TRANSCRIPT

Physician Integration Economics: Managing Physician-Hospital Relationships

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) The current national trends in physician integration.
2) Strategic and financial considerations associated with capturing market share.
3) How to attract referrals to hospital-affiliated specialists.
4) How hospital CEOs can better manage physician relationships by becoming “market managers” in sustainable integrated delivery systems.

> *There are, indeed, certain correct principles in every aspect of our lives, which, if followed, will yield the success we seek.*

Ralph Harding:

Welcome, 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 Physician Integration Economics. Physician Integration Economics explores the fundamentals of successfully partnering with physicians.

Today you will learn the current national trends in physician integration, strategic and financial considerations associated with capturing market share, and how to attract referrals to hospital-affiliated specialists.

You will also learn how hospital CEOs can better manage physician relationships by becoming market managers in sustainable, integrated delivery systems.

We appreciate so much the dozens of thoughtful, excellent questions that you, as health care professionals, posed to Marc during our Ask Campaign, and we have structured our interview questions for Marc with just as many of those questions as possible, considering the time constraints of this broadcast.

However, all of your questions that were submitted during our Ask Campaign that we do not answer during our broadcast will be answered by Marc or another one of the Halley executives via personal e-mail.

Let me call your attention to the blue handout link in the paragraph of instructions right next to Marc's picture on your screen. It says, "Please download this handout."

Please print the handout and be prepared to take copious notes on the sage council that we will be receiving from Marc today on this most important topic. There are some fill-in-the-blank spaces on the handout that I will guide you through when the time comes.

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 entitled 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.

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 on the call. You will be interested to know that we have over 90 healthcare professionals from across the country who have joined us today for this most valuable seminar.

Marc Halley: Thanks Ralph, it's my pleasure to be here with you and with those who are attending.

Ralph: Let's talk for just a few minutes, if we could, about your journey to becoming one of the leading authorities on Physician-Hospital Integration. Was there a specific event or experience early on in your career that served as a catalyst for your passion in this area?

Marc: Ralph, I can't point to a single event or experience. My father taught motivation courses as part of his civilian role at one of our nation's Air Force bases. He introduced me to the likes of Napoleon Hill, Norman Vincent Peale, Frederick Herzberg, and several others, and I became convinced that there are, indeed, certain correct principles governing every aspect of our lives, which, if followed, will yield the success we seek.

This personal philosophy was further developed in business school, as I sought to understand correct business principles and to apply them to case studies, with which many of us our familiar.

Throughout my career, I've had a passion to learn, apply, and finally teach those relevant principles regarding the healthcare industry in general and principles affecting medical practice business in particular.

We've learned many correct principles from our clients over the years, and we've successfully shared and applied those principles with other clients, and my team and I have shared those proven principles in seminars and through our published works.

Ralph: That's a very interesting background that I'm sure our listeners have enjoyed hearing.

The first question I have for you today, Marc, is that the volume, momentum and complexity of change in the healthcare industry are escalating at a brisk pace, especially in our new economic reality. From your perspective, what are some of the key components of that complexity of change?

Marc: You know Ralph, we could spend the entire hour talking about the current trends in healthcare, but let me highlight just a few that particularly affect hospitals and medical practices around the topic of integration.

First of all, we're all aware of the fact that the healthcare industry continues to consolidate. We've seen individual hospitals become part of local systems which frequently then become part of national systems; we've seen small practices become larger group practices, and we've seen a number of networks of small group practices form around the country in many major metropolitan and small urban settings as well.

Many of those networks are owned by hospitals, but also there are some very large networks owned by physicians. So the structural integration is significant in most markets, certainly as the number of providers decreases and the remaining integrated systems get larger, we're going to see continued pressure based on additional competition. We're going to see physicians and others being forced to choose sides and so on.

In addition to that, integration is facilitated by the fact that many physicians, especially those coming out of training programs, want an employment model, and many have targeted hospitals or health systems as a preferred employer, so we've seen that trend, and we'll talk more about that as we move through the discussion.

The cost of healthcare, of course, we saw that rise to greater visibility during the political campaigns of 2008 and 2007, and along with that high visibility, of course, comes greater oversight and regulation.

We see continued pressure on provider reimbursement, and that is downward pressure. There's a very clear agenda from the federal government to reduce the cost of Medicare and Medicaid at the state level, and of course other payers are following suit. Particularly as individuals take on a greater portion of the cost of healthcare, that pressure to reduce costs and reduce reimbursement will continue.

We see the quality conundrum; I guess I use that word purposely. It is very complex as we try and reduce variability, greater use of evidence-based medicine, reduction of errors, we're seeing a shift from pay-for-reporting to pay-for-performance.

There's a lot of emphasis on an electronic medical record that will help improve communication and hopefully result in fewer errors. The hospitalist phenomenon has changed the way primary care physicians practice and changed the relationship between primary care physicians and specialists who used to meet in the hospital every morning before or after rounds, and certainly between the hospital and primary care providers. Many PCPs never show up at the hospital.

Technology, of course, is a huge trend, whether it's a little gray pill called Tagamet 20 or 30 years ago that changed the way we dealt with ulcers, or the da Vinci robotic arm, or certainly stents have changed the way we deal with cardiac patients.

We're all aware of the aging population; some of us who are aging are a little more aware of that than others. We're also aware of the fact that we have provider shortages in many parts of the country. Primary care physicians, specialists, and nurses as well are struggling in many parts of the country to have adequate numbers of nursing specialists.

Of course there are many competitive alternatives that are changing the competitive game. In many communities today, if you can't get in to see your primary care physician, you can run down to Wal-Mart, Walgreens, or CVS and participate and see, at least, for any of eight, ten or twelve key diagnoses, a nurse practitioner or a PA.

We also see medical tourism popping up, at least as shifts in who's responsible for paying for healthcare. Medical tourism will become, we think, a more interesting trend to watch.

It may be cheaper, including airfare, to go to another country to receive medical services. These are definitely extraordinary times, regardless of how you look at it.

Ralph: Absolutely true. The very comprehensive view that you just gave us of the trends is most impressive. Listeners, if you'll turn to page two of your handout, I want to walk you back through some of that information so that you can make sure and have availability of that.

Marc went through that very quickly, so if you'll look at the part of page two that says, *"Current trends include,"* we can fill in that information: *industry consolidation, cost of healthcare—top concern, continued pressure on provider reimbursement—downward pressure,* as Marc said; *the quality conundrum, pay for performance, electronic medical records, the hospitalist phenomenon, technological advances, aging population, provider shortages* and *competitive alternatives.*

Of course then on the right, you have the results of those trends: *lower reimbursement, more regulation, focus on quality and pay for performance, fewer larger systems of providers, market management, increased competition for the right patients, emphasis on cost and productivity,* and *technology driven.*

Marc, the first question from our listeners I thought was interesting. The listener asked, "Why do you believe that physician integration is no longer just a desirable goal, but rather a strategic imperative?"

Marc: Ralph, I've learned that in times of significant change and competitive turmoil, controlling and managing market share become keys to survival and future prosperity, regardless of the industry, particularly applicable to healthcare.

Primary care physicians, in our world, capture, retain, and direct significant market share to specialty physicians and hospitals. Specialists in hospitals fortunate enough to receive patient referrals from these PCPs then generate revenue, and the hospitals generate capital.

Ralph: Very good. Listeners, while we're still on page two, please fill in the blank inside the box with the words: *controlling and managing market share.*

In times of significant change and competitive turmoil, *controlling and managing market share* become keys to survival and future prosperity.

Marc, will you walk us through the process of market share acquisition for a hospital? Many of our listeners asked the question, “How does a hospital capture market share?” Apparently, building a state-of-the-art facility in the right location is no longer enough. Why is that?

Marc: Years ago, when I was a hospital and health system executive, our philosophy was “If we build it, they will come;” “they” being the physicians and patients.

The average age of our physical facility was a key performance indicator. Unfortunately, in today’s competitive environment, having a nice facility and the latest equipment is the minimum ante to stay in the competitive game.

Even members of our own medical staff own equipment and facilities that pull business and revenue away from our hospitals. Hospitals and invasive specialists don’t really have market share. We don’t build long-term relationships with patients.

No one wants to see their surgeon three or four times a year. Only primary care physicians and a few internal medicine sub-specialties that serve chronic ailments build long-term relationships with patients.

The rest of us use terms like “case” or “admission,” which connote a short-term experience. Our market share and our market potential, as specialists and hospitals, reside in primary care practices that prefer our facilities and our affiliated specialists.

Ralph: Listeners, Marc has just provided the answer to one of the most-asked questions by you. So if you will refer to page three of your handout and fill in the blank in the top box: *primary care practices*.

Marc, you talk often about hospital chief executive officers viewing themselves as market managers. This is a real shift in thinking from seeing themselves as hospital administrators. A number of our listeners wanted you to elaborate on the market manager concept.

Marc: Thank you, Ralph. I appreciate the question. In a competitive market, market dominance is, and will be determined by who controls and manages market share. I've already stated that.

CEOs who focus only on a hospital workshop will soon find more astute competitors stealing their business. CEOs who see themselves as market managers understand that their market share is held by their affiliated, either employed or otherwise, primary care physicians.

They also understand that PCPs located in urban and suburban areas tend to serve patients who live within a relatively short drive of the practice. Astute market managers, therefore, will make sure that they position affiliated primary care physicians in or near the geographic areas they want to target as market share.

They may even have a neighborhood-by-neighborhood strategy. They'll build and maintain relationships with these critical holders of their market share. They'll also facilitate the development and maintenance of relationships between these primary care physicians and hospital-affiliated specialists.

Wise market managers will invest personal time, corporate energy, and capital to build and maintain primary care, specialty, and hospital services to meet community needs more effectively than their competitors.

These effective market managers will spend a lot of their personal time working directly with physicians and leave the running of the hospital to a competent chief operating officer.

Ralph: That's most excellent and an absolutely critical concept that we want to emphasize, so again listeners, referring to page three of your handout

in the second box, please fill in the blank space with: *who controls and manages market share*. In competitive markets, market dominance is and will be determined by *who controls and manages market share*.

Marc, here's an excellent question from the Ask Campaign. "If I am a hospital executive, what initiatives, or best practices should I be concerning myself with in my role as market manager?"

Marc: Good question. Market managers realize that their integrated systems have to meet the varied needs, wants, and priorities. All three words are critical: needs, wants, and priorities of patients, of family members, of primary care physicians, and specialty physicians in order to capture, retain, and attract business for the integrated system.

They understand, as we said in our first book, that referrals follow relationships and that all relationships tend to atrophy, or weaken, over time. Smart market managers understand that in order to maintain referral relationships in competitive markets, every service point along that referral path has to leave customers, whether they're patients or referring physicians, saying, "Wow! That was great service!"

Those relationships and that service have to be developed and nourished over time, engaging physicians and staff, all on what we call the "Demand Chain." Those relationships can't be purchased or mandated; they have to be developed and nourished.

Ralph: Excellent. So, again, listeners on page four of your handout you should fill in the blanks in the top box with those critical words: *needs, wants,* and *priorities*.

Marc, from what you've just taught us, understanding the challenges of medical practices and building relationships of trust with primary care physicians and specialists is absolutely essential. So how do I as hospital CEO/market manager start that process? I suppose that really reaching out with the intent to understand would be an important first step.

Marc: Absolutely. Market managers, as we define them, are relationship managers first and foremost. The first step for an aspiring market manager is to understand the medical practice business and the factors driving success or failure in that business.

Understanding how those critical success factors differ between primary care and specialty practices is also essential, because there are some key differences. Whether affiliated practices are hospital-owned or independent, market managers need to understand what is working in those affiliated practices and where their physician partners are struggling to succeed.

They also need to understand how effectively affiliated specialists are meeting the needs of referring physicians and how well hospital-based physicians, hospital departments, and service lines are meeting the needs, wants, and priorities of referring physicians.

Now since PCPs never darken the hospital door in many markets, again due to the hospitalist phenomenon, CEOs need to arrange times to meet physicians, and we recommend on the physician's turf.

Critically, when problems are identified, the market manager needs to personally take responsibility to manage those issues to closure even, and especially, if the answer is, "No, Doctor, we can't do that right now," or "We can't take your advice right now for these reasons."

Some market managers are using well-trained physician liaisons to assist in managing relationships and gathering practice intelligence. They also use a sales database or other mechanisms to formalize their relationship management process and to share information learned as they visit each physician and medical practice.

Ralph: It's so refreshing to hear this very proactive process that you're describing. I want to emphasize, for our listeners, on page four in the second box, fill in that blank space with: *understand the medical practice business and the factors driving success or failure in that business*. It's absolutely critical.

Marc, once the communication channels start to open up and the physicians know that I'm serious about understanding their viewpoint, then comes the action side of the equation, documenting their input from these on-turf visits, creating action plans with accountability and feedback. Am I on the right track?

Marc: Perfect, yes definitely. We encourage our market managers to develop an action plan, to make assignments and hold people accountable to deliver improved policies and improved processes, and improved performance.

Wise market managers are asking, "Are my customers, including patients and referring physicians, saying 'Wow!' at each service point along the command chain?" and if not, why not?

They're communicating with the specialists, with service line managers, with ancillary departments, with surgery departments, and of course, with in-patient services to identify and correct service deficiencies.

Ralph: Listeners, again, referring to the box in the middle of page five, please fill in the blank space in the first sentence with that very important information Marc just provided for us: *assignments, improved policies, processes, and performance*. And in the second sentence, please fill in with the words: *specialists, service line managers, ancillary departments, surgery departments and in-patient services*.

Marc, you addressed this question peripherally, but another listener asked, "In dealing with physicians, does my approach change depending upon whether the physician is employed or affiliated?"

Marc: Certainly there are some differences between affiliated and employed physicians and the tactics and communication that can occur, but both

employed and affiliated physicians are critical customers in most markets these days.

They're members of my medical staff, if I'm a market manager, and need to be included in the relationship management process. Whether they're on my payroll or not, they're still a customer in a very important way.

Naturally, should an independent physician choose to compete with me or to become an adversary, I'll have no choice but to compete, whether he or she is on my medical staff or not.

Ralph: Absolutely. So, just to provide some proper context, can we talk about the evolution of physician employment as an integration strategy?

My recollection is that you were very involved in the acquisition of physician practices during the 1980s, which was the genesis of this strategy. Recount for us, if you will, the historical background and what we know two decades later that we did not know at the outset.

Marc: I won't give a detailed history, but it's worth looking back. The managed care threat was a major motivator for most hospitals to purchase medical practices from the mid-1980s into the mid-1990s.

I acquired my first internal medicine practice on behalf of a hospital client in 1985, and I have to confess that I made all the common mistakes, including disengaging the employed physician from governance of the practice, and assuming that we knew more about managing the business than he did. He wanted out of administration, of course, so he was happy to let us flounder. Boy, was I ever wrong!

As an industry, we made many other mistakes, including fouling up the incentives for employed physicians to remain productive, we overpaid for the practices, we added to the employment cost and the building occupancy cost. We even stripped out the ancillary services, which their patients, of course preferred to have in the practice and which, by the way, provided 15 to 30 percent of net patient revenue.

We treated our owned medical practices like departments of hospitals, assuming that the rules for success were the same. Of course, they're not, and we made these and other mistakes, and then wondered why we were losing so much money on operations.

Ralph: What is your confidence that we'll not repeat the mistakes of the past going forward?

Marc: After about a four-year hiatus between roughly 1998 and 2002, late 2001 to 2002, hospitals began employing physicians again with a vengeance. This time we are employing both specialists and primary care physicians.

The current incentives driving hospitals seem to include service line development, protection, and leadership, and of course recognizing that PCPs control the flow of referrals.

Physicians coming out of training programs with significant debt and wanting to avoid the risks of entrepreneurship, of course as I mentioned, are seeking employment. In fact, hospitals that don't offer an employment option are less competitive from a recruitment standpoint.

Now, while we're not paying huge amounts of goodwill for practices this time around, many of the same common mistakes I demonstrated with a slide I was using in 1994 are just as relevant today.

I guess that's good news for the consulting business, but not such good news for the hospitals or physicians, or those they serve.

Ralph: Indeed not. In fact, that's one of the reasons why you wrote The Primary Care Market Share Connection, which I noticed, as I reviewed the questions from the Ask Campaign, a number of listeners have read that marvelous how-to handbook for market managers and have some excellent questions to ask you from a number of different chapters so that they can receive

help from you to implement the content in the context of what they're dealing with every day.

Marc: Thank you and thanks to all you who've read the book. The Primary Care Market Share Connection, as you mentioned, Ralph, was published by the Foundation of the American College of Healthcare Executives through their Health Administration Press.

Now they also just recently released a study guide to accompany that book as part of their Fellowship Training program that's entitled Building and Maintaining Referral Relationships.

This treatise was written for hospital executives who need to develop and manage a successful implementation of strategy in competitive markets. Let's go on with some of the questions.

Ralph: The first question is "As you begin to lay the ground work for market managers, you introduce a powerful concept: the customer as the center of the universe.

"This fundamental tenant becomes the foundation upon which the rest of the competitive advantage formula is built. Please teach me why this concept is so critical and in many respects, revolutionary to healthcare today."

Marc: We do a good job, and have for years, of talking about customers as the center of the universe, but we don't always define the customer properly. As healthcare professionals, we're trained on meeting the clinical needs of patients who present for care.

Now we're constantly improving our clinical quality. Our patients/customers and our referring physician customers assume that we'll provide our services in a professional manner. Quality is assumed.

Interestingly, patients usually judge our quality using surrogate measures that have little to do with their clinical need and everything to do with servicing their wants and priorities. How they are treated influences their judgment about our clinical competence.

We have learned that what matters most to these customers is meeting their wants and priorities. Yes, they want to get better, but they are not clinicians and can't even spell most of what we do to or for them.

So, interestingly, we found, through interviews with primary care physicians, that they also assume clinical quality in making their referrals to specialists. In fact, when a new physician moves to town, he or she selects specialty physicians much the same way Mrs. Smith, who buys the majority of healthcare for the family, selects a primary care physician, which is usually by word of mouth.

A new primary care physician who needs to refer a patient to an EMT or a cardiologist will likely ask his or her partner down the hall which specialist to use.

That partner will likely refer the new associate to the specialist with whom he or she has had an established referral relationship. It's unlikely that even that physician-to-physician relationship is based on morbidity or mortality statistics.
Quality, again, is assumed.

Factors like appointment access, communication from the specialist to the PCP, involvement of the PCP in the patient's ongoing care, the way the patient is treated at this specialty practice, and other similar factors influence referral patterns.

Otherwise, the best statistical clinician in town would get all the business, and everyone else would starve to death. Getting beyond clinical need to, "Wow, they met my wants and priorities!" is very critical in a highly competitive market where multiple competitive alternatives exist.

Ralph: Very good. Listeners, if you will refer to page seven and fill in the information in the first sentence inside the box, which would say *clinical needs*, and in the second sentence, *servicing their wants and priorities*.

Here's another great question from a listener who has read your book, Marc: "Based on your years of experience in working with hospitals and owned or affiliated medical practices, what do we need to understand about the behavior of retail customers?"

Marc: That is a great question. When we talk about retail customers, of course, we're generally talking about Mrs. Smith. As I mentioned earlier, zip code analysis of most urban and suburban primary care practices indicates that a majority of patients live within about a ten-minute drive of the practice location.

Women make the majority of the healthcare decisions for the family and tend to select the family physician near homes or school. Yes, she will drive farther for her own OB, but for the family's doctor, they tend to be closer to home and school.

That way, when Mrs. Smith gets a call at work from the school nurse, she can leave work, get to the school, to the doctor, and finally back home without having to commute across town.

Further, since Mrs. Smith tends to stay with her physician once selected, even when other practices become available, a primary care practice, once established, is quite sustainable even in the face of new competition across the street or across town as long as that practice provides access to patients and to quality services.

Now this is all great news for market managers; again, those CEOs who have positioned affiliated PCPs to capture Mrs. Smith, who may be defined as market share, in selected geographies.

It's not so great for hospital administrators who have failed to act in capturing market share. The first practice in a neighborhood generally has the advantage in terms of capturing and retaining Mrs. Smith.

Ralph: So, again, a very important heads-up: that first mover advantage is, in fact, a very critical advantage. Listeners, if you will look at page eight of your handout, in the box it should say, "The majority of patients live *within ten minutes* of practice locations; *women* make the majority of healthcare decisions for the family, and they tend to select family physicians that are *close to their home and schools*. They tend to *stay with their original physician choice* when new practices become available."

Here is the next listener question: "One of the central themes of The Primary Care Market Share Connection is meeting the needs, wants, and priorities of retail customers or patients.

"You make a very interesting statement in the book I would like you to expand on. 'Every medical provider in the medical services demand chain interacts with retail customers.'

"Please define the medical services demand chain and explain how a good market manager would coordinate the activities of those in the demand chain to effectively meet the needs, wants, and priorities of the retail customer or patient."

Marc: The concept of the demand chain was first presented by Roger Blackwell in his book From Mind to Market: Reinventing the Retail Supply Chain, published by HarperCollins in 1997.

Blackwell noted that the most successful companies focus the entire supply chain, from raw materials manufacturers to wholesaler to whomever manufacturing and so on, on meeting the needs or demands of the retail customer.

Everyone who has ever had a basic business course is probably familiar with the concept of a supply chain, which starts with the raw material supplier selling to a manufacturer, who sells to a wholesaler, who sells to a retailer, who sells to the ultimate user, who is defined as the retail customer.

In a traditional supply chain, only the retailer sees and interacts with the retail customer. Other members of the supply chain interact only with other links in that chain and rarely see the retail customer.

I like to envision the supply chain moving from left to right in my mind in terms of providing services. Now the demand chain moves from right to left and represents the demand placed on the chain by the ultimate user, the retail customer.

For example, if there is a big game this weekend, the extra cases of beer ordered by my local convenience store were probably ordered weeks ago in anticipation of the extra demand that would be placed on the system by the retail customer this coming weekend.

So, if you will imagine with me now a medical services supply chain which starts with hospital-based physicians who don't see patients unless they're referred to the hospital, followed by hospital in-patient and out-patient facilities and services, followed by specialty physicians, followed by primary care physicians, and ultimately Mrs. Smith in that supply chain.

We offer our services at each link in the supply chain. Now when Mrs. Smith needs services beyond primary care, she and the primary care physician place demand on the chain. But, unlike the demand chains of other industries, every link along the medical services chain potentially sees Mrs. Smith.

For example, when the PCP decides to refer Mrs. Smith or a family member to a specialist, the specialist now has at least two customers. Not one, but two: the referring physician and Mrs. Smith.

When a specialist admits a patient to a hospital, the hospital now has at least three customers: of course the specialist, the PCP, who again, may not darken the door, and Mrs. Smith.

It is essential that all the links along the medical services demand chain are tuned in to meeting the needs, wants, and priorities of the retail customer and all the previous demand chain links or members if the referral relationships are to remain intact.

The successful market manager, the CEO in most cases, has a particularly important role making sure that the demand chain links are coordinated in providing seamless "Wow!" care to Mrs. Smith and to each other.

Ralph: If you look at your handout, listeners, you will notice that Marc has diagramed very nicely the traditional supply chain as well as the medical services supply chain.

Now if you will look in the middle of page nine of your handout, you would want to write in the blank spaces there: *retail customers and all previous demand chain links or customers*.

Also, you'll notice on your screen a picture of the book The Primary Care Market Share Connection, which contains a very in-depth understanding of all the principles we are discussing today. It is in reality the textbook and how-to guide for implementation of these principles.

There is special pricing for those of you who have invested your time to be with us today, and by clicking on the picture of the book you'll be able to access that opportunity.

Marc, what are some of the tools that are available to assist market managers in determining the willingness and ability of their owned or affiliated practices to meet the needs, wants, and priorities of their retail patients?

Marc: We have two tools that I will highlight that we'll make available to those who attended today. These are both self-administered evaluations that each specialty practice and the primary care practice can review on a quarterly basis.

The first is our Retail Readiness questionnaire, which helps medical practices, both primary care and specialty practices, to access their readiness to meet the needs, wants, and priorities of Mrs. Smith.

The second is our Specialist of Choice questionnaire, which helps specialty practices assess their readiness to meet the needs, wants, and priorities of their referring physicians.

Ralph: Here's the next question from a listener who has read your book: "The title of your book postulates the theory that primary care, in fact, equals market share for hospitals. What is the underpinning of that theory, based on your 25 years of experience?"

Marc: Ralph, the doctor, for most of us, is a family physician, a general internist, a pediatrician, or an OB. When Mrs. Smith moves to town, unless a family member has some pre-existing condition, she selects from among these primary care physician specialties to meet her family's needs.

She does not select a cardiologist, just in case her hubby becomes ill. She does not likely know what an otorhynolaryngologist is, let alone when she needs one. Most of us are totally dependant on our PCP to tell us when we need a specialist and who to see.

For this reason, I contend that PCPs capture, retain, and direct the market share of specialists and hospitals. Now my team and I interview, for survey, hundreds of primary care physicians each year, and we ask many of them how easy it is for them to refer their patients to the PCP's preferred specialist.

They tell us that the vast majority of the time, patients who are referred to a specialist, even across town and against migration pattern, have only a few questions like how soon they can be seen and whether or not the specialist is on their insurance.

I also spent time working with hospitals and specialists to redirect referral patterns by building new relationships with established primary care providers.

Ralph: From what you've just described, the primary care physician is a relationship provider versus the specialist who is more of an occurrence provider, correct?

Marc: Exactly. The long-term relationship is built with a PCP until specialty or hospital services are needed. Patients then return to their PCP after seeing a specialist for a procedure in the hospital.

Now, wise internal medicine sub-specialists, those at least who want additional referrals, frequently coordinate ongoing care with the referring primary care physician.

Ralph: Listeners, referring to the top of page ten of your handout please write in *capture, retain,* and *direct* in the top box.

Here is our next question: "Peter Drucker's statement that 'The purpose of an organization is to create and keep a customer' is emphasized several times in your book. Discuss this concept as it specifically relates to the importance of customer retention. What are the critical success factors for creating and keeping customers?"

Marc: When I speak to audiences, I often ask of physicians and managers two important questions. First, "Who is the most important customer of the primary care physician?" The obvious answer is Mrs. Smith or the patient. A satisfied Mrs. Smith will recommend her PCP when asked for a referral.

The second question I ask is "Who is the most important customer of the specialty physician?" Now the less obvious but correct answer is the referring physician, because he or she is the source of future specialty referrals.

Granted, if the specialist or his or her support staff treats Mrs. Smith poorly, she'll give her PCP an earful. But a successful primary care physician and his or her office staff will organize the practice policies and procedures around meeting the needs, wants, and priorities of Mrs. Smith in a way that's profitable to the practice.

Before implementing any policy or procedure or form or decision, the wise primary care physician and manager will ask four key questions:

1. Does this decision maintain or enhance clinical quality as I define it within my practice?
2. Does this decision maintain or enhance service quality? (Mrs. Smith will define that for me.)
3. Does this decision maintain or enhance physician productivity? For obvious reasons, that's where we win or lose the game.
4. Does this decision maintain or enhance practice liability?

If a decision or a form or a policy or procedure can't pass all four tests, then it's tabled or modified or discarded.

The successful primary care physician will identify, be sensitive to, and accommodate where possible Mrs. Smith's needs, wants, and priorities.

For example, let's say there's a strep outbreak at the elementary school and Junior shows up in the school nurse's office with a sore throat. Who will the nurse call if she wants something done? It won't be Dad; sorry, Dad. She'll call Mom, who more often than not is at work.

Let's imagine that it's 10:30 in the morning. What does Mrs. Smith need? Well, she needs a strep test for Junior, and a note from the doctor for the school nurse.

What does Mrs. Smith want? She wants an appointment today, and usually an antibiotic to validate her visit to the physician.

What is Mrs. Smith's priority? Well, her priority is an appointment over the noon hour because she has a critical 1:30 meeting, or perhaps before 4:00 PM because soccer for the other children starts at 5:00.

So, complicating matters, if we cannot meet her needs, wants, and priorities, the local Urgent Care or Minute Clinic can and will. So can the new doctor across the street. So much for PCPs!

If I'm a specialty physician, I have to be sensitive to the needs, wants, and priorities of Mrs. Smith, yes, but my most important customer is the referring doctor. What are her needs, wants, and priorities?

In my experience, communication and access are the two most critical desires of referring physicians. They want to be able to have their referred patients seen in a timely manner.

Some PCPs want to be consulted by telephone before the patient is seen to make sure that the specialist addresses the PCP's objectives for the visit as well the patient's clinical issues.

Other primary care physicians prefer to be included in a conference call to discuss treatment options after the patient has been examined by the specialist. Still others are so busy that they prefer just to be advised of the specialist's findings and recommendations after the fact by letter.

How does a wise specialist know a primary care physician's preferences? Well, he asks and records those preferences on a profile sheet which is available at the front desk, at the nurse's station, and at the specialist's office.

The profile sheet includes, importantly, the primary care physician's office manager's name and the name of the PCP's clinical assistants who may actually make many of the referral calls.

So, the bottom line: primary care and specialty physicians, if you want to keep your customers, focus on your customers.

Ralph: Excellent. Listeners, referring to the bottom of page ten in your handout, please write in *patient* and *referring physician*. *He/she is the source of future specialty referrals*. If you will also refer to the box in the middle of page eleven, please write in *Communication* and *access*.

Marc, one of the most instructive sections of your book deals with principles you and your family experienced personally with your grandson, Kaden, and the role that physicians, and in this case, specialists, should be conscious of as technician or healer.

Please share with us the power of these principles from your very personal perspective.

Marc: Thank you, Ralph. Most of the healthcare experiences we've had with our grandson have been wonderful. We have met wonderful nurses, concerned therapists, skilled and caring physicians, and many others.

As a result of their care and their caring, we have a rambunctious six-year old grandson who receives the majority of his nourishment through a G-tube, but you'd never know it. We couldn't be more grateful to those healthcare providers and others who have been so supportive along the way, but there have been a few bumps.

Those bumps occurred when people forgot that they were dealing with a little baby and frightened parents and grandparents rather than dealing with a diagnosis or a condition or disease state.

Regardless of our skill sets, I have learned that we cannot deliver quality care without the caring. When we become calloused to anything beyond the clinical event, even a perfect clinical event, we deliver sub-optimal care.

I was hired on one occasion by a hospital to help a young and struggling specialist. I visited a lovely office, interviewed the office manager, and sat down to business with the physician.

He proceeded to show me his multiple degrees and to let me know, in no uncertain terms, that he was the best-qualified clinician in the community in his specialty. Unfortunately, his brusque manner offended nearly every patient referred to him by primary care physicians in the community.

I examined his referral log and showed him how referring physicians appeared on that report for a few months and then abruptly dropped off. The facts were indisputable. But despite those facts, the physician insisted that they, meaning the primary care physicians, should recognize his clinical skill and ignore the rest. Of course he didn't last very long in the community.

Ralph: It's amazing how clear we, as patients, are about all of those issues in the market place and how important it is for those who are providing services to recognize those.

Another very important perspective that is illuminated in the book is the concept of primary care physicians as customers of the hospital. Explain why this concept is so important and what astute market managers can do to care for these very important customers.

Marc: We've already discussed the fact, Ralph, that the primary care physicians are the relationship providers who hold the market share for specialists and hospitals.

Until a few years ago, primary care and specialty physicians could be found, as I mentioned earlier, in the medical staff lounge every morning before or after hospital rounds, but with the proliferation of hospitalist programs, many of these PCPs in many communities no longer darken the hospital's door.

Now this presents an interesting relationship management challenge for specialty physicians and for hospital executives and market managers. Astute market managers and the liaisons they hire are acutely aware of this challenge, and they spend time visiting with primary care physicians on their turf.

They proactively make phone calls. They even set up the occasional dinner meetings that include both specialists and PCPs. They work with affiliated specialists to ensure that those specialists understand Specialist of Choice principles.

We found that the best place to start building a responsive model is to engage specialists by service line where we can engage the doctors and hospital teams to become a unified demand chain, focused on identifying and meeting the needs, wants, and priorities of referring physicians and their patients by providing that "Wow!" response in terms of service.

Ralph: Thank you very much. What an excellent answer.

We all know that hospitalist programs have taken hold in many communities around the country but rarely without some angst on the part of primary care physicians who are accustomed to following their own patients.

What are the key factors that market mangers should be sensitive to in order to win the hearts of primary care physicians and attract their referrals to hospital-based physicians?

Marc: Well, Ralph, when we work with client hospitals to establish a hospitalist program, we use a process that engages primary care physicians right up front through interviews and as members of the hospitalist program planning team. We make sure that they see the hospital program as an optional service for them and for their patients.

Fortunately, if we attract competent hospitalists and provide plenty of educational material for PCPs to share with their patients, the transition process can be relatively smooth.

Before long, even the most resistant PCPs will find occasion to try the program even if it's only for a weekend. Then if the program meets their personal needs, they're hooked.

Ralph: Excellent. There's an excellent comment and question from one of our listeners, who says, "You note in your book that most healthcare organizations are reasonably effective at assigning responsibility.

"What many hospitals and medical practices do not do well is create a culture of accountability. What is the definition of a culture of accountability, and how do you structure and nurture that culture?"

Marc: Thank you. My favorite management guru is Peter Drucker, and he noted that we cannot supervise knowledge workers such as physicians in the traditional sense, even if they're on the payroll.

However, everyone, including knowledge workers, must be held accountable for behaviors, for processes, and for outcomes. A culture of accountability formally defines how people will be held accountable and by whom, and then does exactly that: it holds them accountable.

We wrote an article on this topic which was the feature story in the *Group Practice Journal* in March of 2005. Accountability involves more than just feeling responsible; it includes a return-and-report loop where each person has the opportunity and the responsibility to regularly report results or outcomes.

Those whose behavior or performance falls short can be coached, assisted, or ultimately removed from the demand chain if they fail to perform.

Support staff should usually be held accountable by a competent practice manager or a department manager. Managers should be held accountable by physicians and other leaders involved in practice governance.

Employed physicians should be held accountable by their peers, but since many matters can't be dealt with by peers, physicians are ultimately held accountable by the person who signed their employment contract.

Establishing the proper accountability structure, clarifying performance expectations, establishing performance measures, and formalizing the reporting obligation form the foundation of a culture of accountability.

Ralph: Listeners, if you will go to the bottom of page twelve of your handout, and please write in the box *feeling responsible* at the end of the first sentence, and *return-and-report loop* in the middle of the second sentence.

Accountability involves more than feeling responsible; it includes a return-and-report loop where each person has the opportunity, and the responsibility to regularly report results or outcomes.

The Primary Care Market Share Connection concludes with a chapter concerning sustainable competitive advantage. Will you please teach us the formula for building and maintaining a sustainable competitive advantage?

Marc: I've learned from some very astute market managers how to build a sustainable advantage in highly competitive markets. First of all, those market managers need to position financially viable primary care practices throughout their primary and secondary markets.

These practices capture anywhere from 2,000 to 5,000 lives per physician and retain that market share until specialty, ancillary, or hospital services are indicated.

Second, wise market managers connect those PCPs with specialists of choice who have the ability to attract referrals from these PCPs by meeting their needs, wants, and priorities and those of their patients.

Third, wise market managers make sure that their hospital or affiliated hospitals are the hospitals of choice for referring physicians by understanding the needs, wants, and priorities of those physicians and providing outstanding care and caring to both referring physicians and their patients.

And fourth, those wise market managers focus their physicians and staff all along the demand chain to provide "Wow!" in terms of service. That guarantees both short-term and sustainable prosperity for the entire demand chain.

Ralph: That's a very articulate description of the formula which has just absolutely been proven to work again and again.

Marc, what's 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, a great way to contact us is by taking a look at our Web page at www.HalleyConsulting.com, or they can call our office number at 614-899-7325.

Q&A SESSION:

Ralph: As we mentioned at the beginning of this broadcast, our listening healthcare professionals have submitted over 90 excellent questions for me to pose to you today and time has permitted you to answer only ten.

For those of you who can stay on the phone a little longer, I'm going to pose some additional questions to Marc that you as listeners have asked. However, Marc, would it be all right for me to reemphasize to our listeners that any question not answered during our broadcast will be answered personally?

Marc: Absolutely. I'll be glad to do that, or given my travel schedule, we've got 16 other executives who can participate in that Q&A as well.

Ralph: Well let me, if I could, ask you some additional questions that will take us beyond our hour, but they're very excellent questions indeed.

Here's the first one: "Do you believe clinical integration between physicians, employed and private, and hospitals will continue to grow and become a long-term strategy, or is it a short-term strategy to build affinity with physicians that have held ill feelings of distrust with hospitals over the recent decades?"

Marc: Ralph, that's a great question. Personally, I watched this cyclical event again, starting in 1985; by about 1998, integration was being hailed as a failed strategy. There was nothing wrong with the integration strategy. It was failed implementation, in my opinion.

This time around, starting in late 2002, as hospitals are acquiring medical practices, I believe that the integration model is going to be a permanent fixture. I think that the increase in demands on the system and reduced

reimbursement is going to throw us together as hospitals, physicians, ancillary services providers, primary care and specialists all together just to survive, and it's likely to be a permanent fixture.

Ralph: The next question is: "What are the best physician reimbursement models to ensure that provider's interests are appropriately aligned with the institution's?"

Marc: That's a great question and it really has multiple answers. Let me share just a couple. If you're in an employment model, it's quite easy to begin to try to align what's going on out in medical practices with the hospital because physicians, the source of their capital—if they understand that concept—the source of their capital is the hospital. The hospital is the revenue-generating engine, the capital-generating engine.

Primary care practices and specialty practices are usually debt-financed when they are privately owned. They don't tend to retain earnings and build up capital, so the hospital becomes the capital-generating engine.

Of course, aligning employed physicians with a hospital and with the integrated model involves certainly an understanding of how capital flows and is generated. It also involves their own compensation model. We usually recommend a work RVU-based productivity model.

For independent physicians, I think that, again, engaging them in terms of creating a vision along a demand chain that allows those individual physicians to be successful as the hospital is successful and vice versa is probably the best way to align incentives.

Also realizing that at some point in the future, I wouldn't be surprised to see bundled reimbursement for the services that are provided to a patient the way we used to see capitation dollars flow in.

Ralph: Very interesting. Our next question is, "Why have hospital admissions decreased by about five percent over the last year? Is it physician preference, the economy, or payers?"

Marc: Boy, that's an interesting question. I think it's probably a combination of all those factors and others. Certainly, in the last several months, our hospital clients have seen decreases in hospital admissions beginning with things such as elective surgeries. People are delaying care if they can or opting for less invasive alternatives to deal with medical issues.

I think we're also seeing the culmination of impact from alternative locations workshops, whether we're seeing ambulatory surgery centers, specialty hospitals, or multi-specialty or single-specialty groups that have additional equipment and can offer more invasive services outside the hospital's walls.

I think it's a combination of all those factors, and certainly, payers are looking for less expensive workshops and venues in which to have their customers served.

Ralph: That was my reaction to that question as well, that it was a combination. Here's a very provocative question: "What are some ways to get employed physicians to step up and become service line champions and leaders?"

Marc: That's a great question. We have found, and part of the challenge that we face in many markets as we go in and begin working with hospital clients and with employed physicians, is engaging physicians so that they continue to feel a part of this integrated model, as opposed to just showing up for a job and clocking in and clocking out.

In our experience, physician engagement starts with what we call operational governance, and that is engaging physician leaders and hospital leaders, and establishing some shared objectives – what can we do together? – then aligning physician compensation and strategy, based on that vision and strategies to achieve that vision.

We also have found that aligning physicians and hospitals in a demand chain or service lines, as they're frequently called, to meet needs, wants, and priorities of referring physicians is a great way to, again, engage physicians to become champions and leaders.

Physicians are well-trained, and those that we want to do business with are committed to providing high-quality care in a caring environment. They will step up to the plate if we ask them to, in my experience, and if we give them a legitimate seat at the table.

Of course, there may be some who don't want to play and we should cut those folks loose; we need to keep the A-players.

Ralph: Indeed, and we keep coming back to those core principles again and again, don't we?

Here's a related question: "What is the best way to align the goals of the hospital and the physicians?"

Marc: In our experience as we work with clients, we realized that the hospital has certain strategies, and individual physicians – I'm talking independent physicians – have their strategies. Some hospital executives are frustrated that the physicians won't step up and buy into the hospital's mission, vision, and values.

Well again, they probably have similar values in their own practice setting, but they've got to meet a payroll every other Friday, so that dominates their objective. Even if physicians are employed in hospital setting, they live in a very different world if they're in a primary care or specialty practice.

Recognizing those differences, acknowledging them, and looking for ways to set goals that are compelling for both parties: What can we do together that we can't do individually? What can we do together that

will help the physicians meet their payroll, that will help the hospital accumulate capital, and will meet the needs, wants, and priorities of the community?

Ralph: That's absolutely excellent. It's interesting, the importance of that cohesiveness, communication, and really the outreach with the intent to understand and build both sides.

What management or administrative model do you see most frequently in integrated systems? Is it the administrative directors with service line responsibility across the organizational spectrum, or do you see a singular leadership model utilizing an administrator or COO of a clinical operations with departmental leaders?

Marc: That's a great question. In the book we're writing right now, Identifying Best Practices for Hospitals That Own Practices, we recommend as a best practice establishing the management infrastructure consistent with the operational governance infrastructure.

Operational governance, and I'll try to be brief in explaining this, involves two levels. One is the network-wide, governing across a network, which is a combination of key physician leaders and hospital executives, including the market manager that will make decisions that will affect the entire hospital-owned medical practice network.

Then each practice has its own governing model to manage its practice operations. It's very similar to private practice where the physicians and mid-level providers, if there are some, are engaged with management at each site level.

We usually recommend a senior executive who is accountable to that network operations council, and then a practice manager who is accountable to each of those practice operation councils so there will be multiple practice managers, each assigned to those councils.

We prefer the old, traditional model. The reason we like that is because ultimately it yields a bottom line and bottom line accountability. Each of those primary care and specialty practices needs to be financially viable if it's going to be sustainable in the long-term.

Ralph: That's an excellent answer. Listeners, notice that you have an extensive Q&A note-taking section at the end of your handout for your convenience.

Here's a really great question, especially in this environment: "What are your most effective recruiting techniques for physicians?"

Marc: Well, depending on the market, how easy it is to attract physicians to the market place, and how close medical schools are, we have found a couple of different things that we use.

First of all, we like to build relationships with primary care physicians early in their residency training. If you've got medical schools within the state that have primary care residencies, we would begin building relationships with those primary care residencies early on.

We build relationships with hospital executives, practice experts, and even with some physician leaders so that folks understand and look upon us as a viable alternative as they exit their training programs because they'll be looking for and experiencing, in all likelihood, multiple opportunities.

Building relationships early is key. Again, those are legitimate relationships, and sometimes we're teaching practice management principles in concert with those residency programs.

Another method that we've found to be very effective is to use what we call a practice opportunity perspective, and I won't be able to go into great detail, but it's basically a prospectus document that defines for every serious candidate, as well as for our own organization, what the practice setting will look like, who the players are, what the community looks like, what the "deal" will be in terms of attracting those physicians.

We also recommend that you need somebody in-house, even if you use an outside recruiter, particularly for some of the more difficult specialty recruitments. We recommend that you have an in-house person that spends full time in that recruitment arena.

Again, there is a lot of variability depending on the size of hospitals, how easy it is to recruit, and so on, but those are some of the keys that we use.

Ralph: I want to combine two questions here for you next Marc, because they're very closely related.

"How do you engage physicians in relationship-based care when they are not employed by the hospital, and what are the best ways to increase physician engagement in hospital initiatives?"

Marc: This is an age-old challenge for hospital executives. What we have found, again the key here, revolves around the market manager concept, and that is building relationships with physicians.

We need to understand the fact that independent physicians have their own set of issues that they need to deal with, and the better a market manager understands the needs, wants, and priorities of those primary care and specialty physicians who are independent, and the more effectively that market manager organizes his or her resources to meet those needs, wants, and priorities, the easier it's going to be to build and maintain relationships with those independent physicians.

Also, having that trusting relationship, particularly with the market manager and other senior executives on the hospital's team, when and if it becomes time for that physician to say, "You know, I think I want to get out of private practice settings," or "Gee, your competitor showed up on my doorstep and offered me all kinds of money to come and join his team," those physicians are more likely to come to the market manager and give us the opportunity to engage them.

Ralph: We literally have pages and pages of more questions which, as we assured our listeners, we will be answering personally, but I want to conclude with this last question: "How do you manage hospital administrator's expectations for setting up new recruited physicians in practice where the timeframe for insurance credentialing and start-up should be six months, not one to two months?"

Marc: I chuckle because there have been so many times when we've looked at each other and said, "He's starting when?" and realized that, "My gosh, we can't even bill for this doctor because he or she won't be credentialed for three or four months."

What we've found is that a preemptive strike is best. We've literally taken the start-up action plan which we have for medical practice, and taken that plan in to sit down with the hospital CEO, CFO, and business development manager, to show them the start-up action plan steps and the timeline and to solicit their help in advance to try to help us stick to that guideline.

That can help; it really can, because if they understand what we're facing, then we don't hear about it on the back end.

Now despite our best efforts, we know that deals are going to surface or appear and a market manager is going to feel that he or she needs to strike today. Again, if that's the case, we want to be ready to move as quickly as we can, but to alert the market manager and to remind them of those things that will delay this. Payer credentialing is key. Sometimes medical staff credentialing is key as well, before we're going to be able to start billing.

There will be a dollar cost to the organization, in terms of lost reimbursement, if we fail to follow that strategy. But I would start out sitting down with those C-suite executives and sharing with them what your start-up action plan looks like and the timing.

Ralph: Marc, this has been a most informative and valuable hour. We're so appreciative of you teaching us about this very complex, multi-faceted subject of Physician Integration Economics.

I think it's been most particularly helpful to have your insights about how hospital CEOs can better manage physician relationships by becoming market managers.

As we mentioned previously, there is special pricing from Health Administration Press available for you as listeners when you purchase The Primary Care Market Share Connection from the link on this web page.

Again, we want to emphasize that the Primary Care Market Share Connection is the textbook and the implementation guide for the principles that Marc has taught us today.

Marc, are there any parting thoughts that you would like to leave with our listeners before we conclude this event?

Marc: Just my appreciation for the opportunity to visit today. Ralph, thank you very much for facilitating the questions.

These are exciting times, and when I get up every Monday morning, I'm excited to be out there tackling the challenges as I'm sure many of you are. Thank you again for the opportunity.

Ralph: You're most certainly welcome. A special thanks to all of you who 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 website, along with a written transcript for your use.

We will give you notice with in the next few days so you can visit the Halley website 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.