Performance Improvement for Hospital-Owned Medical Practices
Strategies for Success
When Your Practices are Falling Short

OBJECTIVES:
1) Identify and avoid the most common mistakes in owning medical practices.
2) Define the actions you and your organization must take to correct these mistakes.
3) Learn how to position your practice for market leadership.

WEBINAR GUESTS:
Marc Halley
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Hospitals and health systems can enjoy all the benefits of employing physicians without suffering the losses.
Good afternoon, everyone, and welcome to our spring webinar—Performance Improvement for Hospital-Owned Medical Practices: Strategies for Success When Your Practices are Falling Short. This is Ralph Harding, your host for our interview today, with Marc Halley, Judy Treharne, and Lauri Miro of the Halley Consulting Group. Marc is one of the leading authorities in the nation on strategy and performance improvement for physician networks, and Judy Treharne and Lauri Miro are practice management experts who assist physicians and their staff in optimizing clinical and operational performance.

As a result of attending this webinar, you will gain crucial insights that will allow you to 1) clearly identify why your practices are not performing at the level of their private-practice peers, and 2) succinctly define the actions that you and your organization must take to correct these problems. When this webinar concludes, you will understand the criteria your physician network must meet in order to move toward optimal operation, financial viability, and market leadership in the next 12 to 18 months.

We received many thoughtful questions that all of you, as healthcare professionals, submitted during our Ask Campaign. The content of those questions will drive our discussion today, and we will address just as many questions as we possibly can during this 60-minute broadcast. Please note that any Ask Campaign questions not answered during the broadcast will be personally answered by Marc, Judy, or Lauri either by phone or e-mail.

Before we begin, I’d like to call your attention to the handout link in the middle of your screen, just below the “Welcome to the Webinar” heading. Please print the handout, and be prepared to follow along and take notes on the clear counsel that Marc, Judy, and Lauri will be delivering to us today on this very important topic.

Also, you will notice that there is a feedback box at the bottom of your screen, so when the webinar concludes, please take a moment to submit any thoughts, suggestions, or follow-up questions you may have about this webinar. We would love to hear from you.
Before we begin the interview, let me provide you with a view of Marc Halley’s rich background in healthcare, and then I will ask Marc to introduce Judy and Lauri.

Marc D. Halley is President and Chief Executive Officer of the Halley Consulting Group. He has provided management and consulting services to hospitals and medical practices for more than 30 years and has worked with a variety of physician specialties, including hospital-owned medical practices, across the United States. He often facilitates strategic and operating plan work groups including physician leaders, executives, and board members.

Marc is a frequently requested speaker, addressing governing boards, senior executives, physician groups, management teams, and national organizations, including ACHE, the Forum for Healthcare Strategists, Healthcare Financial Management Association, MGMA, The Governance Institute, The Healthcare Roundtable, state hospital associations, and many more.

He has authored and co-authored more than 30 articles that have been published frequently in industry journals such as *Trustee, Healthcare Financial Management, MGMA Connexion, Group Practice Journal*, and the *Journal of Medical Practice Management*. Marc has also been quoted in diverse publications, from the *L.A. Times* to *Becker’s Hospital Review, Physicians Practice*, and *CMA Today*.


Marc received his Bachelor of Arts 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, Judy, and Lauri with us today. Will you please take just a minute and give our listeners some background on Judy and Lauri?

Marc Halley: Thank you, Ralph. I would be happy to do so.

Judy Treharne is a Practice Consultant for Halley Consulting Group. Her extensive healthcare management experience began in 1979, as an instructor in a Health Occupations program at a local community college. Early in her career, she served as Clinic Manager, responsible for day-to-day operations in a hospital-owned setting, and as Administrative Manager of a clinical department in a children's hospital. Beginning in 1992, Judy functioned in a variety of leadership roles within a multi-specialty hospital-owned medical practice network governed by one of the largest health systems in the Midwest. Her accomplishments included improving ambulatory clinical financial performance by $6 million in one year; leading successful JCAHO accreditation surveys; guiding the strategic implementation of practice management systems, which improved the quality of patient care; and facilitating the integration of various independent and hospital-owned practices into the health system. Judy received her Master of Arts degree in organizational leadership from the College of Saint Catherine in St. Paul, Minnesota.

Lauri Miro also serves as a Practice Consultant for our team. She brings 16 years of experience as a staff nurse, practice administrator, and hospital c-suite executive. Her tenure includes directing the operations of a network of 15 hospital-owned physician practices and the associated central billing office. Lauri has also provided network development support to hospital-owned medical practices, including network marketing, practice acquisition, physician recruitment, physician employment, contracting, and management services. As Vice President of Operations for a multi-hospital system in the Midwest, Lauri directed the system-wide strategic planning process for key stakeholders, including board members, management, employees, and physicians. She was a key facilitator for planning and construction of a heart and vascular center. Lauri’s career also includes serving as director
of a children’s hospital, a cardiology service line, and an occupational health program. Her hands-on nursing experience includes both critical and intermediate care units. Lauri received her MBA and nursing degrees from the University of Wisconsin, Madison.

Ralph: Welcome, Judy and Lauri. We are so pleased to have you join us today!

Judy Treharne: Thank you, Ralph.

Lauri Miro: We’re excited to be here!

Ralph: We have a host of healthcare professionals from every region in the country that have joined us today for this webinar, so let’s get started.

Listeners, we will be discussing some of the most common mistakes hospitals make when they own medical practices and employ physicians, but, as Marc says, the good news is that all of these mistakes can be corrected. Hospitals and health systems can truly enjoy all the benefits of employing physicians without the losses.\(^1\) The first step to enjoying the benefits, of course, is to identify the mistakes and then quit making them! In this webinar today, we will answer the questions that you have posed to us about how to identify the mistakes we see most often as we work with hospitals and employed physician networks around the country—and importantly, how to correct those mistakes.

Today, Marc will address listener questions that focus on solutions from the hospital or health system perspective, and Judy and Lauri will answer

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questions that will provide you with their perspective from working inside the practices.

Marc, let’s direct our first question to you, which addresses a shared concern among our listening hospital and health system executives:

In what ways might we be paying too much for the practices we purchase?

Marc:

Ralph, this is a great question to start our discussion. During the first round of practice acquisitions starting back in 1985, hospital executives frequently paid too much for both tangible assets and “goodwill.” As competition to acquire medical practices heated up between competing hospitals, those goodwill payments increased. Subsequently, the hospitals amortized that goodwill through the practice income statement, which, of course, made post acquisition financial performance look terrible. Eventually, however, the goodwill amortization did come to an end.

Today, hospital executives are still paying too much for practices they acquire. But the challenge is more insidious. While we don’t see much in terms of goodwill payments, we often see hospital executives paying employed physicians more income than they ever made in private practice, and more than their productivity can support. Unfortunately, this imbalance is not amortized over a defined period. It is an ongoing problem, at least for the duration of the employment contract, and rectifying that imbalance always has huge implications for the ongoing relationship.

Ralph:

Thank you, Marc, for calling these points to our attention. And we certainly know that compensation can be a tough issue when employing physicians, and we’ll talk more about that as we get further into our discussion today.

Judy, here is a question for you:
What are some of the most common problems you see when you work with hospital-owned medical practices?

Judy:

Well, Ralph, frequently we find ineffective decision-making bodies, ones that do not involve the physicians. This often happens quite by accident when physician practices are acquired. It’s not unusual for physicians to be ready to wash their hands of running their practice. They’re just worn out from the usual decision-making required. They like the idea of making the same salary (or even higher levels of compensation, as Marc mentioned) and just going into the office to take care of patients without worrying about the business side anymore.

Unfortunately, this often is increased as hospital systems recruit new doctors out of residencies and fellowships. They bring in younger physicians with no private practice experience. They are not accustomed to having a voice in how things get done. This means a health system can have a significant number of doctors that are either worn out by trying to keep their practice going or who have no experience running the business side of a practice. To compound the problem, you may have hospital administrators who believe they can manage the practice better than the doctors, even when they have never worked with physician practices - all their experience may have been with hospital-based departments. They think they can treat physicians like other employees in the hospital. That doesn’t often work.

When decisions are being solely made from the top-down perspective, and there is not adequate structure in place to get the physicians involved in decision-making for their own practice, the physicians won’t be engaged—and when they are not engaged, they often are not as productive as they were in private practice. Of course, when compensation goes up at the same time that productivity goes down, you have a substantial problem.

All of these issues underscore the need for an effective governance structure. Proper governance provides the solution to many problems experienced
by integrating health system leadership. It provides a vehicle to involve physicians and administrative leadership in developing a common vision and common goals for the physician network. When physicians help create the practice goals and network objectives, they are much more likely to be engaged and feel accountable to achieving those goals and objectives.

Ralph: Excellent answer, Judy! Lauri, what are your thoughts as you listened to Judy’s response to that question?

Lauri: Well, I think Judy hit upon a key issue with governance. Physicians who have been in private practice think like business owners—like entrepreneurs, if you will. They are used to making financial ends meet on their own, and they are used to a situation where their personal income is a direct result of the end-of-month profit. So when we bring these market-savvy physicians into an employed setting, one of the common problems we see is that hospitals hire them without a governance model in place to keep them involved in the decision-making for their own practices.

To further complicate matters, physicians and their practices in less mature markets are often viewed like another department of the hospital. Hospital administration starts to apply hospital centric approaches to the physician practices that are not really relevant and can be actually counterproductive. Often, there is not a recognition that a physician practice is a very different business than hospital acute care.

So what is the answer? Just like Judy said, and it is definitely worth repeating, there must be a governance model or structure in place that is designed to solicit and utilize physician feedback, to keep them engaged in the management of their own practice. And then it works best when the network operates from the bottom-up rather than from the top-down.
Ralph: Thank you, Judy and Lauri, for identifying really one of the most fundamental problems we typically confront in our work, and for describing a solution that helps health system leadership and physician network leadership to integrate, to find a common vision, and to work toward common goals.

Lauri, I’d like to present this next question to you:

**What are some of the major pitfalls you have seen as hospitals try to develop their physician networks?**

Lauri: Well, Ralph, one of the major pitfalls we find is that there isn’t an effective network development plan that interfaces with the medical staff development plan. Growth is often unplanned, not coordinated among key executives, and it’s reactive to market dynamics. For example, often as hospitals start acquiring practices, they have not really carefully considered the complement of primary care and specialty physicians that are needed in the network, and they end up making decisions without a clear strategy. Without a clear plan, a health system is more likely to respond to physicians knocking at the door, even when those practices may not be viable to achieve added strategic value. Without validating where the physician service gaps are through appropriate market research, health systems often end up with a hodge-podge of practices that may not be well coordinated to meet community needs.

Ralph: Astute observations, Lauri! Thank you. Judy, let’s get your perspective on this question as well.

Judy: Well, there is another pitfall, and it stems from not having an effective network development plan. When this happens, the physician network can grow too quickly - frequently we find this results in referral leakage. For example, when a network grows too quickly, we often find it is because
they are in a reactive mode. The lack of a clearly defined set of required subspecialists to meet community needs may allow the acquisition of subspecialty providers into the network without adequate connection with their primary care providers. Without the primary care physicians’ awareness of new subspecialists, and the development of relationships with them, referral patterns will stay the same as before the acquisition of those subspecialists. Brand loyalty is critical to hospital systems. Keeping patient referrals within the network is your system’s life blood. Therefore, you need to clearly communicate to everyone in the organization which physicians are in your network and which physicians are still independent.

Lauri: Yes, and to further build on what Judy is saying, another way we address the issue is by encouraging the specialists within the system to become what we call “specialists of choice,” so that our primary care physicians within the network not only know which physicians are actually part of the system, but also prefer them to other independent specialists in the market. In order to become “specialists of choice” of course, and for these referral patterns to be sustainable, the specialists must nurture those relationships with the referring primary care physicians by providing excellent access, a great service experience for patients, as well as effective communication back to the referring physicians.

This approach helps to keep the entire health system viable, because primary care physicians are referring to subspecialists in the network, and primary care physicians and subspecialists are making sure that the patients who require more intensive services are admitted to “their” hospital. What this all means, at the end of the day, is that all the providers are driving revenue back to what we call the capital-generating engine, the hospital.

Judy: Also, from a network perspective, we often have to ask hospital administrators (whom we refer to as market managers) to step back and see what they’ve pieced together to date. They really need to look at the
big picture in terms of what subspecialties they truly need to care for their patients in their service area.

**Ralph:** Thank you, Lauri and Judy, for your enlightening comments and solutions.

Marc, we see many hospitals today acquiring practices as sort of a knee-jerk response to competitive influences or other outside conditions.

**What challenges would you caution hospitals or health systems to avoid when acquiring practices?**

**Marc:** Well, Ralph, let’s start with the most significant challenge. Frequently, as Judy and Lauri have alluded to already, hospitals acquire medical practices as a reactive strategy. Given the difficulties of maintaining a private medical practice, hospital CEOs are increasingly forced to respond to practices that are already in financial trouble. The CEOs cannot afford to let these affiliated practices fail or close or go to the competition, especially when they contribute market share to the hospital and its affiliated subspecialists, when they support essential service lines, and when they meet critical community needs. Unfortunately, building a medical practice network without a clear plan often yields a lopsided, specialty-dominated network without adequate primary care market share to feed the downstream providers. Reactive medical practice network development also often results in sub-optimized placement of primary care practices, which negatively affects market share and payer mix for the hospital and its affiliated specialists. Careful geographic placement of primary care practices is very significant in competitive urban and suburban settings where such placement sometimes becomes literally a neighborhood by neighborhood strategy.

**Ralph:** Excellent answer, Marc. I know that you and I have conducted many interviews with hospital executives who would definitely agree with what you’ve just said. So listeners, the solution to these problems that Judy
and Lauri and Marc have just talked about involves carefully crafted and coordinated network development and medical staff development plans.

Lauri, let’s come back to you for just a minute.

**What kinds of problems are you seeing with practice managers?**

**Lauri:**

Well, we often find a lack of site level physician practice management expertise. The result is that the practice isn’t really positioned or organized in a way that will support staff development, provider productivity, and patient satisfaction. This situation often results from the fact that many people who are in the practice manager roles have been with the practice for a long time before it was acquired and may not have had any formal management training or education. Quite often, the managers may have been excellent receptionists or even medical assistants and were promoted beyond their skill level and training. When the practice is then acquired, there is often not a “hands-on” network executive or administrator who can actually develop these managers and bring them up to the skill level needed to function in today’s complex environment. Success at this level is all about training and developing the managers so they can, in turn, then develop their own staff.

**Judy:**

As we alluded to in the response to one of the previous questions, we spend a substantial amount of time on governance in the front end of our network evaluation engagements. Helping clients develop their governance structure and making certain that this area gets the attention required across all practice sites is critical. However, even when there is an effective governance structure in place, we frequently find they are not seeing the results they expected. A key reason for this gap between performance expectations and actual performance is quite simple—a practice cannot make effective progress without a good manager at the site level. Having a strong manager, accountable to and for every practice site moves the whole network forward towards meeting their goals.
And in addition to having strong managers at the site, one of the most powerful tools that we recommend to help bridge this gap are our site-specific action plans. These are implemented under the direction of our Practice Operations Councils, which are practice specific managing councils that include all physicians at the practice as well as the site manager. Some of the biggest improvements are made when you have engaged physicians with a strong manager to implement a plan that is developed specifically for their site. When you tailor revenue enhancement strategies and expense reduction strategies with each site plan, you see that this is really where the rubber hits the road. You can begin to see significant improvements.

So, let’s dig a little deeper into this question, if you don’t mind. You mentioned that problems with practice management can trickle down to the staff as well.

What is the nature of the challenges you find with the staff of medical practices?

Judy, would you like to respond first?

We are happy to expand on that, Ralph. As we just discussed, a lack of physician practice management expertise in turn impacts the staff effectiveness within the clinic sites—not only how staffing models are developed, but even with regard to the competency levels of the staff. Are staff members positioned in the right roles to support the physicians’ delivery of efficient and effective care? Are they organized to support provider productivity and patient satisfaction? Staffing challenges are often a serious issue in enhancing performance.

This is so true, Judy! The solution to this challenge involves developing those managers so they can develop their own staff, and this is critical. If the
physicians are going to feel comfortable delegating duties to the staff, they have to have a high level of confidence in the competence of those to whom they are delegating.

Judy: Right, Lauri! That means the network needs access to effective training programs. We certainly find training programs in place in networks that we work with—internal and external. We can provide feedback on their effectiveness and we can also provide support as well in the areas of coaching, mentoring, and training of management. Many times, in smaller organizations, they just don’t have internal resources to do this on their own. Sometimes the programs are just too hospital focused and they don’t meet the needs of the physician network.

Ralph: Very good! Thank you both for helping us drill down a little deeper into the staffing challenges area. I really appreciate the excellent points that both of you made.

Judy, in reading our listeners’ questions, it seems that many of them may be a little overwhelmed as they try to assess what their networks’ issues might be, and they aren’t quite sure where to begin.

With all the experience that you have acquired in evaluating medical practice networks...

**What are the main areas you would recommend that a physician network, or even an individual practice, focus their attention on?**

Judy: That is a BIG question, Ralph, if it’s not broken down into smaller pieces. The easiest way to answer it, for me at least, is to group the most important areas into three categories: strategic, operational, and human resources.
The **strategic category** begins with the strategic plan. In this category you are concerned with your governance structure, the development of your strategic plan, and how management supports the implementation of that plan. To have sustainable, long-term viability, this work is critical. If you don’t start on the strategic category, you will not find that the work in other categories is sustained.

Then there’s the **operational category**. This is the day-to-day functions such as patient flow and daily operations. These are significantly impacted by what I believe are two major tools that support patient flow—your human resources, plus your health records and practice management systems. And don’t forget revenue cycle—the process that makes it possible for you to actually get paid for the work you do is a critical part of operations.

And the third category is **human resources**, which includes physician compensation, employment contracts, a culture of accountability, training, and staff. These areas, of course, support operations and make your strategic plan work.

It’s important to note that while dividing these areas helps provide focus, it is really about making sure all three categories are working well individually and collectively. You could have a good overall plan, but if the operations category is not functioning correctly, the strategic plan just won’t work. And in the end, it’s people, your human capital, that make both of the other components work.

**Ralph:** Judy, thank you for breaking that down and providing some very actionable takeaways for our listeners.

**Marc,** this next question addresses a common frustration among executives whose hospitals own medical practices:
From your perspective, why do physicians become less productive once we purchase their practices?

Marc:

What a great question. Ralph, the bi-weekly payroll in a private practice provides plenty of real-time incentive for independent physicians to see patients, to code and document properly, etc. This “eat what you treat” mentality, however, is usually lost in a hospital employment setting, because the payroll becomes the hospital’s problem. In other situations, the mature physicians select hospital employment as their glide path to retirement. They enter the arrangement hoping to slow down and to pace themselves so they can continue to practice.

Perhaps, however, most importantly, many hospital-sponsored physician compensation models lack the real-time risk and reward to motivate productivity, to promote appropriate coding and documentation, and to consistently drive attention to clinical quality and service quality. We routinely encounter hospital-owned medical practices with physicians functioning below the 25th percentile when compared to national productivity benchmarks. Such poor performance levels would not be tolerated in any other employment setting and would quickly bankrupt a private practice.

Obviously, a physician compensation model that fails to promote productivity, that does not motivate high quality, that does not provide a market rate of compensation to capture and retain physicians, and that does not support practice viability is by definition, broken!

Ralph:

Thank you, Marc. Those are excellent insights into really a very challenging area of physician compensation and productivity. Lauri or Judy, do you have anything to add to what Marc was just discussing?

Lauri:

One issue that comes to mind, Ralph, as I listened to that question and the response from Marc, is that many times if networks are growing quickly, they
reach a point where there are several different compensations models in place which can often vary significantly. These models can range anywhere from cash collected to various formula driven productivity models. So often when we are doing a network evaluation, we will discover three or four completely different compensation models within one network. This variation makes it difficult for the system administration to manage with consistency, to convey a clear understanding of what the expectations are, and to achieve unity among the physicians.

We address this problem by identifying what those different models are, and then clearly pointing out what’s working well and what’s not working well to address some of the issues that Marc just mentioned. Then we typically encourage the network to move toward a more standardized approach.

We recommend that this be done actually with a physician compensation subcommittee, under the direction of our proposed governing body, the Network Operations Council. Here, the physicians can look at several different models and evaluate what works best for their own network overall. Then, many times our clients will call on us to provide a more detailed analysis on how they can actually migrate to an optimal and more consistent physician compensation model. I don’t know, Judy, if you would agree that this is one of the key issues we deal with during our network evaluations.

Judy:

Yes, Lauri, I would certainly agree. As mentioned earlier, in the heat of the battle for market share, health system leaders might make decisions out of desperation rather than as a result of carefully considering what they’re creating and making sure it is sustainable. Often times acquisitions take place with no one from the network operations management team at the table to serve as the voice of reality and ask, “Will this be sustainable?” This mode of operation increases the problem of multiple physician compensation models and contracts when we don’t engage in advance network development planning.
The physician compensation contract is such a critical piece of the cost structure that the health system executives absolutely must address it. Also Lauri, as you said, sometimes there’s not only three, four, or more different compensation models in a single network. I’m even seeing differing models within the same practice site in the same specialty—and even differing rules, so to speak, on what the expectations are with regard to meeting the terms of the contract. So, for example, on-call responsibilities might not be fairly divided across the group that’s sharing call. This makes it pretty uncomfortable for providers because of the potential for underlying resentment about one colleague having a better deal than another.

**Ralph:** Excellent comments, Lauri and Judy! Outstanding input, and you’re really addressing some very critically important problems that we seem to be seeing over and over again across the country.

Marc, in your response to that question, you mentioned the commitment that independent physicians have—by necessity—to the success of their private practices, along with those real-time incentives that motivate them to perform well.

I know that many of our listeners are asking...

**How do we transition our physicians from an ownership mentality to an employee situation in a way that does not diminish their commitment to the success of the practice?**

**Marc:** Ralph, this question highlights a challenge faced by many, if not most, of those organizations that are using physician employment as their preferred physician integration approach. Over many years working with physicians in employment settings, we have learned that if we treat physicians like employees, they will act like employees and they’ll view their role as simply a “job.”
This issue is part of what both Judy and Lauri mentioned in their discussion about engaging physicians. Again, if we treat them as business partners (partners who happen to be on the same payroll as you and me) and engage them in setting high performance expectations for themselves and others in the areas of clinical quality, service quality, productivity, and financial performance, most of them, if we engage them properly will act like business partners or what we call *intrapreneurs*, and they will achieve high performance levels. The story is just that simple and complex! If we engage employed physicians in setting performance expectations that match their private practice peers, and if our business partnership tolerates nothing less, we will get that level of performance. If, on the other hand, hospital executives ignore the performance problem, or they want to “boss” their employed doctors rather than partner with them, even if they’re using a physician executive as the “boss,” they will reap bright but underperforming employees.

**Ralph:**

So true! Great thoughts, Marc. As you said, engaging physicians as partners and setting high performance expectations is a simple concept. But as we’ve seen time and time again, it works!

**What kinds of burdens do you see hospitals placing on their owned medical practices that inhibit their financial performance from an accounting perspective?**

**Marc:**

Well, Ralph, a couple of the burdens or costs that you refer to immediately come to mind. The first is the often increased employment expense. The cost of human resources comprises 70% or more of the cost structure of a healthy medical practice. In addition to salaries and wages for both the physicians and support staff, the employment expense also includes employee benefits. Now, those benefits are usually lean in a private medical practice when compared to hospital benefits. Most acquiring hospitals impose their benefit
structures on the practices that they purchase, which often increases benefit costs significantly. While this strategy is much appreciated, of course, by the recipients, it contributes to hospital-owned practice losses, and it artificially inflates employment costs in the area for private practices competing for the same support staff.

The second cost that comes to mind is the cost of building occupancy, which is actually the third highest expense in a medical practice. Most private practices (especially solo or small group practices) are housed in what we might call conservative facilities. Now, some of those practice facilities are clearly in need of routine maintenance and upgrades, as well as new equipment and furnishings. But it’s common for acquiring executives to move those medical practices from space costing $9 or $12 or $15 a square foot, to medical office space costing twice that amount or more. Of course, offsetting these additional fixed costs with more volume is challenging if the acquired practices are already mature (that is, full), and especially if employed physician productivity declines.

Ralph: Great comments, Marc, and I think this should give our listeners some excellent ways to improve the financial performance of their owned medical practices from an accounting perspective.

Judy and Lauri, here is a very thoughtful question from one of our listeners:

How do we make the reporting in our practices meaningful in actually driving change that improves performance?

Judy, would you like to talk about this first?

Judy: Ralph, indeed that is a common yet a critical problem. Some organizations pride themselves on having excellent reporting, and they might have the
right numbers, and they tie out, and they give good reports including income statements to their boards, etc. But they don’t have anything that really gets down to the individual site level that feels actionable for the practice managers and physicians that can support them in improving the numbers. So the reports are just not established to support operations. Lauri, what are your thoughts?

Lauri:  
Well, those are excellent points, Judy, and I agree that one of the key areas, once you start to drill down and create accountability at the practice level, is you really have to have adequate tools to shape and manage the data you’re receiving. These must be relevant and tailored reports that are not just extensions, as you mentioned, of hospital reports, or you’re not going to get the information that you need to manage properly. And I think we see this as being a challenge across the country, not only for the staff in the practices, but also for physicians hired from private practice who are used to knowing everything about their practice in great detail. Then, they come into a large system, and many of their costs are variable or hidden, or they don’t get adequate reports to help them understand and manage their performance. It’s a pervasive problem, especially with networks that are immature and growing quickly. Keeping up with the reporting and the data management is not always good. It lags, and so there is often significant frustration.

Judy:  
You’re right! For example, in many markets where the physician compensation models are data-driven, perhaps something as simple as a base salary plus a work RVU incentive, yet there are not trusted reports for the physicians and managers to understand how they’re performing. Sometimes this is because of hospital centricity—what works for a department of the hospital, as you said, just may not apply to the physician network. Oftentimes the sophistication in report development just isn’t there. And that’s another area where we, in our business analytical service area, can be of help. We can create financial reports, migrating information from hospital information systems and practice management systems into a product that
can help practices have good information, good reports, that allow them to feed action plans.

**Ralph:** Great, Judy and Lauri. That’s wonderful information for our listeners. Anything else that either of you want to add before we move to the next question?

**Judy:** Well, yes, just another thing that ties into this reporting area: It’s not just general ledger reporting, but reporting that comes out of the accounts receivable system as well. Because we still find many systems are coming together, they may have two or three or even more practice management systems that they’re still working with because they aren’t yet structurally integrated. They’re working so hard at pulling those tools together that they really don’t have time to optimize the performance of any one tool. They step things up in order to implement quickly, so that pulls all kinds of resources into the electronic medical record, maybe even away from the practice management systems. But because there’s real pressure to get providers onto the same system as quickly as possible, you wouldn’t find that unusual. That means there’s all kinds of focus on go live and not much focus at all on ensuring that the tools they’re using are optimized. So reporting should start with the financial component, and that helps us know where we are from a bottom-line perspective. But those other pieces of information that we pull out of the practice management system, our electronic health system, are critical for us to get the organization moving to that next level of performance.

**Ralph:** Thank you, Judy and Lauri. An important point that stood out in your response was building reporting systems that produce information that is relevant to practice performance and that is immediately accessible, understandable, and actionable.
Let’s talk for just a minute about our network evaluation process and how it helps physician networks to avoid or to correct the mistakes we’ve been talking about today. Judy,

**What are the objectives that you find most hospitals and health systems have when they engage Halley Consulting Group to conduct a network evaluation?**

**Judy:**

Good question, Ralph. Almost all our clients hire us because they want to know very specifically what it takes to be successful in owning a medical practice or a network of practices. So in other words, they want to know what it takes to become operationally and financially viable and to become market leaders in their community.

So in this context, operational viability includes the ability to demonstrate:

1) superior clinical quality as defined by evidence-based medicine;
2) superior service quality as defined by their patients and their referring physicians; and
3) superior productivity of physician providers as evidenced by highest and best use of staffing, which leads to enhanced patient access and thus a greater number of patients served each day.

Financial viability means that the primary care groups are at breakeven and subspecialty groups can also be at breakeven when there is adequate patient volume in the service area.

**Ralph:**

Excellent, Judy. Thank you very much. Lauri, let’s take that a step further and have you answer another question:

**What are the benefits that clients receive from these network evaluations, and why do you believe these specific benefits are important?**
Lauri: Ralph, this is a very important question, and one we are often asked by clients.

The first one we have actually talked quite a bit about today because we believe it’s really important, and that is the full engagement of your employed physicians as partners in managing their practice as well as the network as a whole. Addressing issues that relate to clinical quality, service quality, productivity, etc. are just a few examples. This engagement and collaboration is really the catalyst for all the value created in the network. The fact is that without engaging physicians first at the network level to work with leadership on strategic direction, and then secondly at the practice level to help develop solutions to problems, organizations often find that they simply are not able to achieve performance improvement.

A second, and also pretty significant benefit is that we position our client organizations from a governance perspective to have the sponsorship necessary to effect change. Engaging the senior level health system management, along with the physician leadership, in the governance of the practice network is really critical for long-term understanding, collaboration, and success.

A third benefit is our gap analysis, which compares financial performance of individual providers, by specialty, to external benchmarks. This offers an objective view of the revenue and expense opportunities within each practice when compared to national best practices and benchmarks that have stood the test of time in many diverse markets. Judy, do you see other benefits?

Judy: A fourth benefit is a set of clear, concise recommendations, or in other words, a roadmap that will bring the practice and the network in harmony towards best practice. These best practices have been honed by Halley Consulting Group in our laboratory of experience during the many years of interim management engagements we’ve had leading practices and networks successfully.
Included in these recommendations are performance measures. Therefore, not only do we help our clients to engage both the governance or sponsorship structure for change, and the implementation structure for change, but we also help them to agree on what performance measures should be used, and what the measure or goal should be. We provide our clients with a recommendation regarding how to measure where they are today as part of the gap analysis. Then we report to them about the disparity between the current performance and the best practice benchmarks. We provide the formulas regarding performance measurement, and we teach the principles of site-specific action planning, which again will come as part of the recommendations.

The fifth benefit is a quarterly action plan, which prioritizes the recommendations we make and includes a timeline for the implementation along with the site-specific action plans for each practice.

The reason that each of these benefits is so significant is that, by fully embracing and properly implementing the recommendations, individual practices and the entire network make significant strides toward realizing the ideal in all areas of business administration—especially operational and financial viability and market leadership.

Marc:

Marc: Judy, I might also emphasize that the network evaluation process is very explicit. By the time the evaluation process is complete, we have reviewed all ten areas of business administration, and we equip our clients with a roadmap to move from where they are today to where they need to be in terms of achieving their objectives.

If our clients embrace and apply our recommendations in their primary care practices—for example, if they engage employed physicians to implement improvements in productivity, and then reward that productivity with the right compensation model—their hospital-owned primary care practices should be able to perform as well as private practices in the same community. And such private practices usually break even.
Most subspecialty practices can also achieve private practice levels of productivity if, of course, there is adequate market share captured in affiliated primary care practices, and then attracted to what we call, again, the specialist of choice. Barriers to subspecialty practice performance today include lack of a primary care market share strategy that provides adequate patient volume, often due to inadequate planning. Another common barrier is bad deals, often due to, again, inadequate planning. No one wins an unsustainable deal between a hospital and a subspecialty physician. Unfortunately, the patient is the real loser when financial realities become the focus because of the arterial blood loss on the bottom line, rather than the more important clinical quality and service quality that should occupy our time and energy.

Based on our experience as change managers, we can confidently say that most hospital-owned practices should be expected to function as well as private practices in the same community and specialty. If our practices are not achieving private practice performance levels, we should be asking, why not?

**Ralph:** Outstanding information from all three of you, Marc, Judy, and Lauri. It’s interesting, Marc, after hearing the answers from all of you about our network evaluations, I think this question that we’ve often heard from our prospective clients is very relevant:

**What is the typical cost for these evaluations, and what is the range of return on investment clients receive—and how soon are they realizing that return?**

**Marc:** Well, in today’s challenging environment, our hospital executives should indeed be thinking in terms of return on investment in our services or any other services that they use. Our network evaluation fees usually range between a low of $45 thousand to a high of $110 thousand, depending on the size of the hospital-owned network.
Fortunately, we have a track record that includes clients who have experienced significant tangible and intangible benefit. Our potential clients can talk with our former clients about their experience and those benefits. The financial return on investment—for clients who fully embrace and properly implement our recommendations—has routinely ranged certainly from several times our network evaluation fees to literally millions of dollars.

Organizations that fully embrace and properly implement our recommendations start to see a return at the individual practice level within six months after the implementation process commences. When the situation is urgent, of course, we can deploy a rapid improvement plan that can accelerate the speed of performance improvement. But generally, full implementation across a medical practice network usually takes at least 18 months.

**Ralph:**

Thank you, Marc for that excellent information. Listeners, as you just heard, not only do we inform our clients about where they are today and where they need to be in order to achieve the ideal, but we also show them how to get there. We explain where the sponsorship will come from to manage change in their organization.

Additionally, we teach our clients how to structure their management team so they become implementers rather than just administrators (and our clients need implementers, not administrators, if they are going to really effect change in their organization). Those implementers, of course, need to do what their sponsors tell them to do, at the pace the sponsors are willing to support.

As a result, we teach our clients how to build the sponsorship/accountability model first, and then we add the implementation process, which brings about the benefits that Judy and Lauri and Marc have just described, those outstanding returns.
Marc: We know that hospitals, health systems, and physician practices are concerned about cost, and rightfully so. This is especially true in this era of declining payment and increasing regulatory costs, and increasing demand. However, as Judy pointed out, our clients have found that our network evaluations may be more appropriately classified as investments with a tangible return rather than simply another expense.

Our clients have indicated that they are not aware of any other organization that provides a medical practice assessment with the depth and breadth and power to effect positive change that our network evaluations provide, nor do our competitors provide the level of “on the ground” implementation support that we routinely offer. Our clients have told us that they view Halley Consulting Group not as traditional consultants, but as managers who consult, and we take pride in that significant distinction.

Ralph: Thank you, Marc, Judy, and Lauri, for providing your very valuable perspectives on performance improvement for hospital-owned networks, and for teaching us strategies for success when hospital-owned medical practices are falling short. You have shared some very crucial insights with our listeners.

Listeners, this webinar today has answered the questions that you have posed to us about how to identify the mistakes we see most often as we work with hospitals and employed physician networks around the country, as well as how to correct those mistakes.

Hospitals and health systems can, indeed, enjoy all the benefits of employing physicians without the losses.²

Marc, Judy, and Lauri, thank you so much for being with us today and sharing your answers to our listeners’ questions, which I know will be so valuable to them.

Special thanks, especially, to all of our listeners for investing your time today to join with us for this webinar. For your convenience, and for the convenience of your colleagues who may not have been able to attend, a recording of this webinar will be available on the Halley Consulting Group website, along with a written transcript for your use. We will give you notice within the next week or so, 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.