital revenue to the doctors. Market share growth is always the first criteria we recommend to our clients considering a joint venture so that the hospital and the doctors both benefit from any joint venture relationship. Otherwise, in our experience, those joint ventures are not sustainable.

The fourth option—again, more integrated—includes a number of independent contractor models, often called professional services agreements or PSAs. PSAs come in many flavors, but



often involve physicians selling or leasing practice assets to a hospital and then contracting to provide medical services to the patients.

Obviously, the most structurally integrated model is the physician employment model, which is also the least vulnerable to competitive attack.

Now, one final model I'll mention is a hybrid we call a side-by-side arrangement. That arrangement places a hospital-employed physician in a private practice that is seeking a partner that cannot afford the risk of a new start up. We've seen side-by-sides work very effectively with private physicians who don't want to become employed but need a partner, if those arrangements are structured properly.

Ralph:

Thank you. Listeners, if you'll look on pages three and four of your handout, you'll see that these six strategies that Marc just explained to us are listed there.

Let's move on to the third question: "Would you talk about physician recruitment for a few minutes?" our next listener asks. "I understand that the challenge of recruiting new physicians has changed over the past decade. Can you explain the changes and the challenge of recruiting today's residents?"

Marc:

That's another great question. Years ago, this was in the early 80s, I still remember going to the bank with one of the first physicians I recruited for a hospital client. I helped him arrange for a bank loan to fund his solo primary care practice. Now those days of entrepreneurial risk are long past.



I also remember recruiting a number of PCPs and specialists using income guarantees, often with loan forgiveness based on community need. More recently, those income guarantees are not appealing to residents or fellows.

Today, most young physicians are looking for an employment option. They want to avoid the business of healthcare, and they often already have education debt exceeding \$100,000, and the idea of additional financial risk to start a business is just not appealing, even with loan forgiveness.

Most new doctors want a secure paycheck, guaranteed vacation, and a reasonable call schedule. Some approach practice today as a job rather than a calling. Some multi-specialty groups that have been fortunate enough to employ new physicians on their own are finding that the young folks have different career objectives, a very different work ethic, and no desire to “buy in,” if you will, so the senior physicians can retire.

Ralph:

Very interesting!

Listeners, on page five of your handout under question number three, fill in the blanks with “employment option.” “Today, most young physicians are looking for an employment option.”

Marc, you’ll find this next question interesting; it’s an excellent question: “Given the competition for the best new physicians, what sourcing methods do you recommend to your hospital clients?”

Marc:

Well, sourcing the occasional physician candidate or the unique specialty may require a trusted professional recruiter with a national reach. However, a more active physician



recruitment program, particularly in the primary care specialties, often requires the development of relationships long before a candidate is ready to make a decision.

Hosting a residency program can be very expensive for a hospital, but provides unique access and insights into the best in class. Building relationships with residency directors and programs in your region is another great strategy.

Providing residents with education about practice selection and practice management can be a great relationship-builder. Such relationships provide the upper hand, in our experience, in competitive negotiations, and the regional training ties facilitate retention.

Ralph:

Listeners, in the second box on page five just under question four, the answer is “development of relationships.” So that box will read: “An active physician recruitment program often requires development of relationships long before a candidate is ready to make a decision.”

Marc, here is our next question: “My recruiter tells me that a great time to pilfer new physicians from the competition is two years after they start their first job coming out of residency. Is that true, and if so, why?”

Marc:

That’s true! According to some very credible studies and according to our experience recruiting physicians, many new physicians will change “jobs” within the first five years.

Now understandably, young doctors really don’t know what they’re getting into when they pursue their first practice opportunity. Again understandably, many young physicians have not taken the time or don’t know how to assess



practice opportunities beyond the basics of, “What’s my compensation?” “How much time off will I have?” and whether or not the other doctors are “good guys.”

Relatively few recruiters put the time and energy into defining a practice opportunity thoroughly enough to truly match candidates beyond their specialty, their particular credentials, and whether or not they interview well. Consequently, many young physicians become disenchanted within the first few years of practice.

Ralph: Great answer. Very helpful, I’m sure, to our listeners.

Turning to page six on the handout, the answer in the box at the top is “five.” “...many new physicians change jobs within the first five years.”

Marc, our next listener question says, “We have learned from experience that hiring a physician who is not a good fit for our organization is very expensive. Is our experience typical?”

Marc: Unfortunately, it is. The costs of poor selection are potentially enormous. Starting a brand new primary care practice can cost between \$250,000 and \$500,000 in operating losses alone during the first few years as the practice reaches viability by capturing patients that are attracted to that particular physician.

If the resulting market share is captured and retained over several years, this investment is returned over time in downstream revenues to affiliated specialists and hospitals. But remember, only a portion of that downstream revenue replenishes the capital bucket in a hospital, usually two to five percent, so it takes some time to realize the return on investment, or ROI.



If we subsequently lose the primary care physician due to a poor match, we do not realize that full payback. Often much of the market share that he or she captured dissipates even if other physicians are available to take the load.

There are other hidden costs of poor selection, of course; the new physician who requires an inordinate amount of management attention, for example, imposes a hidden cost on the organization.

The cost of selecting the wrong specialty physician can be significant as well. Again, there's usually significant start-up cost to cover the operating losses over the first year, although they're usually not as much as primary care.

In addition, the referral relationships with established primary care physicians can be lost to competitors if the specialist parts, and unhappy or poorly behaving specialists can also have a devastating effect on his partners and on the hospital's affiliated service lines—a cost that is difficult to measure, but oh so real.

Ralph:

Very real indeed.

This next question is from an executive who attended one of your speeches. He asks, “Marc, in one of your presentations that I attended, you mentioned opportunity development in relationship to selecting the right physician candidates. Could you please elaborate on this concept so that I can understand how we can make certain that we are recruiting and retaining the right physicians for our owned medical practices?”

Marc:

Thank you, that is a great question.



A fundamental principle for successful physician recruitment and retention is developing and documenting in advance a very clear picture of the practice opportunity.

Details about the partners, about how decisions are made, about the patient population, about the workload and the pace, about the staff, about the hospital, about the need for additional capacity, the payers and payer mix, about call coverage, about the community, and many other facts can be documented efficiently and effectively in what we call a Practice Opportunity Prospectus.

The term “prospectus” illustrates the objective of the document, which is to highlight both the risks and the potential benefits associated with the opportunity. Now, the Opportunity Prospectus always includes a realistic pro forma income statement based on anticipated volumes. It also includes a detailed description of the “deal” for the new physician.

The prospectus may also document the on-boarding process, especially if that process includes a physician mentor. The Practice Opportunity Prospectus facilitates matching by providing a clearer view of the current or anticipated practice setting.

Ralph:

Thank you, Marc.

Listeners, we are now on page seven of the handout, and Marc has just given us the answer for the box at the top, which is “Practice Opportunity Prospectus.” “A Practice Opportunity Prospectus facilitates matching by providing a clearer view of the current or anticipated practice setting.”

Marc, our next listener question says, “Please give us your thoughts about negotiating with physicians. How do you



handle tough issues like the compensation model, a covenant not to compete, or performance expectations without scaring off new or established candidates?”

Marc:

Well, first let’s talk about new physicians. To use an old cliché, honesty is truly the best policy. If we feel that we need to sugarcoat or put a spin on our offer, perhaps we should reconsider the offer, or perhaps reconsider the candidate.

We often use a simple terms sheet, a page and a half, maybe two pages to discuss the key elements of what will ultimately be an 18- or 20-page contract. Those terms always include a discussion of issues that are most important to the candidates. So we discuss the salary support that we’ll offer during the start-up time period, which is usually 24 months for primary care and 12 to 24 months for specialists.

We then discuss the productivity compensation model they can expect after the start-up time. Now, as an incentive to help grow the practice quickly, of course, we’ll always allow new physicians to transition into that productivity model as soon as they can increase their own compensation. We allow them to flip, but not to flop.

It is in the terms sheet that we tackle many of those tough, tough subjects. They need to be tackled.

Although it’s not the topic of discussion today, let me mention that a properly functioning productivity compensation model for established physicians (so once they’ve come out of that guarantee period and become established), there are four key factors that result in a successful compensation model. They are:

First, allowing the physician to have control over his or her income based on performance.



Secondly, placing 30 to as much as 50 percent of that income at risk for an established physician.

Third, ensuring timely bonus payout, meaning monthly.

Fourth, the physician compensation model should promote practice viability by encouraging high productivity.

We do our young physicians a favor if we can teach them in advance what their productivity model will look like. Now, when we hire new physicians, we're hiring business partners. Those who don't want to play by the team rules or who want special allowances are not the right partners, let me tell you. Move on. If you cut special deals, you'll pay for them forever and eliminate any hope of building a cohesive network.

Let's talk for a minute about negotiating acquisitions of established practices. Before acquiring the first practice, hospital and physician leaders should develop a Physician Network Operating Plan. Even those who've already acquired but don't have such a plan in place need to do so.

The Operating Plan defines how the network will function in all ten areas of business administration. Those areas, as we define them at least, include:

- Operational governance, meaning the decision making and control factors
- Network growth and development, including recruitment and acquisition standards or criteria
- Management infrastructure, including how the implementation processes will be handled
- Practice and network promotion, including a physician's role in the growth of the practice (that's key, especially for young physicians)



- Human resource issues, including the physician compensation model.
- Practice operations, including our support staffing approach
- Revenue cycle management
- Information technology, including and in particular these days, what our electronic medical record will look like
- Facilities and equipment, including a discussion of the ancillary equipment that will be in the practices and how those decisions will be made
- Finally and importantly, performance expectations for our practices, and how we will measure performance in our practices

That operating plan is key and should be based on correct operating principles in each of those ten areas, and then it becomes “how we do things around here.”

New or established physician candidates can then choose whether or not they want to join our team and play our game, and again, if they don’t want to play our game according to our rules, according to our business plan, let’s just say no and move on to the next candidates.

One of the fundamental errors made by many hospital executives is telling potential acquisition targets that nothing will change after the sale. Not only is this untrue, but both parties should realize that it is unrealistic.

Certainly as these entities come together, things will change. The whole environment is changing. Of course things will



change, sometimes for the better and sometimes for the worst. We certainly want to keep the best practices we find in every acquired practice and share those that are relevant across our entire network, but becoming part of a network means that certain decisions will be made outside the practice, and we should be realistic about having those discussions with potential acquisitions.

Again, if we feel like we need to put a spin on the conversation to close the deal, don't close the deal. Talk about the tough issues and the reasons they're in your Physician Network Operating Plan, and if those terms are unacceptable before the sale, they will certainly be unacceptable realities afterward.

Ralph:

Thank you, Marc.

So listeners, the blanks in the box on page eight should be filled in with "increase their compensation." "Allow new physicians to transition to the productivity compensation model as soon as they can increase their compensation."

Now moving on to page nine, the box at the top refers to the Physician Network Operating Plan that Marc just described for us, so that box will read, "Before acquiring the first practice, hospital and physician leaders should develop a Physician Network Operating Plan."

Marc, here's another very excellent question for you from one of our listeners: "We just acquired a premier practice in town and now other physicians are approaching us expressing interest in practice acquisition. Some of those practices are not of the same caliber as our first practice; in fact, some are struggling to make it on their own. Could you please discuss what constitutes effective practice acquisition criteria, including common mistakes to avoid?"



Marc:

We have so many great questions. We could spend the afternoon trying to answer them all. This is a great one, and a real dilemma for executives who are not prepared to say “no” based on specific criteria.

The success of a hospital-owned physician network is defined by the practices the hospital acquires and the physicians it employs as well as by those physicians who don’t make the grade.

Since most hospitals eventually have limits on capital, we encourage our clients to establish clear criteria for acquisitions based on two very important strategic perspectives.

First, is the practice a strategic fit? Does it fall within our primary care retail strategy or our service-line specialty strategy? If not, let’s have the courage to say “no,” or at least, “not yet.”

Second, have the physicians been successful on their own? A failing practice will not be fixed by throwing in more capital, and let’s face it, hospital executives don’t have much of a sterling track record of managing poorly performing practices back to financial viability. If it’s broken before you buy it, it will be at least that broken after you buy it.

We encourage our clients to target only viable medical practices. By viable, we mean financially viable and operationally viable. Operational viability relates to the ability of physicians and their manager to make principled decisions and to implement correct business principles yielding high clinical quality, high service quality, high physician productivity, and financial viability including the physicians earning a market rate of compensation.



If a practice evaluation does not yield clear evidence of this type of success, we have to encourage management to say, “No. The practice does not meet our operating criteria.” That doesn’t mean that you can’t offer to assist with consulting services and try to help them move in the right direction, but the right answer for a practice that’s not viable is, “No, not yet.”

Ralph: Very good.

Listeners, on page 10 of the handout, fill in the blanks in the top box with “financially” and “operationally.” “Target only those medical practices that are both financially and operationally viable.”

Now let’s review the box at the bottom of page 10, which refers to operational viability. Number One should read, “High clinical quality.” Number Two is “High service quality.” Number Three is “High physician productivity,” and Number Four should read “Financial viability, including physicians earning a market rate of compensation.”

Again, that’s high clinical quality, high service quality, high physician productivity and financial viability.

Marc, will you explain to us what the role of a practice evaluation is in the practice acquisition process? A number of our listeners asked about that.

Marc: I’d be happy to, Ralph.

When physicians decide to sell to a hospital, they usually have three critical questions: First, what will the hospital pay for



the practice? Second, how will the physicians be compensated for their work after the sale? And third, how much control will the physicians have over their work lives subsequent to the sale? Those tend to be the top three; many others follow, of course, but those tend to be the top three issues.

When a hospital decides to buy a practice, many executives are tempted to immediately order an asset valuation as if the decision is solely financial. In reality, as discussed previously, the decision is first a strategic exercise and second, an operational viability review.

Ideally, the strategic exercise occurs during the development of a primary care retail strategy, or a service-line strategy review, or other hospital strategic planning processes. These plans help executives distinguish between the capital consuming temptations and the true strategic practice acquisition opportunities.

Operational viability is determined by conducting an evaluation of all ten areas of business administration within the practice itself. For example, if the physicians do not govern themselves and hold each other accountable in private practice, it's unlikely that they'll feel accountable once they're employed.

If practice management is incompetent or if productivity is low or if service quality is suboptimal, it's highly unlikely that the practice culture will change just because the practice is acquired and the physicians and staff are employed.

Ralph:

Very good. Thank you, Marc.

You will enjoy this perceptive question. "After a practice acquisition is consummated or a new physician signs on, what are the keys to smooth and successful physician on-boarding?"



Marc:

This is an area where many have fouled up in the past. Often there is so much focus on consummating the “deal” that little time and energy are devoted to the transition process in the case of an acquisition or to the start-up process in the case of a newly recruited physician.

The issues that must be addressed in a transition or a start up are almost identical, although our listeners will certainly understand that transitioning an established practice is usually much more complex than starting a new practice or embedding a new physician in an established practice setting.

We use what we call a transition action plan or a start-up action plan that addresses questions in all ten areas of business administration and beyond. Ideally, those action plans are implemented over a 180-day time period, but they can be accomplished in as little as 90 days. We have even implemented new practices in as little as 30 days, but there are consequences in terms of payer credentialing and new physician frustration.

If we take the time to do it right, the physician group can and will serve as a positive reference to others considering joining our network.

We recommend that physicians new to the area be assigned an established physician as a mentor. The mentor is ideally in the same specialty and located in the same practice or reasonably close by.

More importantly, select a mentor who can serve as an example in the areas of clinical quality, service quality, and productivity, who can say to the young new physician, “You’re worried about how to see 25 patients a day. Come on over this afternoon; I’ll show you how I do it.” That’s the kind of mentor we’re looking for.



The mentor helps connect the new physician with the right specialists in the area. The mentor also attends the monthly performance review and provides input to management and to the new physician regarding the progress of practice development. Along with the management team, the mentor becomes part of a support system for the new physician to help ensure his success and retention.

We also recommend that a relevant initial orientation be established for new physicians. This will not be the standard hospital employee orientation process, most of which has nothing to do with the new employed physician. Instead, it will be specifically designed to help the new doctor meet hospital-based physicians, learn about their service commitments to referring physicians, and learn how to connect with their departments.

The relevant orientation will also include learning the hospital's mission and vision and how the physician network and the physician's practice and the individual physician fit into that mission. The orientation also usually includes a detailed review of the practice pro forma and how the new physician and the management team will work together to ensure the successful development of the practice.

Ralph:

Excellent. Thank you very much, Marc. Listeners, let's go over the answers in the box at the top of page 12. The first bullet refers to the "transition action" plan. It should read: "Use a transition action plan, ideally implemented over 180 days, but can be accomplished in 90 days."

The answer on the second bullet is "mentor." "Assign a mentor to physicians who are new to the area." And on the last bullet, fill in "relevant orientation." So the last bullet will read: "Provide relevant orientation (not the standard hospital employee orientation)."



Marc, let's shift gears for just a moment; some of those attending asked questions about referral management. Many of those who have built physician networks seem to be frustrated by the number of patient referrals that leave the integrated system.

One of the listeners said, "We have heard that some hospital CEOs have issued a mandate that their employed physicians will 'refer domestic.' Are these mandates successful, and is there a better way?"

Marc:

Great question. Again, given the huge capital investment hospitals are making in medical practices, this question is certainly timely.

In my experience, whether those employed physician mandates are formal or informal, they certainly work. We see market share shift as physicians are employed by competitors. Sometimes the shift is immediate, at other times it takes several months; either way, referral patterns change as new relationships are built and as employed physicians recognize that their capital-generating engine is their affiliated hospital.

The real power of integration becomes apparent as referrals follow relationships, revenue follows referrals, capital follows revenue, and that capital is reinvested to strengthen the integrated system. That's the real power.

Many of our client hospitals have domestic referral clauses and non-compete covenants in their physician employment contracts. We recommend that clients make sure their legal counsel is comfortable with the language necessary to protect the hospital's investment, especially in primary care practices.



However, we recommend that specialists attract the referrals from primary care physicians by becoming what we call the “Specialist of Choice.” We also recommend that hospitals attract referrals from physicians by becoming what we call the “Hospital of Choice.” Paying special attention to referring physicians as customers is the preferred method of developing and maintaining appropriate referral relationships.

We can and probably should, Ralph, spend an entire session talking about referring physician needs, wants, and priorities, and the ways ambulatory specialists and hospital-based physicians and hospital departments can become the preferred providers for referring doctors. Today, though, let me share one simple, but I think significant, example.

Dr. Curtis Chastain, a general internist, accompanied me on a speaking assignment recently in Chicago. We were discussing developing and maintaining referral relationships with those who attended our presentation. Dr. Chastain shared with the group his experience with the hospitalists who work in his preferred hospital.

He indicated that when they are assigned to one of his patients, the hospitalist uses a Blackberry or an iPhone or some other PDA to call up Dr. Chastain’s profile, which contains this referring physician’s communication preferences and even preferred specialists if a consult is required. Each hospitalist then lives by those preferences to meet Dr. Chastain’s expectations. It is this type of attention to preferences that distinguishes a “Specialist of Choice.”

Our “Specialist of Choice” self-evaluation includes some 50 questions to assess how well specialists and their practices meet the needs, wants, and priorities of their most important customer, the primary care physician.

Now, the most important thing hospitals have to offer invasive specialists is the gift of time through responsive hospital-



based physicians and efficient hospital operations. The most important thing hospitals have to offer non-invasive physicians is, again, responsive hospital departments and hospital-based physicians.

Our “Hospital of Choice” self-evaluation helps executives assess their preparation to meet the needs, wants, and priorities of referring physicians and their patients.

Establishing what we call “choice” initiatives in the hospital and in affiliated specialty practices to actively meet the needs, wants, and priorities of referring physicians is critical to maintain relationships in increasingly competitive settings.

As I said in my first book *The Primary Care—Market Share Connection: How Hospitals Achieve Competitive Advantage*, referrals follow relationships and all relationships atrophy over time. Actively removing barriers to exceptional performance is key to maintaining referral relationships.

Ralph:

Thank you, Marc.

Turning to page 13 of the handout, listeners, we can fill in the blanks with “affiliated hospital.” “Referral patterns change as new relationships are built and employed physicians recognize that their capital-generating engine is their affiliated hospital.”

Then moving on to page 14 there are three blanks in the box there. Fill in the first blank with “choice” and the next two blanks with “maintain relationships.” So that box will read as follows: “Establishing ‘choice’ initiatives in the hospital and affiliated specialty practices to actively meet the needs, wants, and priorities of referring physicians is critical to maintain relationships in increasingly competitive settings.”



Marc, our next listener asks, “One of our objectives for our medical practice network is to engage our employed physicians as partners. How should we proceed to accomplish this goal?”

Marc:

Ralph, I alluded to structural integration earlier in this session. We also often hear the term “clinical integration,” which has become one of those thousand-dollar phrases sweeping through the hospital industry, often promoted by consultants.

Attempts at clinical or service integration are, in many cases, simply little more than a new organizational structure or a contractual arrangement accompanied by a few meetings in the hope that patient referrals will increase and that clinical coordination will improve.

But as many of us have learned, building an integrated network or entering into medical directorships or co-management agreements does not necessarily lead to improved integration of services or to improved clinical quality. True physician/hospital integration is a huge undertaking that requires attention to three key objectives.

First, the integrated network must **capture** patients or market share in primary care practices.

Second, the specialists and the hospital comprising the integrated network must **retain** that market share by providing top quality service, what we call “care and caring.”

Third, and very importantly, the PCPs, the specialists, and the hospital comprising the integrated network must **sustain** that market share by coordinating their efforts around evidence-based best practice.



I love the term “sustain.” Synonyms include words like “continue” or “prolong” or “support” or “without interruption,” which have special meaning as we consider them in the context of providing clinical care.

It is service to referring resources and their patients that motivates continued referrals. But the essence of purposeful integration and the greatest potential sustainable competitive advantage is to engage physicians and management and support staff to provide the best clinical care and service to the patients we share.

In our experience, this engagement is best accomplished by focusing on one service line at a time. It includes engaging already busy physicians and many others who already have full-time jobs, which is a major barrier to its success, but purposeful integration actively links what happens in the ambulatory settings with inpatient, outpatient, and ancillary services.

Such integration requires commitment to service and to clinical quality standards that “wow” those who benefit, including the referring physicians and the patients. It also requires rigorous measurement and sharing of performance against those standards and process improvement to ensure our success.

Now finally, it also requires that everyone along what we call the “Demand Chain” benefits from the success of those efforts in terms of growing the market share pie. Engaging primary care physicians, ambulatory specialists, hospital-based specialists, management and both ambulatory and hospital support staff members in meeting the needs, wants, and priorities of referring physicians and their patients improves access, improves communication, improves service levels, and as a result, it improves the quality of care.



The focused “Demand Chain” becomes the forum for identifying and implementing best operational and clinical practices over time. It sets a new standard of performance and develops a new culture that will be difficult for less astute competitors to match.

Now let’s also remember that the Demand Chain starts at the primary care practice, which can become a patient-centered medical home if and only if we have adequate patient volume, the support staffing, particularly nursing, and the technology necessary to manage that population, as well as a responsive group of affiliated specialty physicians and ancillary and hospital services.

Now, I believe that the organizations with a high level of structural integration have the greatest opportunity to achieve such service and clinical integration, not to the exclusion of other physicians, but as a catalyst to establish a higher standard of performance and momentum that others can join.

Ralph:

Thank you, Marc. A very excellent question by that listener, and I’m sure that answer will keep that group busy for many months.

Listeners, we are now on page 15 of the handout where we can fill in the answers for the three key objectives that Marc has given us for true physician/hospital integration and partnership.

Number One is “capture.” “The integrated network must capture patients or market share in primary care practices.” Number Two is “retain.” “The specialists and hospital comprising the integrated network must retain that market share by providing top quality service.” And Number Three is “sustain.” “The PCPs, specialists, and hospital comprising



the integrated network must sustain that market share by coordinating their efforts around evidence-based best practices.”

Turning over now to page 16, fill in the blanks with “primary care practice.” “The Demand Chain starts at the primary care practice.”

Marc, as you’ve taught us in your presentations and during our previous teleseminars over the past several years, physician/hospital integration is truly a balancing act that involves a number of important principles. Perhaps you could provide as a concluding context for our listeners a review of these key considerations.

Marc:

Thanks, Ralph. Where to start?

Let me just say, in July of this year, MGMA Connection was kind enough to publish an article I wrote titled “Four Business Imperatives to Manage Dynamic Change in the New Healthcare Environment.” Now, in that article, I discuss the fact that regardless of interpretation or changes in the new healthcare reform legislation, two factors are very clear.

First, reimbursement will go down. There’s no scenario under which we see reimbursement increasing. While different providers may have their ox gored from time to time, overall reimbursement will go down.

Second, with healthcare expenditures topping 16 percent of gross domestic product, or GDP, industry oversight and regulation will, of course, increase, driving up the costs of delivering care.

These two factors are guaranteed, and unfortunately, they come at a time when demand for services from an aging population is on the upswing.



In light of these and other dynamics, we believe that healthcare providers must pay special attention to the following four business imperatives.

First, we must have access to market share.

Second, we must demonstrate our service and our clinical quality. Demonstrate.

Third, we must be able to generate and reinvest capital in people, in technology, and in facilities.

Finally, we must increase our productivity all along the Demand Chain to offer our high quality care and caring more efficiently than our competitors.

The healthcare game and the rules for success are clearly changing, and in my opinion, physicians, executives, managers, and support staff will survive and prosper only by working together to learn and implement new rules in a new game.

Let me also mention just a word or two about accountable care organizations or ACOs that are again all the rage. Regardless of the final definition of ACOs, taking clinical and financial risk for a population is reminiscent of the late 1980s and early 1990s, and during those days the successful organizations were those who most effectively captured and serviced a large patient population in primary care practices, and who coordinated care all along the continuum we now call a Demand Chain.

The secret to success under a fee-for-service model is busy and productive primary care practices supported by responsive specialists and hospital services. The secret to success under a capitation model is the same: busy primary care practices supported by those same responsive specialists and hospitals.



Purposefully integrated physicians and hospitals are and will be in the best position to provide service and to prosper regardless of the ultimate outcome of healthcare reform.

Ralph:

Thank you, Marc. This has been a most informative and valuable hour. Thank you for teaching us the critical components of successful physician recruitment, practice acquisition, physician on-boarding and integration as foundational pillars that will position our listeners owned medical practice networks for market leadership.

Most importantly, it has been just a delight to see the marvelous questions that have come in from our listeners; very thoughtful and excellent.

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

Marc:

Two ways, Ralph. First of all, we have a web page: www.halleyconsulting.com, and then we have an 800 number: 1-866-706-5373.

Ralph:

Thank you again so much, Marc, for joining us today and providing the tremendous insights which I know will be so valuable for our listening healthcare professionals.

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



Marc:

Ralph, as you've already mentioned, we had an overwhelming number of questions along this general topic in response to our Ask Campaign, and none of them have been lost. We have a clear record of those questions coming in and as you mentioned earlier, we will pay special attention to getting in touch with those whose questions we felt were unaddressed of necessity during this last 60 minutes.

Ralph:

Thank you. Special thanks to all of you who have invested your valuable 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 website, along with a written transcript for your use.

We will give you notice within the next week 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.