



Achieving Successful Physician Integration: The Key to Market Leadership



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

Market leaders consistently:

- 1) Capture and attract market share.
- 2) Convert market share into volume to generate and raise capital.
- 3) Prevent relationships with referring providers from deteriorating.

Successful physician integration is more than referral management—it involves generating enough capital in the hospital setting to keep the integrated components viable.



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 **Achieving Successful Physician Integration: The Key to Market Leadership**. As a result of attending this seminar, you will learn how to locate primary care practices in the right neighborhoods, facilitate relationships between primary care physicians and your hospital-affiliated specialists, and create sustainable referral patterns between affiliated physicians and your hospital service lines.

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 e-mail.

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 Practices Best Practices* will be released in October 2010. 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 are delighted to have you on the call.

Marc Halley: Ralph, it's my pleasure to be here.

Ralph: You will be interested to know that we have dozens of healthcare professionals from across the country who have joined us today for this most valuable seminar. Let's talk for just a few minutes about your perspective as it relates to assisting hospitals through the process of physician integration by posing the first question from one of our listening hospital executives: "Why is physician integration the key to market leadership?"



Marc:

Ralph, this is a great question to start our discussion! I see different definitions of the term “integration” as I work around the country. For some, integration means owning everything, including the hospital, primary care practices, specialty practices, and providers of ancillary services.

For others, it means more traditional referral relationships between independent primary care physicians, independent specialists, and a hospital. Local market circumstances and competitive strategies appear to drive these – and variations of these – strategic integration approaches or alternatives.

In recent years, the term “clinical integration” has become more common, with a variety of definitions, as well. Clinical integration occurs within the context of and is facilitated by strategic integration.

For our purposes today, physician integration means capturing market share (or, largely, healthy patients) in primary care practices and attracting that market share in the form of referrals to affiliated specialists and/or hospitals when those services are needed by individual patients. This strategic integration also includes the accumulation of capital reserves in the hospital that are then reinvested in building and maintaining primary care capacity, specialty capacity, and the hospital service lines to address both community need and strategic purposes. Again, effective strategic integration will support clinical integration initiatives.

Regardless of the integration approach we use, market leadership always involves capturing and attracting market share. But referral management alone is not enough to ensure sustainability. Sustainable strategic integration also involves generating enough capital in the hospital setting to keep the integrated components viable.

Inner city hospitals, for example, may have tremendous referral volume (including what comes out of their emergency departments), but many do not have the payer mix necessary to generate adequate capital reserves. Without that payer mix, other capital-generating options may not be available to them either, leaving the hospital and its affiliated physicians struggling to achieve their mission and



strategic objectives. Suburban hospitals, on the other hand, may lack the volume, but may have tremendous reimbursement based on the neighborhoods from which they draw their patients.

Ralph: Thank you, Marc. Listeners, turn to page two of the handout, and in the box, fill in the words, *“generating enough capital.”* So that box will read, *“In addition to referral management, strategic integration also involves generating enough capital in the hospital setting to keep the integrated components viable.”*

Marc, here is our next question, and it is a very excellent question: “If we define market leadership as capturing or servicing the most lives in a given geographic area, what are the issues we should address first in developing our strategy to achieve market leadership?”

Marc: That is a good question. Many hospitals assess their market share based on their number of discharges compared to those of competitors. As we said, sustainable market leadership, however, requires not only volume, but also the ability to generate and raise capital.

Operating capital derives from volume and a well-balanced payer mix, which positions a hospital to take advantage of other capital resources as well. Market strategy, therefore, starts with an understanding of the underlying population demographics by zip code and even by neighborhood throughout a hospital’s primary and secondary service areas.

Ralph: So listeners, Marc has just given us the answers for the two boxes that you’ll find on page three of your handout. The top box should read, *“Operating capital derives from volume and a well-balanced payer mix.”* So fill in the blanks there with *“volume”* and *“payer mix.”*

Then, let’s move to the second box on page three, and it should read, *“Market strategy starts with an understanding of the underlying population demographics by zip code and even by neighborhood throughout primary and secondary service areas.”* Again, the answers there are *“zip code”* and *“neighborhood.”*



Marc, here's an interesting question: "In last spring's seminar, you mentioned zip code analysis as being a critical component of well-founded retail analysis. Could you provide us with more information regarding the moving parts of retail analysis and how we should go about that process?"

Marc:

Sure, Ralph. In our recent Physician/Hospital Integration Newsletter, Ashleigh Finley, our content expert in market analysis, shared ten steps we use in the process of performing an in-depth retail analysis. We discussed the same process in our first book, *The Primary Care – Market Share Connection: How Hospitals Achieve Competitive Advantage*, which was published, as you mentioned, by Health Administration Press in 2007. Let's briefly review those ten steps that Ashleigh shared with us:

- First, we **define the geographic market**, at least in general terms, for the hospital, both primary and secondary markets. That definition may be modified as additional demographic analysis is conducted, but having a good starting point is essential. Because most of the data we use – and most of the data that's available – is categorized by zip code, and because most urban and suburban areas have multiple zip codes, they can often be used to stratify the targeted area. Obviously, that doesn't work in very small, rural settings, but for larger suburban and urban settings, it works. This zip code categorization becomes very critical, because women usually select the family's primary care provider near home and schools.
- Secondly, we **collect demographic data about the population within each of our identified zip codes**. That data helps us understand the economic and social characteristics of both current and potential residents within those designated areas. This analysis includes population estimates for various age groups, population trends related to households, average household income, household size, and any significant ethnic populations, just to name a few of the factors that might be included in that demographic analysis.



- Third, and critically, we **analyze the competition** in those areas. That competition may come in a variety of flavors, including physicians employed by other competing hospitals or those who prefer to use specialists affiliated with other hospitals. Competitors also include the other hospitals themselves, ambulatory surgery centers, diagnostic imaging centers, urgent care centers, and even Walmarts or drug stores with “minute clinics.” We generally build an inventory of the competition including their locations, their affiliations, the names, ages, and specialties of the physicians, diagnostic services on site, other services offered, their advertising methods, etc. We also want to know if the competitors are recruiting new doctors, or contemplating new locations or upgrades to existing locations, we want to know if they’re emphasizing certain service lines and other indicators of their competitive strategies.
- Fourth, we **identify current market share by key competitors, and focus on areas of potential market vulnerability** for us or for them. For example, are their service lines truly integrated with their specialty physicians? Are they engaged? Are the competitors focused only on recruiting and employing specialists, or are they recruiting and employing primary care *and* specialty physicians? Could we attract or acquire PCPs in the competition’s backyard?
- A fifth step is **determining both current and anticipated demand for primary care services**. Comparing that demand with the current and anticipated capacity or supply of physicians (including consideration of potential retiring physicians) is essential by zip code. This step can be tricky, especially if the competition is actively recruiting new primary care physicians into the marketplace. Obviously, moving targets are tougher to quantify.
- Step six – we want to **know more about local customer behavior patterns**, such as: How far will a typical patient travel for a primary care office visit? That’s very important. This step can be accomplished by doing a zip code analysis of affiliated or friendly



family medicine, internal medicine, pediatric and obstetric practices in the local market. The answers, of course, will vary by locale including urban, suburban, and rural settings. Remember, in urban and suburban settings, that the majority of patients will likely live within a ten-minute drive or so of the practice itself.

- Step seven – we **look for specific market opportunities**. Is there a submarket within our target area, where there are neighborhoods near existing practices, but where our penetration into those households is low? Can we identify concentrations of potential patients without a convenient primary care location nearby? Can we focus on areas where there is high household growth potential, but below average competition, and perhaps gain a first-mover competitive advantage?
- Step eight often includes **field work**. We’re actually out stepping into the practices of our competitors and validating their locations and what their service offerings happen to be. It also includes identification of retail concentrations or shopping centers, and how many primary care practices are in or near those retail-rich locations – especially in what we call Stage Two and Stage Three retail markets, which we’ll discuss later in this broadcast.
- Step nine includes our desire to **identify potential opportunities**, either to acquire established practices, or to add new physicians to established practices, or potentially to start brand new practices from scratch (which we define as “cold starts”). This last option, obviously, necessitates identification of potential practice sites. It includes a lot more of step eight, which is that field work, but includes considerations such as visibility; zoning; the size of potential space (is there room for expansion?); accessibility from main roads, highways, retail centers, and so on; how close it is to the hospital (which may or may not be an issue); parking availability and cost; ingress and egress (getting into and out of the practice – can you do that safely and comfortably?); and other safety and security issues.



- Step ten involves **developing and prioritizing retail strategy recommendations**. We've gathered all of the data and done all of our research in steps one through nine, and now we make some final recommendations which are subject, usually, to input from a tactical planning session. We score and then rank each potential retail opportunity in several categories, including things like:
 - Market size
 - Market growth
 - Competitive intensity
 - Product demand
 - Presence of target customer segments – do they live there in adequate numbers?
 - Field assessments, neighborhoods
 - Quality of the site (or potential site) characteristics
 - Other opportunities presented by the various options that we consider

Those are the ten steps, and those ten steps of retail analysis usually yield four types of recommendations:

- 1) **Capacity recommendations**, which include new physicians in new markets or new physicians in established medical practices adding primary care capacity.
- 2) **Replacement recommendations**, which include new physicians replacing retiring physicians who have already captured market share.
- 3) **Strategic recommendations**, which include adding physicians to markets that have already been infiltrated by our competitors.
- 4) **Mission recommendations**, which include adding primary care practices – or other specialties, but particularly in this setting, primary care practices – to address the needs of specific, usually underserved, populations.



Obviously, the riskiest of these recommendations are the strategic recommendations because our competitors likely have first-in advantage if they've done well. The most costly, over time, can often be those mission tactics that we get involved in.

Retail analysis also reveals obvious holes in our primary care medical practice geographic coverage. For example, we might identify a brand new neighborhood attracting young families with better than average household income that is, as yet, not served by any of the local health care systems. This discovery will likely yield a recommendation to add capacity to that locale (capacity recommendation).

We may also discover that our competitors have beaten us into a neighborhood. We may need to battle our way in with a physician who “wears our jersey” (strategic recommendation). Retail analysis identifies as well the underlying demographics of the population and may suggest that building a practice in an area needs to occur in order to meet the needs of the uninsured or underserved, and so opening and providing a set of services in particular neighborhoods, along bus lines, can be what we call mission recommendations.

The analysis also considers the age profile of the local PCPs and prompts replacement strategies for those who have reached that magical “55 or older” age category, when many physicians are either wanting to slow down or are at least beginning to think about retirement (replacement recommendations).

Importantly, retail analysis includes, as I mentioned, a scoring mechanism to help strategists to prioritize potential primary care locations or additions based on established criteria. The process actually facilitates wise expenditure of limited capital on what we consider, based on that scoring, to be the highest-impact locations.

Ralph:

Marc, thank you for the very detailed and comprehensive answer. Listeners, on pages four through seven of your handout, you will notice that you have a helpful bulleted summary of the information that Marc just provided for you. Let's turn to page eight of the handout and review the four types of recommendations that Marc has



identified for us. In the box at the top of page eight, fill in “*Capacity recommendations, Replacement recommendations, Strategic recommendations, and Mission recommendations.*” Again, those answers are “*Capacity, Replacement, Strategic, and Mission.*”

Marc, here’s an excellent question from one of our listeners who has studied your book. She says, “Once we understand the need in a specific neighborhood for a particular primary care specialty or specialties, and we know that the timing of our market entry is correct, how do we bring about the growth of these properly placed practices?”

Marc:

Ralph, that’s another great question. Let’s talk for a minute about the application, if you will, of particular primary care specialties in our geographic market – in certain areas of the market. It seems obvious, but we find, still, that many hospitals do not pay much attention to local demographics when they consider how to staff a primary care practice.

As consultants, our practice over the years, and our preference over the years has been to place family medicine physicians in literally all submarkets because of their ability to serve the full age spectrum. Even in markets where we’re used to internists and pediatricians fitting the bill, increasingly adding family medicine physicians is a real boon. General internists, however, increasingly want to be part of suburban practice these days. Many of them are not practicing hospital medicine, and they can be very successful in established markets with a preponderance of older families and empty nesters. Pediatricians can have a tremendous success in areas bustling with younger families.

We’ve even seen a few clients who have paired up pediatric and obstetric practices with some success in the right neighborhoods. The bottom line message is the importance of paying attention to the population demographics, including age, sex, household income, and other factors when thinking about placing primary care practices.



In terms of timing for new practices, we have identified four retail market stages that can help determine the appropriate timing for market entry. What we call a “Stage One” retail market is characterized by small “mom and pop” establishments, including pizza joints, service stations that sell gas and repair cars (as opposed to C-stores), perhaps a Dairy Queen, a local bank, small strip malls, etc. Stage One markets generally support rural areas and newly developing suburbs.

“Stage Two” markets experience the influx of national franchises and chains that occupy distinct concrete pads. We’ve all seen them: McDonald’s restaurants move in, Burger Kings move in, Walgreen’s and CVS drugstores come in, Pizza Hut shows up, Blockbuster Video shows up, we see upscale restaurants and grocers, we see sporting goods stores and others. They roll into town, putting many of the “mom and pop” joints out of business. That’s a Stage Two market. Newer strip malls may also be under construction, and later in Stage Two markets as populations continue to grow, we find Walmart, Home Depot, and Lowe’s appearing as well. Stage Two requires a much more concentrated population in urban and suburban settings.

The distinguishing factor in what we call “Stage Three” markets is the addition of shopping malls with national anchor stores and a variety of unique retailers. These more sophisticated retailers require very large, concentrated populations in urban, suburban, and even regional settings.

Finally, “Stage Four” markets are in decline. Financially viable populations are in flight to the suburbs, leaving those of lesser means to occupy the inner cities. Downtown areas lose retailers, with the exception of those who are required to support the business or financial districts. Many of those retailers do most of their business during weekdays, with only limited activity in the evenings and on weekends.

It is easiest to build new medical practices, obviously, in Stage Two markets, with growing populations to fill up that additional physician capacity.



Investment in Stage One markets has to be made very prudently and usually with family medicine or even with a midlevel provider to start. Some of our clients use Rural Health Center status, which may be possible in some of these locations to enhance reimbursement for these underserved areas.

Stage Three markets may not need additional physician capacity, so our competitive retail tactics may include acquisition of established practices in order to “lock in” market share.

And finally, Stage Four markets often require an investment in mission-based practices, or investment in, or affiliation with, and support of a federally qualified health center.

Adding new physician capacity in any setting – let’s face it – is risky. We usually recommend adding one new physician at a time and allowing the first physician to build for at least a year before adding a second practice, even if there is excess demand for services. A new practice will only attract a certain volume of business, and splitting that volume between two physicians slows the development of both practices. Allowing the first practice to begin building its passive sales force of established patients who will refer others before adding more capacity is usually preferred. Now, I know there are call coverage issues, but certainly in a network setting, these can potentially be resolved across practices.

Ralph:

Thank you, Marc. Listeners, look at the box on page nine and go over the answers there with me. On the first bullet, fill in “*Stage Two.*” *It is easiest to build new medical practices in Stage Two markets.*

On the second bullet, fill in “*Stage One.*” *Investment in Stage One markets must be made prudently, usually with a family medicine or midlevel provider.*

The answer for the third bullet is “*Stage Three.*” *Stage Three may include acquisition of established practices to ‘lock in’ market share.*



On the last bullet, fill in “*Stage Four.*” *Stage Four markets often require investment in mission-based practices or a federally qualified health center.*

Marc, here’s an insightful question: “Assuming we have located the needed primary care practices in the right neighborhoods and they are capturing lives, **how do we overcome the barriers we often face in developing relationships between these providers and our hospital-affiliated specialists**, such as the lack of camaraderie between these two groups of physicians due to their busy schedules, the lack of contact between them, and other competitive pressures?”

Marc:

You know, Ralph, most hospitals these days have a hospitalist program. This dynamic has had a positive affect on reducing average length of stay, on clinical coordination, on process improvement, and on quality indicators in many inpatient settings. A downside, however, of a successful hospitalist program is, of course, the tendency for primary care physicians – those who hold our market share – to abandon the hospital.

Many PCPs no longer darken the hospital door. They don’t attend medical staff meetings, they never wander into the medical staff lounge, most don’t even make courtesy visits to their hospitalized patients anymore. This presents a significant relationship management challenge for both specialty physicians and for hospitals. Remember the two referral management tenets we identified in our first book, *The Primary Care – Market Share Connection*:

- 1) Referrals follow relationships.
- 2) All relationships atrophy over time.

Those are two key factors to remain aware of, particularly for specialists and hospitals.

It was easier to maintain a relationship when physicians ran into each other in the ICU, or on the medicine floor, or in the medical staff lounge. But today, both specialty physicians and hospital executives need to be much more creative and deliberate in their relationship management activities.



We encourage our client hospital executives, for example, to target primary care physicians and to go out and meet with them on their turf. The major purpose of these visits is to demonstrate a sincere interest in the success of the physicians and their practices. Wise hospital CEOs will be most interested in the success and sustainability of their affiliated primary care physicians. They will want to know if their PCPs are struggling, because struggling practices are always vulnerable to overtures from competitors.

In addition to practice vulnerability, the CEO will want to query primary care physicians about the hospital, its affiliated services lines, and hospital-based physicians, and whether or not they are facilitating the PCP's success or creating barriers to that success. Finally, the CEO should want to know if his affiliated specialists – employed or independent – are meeting the needs of PCPs and their patients. For example, are the specialists accessible? Are they engaging PCPs in the treatment of *their* (meaning the PCP's) patients? Are the specialists providing a great service experience for the referred patients?

Ralph: Excellent, thank you. Listen to this pertinent question: “From your experience, Marc, what are the critical success factors for hospital physician liaisons to be effective in nurturing relationships with our owned and affiliated primary care and even specialty care providers?”

Marc: Good question. Obviously, CEOs – even those who are dedicated market managers – can't possibly keep up on all the primary care physicians and specialists affiliated with even a moderately-sized medical staff. This is where the right physician liaisons (or business development experts) can fill the relationship management gap.

I remember the first round of physician liaisons in the late 80s and early 90s – many of whom tried to imitate the drug representatives. But today's liaisons are business development professionals. They often report directly to the CEO and become the driving force behind the relationship management process.



Today's physician liaisons understand the medical practice business. They are also sales management professionals who know how to look for both opportunities in the marketplace and threats as they're around visiting primary care and specialty offices. They know the medical staff members. They understand the challenges being faced by physicians (both those who are independent and those who are employed). They help the CEO, importantly, to document feedback from all of the physician interactions in order to ensure that we don't drop the ball – that we actually provide an appropriate response. They help the CEO monitor – what we recommend is – an action plan derived from physician suggestions and reported problems. They help the CEO work with specialists to become what we call “specialists of choice.”

Ralph: Thank you. Affiliating with the right specialties and the right specialists is so critical to the success of a hospital. Why don't you spend a few minutes talking about “specialists of choice” and the principles for maintaining strong referral relationships between specialists and PCPs?

Marc: Certainly! Happy to do so. And again, remember, these statements are made in the context of “Referrals follow relationships,” and “All relationships atrophy over time, so they must be nurtured.” Let's remember, first, that the hospital is the capital-generating engine for the whole local healthcare market. Medical practices do generate revenue, but there is very little left on the bottom line at the end of the year. Hospitals, those at least with strong operating margins, can retain earnings, which become capital for reinvestment. If those margins are strong enough, hospitals also have access to other forms of capital at favorable rates.

Specialists – particularly invasive specialists – use hospitals as their “workshop,” and they help generate that capital. Although not the subject of today's discussion, it should be obvious that having the right specialties and maintaining relationships with these physicians is essential to the success of any hospital.



Therefore, becoming the “hospital of choice” for specialists in a particular market has more to do with specialty physician relationships than it does with branding strategies (although both are certainly important in the market). In addition to such things as having the right technology, responsive staff, and providing a great patient experience, a hospital with access to a number of primary care physicians and to their market share is a huge draw for specialty physicians wanting to relocate or wanting to “choose sides.”

Wise market managers realize that in today’s competitive markets, they cannot leave the relationships between the specialists and PCPs to chance. Working with their liaisons, they build relationships with the right specialists who understand how to build and maintain relationships with PCPs, even as the specialists’ practices become busier. That’s the big challenge! They may even provide seminars and education and support to busy specialty practices on becoming the “specialist of choice” for medical staff members and for their office managers. Most importantly, they have built relationships with specialists that allow them to sit down and dialogue – have an open discussion – about issues that surface during their interviews with primary care physicians.

As we interview hundreds of primary care physicians each year, we ask them about the specialists they feel are “stars” from a clinical quality and from a service quality standpoint. It’s very interesting how often the same “star” specialists fall into both categories!

We have learned, over the years, that the most important motivators driving referrals from PCPs to specialists are: 1) **Access** - I can get to you when I want to get to you; 2) **Communication** - You’re willing to communicate and treat me like a peer; and 3) **Patient experience** and the resultant feedback to those referring physicians. I have in my mind’s eye the patient who returns to the primary care physician and says, “Doctor, thank you for sending me to Dr. Smith’s office. They were so nice. What a wonderful group of people they have working over there!” You just did a favor for that primary care physician.

Interestingly, clinical quality is usually low on the list of motivators as we interview primary care physicians. When we ask PCPs why this is so, they almost universally say, “Clinical quality is expected!” *Clinical quality is expected.* It only becomes an issue when it is not present,



but it is not a primary motivator driving my decision as to which specialist I will use. These are very important lessons for specialists to consider, particularly as their practices become busier. Wise specialists “bake” access, communication, and high-quality patient experience into their practice systems, and their processes, and their cultures. By doing so, they become the “specialists of choice.”

For example, I’m aware of one group of cardiologists who decided to provide open-access scheduling every weekday afternoon. The PCPs in the community know now that they can get a patient in to see a cardiologist today! It may not be their favorite cardiologist, but they can get a patient in to see a doctor today. I’m also aware of a general surgeon who guarantees that he will return a referring physician’s phone call within 20 minutes – even if he is in surgery!

Other busy specialists ensure that their referring physician telephone line is always answered by a competent human who is scripted to say things like, “Thank you, Dr. Jones, for calling. I know Dr. Smith will want talk with you. He’s in an exam room. Would you like me to interrupt?” Almost never does a referring physician ask to interrupt a specialist. If he does, you better do it! But most of the time, they’ll say, “Oh, no. No need to interrupt.” Then our receptionist is scripted to say, “Where can he reach you in the next 15 minutes?” Of course, that note goes immediately back to the doctor’s nurse where that phone call is placed on time.

These specialists, and many others, understand that their most important customer is the referring physician. They welcome any ideas that will help them more effectively understand and meet the needs, wants, and priorities of primary care physicians. As we say to specialists when I speak around the country, “Don’t worry – if you are too busy to be concerned about these “little things,” you won’t be for long!”

Ralph:

At the top of page 12 on the handout, listeners, we can fill in the top motivators that Marc identified for us. Number one is “*access*,” number two is “*communication*,” and number three is “*patient experience*.” Again, those very important motivators are *access*, *communication*, and *patient experience*.



Marc, here is another great question. “What can we do to prevent relationships with referring providers from deteriorating?”

Marc:

This is the \$64,000 question – and a good one. One of the most important factors, in our experience, in maintaining those relationships is simply monitoring them. We encourage our specialty physician clients to build and maintain a referring physician profile for each primary care doctor. That profile contains contact information for the PCP, for his or her manager, and very importantly, for his or her clinical assistant. It also includes the referring physician’s preferences in the relationship.

For example, some primary care physicians like to talk with the specialist by phone before a consult in order to share their reason for sending the patient and the PCP’s objectives for the visit. Other PCPs don’t want to be bothered. How do we know? We ask! Then, of course, we write it down, and we deliver according to that profile – a copy of which can be found at the reception desk where the referring physician line is answered, at each nurse’s station, and on the physician’s desk.

We also encourage our specialty physicians to periodically talk with each primary care referring physician. They’ll interact on clinical issues, but periodically, at the end of the discussion, they should ask, “Are we meeting your needs and those of your patients? We welcome your feedback, because we really appreciate the trust you have placed in us.”

Comments like that can generate great feedback and can help build a relationship. Just the fact that you’ve asked and that you care enough to wonder whether or not you’re serving my needs as a referring physician is very important. These questions become particularly important if we have noticed a drop in referrals. Of course, we become aware of that referral decline by monitoring, on a monthly basis, referrals by PCP, including the patient’s diagnosis and the payer. Very, very critical.



Ralph: Thank you. Here's another really superb question: "What are the steps we should take to enhance the appeal of our hospital service lines in the minds of referring physicians?"

Marc: In our opinion, hospital service lines are the most important place to affiliate with "specialists of choice." In fact, common service lines like heart and vascular, oncology, orthopedics, women's and children's, and others are simply empty shells without specialty physician partners – and I do mean "partners." Just being a great "workshop" is not enough in competitive markets. It is the physician/hospital "partnership," by service line, that creates a sustainable competitive advantage.

Over the last couple of years, when we have worked with hospital service lines, we usually start the process by meeting with service line staff and the associated physician specialists. But instead of discussing their relationship, we invite them to share their perspectives on the needs, wants, and priorities of their referring physicians.

After documenting their perspectives, we'll go about surveying those referring physicians and asking them a series of questions about the service line and the specialty physicians – including asking them to identify any "stars" among the specialty physicians, in terms of clinical or service quality. Then, armed with that survey information, we return and meet again with the service line staff and specialists in "partnership" to discuss referring physician responses – especially the referring physicians' prioritization of their motivating factors in terms of referrals. "What motivates you to pick our service line? What motivates you to use our particular specialists?"

We'll then work with that hospital/physician partnership to discuss the top few motivators and how they can work together to "WOW" the referring physicians and their patients. We picked that "WOW" concept up from Southeastern Regional Medical Center in Lumberton, North Carolina – wonderful concept of WOWing our customers!

We help the partnership then identify what we call "service commitments" based around those WOW factors that they feel they could make to referring physicians. "What can we commit to?" These service commitments will likely involve both the hospital



and individual specialty practices working together. The service commitments become service guarantees that the partnership is willing to make to referring doctors.

We then work with the service providers, both the physicians and the staff members in the hospital and in the practices, to meet the new performance standards. It's interesting, as a side note, this usually has the significant benefit of helping the hospital better meet the needs, wants, and priorities of the specialists as well. Physicians and staff members at each of these service points, whether it's in the hospital or the individual practices, help develop the measures to track their own performance, and those measures are shared across the service line and ultimately with referring physicians. We'll then help implement the changes necessary for our clients achieve those new standards.

Once achieved, we can go public, frequently with the help of liaisons, to invite primary care physicians to give us a try. The partners will jointly celebrate the successes, and they'll own and fix the failures in that setting. This process can be initiated with a small pilot location, but can soon build momentum because everybody wants to be part of a winning program!

Ralph:

Indeed, they do. Listeners, let's turn to page 13 on the handout and fill in the blanks there. On the first bullet, fill in the blank with the word "*partnership.*" *Create a partnership between service line staff and associated physician specialists.*

On the second bullet, fill in the words "*top motivators.*" *Discover, discuss, and prioritize top motivators driving referrals from primary care physicians.*

Then, on the third bullet, fill in the blanks with "*service commitments.*" *Identify service commitments that can be made to WOW the referring physicians and their patients.*

Marc, earlier, you used the term "hospital of choice." What does that mean in the context of today's discussion?



Marc:

Well, Ralph, the short answer is a hospital that meets the needs, wants, and priorities of physicians and their patients better than competing facilities. When we work with hospital clients, we look at various “hospital of choice” tactics in seven different areas:

- 1) **Strategy and Execution.** If I’m a specialist, and I’m trying to decide which hospital I should connect with or align with, I’m going to ask, first of all, what is their experience in strategy and execution? Does the hospital have clearly defined primary care and specialty physician and service-line strategies? Do strategic planning and the resulting plans involve and include physicians, whether they’re employed or independent? Do physicians see that hospital executives do what they say they will do? Do they feel engaged with hospital executives as “partners” in pursuing their mutual success, or are hospital executives viewed as very hospital-centric and hospital-focused?
- 2) **Current Market Position.** Wise physicians will ask: What is the hospital’s current market position? Is it, or is it not, the “hospital of choice?” Is it the market leader, or is the hospital aggressively pursuing that position?
- 3) **Capital Resources.** Does the hospital have capital resources to provide the facilities and the equipment necessary to attract and retain specialists? Is the hospital actively recruiting and retaining new doctors? Is it growing? Is it vital? Are they using that capital to grow not only the hospital, but also to grow the medical staff?
- 4) **Service Level.** Service level involves both services to physicians and to their patients. Are hospital-based physicians, for example, responsive to specialists and PCPs? Are hospital departments geared up to meet the needs, wants, and priorities of referring physicians and their patients? Do patients report a positive perception of their hospital experience? Is there an adequate and attentive nursing staff? Is the food acceptable? Is the facility clean and efficient? Do visitors feel welcomed and accommodated?
- 5) **Market Management.** Very critical! Is the hospital administration perceived to be interested in the success of affiliated practices, both private and employed physicians? Have hospital executives



proven to be good partners in the past? Is the current administration perceived to be physician friendly and tuned into the needs of those who visit the hospital workshop as well as those physicians who do not?

- 6) **System Relationship.** Many hospitals are part of systems, and that dynamic does play in to what happens in local markets and in to this concept of being the “hospital of choice.” So, do local hospital executives have the support and confidence of health system executives, or is their perceived meddling from afar? Is the local institution sending more capital away to the system than it is receiving?
- 7) **Financial Performance.** Is the hospital performing well, or is there evidence of poor performance, such as layoffs or capital constraints? Are facilities up to date? Is the equipment new and adequate? Are the staff members upbeat about their future?

There are several more questions associated with each of these seven performance areas that determine a “hospital of choice.” Market managers have come to realize that even sole community hospitals must pay attention to these “choice” initiatives if they are going to recruit and retain top-quality physicians and if they’re going to attract their referrals.

Ralph:

Outstanding. Thank you, Marc. This has been a most informative and valuable hour. Thank you for teaching us about Achieving Successful Physician Integration. Most importantly, it has been so helpful to review with you the questions posed by our listeners, and as a result of your answers to those questions, understand the process that results in obtaining market leadership.

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: Well, Ralph, there are two easy ways to get a hold of us. We're on the web: www.halleyconsulting.com, or you can dial our 800 number. That's 1-866-706-5373.

Ralph: Thank you again, Marc, for joining us today and providing the tremendous insights 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: Just one final point. Again, I'd emphasize a couple of items, and this is based on many of the questions that we've seen. Physician integration certainly involves structural relationships, whether it's contracting vehicles, or employment models, or whatever the structural relationship may be. But more importantly, it's the personal relationships that attract and maintain the referral stream. It's those personal relationships and nourishing those relationships that really make or break the physician integration economics model.

Ralph: Thank you. Special thanks to all of you of have 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 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.