DEVELOPMENT AND IMPLEMENTATION OF A PHYSICIAN SUPPORT NETWORK AT HILLCREST HEALTH CENTER: A CASE STUDY

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ABSTRACT

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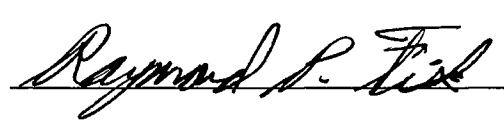
Scope and Method of Study: From September, 1987 until September, 1988, Hillcrest Health Center engaged the consulting firm of Professional Marketing Consultants, Inc. (PMCI) for the purpose of installing a multifaceted Physician Support Network (PSN). The eight programs which comprised the PSN were: Physician Referral System, Physician Practice Support, Occupational Health, Preregistration Card System, Emergency Room marketing, Women's Health Center, Behavioral Medicine Center marketing, and a Network Information System. PMCI promised to develop and install these programs in 12 months, an extremely short time frame. As the Director of Marketing, I was responsible for the project. This case study examines the organizational upheaval which occurs when a project of this magnitude is forced on a service organization by top management.

Findings and Conclusions: Critical mistakes, both in the development and implementation of this project prevented its success. Needless pressure and criticism was engendered by promising an extremely short development and implementation time frame which could not be fulfilled. Initial project approval was forced through the board of directors and medical staff approval process without allowing time for examination. Likewise, in order to secure the board of directors' approval, adequate funding for the project was not requested. The Data Processing Manager was allowed to critically damage the project due to his own ignorance and hostility. The Chief Executive Officer, also the primary administrative supporter of the project, left Hillcrest for another position at a critical juncture in the project implementation. Finally, I made several errors because of inexperience. For these reasons, the Physician Support Network development and implementation at Hillcrest Health Center fell woefully short of its potential.

ADVISER'S APPROVAL 

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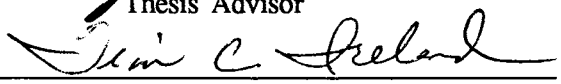

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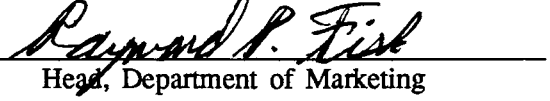

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PREFACE

"The best laid plans of mice and men . . ." My employment between March, 1987 and November, 1988 was more than a job - it was an experience. Hillcrest Health Center, like other hospitals nationwide, was looking for answers. The rapidly changing hospital environment concerned administrators who understood that fundamental changes were occurring but didn't know how to respond. This shifting environment created the ideal conditions for health care consultants to flourish. In July, 1987, Hillcrest decided to use a prominent health care consulting group to implement an ambitious Physician Support Network consisting of eight major programs, all of which were to be installed in 12 months. What followed was a classic study in organizational upheaval. As the person responsible for development and implementation, I wish to pass on to others the lessons learned from this arduous ordeal.

I want to thank Dr. Raymond Fisk, my major advisor, for his excellent guidance and unceasing encouragement on this project. His ongoing critique was invaluable. In addition, I am indebted to Cynthia Gray for her patient counsel on my degree requirements. Finally, I want to thank all of the professors who invested their time in my education at Oklahoma State University.

I wish to express my sincere appreciation to the many employees at Hillcrest Health Center who helped me amass the facts necessary to complete this case study. In particular, I am deeply grateful to Mr. James MacCallum who hired me, supported me and encouraged me in this project. Special thanks are also due to Pete Thibeault, my friend and compatriot at Hillcrest with whom I frequently disagreed yet always respected.

This thesis would not have been possible without the continuing help and "inside information" provided by the current and former staff members of the Marketing department at Hillcrest: Teresa Brekke, Nicholas Hahalis, and Betty Overstreet. The information about the inner turmoil in Data Processing provided by Gary McElwee and Glenna Coultas was indispensable. A special thank you belongs to Cathy Adams for furnishing candid information about the administrative drama so necessary for this case study. I am also grateful to Dr. Leon Silvers for providing an eyewitness historical account of Hillcrest and to Mr. Mike Bernstein for recounting the history of Professional Marketing Consultants, Inc.

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CHAPTER I

HILLCREST HEALTH CENTER

Background

From its beginnings in 1955 as a tiny 18 bed hospital, Hillcrest Health Center has had a long and colorful history. Allopathic (M.D.) physicians unintentionally played a crucial role in the decision to establish Hillcrest.[1]

In the 1950s, allopathic physicians generally held the view that osteopathic (D.O.) physicians were "second class" physicians who were trained at inferior medical schools by practitioners who advocated unproven methods of treatment. Osteopathic physicians could not receive payments from many insurance companies including Blue Cross/Blue Shield as a direct result of pressure from the M.D. community.[2] As a consequence, there was a fair amount of malice between the two branches of medicine.

However, the greatest problem this conflict caused for the osteopathic physician concerned hospitalization. All of the hospitals in Oklahoma City and the surrounding communities were strictly controlled by M.D.s. When the patient of a D.O. needed to be hospitalized, the D.O. had to literally "dump" their patient on an M.D. who had admitting privileges at a local hospital. The allopathic physician would generally not consult with the D.O. and would never allow the D.O. to be an attending physician. Frequently, the M.D. physician would try to persuade the patient to switch to his practice for other medical needs.

Several events took place in 1955 that finally convinced a small group of 12 osteopathic physicians to establish a hospital with an osteopathic orientation. One D.O. took his patient to the emergency room at Baptist Hospital in Oklahoma City with acute appendicitis. Upon arrival he was treated rudely, told that they would perform an original diagnosis to find out what the problem was and that his advice was not needed. Dr. Leon Silvers related that he had made prior arrangements with Hubbard Hospital in Oklahoma City to bring an obstetrics patient in for delivery. When that day arrived, he called the hospital only to be informed that the hospital was completely full and no beds were available. The hospital census was actually about 50%, according to Dr. Silvers. He then took his patient to an El Reno hospital 28 miles away for delivery.

After these events, a small group of D.O.s met and the decision was unanimous: an osteopathic hospital must be built. In all, 12 physicians pooled their resources for the project. The three original incorporators were: Leon Silvers, D.O., Richard Almquist, D.O., and Fred Erhardt, D.O. They purchased the land at Southwest 59 and Pennsylvania in south Oklahoma City and began construction on the first hospital in south Oklahoma City and the second osteopathic hospital in the state.

The physicians developed a unique system for determining the amount of investment required from each D.O. based upon the approximate financial value of the hospital to each specialty. General Practice physicians who wanted admitting privileges were required to invest $1,500 dollars. If they wished to also perform minor surgery at Hillcrest, the fee rose to $5,000 dollars. Likewise, the fee for an Anesthesiologist was $2,500 dollars and the highest fee of $15,000 dollars was required from the Surgeon. Surprisingly, there was little opposition to this schedule.

The hospital name, Hillcrest Osteopathic Hospital (HOH), was chosen as a suggestion from one of the incorporators. It seemed to be an innocuous name that "sounded good."

When the hospital construction was completed in 1955, its 18 beds were filled almost immediately. The osteopathic physicians delayed elective hospitalizations until the hospital opened causing a severe bed shortage. The physicians would meet regularly to discuss their patient's hospitalization needs and would agree among themselves the order in which patients would be admitted.

With the addition of a second general surgeon in 1957, Hillcrest expanded to 24 beds. In 1960, the hospital again expanded to 65 beds. With the help of a federal Hill-Burton grant in 1962, Hillcrest remodeled, added two new floors and expanded to 102 beds. By 1974, the census was consistently high enough to require an expansion to 148 beds. When Mr. MacCallum gained approval for a Behavioral Medicine Center (alcohol, chemical dependency and psychiatric disorders) in 1984, the hospital expanded to its present capacity of 186 licensed beds.

When Mr. MacCallum began as administrator in 1982, he felt strongly that Hillcrest Osteopathic Hospital needed a new identity. In 1986 he proposed a name change to Hillcrest Health Center which was conditionally approved. The Board of Directors approved the name change but many physicians opposed the idea. Therefore, true to form, he authorized a gradual name change. To this day, many of the forms and brochures still read "Hillcrest Osteopathic Hospital", the sign in front of the hospital reads "Hillcrest Hospital" which is also the way the switchboard answers the telephone!

Osteopathic Emphasis

From its inception, Hillcrest Osteopathic Hospital was to have a distinctly osteopathic emphasis. Its active and associate medical staffs were restricted to D.O.s, M.D.s being allowed on the non-voting, non-influential courtesy staff only.

But what exactly is an osteopathic emphasis? To many on the outside, an osteopathic emphasis connotes a skepticism of new medical advances, an aversion to medications, a certain defensiveness about osteopathic medical practice, and a question about osteopathic medical training.[2] This is not surprising considering that Osteopathy was founded by Dr. Andrew Still in 1874 primarily because of his disenchantment with medical practice at that time and with drugs in particular.[3] Unquestionably, the negative position exhibited by the American Medical Association toward osteopathy before 1968 influenced the opinions of many. Compounding the problem, the osteopathic community did little to refute this impression. Beyond the competent practice of medicine, osteopathic physicians and hospitals did not engage in a concerted public relations campaign designed to present a more positive perspective of osteopathy.[4] So, the negative viewpoint remains in the minds of a significant segment of the American public.

To a D.O., and to the administration of an osteopathic hospital, an osteopathic emphasis traditionally *should* consist of several definitive distinctions. In the book *The Difference a D.O. Makes*, author Bob Jones maintains the most important difference is that:

> ". . . the D.O. has been conditioned to view the person as a whole. It becomes second nature for the osteopathic physician to consider all the implications of the diagnosis and the treatment. He evaluates the specific illness or injury and the treatment that is to be administered in a context of the "whole person." He gives careful consideration to the effect that the treatment for that specific problem will have upon all the body systems. He is taught to look for the *cause* of disease and not just treat the *symptom* of disease."[5]

He contends the second most important difference is the training the osteopathic physician receives in manipulative therapy which "is valuable in treating dysfunctions of the musculoskeletal system that may affect other body systems."[6]

Reality, however, tends to refute the first and reinforce the second. At Hillcrest, the notion that a D.O. treats a patient differently than an M.D. in evaluation and diagnosis was given official support and unofficial derision. Numerous physicians told this writer that, in actuality, there is no difference in diagnosis or treatment between M.D.s and D.O.s. Physicians often joked about this assertion, recognizing its *inherent ridicule* of the allopathic branch of medicine. Likewise, members of the hospital administration did not take this "advantage" seriously. It possibly originated from an attempt to favorably position osteopaths and to excuse the lack of specialization in osteopathy.

The second "distinction" is much more important. Osteopathic manipulative therapy (OMT) has been recognized as a treatment for certain musculo-skeletal injuries (especially affecting the back or spine) for many years.[7] This is a particular advantage to osteopathic physicians because back injuries constitute 21% of all on-the-job injuries in Oklahoma.[8] M.D.s do not receive similar training in their basic medical education. Therefore, osteopathic physicians (especially general practitioners) do have a very significant advantage in the treatment of their patients, which the allopathic community has chosen not to duplicate.

But osteopathic physicians have allowed even this genuine advantage to be nullified. Because of their overwhelming fear of any comparison with chiropractors, they almost completely deemphasize their one real strength. Most osteopathic physicians believe that their understanding of manipulation techniques and limitations far exceeds that of a chiropractor (primarily because it is supported by a medical education), yet they have allowed chiropractors to vastly out-market them to the point that back injury treatment is automatically associated with chiropractors.

In a survey of physicians at Hillcrest conducted by the Marketing department in 1988, only 30% of the physicians still perform OMT. Of those who still perform OMT, it only comprises an average of 10% of their practice.

Organizational Structure

Knowledge of the organizational structure and a profile of several key managers is an important foundation for understanding the reasons behind the development and outcome of the 1987-88 marketing initiative.

Hillcrest Health Center's organizational structure is a product of unintended evolution. It is somewhat unusual because there is no president of the hospital. The highest administrative office is Executive Vice President. This matter evolved as a result of an inordinately involved Board of Directors which never felt compelled to vest decision-making power in an office of president.

Below the Executive Vice President are the Directors of the hospital. Again, there is some confusion because though there are officially six directors, many other positions share the title of "Director." The six directors that comprise the Administrative Advisory Committee are: Director of Nursing, Director of Human Resources, Director of Marketing, Chief Financial Officer, Director of Support Services and the Director of the Behavioral Medicine Center. These individuals, along with the Executive Vice President and the Executive Assistant, meet on a regular basis to discuss policy and formulate strategy for the hospital. Though from an overall decision-making aspect directors are above department managers, they receive the same benefits as department managers and are not otherwise differentiated.

As noted above, department managers are below directors yet receive identical benefits. There are about 38 department managers at Hillcrest, ranging from Director of

Volunteers to Director of Information Services (Data Processing). Only a few department managers substantially affect the overall direction of the hospital.

Below the department managers are the supervisors. Supervisors, unlike department managers, must actually oversee the performance of others. This adds to the confusion because a department manager can have one person in his department yet have more authority than a supervisor of 20 people. At one point, Marketing consisted of four department managers and one employee! Obvious feelings of inequity resulted.

Finally, below the supervisors were employees. Most employees punched a time clock unless they consistently worked overtime at which time they could be switched to a salary basis. The key management personnel who played influential roles in this project were:

James M. MacCallum, Executive Vice President

James MacCallum (herein referred to as "Mr. MacCallum") was the "visionary" behind the marketing project. He was an aggressive leader who utilized a diplomatic style with a high degree of success. Though he often seemed low key in his approach, he would nevertheless take risks if he determined the potential rewards were exceptional. It is not an overstatement to say that after five years of management, Mr. MacCallum developed not a single enemy. He strived to motivate every individual in administration and was respected by the medical staff as well.

When confronted with a dispute between two managers, he often took one of two courses. Either he would do nothing and delay the decision or he would try to satisfy both with an unworkable plan. He avoided confrontation to an excessive degree and usually preferred to wait for the situation to force a change. Many times when funds needed to be

expended to correct a damaging situation, he would allow the situation to languish indefinitely.

Cathy Adams, Executive Assistant

Cathy Adams was frequently referred to as the "glue" that held Hillcrest Health Center together. As Mr. MacCallum's secretary, she welded considerable influence over his agenda and over the entire administrative office. Cathy scheduled and supervised the administrative secretaries, a pool which several directors utilized. She was organized, intelligent, and calm under pressure.

G. Peter Thibeault, Chief Financial Officer

G. Peter Thibeault (herein referred to as "Pete") was probably the most talented individual in the administration. He was exceptionally adept with complex financial matters which required original solutions. In addition, he had a good grasp of marketing and was, in fact, a marketing oriented person. His admiration for Tom Peters knew no bounds. (He personally paid for a copy of Peter's book "Thriving on Chaos" for each of his managers.) Pete's unassailable integrity was undergirded by his devout Christian faith. More than any other individual, Mr. MacCallum relied on Pete for advice on any decision that affected Hillcrest financially. Rarely, if ever, did Mr. MacCallum contradict an opinion Pete provided.

Pete did an excellent job motivating his managers. However, his greatest weakness was his inability to fire an obviously poor manager. He simply avoided confrontation requiring this type of action. This weakness would have an critical affect on the marketing project.

Wanda Lewellen, Director of Human Resources

Wanda Lewellen (herein referred to as "Wanda"), a high school graduate originally hired as a general secretary shortly before the hospital opened in 1955, has demonstrated an amazing ability to adapt to changes, grow into positions for which she had little training and relate well with physicians. Wanda, by virtue of her desire to succeed and her assertiveness, steadily advanced through the hospital ranks, gaining power and prestige. When the previous administrator left his position, the Board of Directors appointed Wanda as Interim Administrator, a position she held for nine months before the arrival of Mr. MacCallum.

In addition to her position as Director of Human Resources, she serves on the corporate Board of Directors. Among hospital employees, the unwritten rule was: NEVER offend Wanda Lewellen. Administration employees understand her ability to wield a great deal of power and most attempt to gain her favor.

Because Wanda directly supervised the work of the outside public relations agency before a marketing department existed, she was very interested in the marketing and public relations projects undertaken by the hospital.

Eddie Wiseman, Data Processing Manager

Eddie Wiseman (herein referred to as "Eddie") came to Hillcrest after having spent the majority of his career working in a mainframe computer environment. His resume appeared to be impeccable for the position: double major in computer science and marketing, employed in the data processing field for five years, no major career problems. In addition, I had been acquainted with Eddie for years in church activities. Therefore, when Pete Thibeault suggested hiring him for the position of Data Processing Manager, I gave him substantial encouragement. He was hired in November, 1987, two months after we began the marketing project.

It became very clear, however, that Eddie's idea of management could be summarized in one word: control. He seemed to be obsessed with controlling every decision and action concerning computers or peripherals. This trait would have been tolerable if Eddie had demonstrated the necessary technical knowledge for the position. Unfortunately, he knew very little about the micro-computer environment.

Ken Arfa, Professional Marketing Consultants, Inc. (PMCI)

Though other managers from PMCI had substantial influence on the project, Ken Arfa (herein referred to as "Ken") was involved throughout. Ken holds a Masters of Public Health (MPH) degree and came to PMCI from HCA where he was a regional manager of Marketing and Planning. He gained vital early experience with the marketing and distribution of a hospital "health card" when this was virtually unheard of.

Ken consistently conveyed a sense of urgency, almost panic, to get things done. He would always speak as if we were behind schedule even if there was no possible way to move that quickly. Ken worked 70 - 80 hours per week, flying all over the country, and seemed to thrive on it ("my kids call me 'Sir'"). As one of the founders of PMCI, Ken kept in close touch with the project even when the project was under the direction of another project manager.

Other Representatives from PMCI

Mike Bernstein (herein referred to as "Mike"), our first contact with PMCI, was a driven, hyperactive personality who could at once be charming and blunt. Mike also held a MPH degree and before coming to PMCI was a Senior Vice President at a 200 and a 400 bed hospital. Mike had a strong need to feel important so he frequently exaggerated his and PMCI's accomplishments. He negotiated new project sales for PMCI and in the sales process, he constantly "oversold" PMCI's responsibilities (according to Ken Arfa). Mike

left PMCI in April, 1988 with tremendous animosity. Though one of the founders of the company, he was unceremoniously fired after challenging Rich Ekwall's leadership, according to an interview with Mike. Ken Arfa was not kind in describing Mike's shortcomings when justifying Mike's ouster. Later, Mike visited Hillcrest and bitterly reported PMCI's numerous internal problems.

Rich Ekwall (herein referred to as "Rich"), the president of PMCI, was previously one of the principle architects of the acclaimed Borgess Medical Center network as an executive for CyCare Systems, a healthcare computing firm. He was a rotund person who could ask for vast sums of money without a blink. Others at PMCI spoke reverently of Rich as an expert in just about every area, especially information systems.

Marketing at Hillcrest

Mr. MacCallum believed in marketing. He was keenly aware of the marketing endeavors by other hospitals in the Oklahoma City area and he stated on many occasions that the future of Hillcrest depended on successful marketing. However, he had little understanding of what those words involved.

Consequently, when he hired the first marketing director, Jack Fortenberry, he instructed him to "lay low and cool your heels" for the first three months. He was not given a job description, nor any mandate to accomplish. Jack, whose background was in the oil industry and had no healthcare experience, had a multitude of good ideas but virtually no authority. As is so common in the service sector of our economy, marketing was considered nonessential and therefore unimportant. In addition, Jack had difficulty relating to physicians. When they disagreed with his plans, he would argue and cajole, many times in busy office waiting rooms or hospital corridors. The doctors could not abide this and finally forced Mr. MacCallum to terminate Jack.

For the previous three years, public relations for Hillcrest was executed by Dowdy & Associates, a small PR firm consisting of Susie Dowdy and her parents. Susie handled ad placement and brochure production on a retainer plus expenses basis. Jack maintained that Susie was seriously overcharging the hospital through hidden costs in brochures and other material. (I later proved that this was correct.) Public Relations and Marketing were completely uncoordinated because Susie and Jack despised each other, avoiding almost all communication.

Therefore, when I began my tenure as Director of Marketing upon Jack's departure, expectations were non-existent. Physicians and staff welcomed me because any change was viewed as an improvement. Though marketing was still awarded very little status, my arrival was greeted with relief and approval.

Recent Hospital Performance

Hillcrest's financial performance for the preceding five years had been nothing short of spectacular. When Mr. MacCallum arrived, Hillcrest generated $14,000,000 in revenues and frequently delayed payment on current bills depending on cash flow. Morale was dismal and the hospital was administratively disorganized.

One of the decisive actions Mr. MacCallum took was to hire Pete Thibeault, an auditor from Price Waterhouse. As Chief Financial Officer, Pete quickly became Mr. MacCallum's trusted adviser. Few decisions with financial consequences were made without Pete's input.

Mr. MacCallum quickly began to expand the medical staff and Pete completely reorganized the Business Office. The result was a dramatic increase in hospital revenues. From $14,000,000 in 1982, revenues soared to $34,000,000 in 1987! Services expanded too, with the addition of a Behavioral Medicine Center and other ancillary services such as home health care and a skilled nursing unit.

Mr. MacCallum knew, however, that in order for progress to continue, Hillcrest would have to become even more aggressive in the increasingly competitive healthcare environment.

CHAPTER II

PROJECT BACKGROUND

Professional Marketing Consultants, Inc. (PMCI)

Professional Marketing Consultants, Inc. (PMCI) was founded in 1985 by Rich Ekwall, Ken Arfa and Mike Bernstein.[9] Rich Ekwall, the principal, provided the funding necessary to begin PMCI and held the title of President. Ken Arfa and Mike Bernstein were Vice Presidents and provided, along with Mr. Ekwall, the hospital consulting expertise.

The stated purpose of the company was to assist the design and implementation of Physician Support Networks for client hospitals. PMCI would also assist on other projects if requested.

PMCI began with four employees and expanded to ten by the time they acquired Hillcrest. In the two years previous to their work with Hillcrest, they had installed Physician Support Networks at seven hospitals.

TONACK, 1987: Hillcrest Discovers PMCI

In July, 1987, Mr. MacCallum and Pete Thibeault attended the annual osteopathic TONACK conference. Representatives from Texas, Oklahoma, New Mexico, Arizona, Colorado and Kansas (TONACK) osteopathic hospitals convene to attend workshops on a wide range of subjects.

PMCI presented a workshop on Physician Support Networks (PSN), a very popular topic in 1987. In his presentation, Mike Bernstein contended that hospital marketing in general was unfocused, unprofessional, unappealing and amateurish. He spoke of "brochure mentality", the idea that the role of marketing was to produce and distribute brochures about hospital programs. It was his view that most hospital marketing an unfocused scatter-shot attempt to advertise hospital programs. Instead, he maintained that hospital marketing must focus on the physician and must be driven by a clearly articulated business plan that provides the direction for each program.

Mr. MacCallum and Pete were clearly impressed. They felt that this approach was exactly what Hillcrest needed. Before leaving the convention, they arranged to have PMCI come to Hillcrest for an initial assessment.

PMCI's Initial Assessment

Two weeks after TONACK, Mike Bernstein came to Hillcrest for a two day assessment. He conducted interviews with several key physicians, all of the hospital directors and several other managers. In addition, he met with Mr. MacCallum and the Chairman of the Board, Mr. Carlton Myroh.

Through the interview process, Mike tried to ascertain any problems that existed which would hinder the project. He was highly critical of Susie Dowdy, recommending that we hire a full time Public Relations Director instead. Though it was PMCI's policy to hire a person to coordinate the project on-site, Mike felt that I would be the best person to be the "Network Director." I was very enthusiastic because I wholeheartedly endorsed PMCI's systematic methodology and felt that their involvement would provide the expertise I lacked to develop the programs that were clearly needed.

Physician Support Network Programs

Once the initial assessment was completed, an initial list of programs was delineated. These components had been suggested by PMCI several times previously and it was clear that they felt qualified to work within the context of these programs. It is open to question whether or not these programs would have been recommended regardless of the assessment interviews. In fact, physicians were told that programs would be identified upon completion of the business plan research.

Nevertheless, the programs to be developed for the overall Physician Support Network were:

* Physician Referral System
* Occupational Health
* Emergency Room Marketing
* Physician Practice Management Support
* Women's Health Center
* Behavioral Medicine Center Marketing
* Network Information System

The most attractive and incredible claim presented by PMCI about this PSN was that they would design and install all of the components within one year! They claimed that it would take three years to bring the programs to maturity but that each would be "up and running" in one year. In other words, they would not be consultants that would continue to require large fees year after year, removing one of the major criticisms against hospital consultants. This "fast tracking" of the project was extremely appealing because it provided a sense of quick accomplishment.

Looking at the items to be accomplished and the time frame for accomplishment should have provided a clue that something was amiss. However, the four reference hospitals I called all related that PMCI was indeed an excellent, action-oriented consulting

firm. Even then, one of the hospitals complained that PMCI tended to "force feed" programs whether or not it happened to be advantageous for that particular hospital.

Creative Financing

The Finance Committee and the Board of Directors at Hillcrest are exceptionally involved on an operations level. For example, any expenditure in excess of five hundred dollars must be brought to the Finance Committee for approval! Mr. MacCallum knew that there was no possibility of gaining quick approval for this venture which was projected to cost $162,000 for the consulting services alone. This does not include any expenditures for the project itself, such as expanding the marketing staff from one to ten persons, peripheral equipment, advertising, or construction of the Women's Health Center.

Knowing this, Mr. MacCallum decided to make the immediate costs appear painless and write all of the major costs into the following year's Marketing budget. Since the combined budget for Marketing and Public Relations was approximately $250,000, he proposed to the chairman of the Finance Committee that the required $170,000 come from the existing budget. Since the Marketing and Public Relations budgets had already been approved, no further approval was required from the Finance Committee. It appeared that this project was simply a shift in priorities. In reality, however, none of the budgeted marketing or PR projects were curtailed which resulted in enormous budget overruns.

In addition, because Mr. MacCallum never gained Board approval for the PSN, we never had Board support when inevitable problems arose. This precipitated very destructive criticism from those who correctly felt that this project had been forced through the system.

On September 1, 1987, Mr. MacCallum and Mike Bernstein signed the agreement for consulting services. See Appendix A for a copy of this agreement.

CHAPTER III

THE FOUNDATION, SEPTEMBER - DECEMBER 1987

Development of the Business Plan

The "hub" of Hillcrest Health Center's Physician Support Network was an extensive business plan. This plan was to provide the focus and direction for each day's activity, furnishing the model by which we judged our current performance.

Physician Interviews/Data Collection

Immediately upon signing the contract for the PSN with Hillcrest, PMCI began interviewing physicians. Invitations were sent to every physician on active staff (about 73 doctors). In all, 32 interviews were completed, about average according to Ken Arfa. The original questionnaire was shortened considerably in the actual interviews and elicited opinions about the physician's practice, Hillcrest Health Center, how their patients felt about Hillcrest, the different hospital departments, services they need from the hospital and changes they expect in the future. Each interview lasted approximately 45 minutes.

Two departments, Medical Records and the Business Office were most affected in the collection of data. Medical Records, especially, was called upon to provide the majority of the data. Referral and practice patterns were explored for every physician in great detail. Patient origin, demographics, ancillary departmental needs, payment patterns, and other factors were examined. Revenues were tracked from origin in each department and areas of

revenue weakness and potential were identified. Fixed and variable costs were identified. In all, approximately 250 hours of research were furnished by the Business Office and Medical Records.

See Appendix B for samples of the physician survey instumment and the data collection worksheets.

Decisions on Priorities

In theory, the programs most beneficial to the hospital were to be identified from the results of this research. This would have ensured that we developed programs for which the hospital demonstrated a need. Hospital employees and the medical staff were assured that this, in fact, was the procedure we were following.

In retrospect, however, it is clear that this procedure was not followed. The programs were decided upon de facto when Mike Bernstein completed his initial assessment. Once the research was completed, Mr. MacCallum, Ken Arfa and I met to identify the order the programs should be implemented. There was no discussions of research results. Each program was broken down in detail in the time specific "Action Plan" (Appendix C).

Similarly, the Ideal Bed Mix (IBM) was a central concept early in the project. The IBM was the ideal mix of specialties represented by peak census in the hospital. In other words, if the hospital operated at 100% census with all 186 beds occupied, what mix of specialties would represent those patients? This conclusion would, in theory, determine the kinds of programs necessary to bring about this result.

In reality, the Ideal Bed Mix was determined at a meeting between Mr. MacCallum and myself. We simply discussed different specialty mix scenarios and chose one that we estimated would bring about the highest hospital revenue, given our existing facilities and

the specialties represented by the medical staff. Once the IBM was decided upon, it was never mentioned again, nor did it play any significant role in the remainder of the project.

Staffing Needs

When this project began, the Marketing department at Hillcrest had exactly one employee: the director. In addition to the director, Hillcrest utilized a public relations agency part-time. Obviously, a project of this size and scope required an organization to develop and implement the plans. Though Mr. MacCallum tacitly agreed to increasing the marketing staff, he never firmly committed to the size staff the Business Plan required. Originally, the marketing staff was to include:

Director of Marketing (Network Director)

Public Relations Director

Physician Support Liaison

Physician Referral Coordinator

Physician Referral Assistant

Occupational Health Manager

Occupational Health Nurse

Women's Health Coordinator

Connection Card Coordinator

Marketing Secretary

This staff needed to be established during the first year to ensure the program progressed according to our timetable. However, Mr. MacCallum wanted to move very slowly because the Board and the physicians were skeptical about an expanding Marketing department. Whenever I needed to hire an individual, I had to wait months for the need to become convincing (i.e. fall behind schedule, resort to crisis management.). For example,

the need for a Public Relations Director was identified in September, 1987. The position was filled March 16, 1988.

The Occupational Health Coordinator was secured in December, 1987. Until this time, I tried unsuccessfully to develop this program and make the sales calls necessary to sustain it while developing all of the other project areas.

It was a disaster! For several months, I had so many responsibilities that I was literally running from 7:00 am each morning until 8:00 pm each evening. While I was overloaded from every area of the PMCI project, I also had all of the marketing responsibilities of the hospital apart from PMCI. The busier I became, the less time I had to make sure each task was completed adequately. If something went wrong or took longer than necessary (a frequent occurrence), my schedule would fall apart. This frenzied schedule lasted for six months, September 1987 until February 1988. Afterward, my schedule was hectic but not quite so chaotic. Unfortunately, valuable time was lost and mistakes were made which would eventually damage the project.

Return on Investment!

The most exciting aspect of this project were the astounding return on investment figures. They more than justified the extensive outlay of funds for the project and promised to continue the spectacular growth that Hillcrest had experienced in the previous five years.

In the three years necessary to fully implement the program, census was expected to rise from 65% of staffed beds to 80% of staffed beds! (The hospital was only operating at 60% of staffed beds at the time but no one seemed concerned about the 5% discrepancy.) This 15% rise in census represented new revenue of $7,873,600 over three years. Total three year incremental revenue for the 15% increase would be $3,858,064. These figures did not include the Behavioral Medicine Center costs or revenue nor did they include the Women's Health Center financial results.

When total revenue figures were compiled (including ancillary revenue figures), total incremental revenue would be $8,268,314, total program costs would be $1,236,879 for a net margin of $7,031,435! This represents a cost/benefit ratio of 1:5.68. At every meeting with physicians, PMCI continually emphasized that this project would return 5.68 dollars for every 1 dollar expended by Hillcrest.

Program costs were delineated well and seemed to be within a reasonable range. However, when taken as a whole, they represented a very large total expenditure. At one point early in the project, I was concerned because a needed purchase request was being delayed. I met with Mr. MacCallum and asked him if he was aware of the total expense required by this project. He responded that he thought so. When I showed him the detailed expenditures from the Business Plan, he winced and stated that "we will have to be careful about expending that kind of money. We'll need to go slow with major expenditures." This was a foreshadowing of the future. See Appendix D for the expected return and expenditure figures.

The Final Product

When the Business Plan was completed and delivered in January, 1988, it was an impressive document. Obviously, PMCI utilized the data provided to present an impressive case for their programs.

Book I, the Executive Summary, focused on the Physician Support Network. It furnished a theoretical framework to support it and explored the primary programs that comprised the PSN. Book I strongly articulated the crucial importance of hospital commitment throughout the implementation and declared (predicted?) that "a network under-financed, under-staffed, and lacking total commitment would be more detrimental to HHC than no program implementation." Prophetic.

Book I also supplied the return on investment figures discussed above and the action plan, which was the time table we attempted to meet. Excerpts from Book I are contained in Appendix E.

Book II contained the results of physician interviews, demographic and competitive analysis, medical staff analysis and other data collection. This document exhaustively analyzed the available data, demonstrating a comprehensive grasp of the issues relevant to the hospital competitive environment. Those in administration who took the time to read it were extremely impressed. Its analysis of Hillcrest's physician base and need for affiliation was superb. Excerpts from Book II are contained in Appendix F.

Book III was actually an appendix for Books I & II.

The rest of the Business Plan consisted of separate in-depth plans for each PSN program. Much of these documents appeared to be boiler plated material. This is not to infer that it was sub-standard, on the contrary, these plans contained excellent delineations of the programs.

One might expect that this document would be read by Board members and physicians alike. Unfortunately, the Board didn't read it because they never approved it in the first place and probably didn't feel any ownership. Physicians simply weren't interested. Who did read this document which cost thousands of dollars and provided excellent marketing research? Mr. MacCallum, Pete Thibeault and myself.

Internal Promotion of the Project

From the beginning, Mr. MacCallum was the principal promoter of the PSN project. At every manager's meeting he spoke of "revolutionizing" Hillcrest with Marketing taking the lead. Though he sought to gain the support of other hospital managers and employees, he actually conveyed a sense that Marketing was receiving most of the attention (and

dollars) in the hospital. This naturally led to outspoken resentment among many of the department managers.

To combat this, we set up a Network Task Force consisting of key department managers whose cooperation was necessary for project success. This task force was supposed to engender team ownership and support among department managers. Unfortunately, we met infrequently although we envisioned giving each member frequent assignments, this never materialized. The meetings were basically reports on the progress of the project. We did not have a meeting during the final four months of the project.

CHAPTER IV

PROGRAM DEVELOPMENT, JANUARY - AUGUST 1988

The Consulting Relationship

PMCI normally employed someone on their payroll to execute the project on site. In this case, our Board Chairman, Carlton Myroh, felt that this would be redundant since we already had a Director of Marketing. Therefore, I was given the responsibility of implementing the project.

PMCI exercised tremendous authority in the early days of the project. Because this project had complete support from Mr. MacCallum, hospital employees were aware of its importance. PMCI tried to engender a feeling of monumental and historic significance toward the establishment of a PSN among employees at Hillcrest by relating in small employee groups the "revolutions" that had occurred at other hospitals which had installed their PSN.

Project Management

PMCI's method of managing a project was to send different professionals (according to the need) to the project site approximately two or three times per month for visits of two or three days each. On a site visit, the PMCI representative would meet with the on-site project coordinator for project status meetings and then would assist the project in any way necessary during the visit. At the end of the visit, the PMCI representative would give the

on-site coordinator a long list of follow up activities. One or two days after the visit, a trip report would arrive detailing the accomplishments of the visit and listing the follow up activities to be performed by the on-site coordinator. Samples of several trip reports are contained in Appendix G.

The project was managed by a Project Manager, a senior level employee of PMCI. Though PMCI brought various professionals on-site for particular reasons, the Project Manager generally made the on-site visits.

Though Ken Arfa was always kept abreast of the project at Hillcrest, he was not a Project Manager initially. Our first Project Manager, Frank Dingler, remained on the project from September, 1987 to February, 1988. He was a competent, low-key individual who was always rather distant personally. He left PMCI in February, 1988 and we were told he simply didn't like the hours and the travel involved.

Todd Hamilton, our Project Manager from February, 1988 until July, 1988 was a different sort altogether. Todd was tall, thin, bespectacled and never quite presented a good appearance. Yet technically, he was very sharp. Todd was also adept at mediating conflict, which was often necessary during his tenure as Project Manager. When he left, "for personal reasons," Ken Arfa painted a very unflattering description of someone with marital and financial problems.

Upon Todd Hamilton's resignation, Ken Arfa assumed the position of Project Manager. Because Ken had worked so closely with the project, there was no real lag in the transition process.

Occupational Health

From the very beginning of my employment with Hillcrest, Occupational Health had been a priority program for the hospital. It was viewed by Mr. MacCallum as a broad new market that should be actively pursued. Hillcrest's nearest neighbor and closest competitor,

South Community Hospital, operated an extremely successful Occupational Health program that had over 400 businesses enrolled and resulted in significant revenue for the hospital.

Mr. MacCallum was so intent upon developing an Occupational Health program at Hillcrest that he included an incentive provision in my employment contract which provided a bonus determined by the number of employees at the company.

During my first six months of employment (April - September, 1987), I developed a comprehensive Occupational Health package entitled Good Neighbor Care, which consisted of six basic elements: pre-employment physicals, on-the-job injury treatment, drug screening, Sick and Safe (nursing day care for sick children), drug and alcohol rehabilitation, and ancillary services (physical therapy and audiology screening). This was printed in an expensive, high quality binder.

One of the major issues confronted early in the program design process was negative criticism from some General Practitioners (GP) who felt that because of the Occupational Health program, the hospital was now competing for their patients. Because Hillcrest is dependent upon the loyalty of its medical staff (as are other hospitals), this was a very serious situation. I could not afford to offend our GPs, yet at the same time, Occupational Health seemed to be an important target market.

After weighing the situation carefully, I decided to try to incorporate our GPs into the Occupational Health package as satellite clinics. If an employer near one of our physicians had an employee who needed treatment, the employer could either call the physicians office to confirm availability, or the employer could bring the employee into the hospital emergency room. This seemed to meet the objections of the physicians.

In the package design, we listed our General Practitioners (termed "Good Neighbor Clinics") and characterized them as "company doctors." In one sense this made our package much more attractive because we supposedly had 13 satellite Occupational Health clinics in south Oklahoma City.

In practice, it was a fiasco. The GPs would not agree to any common pricing or hours nor would they use any common forms or procedures. Quality control was non-existent. When physicians would ignore Occupational Health policies and offend a client company, I had no recourse. The hospital emergency room was controllable and the ER director was extremely cooperative but I could not organize the clinics.

When a company "enrolled" with Good Neighbor Care, they simply signed a non-binding agreement, choosing the programs they wanted to use. Because the agreement was completely non-binding, the affect of the enrollment was purely psychological. As an incentive to "sign-up," companies were given a coupon that entitled them to their first treatment free of charge in the programs they selected. If they went to a Good Neighbor Clinic, the hospital would reimburse the physician for the treatment.

Our competition, not only from South Community Hospital but also from dedicated clinics such as the Meridian Industrial Clinic, were standardized, well organized and very professional. We were out-classed, out-performed, and under-priced.

Staffing

When the full magnitude of the PSN was revealed in September, 1987, it became clear that someone needed to be recruited as an Occupational Health Manager. Previously, Pete Thibeault had introduced me to a lovely saleswoman named Vicki Mathews. Vicki had been involved in health care sales for 15 years with Pro Health at Baptist Medical Center in Oklahoma City. At that time, she was managing a temporary help agency and was forthcoming about her desire to return to health care. Vicki was 35 years old, very pretty, intelligent and presented herself as the ideal candidate. After some protracted negotiations, Vicki was hired as the Occupational Health Manager on December 1, 1987. Her contract included a bonus for each company enrolled in Good Neighbor Care.

Initial Plans/Revisions

Initially, PMCI liked the work I had completed on Good Neighbor Care. However, they felt that the slick program manual that we were using was not flexible enough and should be reprinted as a less expensive folder with inserts. They also recommended providing volume discounts to companies. For example, if a company's treatment revenue exceeded $5,000, the company should receive a percentage rebate at year end. When the revenue exceeded $10,000, a higher percentage rebate should be paid.

They recommended a work-site nurse be hired to make personal trips to the companies at regular intervals for purposes of on-site treatment and evaluation.

PMCI initially felt that the Good Neighbor Clinic physician participation problems could be remedied by better training the clinic front office staffs. This proved to be false because the network was too diverse to manage even with training. In addition, training was resented by the physicians themselves so it was difficult to accomplish.

Public Relations

Hillcrest retained Dowdy & Associates for 10 hours per week and paid full $65 per hour rates for overtime. (Susie usually worked 20 hours per week.) I felt that it would be cost effective for us to terminate Dowdy & Associates and hire a permanent Public Relations Director. However, because she had been at Hillcrest for such a long period, this suggestion was not taken seriously. In fact, Mr. MacCallum did not feel that Hillcrest could utilize a Public Relations professional full time.

PMCI dispelled that idea. Not only did they dislike Dowdy & Associates' work, they recognized that I was overloaded and desperately needed some relief. Once the decision had been made to terminate Dowdy & Associates, I began to interview several public relations candidates for the position.

One of the candidates, Lori McCaslin, had been recommended to Wanda Lewellen by a friend. When I interviewed Lori in the presence of Mr. MacCallum and Wanda, she made a curious statement. She asked if the Director of Public Relations was subordinate to the Director of Marketing or if they were on the same organizational level. When informed that the Director of Public Relations was subordinate, she stated that she felt they should be on the same level "like at Baptist," yet she didn't pursue this idea any further. After reviewing her work, I recommended we hire her. That is one decision I learned to regret.

Staff Chaos/Reprimand

Unknown to me, Vicki Mathews felt threatened by Lori McCaslin. Once Lori was hired there was immediate friction between Lori and I. She seemed to resent each and every attempt I made at supervision. This resulted in a very icy atmosphere in the office, one that Vicki quickly sensed.

On Monday, Lori's first day, Vicki told me that Lori informed her that she still wanted to separate Public Relations and Marketing. She wanted to report only to Mr. MacCallum. Obviously, I was greatly disturbed. These increasingly provocative reports continued throughout the week as resentment built between Lori and I. By Thursday of that same week, I determined to terminate Lori.

On Friday, I confronted Lori with the allegations. She was shocked and categorically denied each allegation. I called Vicki and asked her to meet with us. At this point, I began to see another side of Vicki Mathews. Vicki was now very unsure of her facts and could not look either of us in the eye. She still maintained that Lori was guilty of the allegations but she now seemed to by lying about what had actually transpired. From the meeting, I could not determine if Lori was indeed guilty.

Actually, I was disappointed because it was evident Lori and I could not work together. Fortunately, Lori sensed the same thing because she resigned the following Monday, after having worked at Hillcrest only one week.

This situation would not have been important except that it was the key incident that soured the relationship between Wanda and I. Lori provided a very negative report to Wanda about my performance before she left and Wanda felt it was serious enough for a formal review of my performance by Mr. MacCallum. A meeting was called and attended by Mr. MacCallum, Wanda, Pete Thibeault and myself.

In the meeting it was revealed that both Lori and Vicki had been to see Wanda, both giving diametrically opposite accounts of what had occurred. However, both had very negative opinions of my performance in the dispute and in general. I was reprimanded for my performance in the dispute and was given notice that if anything like it happened again, I would be terminated. At this time, Wanda made a very curious statement concerning Vicki Mathews. "Gary, I don't believe Vicki Mathews and if you're smart, you'll watch your backside."

Until this time, I had always considered Vicki to be the perfect employee. She was sharp, organized, very loyal (according to her), humorous, and somewhat seductive (or at least very flattering). What I did not know was that she wanted my position as Director of Marketing. At the same time she was telling me what an incredible boss I was, she was providing the opposite report to other key employees, even those within the Marketing Department who reported her intentions to me at the time. Before this event, I simply did not believe the reports that she was acting in this duplicitous manner. Now, there was no question. She would be difficult to replace, however, so as long as she performed her job, I decided not to terminate her.

A Jewel From Baptist

On the day Lori McCaslin resigned, Ken Arfa called one of his contacts at Baptist Medical Center and learned that one of their best public relations associates, Teresa Brekke, wanted to leave. An interview was scheduled that same day and she was hired within 48 hours. Teresa could not start for three weeks, but her outstanding quality seemed well worth the wait.

Teresa was an incredible employee. As Public Relations Director, she was immensely productive, yet had no ego to offend. She was universally liked, produced top quality work and would literally do whatever the task demanded. Teresa never had to be told what to do. Her creativity allowed her to "see" and develop potential stories. Teresa required very little supervision which helped me focus on other areas of the PSN. She was the best asset our department had.

Physician Referral

Physician referral was a natural program to develop. Other physician referral programs in Oklahoma City had proven to be very successful and we were eager to follow suit. It was rumored at the time that MedSearch, the program sponsored by Presbyterian Hospital, received about 1000 calls per month. Baptist Medical Center's "Baptist CARELINE" was rumored to be receiving about the same number of calls per month. Even South Community Hospital, our nearest neighbor, was receiving about 380 calls per month on their poorly advertised referral line, according to medical staff meeting reports.

A physician referral system (PRS) is actually a very simple operation. It requires an operator to receive calls, a computer system or a manual card system to ensure fair rotation of physicians, and advertising to generate the phone calls. It sounds simple and the basic system is simple. PMCI added a substantial amount of record keeping for tracking purposes. For example, each month the billing for patients who were admitted to the hospital as a result of the physician referral system was totalled and reported. This was an

excellent tool that we utilized to justify our existence. PMCI estimated that over time, about 5% of the patients referred to a physician would be admitted to the hospital.

Conflict With Data Processing

PMCI recommended that we begin with a manual card rotation system and quickly move to a computerized system. They recommended a computer system they developed for St. John's Medical Center in Tulsa, Oklahoma. It ran on an IBM System 36 minicomputer. Early in October, 1987, Cathy Adams, Eddie Wiseman and I went to St. John's Medical Center for the purpose of evaluating their system. Eddie Wiseman, the Data Processing Manager, had only been hired two weeks earlier. He informed me on the trip up to Tulsa that he was opposed to the purchase of the System 36 because it was "old technology" and that if we purchased it, Data Processing would not support it.

I was astonished. I couldn't believe that a manager so new to the job would be making flat statements about what would or would not be done in another department. This development worried me too because the System 36 supported not only physician referral but also the entire health card preregistration system and a proposed occupational health computer system.

The site visit at St. John's was very impressive but Eddie remained adamant that he would have nothing to do with a System 36. At the same time, I was beginning to have strong doubts about Eddie's technical ability. In a phone conversation a few weeks later, Eddie complained that he could not seem to get a newly formatted diskette to boot up on his computer.

Eddie: "I have formatted the disk 5 times and it still won't boot."

Gary: "Did you format it 'a:/s'?"

Eddie: "No, what do you mean?"

Gary: "Eddie, if you want to format a diskette so it will boot, you must type a '/s' after the a: so it will transfer the hidden system files."

Eddie: "Oh, gee, thanks a lot, Gary."

Formatting a diskette is the first lesson anyone learns after turning on a computer. Eddie was the Data Processing Manager. Something didn't compute.

Less than a week later, I had another disturbing conversation with Eddie, this time over the choice of the major hospital information system.

Eddie: "I've about decided that the hospital needs to go with a DEC Microvax minicomputer as our primary computer."

Gary: "Well, Eddie, are you sure a Digital computer is the best choice?"

Eddie: "I'm not talking about a Digital computer, I'm talking about a DEC Microvax."

Gary: (Shocked) "Eddie, DEC stands for Digital Equipment Corporation."

Eddie: "Oh . . . I guess I didn't notice that."

At this point, I still considered Eddie a good friend but these two conversations concerned me a great deal. I simply could not understand how anyone could become Data Processing Manager without knowing how to format a diskette. True, all of Eddie's past experience had been with mainframe systems rather than micro computers. In that case, how could he not know that DEC and Digital were the same company?

Because of these and several other incidents, I lost respect for Eddie's technical ability. In retrospect, this had a profound influence on our future cooperation.

Meanwhile, during the stalemate, Mr. MacCallum decided that because we were in the midst of development, a decision on a physician referral computer system could be postponed.

Competitive Positioning: Image Strategy

Hillcrest Health Center did not have the advertising budget to directly compete with other physician referral competitors. If we conceived a generic, city wide physician referral system, we would logically advertise similarly to MedSearch. This we could not afford.

On the first issue of whether or not to create a generic PRS or a PRS that would bear the Hillcrest name and association, I strongly advocated a generic system. The hospital community was divided on the issue. Some, like the highly successful MedSearch, made no mention of Presbyterian Hospital, the creator of the PRS. Others, like Mercy Physician Referral from Mercy Health Center, were clearly linked to a hospital. Hillcrest Health Center had three strikes against it: In the 1970s it developed a poor reputation, it had few physicians compared to other hospitals and finally, compared to other hospitals, Hillcrest had a small public presence. Therefore, I believed that Hillcrest must establish a PRS with an identity independent of Hillcrest Health Center. Whether or not this would offend the medical staff was a very real consideration at the time.

The second issue concerned the target market. Should we develop a citywide physician referral like most other hospitals? To do this would burden the advertising budget and do nothing toward the creation of a unique image. The location of our physicians was a decisive factor. They were all located in South Oklahoma City or one of the surrounding areas of Midwest City, Del City, Yukon, Mustang, Moore, Choctaw, and Harrah. In addition, the business plan from PMCI indicated that the vast majority of our patients lived in these communities.

Therefore, I recommended we name the PRS "South Oklahoma City Physician Referral" and should not identify it with Hillcrest in any way. Although Mr. MacCallum doubted the medical staff would accept this, to our complete surprise they wholeheartedly endorsed this title.

Competitive Positioning: Promotion

Promotion for physician referral centered primarily around the Yellow Pages. PMCI indicated that we could expect about 80% of the calls to come directly from Yellow Pages advertising. When perusing the Yellow Pages, I was struck by the fact that all of the physician referral ads were at the very end of the Physician section under the heading "Physicians & Surgeons Referral & Information Service." The major ads were either full page or one half page ads. An ad for "South Oklahoma City Physician Referral" would be placed at least two or three pages from the beginning of the classification.

Another classification was intriguing, however. "Physicians & Surgeons Exchanges" was a very small classification with only a few listings. It was located between the listings for D.O.s and M.D.s, close to the middle of the Physicians section. Additionally, the Yellow Pages automatically discounts a display ad by 50% if it is the first display ad in any particular classification. This would lower our annual outlay by about $10,000 dollars on a three quarters of a page ad. Because of these factors, Hillcrest became the first hospital to use this classification for a major PRS ad.

In addition to our Yellow Pages strategy, we regularly placed a physician referral ad in the South section of the Daily Oklahoman. Several small billboards and bus benches were acquired in South Oklahoma City to provide a permanent public presence. Brochures and posters were placed in over 100 public places by contract workers to complete our promotion strategy.

Staffing

The person answering the telephone is a critical link ultimately influencing the percentage of callers that decide to make an appointment with their assigned physician. Though the PRS operator utilizes either a manual or a computerized system with uniform

procedures for making the referral, the operator must establish credibility and trust if he or she hopes to convince the caller to actually make an appointment.

We were fortunate because about the time we decided to begin the search for an operator, one of Hillcrest's founding physicians, Dr. Leon Silvers, decided to retire. His office manager, Betty Overstreet, had worked for him for 24 years and now needed a new job. Dr. Silvers called Hillcrest to inquire about possible positions. Betty was referred to me and her qualifications were excellent. She knew most of our physicians on staff, she was courteous, she understood osteopathy, and she kept detailed records. Betty was hired in February, 1988, the third person to join the Marketing staff.

The Connection Card

The pre-registration health card system was the "hub" of the Physician Support Network. It was the database that linked all of the programs together and was meant to provide the vehicle for extensive cross-sales ability. We wanted card holders to feel that they were a part of a healthcare network that contained several benefits including fast, convenient hospital admission. We envisioned utilizing direct mail extensively to promote hospital services to a demographically stratified mailing list. (One example would be special mammography coupons to women over age 35.) Once "good" customers were identified from lists of former hospital patients, purchased mailing lists, and current physician patients, they would be sent a packet of information about obtaining their own pre-registration card.

In a strategy session, Ken Arfa and myself decided upon the name "Good Neighbor Connection Card" or the "Connection Card" for short. We felt that by associating it with our Good Neighbor Clinic network of physicians would enhance its acceptability by the medical staff.

In order to induce selected customers to complete the Connection Card application, we added benefits such as retail merchant discounts, hospital discounts, and ease of hospital admission. Once we decided upon the basic framework of the card program, we contacted local merchants about providing discounts for our cardholders. Discount providers included:

SAFEWAY PHARMACIES: Prescription items at a 10% discount.

SOUTHSIDE YMCAS: First 10 visits free of charge.

AMERIFIT FITNESS CLUB: Waiver of initiation fee.

ROYAL OPTICAL: 40% discount on glasses and 20% discount on contact lenses.

HERITAGE EYE SURGICENTER: 40% discount on eye exam and 25% discount on any other eye service.

DR. PHILIP WHITLOW, OPTOMETRIST: 15% discount on all services.

HILLCREST HEALTH CENTER: Private room at semi-private rate, waiver of security deposit, 50% discount on inpatient deductible up to $100.00, free cholesterol testing, free breast self-exam information, free physician referral, 30 days to pay patient portion of the hospital bill. (The last two items were "filler"; they were free to anyone.)

Our business office had a very negative reputation among our physicians. The medical staff generally felt that in addition to sending incorrect bills, the business office often sent computer generated harassment letters to even their best patients. The business office also had a practice of calling a patient about their bill while the patient was still in the hospital, a tactic which annoyed some patients. I knew that if we could promise this practice would be eliminated for all Connection Card holders, physicians would not only support the program, they might also furnish us with their patient lists. Therefore, this was my primary selling point when presenting this program to numerous physician committees. Unfortunately, the physicians didn't believe that this program (or any program) would solve

business office harassment of patients. They were skeptical although this approach did engender some medical staff support among younger physicians.

Data Processing Deadlock

While we could afford to delay a computer system for physician referral, the pre-registration system depended on a computer system. In early January, 1988, we were still at odds with Eddie Wiseman in Data Processing. While we wanted to purchase the System 36 mentioned earlier, Eddie was still threatening that if we did, Data Processing would not support it. He had plans to install a Local Area Network (LAN) of IBM PCs and he was afraid that a System 36 would be incompatible.

Then, I made an important discovery. While getting the documentation from Kurt Vanderwater of Meridian Microdata Systems which I needed to prove that one could indeed link a System 36 and a LAN harmoniously, I was shown a database language that could potentially solve our software problems without a System 36.

Advanced Revelation from Revelation Technologies was a fourth generation language that had several advanced features which would allow us to develop our own system much more quickly than would otherwise be possible. Primary among these attributes was the ability to construct a system without programming. One could "paint" the entry screen (simply type the screen exactly as it should appear) and the source code for this screen would be automatically generated. All data variables were selected from menus which made changes very simple to accomplish. This combined with a database built around the concept of variable length fields meant that changes could be made at anytime in the design of the database or the fields without disturbing the data. In other words, instead of long, tedious hours spent meticulously planning every aspect of the system, one could "program on the fly", confident that if mistakes were made, they could be easily corrected without

major redesign of the system. Obviously, none of this would be possible in a "normal" programming language that relied on perfectly written lines of code.

This was of paramount importance to the project because if we designed our own program, we would not have the benefit of PMCI's expertise. They agreed to give us a general description of how the system should function, but they were not going to spend time on specific technical explanation because this was not in their contract. Therefore, I felt strongly that any alternative system must have the ability to be modified instantaneously because without extensive prior design, many modifications would be necessary.

Once I saw a demonstration of Advanced Revelation, I told Pete Thibeault about it. As Eddie's superior, he had been acting as an intermediary between Eddie and I. Pete went to see a demonstration, was amazed at "A-Rev's" flexibility and immediately purchased the database. (Pete originally wanted to build the entire hospital information system with A-Rev.)

Without ever seeing Advanced Revelation, Eddie was adamantly opposed to using the language. He had decided that the hospital would only use three software packages: *Lotus 123* for spreadsheet applications, *Word Perfect* for word processing, and *dBase III+* for database applications. This time it was my turn to complain about "old technology." dBase III+ was an upgrade from dBase II, a common microcomputer language that I had programmed in for two years. As a language which must be coded line by line, it lacked flexibility which was crucial to success. Nevertheless, Eddie believed that because it was a "industry standard," we should not deviate from it. His strongest argument, however, was that by programming in dBase III+, Data Processing could provide the maintenance support. With Advanced Revelation, we would have to rely on an outside computer firm (Meridian Micro Data) for support.

The major problem, from my point of view, was that Eddie was trying to prescribe solutions for problems he knew very little about. dBase III+ was a unsuitable for this

application because one simply could not develop the application quickly enough, nor could the program be easily modified.

Numerous Conflicting Decisions

As the intensity of the debate grew between Eddie and I, the quality of our communication decreased. Because I frequently went to Pete Thibeault to complain about Eddie's position, Pete naturally was drawn into the debate. Technically, Pete was Eddie's boss and my equal but in reality, Pete exercised substantial authority because Mr. MacCallum relied on him in most situations.

Pete was already "sold" on A-Rev. When A-Rev was demonstrated to PMCI, they agreed that it would work well for our application. They also recommended against dBase III+. Therefore, Eddie remained the only person opposed to A-Rev.

That opposition was enough. Because Pete had an almost unyielding policy of letting his managers manage by not overruling them, he felt obligated to give Eddie his support. However, he also believed that Eddie was wrong in his conclusion.

This resulted in nine different "decisions" in six months on the type of hardware and software to use. It fluctuated back and forth between the IBM System 36, Advanced Revelation and dBase III+. It became a battle of who could convince Mr. MacCallum they were right. At one point it became obvious that the decision depended only on who had last met with Mr. MacCallum. After one of the first decisions in favor of A-Rev, a preliminary system was developed in about six hours of programming time. However, we couldn't use it because by the time it was developed, the decision had changed again. Finally, with the overall project six months behind schedule, we all decided that Marketing would communicate to Data Processing its needs and Data Processing would be responsible to provide the computer support necessary to meet the needs of Marketing. Both Pete and

Mr. MacCallum assured me that if Data Processing couldn't produce, Eddie would be terminated.

Data Processing's Attempt

Instead of programming the application "in house", Eddie hired a programming firm to develop the pre-registration system. The system itself was not complex. Basically, it was a data base that would print the information on a hospital admission form. However, a week later, Eddie called and asked me to look at the system that had taken 62 hours to develop and was about 60 - 70% complete. Pete and I believed this was the final straw for dBase III+. This system, only partially complete, had taken 10 times longer to complete than the A-Rev system.

In addition, Eddie not only contracted with and outside vendor to program the system, he also decided that it should be programmed in *Clipper*, a dBase "clone" that is much faster than dBase. The only problem was that the hospital did not own a copy of Clipper, nor did anyone in Data Processing have any experience with it. Therefore, even if the system worked, the hospital would still be dependent on an outside consultant for support.

Because we had both systems now available, I suggested a side by side benchmark comparison. I felt that by directly comparing the two products, the right decision would be self-evident. However, Eddie steadfastly said no. He simply said that his decision was dBase III+ and therefore he would not take part in a comparison.

Pete again switched opinions decided we needed to give Eddie more time to develop his system. When the dBase system had over 100 hours invested in development, it was delivered to Marketing.

The system was hopeless. It had numerous bugs and had not been programmed according to specifications in several places. In addition, there were several things that

needed modification once we tried to use the system in the hospital. The outside firm took days to respond, I was ignored in Data Processing and my frustration grew.

Finally, I told Pete that I could not work with the system, detailed the reasons, and told him the overall project was in serious jeopardy. By this time Eddie was frustrated too and wanted out from the responsibility of the system. I was given back the responsibility for the system at the end of July, 1988. We had promised the physicians that the system would be installed by May 1.

Completion of the Software

A short time later, the pre-registration system in Advanced Revelation was completed. Because we involved end users to decide features, it evolved into an elegant system. In fact, the "wish list" of features became so extensive that we had to limit our modifications. In all, the system probably had about 35 programming hours involved after including most of the user wishes.

Hardware Delays

One of the principle reasons for choosing against the IBM System 36 was the proposed Local Area Network. Eddie had promised the LAN would be in place by February, 1988 which would have been acceptable to our time frame. Because of his lack of microcomputer experience, he planned to hire a "LAN Administrator" to install and support the LAN. This proved to be much more difficult than expected. Finally, in June, Eddie hired a LAN Administrator (who happened to be a friend of mine), and the LAN became a reality in August, 1988 at which time the system actually became a reality.

Material Development

The Connection Card presentation materials were developed swiftly after Teresa Brekke began as Public Relations Director. They were divided into three phases:

PHASE I: The teaser postcard. Three days before the Phase II packet was to arrive, we mailed a colorful postcard to the recipient with the message "The Connection Card is Coming!" and a brief detail of the card benefits.

PHASE II: The enrollment packet. This initial packet consisted of a specially printed envelope, a cover letter, a brochure detailing the benefits of Connection Card membership and an application/self-mailer.

PHASE III: The fulfillment packet. This packet contained another cover letter, the embossed card, the card presentation brochure (the card fit inside), the Connection Card benefits brochure (same as in Phase II), and a small gift of a forehead thermometer.

Staffing

The old saying "what goes around, comes around," ironically occurred in the case of the Connection Card Coordinator. The Coordinator had to be a person of many talents including administrative skill, social talent and technical knowledge of computers.

By the time the deadlock with Data Processing was broken, I was anxious to hire someone quickly. Mike Oelke, who became the Connection Card Coordinator seemed to be well qualified, with several years experience in the computer field. Though he worked primarily with mainframe computers, he didn't seem to have any reservations about working in a microcomputer environment.

The lesson that mainframe experience does not translate to microcomputer expertise became painfully evident . . . again. Mike was very intimidated by his position, especially with the computer aspect. He knew very little about MS-DOS and Advanced Revelation was very difficult for him to grasp.

The result was that the Connection Card program continued to dominate my time and required continual oversight. Though Mike eventually became more proficient, my hiring error kept the program in turmoil.

Physician Practice Support

Because PMCI viewed the physician as a customer of the hospital with a choice to take their practice elsewhere, they believed that the hospital which identified and met physician needs would be the prosperous hospital in the future. The Physician Practice Support program was a key element in their strategy to strengthen physician loyalty while at the same time increasing hospital revenues.

Physician Office Management Needs

Physicians vary widely in their business acumen. Some are extremely proficient, others are extremely poor. Most physicians are somewhere in between. Not only must physicians stay current on new medical advances, they must supervise billing, collections, personnel, purchasing, record keeping, and scheduling in their offices. Yet they usually do not have specific training in any of these areas.

Physician Support Liaison

While the Physician Practice Support program consisted of several components, the primary focus was on the role of the Physician Support Liaison. The Physician Liaison needed to be a person with expertise in physician office management, preferably someone with physician consulting experience. Their responsibility would include providing a comprehensive practice assessment for the doctor with follow up meetings scheduled to resolve specific weaknesses uncovered by the assessment. The Physician Liaison would provide these services to as many physicians as possible. PMCI stipulated that this would not only increase physician loyalty but would also result in higher hospital admissions as physician practices became more profitable. Indeed, physicians would be told that they should derive a minimum of 5% of their gross revenue from hospital treatment. Some physicians averaged more than 5% and many physicians averaged less. Also, the Physician Liaison would travel to rural osteopathic physicians, providing consulting services which encourage hospital admissions.

PMCI's Unique Criteria For Staff

PMCI believed the best candidate for the position would be a sharp "front office girl" with experience in physician office management. They would then train this person to conduct the practice assessments and the follow up consultations would either be conducted by the Physician Liaison or would be contracted out to an expert in accounting, personnel, etc.

I felt strongly that this was a certain recipe for disaster. We were telling our medical staff that the Physician Liaison was an office management expert. If we sent anyone without genuine expertise, our credibility would be destroyed and our physicians would not be willing to work with our Liaison. In my view, it was critical that we hire an expert in which both we and they could be confident.

One of the initial candidates for the position was a man named Nicholas Hahalis. His qualifications and experience were perfect. Previous experience included a management position with the Hospital Corporation of America in which he bought and sold rural hospitals, frequently becoming Interim Administrator at the facilities directing administrative and financial reorganization. During the past 10 years, he was president of Medical Management Group (MMG), which provided physician office management and consulting services. He was also a registered nurse. A year previously, he sold MMG to begin law school at Oklahoma City University. According to Nicholas, he found law school to be much easier than he had expected and therefore wanted the position because "he could do it with his eyes closed" and would provide extra income for his wife and children. I wanted to hire Nicholas and fortunately, Mr. MacCallum who had previously met Nicholas, supported this decision also.

My recommendation to hire Nicholas was firmly opposed by Ken Arfa at PMCI. At first, Ken said that because of Nicholas' expertise, he would spend too much time at each office solving problems and would not be able to provide services quickly enough to our active staff and rural physicians. Then he said that Nicholas would be far too busy in law school to work full time. After all, most physician meetings are in the evening. Nicholas assured me that he would devote full time to the position for at least three years. I never could get Ken to explain why he needed to attend evening physician committee meetings.

Finally the real reason emerged. Nicholas Hahalis was Greek. Ken assured me that our physician staff would never accept Nick because of his race and that we needed to hire a "blond with big tits" to win the confidence of the medical staff. This *really* irritated me. Mike Bernstein, Rich Ekwall and Ken Arfa were "unblemished" Jews with all of the stereotypical Jewish features. Yet race was never a factor when Hillcrest hired *them*. Of course, I couldn't let Nick know the real reason for the delay in our decision so I gave him

one excuse after another as we postponed the program for three months. Out of a dozen other candidates interviewed, none even came close to the matching Nicholas' skill and experience.

The Obvious Choice

After a delay of three months, our physicians were becoming restless. They were beginning to complain that the Physician Practice Support program would never materialize. In a meeting with Mr. MacCallum, we decided to hire Nick and take the chance of physician rejection. Ken reluctantly agreed.

Success From the Beginning

When we introduced Nicholas as our Physician Support Liaison, and briefly reviewed his qualifications in the Medical Staff Executive Committee meeting, three physicians immediately raised their hands to request that Nicholas visit their offices first. By the end of the meeting, Nicholas had seven appointments with doctors. Needless to say, acceptance was not a problem.

The Physician Practice Support program was the most successful program we introduced. Nicholas won rave reviews from almost every physician he contacted. In several cases he was able to help them realize revenue increases ranging from 20 - 50% and he helped several others resolve partnership problems. In addition, Nick was a self-motivated individual who required very little supervision. PMCI provided no substantive help to Nick. He didn't need it.

Strengths and Weaknesses of PMCI

As a consulting firm, PMCI demonstrated several evident strengths and weaknesses.

Strengths

1. Combined knowledge of the founders. Ken Arfa, Rich Ekwall and Mike Bernstein together had a great deal of experience with Physician Support Networks in other hospital settings. Their decisions were tempered by previous experience in both large and small hospitals.

2. Sound, systematic methodology. PMCI believed that the physician should be the central focus of a marketing program. They built their Physician Support Network around the concept that loyal, prosperous physicians will ensure hospital prosperity. In addition, they developed and utilized a structured method for implementing a PSN with little deviation from hospital to hospital.

3. Well-researched foundational business plan. By requiring such extensive and time consuming data collection, PMCI was able to deliver an impressive Business Plan. Formulation of the plan enabled them to gain an excellent grasp of hospital strengths and weaknesses which helped them avoid potential problems someone with less working knowledge might encounter. Though the plan was not utilized to its fullest extent, it remains a valuable document for future decision-making.

4. Clear objectives. PMCI clearly articulated where they wanted to take the hospital in 12 months. They defined each program in detail and explained the benefits to be realized. Financially, they delineated the costs of each program in detail and explained their basis for projected revenues.

5. Ability to generate excitement. PMCI, first and foremost, articulated an exciting vision for the hospital. They presented themselves as movers and shakers, the kind of firm that would completely revolutionize a hospital in 12 months. They would enable us to cut

through bureaucratic inertia and accomplish in one year what might ordinarily take four or five years. "Twelve months from now, Gary, you will be a star and South Community will be in panic," Mike Bernstein told me at our first meeting. It was the kind of challenge that dreams are made of and this dream infected all of us in administration.

Weaknesses

1. Unreasonable objectives. PMCI made the classic sales mistake. They over promised and under delivered. It wasn't that they didn't have the expertise to deliver everything they promised, it was that they set time schedules that could only be reached if everything went perfectly (and then it would have been difficult). Therefore, when we encountered a deadlock with Data Processing over the computer system, we fell hopelessly behind schedule. The further behind we became, the more we had to compromise programs to retain some semblance of a schedule.

2. Thin organization. Perhaps at the beginning of our project, PMCI had average depth of organization. However, once Frank Dingler, Todd Hamilton and Mike Bernstein departed, PMCI was left woefully short of qualified, executive personnel to fulfill their commitments.

This was compounded by their practice of working on four or five projects simultaneously. When their senior executives departed, PMCI was forced to hire new individuals immediately and it was obvious these new executives were given only cursory training. This made a poor impression on the administration at Hillcrest.

3. Willingness to compromise to generate work. When Mike Bernstein agreed to reduce the number of employees necessary to implement the PSN at Hillcrest, he was assuring the PSN could not be installed as quickly as they projected. In addition, when Mr. MacCallum outlined how the program would be financed by taking monies out of the current marketing budget thereby avoiding the Finance Committee, Mike Bernstein should have refused to

accept Hillcrest as a client. There was no possible way to avoid angering the Finance Committee and Board of Directors by sneaking the PSN into effect on a piecemeal basis the first year on the assumption that in the following year, a comparatively enormous budget would be required and therefore forcibly approved. Yet that is exactly what happened.

4. Boilerplate programs. As mentioned before, PMCI knew before the Business Plan was ever delivered which programs they wanted to pursue at Hillcrest. While the systematic methodology enables programs to be enacted quickly, it does not ensure that the program components will work in any particular hospital. There were numerous instances where PMCI would insist on an item that was completely inappropriate for Hillcrest. Occupational Health was especially troublesome because PMCI wanted to force fit a program that our doctors would not tolerate.

CHAPTER V

PROGRAM IMPLEMENTATION AND OPPOSITION: MAY - AUGUST 1988

Physician Unrest

Because physician expectations were raised to excessive heights, every problem we encountered provided further evidence to a few that the program contained empty promises or was being incompetently implemented. From October, 1987 until June, 1988, I attended most monthly physician committee and subcommittee meetings. As time passed with one problem or another blocking progress, the doctors became increasingly critical.

It is important to note that the opposition on the medical staff actually resulted from the strong criticism of only four or five doctors. On a staff of 73, there were also about 10 supporters of the marketing project and the rest had no opinion. The opponents, however, were able to sway a large number of "uncommitted" physicians.

Three programs especially drew criticism. The first, occupational health, was conceptually plagued from the outset with unworkable compromises negotiated to gain physician acceptance. As mentioned earlier, the primary compromise that damaged the program was the decision to utilize physician offices as occupational health clinics. Once employees actually began using the system, the vast majority simply opted to use the hospital emergency room instead of attempting to visit a clinic that may or may not be open. This exacerbated the dissatisfaction of General Practitioners who suspected that the

hospital was trying to compete with their practice. However, when Worker's Compensation patients went to their offices, major mistakes occurred literally every visit, usually in billing.

The medical staff was generally supportive of the Connection Card program when it was introduced because they hoped it would provide easier admission and discharge, among other benefits. However, when the delay in the program stretched into months, the medical staff became angry and strident in their criticism. I felt the blame lay squarely on the shoulders of Eddie Wiseman but I couldn't say that in a medical staff meeting. So I provided one excuse after another which undermined my credibility and increased physician criticism.

The third major disappointment expressed by the medical staff was the Women's Health Program. Mr. MacCallum was very non-committal about funding for the program and his clear direction was to "go slow." All our medical staff saw, however, was another program where little progress was being made.

One of the primary ways we tried to obtain physician input in the marketing process was through regularly scheduled Physician Marketing Committee meetings. We met once a month to discuss the project progress and to get their input on how to tailor the programs in the areas that affect their practices. The chairman of the group, Dr. Edward Glinski, was completely supportive of the PSN and he tried to keep negative physicians off the committee. However, some physicians who were negative requested to be on the Physician Marketing Committee and this resulted in better interaction because their objections helped us avoid several pitfalls. Unfortunately, a few of these physicians seemed more interested in picking apart the project. Interestingly, the physicians who were the most negative were also the physicians who were experiencing severe financial problems in their practice.

After July, I found myself consciously avoiding regular hospital medical staff meetings. Though there were reasons for the difficulties we experienced in several programs, the meetings had become very harsh and I found many reasons for

nonattendance. This created further alienation and did nothing to bolster Marketing's image among our physicians.

Employee Resentment

As the project progressed, significant employee resistance developed. For example, Hillcrest relied on a very arcane purchasing system. Because the PSN was bound by a very tight time schedule, many products and services were needed on a moments notice. Purchasing was very resistant to any change in their procedures, which usually delayed the purchasing process by days or weeks. Because of problems like this, a meeting of department managers was scheduled to discuss methods to "cut red tape." At this meeting, several managers complained that Marketing was receiving favored treatment and they resented it. While there was general agreement that unnecessary "red tape" should be avoided, the real message was one of a growing resentment of Marketing's "privileged" status.

PMCI recommended a "Network Task Force" consisting of key department managers that would involve them in decision making and provide a sense of ownership for the managers. However, the meetings were actually information sessions and did not require any real input from the participating managers. These meetings were discontinued in May, 1988.

By June of 1988, several managers became vocal about the number of computers Marketing was purchasing and the number of employees added to the Marketing staff. Other managers felt that Marketing, by virtue of what they imagined was an unlimited budget, was receiving a disproportionate share of microcomputers. In addition, almost all of the employees in Marketing were managers, which meant they were accorded the highest level of benefits the hospital offered.

Early Success: Physician Referral and Physician Practice Support

At a hospital Board of Directors meeting in January, 1988, our numerical projections for Physician Referral were being challenged. I responded, somewhat brashly, that if the hospital was not receiving 400 total incoming calls by September, "the hospital should look for a new Director of Marketing." When I made that assertion, Wanda Lewellen somewhat lightheartedly stated that "now the Board has something concrete to hold you to." I knew she was serious, yet I was not overly concerned because "total incoming calls" included all calls on the "Connection Line", a line that received inquiries about all of the hospital programs and services. Any numerical concerns vanished once the Yellow Pages were released in mid-July as shown below.

TABLE I

PHYSICIAN REFERRALS AND TOTAL CALLS:

FIRST SEVEN MONTHS OF OPERATION

	Physician Referrals	Total Incoming Calls
Feb. 1988	25	32
Mar.	43	51
Apr.	50	77
May	79	106
June	56	260
July	153	476
Aug.	240	524

Even the most ardent opponents of Marketing on the medical staff conceded that South Oklahoma City Physician Referral was a great success.

Similarly, Physician Practice Support demonstrated impressive success from the start. Nicholas Hahalis completed 32 physician practice assessments in the first three months of his employment and the medical staff overwhelmingly approved of the program. After an assessment, Nicholas was available to provide the assistance necessary to implement his

recommendations. Many physicians began to rely on Nicholas for wide ranging practice advice and he also served as an analyst for several opportunities the hospital considered. Nicholas believed that he would increase the physician patient admission rate by 5% *per physician* because of the assistance and advice he furnished.

These two programs were the primary success stories of the PSN. They illustrate the potential that correctly implemented Marketing programs can provide to improved medical staff loyalty and prosperity.

Forgotten Programs

When problems inevitably slowed progress on the core programs in the PSN, other programs were given cursory treatment. Though PMCI was paid to implement all eight programs, they did not implement the following four.

Emergency Room Marketing

The Emergency Room at Hillcrest has the worst physical plant of any in Oklahoma City. It is small, cramped and has a deplorable entrance. The entry, which looks like a warehouse entrance with a brown steel door and unclear, antiquated signage, has long been an embarrassment to the hospital.

In contrast, the Emergency Room service ranks among the very best in Oklahoma City according to AmCare drivers and attendants (the city ambulance service). The Emergency Room director, Dr. Dale Askins, was widely regarded as the best asset Hillcrest had. Mr. MacCallum hired Dr. Askins to improve ER service five years ago, paying him extremely well. In addition to exceptional medical skills, he was a marketing oriented physician who set out to ensure that the ER developed a reputation for excellence in service to patients. Dr. Askins upgraded the ER status to Level II, equal to the best in the Oklahoma City area.

The first priority was appearance. PMCI felt that it would be counterproductive to develop and promote programs designed to increase ER traffic only to display a poor image due to a substandard physical appearance. A new Emergency Room was planned in an eight million dollar construction project that was about to begin. Therefore, every time we tried to order much needed interior and exterior furnishings, they were delayed because of uncertainty over the new plans. Finally, PMCI delivered an Emergency Room marketing plan that could be implemented whenever the hospital built the new ER.

Information Systems

Originally, PMCI planned to install a complete computer network capable of supporting the marketing programs. In addition, they would have provided technical assistance to ensure that the overall hospital computer system was functioned compatibly with the marketing network computer system.

However, because they encountered utter hostility from Eddie Wiseman in Data Processing, they could not accomplish their objectives.

Finally, they delivered a generic computer network plan that detailed the design and function of a network computer system.

Behavioral Medicine Marketing

The Behavioral Medicine Center (BMC), established in 1985 by the insistence of Mr. MacCallum, had developed into a major asset for Hillcrest, contributing about 30% of hospital revenues. The BMC consisted of alcohol/chemical dependency treatment, psychiatric treatment, outpatient counseling, and crisis intervention.

Under the leadership of Betty Chase, a psychiatric nurse, the BMC essentially behaved as a separate entity from the hospital, frequently acting on its own directives with its own marketing plan. Mr. MacCallum envisioned the marketing plan from PMCI as a

method of integrating the BMC back into the overall hospital direction. However, Betty Chase was very protective of the BMC and viewed PMCI as a possible threat to their independence. However, unlike Eddie Wiseman, she decided to define the help she wanted, thereby controlling the input she received.

PMCI's consultant in the mental health arena was truly major figure in the psychiatric world. Dr. Mel Kolb, the chief psychiatrist for Champus and a dominant military and governmental insurer, had extensive consulting experience with mental health facilities. He was also an osteopathic psychiatrist, a relatively rare osteopathic specialty. PMCI arranged a telephone interview between Dr. Kolb and Betty Chase to discuss operational and recruiting issues. Their interview was transcribed and delivered as part of a Behavioral Medicine Center marketing plan. As in other "forgotten" programs, the marketing plan was quickly disregarded and never affected actual operations.

Women's Health Center

Unlike the other "forgotten" programs, the proposed Women's Health Center (WHC) began as a priority program. Newborn deliveries at Hillcrest had reached a low-point by the time the Women's Health Center was proposed. General Practice doctors had all but ceased delivering babies because of the enormous increase in malpractice rates charged to GPs who practiced obstetrics. The two OB/GYN specialists on staff, Dr. Raymond Deiter and Dr. Mona Motz, were unhappy because they were receiving only an average number of referrals by GPs because of some perceived "political" problems. Because of a recent malpractice suit that involved a General Practitioner and the hospital, some doctors were beginning to suggest that Hillcrest would be better off without obstetrics altogether.

Expense posed one of the biggest obstacles to a Women's Health Center. Several hundred thousand dollars would need to be expended for a competitive WHC. These expenses were not included in the original Business Plan submitted by PMCI. In addition to

the expense, even a minimal return on investment would not be realized for five years or longer.

After several planning meetings with Drs. Deiter and Motz, PMCI brought in Deborah Martin, the primary designer of the Women's Health Center at St. Joseph's Hospital in Atlanta, Georgia. In meetings with Drs. Deiter, Motz and others, Deborah convinced them that not only did she thoroughly know every aspect of a WHC, she convinced them that it would revolutionize the OB/GYN department at Hillcrest. She greatly impressed physicians that were initially very skeptical.

However, once their expectations were raised, Mr. MacCallum became somewhat ambivalent. When I requested funding for the WHC Product Line Manager position, I was told we needed official approval from the OB/GYN department and the Executive Committee of the medical staff. This delayed a decision for about six weeks. Then once I received those approvals, Deborah Martin became very absorbed in another hospital project. Meanwhile, Drs. Deiter and Motz were becoming very inpatient and vocally critical at medical staff meetings. Finally, we simply needed funding for progress. I gave the request for funding to Mr. MacCallum and began to concentrate on other problems in the PSN. The WHC project literally faded away.

Launching the Connection Card

Once we initially designed the Connection Card software in Advanced Revelation, we began the mail outs to former patients, occupational health employees, and purchased mailing list prospects.

Finding former patients who we felt would be "good payers" was much more difficult than we initially presumed. It seems that the hospital kept meticulous records on

those who did not pay their hospital bill, but "purged" those who did. We had no idea who our good "customers" were. Finally, we changed the procedures and began keeping records of our good paying patients.

While searching for a company to purchase a select mailing list, I discovered a company that could give us a list of those with hospitalization insurance. We purchased a mailing list of 5000 heads of households in certain zip codes in south Oklahoma City that were over 20 years old and had hospitalization insurance.

Response to the Connection Card packet from the purchased mailing list was poor. The response rate was only about 1.4%, somewhat below the rate of most "cold" mailings.

In the beginning, the low response rate was an advantage. The laboratory, which was responsible for the free cholesterol testing, was very recalcitrant. The lab director believed they were having to expend time and energy on "Marketing's project" that they did not care anything about.

In addition, because of problems getting inpatient admission forms to function properly with the selected hardware, the Connection Card computer software was only operated in the outpatient area. The inpatient admission forms were 12-part forms typed on a typewriter. We could not find a printer that would function with 12-part forms so we decided to design two 6-part forms that would be printed twice. Unfortunately, I selected a printer that did not work correctly. Instead of working through the obstacles, Eddie Wiseman succeeded in getting the Connection Card software and hardware confined to the outpatient area. This does not mean it was not extensively used, on the contrary, the hospital registered about 1000 outpatients per month versus about 500 inpatient admissions. Because of the relatively low initial distribution of the Cards, very few actual problems occurred.

Occupational Health Disaster

As mentioned before, Occupational Health had been fraught with problems from the outset. These problems were exacerbated by the excellent sales success of Vicki Mathews. She signed several companies immediately and eventually signed about 17 companies to be Good Neighbor Care members.

The two most important factors to an employer considering an occupational health program were cost and rapid treatment. Cost was fairly easy to manage. Since no one in Hillcrest's Business Office had any idea what the real cost of providing service was, we simply based our prices on what other competing hospitals or clinics were charging. Unfortunately, this was far below our standard rates. However, Mr. MacCallum was determined that we should do whatever it took to be competitive. Therefore, if other services were charging $35 dollars for minor injury care, we would charge $35 dollars. We thought we were probably losing money at this rate but the goal was to build a competitive occupational health program. Therefore, we instituted a separate occupational health charge scale for those employers that were members of Good Neighbor Care. (Rarely, if ever, was a correct billing sent to an employer. In fact, incorrect billing was so chronic that Vicki began checking every bill before it was sent.)

Rapid treatment was equally or more important to employers. Fortunately, we already had one of the fastest emergency rooms in the city with most patients initially treated within 5 to 10 minutes upon arrival. In fact, the Emergency Room director, Dr. Dale Askins, advised the ER physicians to *meet Amcare Ambulances at the door* whenever possible. This was virtually unheard of and was illustrative of the tremendous marketing sense Dr. Askins exhibited. Needless to say, AmCare drivers were impressed. Dr. Askins was completely supportive of occupational health and vowed to treat those patients with the utmost speed.

As it goes for an ill-fated program, disaster struck. One of our General Practitioners was called to the ER when one of his patients arrived with an injury.

Moments later, an Occupational Health patient also arrived. The ER personnel rushed the Occupational Health patient ahead of the GP's patient, explaining that Occupational Health patients receive priority. The General Practitioner was furious. Then he discovered that Occupational Health patients were being charged much less than his patient for the same injury treatment. This just added fuel to the fire. He called the physicians who were opposed to Occupational Health and they demanded we form a committee of Good Neighbor Clinic General Practitioners to govern Occupational Health.

At the first meeting for the Occupational Health committee, the doctors directed us to stop all marketing activities associated with Occupational Health. We could still service the member companies, but we were not to sign up any additional companies. I explained that the intent of the rapid treatment was not that one patient would be rushed ahead of another - this had never been suggested - but that special attention would be given to Occupational Health patients to ensure that there were not any unnecessary delays. Nevertheless, the physicians directed that the program be placed on "hold" until they could provide us with guidelines they were to design.

Shortly after this meeting, Vicki Mathews and I met with Mr. MacCallum to discuss the results of this physician meeting. She was distressed over the moratorium placed on new accounts because she was paid a commission based on the number of new companies she signed. In addition, she had already started negotiations with several new companies. "What should I do with the companies I've already talked to? Should I just let them drop?" she asked. "No, I wouldn't want you to do that," replied Mr. MacCallum, "You keep selling, just don't be vocal about it."

CHAPTER VI

TRANSITION AND DISINTEGRATION

TONACK, 1988

For the 1988 TONACK conference in Corpus Christi, Texas, Mr. MacCallum, Pete Thibeault and myself were scheduled to present an overview of the PSN development and installation at Hillcrest. PMCI had a booth at the conference and ultimately, we hoped to persuade another osteopathic hospital to engage PMCI. (A clause in Hillcrest's contract with PMCI provided that Hillcrest would be paid 10% of any PMCI hospital contract that Hillcrest helped secure.)

After our presentation, Mr. MacCallum "dropped a bombshell." As we walked by the bay, he informed me he had accepted an offer from Oklahoma Osteopathic Hospital (OOH) in Tulsa to become their new President. I knew this was quite an opportunity for him because OOH happened to be the largest osteopathic hospital in the nation at 533 beds. They had experienced financial difficulty in the past few years and were looking for someone to turn the hospital around.

I also knew, however, that this could portend ominous things for my situation. My strong base of support at the hospital was primarily with Mr. MacCallum and Pete Thibeault. Mr. MacCallum assured me that Pete would at least be the interim administrator and could possibly become the new administrator. However, there was no assurance that either would occur. If neither of these occurred, Wanda Lewellen would probably be

chosen as the interim administrator because she held this position for nine months before Mr. MacCallum came to the hospital. I had a nagging suspicion that if Wanda became interim administrator, I would have to leave.

Non-Renewal of PMCI's Contract

Meanwhile, PMCI had begun to discuss a substantially higher contract for the following year. When Hillcrest began discussions with PMCI, one of the attractive aspects was their commitment to a one year timetable. They would complete the project in one year with a small retainer fee of approximately $2,000 per month the following year. This sharply contrasted with other consultants who would sometimes require years to complete their projects at enormous cost. Mike Bernstein, in fact, told us that if they did not complete the first year tasks in a year, they would stay at no charge until they were completed.

When we finally met to discuss new contract terms in early September, 1988, the second year contract had grown to approximately $135,000! The second year project basically called for a restructuring of Occupational Health and implementation of three of the "forgotten" programs: Women's Health Center, Behavioral Medicine Center Marketing and Emergency Room Marketing. Worse still, they had simply copied large sections of the original contract and tied it all together into the second year contract. After discussion with Pete and I, Mr. MacCallum told them there was no possibility the Board would approve such an extension after having just approved a mammoth Marketing budget in June.

PMCI then submitted another second year contract that totalled about $81,000. However, as Pete was quick to point out, the only thing that changed between the first submission and this revision was the fee. They simply resubmitted the initial second year plan with a lower dollar figure. This made us ever more skeptical because they had consistently maintained that their profit margin was only in the 5 - 10% range.

At a meeting to discuss this revised second year contract, Mr. MacCallum asked them why they expected us to again pay for the implementation of programs promised in the initial contract. In each program they explained that the delays were not a result of their mistakes but resulted from administrative decisions or conflicts. They were right, of course. However, this still meant that for whatever reason, they did not expend the time and effort for these programs. "Why shouldn't we expect you to provide this consulting time which we paid for and haven't received?" asked Mr. MacCallum. "Because of unexpected problems such as the computer system, we spent our allotment of consulting time," replied Ken Arfa. This assertion was probably true but it still didn't convince us that another year at this level of funding was a wise choice. Mr. MacCallum delayed the decision.

Another grievous mistake concerned their expenses for the contract negotiation trip. Since the former contract expired in August, there were no contract payments in September. After their trip, they submitted a $2,500 bill to Hillcrest for the two days of contract negotiations. This action incensed Pete. Since we did nothing during those two days except discuss future contracts, Pete, Mr. MacCallum and I felt that submitting this bill was in extremely poor taste.

The second year contract issue was delayed until after Mr. MacCallum left for OOH. Wanda Lewellen, after discussing the issue with Pete and myself, declined to renew the contract.

Physician Revolt

Shortly before Mr. MacCallum departed, Ken Arfa and I attended a Physician Marketing Committee meeting. Instead of Mr. MacCallum, Wanda Lewellen was present at the meeting. This made an incredible difference in the attitudes of the negative physicians. When Mr. MacCallum was present, the physicians never stridently attacked the PSN and Mr. MacCallum always demonstrated unqualified support. This was entirely different.

I began by presenting the statistics for Physician Referral which were very positive. From the moment I began, the primary "attack" physician, Dr. Pamela Hiti, began to complain loudly about the quality of her referrals. From the tone of her voice, I suspected that she had been drinking. She was evidently very angry. However, Physician Referral was so successful that she was quickly contradicted by several other physicians in the room.

Next, I began to discuss Occupational Health, a program that was in the midst of severe difficulty. Dr. Hiti began to castigate me for the problems in the program and at that moment I made the worst mistake of my career at Hillcrest. In defense of the program, I revealed that Vicki Mathews had signed three new companies the previous week. Dr. Hiti became apoplectic, "Do you mean that after we specifically told you at our last meeting to completely stop all marketing activities in Occupational Health, you let Vicki go out and continue selling? Against our direct orders?"

She was furious and her face was now red as a beet. Silence engulfed the room. Every eye was on me. My mind was spinning. Should I tell them what Mr. MacCallum instructed us to do? What should I say? Finally, I rather sheepishly said, "Vicki simply closed on some companies she had previously made contact with. We didn't think we should just leave them hanging."

"That doesn't matter," she shouted, "We told you to stop and we meant stop, period. It's clear you will not listen to us. And I'm going to check with Vicki to see if she really had made previous contact with those companies." Immediately, I knew that if Vicki realized the precarious position I was in, she would lie without a blink and say that the companies had not been previously contacted.

Dr. Glinski broke the tension and asked me to report on the Connection Card. I reported that we had about 2,000 cardholders, many of whom were former patients. I also related that the computer hardware and software was functioning smoothly in the outpatient admitting area. Then Dr. Askins expressed disappointment because the computer hardware

and software had not been installed in the ER yet. I explained that we had experienced long delays in the installation of the Local Area Network and with the printer for the 12 part admitting forms. Dr. Hiti angrily interrupted, "I don't care whose fault it is, I hold you personally responsible for the screw ups in that system. It's your fault and I hold you responsible! Do you understand me?" At that moment, another very negative physician, Dr. Ronnie Keith, stood up, wadded up his meeting agenda, threw it on the table and said, "What's the point of this meeting? What are we here for?" as he stormed out of the room.

Dr. Glinski again broke the silence by asking me to report on the Physician Support Program. Finally a program that exceeded its goals! Nicholas Hahalis had entered the room a few minutes before and so I presented a brief report and asked Nick to comment. Doctors almost unanimously volunteered that the program had provided some very tangible benefits to them. When Dr. Hiti tried to criticize some of the recommendations Nick provided, Dr. Glinski and others interrupted her in disagreement and she ceased her criticism. The meeting quickly adjourned.

The suspicions I had about the continuation of the PSN after Mr. MacCallum's departure were confirmed that night. Leadership made all the difference. I am convinced that if Mr. MacCallum had been present that the meeting would have taken an entirely different course. The following morning he told me that he would have never allowed the unjust criticism and would have taken personal responsibility for any criticism offered. In addition, when he would have cooled strident criticism immediately, not allowing it to build. He said, "I would have made it clear that any criticism of the program was a criticism of me because I have been closely involved in all respects." In short, he would have expressed unqualified support for the project.

In contrast, Wanda Lewellen did not say anything the entire meeting, even when she personally knew some of the criticism was unjust. Instead she was silent.

In retrospect, I believe that a fast-track, "let's change everything" project like this one is positively doomed unless it receives unequivocal support from the C.E.O. of the hospital. In addition, the C.E.O. must command the respect of those who will inevitably attack the program. If the C.E.O. is not in a very strong position with key hospital factions, the C.E.O. may not be able to withstand the storm of criticism that will result from the imposition of tremendous organizational change. If, on the other hand, the C.E.O. tries to escape the criticism by allowing it to focus on those involved with the installation, the program will disintegrate as the primary implementors are forced to leave.

An Unlikely Interim Administrator

When Mr. MacCallum announced he had accepted the Presidency of Oklahoma Osteopathic Hospital in Tulsa, everyone assumed that Pete Thibeault would be the Interim Administrator. He was the logical choice because he understood every aspect of hospital administration. As mentioned previously, Pete was the co-architect with Mr. MacCallum of Hillcrest's spectacular financial performance.

However, Pete had one major shortcoming. He tended to be rather tactless and straightforward even with the Chairman of the Board, Mr. Carlton Myroh. Mr. Myroh tended to look at financial reports and draw the wrong conclusions, sometimes critical of Pete. If Pete was exasperated, he would respond, "I can't help it if people who are *ignorant* of financial principles draw that conclusion." Then he would drive the point home by proving conclusively Mr. Myroh's error. This scenario was repeated more than once.

Therefore, shortly after Mr. MacCallum resigned in late July, the Board recommended that Pete and Wanda be Co-Interim Administrators. When Pete was informed of the decision, he refused. He felt this was a ludicrous idea that would be awkward at best. Pete also suspected that Wanda, a Board member herself, influenced the decision. In his opinion, Wanda had little education, knowledge or ability to lead Hillcrest. Virtually no

progress resulted from Wanda's previous stint as Interim Administrator when hospital revenues were only about $14,000,000 annually. Since that time, the hospital had grown in both revenues and complexity. When Pete refused the recommendation, the decision was delayed.

Three weeks later, Pete decided that even if he were offered the position of Interim Administrator, he would refuse. At the time, he told me he "wanted to keep his options open." Accordingly, the Board chose Wanda to be Interim Administrator and Pete was appointed to the position of Interim Assistant.

Mr. MacCallum's Departure

Mr. MacCallum's last day as Administrator, September 16, was a sad one for Hillcrest. In all of the festivities surrounding his departure, one theme kept arising: Hillcrest had experienced its "golden" years. It was almost an ominous inference that the future was not as bright as the past. His last request to the Board was that Marketing's endeavors not be permitted to fade.

Director of Marketing Resigns

During this period of time, I had an ominous feeling that Wanda had been discussing ways to force my departure with certain physicians on staff. Because all of my performance reviews had been very good to excellent, she needed a reason to persuade me to resign. So, I just had a premonition that something was happening to bring this about.

Shortly after Mr. MacCallum left, I wanted to take the steps necessary to improve my relationship with the negative physicians on the staff. As I was planning my strategy, I decided to call Wanda for her advice. After all, I called Mr. MacCallum many times in the past for advice on how to handle various situations and Wanda was now my boss. When I reached her, she seemed to be very uncomfortable with my plans. Finally, she said, "Gary,

why don't you wait until after the medical staff meeting Tuesday night." When I asked why, she didn't have an answer. At this point, I knew that something was up.

A few days later on Wednesday morning after the medical staff meeting, Wanda called me for a meeting. I knew what the meeting would entail. When the meeting began, Wanda told me that at the medical staff meeting the previous night, the medical staff recommended that I be replaced. She was very gracious. She said, "Gary, what do you want to do? What do you think is best for you in this situation?" As I considered my options, I could either refuse to resign and attempt to work with an alienated medical staff or I could resign on my own time schedule. I chose the latter and responded, "Wanda, there are several things that need to be accomplished so the PSN will continue on a stronger foundation. This will take about six weeks. I will plan to leave on November 1." Wanda said, "That sounds great, Gary. I just don't want anyone to say that the first thing I did was force you out. That's the last thing I want anyone to think." She then complimented me on my performance and insisted that I would always have a good recommendation from her. I didn't believe a word of this but she was gracious in her remarks.

Programs On Hold

All progress went on "hold" at this point. I pushed through the completion of the Physician Referral software because without it, the entire program depended on Betty Overstreet's expertise. The Connection Card system was also refined. I recommended that Teresa Brekke serve as the coordinator for Marketing.

CHAPTER VII

CURRENT STATUS AND SUMMARY

Comparative Position of Hillcrest Health Center

Census Trends

After falling dramatically to less than 100 patients per day in November and December, 1988, the average daily census (ADC) climbed to record levels in January through March, 1989. February, 1989 was a record month for Hillcrest with an ADC of about 120 patients per day (70% full). March continued with a very high ADC, according to Nicholas Hahalis.

Reasons for the high census varied but Nicholas attributed some of the increase to the cumulative affect of Physician Referral and the patient load improvements effected by the Physician Support program.

Administrative Staff Changes

Shortly before I left Hillcrest, the Board of Directors voted to appoint Wanda Lewellen permanent administrator. They raised her annual salary from approximately $45 - 50,000 to $80,000. This came as a complete surprise to the employees at Hillcrest. Before this time, Wanda had always maintained that she did not want to be the Administrator.

Within three weeks after Wanda was appointed permanent administrator, Pete Thibeault announced his resignation. He accepted an offer from Mr. MacCallum to become

the Chief Operating Officer at OOH in Tulsa. When Pete announced his intention, Wanda and the Board of Directors panicked. Pete was the only person at Hillcrest who understood hospital finances and operations. The Controller, Phil Ross, had been at Hillcrest less than a year, having no previous healthcare background. The Board made Pete several counter offers, eventually offering him slightly more than he had been offered at OOH. Pete, however, was weary of the convoluted Board committee control over operational decisions. In tears, Wanda begged Pete not to leave, saying that she couldn't run the hospital without him. However, Pete told me that Wanda only spent a couple of hours with him in the *two months* following Mr. MacCallum's departure. In contrast, Mr. MacCallum rarely ever make a substantial decision without Pete's input. Pete was also disgusted with Wanda's salary increase. He thought it was completely unwarranted in view of her qualifications. Additionally, Human Resources, under Wanda's direction, had just completed a scientific job description and classification system. They hired a firm for this very purpose, spending thousands of dollars. Pete was incensed that Wanda simply ignored the minimum educational and experience requirements formulated for the position of Administrator when she accepted the appointment.

Pete certainly "burned his bridges" before he left. He wrote Wanda a scathing memo that said, among other things, that Wanda was not a leader and did not have the background to make administrative decisions. Pete read the memo to Wanda at his last meeting with her. Her response was that she never wanted the position in the first place.

Shortly after Pete left in mid-December, Mike Oelke, the Connection Card Coordinator, announced his resignation. Mike had been frustrated with the Connection Card program and he did not see any future for his position. He found a government position working in a mainframe computer environment.

Teresa Brekke shocked the hospital by announcing her resignation effective February 15, 1989. Teresa had always been the most creative, talented and productive employee in

Marketing. Even more important, her attitude literally gave everyone hope that things would improve. Therefore, when she resigned, it was very distressing to everyone in administration. She accepted the position of Director of Physician Recruitment at the Oklahoma City Clinic. This position, she said, would allow her to broaden her skills.

Privately, Teresa expressed disappointment concerning Wanda's leadership. Organizational leadership was of great importance to Teresa and she was extremely confident in Mr. MacCallum. In fact, no one expressed greater sorrow at his resignation. Unfortunately, she could not follow Wanda with the same enthusiasm.

On March 6, 1989, Hillcrest hired Janet Sellers to become the new Director of Marketing/Public Relations. Janet formerly worked in the Public Relations department at Presbyterian Hospital in Oklahoma City.

Physician pressure on Eddie Wiseman increased substantially in 1989.[11] The physicians had been promised a new Hospital Information System (HIS) a year earlier and very little had actually been accomplished. Dr. Joe Anderson, a very outspoken Internal Medicine specialist, led the physician opposition. Meanwhile, Gary McElwee, LAN Administrator, and several other Data Processing Department employees met with Wanda in early March to report their dissatisfaction with Eddie.

On Tuesday, April 4, Dr. Anderson and Dr. Larry Schwartz, another vocal critic of Eddie, showed up uninvited at an Information Systems steering committee meeting. These meetings were held to discuss the Hospital Information System (HIS) options available to the hospital and were attended by Wanda and most of the department managers. Dr. Anderson and Dr. Schwartz proceeded to castigate Eddie about the lack of progress on the HIS and Eddie's inability to grasp the technical issues involved. According to Glenna Coultas, the meeting was "stormy." Eddie was officially "placed on probation" that day. In reality, he was given the opportunity to resign with two weeks notice. Eddie's last day was April 18, 1989. Gary McElwee was named Interim Data Processing Manager.

"He's only getting what's coming to him," commented Glenna Coultas. "Eddie did everything he could to undermine the Connection Card program. He told us specifically not to support the Connection Card in any way and when you left, he told us that it had been a mistake to begin with and he was going to dismantle it."

Review of Each Program[10]

Physician Referral

Calls to South Oklahoma City Physician Referral have remained strong with about 200 - 250 actual referrals occurring each month. In its first year of existence, Physician Referral generated over $200,000 in gross revenue. Betty Overstreet reported that the hospital as a whole seems to be satisfied with the performance of Physician Referral.

However, Betty became distressed over the changes in the Marketing staff. She interviewed for the position of Physician Referral Specialist at Oklahoma Osteopathic Hospital in Tulsa in late March but did not get the position. When I last spoke to her in early April, she told me she was continuing to interview because she "had to get out of this place."

Physician Practice Support

Physician Practice Support is another area which has experienced good success with few problems. Nicholas Hahalis has provided practice assessments for 42 physicians out of a total staff of 73. Most of the physicians interested in an assessment have already received one and as of April, 1989, Nicholas was primarily providing follow up consulting for physicians.

Nicholas has always been involved in healthcare ventures apart from his hospital consulting. He expects to leave Hillcrest soon to further develop a healthcare plan called "Medical Trust" that operates similarly to an Health Maintenance Organization (HMO).

Occupational Health

After the disastrous Physician Steering Committee meeting referred to in Chapter VI, all promotion of Occupational Health ceased. While the Physician Steering Committee maintained that they still wanted an Occupational Health program, the Good Neighbor Care price and treatment guidelines were abandoned almost immediately. After no progress was made developing a program acceptable to the physicians, discussion about the program slowly faded away. By January, 1989, Occupational Health had essentially dissolved.

Vicki Mathews became involved with the Behavioral Medicine Center, doing whatever was needed. She attended seminars as a representative of the BMC and basically performed "odd jobs" as needed.

Connection Card

As mentioned before, because Eddie Wiseman opposed the Connection Card so vigorously, the supporting computer system was only installed in outpatient registration. Once I left, he tried to dismantle even that portion of the system but was restrained by the protests of Teresa Brekke. Teresa also tried to get the system expanded to the inpatient admitting area and the Emergency Room as per the original plans but Eddie paralyzed this process by claiming that it would require $60,000 in new equipment to install the system in these areas.

Finally, in February, 1989, a physician's wife with a Connection Card came into the Emergency Room. Because there was no computer database with her information to speed registration, the ER registration took the same amount of time as it would for a person

without a Connection Card. This infuriated the physician who recognized that the Card made no difference whatsoever. The physician angrily called Wanda about the situation. Wanda called Eddie and demanded the system be expanded to inpatient admitting and the Emergency Room. Eddie told Gary McElwee to get the system installed *quick.* Since the computers had previously been purchased, Gary McElwee simply purchased two printers that cost about $1000 and brought the system up in a couple of days. Within two weeks, all of the end users had been trained and the Connection Card computer system was fully operational.

Though the computer support was finally installed, the promotion of the program had fallen to Steve Petty, who was transferred to Marketing from the Business Office. Steve had no experience in Marketing and he simply tried to keep the program afloat. After four months of further promotion, the Connection Card program was deemphasized. As of April, 1989, the Card program was simply being maintained at current levels of membership.

Public Relations

After Teresa Brekke's resignation, advertising decreased sharply. However, annual public relations events continued with the help of other hospital staff members.

Morale and Expectations

Both Cathy Adams and Nicholas Hahalis described Hillcrest in April, 1989 as a "ship adrift without a captain." The medical staff has become extremely negative and, according to Nicholas, they are becoming dissatisfied with Wanda's leadership to the point of demanding her resignation. Cathy disagreed with this assessment but she did think that Wanda would leave of her own volition in the near future. "Wanda honestly doesn't want her job," Cathy said, "She told me, 'Cathy, I guarantee you I won't be here a long time.'"

The leadership vacuum is evidenced by Wanda's avoidance of medical staff meetings. "She has simply stopped going," Cathy said, "In fact, she's only working about six hours a day." Both Nicholas and Cathy complained that important decisions are delayed and "firm" decisions are reversed numerous times. This has severely affected employee morale. "I think eighty percent of the managers would leave if they had a place to go," Cathy said. The much needed building program is at a standstill.

In the absence of administrative leadership, the medical staff has begun to assert itself in operational decisions. The medical staff has always tried to exercise undo influence on administrative decisions but Mr. MacCallum maintained a clear separation between physician input and physician imposition. Otherwise, it becomes very difficult for the administration to manage properly. The trend toward physician imposition in administrative decision-making has become alarming at Hillcrest, according to Cathy and Nicholas.

Summary

What began as a bold initiative filled with promise and excitement concluded far short of its original objectives in general disarray. Why? What fatally crippled this ambitious project?

PMCI proposed a bold plan in a very short time frame. For Hillcrest Health Center and possibly for any other hospital, the time frame was far too short. To finish a project of that magnitude in 12 months was a noble but foolish objective. To accomplish this, each program would needed to be developed and implemented without any major problems. This is too much to expect. PMCI should have proposed a longer time frame taking into account the problems and setbacks that occur in any organizational setting. There is no penalty for accomplishing a task early. PMCI over promised and under delivered.

From the beginning, the PSN was "fast-tracked" through the approval process. By doing so, the Board of Directors and the medical staff never fully supported the PSN and

never really gained a sense of "ownership" in the ensuing development. They recognized the methods that were utilized to "force" the PSN through committees without the normal approvals. Later, when problems occurred, these groups were the first to openly criticize rather than support the project. It is probable that pushing the project through the process created hidden animosity which appeared when the project encountered problems.

Also related to the initial handling of the approval process was the funding for the project. Because adequate funding was never requested at the onset, the PSN was continually delayed because the funding was not available. I was told numerous times to "wait until the new budget" for items needed immediately. In reality, this was ludicrous because the "new" budget year began in July, 1988 and the project was to have been completed in August 1988. This resulted in numerous personnel and equipment delays which inevitably caused time delays. When the new budget was finally developed, it was triple the previous budget and by that time, delays had engendered significant animosity from the very groups needed for budget approval.

Eddie Wiseman was also a major cause of project difficulties. His almost total incompetence combined with direct hostility toward the PSN resulted in a six month delay of the principal programs. In addition to the delay in the computer system which served as a foundation to the PSN, his antagonistic opposition caused PMCI and myself divert our energy from other program developments as we tried to counter his disruptions. Pete Thibeault, by allowing this situation to continue month after month, fully aware of Eddie's incompetence and hostility, himself played an indirect role in the project failure. If Eddie Wiseman had not been employed at Hillcrest, the PSN would have been implemented *far more* successfully.

No one could have foreseen the administrative upheaval which transpired. Mr. MacCallum played a crucial role in the PSN success because of his eminent stature in the eyes of the Board and the medical staff. When he left, those who opposed the project were

free to attack with tacit approval from the new administrator. It is amazing how fast the PSN unraveled once this process began.

Finally, I made several errors because of inexperience. I was not able to engender support from other managers or from physicians and this resulted in little cooperation from these groups. Because of time constraints, I made several key incorrect decisions. For example, I did not consult the appropriate department or physician group before making a decision directly affecting them. Instances like these compounded the problems from other sources.

Overall, the Physician Support Network development and implementation at Hillcrest Health Center was unsuccessful. The hospital benefitted significantly from the programs which were successfully implemented but when compared to the original objectives, the final results fell woefully short.

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8. State of Oklahoma Worker's Compensation Court Annual Report, 1986/87, p. 75.

9. Unless otherwise indicated, information on the founding of PMCI issued from a personal interview with Michael Bernstein, February 24, 1989.

10. Unless otherwise indicated, information about the current status of Hillcrest was obtained from personal interviews with Nicholas Hahalis on April 3, 1989, Cathy Adams on April 4, 1989 and numerous telephone conversations with Betty Overstreet.

11. Information about Data Processing Department developments issued from interviews with Gary McElwee, Local Area Network Administrator and his assistant, Glenna Coultas on April 11 - 12, 1989.

APPENDICES

APPENDIX A

AGREEMENT BETWEEN HILLCREST HEALTH CENTER AND PMCI

AGREEMENT

THE FOLLOWING AGREEMENT is being executed between PROFESSIONAL MARKETING CONSULTANTS, INCORPORATED, a Colorado Corporation, hereinafter referred to as "PMCI" located at 11479 South Pine Drive, Parker, Colorado; and HILLCREST HEALTH CENTER, hereinafter referred to as "HHC" located at 2129 S.W. 59th Street, Oklahoma City, Oklahoma, for the purposes as defined below and pursuant to the terms and conditions as stated herein:

1.0 PROJECT DEFINITION

1.1 PMCI shall act as the primary marketing contractor to HHC for the purpose of implementing a Physician Support Network (PSN) at HHC as well as other specific product lines defined in Appendix I(A) - I(H).

1.2 A Physician Support Network (PSN) as referenced in this Agreement shall mean, "the implementation of an integrated marketing program designed to strengthen primary care and remote physician alliances to HHC through the creation, promotion, and enhancement of HHC programs and services."

1.3 For purposes of this Agreement, HHC's primary or immediate service area shall be described as a geographic area encompassing the counties identified in Appendix II of this Agreement, and by this reference shall become a part of this Agreement.

2.0 PROJECT SCOPE

2.1 The scope of work to be performed by PMCI shall include, but may not be limited to, the following specific projects:

A. The design of a Physician Support Network Business/Action Plan;

B. The design, implementation, and promotion of a Physician Referral and Program Information Service;

C. The design, implementation, and promotion of a Occupational Health-Case Management program;

D. The design, implementation, and promotion of a comprehensive Emergency Department Marketing program;

E. The design and implementation of a Physician Practice Management and Physician Support program;

F. The design of an integrated Network Data Information program;

G. The design, packaging, and promotion of the HHC Women's Health Services Program;

H. The design, packaging, and promotion of the HHC Behavioral Medicine Center.

2.2 Action steps for projects identified in Section 2.1 shall be included in Appendix I(A) - I(H) of this Agreement and by this reference shall become a part of this Agreement.

2.3 The substitution of projects as outlined in section 2.1 shall be at the discretion of HHC and projects defined in section 2.1 and Appendix I(A) - I(H) may be altered, amended, deleted, and/or other projects may be incorporated providing PMCI and HHC arrive at a mutually agreeable implementation schedule for such alterations, amendments, deletions, and/or other projects. Such alterations, amendments, deletions, and/or other projects not originally defined in Appendix I(A) - I(H) of this Agreement shall be documented by PMCI and shall become, by reference, a part of this Agreement when accepted by both parties.

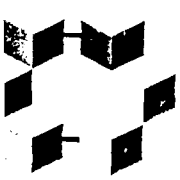
2.4 The scope of this project shall also include the necessary and required training by PMCI of designated HHC personnel associated with the Physician Support Network (PSN) to insure the program's long term success.

2.5 The scope of the work to be performed by PMCI shall include, may not be limited to:

A. The program design and documentation;
B. The program packaging and pricing;
C. The establishment of acceptable program policies and procedures;
D. Assisting with the designing of appropriate program collateral and promotional materials; and
E. The training of persons associated with program operations.

3.0 DUTIES AND WARRANTIES

3.1 PMCI shall use its best efforts to perform and implement the components as described in this Agreement, and warrants to use its full power, legal and authoritative right to execute, deliver, and perform under this Agreement, and that



the officer executing this Agreement on behalf of PMCI has the full right and authority to do so.

3.2 PMCI and its personnel shall demonstrate its most professional manner in the design, development, implementation, training, and execution of this Agreement and shall be held accountable to James MacCallum, Executive Vice President, or his designee, for the manner of the duties of this Agreement.

3.3 Costs of services and/or materials (i.e. computer hardware, software, printing, postage) supplied by third party vendors are not reflected in the costs defined in Section 5.0 of this Agreement, and PMCI cannot be held liable for any services and/or materials not directly provided by PMCI or its subsidiaries.

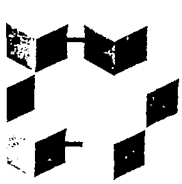
3.4 PMCI makes no warranty or representation, expressed or implied, that the Physician Support Network Programs as defined in the Agreement and the referenced Appendix I(A) - I(H) will, after being implemented, have a specified impact on the utilization of HHC's physicians or inpatient/outpatient facilities affiliated, owned, and/or managed by HHC.

3.5 PMCI shall take full responsibility for the execution of this Agreement and shall work with and/or assist others within the HHC organization to provide an atmosphere conducive to the harmonious implementation of this project.

4.0 TERM

4.1 The length of term of the Agreement shall be for a period of twelve (12) months. This twelve month period shall commence after PMCI's first HHC authorized site visit, and shall occur following receipt of HHC's executed Agreement and deposit amount as defined in Section 5.0 of this Agreement. PMCI reserves the right to extend the length of this Agreement in the event that HHC should fail to provide the requested information in a timely fashion per Section 6.1 of this Agreement.

4.2 Notwithstanding the foregoing, either party may cancel this Agreement only after 6 months from the date of execution, provided the terminating party notifies the other party in writing at least thirty (30) days prior to the intended date of cancellation. Said termination shall become effective thirty (30) days from the first day of the succeeding month.



4.3 Should this Agreement be cancelled by either party, all monies and fees must be paid to the appropriate parties prior to the date of cancellation and cannot be held by the terminating party pending resolution of any dispute which may require arbitration or legal action.

5.0 PROJECT COSTS

5.1 PMCI shall invoice HHC and HHC agrees to pay such invoicing within fifteen (15) days following receipt of invoice from PMCI according to the following schedule:

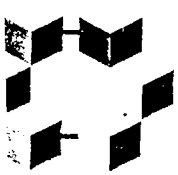
TOTAL PROJECT COST	$162,000.00
DEPOSIT DUE WITH AGREEMENT	$ 27,540.00
MONTHLY AMOUNT TO BE INVOICED (for 12 consecutive months beginning thirty (30) days following the execution date of this Agreement)	$ 11,205.00

5.2 All costs stated in this section shall represent "Total Costs" to HHC as it relates to all training and PMCI materials as described in Section 2.0, and all PMCI personnel necessary to fulfill the terms and obligations of this Agreement.

5.3 Costs outlined in Section 5.1 do not include the actual cost of reasonable travel, lodging, and per diem of PMCI staff incurred on behalf of HHC. These direct out-of-pocket expenses will be invoiced to HHC as a separate line item on the monthly invoice and are due and payable with the monthly invoice. PMCI shall receive pre-approval on all expenses to be invoiced to HHC.

5.4 Costs stated in this clause shall not include costs incurred by HHC personnel, third party personnel, or other persons who participate in this project including but not limited to personnel time, travel, lodging, per diem, training, and materials.

5.5 PMCI warrants the costs stated herein shall not be increased during the term of this Agreement unless HHC chooses to expand the scope of this project. Alterations, amendments, deletions, and/or other projects as defined in Section 2.3 shall be considered "substitutions" and therefore shall not be considered to "expand" the scope of this project.



6.0 GENERAL TERMS

6.1 HHC shall make available to PMCI and its representatives any HHC personnel and financial, demographic, or utilization information deemed appropriate to the success of this project providing reasonable notice has been given by PMCI.

6.2 Both parties to this Agreement recognize the sensitive nature of this project and the proprietary relationship of the information deemed important to the success of this project; therefore both parties to this Agreement shall treat all information regarding this project as confidential and shall exercise due care and caution with its use. This statement of confidentiality shall survive the term of this Agreement.

6.3 Due to the magnitude and scope of these projects, both parties understand and agree that a cooperative effort between the parties is required for successful implementation. Both parties agree to dedicate appropriate manpower as well as other resources required to execute the terms of this Agreement.

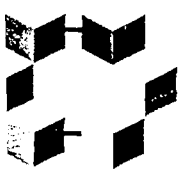
6.4 If either party institutes arbitration or legal proceedings to enforce any portion of this Agreement, the prevailing party shall be entitled to receive all costs and fees, including reasonable attorney's fees, incurred in the enforcement of this Agreement.

6.5 PMCI is acting as an independent contractor under this Agreement and no act shall be construed to any employee, officer, or board member of either party which violates the independent contractor status of PMCI.

6.6 This Agreement represents the entire agreement between the parties and supercedes all prior oral and written communications. No representation or statement made by either party to the other not stated herein shall be binding on either party.

6.7 This Agreement shall be construed and interpreted in accordance with the laws of the State of Colorado.

6.8 If any provision in this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions will nevertheless continue in full force without being impaired or invalidated in any way.



6.9 HHC recognizes that as long as there is no breach of this Agreement and providing this Agreement is not terminated prior to the end of the twelve (12) month period, PMCI shall not take part in any business, association, or affiliation that competes with HHC within HHC's service area, as defined in Appendix II of this Agreement, for a period not to exceed three (3) years from the original termination date of this Agreement. HHC recognizes that a portion of PMCI's fee described in Section 5.2 of this Agreement reflects the inability of PMCI to market its services, programs, and/or employees within the service area of HHC for the period defined herein.

BE IT HEREBY Agreed and Approved as written by the following duly authorized representatives of both parties:

THIS 1 day of September 1987.

HILLCREST HEALTH CENTER

James W. MacCallum

James MacCallum
Executive Vice President

PROFESSIONAL MARKETING CONSULTANTS, INCORPORATED

Michael Bernstein

Michael Bernstein
Executive Vice President

APPENDIX B

PHYSICIAN SURVEY INSTURMENT AND

DATA COLLECTION WORKSHEETS

HILLCREST HEALTH CENTER
PHYSICIAN SURVEY INSTRUMENT
SEPTEMBER 1987

1. What is your specialty? _____

2. How long have you practised within Hillcrest Health Center's primary service area?

Years _____

3. On average, how many total patients to you admit to hospitals on a monthly basis?

_____average patients per month

4. What are the main reasons you support Hillcrest Health Center?

_____

_____

_____

5. What are the characteristics about Hillcrest Health Center that you like least?

_____

_____

_____

6. Do you presently use the ER department to treat your patients?

In what way? What is your impression of ER?

_____

_____

_____

7. What specific services/programs can the hospital offer your practice specialty to help you competitively?

_____

_____

8. Are you presently working with area employers to provide industrial/occupational health services?

Yes _____ No ____

If yes, what type of services are you providing?

_____

_____

_____

9. Have other hospitals approached you seeking an affiliation?

Yes _____ No _____

Which hospitals? _____

_____

10. Which hospitals to you admit to?

1st _____ %_____
2nd _____ %_____
3rd _____ %_____

11. What is your main reason for admitting to hospitals other than Hillcrest Health Center?

_____

_____

_____

12. What does Hillcrest Health Center need to do differently in the next three years to stay competitive?

_____

_____

_____

13. In general, do you feel you have easy access to the administration at Hillcrest Health Center?

_____

_____

_____

14. Are you accepting new patients into your practice?

Yes _____ No _____

15. Has your practice volume increased, decreased or remained the same in the past 2 years?

Increased _____ Decreased _____ Same _____

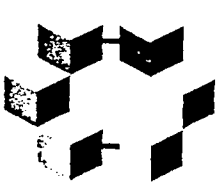
16. Would you support Hillcrest Health Center marketing area residents and referring them to your practice?

Yes _____ No _____

FORM 7 INSTRUCTIONS

1. Indicate the year covered as the Last Year.

2. Enter the appropriate number in each column for the years indicated.



ate _____ Form 7

HOSPITAL UTILIZATION TRENDS

INPATIENT PROFILE

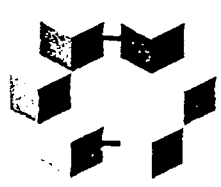
Variable	[redacted]	Prev. Year	Prev. Year	Last
dmissions				
atient Days				
verage Length of Stay				
edicare Admits				
edicare Days				
edicare Average LOS				

NEWBORN PROFILE

assinets				
irths				
ewborn Days				
verage NB Census				
ercent NB Occupancy				
verage NB LOS				

EMERGENCY ROOM PROFILE

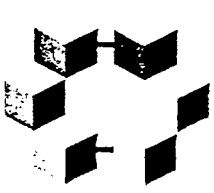
R Visits				
umber Admitted				
ercent Admitted				
ercent of Hospital Admissions				



orm 7 continued

SURGICAL PROFILE

Variable	~~Prev. Year~~	Prev. Year	Prev. Year	Last
otal Surg. Visits				
ercent Outpatient Surgery				
npatient Surgery Visits				
utpatient Surgery Visits				
ercent Outpatient Revenue				
urgeries/100 Admits				



FORM 11 INSTRUCTIONS

1. Enter all information requested for all patients discharged during the sample period. Please code the physician specialties and destination of the patient from the code list below.

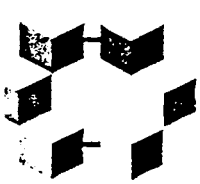
Specialty Codes:

01 - Family/General Practice
02 - Internal Medicine
03 - Obstetrics/Gynecology
04 - Pediatrics
05 - Allergy
06 - Cardiology
07 - Dermatology
08 - Endocrinology
09 - Gastroenterology
10 - Hematology/Oncology
11 - Infectious Disease
12 - Nephrology
13 - Neurology
14 - Phy Med/Rehabilitation
15 - Pulmonary Medicine
16 - Rheumatology
17 - General Surgery
18 - Neurosurgery
19 - Ophthalmology
20 - Orthopedic Surgery
21 - Otolaryngology
22 - Plastic Surgery
23 - Proctology
24 - Urology
25 - Vascular/Thoracic Surgery
26 - Dentistry
27 - Psychiatry
28 - Podiatry
29 - Anesthesiology
30 - Emergency Medicine
31 - Pathology
32 - Radiology
33 - Nuclear Medicine
34 - All Other

Destination Codes:

1 - Home/Family
2 - Nursing Home
3 - Other Hospital
4 - Expired
5 - Retirement Facility
6 - Home Care
7 - Other

2. Use the above information and codes to fill out forms 12 and 13, concerning outpatients and emergency room patients, respectively. On these forms, however, substitute the CPT code (Current Procedural Terminology) for the DRG. This code describes the procedures performed by the physician.



Sample period _____ page ___ of ___

INPATIENT DISCHARGE ANALYSIS

Zipcode	Length of Stay	D.R.G.	Patient's Age	Admit. Phys. Specialty	Employer of Guarantor	Insurance Coverage	Destinat Code

FORM 15 INSTRUCTIONS

Information for this form is available from your state or local medical association or state licensure board directory of current active physician.

1. For each zipcode or city in your service area, record the total number of physicians in each specialty category.

2. Form 14, the medical staff analysis, will show the count of your medical staff by zipcode. Enter this in Column E.

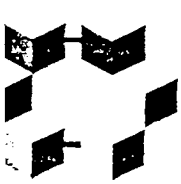
3. Add columns A through D and enter the sum in Column G.

4. Column F is equal to the difference between Columns G and E.

5. Column H data can be found on Form 2.

6. Dividing Column H by Column G will give you the population to physician ratio. If this ration is greater than 2000 to 1, then some very real opportunities exist in that area.

7. Total each page, then add these subtotals to get a grand total on the last page.



AREA PHYSICIANS BY SPECIALTY

Zip Code	FP/GP Physicians (A)	OB/GYN Physicians (B)	Int. Med. Physicians (C)	Other Physicians (D)	Your Hosp. Physicians (E)	Other Physicians (F)	Total in Area (G)	Area Pop. (H)	Populat per Phy (H/G)

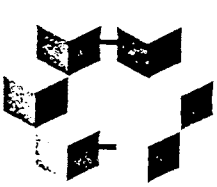
ate _____ Form A

DEMOGRAPHIC DATA REQUEST

lease indicate those areas which comprise your present and potential serv
reas.

Counties	Major Cities	Other Are

Zipcodes



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Marketir
Consulta

PATIENT DISCHARGE ANALYSIS

EMERGENCY ROOM PATIENTS

Sample Period: _____
(A ~~two~~ one month sample is recommended)
1,000 samples

Patient	Zip Code	CPT Code	Total ER Charge	Patient Age	Employer	Insurer	Inpat Admit	Outpat Admit

EMERGENCY ROOM UTILIZATION

Number of Visits

MONTH	1983	1984	1985	1986	1987 to Date
January					
February					
March					
April					
May					
June					
July					
August					
September					
October					
November					
December					
TOTAL					*

* Projected Year to Date

EMERGENCY ROOM UTILIZATION

	1983	1984	1985	1986	1987 to Da
ED Visits					
ED Patients Admitted to Hospital					
Percent of ED Patients Admitted to Hospital					
Total Hospital Admissions					
ED Admits as a Percent of Hospital Admits					

PROFESSIONAL MARKETING CONSULTANTS, INC.
MULTI-VARIABLE WEIGHTED
ANALYSIS MATRIX
HILLCREST HEALTH CENTER

Criteria	Weight Value	ALL	CARD	CR SURG	DERM	ENDO
Hospital Mission						
Percent of Revenue Collected (Commercial)						
Percent of Overall Revenue						
Facility Investment						
Equipment Investment						
Physician Affiliations/ Deals in Progress						
Spin-off Benefits/ Cross Referral						
Market Opportunities/ Distinctive Competency						

PROFESSIONAL MARKETING CONSULTANTS, INC.

MULTI-VARIABLE WEIGHTED ANALYSIS MATRIX

HILLCREST HEALTH CENTER

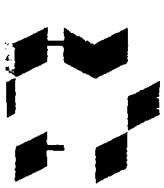
Criteria	Weight Value	FP	GAST	GEN SURG	HEM	INF DIS
Hospital Mission						
Percent of Revenue Collected (Commercial)						
Percent of Overall Revenue						
Facility Investment						
Equipment Investment						
Physician Affiliations/ Deals in Progress						
Spin-off Benefits/ Cross Referral						
Market Opportunities/ Distinctive Competency						

PROFESSIONAL MARKETING CONSULTANTS, INC.
MULTI-VARIABLE WEIGHTED
ANALYSIS MATRIX
HILLCREST HEALTH CENTER

Criteria	Weight Value	IM	NEPH	NEURO	NEURO SURG	OB/ GYN
Hospital Mission						
Percent of Revenue Collected (Commercial)						
Percent of Overall Revenue						
Facility Investment						
Equipment Investment						
Physician Affiliations/ Deals in Progress						
Spin-off Benefits/ Cross Referral						
Market Opportunities/ Distinctive Competency						

ROFESSIONAL MARKETING CONSULTANTS, INC.
ULTI-VARIABLE WEIGHTED
NALYSIS MATRIX
ILLCREST HEALTH CENTER

Criteria	Weight Value	OPHTH	ORTHO SURG	ENT OTO	PED	PHY MED
ospital Mission						
ercent of Revenue ollected (Commercial)						
ercent of Overall evenue						
acility Investment						
quipment Investment						
hysician Affiliations/ eals in Progress						
pin-off Benefits/ ross Referral						
arket Opportunities/ istinctive Competency						



Professional
Marketing
Consultants,

PROFESSIONAL MARKETING CONSULTANTS, INC.

TI-VARIABLE WEIGHTED
LYSIS MATRIX

ILLCREST HEALTH CENTER

Criteria	Weight Value	PLAS SURG	POD	BMC PSYCH	PUL MED	RHEU	THOR SURG
pital Mission							
cent of Revenue lected (Commercial)							
cent of Overall enue							
ility Investment							
ipment Investment							
sician Affiliations/ ls in Progress							
n-off Benefits/ ss Referral							
ket Opportunities/ tinctive Competency							

APPENDIX C

ACTION PLAN

HILLCREST HEALTH CENTER
IMPLEMENTATION ACTION PLAN
Physician Support Network

IMPLEMENTATION TASKS REQUIRED	RESPONSIBLE PARTY	1987				1988							
		9	10	11	12	1	2	3	4	5	6	7	8
A. NETWORK ADMINISTRATION													
Coordinate with HHC executive management													
Appoint/coordinate with physician advisory committee(s)													
Develop implementation strategy/timing													
Determine management priorities													
B. BUSINESS PLAN													
Collect internal/external market data													
Interview selected physicians													
Analyze data/identify needs and/or trend													
Draft mini-plans by program													
ROI by program													
C. PROMOTION													
Determine physician affiliations by location													
Integrate marketing effort													
- Hospital program/departments													

HILLCREST HEALTH CENTER
IMPLEMENTATION ACTION PLAN

Physician Support Network

IMPLEMENTATION TASKS REQUIRED	RESPONSIBLE PARTY	1987				1988							
		9	10	11	12	1	2	3	4	5	6	7	8
D. STAFFING													
Free-up Marketing Director time													
Recruit Healthcare Public Relations Manager													
E. IMPLEMENTATION OF PROGRAMS													
Physician Referral System													
Emergency Department Marketing													
Occupational Medicine													
Practice Management/support													
Women's Health													
Behavioral Medicine													
Network information													

HILLCREST HEALTH CENTER
IMPLEMENTATION ACTION PLAN
Physician Referral/Program Information Service

IMPLEMENTATION TASKS REQUIRED	RESPONSIBLE PARTY	1987				1988							
		9	10	11	12	1	2	3	4	5	6	7	8
A. ADMINISTRATION													
Obtain physician commitment to PRS													
- System requirements - Level of participation - Weighting for referral - Appointment confirmation - Reporting to physician													
Obtain department commitment to program information service													
- Inventory programs - Inventory minor emergency/physician offices													
Select PRS													
- Manual versus automated - Site visit(s) - Negotiate contract(s)													
Order hardware/software/maintenance													

HILLCREST HEALTH CENTER
IMPLEMENTATION ACTION PLAN

Physician Referral/Program Information Service

IMPLEMENTATION TASKS REQUIRED	RESPONSIBLE PARTY	1987				1988							
		9	10	11	12	1	2	3	4	5	6	7	8
B. DESIGN													
Draft operator protocols													
Gather physician data													
Gather program data													
Compute ROI - determine benefits - determine volume - determine operating costs - determine capital costs													
Determine sources of undoctored patients and how to link them into PRS													
Draft maintenance (info change) forms - medical staff office - physician support - departments/programs with community education requirements													
C. PROMOTION													
Determine name of service													
Determine telephone number(s) for service													
Develop promotional strategies - advertising copy - collaterals													

IMPLEMENTATION ACTION PLAN

Physician Referral/Program Information Service

IMPLEMENTATION TASKS REQUIRED	RESPONSIBLE PARTY	1987				1988							
		9	10	11	12	1	2	3	4	5	6	7	8
D. STAFFING													
Provide telephone receptionist job description				—									
Identify/recruit PRS operator(s)				—	—								
E. INSTALLATION													
Operator training - hardware - file maintenance - referral/appointment - program registration - protocols							—	—					
Enter "master" data							—						
"Go live" with PRS								●					
"Go live" with program information service									●				
F. FOLLOW-UP													
Fine-tune protocols									—	—	—		
Review/update promotion as required									—	—	—	—	—
Review physician/program maintenance for compliance									—	—	—	—	—
Incorporate new program cross referral as appropriate									—	—	—	—	—

HILLCREST HEALTH CENTER
IMPLEMENTATION ACTION PLAN

Emergency Department Marketing

IMPLEMENTATION TASKS REQUIRED	RESPONSIBLE PARTY	1987				1988							
		9	10	11	12	1	2	3	4	5	6	7	8
A. ADMINISTRATION													
Determine fast-track/pre-registration capability													
- facility considerations													
- staffing													
- training													
Recommend general facility improvements													
Assess whether to coordinate with good neighbor program/urgi-care centers													
Determine ER activity/profile in other consumer programs													
B. DESIGN													
Review/update standing order protocols													
Develop policies and procedures for new programs													
Prepare benefit package													
Determine ER cross-sale capability													

HILLCREST HEALTH CENTER
IMPLEMENTATION ACTION PLAN

Emergency Department Marketing

IMPLEMENTATION TASKS REQUIRED	RESPONSIBLE PARTY	1987				1988							
		9	10	11	12	1	2	3	4	5	6	7	8
Review EMS relations program				—	—	—							
Design Hellipad strategy				—	—								
Draft program coordinator role/procedure			—	—									
Develop guest relations procedure/follow-up						—	—	—					
Compute ROI					—	—							
- operating costs													
- capital costs													
- collection history													
C. PROMOTION													
Develop promotion strategies						—	—	—	—	—	—	—	—
- EMS													
- direct mail													
- electronic/print media													
- community interface													
- physician referral													
- hospital newsletter													
- hospital public relation													
Develop cross-sale opportunities			—	—	—	—	—	—	—	—	—	—	—

HILLCREST HEALTH CENTER
IMPLEMENTATION ACTION PLAN
Emergency Department Marketing

IMPLEMENTATION TASKS REQUIRED	RESPONSIBLE PARTY	1987				1988							
		9	10	11	12	1	2	3	4	5	6	7	8
D. STAFFING													
Identify fast track/pre-registration coordinator													
Identify guest relations representative													
E. INSTALLATION													
Train staff on new procedures													
Start-up programs identified in step A and B													
Track program progress/referrals													
F. FOLLOW-Up													
"Fine-tune" protocols/procedures as appropriate													
"Fine-tune" promotion as appropriate													

IMPLEMENTATION ACTION PLAN

Occupational Health Program

IMPLEMENTATION TASKS REQUIRED	RESPONSIBLE PARTY	1987				1988							
		9	10	11	12	1	2	3	4	5	6	7	8
A. ADMINISTRATION													
Enhancement analysis of current package													
Determine provider access sites													
Coordinate interdepartment participation													
Determine fees													
Determine discounting													
Establish market penetration goals													
B. DESIGN													
Draft components of program - worksite nursing - worker's compensation - card program													
Design interface with pre-registration and PRS													
Draft policies/procedures/protocols													
Prepare benefit package													
Select business/industry targets													
Compute ROI													
Define sales incentives													
Integrate with PRS													

IMPLEMENTATION ACTION PLAN

Occupational Health Program

IMPLEMENTATION TASKS REQUIRED	RESPONSIBLE PARTY	1987				1988							
		9	10	11	12	1	2	3	4	5	6	7	8
C. PROMOTION													
Develop promotion strategies													
- advertising copy - collaterals - commissions/incentives													
Draft/update promotional material													
Determine/capitalize on cross-sale potential													
Employee participation component													
D. STAFFING													
Identify/recruit sales force													
Identify program coordinator/medical director													
E. INSTALLATION													
Create physician network interface													
Assure ER coordination													
Begin individual sales campaign													
Develop cooperation/coordination with appropriate agencies/payors													

IMPLEMENTATION ACTION PLAN

Occupational Health Program

IMPLEMENTATION TASKS REQUIRED	RESPONSIBLE PARTY	1987				1988							
		9	10	11	12	1	2	3	4	5	6	7	8
Train service access locations													
Track program finances/referrals/market penetration													
Link program with other practice building programs													
F. FOLLOW-UP													
"Fine-tune" benefits/sales approach as appropriate													

IMPLEMENTATION ACTION PLAN

Physician Practice Management/Support Program

IMPLEMENTATION TASKS REQUIRED	RESPONSIBLE PARTY	1987				1988							
		9	10	11	12	1	2	3	4	5	6	7	8
A. ADMINISTRATION													
Determine programs/services to offer/broker													
Coordinate with marketing task force													
Determine participation requirements													
Determine pricing schedule													
Select initial targets													
B. DESIGN													
Assess current support strengths													
Draft policies/procedures													
Assess high demand needs													
Access low risk programs													
Compute ROI													
Design coordinating function with other network programs													
Design tracking mechanisms													

IMPLEMENTATION ACTION PLAN

Physician Practice Management/Support Program

IMPLEMENTATION TASKS REQUIRED	RESPONSIBLE PARTY	1987				1988							
		9	10	11	12	1	2	3	4	5	6	7	8
C. PROMOTION													
Develop collaterals													
Conduct pre-testing													
Develop distribution strategies													
D. STAFFING													
Recruit physician liaison													
Recruit remote physician liaison													
E. INSTALLATION													
Train physician liaison/support personnel													
Phase in support programs (on small scale/low risk at first)													
Track referrals/admits													

IMPLEMENTATION ACTION PLAN

Women's Health Services

IMPLEMENTATION TASKS REQUIRED	RESPONSIBLE PARTY	1987				1988							
		9	10	11	12	1	2	3	4	5	6	7	8
A. ADMINISTRATION													
Appoint medical director for women's center program													
Develop pricing package													
Determine logo/image for program													
Determine facility arrangements for education/assessment/compliance programs													
Appoint product line committee													
Determine program features													
Coordinate interdepartment participation													
B. DESIGN													
Draft policies/procedures													
Design interface with pre-registration/PRS													
Prepare benefit package													
Link pediatric/total family services													
Develop guest relations and program feedback mechanisms													
Compute ROI													

IMPLEMENTATION ACTION PLAN

Women's Health Services

IMPLEMENTATION TASKS REQUIRED	RESPONSIBLE PARTY	1987				1988							
		9	10	11	12	1	2	3	4	5	6	7	8
C. PROMOTION													
Develop promotion strategy													
- collateral - mass media - free services													
Develop communication format with primary care physicians													
Develop promotional "prizes" for attendance/referrals													
D. STAFFING													
Identify program coordinator													
E. INSTALLATION													
Develop cooperation/coordination with appropriate agencies													
Train service access locations													
Install network/PRS linkage													
Track program progress/referrals													
Train unit staff													

IMPLEMENTATION ACTION PLAN

Behavioral Medicine Center

IMPLEMENTATION TASKS REQUIRED	RESPONSIBLE PARTY	1987				1988							
		9	10	11	12	1	2	3	4	5	6	7	8
A. ADMINISTRATION													
Assess primary care physician involvement in treatment program													
Assess current programs													
B. DESIGN													
Enhance/add appropriate programs													
Draft new policies/procedures													
Design interface with PRS and other network programs													
Review payment mechanisms													
Compute ROI													
C. PROMOTION													
Develop marketing/promotion strategies													
Develop distribution strategies													

IMPLEMENTATION ACTION PLAN

Behavioral Medicine Center

IMPLEMENTATION TASKS REQUIRED	RESPONSIBLE PARTY	1987				1988							
		9	10	11	12	1	2	3	4	5	6	7	8
D. STAFFING													
Recruit BE/BC psychiatrist													
E. INSTALLATION													
Train unit staff in new programs as applicable													
Enhance cooperation/coordination with appropriate agencies													
Track program progress/economics													

IMPLEMENTATION ACTION PLAN

Network Data/Information Design

IMPLEMENTATION TASKS REQUIRED	RESPONSIBLE PARTY	1987				1988							
		9	10	11	12	1	2	3	4	5	6	7	8
A. ADMINISTRATION													
Finalize network information systems strategic plan													
Determine info systems priorities													
B. DESIGN													
Complete network functional design													
Design interim manual system - patient tracking - referral tracking - marketing/competitor intelligence													
Evaluate hardware/software acquisition options													
Assess linkages within and outside hospital													
Compute ROI													
C. PROMOTION													
D. STAFFING													
Manual tracking clerk													
DP staffing as developed in overall													

IMPLEMENTATION ACTION PLAN

Network Data/Information Design

IMPLEMENTATION TASKS REQUIRED	RESPONSIBLE PARTY	1987				1988							
		9	10	11	12	1	2	3	4	5	6	7	8
E. INSTALLATION													
Link network programs													
- referrals - tracking - finances													
Train admissions/registration personnel													
Link pre-registration to tracking system													
Link PRS to admitting/registration tracking system													
F. FOLLOW-UP													
Implement information systems strategic plan													

APPENDIX D

FINANCIAL PROJECTIONS

VII. RETURN ON INVESTMENT

It is imperative that the Hillcrest Board and management clearly identify and clarify Return on Investment expectations and how they will be measured and evaluated.

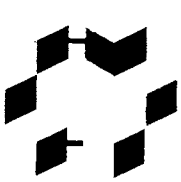
As stated earlier in this Business Plan, without an integrated tracking information system, manual and "base line" tracking assumption techniques must be used to measure network results.

Admission patterns per specialty are recommended as the primary indicator for base line measurement. PMCI experience indicates that it will take a full-blown network commitment of approximately three years to reach various desired occupancy levels. This three year period begins when all core programs are in place.

A network is not a "quick fix" tool for hospital performance. It will take Hillcrest a full year to become completely operational, and even longer for physician relationships to become concrete. The Physician Support Network is a long term program, and takes time in which to build momentum.

Revenue Projections

The physician support network revenue projections are based upon admissions as reported to PMCI. Projections are based upon the additional admissions required to reach overall hospital occupancy levels of 70% one year after core programs are fully installed and 80% in three years. HHC's current occupancy rate was computed at 65%. Revenue (inpatient and outpatient) at $4,921 per admission, and $144 per ER visit was reported by the



HHC financial department. Incremental Revenue was based on 49% of projected revenue, and is extremely conservative in that 1987 charges are used to project revenues for the next three years with no increased assumptions. In addition, expenses projected considered cost of living increases and inflation.

Exhibit 1 indicates that with an increase of occupancy from 65% to 70%, Hillcrest will realize 685 additional admissions. This translates to $1,651,734 in incremental revenue. The third year goal is 80% occupancy. Thus, HHC is projected to take three years to gain 15% occupancy. The three year program goal is to gain 1,600 admissions above the 1987 admission level.

It should be noted that years one and two are not as productive as year three due to start-up cost and the amount of time it takes to build relationships with physicians.

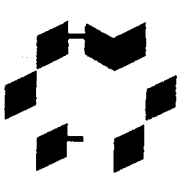
Exhibit 2 is a total three year program breakdown of incremental gross revenue, program cost, and net margin. Ultimately, for every dollar invested, $5.68 will result in returned incremental revenue. This ratio, however, will need to be adjusted when the BMC and Womens' Health plans are adopted. Exhibit 3 shows a breakdown by project of years one, two, and three.

Projected Revenues

Exhibits 4 through 9, show projected revenue calculations for all the core programs.

Direct Contracting/Occupational Health - (See Exhibit 4)

This projection assumes that 15% of the south Oklahoma City labor force is pre-registered in three years. This is very

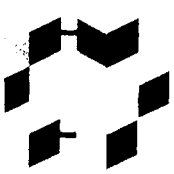


realistic considering that this requires only 4,400 employees to sign up per year. This projection also assumes that each pre-registrant will have 1.5 dependents. A few larger employers per year could literally accomplish this goal.

This calculation also assumes that only 15% of the employees who pre-register will actually use HHC network physicians and programs. Projected hospitalizations from these pre-registrants are then reduced by HHC's market share so as not to include enrollees who would have used HHC regardless of the program.

Telemarketing/Physician Referral - (See Exhibits 5 & 6) This projection is extremely conservative in that it only assumes around five calls per day. Of these, only 75% of the calls or about four physician appointments are assumed to be made per day. Only 80% of physician appointments actually show at the physician's office, thus, three patient visits result per day. Of total patients who visit the physician, about 5% actually are hospitalized for the cause of visit. PMCI also reduced anticipated hospitalizations by HHC's market share, to account for patients who would have gone to HHC regardless of the program.

Exhibit 6 indicates that if half the undoctored patients visiting the emergency department were referred to physicians, and if 60% actually showed, 153 hospital admissions, less 9 to account for HHC's market share, or 144 would be hospitalized over a three year period. Both Exhibits 5 and 6 were included together as physician



referral service projected revenues.

Workers' Compensation/Employee Physicals - (See Exhibit 7) Exhibit 7 projects the total market that exists in south Oklahoma City for Workers' Compensation visits and employee physicals. These projections were made using standard industrial code estimates, and U.S. Department of Labor incidence statistics. PMCI has not included these revenues as hospital income, as most of these cases would be directed to physicians in the network. Realistically speaking however, a portion of these revenues will be directed to HHC's emergency department.

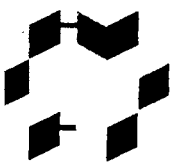
Pre-Registration - Emergency Room Volume - (See Exhibit 8) Exhibit 8 forecasts emergency room volume increases as a result of HHC's Emergency Room Marketing Plan. This project assumes a 10% increase in emergency room utilization each year.

Program Expenses

It should be noted that program expenses shown in this report reflect all the extra expenses per the recommendations in this Business Plan. As indicated earlier in this document, the hospital currently spends less than 1% of total net operating revenues on marketing activity. The first year total costs for this plan are $367,556 or 1.5% of HHC's net operating budget (this does not include consultant installation costs). Even the inclusion of first year consultant installation costs total less than 2.3% of the total operating budget. PMCI's recommendation for marketing in a hospital like HHC, with its competitive climate, is approximately 2.5 to 3.5% of the total operating

budget.

Exhibit 10 reflects the costs associated with the Physician Support Program. This includes a full-time physician liaison representative, brochures and printing, practice management services, and a communications representative. Exhibit 11 outlines the Occupational Health Program, which includes the program manager and sales/contracting representative. Exhibit 12 outlines the Telemarketing/Physician Referral Services Program. This includes 50% of the expense of hardware and software for an automated system. The remaining 50% of the cost for this system appears in the pre-registration program budget, as the same equipment can be used for pre-registration (software for pre-registration is slightly extra). Exhibit 13 includes the Pre-Registration and Emergency Marketing budgets.



HILLCREST HEALTH CENTER
REVENUE PROJECTIONS

OCCUPANCY LEVEL	@ 70%	@ 75%	@ 80%
Additional Admits	685	1,144	1,600
Inpatient/ Outpatient Revenue ($4,291/admit)	$3,370,885	$5,629,624	$7,873,600
Incremental Revenue (4 of 6?)	$1,651,734	$2,758,516	$3,858,064

Source: PMCI Computations.

Exhibit 1

HILLCREST HEALTH CENTER
PROGRAM THREE YEAR TOTALS

Program	Incremental Revenue	Program Costs	Net Margin
PSN	$3,698,492	$384,005	$3,314,487
Occ Hlth	$2,240,088	$265,680	$1,974,408
PRS	$716,153	$256,557	$459,596
Pre-Reg/ER	$1,613,581	$330,637	$1,282,944
Total	$8,268,314	$1,236,879	$7,031,435

Cost/Benefit Ratio 1:5.68
(Note: To be modified with BMC and Women's Health budget)

Exhibit 2

HILLCREST HEALTH CENTER
INCREMENTAL REVENUE

	PSN	Occ Hlth	PRS	PRE-REG/ER
YEAR I				
Incremental Revenue	$564,294	$373,750	$226,661	$487,029
Admissions	254	165	97	169
YEAR II				
Incremental Revenue	$1,236,304	$747,500	$238,718	$535,994
Admissions	526	330	102	186
YEAR III				
Incremental Revenue	$1,897,894	$1,118,838	$250,774	$590,558
Admissions	793	495	107	205

Exhibit 3

SOUTH OKLAHOMA CITY
DIRECT CONTRACTING REVENUE

LABOR FORCE (1985)	88,000
CARD DISTRIBUTION (FOR 3 YEARS)	13,200
POTENTIAL DISTRIBUTION (1.5 DEPENDENTS/CARD)	33,000
PRE-REGISTRANTS CAPTURED (15%)	9,900
HOSPITAL DEMAND (100 ADMITS/1,000)	990
MARKET SHARE CAPTURED	(61)
ADDITIONAL ADMISSIONS	929
ADDITIONAL INPATIENT/ OUTPATIENT REVENUE ($4,921/ADMIT)	$4,571,609
INCREMENTAL REVENUE	$2,240,088

Source: PMCI Computations.

HILLCREST HEALTH CENTER
PHYSICIAN REFERRAL SERVICE

TOTAL CALLS (150/MONTH FOR 36 MONTHS)	5,400
ACTUAL TELEPHONE REFERRALS (75%)	4,050
ACTUAL SHOW REFERRALS (80%)	3,240
ADMISSIONS (5% RATE)	162
MARKET SHARE CAPTURED	(9)
ADDITIONAL ADMISSIONS	153
ADDITIONAL INPATIENT/ OUTPATIENT REVENUE ($4,921/ADMIT)	$752,913
INCREMENTAL REVENUE	$368,928

Source: PMCI Computations.

HILLCREST HEALTH CENTER
PHYSICIAN REFERRAL SERVICE

TOTAL ER VISITS FOR 3 YEARS)	41,035
UNDOCTORED PATIENTS (25% PER YEAR)	10,250
FAVORABLE ACCOUNTS (50% PER YEAR)	5,130
PHYSICIAN REFERRALS (60% PER YEAR)	3,078
ADMISSIONS (5% RATE)	153
MARKET SHARE CAPTURED	(9)
ADDITIONAL ADMISSIONS	144
ADDITIONAL INPATIENT/ OUTPATIENT REVENUE ($4,921/ADMIT)	$708,624
INCREMENTAL REVENUE	$347,225

Source: PMCI Computations.

SOUTH OKLAHOMA CITY
OCCUPATIONAL HEALTH OUTPATIENT REVENUE

1. WORKERS' COMPENSATION - BASED ON EACH CASE INVOLVING TWO OFFICE VISITS, ONE EACH FOR TREATMENT AND FOLLOW-UP. (8,560 CASES)

2. PRE-EMPLOYMENT PHYSICALS - BASED ON 38% OF COMPANIES CONDUCTING PRE-EMPLOYMENT PHYSICALS AND A 10% ANNUAL TURNOVER RATE. (3,344 EXAMS)

3. COMPREHENSIVE PHYSICALS - BASED ON 29% OF COMPANIES PARTICIPATING IN PROGRAM, COUNTING ONLY EXECUTIVES, PROFESSIONALS, PROTECTIVE SERVICES, AND SALES, (6,992 PHYSICALS)

Source: PMCI Computations.

SOUTH OKLAHOMA CITY
OCCUPATIONAL HEALTH OUTPATIENT REVENUE

PROGRAM	REVENUE
W/C TREATMENT ($50)	$428,000
W/C FOLLOW-UP ($25)	$214,000
PRE-EMPLOYMENT PHYSICALS ($25)	$83,600
COMPREHENSIVE EXECUTIVE PHYSICALS ($250)	$1,748,000
POTENTIAL REVENUE	$2,473,600

Source: PMCI Computations.

HILLCREST HEALTH CENTER
EMERGENCY ROOM UTILIZATION

TOTAL ER VISITS (1987 ANNUALIZED)	11,270
ADDITIONAL ER VISITS (3 YEAR TOTAL)	3,731
ER VISITS ADMITTED (15%)	560
ADDITIONAL INPATIENT/ OUTPATIENT REVENUE ($4,921/ADMIT)	$2,755,760
ADDITIONAL ER REVENUE ($144/VISIT)	$537,264
ADDITIONAL REVENUE	$3,293,024
INCREMENTAL REVENUE	$1,613,581

Source: PMCI Computations.

HILLCREST HEALTH CENTER

PHYSICIAN SUPPORT

	YEAR I	YEAR II	YEAR
INCREMENTAL REVENUE PROJECTIONS	$564,294	$1,236,304	$1,897
EXPENSES			
Liaison Representative	30,000	51,250 (2 FTE's)	53 (2 F
Benefits	6,000	7,688	8
Brochures/Printing	8,000	10,000	12
Training/Equipment	4,000	2,000	2
Entertainment/Travel	4,800	9,000	12
Benefit Package	15,000	20,000	30
Sales Productions	5,000	1,000	1
Practice Management Services	10,000	12,000	14
Communications	15,000	15,750	16
Benefits	2,250	2,363	2
TOTAL EXPENSES	100,050	131,051	152
NET INCREMENTAL REVENUE	$464,244	$1,105,253	$1,744

Exhibit 11

HILLCREST HEALTH CENTER

OCCUPATIONAL HEALTH

	YEAR I	YEAR II	YEAR III
INCREMENTAL REVENUE PROJECTIONS	$373,750	$747,500	$1,118,838
EXPENSES			
Program Manager	32,000	33,600	35,280
Commission Potential	10,000	10,000	10,000
Benefits	5,700	5,900	6,100
Print Media/Drop Package	12,500	15,000	18,500
Tabletop Video and Equipment	6,500	1,000	1,000
Mileage/Entertainment	4,800	5,200	5,600
Physician Office Coupons/Misc.	8,500	9,500	10,500
Pre-Reg. Processing	5,000	6,000	7,000
TOTAL EXPENSES	85,000	86,700	93,980
NET INCREMENTAL REVENUE	$365,250	$660,800	$1,024,858

Exhibit 10

HILLCREST HEALTH CENTER

PHYSICIAN REFERRAL SERVICES

	YEAR I	YEAR II	YEAR III
INCREMENTAL REVENUE PROJECTIONS	$226,661	$238,718	$150,774
EXPENSES			
Telephone Expenses	5,500	6,500	7,500
Salary Expenses/Benefits	20,700	21,735	22,822
Educational Allowance	500	550	575
Continuous Feed/Cards/Forms	4,000	4,200	4,410
Letters/Postage - In/Out	2,000	2,100	2,310
Postcards/Letters to Phys.	500	550	575
Surveys/Return Postage	400	440	462
Newcomer Letters	1,500	1,575	1,653
Advertising/Printing/ Electronic Media	12,000	20,000	25,000
Yellow Pages	15,000	16,500	17,000
Brochures/Direct Mail	4,000	6,600	7,260
Computer Installation/ Monthly Maintenance	1,092	1,092	1,092
Software	8,500	-0-	-0-
Hardware	8,361	-0-	-0-
TOTAL EXPENSES	84,053	81,842	90,662
NET INCREMENTAL REVENUE	$142,608	$156,876	$160,112

Exhibit 12

HILLCREST HEALTH CENTER

PRE-REGISTRATION/ER

	YEAR I	YEAR II	YEAR III
INCREMENTAL REVENUE PROJECTIONS	$487,029	$535,994	$590,553
EXPENSES			
Product Line Coordinator/ Worksite Nurse	11,000	24,000	26,000
Design/Production/Pre-Reg. Card Design	48,000	50,000	52,000
2-Track Staffing	10,000	20,000	22,000
Pre-Reg. Hardware	8,361	-0-	-0-
Pre-Reg. Software	4,000	-0-	-0-
Computer Installation/ Monthly Maintenance	1,092	1,092	1,092
Data Specialist	16,000	16,000	22,000
TOTAL EXPENSES	98,453	111,092	121,092
NET INCREMENTAL REVENUE	$388,576	$424,902	$469,466

APPENDIX E

EXCERPTS FROM BUSINESS PLAN BOOK I

HILLCREST HEALTH CENTER

BUSINESS PLAN

BOOK I
(of III Books)

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I. INTRODUCTION

This Business Plan has been commissioned by James MacCallum, Executive Vice President of Hillcrest Health Center in Oklahoma City, Oklahoma. Hillcrest management worked in conjunction with Professional Marketing Consultants, Inc in the development of this Business Plan. Without the enthusiastic support of the key management of Hillcrest, this report would not have been possible. Several other department heads also were extremely helpful in contributing to this document. Finally, key medical staff members and board members were instrumental to the Business Plan process.

Purpose

The purpose of the Physician Network Business and Action Plan, as stipulated in the contract, is to:

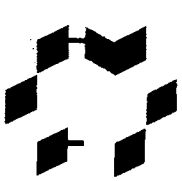
A. Establish and implement a strong physician support program to include practice management;

B. Address financial responsibility and return on investment;

C. Generate a strong action plan which clearly defines roles, responsibilities, and time frames;

D. Base physician affiliation needs on ideal HHC inpatient bed mix goals;

E. Address interface with occupational health, emergency services, women's health services, outpatient surgery,



and other appropriate programs and services;

F. Measure outlying physician needs and design involvement strategy;

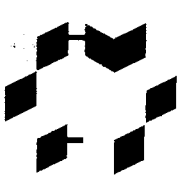
G. Incorporate data system design;

H. Structure the network as part of HHC, but so it can be viewed as a separate physician support advocate.

In order to fulfill this purpose, PMCI representatives reviewed the status of existing services at Hillcrest and its major competitor hospitals. PMCI gave particular consideration to the status of relationships between physicians and hospitals. In that process, individual interviews were held with members of the medical staff, the hospital board of directors, and rural referring physicians.

In addition, a detailed internal analysis was conducted. Inpatient and emergency patient records were abstracted and reviewed. Financial data was scrutinized and applied to revenue projections. Hospital personnel were interviewed to assess operational aspects of marketing.

At the present time, Hillcrest does not have an overall strategic plan or action plan delineating activities required to develop and implement a physician network marketing program. By developing this plan, this process can be updated and evaluated on a regular basis.



Business Plan Objectives

The objectives of the Physician Network Business Plan and Action Plan, are to:

A. Increase utilization of targeted inpatient and outpatient HHC services.

B. Provide for a phased sequence of implementation for a regional health delivery system.

C. Develop and maintain strong hospital physician bonding able to benefit from non-inpatient diversified revenue opportunities.

Scope of Project

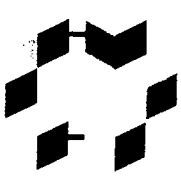
The scope of this Business Plan includes the following:

A. Data collection and analysis pertaining to financial trends, utilization trends, patient origin, payor mix, ideal service mix, service area analysis, applied demand factors, and patient mix strategies;

B. Development of a medical staff analysis to include admission patterns, location analysis, supply and demand, and physician recruitment needs;

C. A competitive analysis taking into consideration the strengths and weaknesses of other healthcare providers;

D. Target market recommendations with specific program approaches;



E. Program recommendations on competitive positioning, service access locations, recommended organizational approaches, revenue projections, marketing goals and objectives, product strategies, and promotion and marketing strategies;

F. Product development reporting systems, sales approaches, and database development;

G. An Action Plan outlining specific responsibilities and timetables;

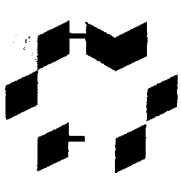
H. Budget development and return on investment.

The design, packaging, and promotion of Hillcrest's Women's Health Services Program, and Behavioral Medicine Center are being addressed separately after the core programs associated with this plan are installed.

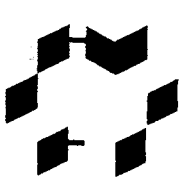
Role of PMCI

In the course of this project, PMCI worked with Hillcrest staff, physicians and board members and jointly collected information necessary to accomplish the objectives outlined above. PMCI interviewed appropriate management personnel and medical staff as well as board members to determine the most effective strategies.

The emphasis of this document is to create a work plan for specific completion and to assign appropriate responsibilities for program recommendations. PMCI has incorporated action steps which address these new strategies and reflect additional revenue generating programs.



PMCI has also been very sensitive to assure that appropriate personnel are involved in the development of this document to promote a sense of ownership and departmental commitment. One of the other major roles PMCI has played in the development of this Business Plan is to facilitate a series of meetings in which strategy was formulated. PMCI incorporated all of the results of these strategy sessions into this document.



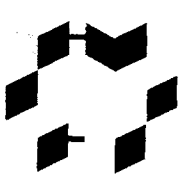
II. SUMMARY OF RECOMMENDATIONS

This plan is the culmination of a thorough review of data, intensive strategy sessions, interviews, and analysis of many sources of information pertaining to Hillcrest Health Center and its marketplace. Physicians, board members, area residents and management personnel contributed to its content.

HHC is now at the crossroads of either ensuring itself as a full service hospital well into the future, or placing itself at the mercy of some very aggressive competitors. PMCI considered several general strategy options for HHC, including its becoming a specialty service hospital and no longer functioning as a full service acute care facility. However, we found these options to be impractical, particularly because of its important identity as the only Osteopathic facility in Oklahoma City. During the past few years, HHC management has taken admirable steps to improve the hospital through managerial excellence.

It is clear, however, that if HHC does not take some considerable competitive actions, it is on a disastrous course. Between 1982 and 1986, inpatient utilization declined 4% at Hillcrest. Further, HHC is financially vulnerable in terms of maximizing optimum service and pay mix due to the lack of a well supported business plan.

The final recommendations of this plan outline a three-year marketing effort that is conservatively projected to realize a total of $8,268,314 in incremental revenues, with a $7,031,435 margin after program costs for a three year period. For every dollar invested in the program, almost $5.68 is expected in



incremental revenue. This cost/benefit ratio will slightly change when marketing expenses are added for Women's Health, BMC, and Outpatient Surgery. However, any cost/benefit ratio in addition to 1:4 is considered to be within industry standards. This goal is not unrealistic. In fact, this plan only calls for an average of 5% bed occupancy increase each year.

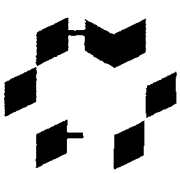
Three-Year Marketing Effort

This plan first outlines the ideal service mix for HHC by medical specialty, and then indicates the physician referral patterns that are necessary to realize goal levels of bed occupancy and program utilization. In order to realize these goals, several key actions must occur.

1. The Board of HHC must come to the realization that it must spend money to make money, or it will see its revenue base slowly erode away year after year. Currently HHC spends less than 1% of its net operating revenues on marketing. It needs to spend closer to 2.5% to 3.5%.

2. A new marketing infrastructure, with resources backing it, must be developed to build a physician support network. Current marketing efforts are built around hospital programs rather than the medical staff.

3. HHC needs to receive the additional equivalent support that 13 full-time practices would provide if all of their patients were directed to one hospital. Particular specialties include Oncology, General Surgery, ENT, Ob/Gyn, etc.



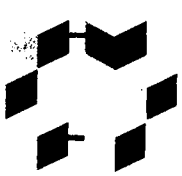
4. HHC must strengthen its primary care referral base and include new affiliations with approximately four General Medicine physicians, three Ob/Gyn's, and one Pediatrician. On an average, these physicians need to refer one-half of their patients to loyal targeted HHC sub-specialists.

6. A series of critical "Feeder Programs" must be initiated that will attract patients to targeted physicians so the above goals can be realized. These "Feeder Programs" include:

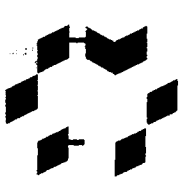
- A Physician Support Department
- A Pre-registration Program
- An Occupational Health Program
- An Intensified Emergency Services Marketing Program
- A Telemarketing/Physician Referral Program

The above programs are the "work horses" that make this program succeed. They require adequate financial backing, or they should not be attempted. If done properly, there is excellent market demand potential in the Oklahoma City area to support their success.

This document outlines specific information on physician affiliations, strategies, marketing organization, budgets, projected revenues, return on investment, and timetables. A detailed set of recommendations and key observations are included in the Executive Summary.



In closing, HHC has a unique set of opportunities in many areas, but it must act immediately, or these opportunities will most certainly be short lived.



III. RECOMMENDATIONS

Service/Program Focus

1. **HHC marketing efforts should be guided by the ideal desired bed and service mix and the physician affiliations necessary to sustain those services.**

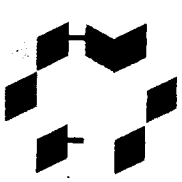
Rationale: The financial security of HHC is dependent upon the success of specific inpatient and outpatient services. Physician referrals by far have the most profound impact upon those services, especially in Oklahoma City, Oklahoma.

2. **HHC should focus its growth efforts upon the following inpatient service areas:**

General Medicine	Cardiology
General Surgery	ENT
Ob/Gyn	Oncology
Pediatrics	Psychiatry
Urology	Podiatry

Rationale: A multi-variable review of services by PMCI and hospital management was conducted considering hospital mission, estimated profitability, market strength, revenue base, physician affiliations, facility and equipment investment, and market opportunity. These services were then confirmed by intense physician and board interview activity.

3. **Outpatient surgeries and outpatient procedures should be given high marketing priority.**



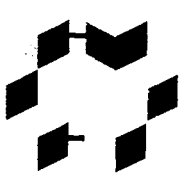
Rationale: HHC has a strong physician base for those specialties dependent on outpatient procedures, such as Orthopedic Surgery, General Practice, General Surgery, and Ob/Gyn. Third party payors will also continue to encourage outpatient treatment.

4. During the next 3 years, HHC should increase physician loyalty and/or establish new affiliations in the following specialties with commensurate full-time practice support equivalents.

Specialty	FPE Support
ENT	4
Oncology	3
Podiatry	3
General Surgery	2
Psychiatry	2
Cardiology	1
Urology	1

Rationale: The above additional affiliations or increased referral equivalents will result in an 80% occupancy level, with HHC's desired bed mix. It will result in over 8 million dollars of additional incremental revenue over a three year period.

5. In order to support the necessary additional specialty affiliations, it will be necessary for HHC to affiliate with the following additional primary care physicians during the next three years:



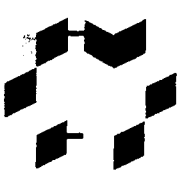
General Medicine	4
Ob/Gyn	3
Pediatrics	1

Rationale: The sub-specialist physicians HHC needs to attract during the next three years will require about 8,600 patient referrals from other physicians in order to generate an additional 3,429 patient admissions for HHC during the next 3 years. New physician referrals will come from a combination of affiliating further with physicians who in the past did not refer much to HHC physicians, or by affiliating with new physicians and building practice volume as necessary.

6. HHC should establish primary care affiliations with physicians in areas located throughout south Oklahoma City. Areas recommended per each specialty in this report are:

Northeastern South OKC (Midwest City/Del City)	GM
Southern South OKC (Moore)	GM, OB/GYN
Northwestern South OKC	GM, OB/GYN, PED

Rationale: Multi-variable weighted formulas explored each zip code in Hillcrest's service area for physician loyalty, demand, population density, income, proximity to competition, transportation, etc. Access to all areas will be necessary if physician referral services are established, and if HHC is to have success in managed care contracting. The current maldistribution of primary care physicians



presents multiple opportunities.

Note: Information regarding remote affiliation areas was not provided by HHC, but upon a preliminary analysis of information available, PMCI recommends investigation of primary care and specialty physician affiliations in Mustang, Tuttle, Newcastle, Choctaw, and Harrah. These areas offer significant affiliation opportunities for Hillcrest Health Center.

Physician Marketing Strategies

1. HHC marketing strategies should center around each medical specialty. For example, in promoting Cardiology, HHC should:

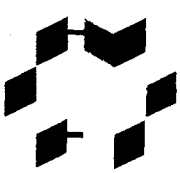
   - Conduct high risk heart disease screening with employers.

   - Conduct media features on its Cardiologists.

   - Promote a "chest pain clinic" through the emergency room.

   - Form a cardiology marketing task force with physicians, department heads, and HHC management participation.

   - Have cardiologists conduct more educational seminars for the rest of the medical community, and bring in national speakers.



- Promote cardiologists through an aggressive physician referral service.

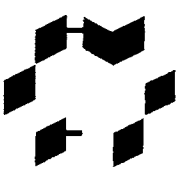
- Consider affiliating with a tertiary facility that provides open heart and other high acuity procedures.

Note: Detailed strategy recommendations for each medical specialty are found in Section II (F).

Rationale: When interviewed, physicians expressed a strong need to be more directly involved in hospital marketing. Current marketing programs are centered around "hospital programming" and not directly focused on getting patients through the doors of its medical staff offices.

2. A network of loyal primary care physicians should be promoted to the public and marketed through a common tradename. Ultimately, HHC should have about 20 convenient locations dispersed throughout Hillcrest's service area. A primary care marketing task force should convene to determine the types of community promotion it wishes to conduct, which could include special screening events, common office hours, special promotional fees (flu shots, school physicals, immunizations, etc.) and contracts with managed care providers, employers, and insurance companies.

Rationale: It is prohibitively expensive for an individual physician to successfully advertise himself. The strength of HHC is its primary care referral base, and if HHC is to



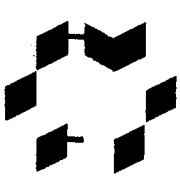
be successful at managed care contracting, it must demonstrate that it is capable of organizing such a system.

Programs to Build Market Share

1. **An organized Telemarketing Service should be established to receive return calls on programs promoted by HHC. This service should accommodate calls pertaining to Physician Locator Services, Occupational Health Services, Behavioral Medicine/Chemical Dependency Units, Women's Health Services, Patient Pre-registration, Physician-to-Physician Referral and information, etc.**

Rationale: Currently, HHC has no permanent focal point for the consumer or physician to respond to when programs and physicians are promoted. Marketing program coordination and communications are fragmented at best. A centralized telemarketing service is cost effective in that one operator can handle several programs at once, without disrupting the operations of clinical departments. A physician referral service alone has a potential of over 5,400 calls in three years according to PMCI. With the referral of over 3,000 undoctored residents, and follow up with favorable accounts undoctored patients in the ER, over $720,000 in incremental revenue could be generated over three years.

2. **A formalized Occupational Health sales initiative and direct contract program should be focused upon as a top priority. This should center upon a workers' compensation program, employer cost containment, and contract volume incentive discounting for inpatient and**



outpatient services. Employees should be pre-registered and given a HHC enrollment card that entitles them to a variety of benefits they are unable to attain elsewhere. The Good Neighbor Clinics need to be tied into this effort.

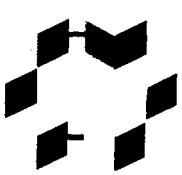
Rationale: Approximately 88,000 employees are within Hillcrest's service area. HHC is well positioned to service mid-sized to large employers and has unlimited market opportunity. PMCI calculations (see ROI sections) indicate a market demand of nearly 2.5 million dollars in outpatient worker's compensation and employee physicals. If HHC were able to penetrate just 15% of the potential market over three years, it could net over 2.2 million dollars in incremental revenue for inpatient and outpatient services.

3. A strong Pre-registration program, entitling card holders to medical benefits such as pharmacy discounts, non-acute immediate ER treatment and registration, screening, special preventive check-up discounts, etc. should be developed immediately. This pre-registration program should be marketed to ER patients, employees, former HHC patients, HHC physician patients, etc.

Rationale: A pre-registration system could net 1.6 million dollars in incremental revenue during the three-year marketing program. (See ROI section).

Operational Issues

1. HHC must resolve some internal medical staff perceptions immediately. These include the following:



A. Hospital Red-Tape and Politics
B. "Unfair" surgical scheduling
C. Inadequate staffing and staff training
D. Difficulty in patient registration

Rationale: When physicians were interviewed, PMCI detected the above perceptions. The comments PMCI heard about these issues were voluntary and unassisted, making them even more significant.

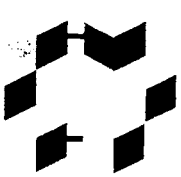
2. A cost accounting system should be installed, or at minimum a profitability of service portfolio study should be conducted.

Rationale: While management is doing all it can to evaluate the financial consequences of different services, it is impossible to accurately determine program profitability with current information accounting systems.

Marketing Organization

1. A physician network model of organization should be established to build marketing programs around the medical staff instead of around hospital programs. (See Marketing Organization, and Return on Investment).

Rationale: Hospital contact with physician offices and physician involvement in marketing activity builds census far more effectively than advertising and image campaigns. Recent national surveys indicate that physicians will increase patient referrals to the hospital if the hospital successfully assists them with practice management and



marketing.

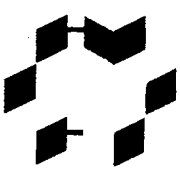
2. A physician liaison representative will be necessary to reach out to local and remote practices. This function must be backed with a commitment from HHC to provide physician services as in demand from the medical staff.

Rationale: South Community and other hospitals have already developed the above services. HHC physicians are already being approached by them.

3. HHC must commit itself to dedicating close to 2.5% of its net operating revenues toward marketing in order to have a significant impact on market share.

Rationale: In the final analysis, HHC's conviction about marketing will be tested by financial allocation. In 1987, HHC's current marketing expenditures fell under 1% of its net operating revenues. This is a fraction of what can today be considered to be adequate when HHC faces considerable adversity such as negative public perception and considerable competition from South Community, Baptist, HCA and other organizations. If HHC is to achieve the goals set forth in this plan, the Board will have to come to grips with the reality that you have to spend money to make money.

4. Programs such as the Good Neighbor Clinic Promotions, Good Neighbor Health, BMC, ER, etc. are worthy of continuance, but need to be strengthened with product line management, better cross sold, better coordinated with one hospital theme, and better tied into physician

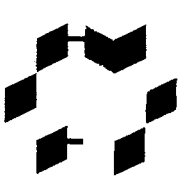


referral and participation.

Rationale: HHC's grassroots position with the Pediatric market, Women's Health, Alcohol Rehab, and Outpatient Care make it a strong candidate for intensive marketing in these areas. However, these must all be strengthened with the appropriate physician involvement, resources, outreach, and telemarketing.

5. **HHC's information systems and public relations resources need to be upgraded and intensified in order to successfully support the formalization and strengthening of a successful physician network.**

Rationale: As it becomes more and more essential for HHC to invest in a prudent marketing effort, it will be increasingly important to track return on investment. ADS systems will also demand more specific marketing and financial information in the future. As for public relations, it is now obsolete for HHC to depend on such services on an outside contractual basis. It is also more cost effective to conduct these services in-house.



IV. KEY OBSERVATIONS

General Competitive Observations

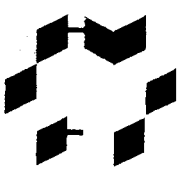
While Hillcrest has experienced slight declines in inpatient admissions and occupancy between 1983 and 1986, their competitors have experienced much greater decreases. At the same time, Hillcrest experienced increases in several areas such as patient days, average daily census, births, surgical procedures, and emergency room utilization.

Between 1983 and 1986, Hillcrest experienced only a 1% inpatient admissions decline compared to declines of from 9% to 30% by their competitors.

In spite of this relative success, there is considerable reason for HHC to be concerned about its future security. In addition to "macro-environmental" competitive forces, hospitals such as South Community, Baptist, St. Anthony, and Presbyterian can be expected to take increasingly competitive postures.

Alternative delivery "managed care" systems will continue to grow, putting additional pressure on HHC to minimize health care delivery costs, and increasing pressures to find more traditional commercial indemnity patients.

Changing reimbursement patterns will continue to force physicians to provide services on an outpatient care basis. Physicians will increasingly be in direct competition with hospitals for ambulatory services unless win/win affiliation relationships are strengthened between physicians and hospitals.



HHC still has a respectable market share penetration in south Oklahoma City, however, this will continue to decline unless it takes aggressive action immediately.

HHC is at the crossroads of making major marketing investment decisions that will determine its future as either a competitive full service hospital, or a hospital that will have a series of fragmented "niche" programs.

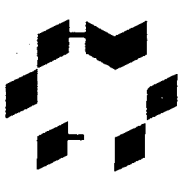
Ironically, as many opportunities as threats exist in HHC's service area, demand for several physician services exists. A large employee population base presents a market virtually untapped, though competitors are now selling occupational health services aggressively.

Internal Analysis of HHC

HHC has a strong primary care base, allowing for development of sub-specialties. General Practice, Internal Medicine, Pediatrics, and Ob/Gyn account for about 73% of all admissions and 61% of all revenues generated.

HHC has a booming outpatient procedure market. Primary care specialties were responsible for 65% of all procedures. As primary care physicians become more plentiful in south Oklahoma City, this market will be threatened as more physicians compete with the hospital. This can be prevented if HHC forms stronger bonds with its physicians.

Surgical procedures are declining on an inpatient basis and growing on an outpatient basis, resulting in a relatively constant total number of procedures. HHC has developed strength



in outpatient procedures, and has good market share considering its size in its service area compared to inpatient care. General Practice inpatient admissions, Pediatric inpatient admissions, and Behavioral Medicine/Mental Health inpatient admissions increased between 1986 and 1987. Pediatrics experienced a 4% increase, while BMC/MH and General Practice experienced 3% and 1% increases respectively.

General Surgery and Ob/Gyn were the only specialties resulting in increased surgical procedures between 1986 and 1987. General Practice, Orthopedic Surgery, General Surgery, and Ob/Gyn accounted for nearly 86% of 1987 surgical procedures.

HHC's Market Place

Almost 70% of HHC's patients originated from Oklahoma City in 1987. The southern portion of Oklahoma City accounted for over 60% of HHC patient origin.

HHC has significant market share in the central portion of south Oklahoma City. Though HHC has a lower market penetration in northern Oklahoma City, it still has meaningful market share in southwest and southeast Oklahoma City.

Nearly 41% of Hillcrest's inpatient admissions came from commercial accounts in 1987. Medicare represented nearly 25%, while medicaid accounted for 20%. In the emergency room, 35% of visits were from commercial accounts, with 33% from self pay accounts. Compared to other hospitals, these are relatively positive levels.

Almost half of all HHC inpatients are below the age of 18 or over

56 years of age. The families of these age groups need to be communicated with to attract their attention to HHC services.

Conversely, nearly 58% of ER patients are between the ages of 17 and 55, indicating a tremendous opportunity to cross sell other services to this "captive audience".

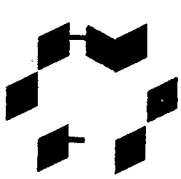
HHC is located in a relatively high pediatric and female concentration area, with a respectable median household income level in its immediate service area and particularly to the immediate south. This offers many opportunities for Hillcrest in terms of programs and physician affiliations.

HHC has a significant employer base, and is positioned extremely well to successfully provide major occupational health service programs in south Oklahoma City.

Current Marketing/Advertising Efforts at HHC

Prior to PMCI's involvement, HHC had a marketing director. Programs such as the Good Neighbor Clinics, and Good Neighbor Care had been initiated but not highly developed. The BMC program and ER departments both had demonstrated very positive marketing potential and success. Excellent new management expertise had contributed positively to the hospital's bottom line. A high level of physician loyalty existed through osteopathic and historical bonding.

However, no PR resources were existent internally, and no continuity existed in terms of hospital program promotion or graphics. The hospital had no master plan for marketing or pro-active budget. No formalized physician support activities had



been centralized, and there was no marketing database.

Physician Analysis

Overall, Hillcrest has a very young medical staff with an average age of 41. There are only 5 physicians on HHC's medical staff over 55 years of age, representing over 4% of all admissions and over $764,000 in revenue, based on inpatient/outpatient revenue.

A total of 10 physicians are responsible for nearly 45% of Hillcrest's admissions and 53% of Hillcrest's revenues.

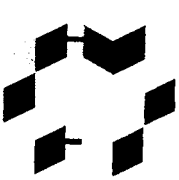
There is no cost accounting system or profitability portfolio study available at HHC, making it difficult to specify what services are financially desirable. Such a system study is sorely needed.

Using a multi-variable formula, HHC management and PMCI chose the following bed mix services to be those they wish to expand:

General Medicine	Cardiology
Oncology	General Surgery
Orthopedic Surgery	ENT
Urology	Podiatry
Chemical Dependency Unit	Mental Health

Criteria used: Mission, perceived profitability, physician affiliations, facility and equipment investments, distinctive marketing competency.

Population demands create several physician shortages in south



Oklahoma City. These shortages exist in all the primary care specialties.

Age/sex breakdowns of the population in south Oklahoma City indicate that there is a significant maldistribution of physician office locations with surpluses clustered around hospital locations.

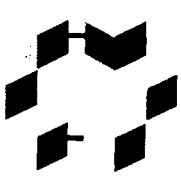
Primary care shortages largely due to maldistribution exist in all of the south Oklahoma City area, except for those areas surrounding the hospital.

If HHC were able to attain the following additional primary care practice affiliations and maintain its current referral patterns, in the next three years, it could realize an addition of approximately 3,429 admissions, and $8,268,314 in incremental revenues:

General Medicine - 4 Ob/Gyn - 3
Pediatrics - 1

In order for HHC to attain a 70% occupancy rate, or an additional 685 inpatient admissions, it will be necessary to attain the full-time equivalent support of approximately 7 additional physician practices. HHC must also retain its existing market share. With an aggressive marketing effort, this goal can be attained in one year.

Average full-time equivalent physician practice support per physician is currently 86%. In order to attain 70% occupancy, average practice support must increase to 104%.



With a full blown marketing effort, HHC could achieve an 80% occupancy rate in three years. This will require approximately 13 additional full-time practice equivalents, and average practice support would need to increase from 86% to 118%. Significant hospital marketing resource commitment must take place for this to occur.

Operational Issues

HHC's current information system lacks patient tracking capabilities, market data capabilities, and cost accounting capabilities.

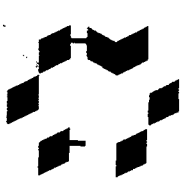
Physician perceptions of hospital red-tape and politics, unfair surgical schedules, and inadequate staffing and training need improvement.

Attitude Research

Thirty-two Oklahoma City area physicians were personally interviewed by PMCI. Most of the questions on the survey were open-ended allowing for unassisted responses by physicians. Major findings were as follows:

- Both primary care and specialty physicians listed Hillcrest as their primary hospital. While primary care physicians viewed Moore as their secondary hospital, specialty physicians listed Moore and South Community.

- Primary care physicians listed patient preference, unavailable services, and location as main reasons for admitting outside Hillcrest. Specialty physicians



listed equipment/services, referral, and location as their main reasons for admitting to a hospital other than Hillcrest.

- Physicians have extremely strong influence in terms of directing patient hospital selection.

- Physicians felt that Hillcrest's emergency room, while needing renovation, was clinically very good and provided good back-up coverage.

- Most physicians stated that the quality of Hillcrest's medical staff was one of its greatest assets, and viewed the staff as being young and aggressive.

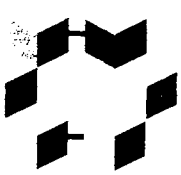
- Concern regarding the quality of Hillcrest's dietary services was voiced, both on the patient level and the general public level.

- Ancillary services need improvement and enhancement, especially regarding lab service costs and response.

- Physicians voiced concern regarding difficulties with the outpatient department and surgical department in both scheduling and admitting.

- Physician were extremely supportive about hospital marketing.

- Physicians felt that the hospital needed to do more to support and strengthen its primary care physician base.



- Physicians expressed the need for the hospital to affiliate with additional specialists, particularly in Cardiology and Neurology.

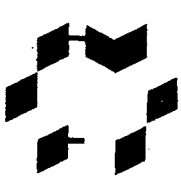
- Physicians stated that some patients had bad perceptions of the hospital, and Hillcrest needed to do more in the way of positive public relations.

- There was little opposition to HHC being involved in Occupational Health Programs, so long as physicians are closely involved.

- Most physician's practice volume was increasing, but only slightly. Several doctors stated that their practice volume was decreasing, by their own choice.

- There are four physician practice support services that a large majority of physicians felt they needed. These were practice marketing, physician office staff training, financial services, and physician referral/traffic building services.

- Most of the physicians involved in the Good Neighbor Clinic expressed concern regarding the program. Most physicians stated they did not receive referrals from the program and the program was not well promoted.



V. PHYSICIAN SUPPORT NETWORK

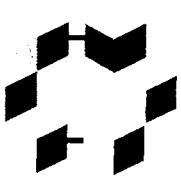
A. DEFINITION

The Physician Support Network (PSN) is a comprehensive, dynamic health care delivery system which is specifically designed to meet Hillcrest's goals; maintaining existing markets as well as creating new patient demand for the hospital and its medical staff. Designed to capture and retain patients at the primary care physician level, the network serves to unite Hillcrest's individual program components in a coordinated manner.

Composed of existing and newly targeted primary care practices, the PSN is based on the concept that primary care physicians will serve as the "gatekeepers" of patient referrals to Hillcrest Health Center and its medical staff.

With a well-defined package of services and benefits, marketed to targeted physician practices identified using sophisticated supply and demand formulas, the network will tie into and build upon the existing strengths, programs, facilities, and the specialty medical staff of Hillcrest Health Center.

The PSN strengthens the visibility of each participating component of the network by exposing a greater number of patients to primary care physicians loyal to Hillcrest Health Center.



B. PURPOSE

There are five primary objectives for Hillcrest's Physician Support Network:

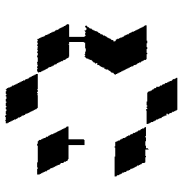
- To create a network of primary care physicians strategically located in Hillcrest's service area who will utilize the hospital's facilities and support the specialty physicians through a strong and long-term referral program;

- To create an awareness and comfort level with patients in Hillcrest's service area through targeted and sustained marketing programs that will develop, retain, and increase the market share for inpatient and outpatient services;

- To provide the market with an integrated health care system comprised of physicians, programs, and services appropriately designed to satisfy the demands of the marketplace (examples include: Occupational Health Services, Physician Referral Programs, Women's Health Services, and Emergency Department Programs);

- To attract high quality physicians into the network to maintain the high standards of the institution, and to increase the quality of care provided in remote areas;

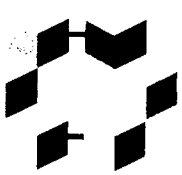
- To create a strong relationship between physicians, programs, and hospital services that will be self sustaining and directed to appropriate and profitable



target markets.

Achievement of these objectives will lead to the accomplishment of the Physician Support Network's primary goal:

> "An affiliated organization capable of increasing the utilization of Hillcrest's physicians, programs, and services in a profitable manner."



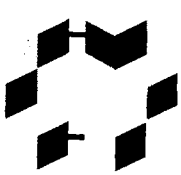
C. THE APPROACH

The development and implementation of a PSN is generally a three phase program. Each phase has special components contributing to the overall success of the PSN implementation. Because of the complex nature of a PSN including the program design, internal politics, physician marketing programs, and the data management systems, this project requires absolute commitment from the onset. Each phase must be planned, managed, and monitored by highly experienced professionals if the project is to be implemented successfully.

Phase I involves the development of a marketing and strategic plan that will support and guide the implementation process. It includes:

- Collecting and evaluating pertinent hospital, physician, and financial data with advanced PMCI software packages;
- Performing a competitive review of the hospital's service area;
- Projecting supply and demand calculations for actual network design;
- Identifying profitable program opportunities, competitive threats, and recommended action plans.

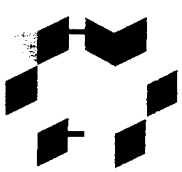
The strategic plan will be developed by analyzing the data collected and will: (1) define the hospital's proposed PSN; (2)



calculate the number of primary care physicians and specify their location by zip code; (3) identify advertising programs and public relations activities; (4) project a realistic budget for the first year and subsequent two years; and (5) detail a program by program "return-on-investment". Phase I becomes the action plan for implementing the PSN. A majority of this activity will be completed in January.

Phase II is the actual implementation of the hospital's PSN. This phase includes the installation of the PSN data processing systems, product specific programs, advertising programs, and physician support systems. Physician support programs defined in Phase I are created and consolidated into a package which is discretely marketed to the targeted primary care providers. Affiliation agreements for facilities, programs, and physician participation are furnished by PMCI and utilized. Patient awareness and referral programs are implemented and finally, tracking programs critical to determining the success and impact of the PSN are developed. The Physician Referral Service and Occupational Health Program components of this Phase will begin in January.

Phase III is the ongoing management and support phase which is crucial to the eventual long-term success of the PSN. As the PSN matures and competitors react to its success, constant monitoring of each program, physician, and facility is required. The system is dynamic, and therefore, requires an ongoing evaluation of supply and demand trends. Phase III focuses on the placement of mechanisms and monitoring devices to adjust to those changes.

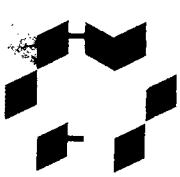


D. HOSPITAL COMMITMENT

The establishment of a physician support network will be a major undertaking for HHC. This network will demand high level commitment from the hospital's Board of Directors and its physicians and administrative staff. The program must have the respect of each primary care and specialist physician targeted. Most importantly, the success of the physician support network is totally dependent upon the medical and residential community's perception of the values of membership in the network.

The implementation of a valuable, self-sustaining network is not inexpensive. It requires financial commitment and, as with any program of this scope, a physician support network must have the appropriate funding, staffing, and resources to be successful. A network under-financed, under-staffed, and lacking total commitment would be more detrimental to HHC than no program implementation.

The consumer of health care is a major target of the physician support network. If the consumer is not treated servingly during his first encounter with a promoted program, all the effort and expense utilized to create the network will be wasted. The quintessential marketing adage certainly applies: "one bad experience is worth ten good references". Consumers have friends, family, and employers. Consumers relate their experiences to those around them proficiently and constantly. Conversely, a network properly constructed, financed, and staffed can yield tremendous benefits. The overall cost of securing a new patient is far outweighed by future utilization dollars to HHC, its medical staff, and the primary care member physician.



Direct benefits can be measured as new targeted patients are admitted to the hospital and more patients receive care from the medical staff. Even the primary care member physicians will receive direct benefits as their practices grow and prosper. All of these monetary benefits contribute heavily which more than justifies the cost associated with implementing a physician support network program. A preview return on investment analysis is included in this document.

The indirect benefits of a network can be even more important. While it is difficult to accurately measure these benefits, they strongly influence the success of HHC, its medical staff, and the primary care member physician. Enhanced community awareness, the delivery of better quality care, and the development of an efficient well-organized health care delivery system will ultimately benefit Hillcrest Health Center in many intangible ways.

Physician Support Network Approach

The Physician Support Network is designed to dramatically affect multiple components of the hospital programs and staff:

- Specialty and Primary Care Physicians
- Ancillary Department Services
- Physician Referral Program

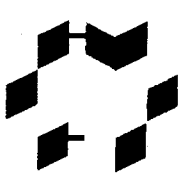
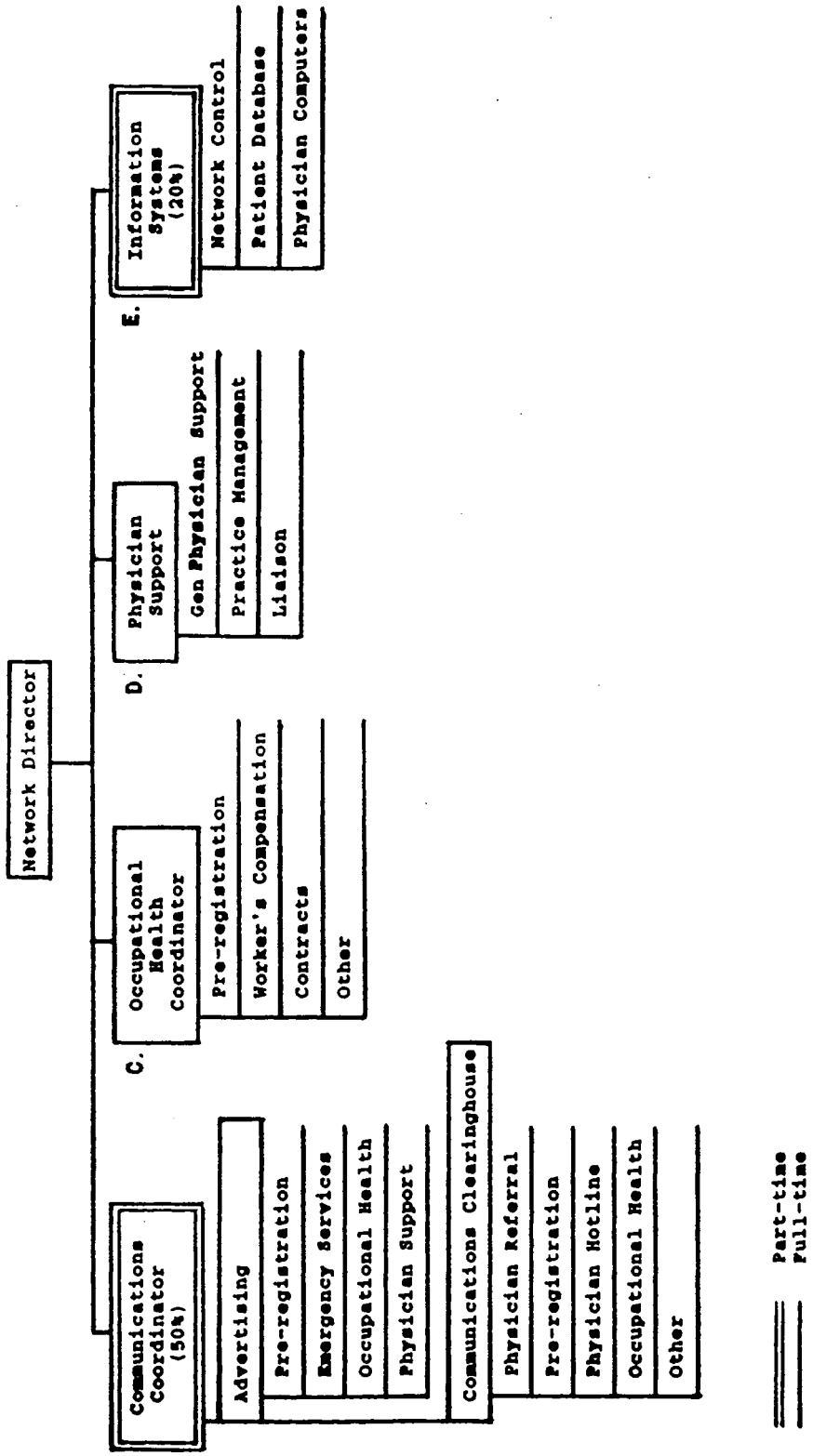


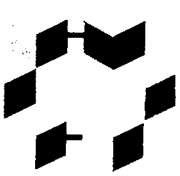
Exhibit 2


Network Director
B.
Communications Coordinator (50%)
Advertising
Pre-registration
Emergency Services
Occupational Health
Physician Support
C.
Occupational Health Coordinator
Pre-registration
Worker's Compensation
Contracts
Other
D.
Physician Support
Gen Physician Support
Practice Management
Liaison
E.
Information Systems (20%)
Network Control
Patient Database
Physician Computers
Communications Clearinghouse
Physician Referral
Pre-registration
Physician Hotline
Occupational Health
Other
Part-time
Full-time

NETWORK DIRECTOR

RESPONSIBILITIES

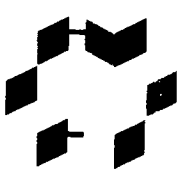
- Develop all Business/Action Plans with PMCI
- Execute Action Plan with PMCI
- Communicate all Program Activity to Board, Management, Physicians
- Negotiate Employer Contracts
- Negotiate and Maintain Benefit Package Contracts for:
  - Consumers
  - Physicians
  - Employees
- Supervise:
  - Occupational Health Coordinator
  - Physician Liaison Representative
  - Telemarketing Representative
  - Communications Coordinator
- Track ROI and Referral Activity
- Implement and Execute:
  - Physician Support Program
  - Occupational Health
  - Public Relations Program
  - Physician Referral Services
  - Emergency Services
  - BMC
  - Womens' Health
  - Other



COMMUNICATIONS COORDINATOR

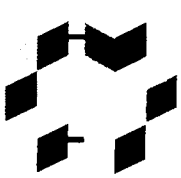
RESPONSIBILITIES (50%)

- Advertising/Public Relations for:
  - Occupational Health
  - Pre-Registration
  - Emergency Services
  - BMC
  - Physician Referral Services
  - Womens' Health
  - Other
- Pre-Registration Mail Fulfillment
- Guest Relations Training
  - Point of Entry
  - Physician Office Staff
- Physician Practice Promotion
- ADS Relations
- Major Employer Relations



PHYSICIAN SUPPORT LIAISON
RESPONSIBILITIES

- Hospital/Physician Communications
- Deliver Physician Benefit Package
- Physician Needs
- Practice Management Support
- Targeted Physician Visits
- Recruitment as Appropriate
- Staff Training Services
- Remote Outreach



OCCUPATIONAL HEALTH COORDINATOR

RESPONSIBILITIES

Program Development with PMCI
Sales Quota Activity
Case Management/Policies and Procedures
Patient Tracking and ROI
Employee and Employer Training
Execute Brokerage Programs
Good Neighbor Clinic Coordination
ER Coordination
Hospital Department Coordination
Physician Education

APPENDIX F

EXCERPTS FROM BUSINESS PLAN BOOK II

HILLCREST HEALTH CENTER

BUSINESS PLAN

BOOK II

(of III Books)

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I. MARKET ASSESSMENT

A. COMPETITIVE PROFILE

Hillcrest Health Center operates within a competitive environment that has the following general characteristics:

1. The Oklahoma City health care market is impacted by changing delivery patterns towards increased ambulatory and outpatient care. The national trends of decreasing inpatient care utilization rates along with increased bedding continue to apply significant pressure on Hillcrest to increase its competitive posture.

2. Hospital competition, declining admission rates, and declining length of stay places additional pressure to decrease HHC's occupancy.

3. In addition, to "macro-environmental" competitive forces, hospitals such as South Community, Baptist, Presbyterian, and St. Anthony's can be expected to continue extremely competitive postures.

4. Alternative delivery systems will continue to grow, putting additional pressure on HHC to minimize health care delivery costs.

5. Changing reimbursement patterns will continue to force physicians to provide services on an outpatient basis which used to be provided in an inpatient setting. Unless given options, physicians will increasingly be in direct competition with hospitals for ambulatory/

outpatient services as they try to further develop secure practices.

Acute Care Hospital Competitors

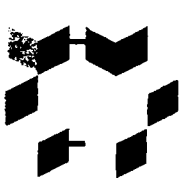
Hillcrest Health Center has several key competitors in its primary and secondary service areas. These hospitals include South Community Hospital, Baptist Medical Center, Presbyterian Hospital, and St. Anthony Hospital. See Exhibits 1 through 4 for hospital locations, facility assessments, and admission trends.

South Community Hospital

South Community Hospital is the only other hospital located in south Oklahoma City. This hospital is a 391 bed facility located east of Hillcrest Health Center. In 1986, this facility had admissions in excess of 11,000, a 30% decrease from their 1982 admissions. South Community Hospital offers several programs that are not found at Hillcrest. Some of these programs are Open Heart Surgery, Hemodialysis, and Cardiac Catheterization. Hillcrest, on the other hand has several programs that are not offered by South Community. These include Skilled Nursing, Psychiatric Services, and Inpatient/Outpatient Alcohol/Chemical Dependency.

Baptist Medical Center

Baptist Medical Center is located north of Hillcrest on the other side of the North Canadian River. This 577 bed hospital had admissions in 1986 of 20,000, a decrease of 6% from 1982. Baptist offers a very large cross-section of programs, many of which are not offered at Hillcrest. Some of these programs include Cardiac Intensive Care, Open Heart Surgery, Hemodialysis, Organ Transplant, Burn Care,



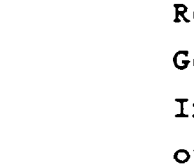
Inpatient/Outpatient Rehabilitation, Cardiac Catheterization, and Neonatal Intensive Care. Hillcrest, however, does provide services not covered by Baptist including a Trauma Center, Skilled Nursing, Home Care, and Inpatient/Outpatient Alcohol/Chemical Dependency.

St. Anthony Hospital

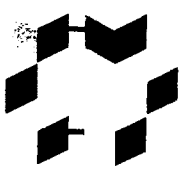
St. Anthony Hospital, which is also located northeast of Hillcrest, is a 684 bed facility. This hospital had admissions in excess of 16,000 in 1986, nearly a 15% decline from 1982 admissions. St. Anthony Hospital offers many programs not available at Hillcrest. Some of these programs include a Cardiac Intensive Care Unit, Open Heart Surgery, Organ Transplant, Hemodialysis, Outpatient Rehabilitation, Geriatric Services, and Cardiac Catheterization. Hillcrest does, however, offer several programs not available at St. Anthony, programs such as a Trauma Center, Skilled Nursing, Inpatient/Outpatient Psychiatric, Birthing Rooms, and Home Care.

Presbyterian Hospital

Presbyterian Hospital is located north of the river, just northeast of Hillcrest. This hospital is a 407 bed facility. Between 1982 and 1986, Presbyterian's admissions fell nearly 28%. Presbyterian Hospital also offers a full range of programs, some of which are not offered at Hillcrest. Some of these programs include Open Heart Surgery, Organ Transplant, Hemodialysis, Outpatient Rehabilitation, Recreational Therapy, Family Planning, Genetic Counseling, Cardiac Catheterization, and Neonatal Intensive Care. Hillcrest offers several programs not offered at Presbyterian, such as Skilled Nursing,



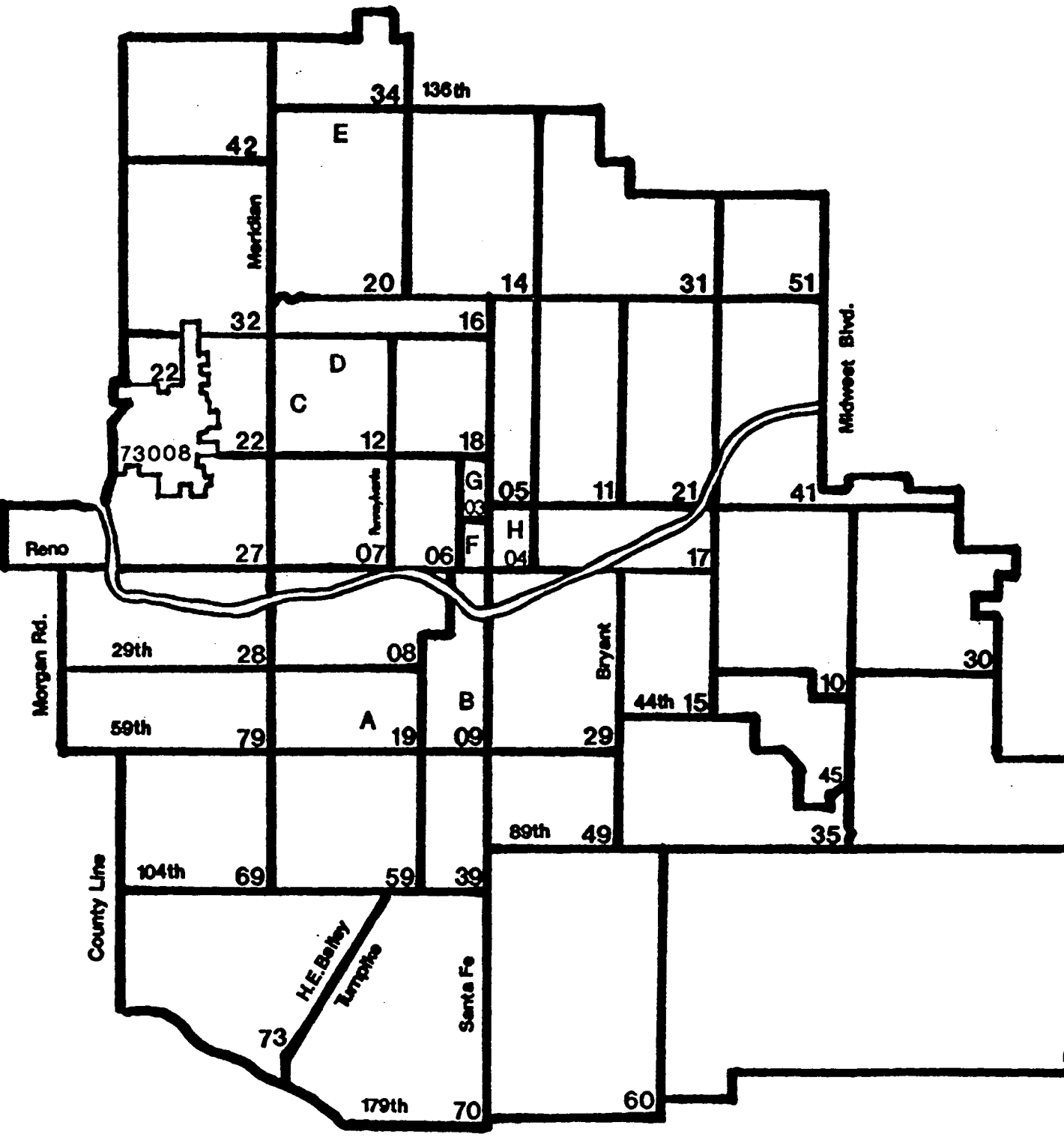
Psychiatric Services, and an Inpatient Alcohol/Chemical Dependency Unit.



OKLAHOMA CITY

Hospital Locations

Exhibit 1



A Hillcrest
B South Community
C Deaconess
D Baptist Medical

E Mercy Health
F Doctors General
St. Anthony
G B&J Hospital

H VA Medical
Presbyterian
Oklahoma Teaching

Zip Code = 731 + two digits shown on map

HILLCREST HEALTH CENTER
FACILITY INVENTORY

Exhibit 2

Facilities	Hillcrest	S. Community	Presbyterian	St. Anthonys	Baptist
Ambulatory Surgery	X	X	X	X	X
Intensive Care (Cardiac Only)				X	X
Intensive Care (Mixed)	X	X	X	X	X
Open Heart Surgery		X	X	X	X
Trauma Center	X	X	X		
Ultrasound	X	X	X	X	X
X-ray Radiation Therapy		X	X	X	X
Megavoltage Radiation Therapy		X	X	X	X
Radioactive Implants		X	X	X	X
Diagnostic Radioisotope	X	X	X	X	X
Therapeutic Radioisotope		X	X	X	X
Histopathology Laboratory	X	X	X	X	X
Organ Transplant			X	X	X
Blood Bank	X	X	X	X	X
Health Promotion	X	X	X	X	X
Respiratory Therapy	X	X	X	X	X
Burn Care					X
Skilled Nursing	X				
Hemodialysis		X	X	X	X
Physical Therapy	X	X	X	X	X
Occupational Therapy	X	X	X	X	X
Rehabilitation Inpatient		X			X
Rehabilitation Outpatient		X	X	X	X
Psychiatric Inpatient	X			X	X
Psychiatric Outpatient	X				X
Psychiatric Partial Hosp					X
Psychiatric Emergency Services	X			X	X
Psychiatric Consult/Ed	X			X	
Clinical Psychology Services	X	X	X	X	X
Organized Outpatient Depart		X	X	X	X
Emergency Department	X	X	X	X	X
Birthing Room	X	X	X		X
Obstetrics	X	X	X	X	
Home Care Program	X		X		
Recreational Therapy			X	X	
Day Hospital	X		X	X	
Speech Pathology	X	X		X	X
Hospital Auziliary		X	X	X	X
Volunteer Services	X	X	X	X	X
Patient Representative	X		X	X	X
Alcohol/Chem Depend Inpatient	X			X	
Alcohol/Chem Depend Outpatient	X		X	X	
Geriatric Services				X	
Pediatric Inpatient	X	X	X	X	
CT Scanner	X	X	X	X	X
Cardiac Catheterization		X	X	X	X
Family Planning			X		X
Genetic Counseling			X		
Neonatal ICU			X		X

Source: AHA Hospital Guide, 1987.

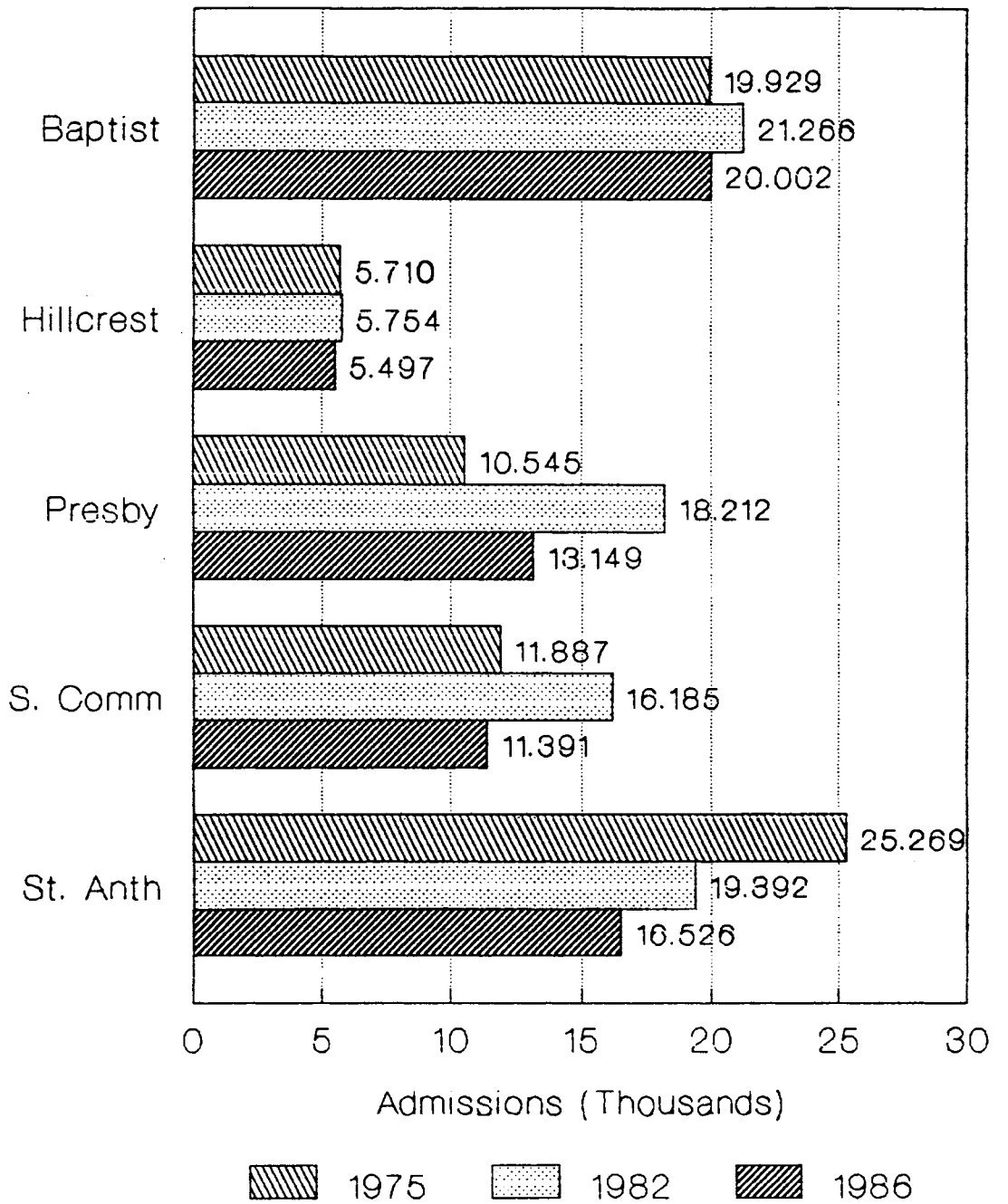
Exhibit 3

TLLCREST HEALTH CENTER
COMPETING HOSPITAL PROFILE

Hospital	1986 Licensed Beds	1975 Admissions	1982 Admissions	1983 Admissions	1984 Admissions	1985 Admissions	1986 Admissions
Baptist Medical Center of OK	577	19,929	21,266	21,957	21,785	20,558	20,002
Hillcreast Health Center	186	5,710	5,754	5,561	5,387	5,339	5,497
Presbyterian Hospital	407	10,545	18,212	18,249	16,919	14,592	13,149
South Community Hospital	391	11,887	16,185	15,362	13,432	11,659	11,391
St. Anthony Hospital	684	25,269	19,392	18,886	19,685	17,802	16,526

Source: Acute Care Hospitals Report, 1975, 1982 - 1986.

HILLCREST HEALTH CENTER
COMPETING HOSPITAL PROFILE



Source: Acute Care Hospitals Report.

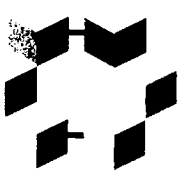
B. INTERNAL ANALYSIS

Major Services

Hospital services in this marketing plan will be analyzed according to admitting physician specialty. The purpose of this approach is to analyze services according to admission patterns, so these admission patterns can be controlled on a proactive basis. While it is understood that many admitting physicians ultimately refer the patient in the form of a consult to other medical specialty physicians, this represents the most consistent approach to physician referral tracking possible given HHC's current information system. In addition to inpatient admission patterns, PMCI also conducted analyses of outpatient procedures surgical procedures, and inpatient/outpatient revenues by specialty.

Inpatient Services

Based upon an analysis of Hillcrest's admissions by physician specialty for July 1986 - June 1987, General Practice was responsible for the largest percentage of specialty admissions, representing nearly 50%. General Practice admissions in Fiscal Year 1987 totalled 2,812, a 1.4% increase from Fiscal Year 1986. The specialty responsible for the second largest percentage of admissions was Internal Medicine with 11%. Internal Medicine admissions for 1987 decreased just slightly from Fiscal Year 1986 by around 1%. Other specialties responsible for significant percentages of 1987 admissions included Orthopedic Surgery at 9%, BMC/Mental Health with nearly 8%, Pediatrics with 7%, and Ob/Gyn with almost 6%. While Pediatrics and BMC/Mental Health represented increased admissions from the previous year, Orthopedic Surgery and Ob/Gyn both experienced decreased admissions. The four primary care specialties (General Practice,



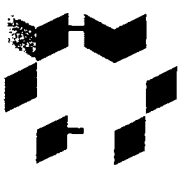
Internal Medicine, Pediatrics and Ob/Gyn) represented nearly 73% of all 1987 Fiscal Year specialty admissions, an increase of only 1% from 1986. (See Exhibits 1 through 4).

Outpatient Procedures

Outpatient procedure data was obtained from Hillcrest Osteopathic Hospital Doctor Analysis Report, Fiscal Year July 1985 - June 1986. Emergency Medicine outpatient procedures were excluded to reflect specialty procedure trends. General Practice was responsible for the greatest number of outpatient procedures in Fiscal Year 1986 with 4,470, or nearly 53% of all procedures. Orthopedic Surgery, with 1,333 procedures, represented almost 16% of total 1986 procedures. Internal Medicine outpatient procedures were responsible for nearly 7% of outpatient procedures, while Gastroenterology and Ob/Gyn, with 377 and 314 procedures respectively, represented around 4% of total outpatient procedures each. All primary care specialties combined were responsible for almost 65% of all outpatient procedures at Hillcrest Health Center in Fiscal Year 1986. (See Exhibit 5).

Surgical Procedures

Surgical Procedures were obtained for Hillcrest Health Center by physician specialty for Fiscal Years 1986 and 1987. Nearly 33% of all surgeries performed at Hillcrest during Fiscal Year 1987 were performed by General Practice. This represented a decrease of nearly 16% from the previous year. Orthopedic Surgery, accounting for almost 24% of 1987 surgical procedures, declined by 26% from 1986. The largest growth in procedures between 1986 and 1987 was found in General Surgery, with a 24% increase. General Surgery accounted for 10% of surgical procedures in 1986 and nearly 16% of all surgical procedures in 1987. The most



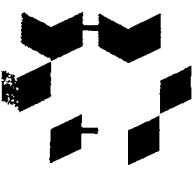
substantial decline in surgical procedures between 1986 and 1987 occurred in Gastroenterology, going from 158 procedures in 1986 to 42 procedures in 1987, a decrease of over 73%. Overall, surgical procedures declined nearly 18% between 1986 and 1987. (See Exhibits 6 through 8).

Revenues

A profile of revenues generated by physician specialty for inpatient/outpatient procedures was prepared based upon Hillcrest Health Center Doctor Analysis Report by Specialty for Fiscal Years 1986 and 1987 (July - June). General Practice was responsible for nearly $11.9 million in revenue for Fiscal Year 1987, representing over 44% of total specialty revenues. Over 12% of specialty revenues came from BMC/Mental Health, with over $3.2 million, while Internal Medicine, with nearly $3.2 in revenues, represented almost 12% of all specialty revenue. The four primary care specialties combined accounted for 61%, or over $16 million of the nearly $27 million of revenue generated by all specialties. Other specialties responsible for substantial revenues included Orthopedic Surgery with 8%, Emergency Medicine responsible for nearly 5%, General Surgery representing 4.5%, and Gastroenterology and Ob/Gyn with around 3% each of total specialty revenues. Overall, specialty revenues increased by 1% between Fiscal Year 1986 and 1987. (See Exhibits 9 and 10).

Inpatient Origin

Oklahoma City accounted for almost 70% of all Hillcrest's admissions based on a sample of 826 discharges from 1987. The areas within Oklahoma City with high patient origin were predominately found in the southern portion of the city. It is interesting to note that over 60% of Hillcrest's patients come from those zip codes south of the North Canadian River. Those



areas with the highest inpatient origin include zip codes 73129 and 73119 with around 10% each. (See Exhibits 11 and 12).

Inpatient Market Share

Market share by zip code was estimated by calculating the county utilization rate, using 1987 population and 1986 hospital admissions. An inpatient utilization rate of 153 admissions per thousand population was derived. In order to determine Hillcrest Health Center's market share, PMCI annualized the inpatient discharge sample used in the inpatient origin analysis. Hillcrest captures its largest market share in those areas south of the North Canadian River. Those areas where Hillcrest has high market share include zip code 73108 with nearly 14% and zip code 73129 with over 13%. (See Exhibits 13 and 14).

ER Patient Origin

PMCI sampled 1,000 ER patient discharges from 1987 in order to determine Hillcrest Health Center's ER patient origin. Nearly 67% of Hillcrest Health Center's ER patient origin comes from those areas south of the North Canadian River. Only 8% of Hillcrest's ER patients come from those areas north of the river. The remaining 25% come from areas outside of Oklahoma City. Those areas directly surrounding the hospital have the highest ER patient origin. Over 50% of ER patient origin come from zip codes 73108, 73119, 73159, 73139, 73109, and 73129 in south Oklahoma City. Over 11%, or 113 of the sampled ER patients from 1987 were admitted to the hospital. Around 58% of those admitted ER patients came from areas south of the North Canadian River. Zip code 73119, where Hillcrest is located, was responsible for over 12% of ER admissions. Nearly 5% of the ER patient admissions came from those areas north of the North Canadian

River, with over 37% of the ER patients admitted coming from outside Oklahoma City. (See Exhibits 15 through 18).

Inpatient Payor Profile

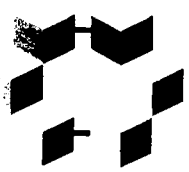
Payor information was obtained from a sample of 826 inpatient admissions for Hillcrest in 1987. During this time period, nearly 41% of HHC's inpatient admissions were Commercial patients. Medicare patients were responsible for the second largest percent of admissions with almost 25%. Medicaid was responsible for nearly 21%, with the remaining 14% of inpatient discharges from Self, HMO/PPO, Workers' Comp, Blue Cross, and Welfare. (See Exhibits 19 and 20).

Emergency Room Payor Profile

Emergency Room payor information was taken from the sample of 1,000 ER visits in 1987. Commercial patients were responsible for 35% of all ER visits, with Self Pay representing 33% of patients. Blue Cross patients were responsible for nearly 10%, Medicare patients represented nearly 7%, and Welfare patient accounted for over 6% of ER visits. Workers' Comp and Hillcrest Health Center represented 5.5% and 3.5% of ER patient visits respectively. Of the 113 ER visits admitted in the sample, over 27% were Medicare patients. Commercial patients represented the second largest group, responsible for nearly 25% of ER admissions, followed by Self Pay with 22%. Blue Cross patients were responsible for 15% of the ER admissions, with the remaining 11% going to Welfare, Workers' Comp, and Hillcrest Health Center. (See Exhibits 21 through 24).

Inpatient Employer Analysis

Admissions by employer were also obtained from the 1987 sample data. Nearly 43% of the sample were listed as being Unemployed,



having No Employer, or Unknown. Around 8% of those sampled were Retired, nearly 2% were Self Employed, and nearly 1% were Disabled. Those employers responsible for the most discharges were General Motors with 4%, Tinker Air Force Base with 3.5%, and Hillcrest Health Center with nearly 3%. (See Exhibits 25 -26).

Emergency Room Employer Analysis

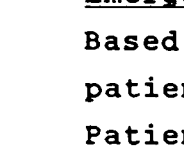
Emergency Room visits by employer were obtained from the 1,000 ER visit sample for 1987. Of those sampled, 471 or 47% were listed as having No Employer, Unemployed, or Unknown. Those employers responsible for the largest number of ER visits were Hillcrest Health Center with nearly 5%, Self Employed with over 3%, General Motors with 2.5%, Tinker Air Force Base with nearly 2%, and AT & T and FAA with 1% each. Of the 113 ER visits admitted, 61% were listed as having No employer, Unemployed, or Unknown. General Motors was responsible for the largest number of ER admissions with 3.5%, followed by Self Employed with nearly 3% and US Post Office with nearly 2%. (See Exhibits 27 through 29).

Inpatient Age Analysis

The 1987 inpatient discharge sample data was also analyzed by age cohort. Those patients between the ages of 0 and 17 were responsible for 16% of inpatient admissions. The largest number of admissions belonged to those patients between the ages of 18 and 45 with 43%. Patients age 46 to 64 represented 17%, with those aged 65 and older responsible for nearly 23%. (See Exhibits 30 and 31).

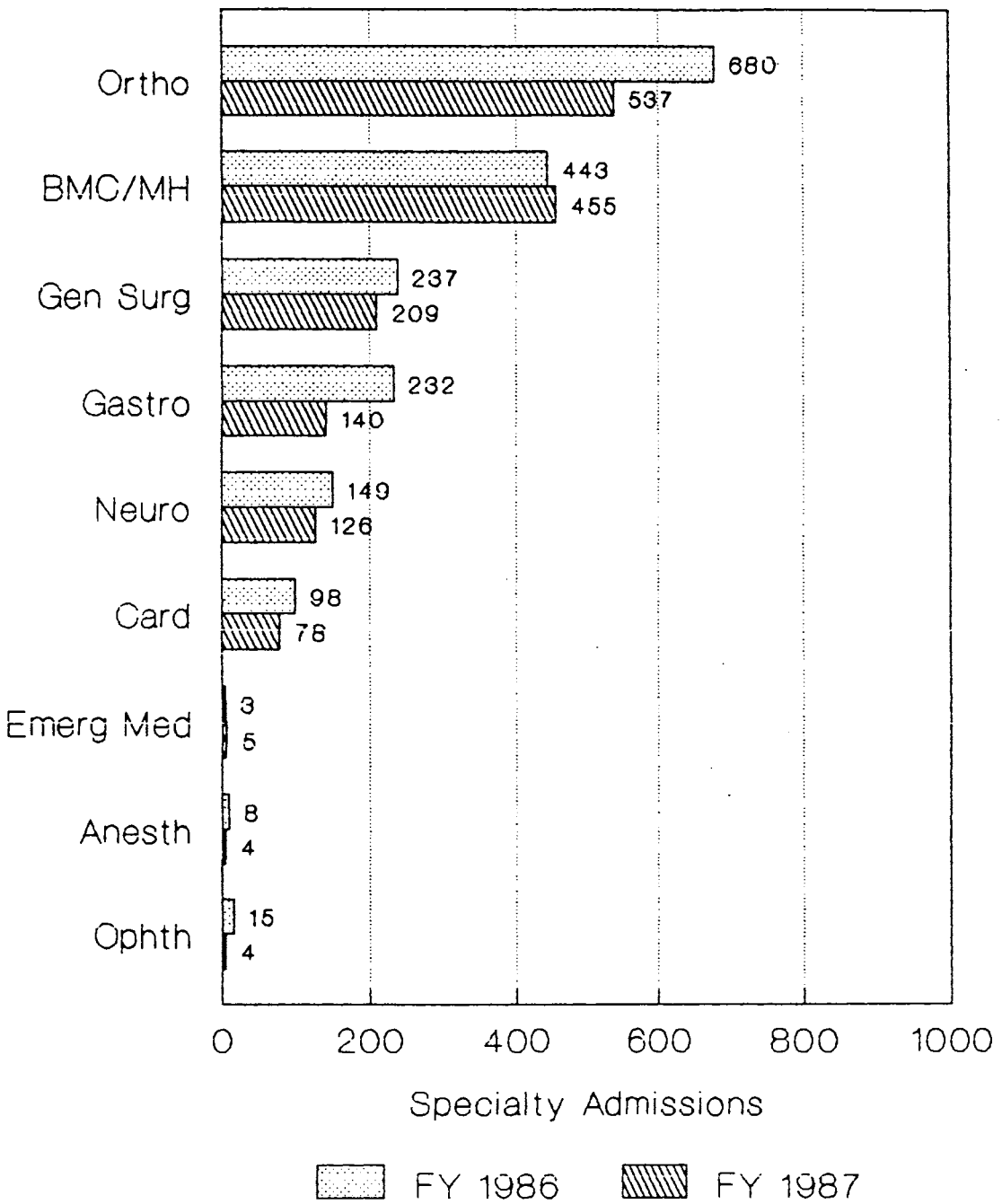
Emergency Room Age Analysis

Based on the 1,000 sampled ER visits, nearly 51% of all ER patients at Hillcrest are between the ages of 18 and 45. Patients under age 18 represented almost 32%, while those over



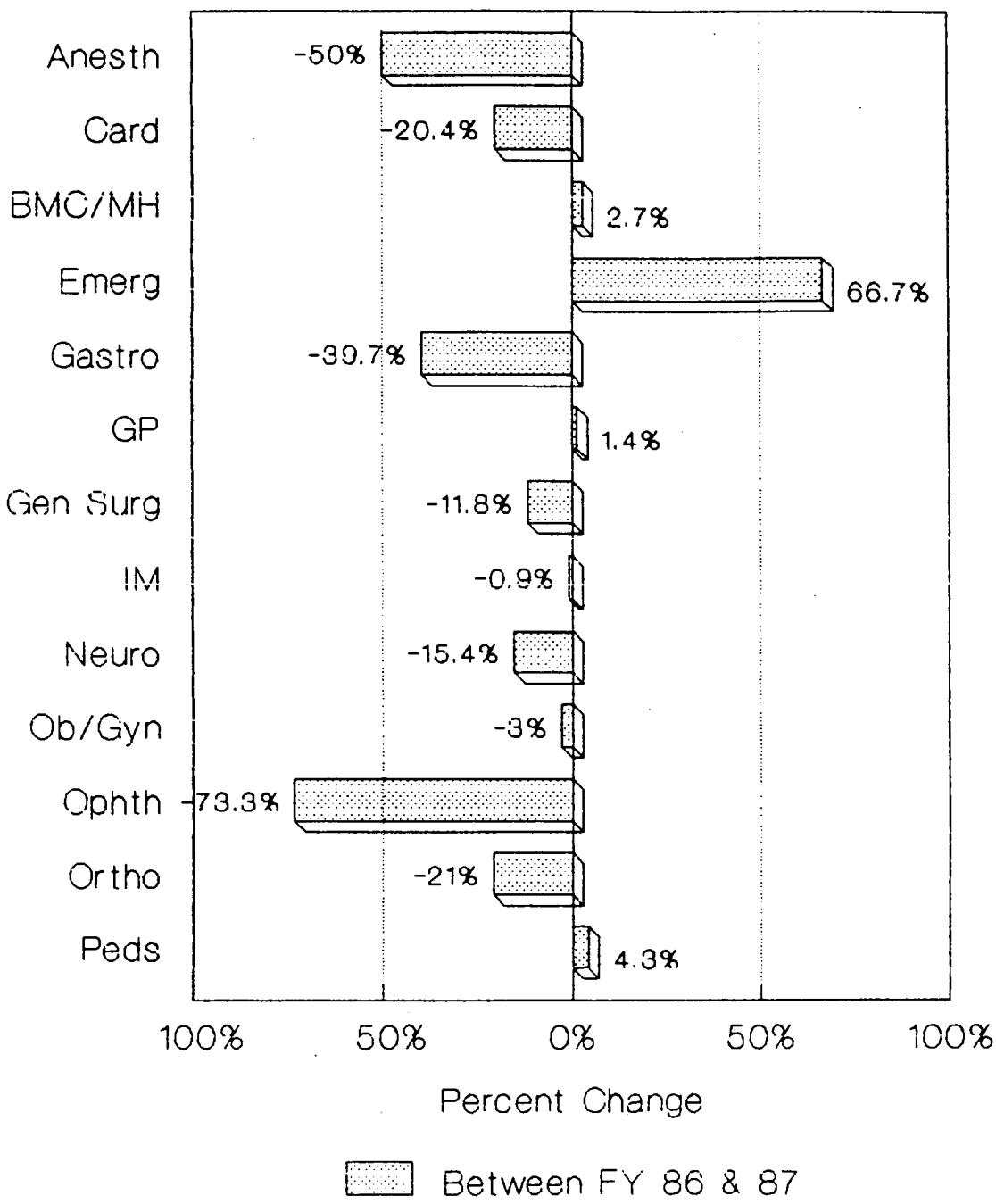
the age of 45 were responsible for 17%. While 17% of ER patient visits are age 45 and older, over 44% of those ER patients admitted fall into this age category. Patients between the ages of 18 and 45 represented nearly 42% of ER patient admissions, while patients under age 18 were responsible for 14%. (See Exhibits 32 through 35).

HILLCREST HEALTH CENTER
HOSPITAL ADMISSIONS



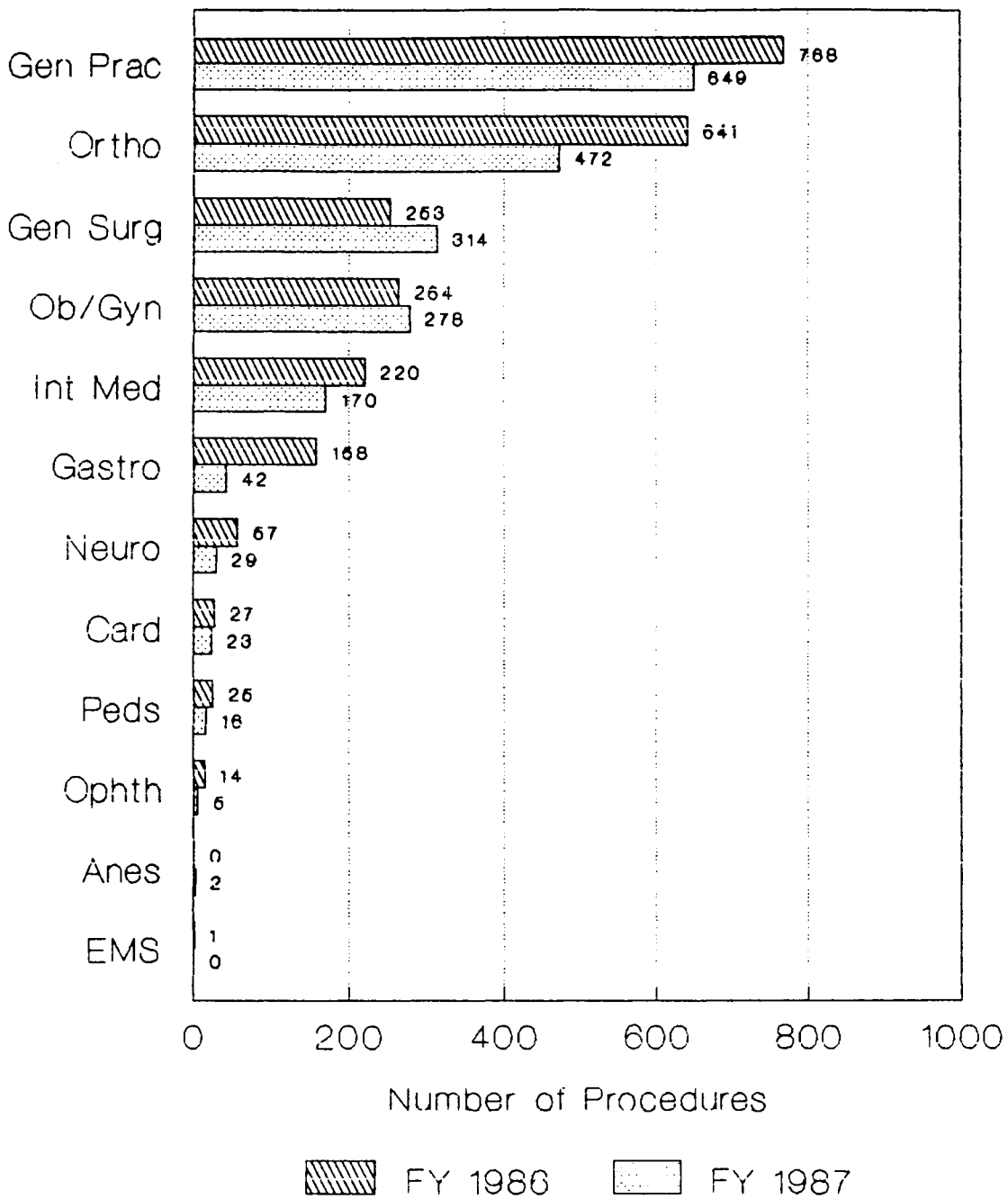
Source: Medical Records, Fiscal Years.

HILLCREST HEALTH CENTER
CHANGE IN ADMISSIONS



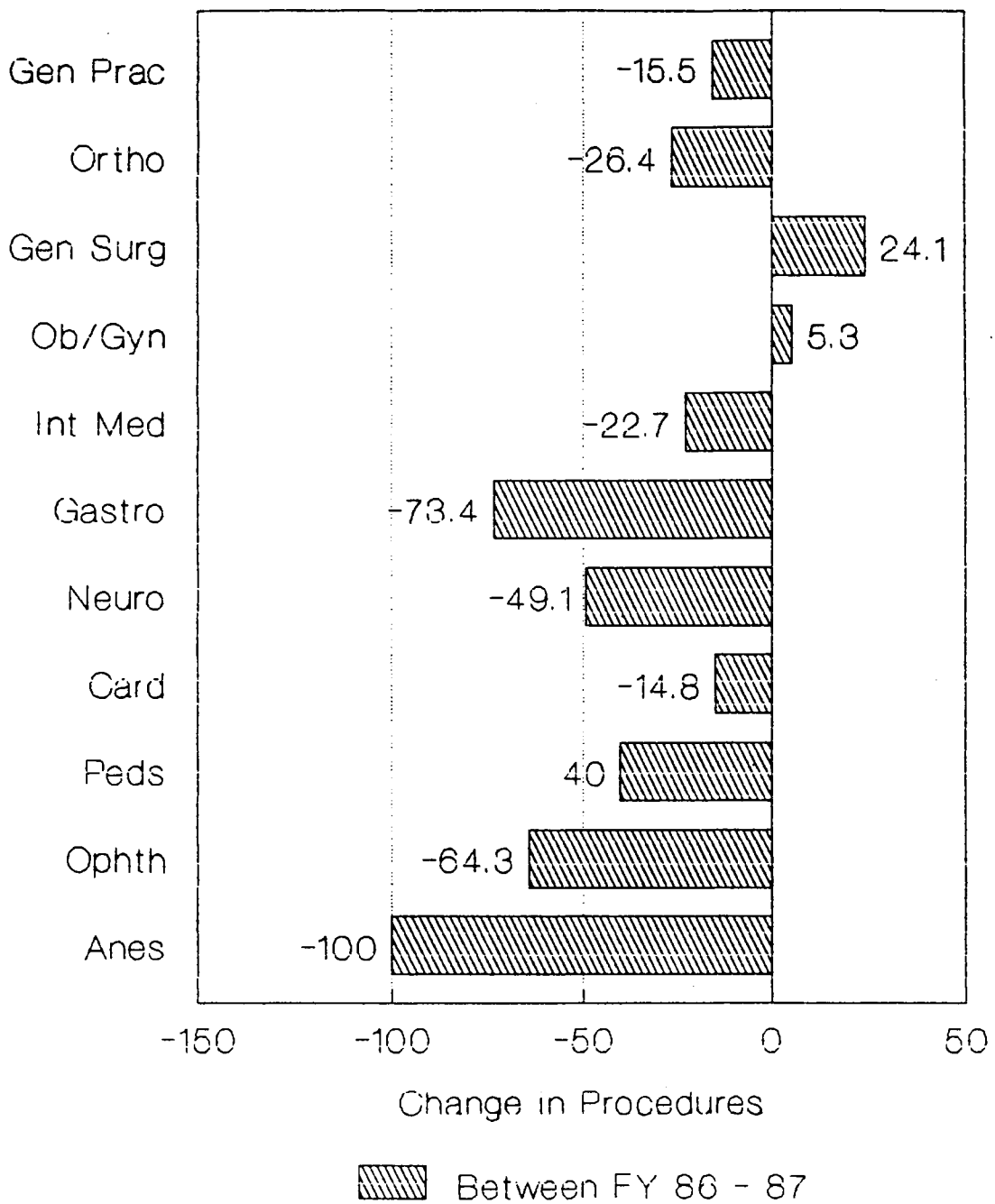
Source: Medical Records, Fiscal Years.

HILLCREST HEALTH CENTER
TOTAL SURGICAL PROCEDURES



Source: HHC Records, Fiscal Years

HILLCREST HEALTH CENTER
TOTAL SURGICAL PROCEDURES

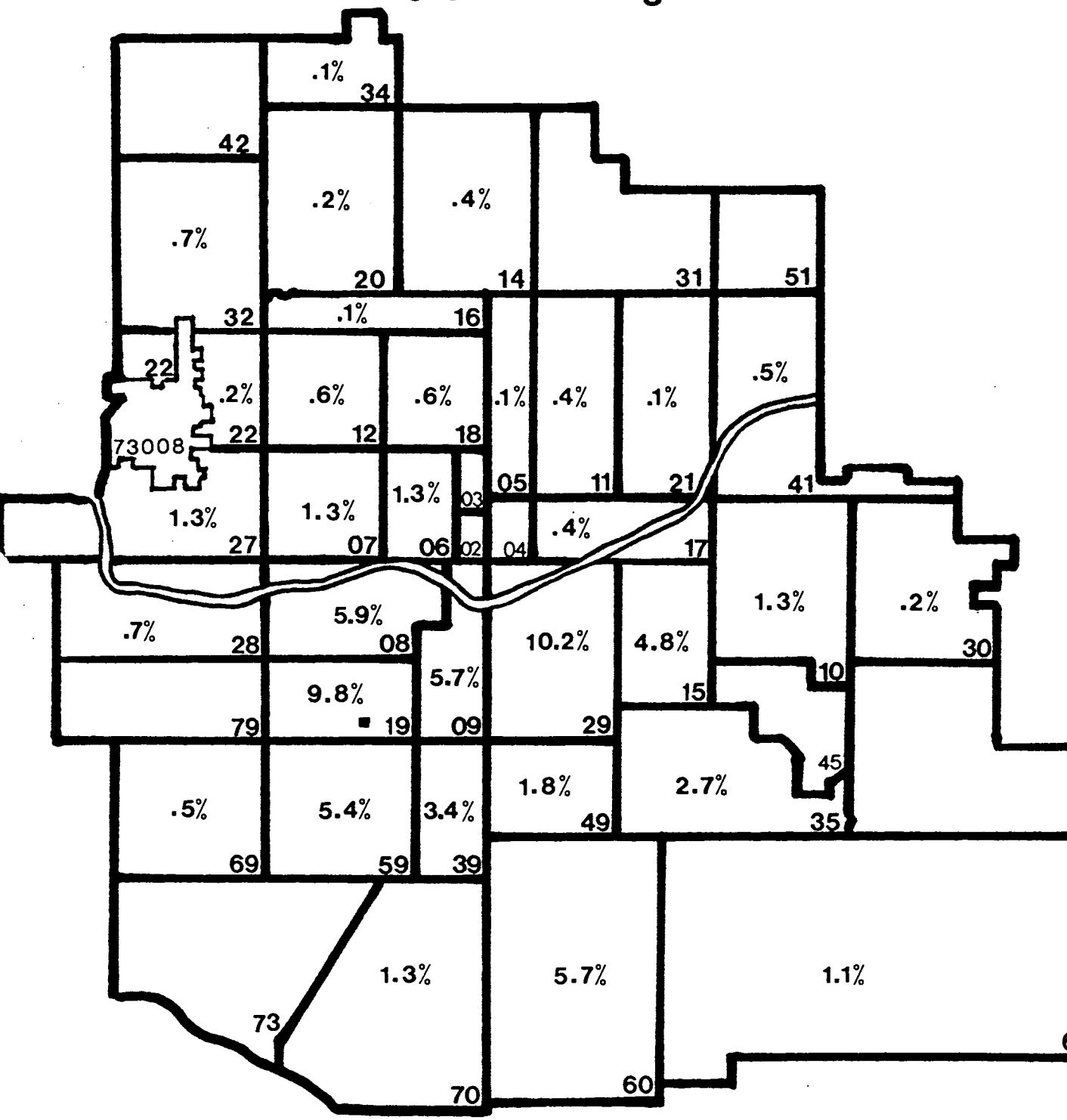


Source: HHC Records, Fiscal Years

OKLAHOMA CITY

Exhibit 12

1987 Inpatient Origin
% of Discharges



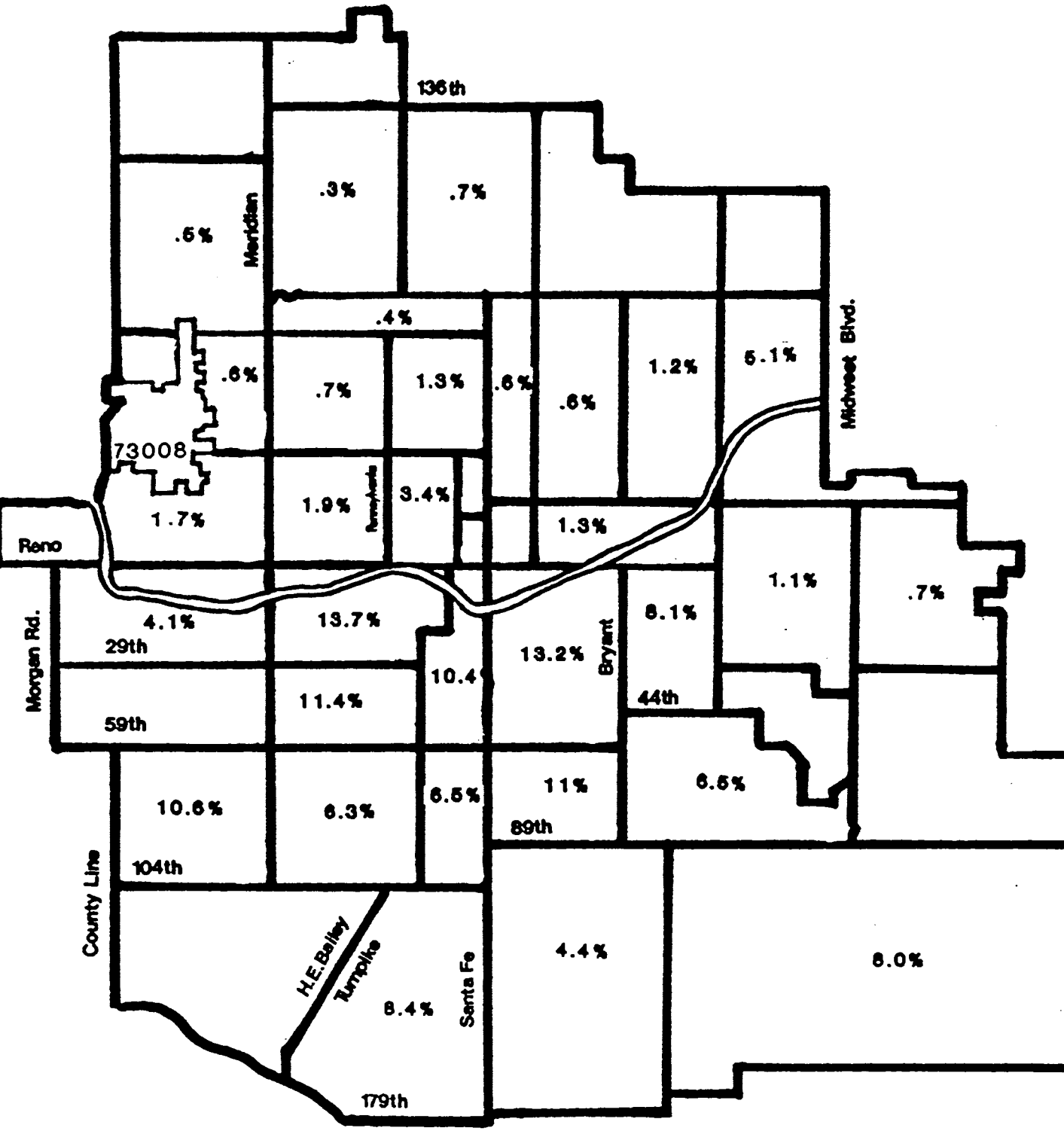
Ip Code = 731 + two digits shown on map

ource: Hospital Records

OKLAHOMA CITY

Exhibit 14

1987 Inpatient Market Share

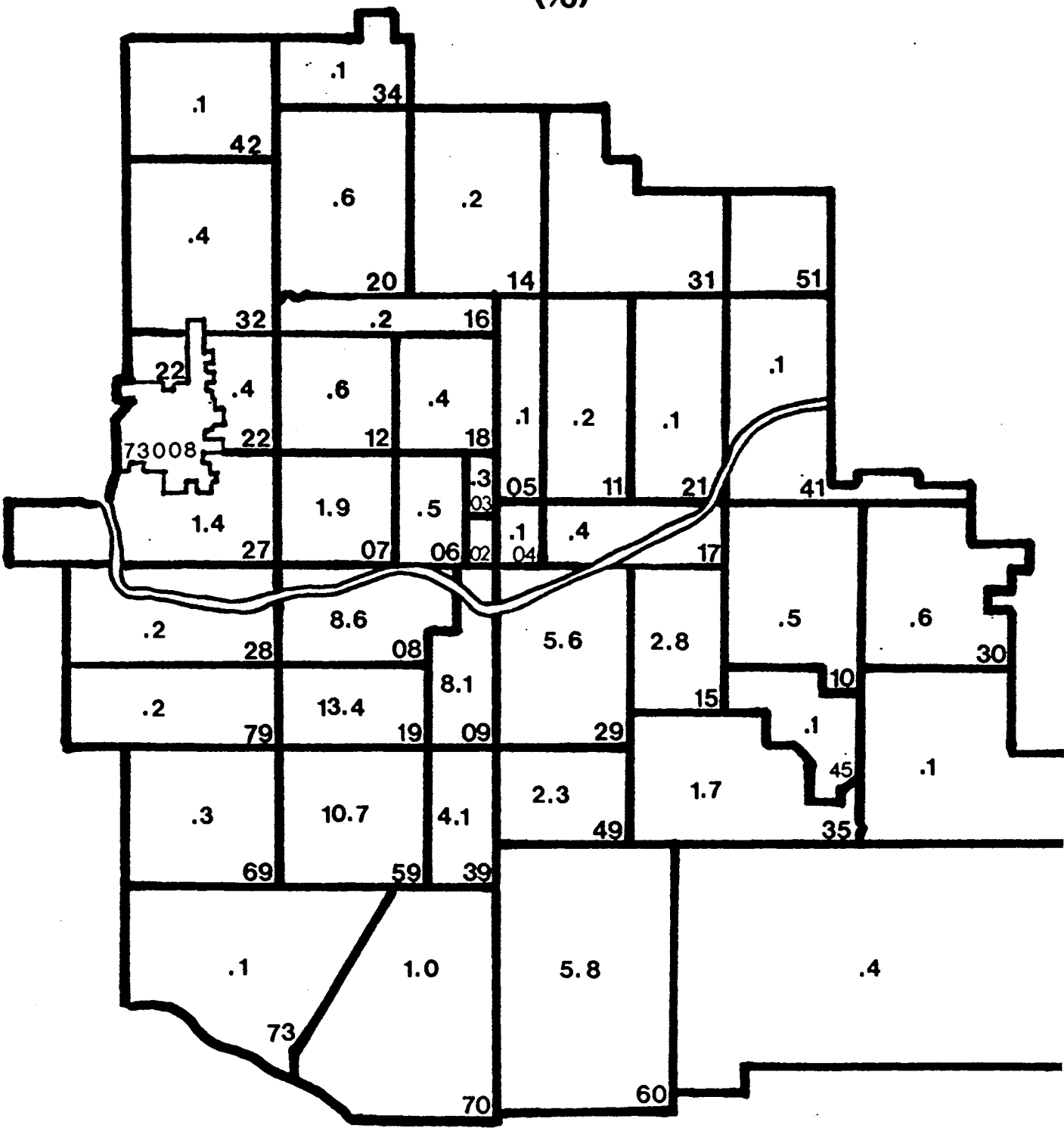


Source: PMCI Computations.

OKLAHOMA CITY

Exhibit 16

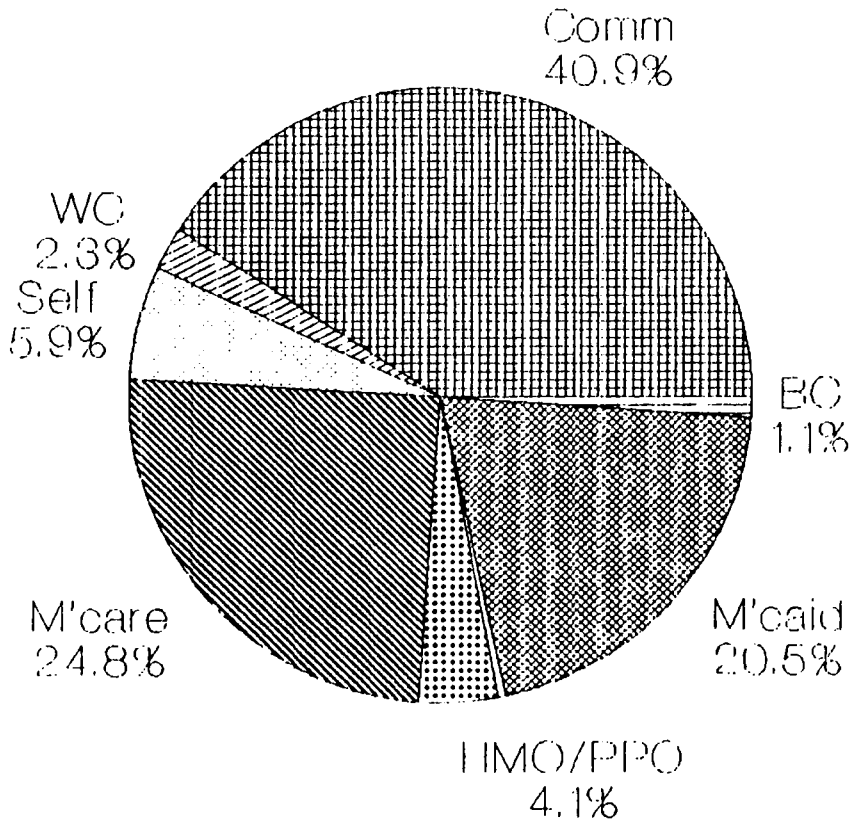
1987 ER Patient Origin
(%)



Zip Code = 731 + two digits shown on map

Source: Hospital Records

HILLCREST HEALTH CENTER
DISCHARGE ANALYSIS BY PAYOR



Source: Hospital Records, 1987.

Exhibit 20

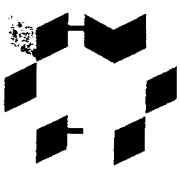
C. EXTERNAL ANALYSIS

Utilization Review

Hospital utilization reports were reviewed for Hillcrest Health Center and its closet competitors, South Community Hospital, Baptist Medical Center, Presbyterian Hospital, and St. Anthony Hospital for 1983 - 1986. Information regarding Hillcrest's surgical utilization was reviewed for Fiscal Years 1985 through 1987, as well as emergency room utilization for Calendar Years 1983 through 1987 (annualized). The following summarizes these trends.

Admissions

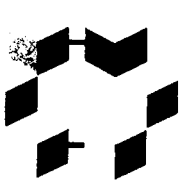
Between 1983 and 1986, Hillcrest experienced a drop of approximately 64 admissions, only 1%. Between 1985 and 1986, Hillcrest actually saw an increase in admissions of nearly 3%. During the same four year span, the other hospitals in Hillcrest's service area saw greater declines in admissions. Presbyterian experienced a loss of 30% in admissions between 1983 and 1986, the greatest of which occurred between 1984 and 1985 with a loss of 2,327 admissions. South Community's admissions fell drastically between 1983 and 1986, by nearly 4,000, a loss of nearly 26%. Like Presbyterian, South Community experienced its greatest decline between 1984 and 1985 with a loss of 13%. Baptist with the greatest admissions, experienced nearly a 9% decline between 1983 and 1986. Baptist admissions went from 21,957 in 1983 to 20,002 in 1986. St. Anthony experienced a 12% decline in admissions between 1983 and 1986, going from 18,886 to 16,526. Between 1983 and 1984, while most hospitals experienced declining admissions, St.



Anthony's admissions actually increased by 4%. But by 1986, its admissions proceeded to fall 16%. (See Exhibit 1).

Patient Days

While Hillcrest's admissions decreased between 1983 and 1986, its patient days increased by over 8%. Between 1983 and 1985, Hillcrest's patient days fell nearly 7%, but increased by over 16% between 1985 and 1986. South Community had patient days in excess of 95,000 in 1983, but by 1986 the hospital's patient days had dropped to around 77,000, a loss of nearly 18,000 days, or 19%. South Community decreased by nearly 23,000 patient days between 1983 and 1985, but increased in patient days by 7% between 1985 and 1986. Baptist with the highest number of patient days in 1983, went from 162,716 days to 138,891 days in 1986, a loss of over 23,800 days. Between 1983 and 1985, Baptist's patient days declined by over 13%, but between 1985 and 1986 these days fell only 1.5%. St. Anthony had patient days just over 150,000 in 1983, by 1985 its patient days dropped by 11,000, a loss of over 7%. Between 1985 and 1986, however, St. Anthony's patient days increased by over 1%. Presbyterian experienced by far the greatest decline of these hospitals, going from 125,398 patient days in 1983 to 82,851 patient days in 1985, a loss of over 42,500 patient days or 34%. The greatest portion of this decline occurred between 1984 and 1985 with a 23% loss. while experiencing large decreases between 1983 and 1985, Presbyterian experienced only a 2% decline between 1985 and 1986. (See Exhibit 2).

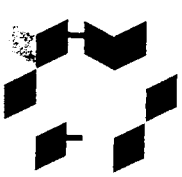


Average Daily Census

Hillcrest is the only one of the five hospitals to experience an increase in average daily census between 1983 and 1986. Hillcrest's ADC increased by over 8%, going from 93.7 to 101.4. Between 1983 and 1985, however, Hillcrest experienced a 7% decline in ADC, but increased by over 16% between 1985 and 1986. Between 1983 and 1986, South Community saw nearly a 19% decline in its ADC. South Community's ADC actually dropped nearly 24% between 1983 and 1985, before rebounding 7% in 1986. Baptist had the highest ADC in 1983 with 445.8, this fell to 380.5 by 1986, nearly a 15% decline. St. Anthony's ADC decreased 6% between 1983 and 1986. Like Hillcrest and South Community, St. Anthony's ADC declined between 1985 before rising in 1986. It experienced a 7% decline between 1983 and 1985, with a 1% increase in 1986. Presbyterian also experienced a great decline in ADC, going from 343.6 in 1983 to 227 in 1986, a loss of nearly 34%. (See Exhibit 3).

Average Length of Stay

Hillcrest's ALOS has fluctuated between 1983 and 1986, and has increased nearly 10% since 1983, to an ALOS of 6.7. South Community's 1986 ALOS was 6.8, a gain of nearly 10% from 1983's ALOS of 6.2. Baptist's ALOS went from 7.4 in 1983 to 6.9 in 1986, a decline of nearly 7%. St. Anthony has the highest ALOS of the five hospitals. Its ALOS increased by over 7% between 1983 and 1986, going from 7.9 to 8.5. Presbyterian's ALOS fell nearly 9% between 1983 and 1986, but increased by nearly 9% between 1985 and 1986. (See Exhibit 4).



Occupancy

Hillcrest's occupancy level fell nearly 14% between 1983 and 1986, going from 63.3% to 54.5%. Hillcrest did experience a very slight increase in occupancy from 1983 and 1984, but then started on a downward trend. South Community's occupancy level, while going from 67% in 1983 to 54.5% in 1986, actually increased 7% between 1985 and 1986. Baptist's occupancy declined by over 13% between 1983 and 1986. Its occupancy went from a high of 76.2% in 1983 to a low of 65.9% in 1986. The occupancy level at St. Anthony fell the least between 1983 and 1986, going from 60.1% to 56.4%, a decrease of only 6%. St. Anthony's occupancy fell 7% between 1983 and 1985, before increasing 1% between 1985 and 1986. Presbyterian had the highest 1983 occupancy level of the five hospitals at 77.2%. By 1986 this rate fell to 55.8%, a decline of nearly 28%. (See Exhibit 5).

Births

Births at Hillcrest increased 4% between 1984 and 1986, going from 449 to 468. Hillcrest experienced nearly an 8% decline between 1984 and 1985, before gaining nearly 13% by 1986. South Community's births went up 3% between 1984 and 1986. It experienced a slight decline between 1984 and 1986, before gaining 4% by 1986. Births at St. Anthony's fluctuated greatly between 1984 and 1986, going from a low of 617 in 1984 to a high of 990 in 1985, a gain of 60%. Between 1985 and 1986, however, St. Anthony's births fell by nearly 26%. Its births in 1986 were still 19% higher than births in 1984. Baptist also experienced some fluctuation in birth volume between 1984 and 1986, going from 1,762

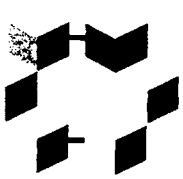
births in 1985 to 1,849 births in 1985, and 1,748 births in 1986. Births were 7% higher in 1986 than in 1984. (See Exhibit 6).

Surgical Procedures

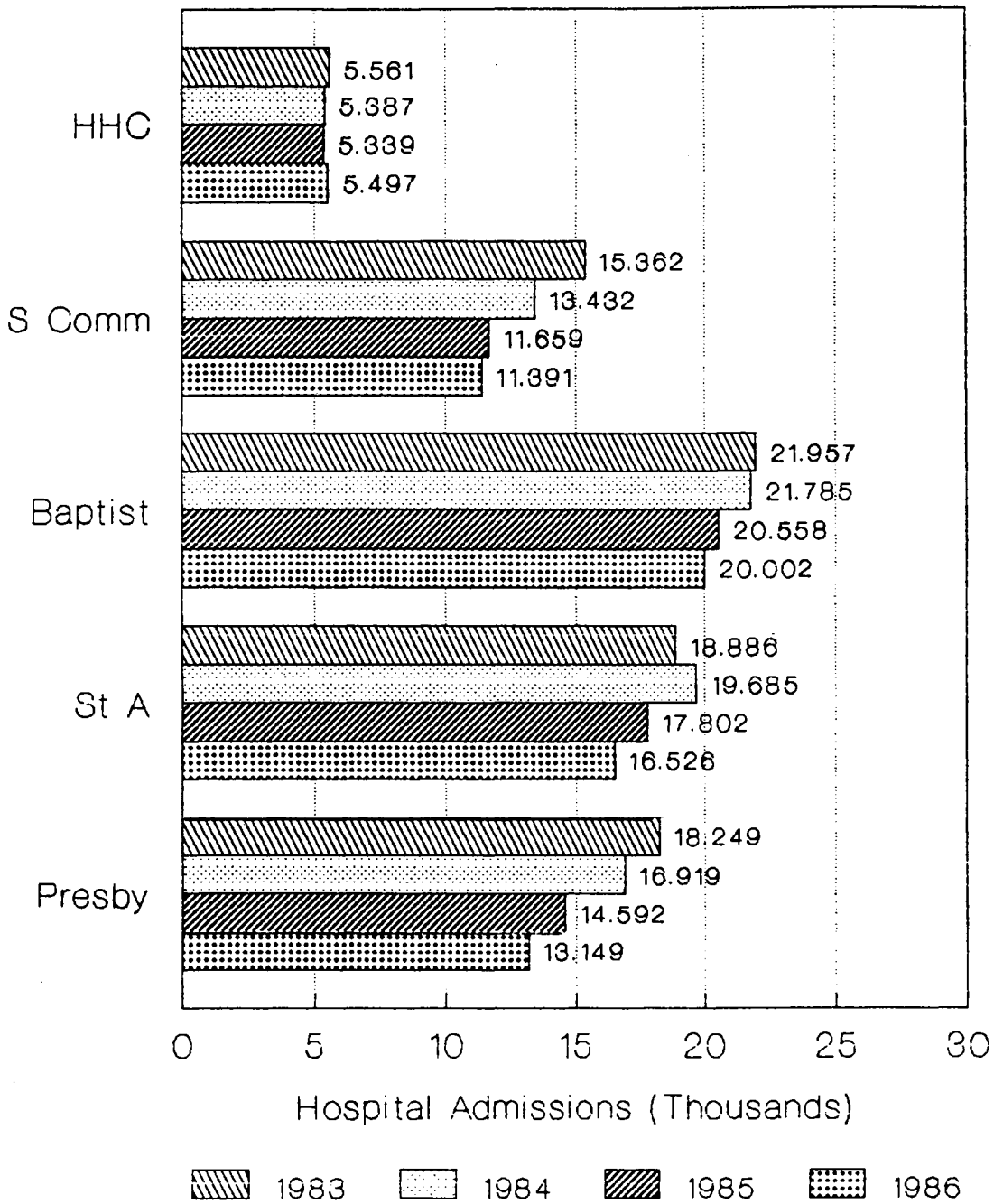
Total surgical procedures at Hillcrest were up nearly 3% in Fiscal Year 1987 from 1985. This, however, did represent a 5% decline from 1986 surgical procedures of 3,058. While inpatient surgical procedures declined 24% since 1985, outpatient procedures rose 81%, going from 722 in 1985 to 1,308 in 1987. (See Exhibit 7).

Emergency Room

Emergency room visits for Hillcrest in 1987 (annualized) are projected at 11,270, an increase of 31% from 1983. This 1987 figure represents a 1% decline in visits from 1986. The percent of emergency room visits admitted at Hillcrest has stayed constant since 1984 at 15%. The percent of ER visits admitted as a percentage of total hospital admissions has risen from 26% in 1983 to 33% in 1987. (See Exhibits 8 and 9).

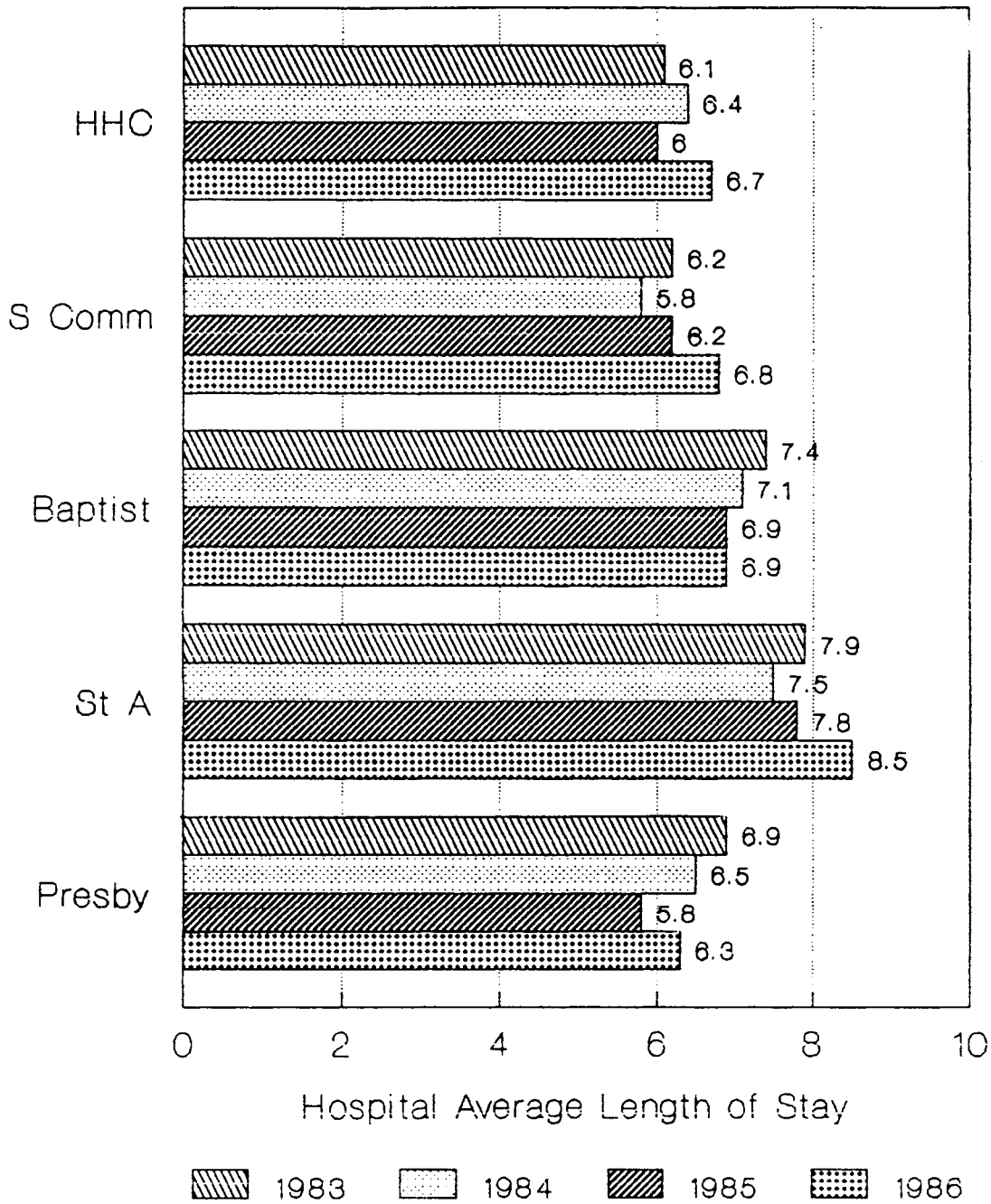


HILLCREST HEALTH CENTER
COMPETING HOSPITAL UTILIZATION



Acute Care Hospital Report, 1982 - 1986.

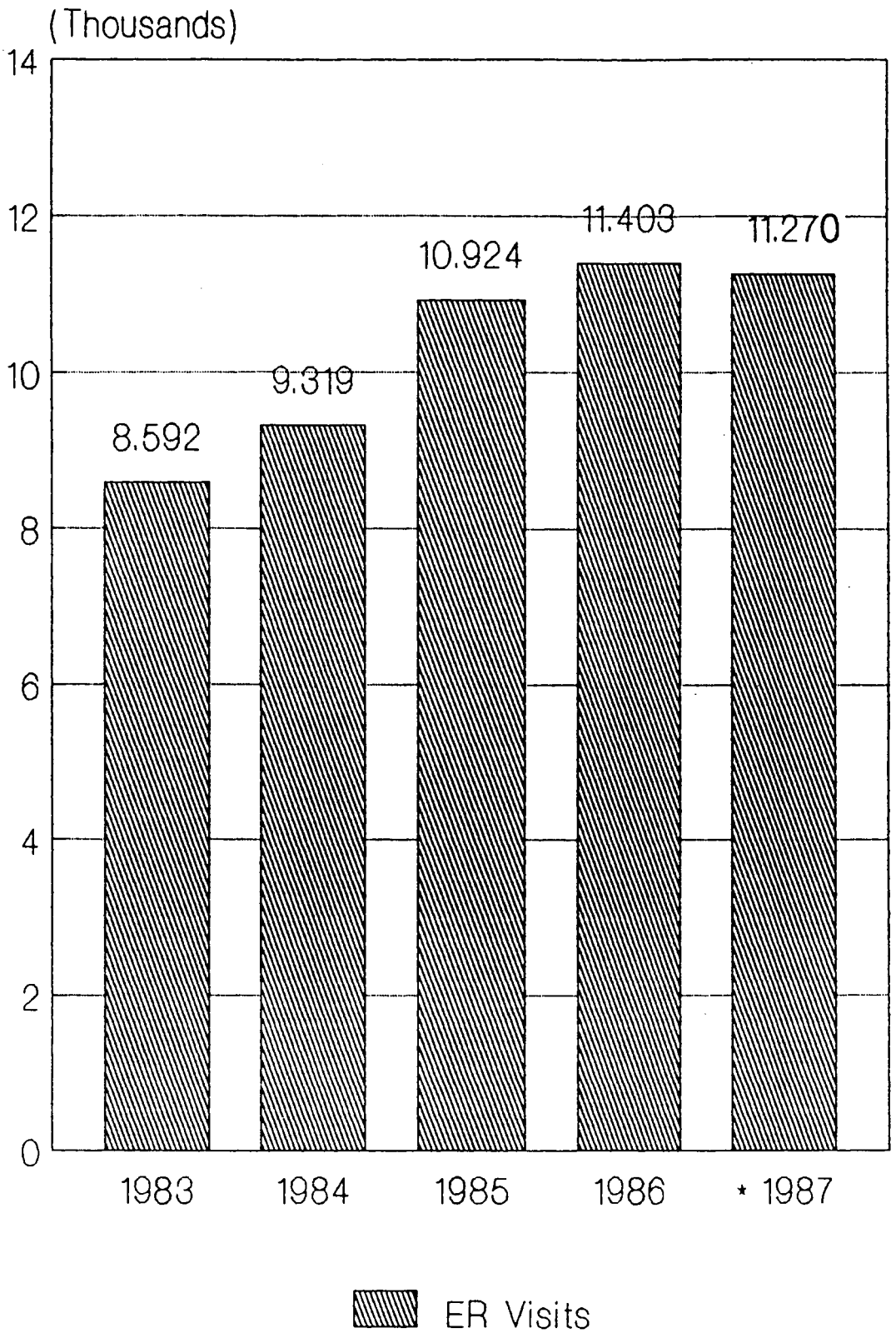
HILLCREST HEALTH CENTER
COMPETING HOSPITAL UTILIZATION



Acute Care Hospital Report, 1982 - 1986.

HILLCREST HEALTH CENTER
EMERGENCY ROOM UTILIZATION

Exhibit 8

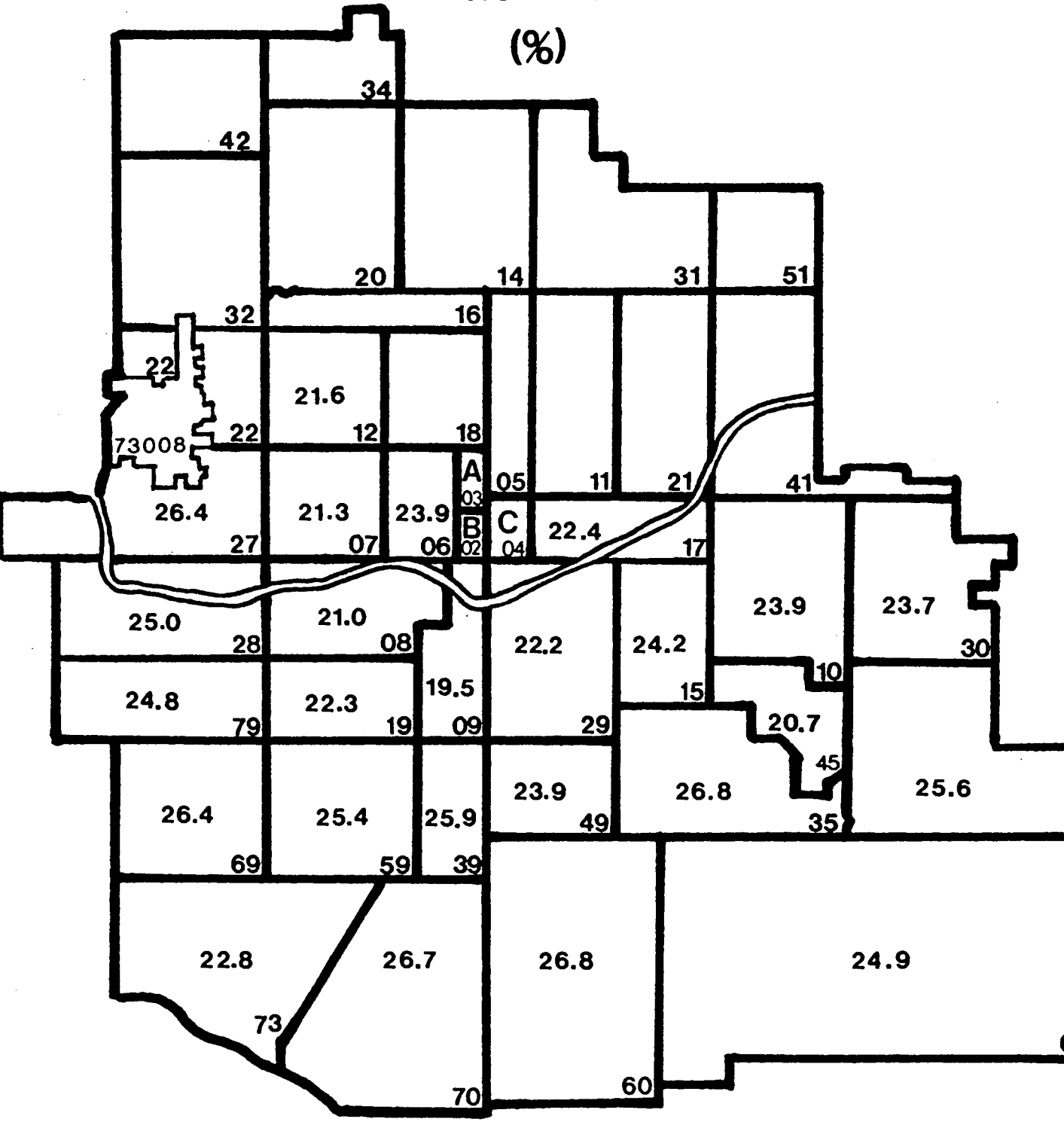


* 1987 Annualized, Calendar Years.

OKLAHOMA CITY

Exhibit 5

1987 Female Population (15-44) (%)



A 24.0

B 16.3

C 20.7

National 24.3%

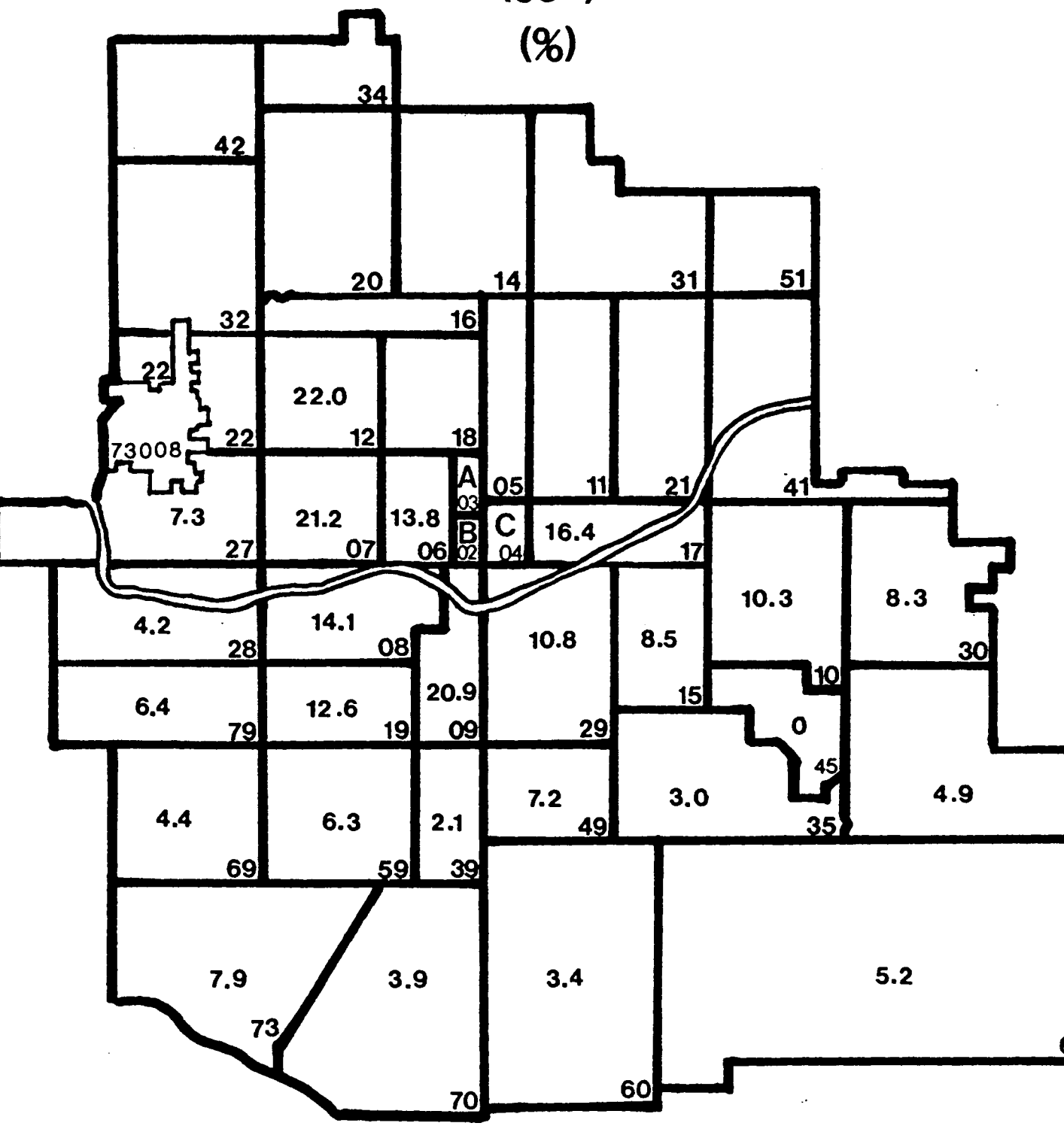
Zip Code = 731 + two digits shown on map

Source: NRDC

OKLAHOMA CITY

Exhibit 6

1987 Elderly Population
(65+)
(%)



County	11.1%
State	12.7%
National	12.0%

A 14.3

B 21.2

C 15.7

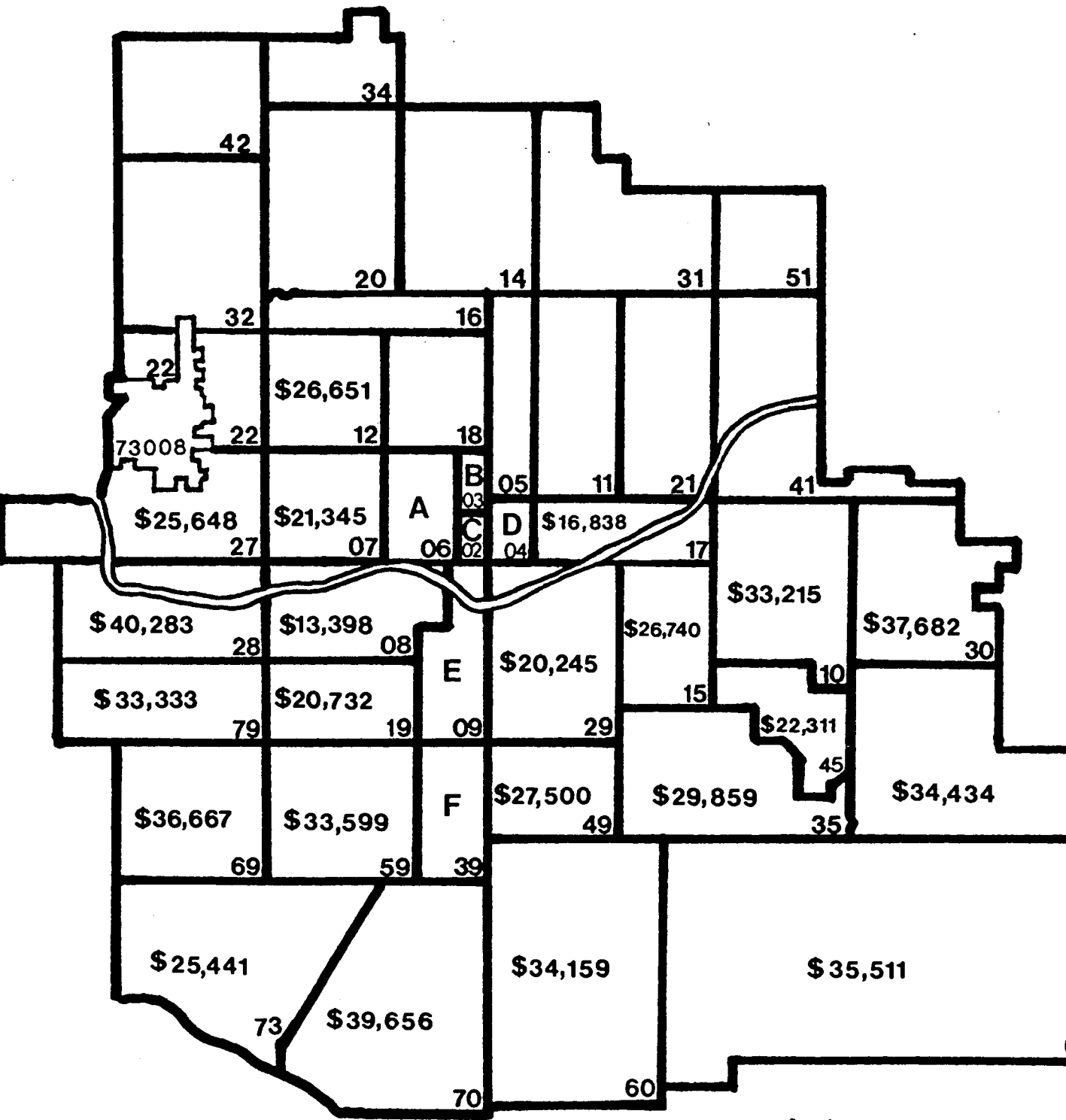
Zip Code = 731 + two digits shown on map

Source: NRDC

OKLAHOMA CITY

Exhibit 7

1987 Median Income



County	$28,314
State	$24,997
National	$23,618

A	$14,398
B	$14,055
C	$10,908
D	$11,237
E	$16,855
F	$36,291

Zip Code = 731 + two digits shown on map

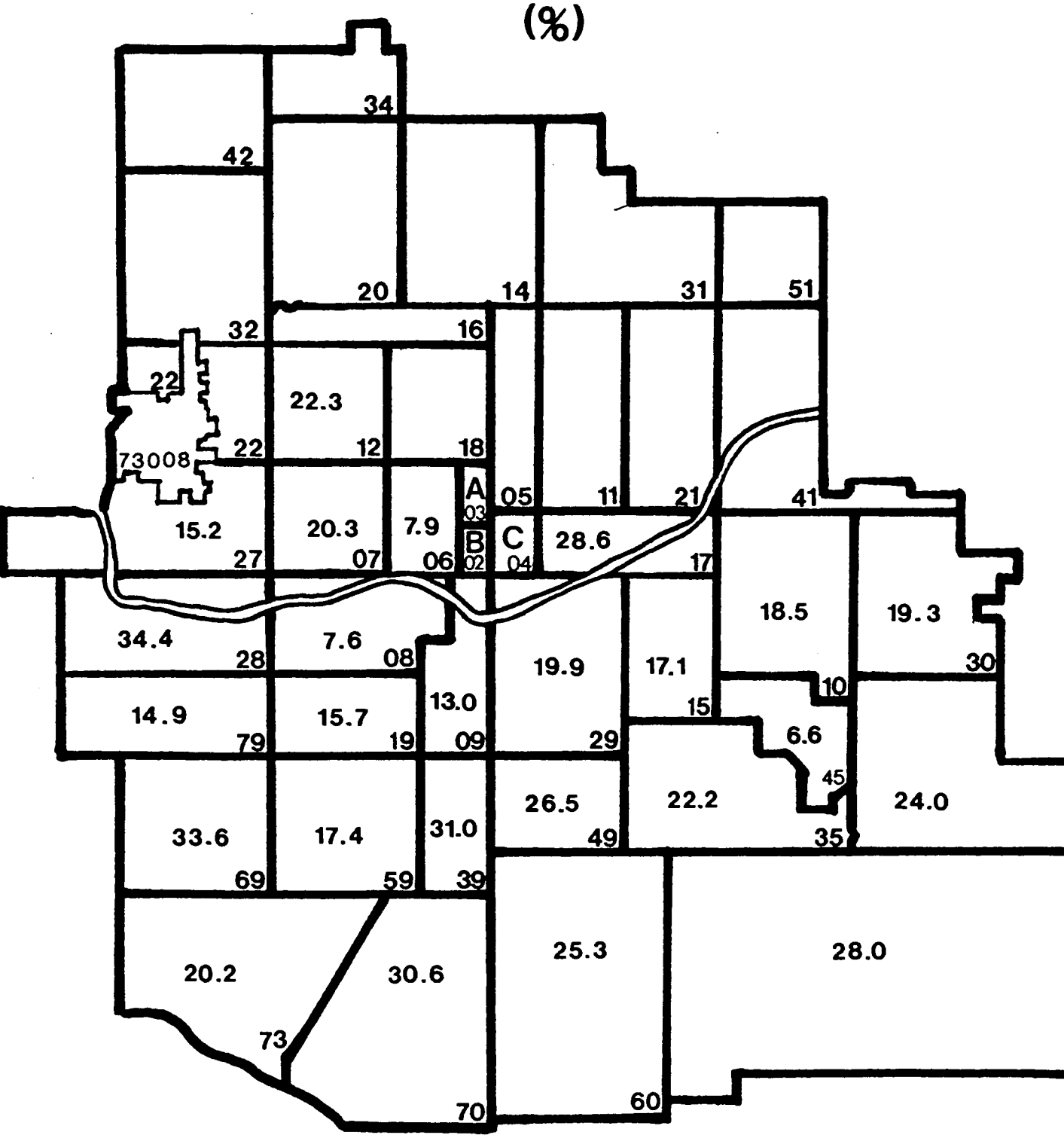
Source: NPDC

OKLAHOMA CITY

Exhibit 8

1987-1992 Median Income Change

(%)



A 6.5

B 12.1

C 17.1

Zip Code = 731 + two digits shown on map

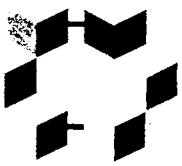
Source: NPDC

II. PHYSICIAN ANALYSIS

This medical staff analysis has been prepared for Hillcrest Health Center. In establishing a Physician Support Network, it is essential that all physicians be closely monitored in terms of referral patterns, percent admissions contributed to their specialty, the "life cycle" of their practice, and other factors.

It is also important to the success of any Physician Support program that physician specialty composition in the network be closely tracked. A delicate balance of primary care physicians and specialists in each specialty must be readily available to the public to make the network a marketable commodity to consumers, employers, and insurers.

The primary intent of the medical staff analysis in this section is to furnish Hillcrest Health Center with a tool that can be used on an on-going basis to monitor physician status. The following specialty assessments will highlight findings of the reports that may be worthy of further study by HHC.



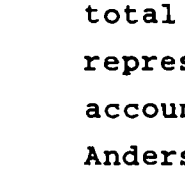
A. MEDICAL STAFF PROFILE

An analysis of admissions by physician specialty was compiled for Fiscal Years 1986 and 1987, July - June. Surgical procedures by physician specialty were also analyzed for the same time periods. Outpatient procedures by physician specialty based on July 1985 through June 1986 were obtained from Hillcrest's Doctor Analysis report. This report also included revenue by physician for Fiscal Year 1986, and Fiscal Year 1987 physician revenue data was obtained from the July 1986 through June 1987 Doctor Analysis report. Detailed reports by physician specialty can be found in the Addenda of this report. Ob/Gyn admissions for Fiscal Years 1986 and 1987, while being admitted under Dr. Dieter's name also include admissions by Dr. Motz. Because PMCI was unable to distinguish between those admissions, all Ob/Gyn activity will be listed as Drs. Dieter/Motz.

There are 5 physicians on Hillcrest's medical staff who are 55 years of age or older. These 5 physicians represented almost 4% of the hospital's total admissions in 1987. The hospital has an overall average age for its medical staff of 41 years of age, which is lower than national averages. (See Exhibit 1).

Admissions

The top 10 physician admitters in 1987 were responsible for nearly 45% of all physician admissions at Hillcrest. Drs. Dieter/Motz and Marcus each were responsible for around 6% of total physician admissions, with Drs. Leply and Abston representing almost 5% each. The remaining doctors each accounted for around 4% of admissions. Only Drs. T. King and Anderson experienced increases in admissions from the previous



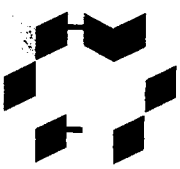
year. Exhibits 2 through 4 show a breakdown of these top admitters.

General Practice

General Practice with 2,812 physician admissions, represented over 53% of total physician admissions in 1987. These admissions represented a 1% increase from the previous year. In 1987, nearly 9% of General Practice admissions came from Dr. Abston with 244. His 1987 admissions represented nearly a 19% decline from his 1986 admissions. Dr. T. King, with 229 admissions, was responsible for 8% of total physician admissions, while Drs. Blue and T. Moore accounted for around 8% each. Drs. T. King and T. Moore experienced slight increases in admissions between 1986 and 1987, while Dr. Blue's admissions represented nearly a 39% decline. Together these four doctors accounted for almost 31% of General Practice's 1987 admissions.

Internal Medicine

In 1987, Internal Medicine physicians were responsible for nearly 12% of all physician admissions. Internal Medicine admissions declined by 1% between 1986 and 1987. Dr. Marcus, with 305 Internal Medicine admissions, was responsible for nearly 49% of this specialty's total admissions. His 1987 admissions represented a slight increase from his previous year's admissions. Around 32% of Internal Medicine's admissions came from Dr. Anderson, who increased admissions by 20% between 1986 and 1987. Together, Drs. Marcus and Anderson were responsible for 81% of Internal Medicine's 1987 admissions.



Orthopedic Surgery

Orthopedic Surgery physicians accounted for 10% of physician admissions in 1987, and experienced a 21% decline in admissions between 1986 and 1987. Dr. Hughes was responsible for 220 Orthopedic Surgery admissions in 1987, or 41%, while Dr. Cruse admitted 192, nearly 36% of Orthopedic Surgery admissions. Combined, these two doctors were responsible for 77% of Orthopedic Surgery admissions. Both of the above doctors experienced a decline in admissions from the previous year.

Pediatrics

Between 1986 and 1987, Pediatric physician increased admissions by 4%. In 1987, Pediatrics represented nearly 8% of physician admissions. Dr. Leply with 257 admissions, was responsible for 63% of these Pediatric admissions. This represented a 20% decline from his previous year's admissions.

Ob/Gyn

Ob/Gyn physicians accounted for 6% of physician admissions in 1987, which represented a 3% decrease from 1986 admissions. Drs. Dieter/Motz, with 319 admissions, were responsible for 100% of these Ob/Gyn admissions in 1987.

General Surgery

In 1987, General Surgery physicians were responsible for 4% of all physician admissions. Between 1986 and 1987, however, General Surgery admissions fell nearly 12%. Dr. Schelle represented over 39% of General Surgery admissions, while Dr. Benien accounted for 35%. Together, these two doctors were responsible for nearly 75% of General Surgery

admissions. Dr. Benien experienced a 30% decline in admissions between 1986 and 1987, while Dr. Schelle increased admissions by 8%.

Gastroenterology

Gastroenterology physicians accounted for nearly 3% of total physician admissions in 1987. Between 1986 and 1987, Gastroenterology admissions fell by over 39%. Dr. Hogin, with 140 admissions, accounted for 100% of Gastroenterology admissions.

Neurology

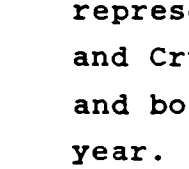
In 1987, Neurology physician admissions represented just over 2% of total physician admissions. Neurology admissions declined 15% between 1986 and 1987. Dr. Robbins with 126 admissions, accounted for 100% of Neurology admissions.

Cardiology

Cardiology physician admissions in 1987 totaled 78, representing over 1% of total physician admissions. Between 1986 and 1987, Cardiology admissions fell over 20%. Dr. Mowdy was responsible for 100% of these Cardiology admissions.

Surgical Procedures

Nearly 64% of surgical procedures performed at Hillcrest Health Center in 1987 were by 10 physicians. Almost 14% of surgeries were performed by Drs. Dieter/Motz, with 278 procedures. This represented a 5% increase in procedures since 1986. Drs. Hughes and Cruse each accounted for around 9% of surgical procedures, and both experienced a decline in procedures from the previous year. Dr. Schelle, with a 29% increase in surgical procedures



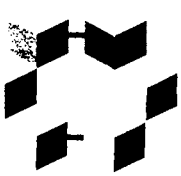
since 1986, represented over 6% of total surgical procedures. Drs. Benien and G. Smith, with over 5% of total surgical procedures each in 1987, experienced a decline from 1986. The remaining 14% of surgical procedures by the top 10 physicians came from Drs. Marcus, Keith, Blue, and T. Moore. Both Drs. Marcus and Blue increased surgical procedures from the previous year. A breakdown of surgical procedures by the top ten physicians can be found in Exhibits 5 through 7.

General Practice

Over 32% of surgical procedures in 1987 were performed in General Practice. General Practice surgical procedures declined by over 15% between 1986 and 1987. Drs. Blue and T. Moore were each responsible for 10% of General Practice procedures, with Dr. T. King accounting for 9%. Drs. Blue and T. King both experienced decreases in surgical procedures between 1986 and 1987. Nearly 15% of General Practice surgical procedures came from Drs. Tomlinson and Nickels, while 6% came from Dr. Goodmon. All three of these doctors showed a decline in procedures from the previous year.

Orthopedic Surgery

Nearly 24% of surgical procedures in 1987 were in Orthopedic Surgery. This specialty had a decrease in procedures of 26% since 1986. Dr. Hughes with 187 surgical procedures, accounted for nearly 40% of specialty procedures, while Dr. Cruse was responsible for 177, nearly 38% of procedures. These two doctors had a combined decrease in surgical procedures of 22%.

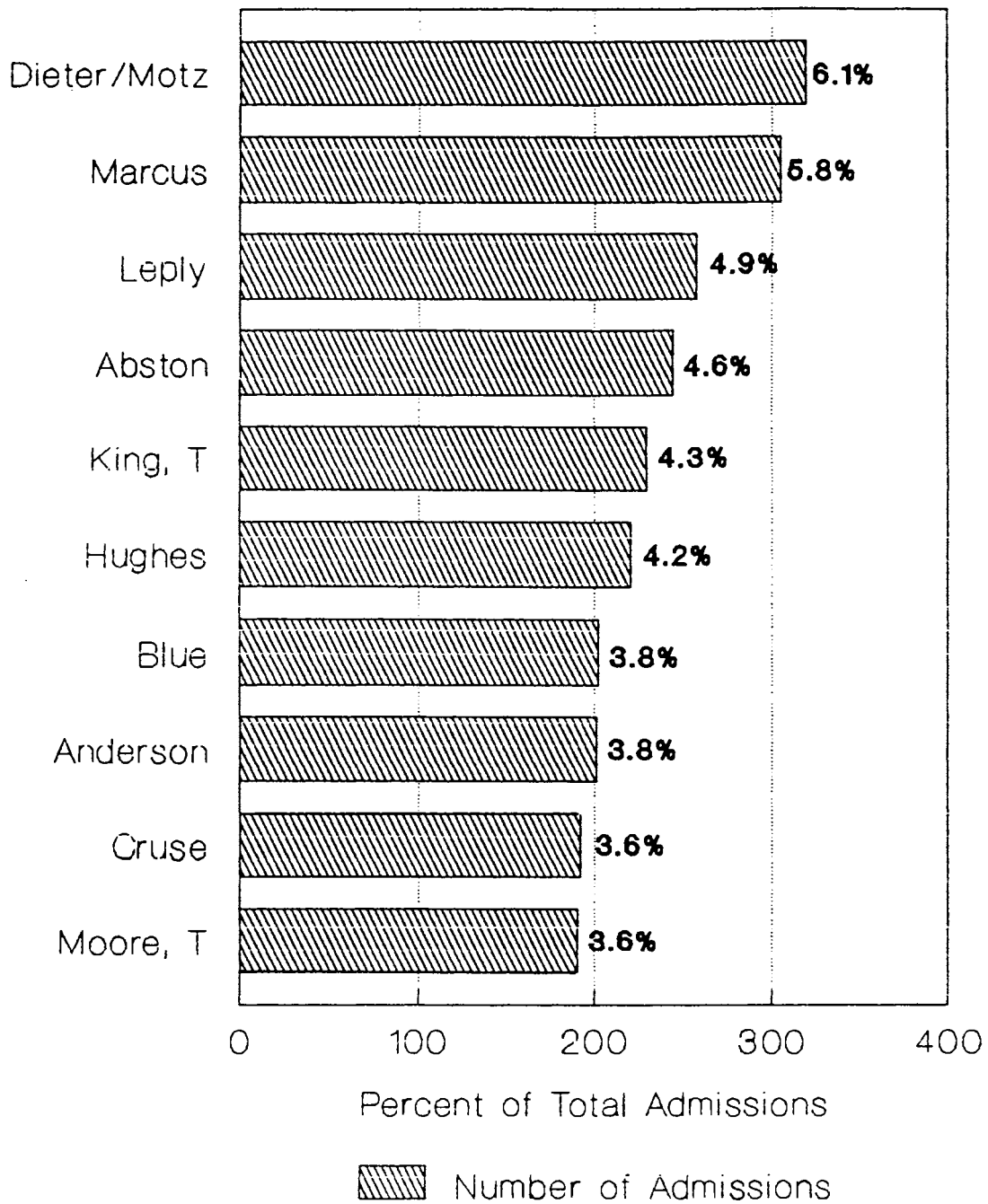


HILLCREST HEALTH CENTER
MEDICAL STAFF ANALYSIS

Specialty	Average Age
Anesthesiology	42
Cardiology	41
Emergency Medicine	36
General Practice	39
Gastroenterology	36
General Surgery	43
Internal Medicine	54
Neurology	42
Ob/Gyn	40
Ophthalmology	42
Orthopedic Surgery	41
Pediatrics	37
Pathology	44
Radiology	43
Other	35

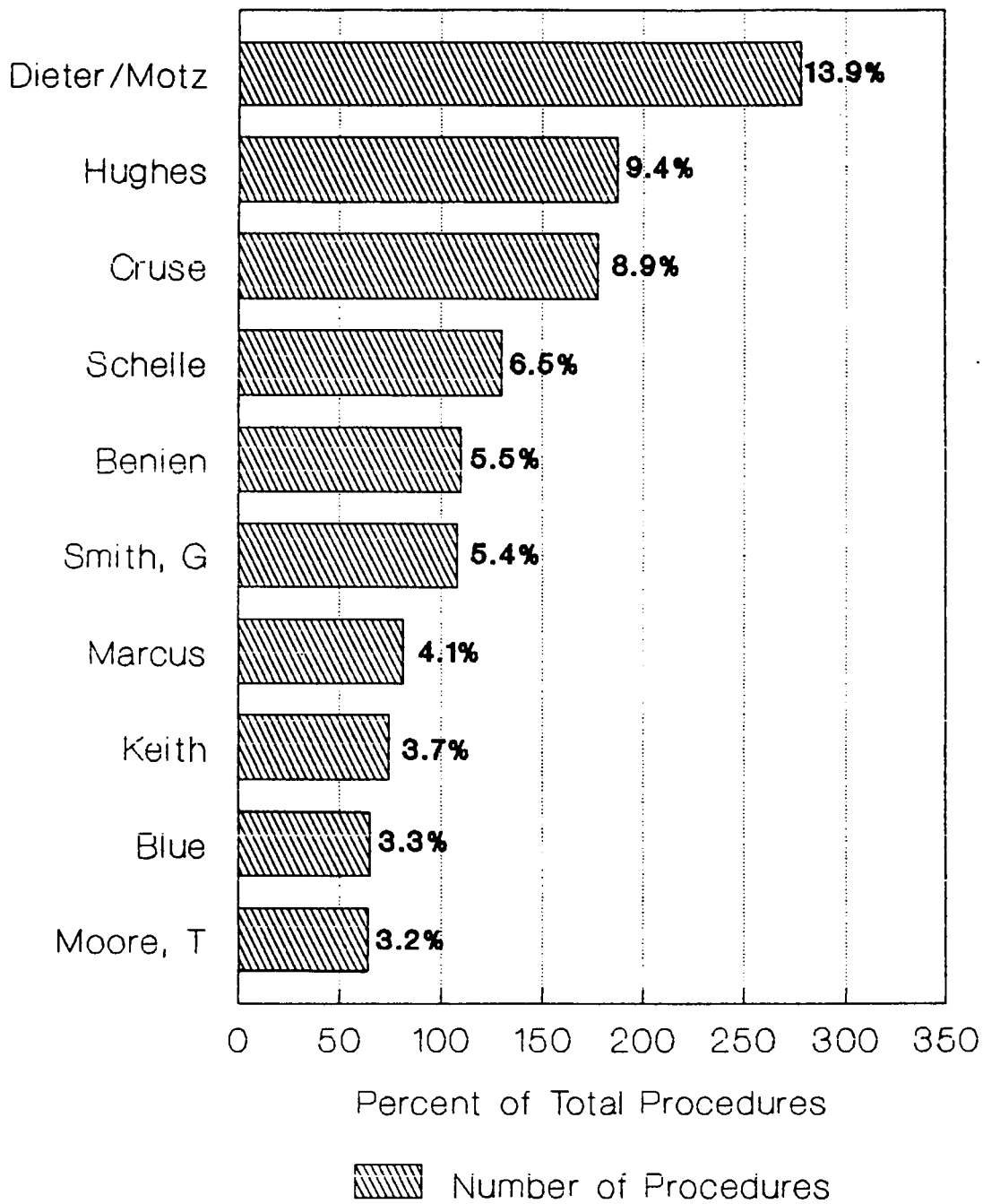
Source: Medical Records

HILLCREST HEALTH CENTER
1987 TOP 10 ADMITTERS



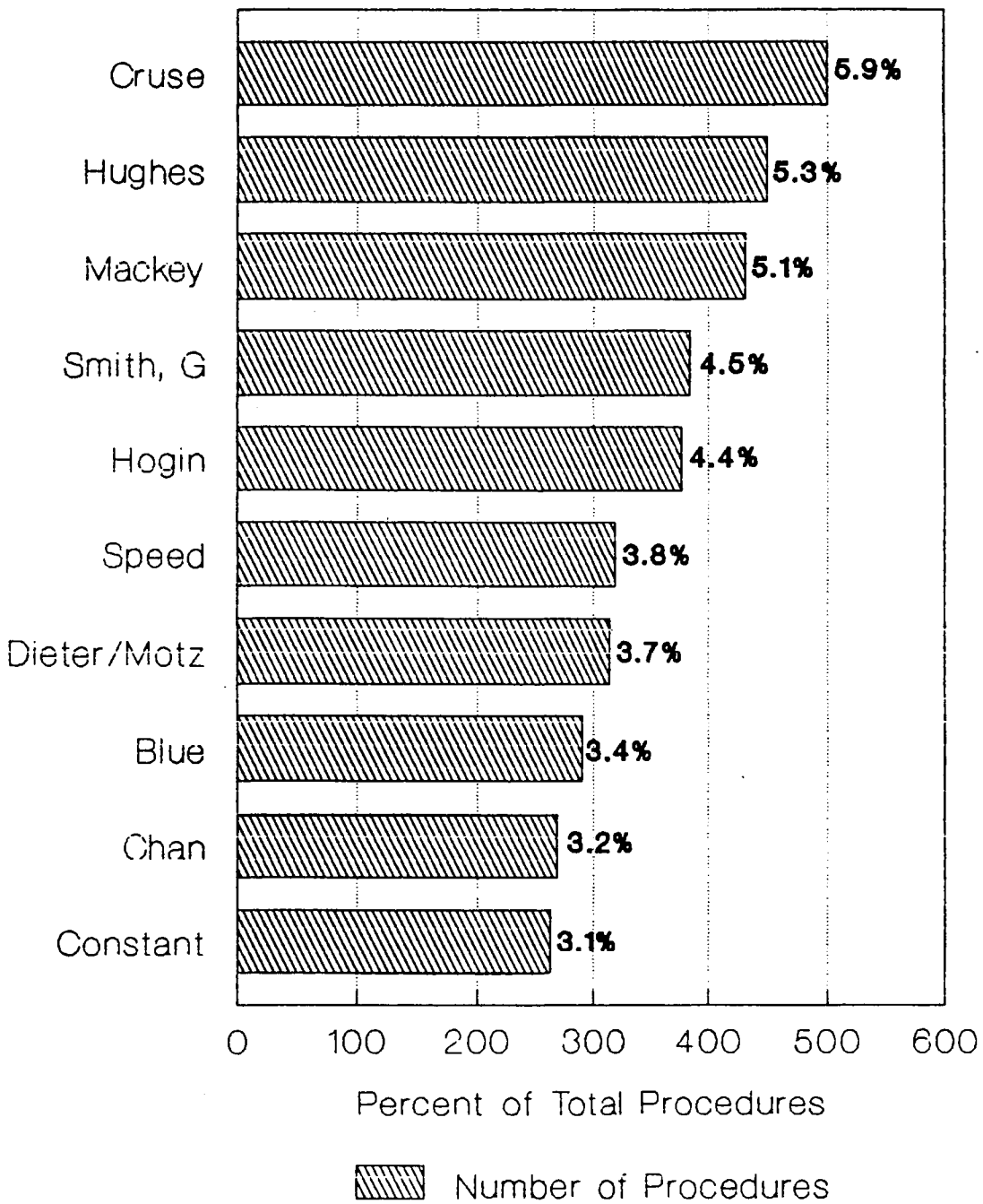
Source: Hosptial Records, Fiscal Years.

HILLCREST HEALTH CENTER
1987 TOP 10 SURGICAL PERFORMERS



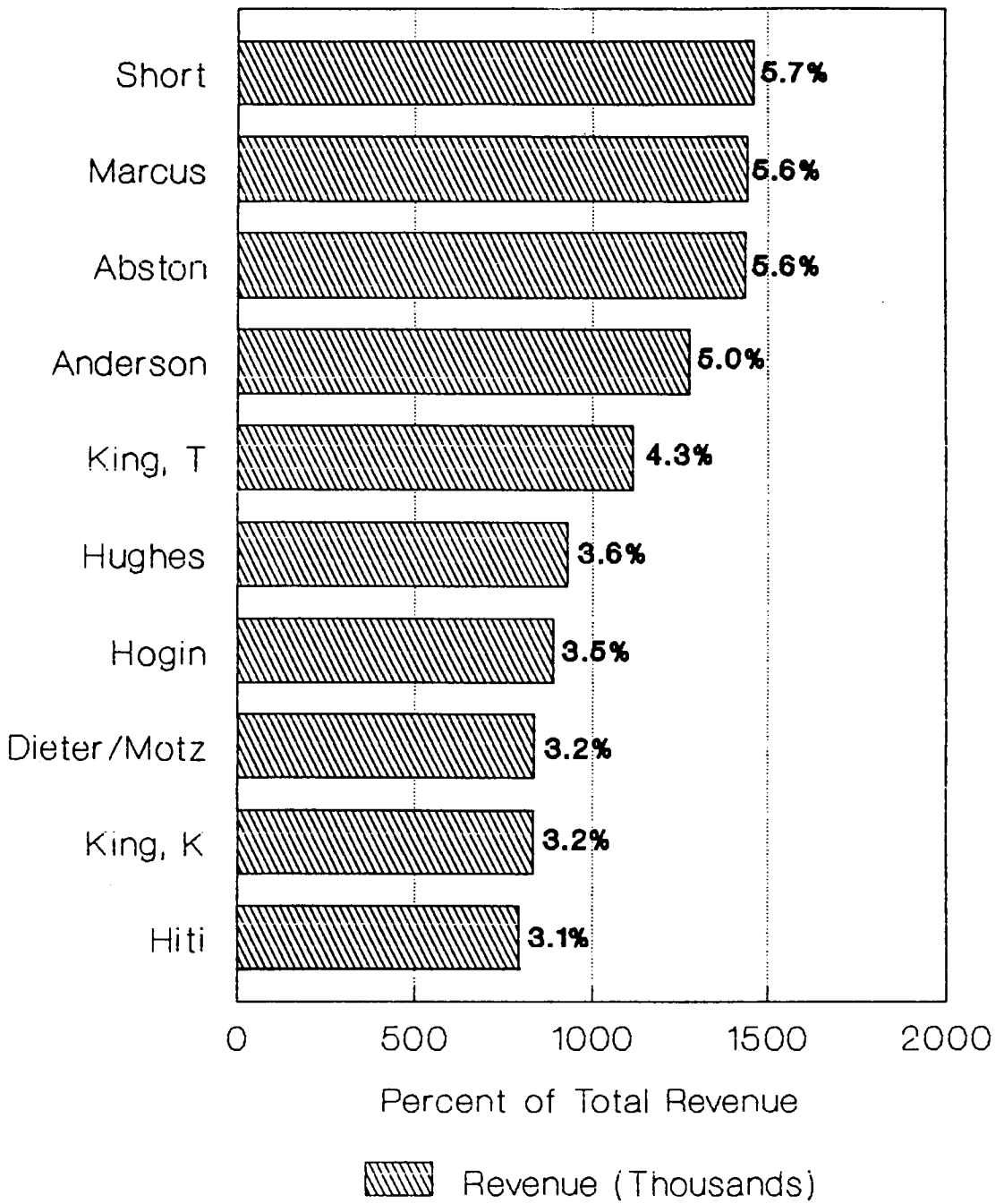
Source: Hosptial Records, Fiscal Years.

HILLCREST HEALTH CENTER
1986 TOP 10 OUTPATIENT PERFORMERS



Source: Hosptial Records, Fiscal Years.

HILLCREST HEALTH CENTER
1987 TOP 10 REVENUE GENERATORS

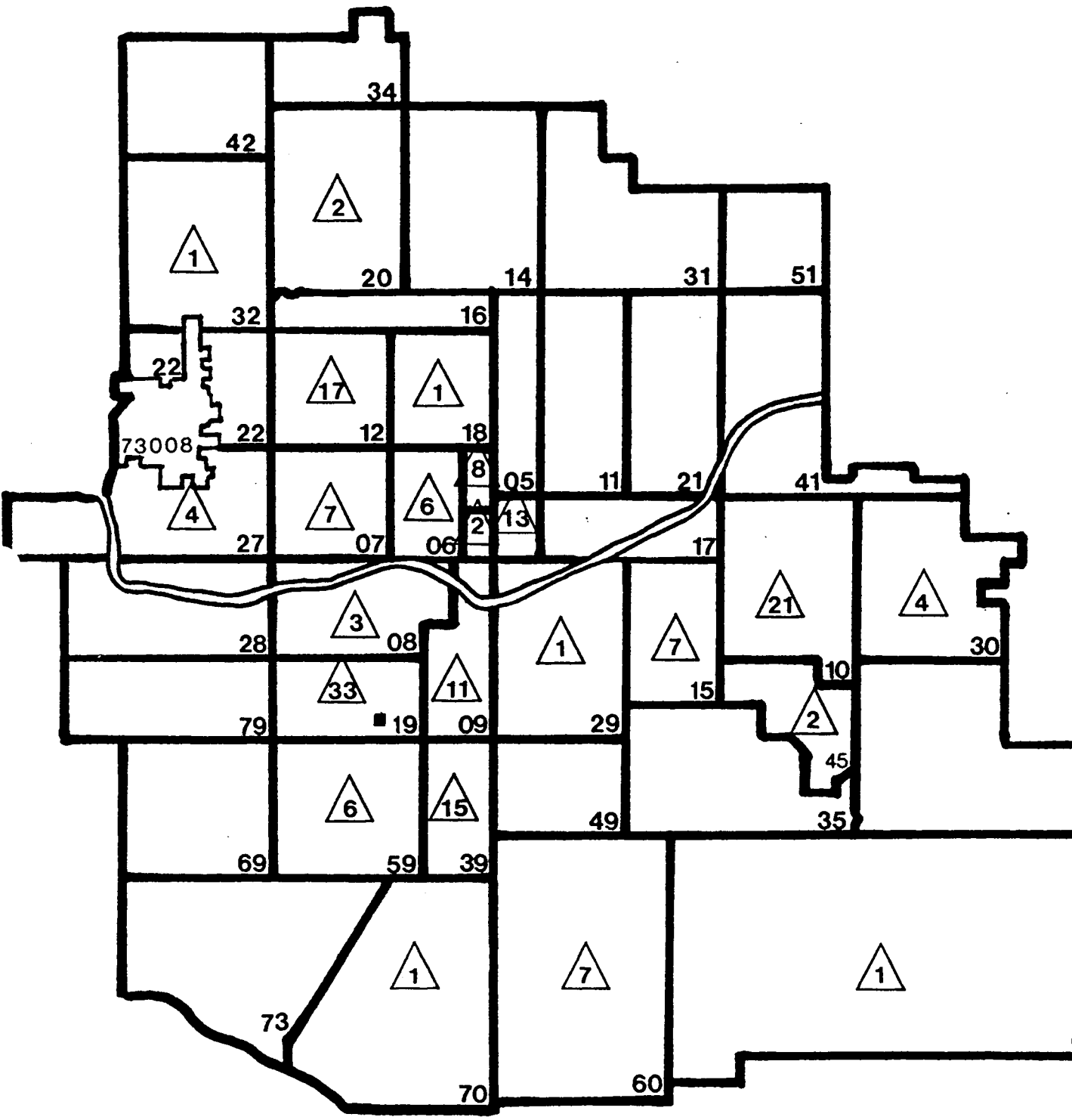


Source: Hosptial Records, Fiscal Years.

OKLAHOMA CITY

Exhibit 7

Family/General Practice Physicians



Zip Code = 731 + two digits shown on map

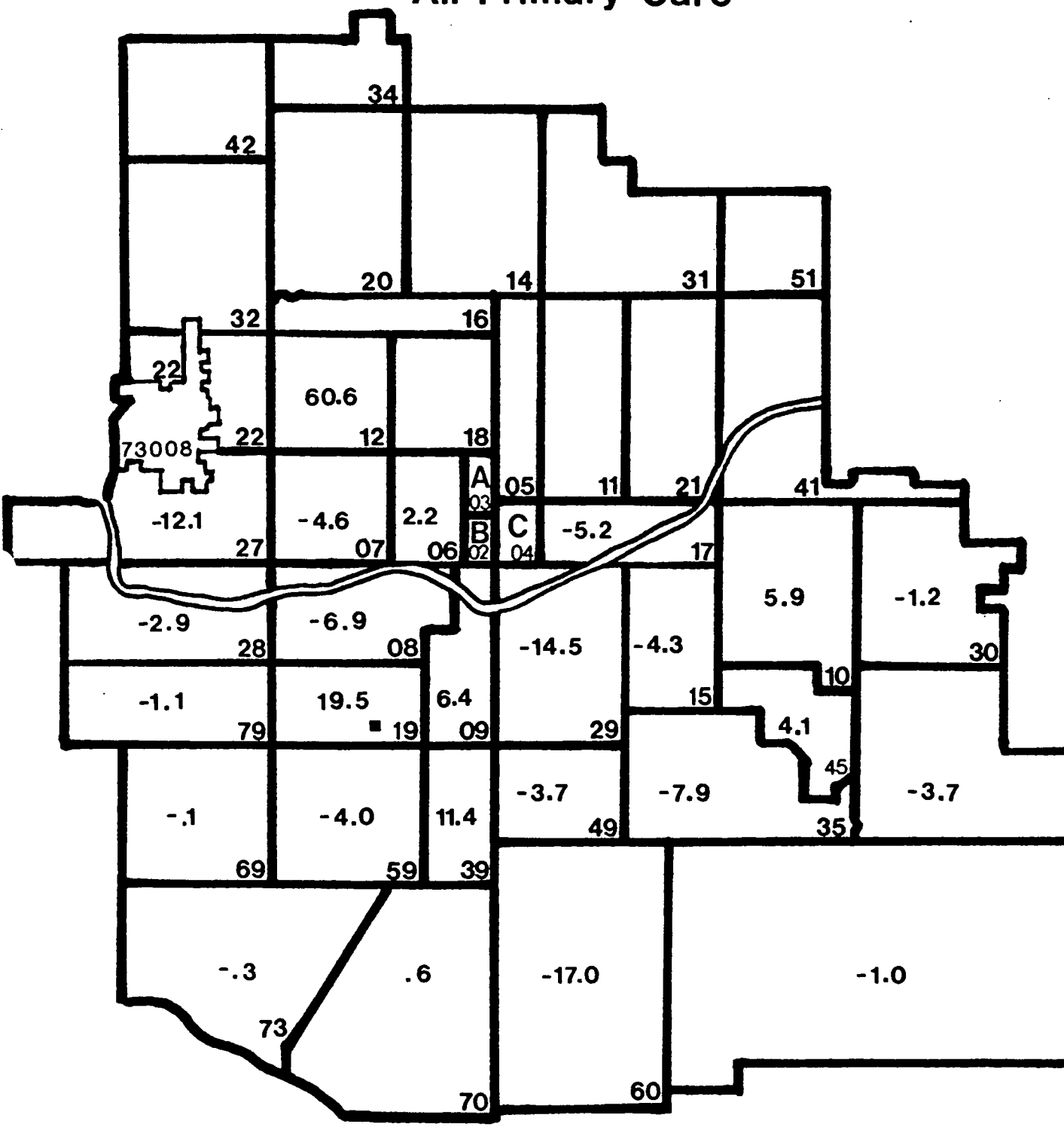
Source: Oklahoma Medical Association, 1987

OKLAHOMA CITY

Exhibit 11

Physicians Surplus/Shortage

All Primary Care



A 27.1

B 3.6

C 99.7

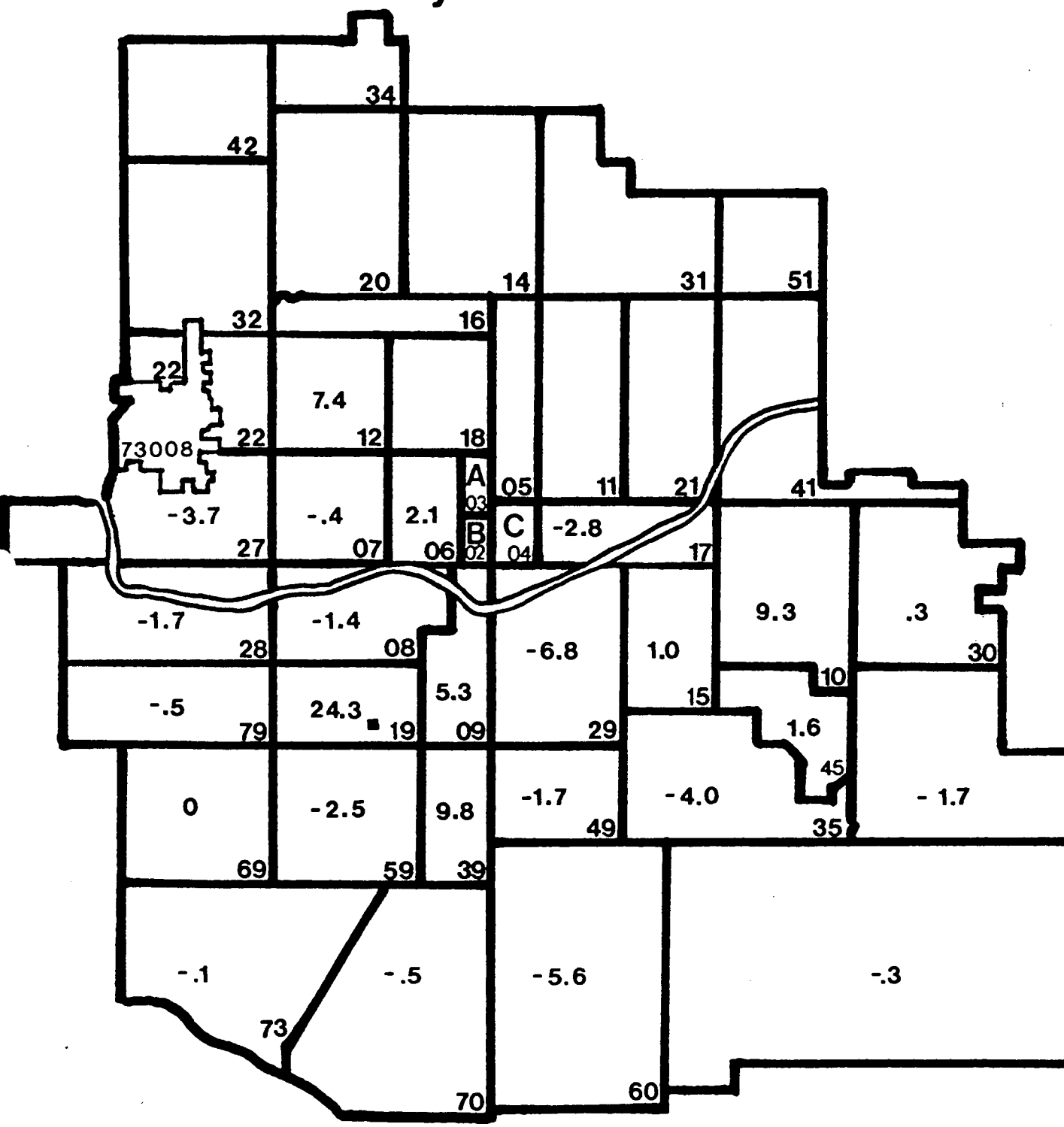
Zip Code = 731 + two digits shown on map

Source: PMCI Computations

OKLAHOMA CITY

Exhibit 12

Physicians Surplus/Shortage
Family General Practice



A 6.2
B 1.4
C 11.5

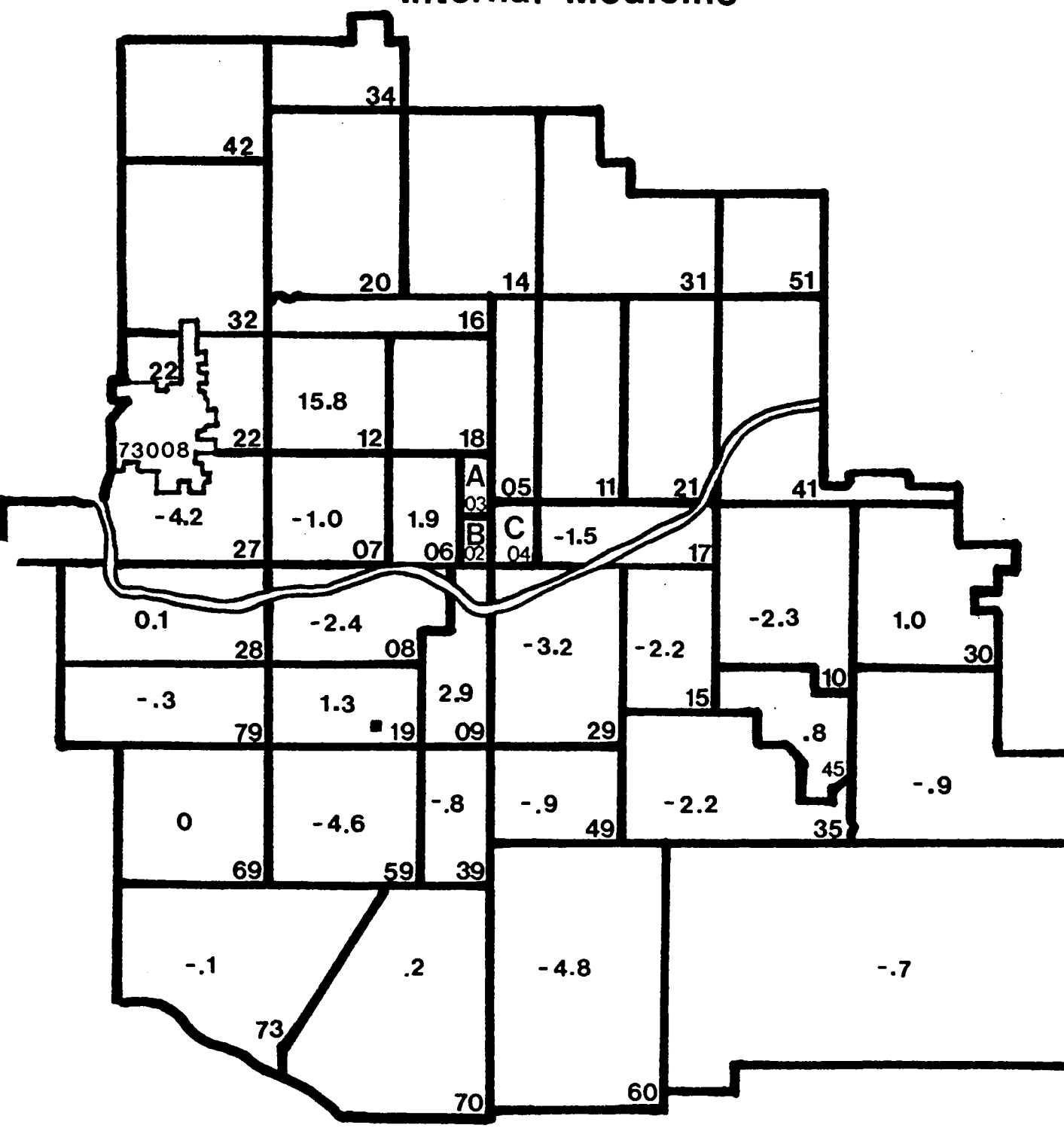
Zip Code = 731 + two digits shown on map

Source: PMCI Computations

OKLAHOMA CITY

Exhibit 13

Physicians Surplus/Shortage
Internal Medicine



A 13.1

B 2.7

C 47.2

Zip Code = 731 + two digits shown on map

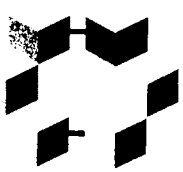
Source: PMCI Computations

C. FULL-TIME PHYSICIAN EQUIVALENT ANALYSIS

One of the most important tools that PMCI uses to determine the need for physician affiliations is the Full-Time Physician Equivalent Analysis. This analysis is used nationally by leading hospital chains, and it has been significantly upgraded in methodology by PMCI.

The "unit of measurement" used in this analysis is the average number of visits per specialty per full-time practice of a loyal physician. The number of patients a physician admits to a given hospital from a "full-time" practice varies according to type of practice, physician age, office hours, and the individual habits of each physician. However, it is possible for a hospital to anticipate the average number of admissions its fully loyal physicians should be expected to refer. Hillcrest management worked closely with PMCI in order to identify the average physician referrals per full-time practice given HHC's market climate. The latest regional averages of admissions per specialty were reviewed, along with current admission patterns at HHC.

Next, HHC management was asked to identify the "ideal" inpatient bed mix based upon such variables as profitability, specialty programs, services it wishes to offer the medical community, managed care providers, etc. The number of full-time practices necessary in each specialty to refer this case mix is then identified through the Physician Equivalent Analysis. The full-time Physician Practice Equivalent Analysis is a "yardstick" that determines the type of specialty practices that need to be referring patients to the hospital in order to attain desired patient bed mix goals.



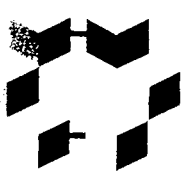
Average Support per Physician/Methodology

The first computation table for the above process can be found in Exhibit 1. The first column lists Fiscal Year 1987 admissions based on July 1986 through June 1987 data. The second column lists the average admissions that can be expected from a full-time practice physician in Hillcrest Health Center's service area. This number was computed by taking PMCI national averages, Jackson and Coker survey averages (1986), and comparing them to most physicians who are currently expressing full-time or near full-time loyalty to HHC. Several factors have an impact on the "averages" in column 2. Some of these factors include:

- Medical Specialty Procedures of Practice
- Loyalty to more than one hospital
- Physician age
- Outpatient Procedures
- Personal work habits of each physician

The third column of this report indicates how many Full-Time practices are supporting HHC. For example, the hospital is currently receiving 2,812 General Practice admissions. The average General Practice physician at HHC admits about 140 patients on a full-time basis. Therefore, Hillcrest Health Center is benefitting inpatient admissions in the amount of approximately 20.1 full-time practices (2,812 divided by 140).

The fourth column of Exhibit 1 indicates the number of active admitting physicians at HHC. Physicians admitting fewer than 1% of total specialty admissions were not included in this calculation.



The fifth and final column of this Exhibit reflects what percentage of admissions from an average full-time practice HHC is receiving from its specialists on the active medical staff.

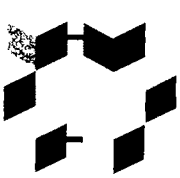
If the number is greater than 100%, this indicates that on an average, the hospital is receiving excellent support from its physicians. If this number is less than 100%, this indicates that physicians on average are either sending their patients elsewhere, or that they have exceptionally low practice volume. Exhibits 2 - 4 indicate the new percentage of support per active physician at HHC that would be required to achieve 70%, 75% and 80% occupancy with current physicians. Exhibits 5 and 6 summarize the physician support levels necessary.

Average Full-Time Physician Support-Results

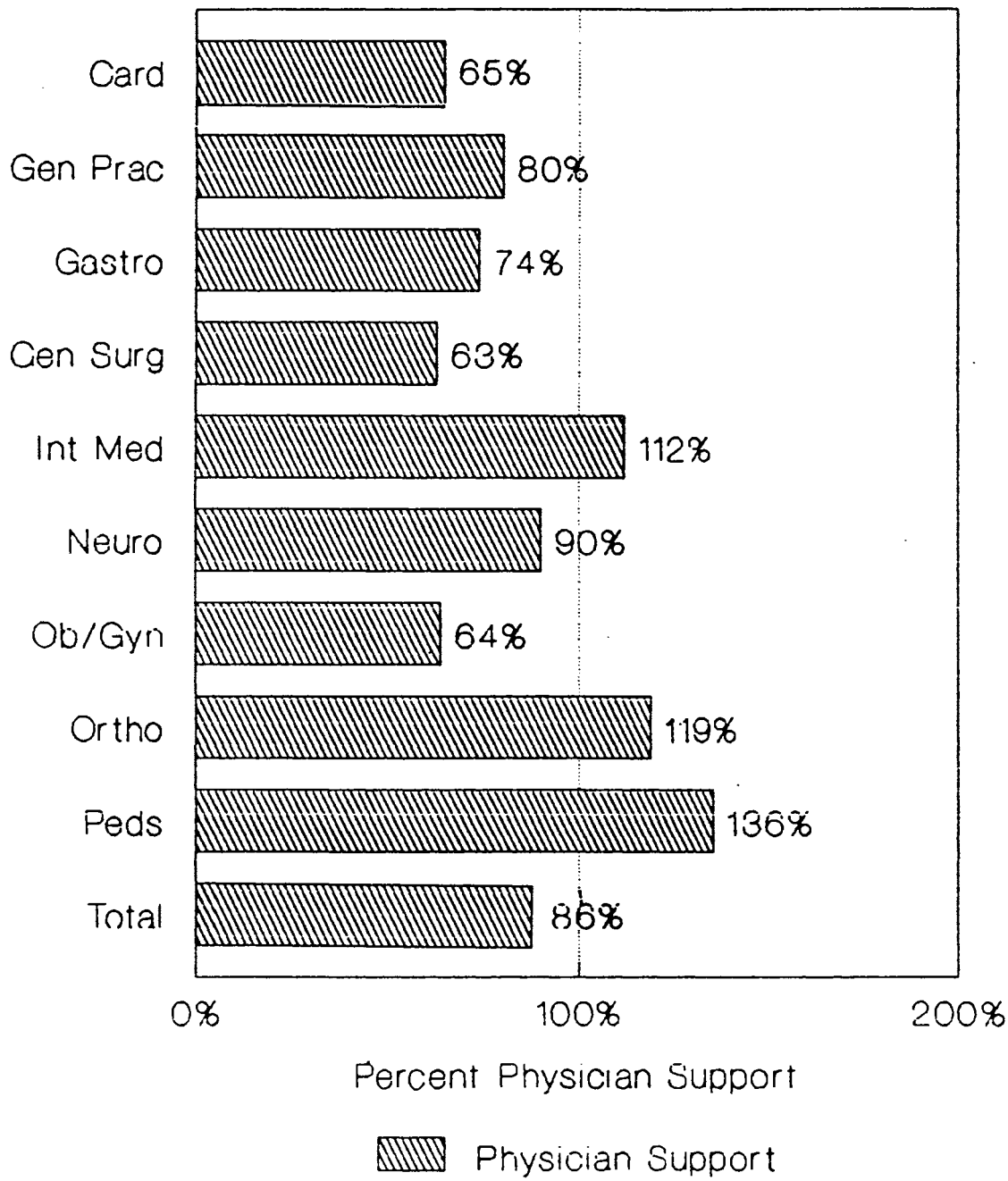
The physician specialties below are providing HHC with support levels as follows:

Specialty	% of Full-Time Practice Support
Pediatrics	* 136%
Orthopedic Surgery	* 119%
Internal Medicine	* 112%
Neurology	90%
General Practice	80%
Gastroenterology	74%
Cardiology	65%
General Surgery	65%
Ob/Gyn	64%

* Note: Support at greater than 100% indicates that additional physician recruitment should be explored.

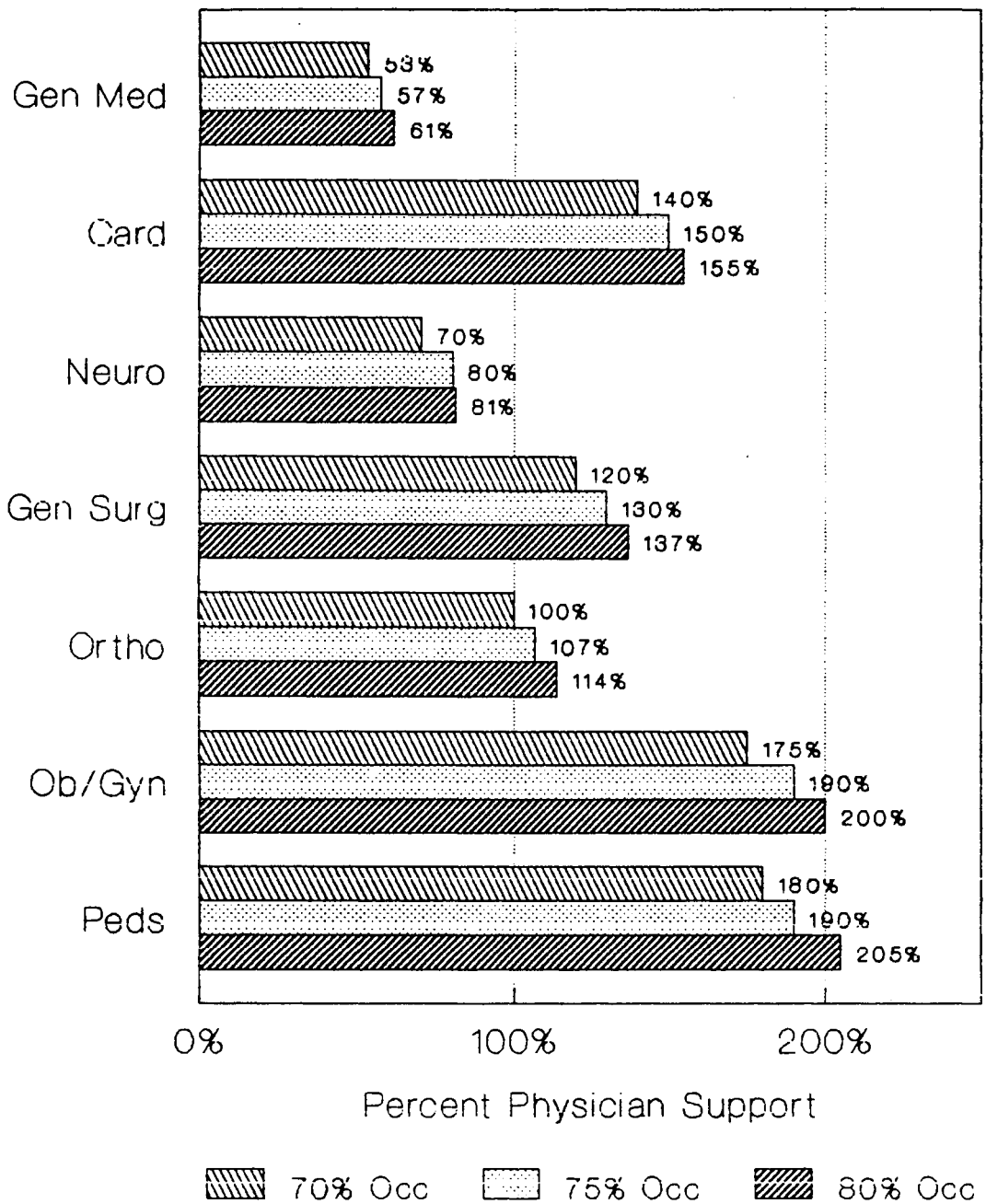


HILLCREST HEALTH CENTER
FULL TIME PHYSICIAN EQUIVALENT ANALYSIS



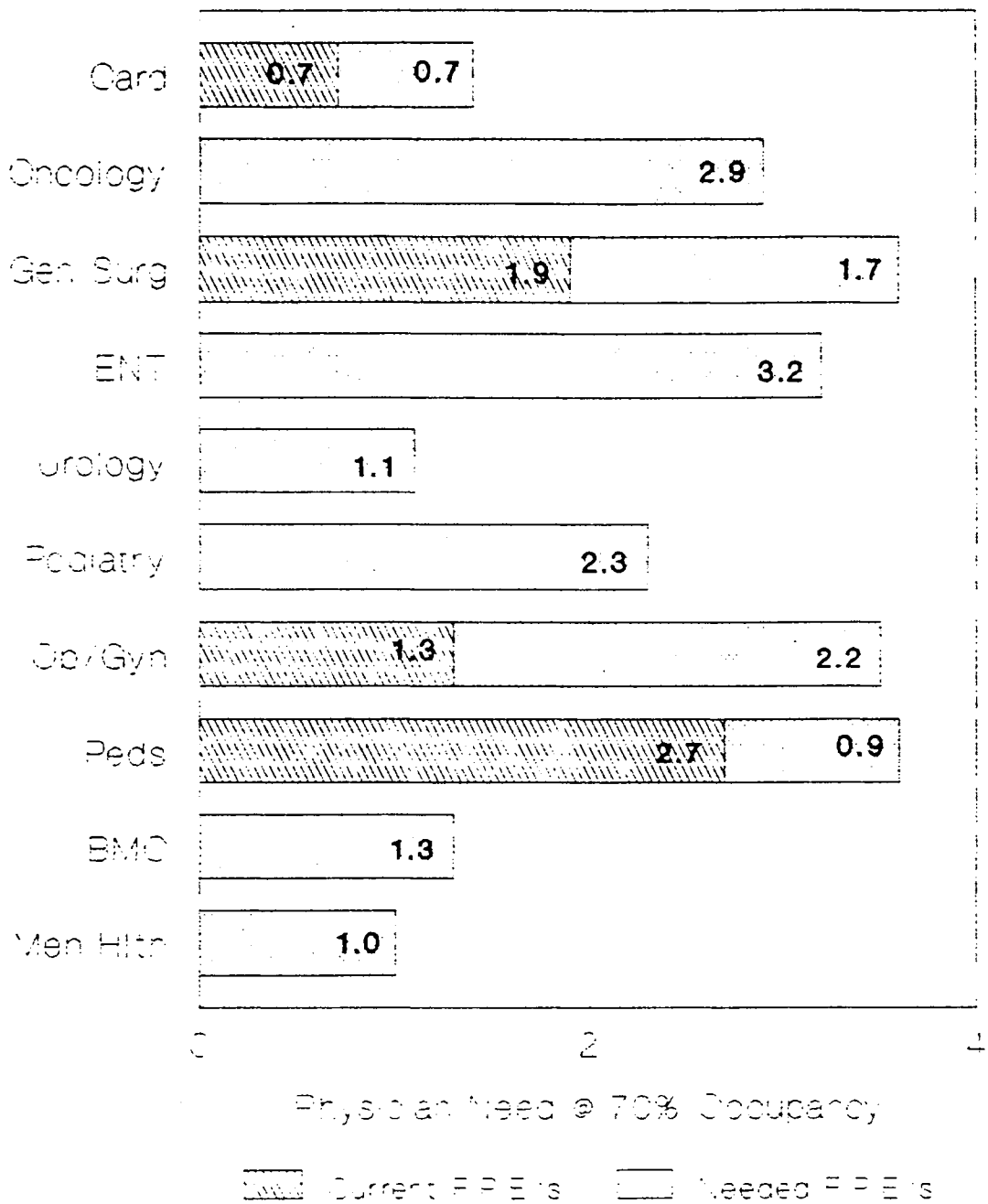
Source: Medical Records, Fiscal Year.

HILLCREST HEALTH CENTER
FULL TIME PHYSICIAN EQUIVALENT ANALYSIS



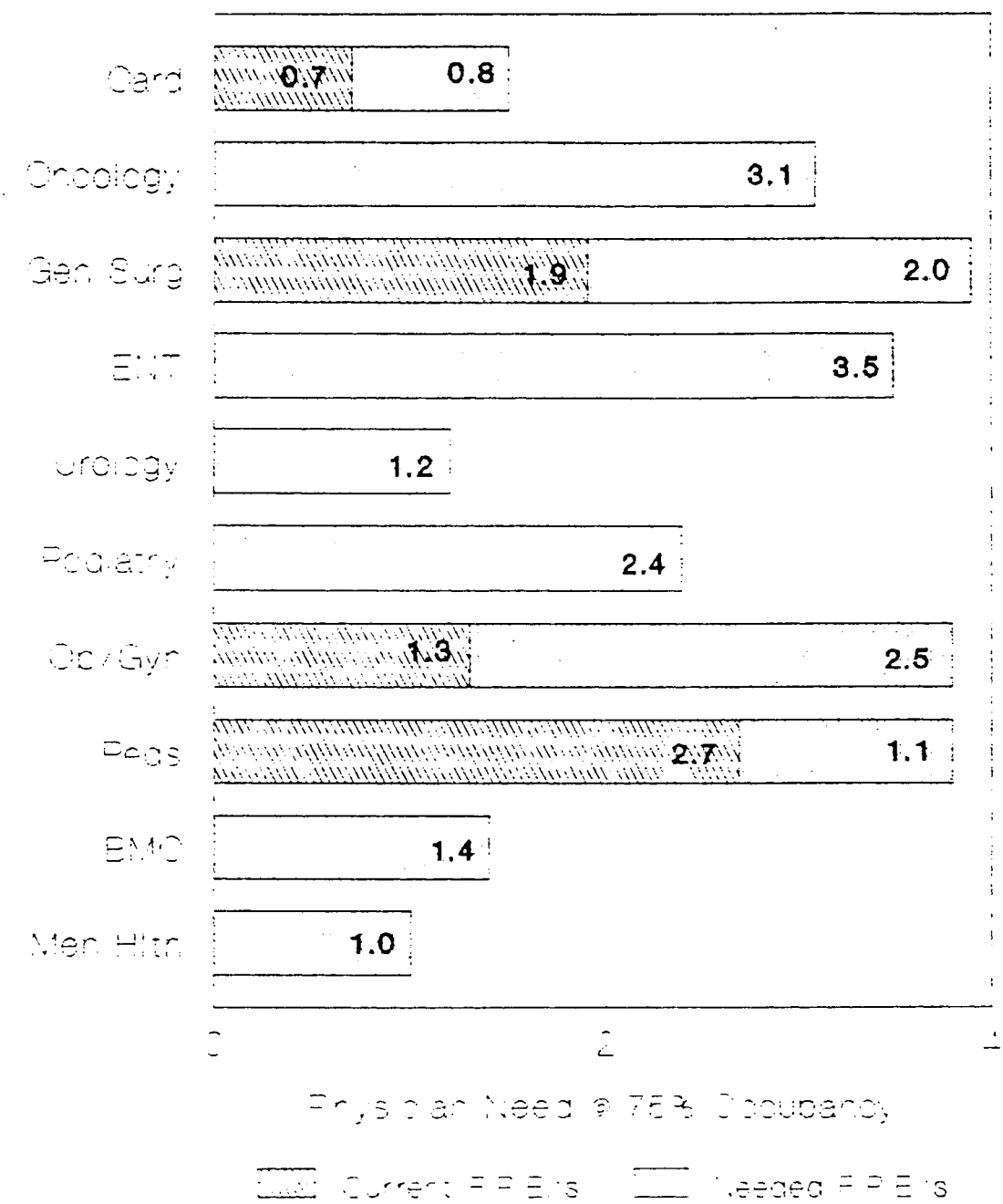
Source: Medical Records, Fiscal Year.

HILLCREST HEALTH CENTER
FULL TIME PHYSICIAN EQUIVALENTS



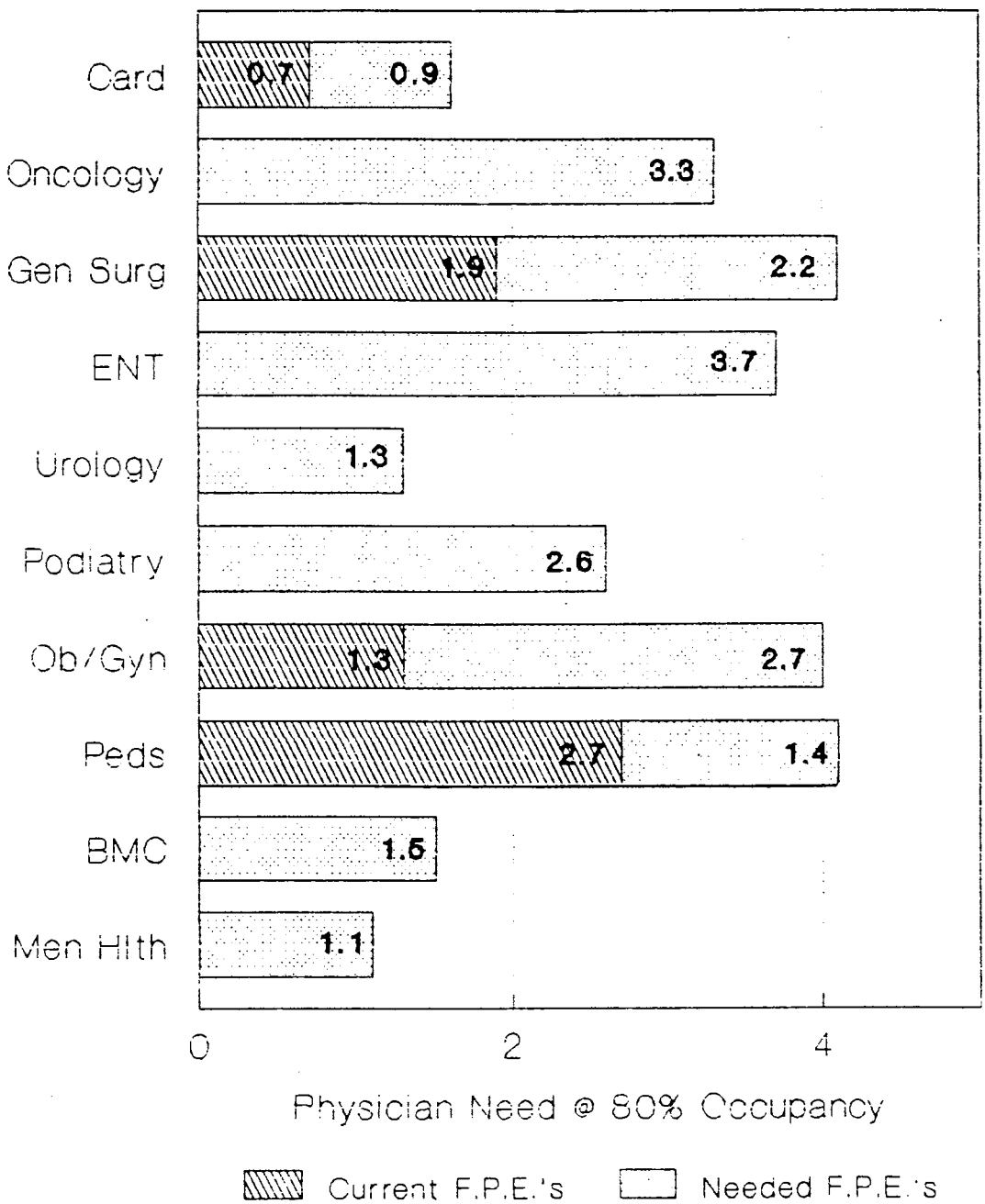
Source: Medical Records, Fiscal Year 87

HILLCREST HEALTH CENTER
FULL TIME PHYSICIAN EQUIVALENTS



Source: Medical Records, Fiscal Year 87

HILLCREST HEALTH CENTER
FULL TIME PHYSICIAN EQUIVALENTS



Source: Medical Records, Fiscal Year 87

E. AFFILIATION ACTIONS NEEDED

Exhibit 1 summarizes affiliation needs according to practice replacement needs, additional physicians needed to attain bed mix and occupancy goals, and new primary care affiliations needed to "feed" desired sub-specialties.

Additional Loyalty/F.P.E.'s Needed in the Following Specialties:

Specialty	No. of Physicians
Cardiology	1
Oncology	* 3
General Surgery	2
ENT	4
Urology	1
Podiatry	3
Ob/Gyn	3
Pediatrics	1
Psychiatry	2

* To include Dr. McKinney

Additional Loyalty/Affiliations Needed to Refer to Desired Specialists:

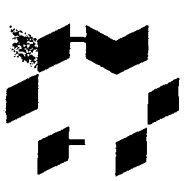
Specialty	No. of Physicians
General Medicine	4

Strategies to Build Physician Support

In order to attain desired utilization patterns, HHC must use a customized strategy for each physician specialty. In some cases, particularly when a surplus of a particular specialty exists, aggressive physician support and liaison is advisable as a way to increase loyalty. See Exhibit 2.

In the case of "consumer driven" services and primary care, it is often advisable to intensify marketing programs and "build traffic" in each practice. When certain regional programs are in the best interest of HHC, development of satellite offices or "circuit riding" might be advisable.

Clearly, HHC's versatility to use different strategies for each specialty will determine success or failure of affiliation and physician loyalty. PMCI has prepared a matrix of physician support strategy in the following section which outlines specific strategy that should be taken in the case of each specialty.



APPENDIX G

SAMPLES OF TRIP REPORTS

September 21, 1987

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onsultants, Inc.

Mr. Jim MacCallum
Chief Executive Officer
Hillcrest Health Center
2129 S.W. 59th Street
Oklahoma City, OK 73119

Dear Jim:

It was a pleasure meeting you last week. After my initial assessment, I feel most confident that successful program development can occur with the combined efforts of management, medical staff, and PMC. Consequently, we are looking forward to receiving the information necessary for us to complete the business/action plan as soon as possible. Below, I am outlining activities from my September 16th and 17th visit. I am also outlining the follow-up activities that are necessary from that visit, and those activities that are recommended for our next visit. As we discussed, Frank Dingler is the PMC project coordinator at Hillcrest. He will be visiting Hillcrest Health Center on September 28, 29, and 30. During that time, he and one of our research specialists will be interviewing a number of physicians on your medical staff.

ACTIVITIES CONDUCTED ON SEPTEMBER 16th and 17th

- Project orientation with Jim MacCallum.
- Discussed programs support activities, and business/action plan preparations.
- Began ideal bed mix/occupancy identification process.
- Met with Gary Brown, Director of Marketing.
- Conducted initial program inventory.

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rker Colorado 80134
03) 841-3393

- Submitted data collection requests pertaining to the following:

  - Medical staff profile
  - Inpatient discharge analysis
  - Area physicians by zip code and specialty
  - Inventory of non-hospital competition
  - Demographic data by zip code (age and sex specific)
  - Major employer information
  - Hospital utilization trends
  - Other information as requested

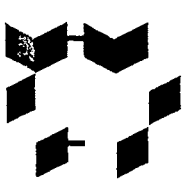
- Met with Dr. Dale Askins, Emergency Department Director.

- Completed questionnaire in preparation for emergency department marketing activities.

- Met with Dr. John Hughes, Chief of Staff. He discussed several items including: the need for more community education about Hillcrest Hospital; physician programs; the interest the medical staff has in electronic claims processing services; the promotion of outpatient surgical services; and, the need to provide marketing services to physicians, especially general practice physicians. Dr. Hughes was informed about the upcoming physician interviews. Upon the completion of these interviews, he was informed that he would be given a summary report. We will of course review this summary with management prior to presenting it to any members of the medical staff.

- A "product/program inventory" was conducted on such programs as Good Neighbor Care, the Good Neighbor Clinic, Sick and Save, and the Behavioral Medicine Center.

- Toured Hillcrest Health Center, its surrounding community, and visited South Community Hospital to assess their emergency services and the rest of their physical plant.



FOLLOW-UP ACTIVITY

- The information requests for the business plan/action plan need to be responded to no later than October 9th in order for us to keep the program on schedule. We normally allow approximately three weeks for this information collection process, and would remind you that a great deal of attention must be placed upon this activity if we are to meet this time frame.

- Physician interview appointments for September 28, 29 and 30 need to be scheduled immediately. Your reinforcement as to the importance of this activity is appreciated.

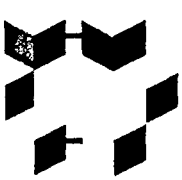
- Under separate cover, a Physician Survey instrument has been sent to you for your review. This survey instrument is a comprehensive inventory of a number of questions that can be asked during our interviews with your physicians. Frank Dingler will be in contact with you to make sure that all the questions that are of concern to you are being asked during the course of the interviews.

RECOMMENDED ACTIVITY FOR NEXT VISIT

1. Conduct physician interviews

2. Frank Dingler to meet with Jim MacCallum and Gary Brown to draft the overall program timetable as it pertains to the following:

   a. Physician Network/Business Plan
   b. Physician Referral and Program Information System
   c. Emergency Department Marketing Program
   d. Occupational Medicine Program
   e. Outpatient Surgery Marketing Program
   f. Womans Health Services Marketing Program
   g. Behavioral Medicine Center Marketing Program
   h. Data Processing



3. Work with management team to assure that data collection process is going smoothly.

4. Discuss occupational health research needs.

I know that Frank is looking forward to meeting you during his visit on September 28. In the meantime, we will remain in continual contact with you and your staff in order to make sure the project remains on schedule. Again, it was a pleasure meeting you last week, and we look forward to a most exciting project.

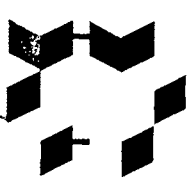
Yours sincerely,

Kenneth Arfa

Kenneth Arfa
Executive Vice President

KA:pp

cc: Gary Brown, Director of Marketing
Frank Dingler, Director of Client Services
PMC Research Department



October 2, 1987

Mr. Jim MacCallum
Chief Executive Officer
Hillcrest Health Center
2129 S.W. 59th Street
Oklahoma City, OK 73119

Dear Jim:

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onsultants, Inc.

It was a pleasure meeting you Monday, September 28. I was impressed with your management team and their dedication to Hillcrest.

As you know, we spent the entire visit interviewing physicians. Once we have reviewed our notes, we will summarize the findings and forward the summary to you. I do not think there will be any additional findings from those I reviewed with you prior to my departure.

In a conversation with Gary Brown today, he indicated there was confusion on the part of Hillcrest management as to who the PMCI contact is. I am the primary contact for Hillcrest and will be responsible for coordinating the installation effort. If you have urgent problems and I am not in, discuss them with Ken. He will inform me of any issues I need for coordinating the installation.

Before I left on Wednesday, September 30, I told Carol I could return October 16 to meet with you, Pete, Gary and the Price Waterhouse principal about data requirements for the network. If the date is convenient for Price Waterhouse please let me know.

Jim, I look forward to this very exciting project. With the level of interest I saw during my last meeting, this will be a very productive and satisfying engagement.

Sincerely,

Frank

Frank Dingler
Director Project Services

FD:pp

cc: Gary Brown
Ken Arfa

79 S Pine Drive
ker, Colorado 80134
03) 841-3393

Gary

October 19, 1987

Mr. Jim MacCallum
Chief Executive Officer
Hillcrest Health Center
2129 S.W. 59th Street
Oklahoma City, OK 73119

Dear Jim:

It was a pleasure being in Oklahoma City again. As I told you, I am very excited about the Good Neighbor Clinic program potential. I believe it will become the backbone of your network. I was also pleased to hear that your latest occupational health sale will be serviced through the Good Neighbor program.

The following is a synopsis of my visit.

Activities Conducted October 16, 1987:

- Interviewed Occupational Health sales candidate, Vicki Mathews. Discussed her background and how she would approach the Occupational Health program. Vicki seems motivated and knowledgeable about the healthcare industry, hospitals, physicians and their interaction. Ken Arfa will meet Ms. Mathews during his visit on October 21 and 22.

- Met with Ed Wiseman, P. Thibeault and Gary Brown about Hillcrest's information systems direction. Discussed needs for network support from data systems. Discussed pre-registration data base conceptual design.

- Interviewed Dr. Deiter. He was unable to keep his interview appointment during PMCI's physician visit.

- Reviewed draft of implementation action plan with G. Brown and J. MacCallum. Decided to start immediately with Physician Referral System and Occupational Health. Emergency Department Marketing will follow Occupational Health.

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- Discussed need for "Good Neighbor" clinics to be focus of initial network marketing effort. Need perception that hospital is moving and doing something positive for doctors. Resolved that pre-employment physicals and minor worker's compensation injuries will be directed into Good Neighbor clinics. G. Brown will develop coupon book for occupational health customers to redeem free visits. Coupon will be presented to Good Neighbor physician who will turn it over to hospital for payment.

Follow-Up Activity:

- G. Brown, E. Wiseman and C. Adams will visit Tulsa on November 18 to view Physician Referral program. As soon as site visit is over, Hillcrest needs to decide which referral system they will use. The service is to be of high priority to help build volume to primary care, and especially to Good Neighbor clinics.

- G. Brown to visit D.O. primary care locations in South Oklahoma City during October. He will explain Occupational Health program and how it feeds primary care. Only Good Neighbor clinics will be reimbursed for providing free occupational health services. After a couple more occupational health sales, hopefully more practices will see the benefit of joining the Good Neighbor program.

- K. Arfa to review Occupational Health program to date on his October 21 and 22 visit. After this visit, PMCI will prepare specific recommendations of program enhancements or changes prior to major sales efforts.

Recommended Activity for Next Visit:

- K. Arfa to interview Occupational Health sales candidate and review program.

- Finalize action plan priorities with J. MacCallum and G. Brown.

- Decide next visit for F. Dingler. First or second week of November.

- Review November through February's Good Neighbor promotions. Decide promotion media and who will develop copy.

- Conduct initial assessment for Womans Health Services.

- Assess public relations service provisions for network programming.

I will be back again early in November. By that time, you should have the next three to four months of Good Neighbor promotional campaigns identified. We can then tie them into the action plan.

Sincerely,

Frank Dingler
Director, Project Services

FD:pp

cc: Gary Brown
Ken Arfa

November 12, 1987

Mr. Jim MacCallum
Executive Vice President
Hillcrest Health Center
2129 S.W. 59th Street
Oklahoma City, OK 73119

Dear Jim:

Below is a synopsis of my November 5-6 visit. Gary and I covered our planned agenda, and he and I have agreed on the actions that must be accomplished in November.

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General:

1. Reviewed the initial medical staff data with J. MacCallum and G. Brown. Stated that PMCI is analyzing the demographic data to pinpoint which zip codes are under/over served. J. MacCallum agreed to review the initial data, and contact F. Dingler if there were any results he did not understand or agree with.

2. Determined the three new marketing/network positions. Occupational Health Manager, Physician Liaison and Public Relations Director have been approved by J. MacCallum. Since their salaries will be a significant budget variation, the expenditure must be approved by the Board at their November 24 meeting.

3. J. MacCallum and G. Brown will interview a public relations candidate on November 10.

Occupational Health:

1. Hillcrest has made an offer to V. Mathews as the Occupational Health Manager. Salary and commission negotiations are in process with offer slated for November 10. F. Dingler reviewed the proposed offer and suggested a minor change in the commission formula. Suggested the formula be reviewed in six months and one year.

2. Discussed proposed Occupational Health shingled folder with G. Brown. He will draft content and gain approval before sending it out for design, type setting and printing. Idea is to finalize content to help reduce production costs.

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03) 841-3393

3. G. Brown ordered list of South Oklahoma Businesses of 30 plus employers. Awaiting delivery of report from State Employment Agency.

Pre-registration:

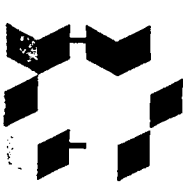
1. Outlined contents of the network pre-registration data base with E. Wiseman and G. Brown. Also, discussed how and who uses the data. Discussed possible entry points into data base and their needs, including: Hospital inpatient, hospital outpatient, marketing, business office, physician offices, consumer promotional programs, etc.

2. Discussed progress in developing consumer benefits with G. Brown. He has investigated Amcare and eye glass discounts. G. Brown will be meeting with YMCA next week. Waiting on a lead from K. Arfa before contacting pharmacies.

3. G. Brown and E. Wiseman will visit Tulsa on November 18 to view St. John's PRS. G. Brown will be looking at functionality while E. Wiseman will concentrate on the pre-registration data base aspects. Decision to proceed with PRS must be made immediately after visit as ROI needs to be prepared for Board approval of hardware and software. There is a 60-day lead from order to installation (minimum), so any delay could push PRS back significantly.

Emergency Services:

1. As part of the building project, a new building will be constructed in present doctor's parking lot. This building will be first phase of construction, with completion slated for August 1988. ER will be moved to new building while old ER is remodeled. Signage will be used in interim to inform patients of construction and ask indulgence. No temporary changes to present ER are planned in interim.



Physician Support:

1. G. Brown is to visit each Good Neighbor Clinic physician and as many other general practice physicians as possible between now and year end. He will explain Occupational Health program and other planned programs. He intends to solicit suggestions, complaints and answer questions. He will also use the opportunity to sign up additional physicians in Good Neighbor Clinic.

2. Toured Dr. Nichol's vacant office. Facility is modern and very well layed out with good location. The hospital should assist in finding a physician(s) who wants a practice location. Once an individual is found, PMCI can work with Hillcrest in developing an appropriate support package for the new doctor as part of the physician support program.

3. Interviewed Dr. Keith, general surgeon. Dr. Keith was unavailable during PMCI's initial interviews. Dr. Keith's comments were in line with comments made by previously interviewed doctors.

4. Good Neighbor Clinic doctors are responding very positively to initial consumer promotions. G. Brown will solicit additional ideas for promotion campaigns during his clinic visits. Goal is to have a different promotion monthly. Hillcrest will try to get agreement on 10-12 promotions, so the promotions are not repeated to often.

Women's Health:

1. Performed a women's health audit with L. Sewell, RN. F. Dingler will send audit questions to L. Sewell as a tool for what needs to be done in designing women's health.

Follow-Up Activities:

1. K. Arfa will attempt to discover status of South Communities Occupational health program and report results to J. MacCallum.

2. Presentation of network potential occupancy increases and financial impact on hospital to Finance Committee at their November 24 meeting.

3. G. Brown and F. Dingler to review progress to date via telephone conversation.

4. G. Brown to pull a sample of ER undoctor patients and determine how many were referred and results. ER says they refer these patients, primary care complains they only get poor paying patients through the program.

5. Finalize consumer benefit package.

6. Send womens health audit to L. Sewell.

7. Call Dr. Mobley on phone. Unable to meet with him this last visit.

8. Draft shingle content of Occupational Health Phase I package.

9. Begin V. Mathews orientation.

Jim, we are making real progress - particularly in Occupational Health and Good Neighbor Clinic physician acceptance. The next month will see continued progress in these programs, as well as major progress in selecting and planning the installation of PRS. If you have any questions or problems, please call.

Sincerely,

Frank Dingler
Director, Project Services

FD:pp

cc: Ken Arfa
Gary Bauer

December 23, 1987

Mr. Jim MacCallum
Chief Executive Officer
Hillcrest Health Center
2129 S.W. 59th Street
Oklahoma City, OK 73119

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rketing
nsultants, Inc.

Dear Jim:

I hope you have a wonderful holiday break, and I enjoyed visiting with you last week. I am listing below those activities that were conducted on December 17 and 18. I am also outlining the follow-up activities that need to occur in preparation for next months programing.

<u>ACTIVITIES CONDUCTED ON DECEMBER 17th and 18th</u>

- Met with Dr. Mobley to discuss potential practice acquisition. Dr. Mobley currently has an office with four treatment rooms, plus an emergency treatment area. The patient waiting area has enough seating for approximately 20 persons. There is an x-ray unit and a separate lab area, along with an x-ray technician. Dr. Mobley desires to either sell his practice or to divest it altogether. His incentive to scale down his practice is the numerous hours of management required by the practice. Dr. Mobley would be willing to continue working at that location if he did not have to dedicate his time to practice management. He would be willing to either, (a) sell the practice, (b) have an entity manage the practice, or (c) have a new intern take over the practice and purchase the practice based on a percent of revenue collected. I indicated that I would speak to Hillcrest management about performing the following services for him:

  a. The Physician Liaison Representative would assess his practice and distribute sale information to other physicians in the community.

  b. We will contact the OU Medical School, and the D.O. Medical School in Tulsa to identify potential candidates for practice buyout.

  c. Hillcrest Health Center will speak with all interns to determine their interest in the practice.

d. Hillcrest Health Center will inquire into potential management companies that might be willing to provide management of the practice in exchange for a percentage of revenues collected.

Dr. Mobley appeared to be very satisfied in terms of the follow-up work that we reviewed, and he understands the hospital's position in term of being unable to purchase his practice due to political and financial constraints.

- Furnished Gary Brown with Physician Liaison advertisement to fill that position when appropriate.

- Review the status of the letters that were sent to HHC physicians to inquire about their willingness to participate in various marketing programs.

- Worked on the development of the Consumer Benefit Package and Occupational Health Package.

- Discussed Physician Referral Program. South Community Hospital will be receiving the Baxter Travenol Software package any day now. Our market intelligence sources indicate that they are in the process of installing the IBM System II, however, they are awaiting delivery which may take several months. The Baxter Travenol software will thus not be put into effect until they receive the delivery of hardware.

- Created final name recommendations for the Consumer Health Package "Connection Card", along with other recommended names such as "The Senior Connection", The VIP Connection", "The Womens Health Connection", etc.

- Completed final recommendations for the yellow pages ad, and other promotion related to PRS.

- Met with the physician marketing committee, and explained the marketing program proposals. Received initial support for all programs including Occupational Health Marketing, Emergency Services Marketing, Physician Referral Services, and the Physician Liaison function. The

physicians reviewed major services they felt would be in demand, and stressed the importance of laying the ground work for an information system which would support reimbursement activities in their offices. Thus, computer support services were heavily supported. PMC recommends that HHC consider the installation of two or three test sites.

During the meeting, the physicians also expressed their initial endorsement of using the name "South Oklahoma City Physician Referral Service".

- Met with Dr. Dieter and partner to discuss the marketing of OB services. In brief, follow-up activities were listed as follows:

  1. Intensified marketing to general practitioners to invite their referrals. This should include continuing medical education activity.

  2. Encourage increased referrals from the emergency department of paying patients.

  3. Promote OB services through targeted occupational health accounts that have a high percentage of females in the working force.

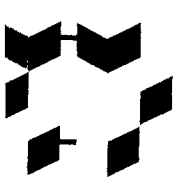
  4. Explore affiliations with tertiary hospitals that can provide backup services for high risk delivery cases.

  5. Promote $50 mammographies and other health specials to employers and the general public.

  6. Offer discounts on gynecology assessments promoted to the public and occupational health accounts.

  7. Heavily promote Ob/Gyn physicians through the physician referral services.

  8. Utilize HHC agreements such as the Blue Cross/Blue Shield PPO provider and Prucare contract to increase Ob/Gyn referrals.



9. Survey remote DO physicians to see if they wish local Ob/Gyn's to perform diagnostic procedures such as Colposcopies and ultrasounds, possibly at reduced or no charge. Also, survey physicians to assess demand for Indametrio Biopsies.

10. Explore Ob/Gyn needs in communities such as Shawnee, El Reno, Harrah, and Mustang.

FOLLOW-UP ACTIVITIES

- Complete remote survey instrument, and mail out first few weeks in January.
- Advertise DONE for the Physician Liaison position.
- Collect and tabulate the results of the physician marketing letter that was sent out.
- Complete the consumer benefit package including Amcare benefits, and complete the Occupational Health package.
- Have Pete review discounting percentage package, and finalize this benefit.
- PMC to furnish HHC with "Health Yourself" document.
- PMC to furnish HHC with remainder of the general business plan package.
- HHC to determine hardware and software for PRS system, along with pre-registration hardware and software package.
- Medical Coordinator needed for physician support program. Tim King?
- Occupational Health Medical Director needs to be formally endorsed. Dale Askins?
- The Network Physician Advisory Committee needs to be finalized and endorsed. DONE
- The finance committee needs to approve a budget for the physician support network program.

- Graphic work for the "Connection Card" and all related collateral materials need to be developed.

- The Public Relations Director needs to be recruited as soon as possible, and in the interim materials immediately necessary need to go into production through contractual arrangements.

- The Physician Referral Service ads and announcements to the community need to take place as soon as possible.

- Patient lists from the emergency room for undoctored patients need to be finalized.

- The employee and employer zip code analysis needs to be completed. CLOSER

- Practice Management contract resources in the community need to be identified.

- Collection agencies need to be assessed for inclusion in the physician benefit package.

- In January, Deborah Martin from PMCI needs to visit with HHC to draft the Woman's Health Promotion plan.

Thank you for your attention to the above matters, and I will be looking forward to seeing you next month.

Sincerely,

Kenneth Arfa
Executive Vice President

KA:pp

cc: Gary Brown

Gary's c

January 12, 1988

Mr. Jim MacCallum
Executive Vice President
Hillcrest Health Center
2129 S.W. 59th Street
Oklahoma City, OK 73119

Dear Jim:

I wish I could say I enjoyed the wonderful weather last week! I never thought I'd ever look forward to getting back to the winter weather in Denver - as they say, there's always a first time! Below is my trip report.

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Activities Conducted on January 5-7:

- Completed remote physician mail-out survey instrument.
- Determined automation system plans for PRS.
- Helped acquire approval for preliminary network staffing from Mr. Myro.
- Met with Mike Reger (market intelligence).
- Furnished HHC with vendor agreement guidelines for the consumer benefit package.
- Provided HHC with the Manual Physician Referral System.
- Provided HHC with the Employer Cost Containment program to be included with the consumer benefit package.

Follow-Up Activities:

- Complete Phase I of the Occupational Health Promotional package.
- Meet with ER medical Director re: Occupational Health program and Emergency Marketing.
- Meet with Dr. Hughes and Dr. King for update session.
- Meet with Pete regarding Occupational Health program.
- Plan next meeting for Network Physician Advisory Committee.
- Coordinate as appropriate with Board Finance Committee/Chairman.

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arker, Colorado 80134
03) 841-3393

- Help HHC prepare master marketing budget.

- Deborah Martin, of PMCI, to meet with Drs. Dieter and Motz, and OB Coordinator to prepare Womens Health Marketing plan.

- Meet with new PR Coordinator and Practice Liaison candidates.

- Meet with Practice Management contract candidates.

- Work on completion of Connection Card Campaign and all related promotional pieces.

- Arrange for BMC marketing plan initial marketing audit.

- Gary Brown needs to send follow-up letter to Dr. Dieter and partner (see December 23rd trip report).

I am scheduled to arrive on my next trip at approximately 10:30 a.m. on Thursday, January 21st. I expect to be on site until Friday at about 3:00 p.m. I'll look forward to seeing you then!

Sincerely,

Kenneth Arfa
Executive Vice President

KA:pp

cc: Gary Brown

February 12, 1988

Mr. Jim MacCallum
Executive Vice President
Hillcrest Health Center
2129 S.W. 59th Street
Oklahoma City, OK 73119

Dear Mr. MacCallum:

I would like to recap the activities of my visit to your hospital on February 10. First, however, I was disappointed that I did not get to meet you. Nevertheless, I was given a thorough tour of the hospital and was introduced to many of your managers by Gary Brown.

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Physician Referral

I met with Gary Brown at length to set strategies for promotion and support of the PRS line. I suggested revisions to the yellow pages ad which Gary adopted. I met with Betty Overstreet to provide initial training and advice regarding operation of the PRS line. This proved to be a very timely intervention on our part which will enhance her ability to handle inquiries on kickoff day, February 15, 1988. I also met with Pete Thibeault regarding the "Advanced Revelations" alternative to the System 36. PMCI does not object to this alternative, if it can be shown to operate as promised. Its projected cost-effectiveness is dramatic.

Behavioral Medicine Center

I met with Betty Chase and discussed the key ingredients of our contract to provide marketing support to BMC. She gave me a briefing on the organization, operations, and strengths of her department. She also related the perceived new threats in the market. Since 1988 is a very critical year for BMC, it is important to intervene quickly to increase the involvement of the medical staff in BMC. The interface with the PRS line was discussed as one mechanism for that purpose.

Occupational Medicine

Vicki Matthews briefed me on the development of collateral materials for sales calls. Gary Brown provided me with copies of the draft materials: a three-fold brochure and a re-formatted loose folder version of the bound document. Vicki's goals are to enroll four companies per month between February and April. We discussed the advisability of concentrating on companies located in the general vicinity of Hillcrest.

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AmCare

I discussed with Gary Brown strategies for attaining closure with AmCare for the benefits package. After some brainstorming, I recommended that Mr. MacCallum contact the Executive Director to propose the following: Connection Card holders will be encouraged to subscribe to AmCare. Since AmCare's annual subscription runs October, 1988 - September, 1989, Connection Card holders who pre-pay for 88-89 this spring would be covered free prior to October.

If you cannot effect this or a similar agreement, Mr. Myro should be asked to intervene.

Connection Lines

I would like to clarify one point regarding the telemarketing program. Three separate lines will be promoted: South Oklahoma City Physician Referral, the Women's Connection Line, and a multipurpose Connection Line. All would be answered by the PRS operator, and all would employ the same hardware/software configuration.

Follow-up Activities

I will continue to advise the PRS operator as needed. I will also schedule a return visit to advance the Behavioral Medicine component of our marketing contract.

My compliments to Hillcrest. The hospital and personnel made for an enjoyable and productive visit.

Sincerely,

Todd Hamilton

Todd Hamilton
Director, Client Services

TH:pp

cc: Gary Brown
Ken Arfa

M E M O R A N D U M

TO: Jim McCallum

FROM: Ken Arfa

RE: February 25-26, 1988 Trip Report

DATE: February 26, 1988

==========

Below are those activities that were conducted, and those that need to take place before my next visit. Jim, there are some areas concerning project action delays which I would like to address in this trip report. They relate to Network Information Systems, Print Media Production, and project focus regarding Gary Brown's time.

NETWORK INFORMATION SYSTEMS:

Two weeks ago we were advised that Hillcrest did not wish to select the System 36. In that there was a preferred local alternative. While we seriously hope this alternative is the right answer for Hillcrest, we need more information about the progress being made with the physician referral software development, and with pre-registration software development.

Please understand that the St. John's software we recommended took us almost one year to develop in conjunction with that hospital. While I hope the "advanced revelations" package is able to meet your needs, Rich has some serious concerns that the development of these programs will require excessive time demands on your staff. Consequently, this could result in delays to our action time table.

Finally, please remember that our contractual committment in Network Data Systems is limited to the review of software requirements and the identification of development requirements. As for the physician referral program, our contractual obligation is to "select a computer software package". As HHS has choosen not to adopt our selection and rather develop its own software, we cannot be responsible for any resulting delays or program consequences in the action plan.

Next week, you, Pete, and Gary will be receiving our functional design recommendations for the Network Control System with response to Appendix I(H) in our contract. At this point we await internal decisions at Hillcrest regarding your hardware and software network configurations. When these major choices are

made, it is important that your information systems department coordinate with Rick Ekwall to further discuss interface with the various components of the Physician Network Program. If you have any questions about this, please let me know.

PRINT MEDIA PRODUCTION

The HHC PR coordinator internal budget vacancy delays and employee turn-over has delayed the design and production of the following:

- Pre-registration materials
- Physician referral brochure
- Occupational health materials

Even with a full-time PR Director, it is unreasonable to expect design of all these materials to be done in-house. The time and equipment is simply not available. I am glad that you have agreed to proceed with this activity on a contractual basis. It is imparative that these materials be ready for production in two to three weeks, so we can share them with the Physician Marketing Committee, and not lose precious timing.

MARKETING DIRECTOR'S TIME

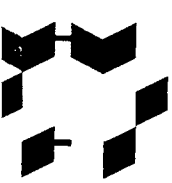
Gary's time is continuing to be pre-occupied with many non-network distractions. These include special events, public relations functions, etc. While I hope that the new PR Director position will resolve this problem, it is imparative that these distractions be cut to a minimum. Our plans have always called for a full-time director on-site. HHC agreed to commit to this at the onset of the project.

OCCUPATIONAL HEALTH

There are three target markets that Viki Matthews needs to focus her attention upon. These three markets should be quite lucrative for HHC:

- Vendor companys in Oklahoma City that supply HHC
- Board member contact companies
- Company contacts through the medical staff

HHC should also consider a "business advisory board" for the occupational health program. This advisory board should help HHC identify further employer needs and identify good prospects.



PHYSICIAN MARKETING STEERING COMMITTEE

Follow-up:

- Eligibility criteria for the Physician Referral Service needs to be discussed and approved at the next meeting.
- A special inventory of physician capabilities at HHC that can be promoted to remote areas needs to be conducted.
- Patient lists for the connection card need to be collected from participating physicians.
- Physician office brochures and application forms for pre-registration need to be distributed. This function will eventually be performed by the physician representative.
- Physician front office staff need to be educated regarding the physician referral service and the pre-registration program.
- The Good Neighbor Clinic promotions in Diabetes Screening and Mammography this Spring need to be tied into the Connection Card mail-out and promotions.

NETWORK ADMINISTRATIVE TASK FORCE

We are at the point in the project that it will be extremely important for an on-going Network Administrative Task Force to meet each time we visit. This task force will be involved in every facet of network activity, and I would recommend that you consider the following participants: CEO Chief Financial Officer, Marketing Director, Director of Information Systems, Director of the Business Office, Occupational Health Manager, Public Relations Director, Physician Liaison Representative, Personnel Director, Director of Nursing, and Emergency Department Supervisor. Pete Thibeault, Larry Brown, Eddie Wiseman, Phil Ross, Vicki Mathews, Teresa Bekke Wanda Llewellen, Vicki Casey, Mike O'Connell, Betty Cross

This committee will meet for the purpose of being directly involved in network activity, and for the purpose of providing input into the process. We need to instill a sense of ownership among all participants and make sure that all participants are well educated about the importance of the program. At each meeting, appropriate tasks will be assigned to make sure that the program has continuity. If there are any revisions, additions, or deletions that you feel need to be made on this list, please let me know.

WOMAN'S HEALTH PROGRAM

I am enclosing a copy of the Woman's Health Report relating to Debbie Martin's recent visit. A copy of this report with the

exception of the budget figures has been forwarded to Dr. Deiter for his review and comment.

BEHAVIORAL MEDICINE CENTER

Todd Hamilton is planning on visiting BMC to work on the BMC Marketing Plan within the next few weeks. He will coordinate his visit with you, Gary Brown, and Betty Chase. When he arrives on this visit, it is important that the following information be ready:

- Census by month per unit 1986 - 1987.
- Number of admits by referral source and category 1986 - 1987.
- Number of admissions by admittor.
- Patient orgin of admissions.
- Any previous attitude studies, awareness studies, level satisfaction reports.
- Current physician relations strategy.
- Data on crisis line calls and disposition.

We have concerns over the low percentage of direct physician referrals to the BMC. Other site programs dealing with general adult, adult CD and adolescent CD has much higher percentages of direct physician admissions. As a part of our contract obligation, Todd Hamilton will also plan to interview several physicians to learn more about referral issues. I am enclosing a draft outline of the Marketing Plan for your review.

Jim, I will be speaking with you soon to schedule my next visit, which will hopefully be in conjunction with your next board meeting. At that time we can also discuss Debbie Martin's next site visit. Thank you for your attention to these matters, and please contact me if you have any questions.

KA:sm

cc: Gary Brown
Pete Thibeault

M E M O R A N D U M

TO: Jim MacCallum

FROM: Ken Arfa KA.

SUBJECT: Trip Report, March 16 through March 18, 1988

DATE: March 25, 1988

==========

Below are the activities conducted during our recent visit, and the follow-up activities that need to be addressed:

Activities Conducted:

- Reviewed pre-registration, physician referral, and occupational health promotional materials with Denise York, Teresa, and Gary.
- Met with Physician Marketing Committee.
- Met with Ob/Gyn physicians to discuss Women's Health Plans.
- Discussed Occupational Health Sales Strategies with Viki Mathews.
- Discussed PRS program with Betty Overstreet.
- Met with Wanda Lewellen to prepare for employee orientation regarding Connection Card.
- Presented orientation to the Network Administrative Task Force. (Rich Ekwall was present.)
- Met with Pete to discuss System 36 VS Advanced Revelation Package. (Rich Ekwall was present.)

Follow-Up:

Pre-Registration:

1. ~~Favorable~~ account patient listings need to be generated as ~~soon~~ as possible, and keyed in.
2. ~~Denese~~ York needs to have all printing completed within the ~~next two~~ to three weeks.

3. Arrangements need to be made for mail-out preparation and fulfillment.

4. Physician office patient lists need to be collected through a request from Dr. Hughes and purged from hospital master list.

5. Pre-Registration application forms need to be printed.

6. Connection Cards need to go into final production (Gold cards need to be ordered).

7. Mailing lists from third party insurers need to be obtained if possible, and duplicate names purged from HHC master list. VC WA4

8. A special insert for the Connection Card mail piece on family screening at Good Neighbor Clinics, physician referral, and Woman's Health Screening Special, needs to be developed.

9. The copy on the Connection Card brochure and direct mail piece program description needs to be changed to include a basic description of non-health related discount benefits (Anthony's, Tires, etc.).

10. Wanda Lewellen needs to follow-up on non-health related discounts.

11. Todd Hamilton or Cindy Martinez need to visit to "train the trainers" for the Connection Card orientation program.

Physician Referral Services:

1. ER undoctored lists must be provided to Betty Overstreet. For some reason, there is a lack of cooperation which needs to be rectified.

2. The hardware and software for the System 36 needs to be ordered.

3. Newspaper promotion, and the posters, needs to be placed on an ongoing basis.

Occupational Health:

1. Viki needs to have the HHC purchasing director make appointments for her off the vendor list.

2. Employee contacts through HHC employees need to be acquired during the Connection Card orientation session.

3. A drop package needs to be produced by April 15. This should include independent summary sheets that can be used interchangably. (This should also include the discount program.)

4. The employee nurse program needs to be discussed at the next Physician Marketing Committee meeting.

Physician Marketing Committee:

Follow-up letter from Dr. Glensky needs to be sent outlining:
   a. Policy on physician eligibility.
   b. Rights of committee to modify participation requirements in order to protect the integrity of the program.
   c. Screening program offer as recommended by the marketing department (Gary and Ken to discuss).

Women's Health:

1. The Physician Marketing Committee and Ob/Gyn department needs to write letters to the Med Executive Committee and Board requesting support for a Women's Health Center Program.

2. A Women's health special promotion needs to be developed and put into the direct mail piece for the May Connection Card campaign.

BMC:

~~Todd Hamilton~~ and Dr. Mel Kolb to finish marketing plan in April.

Physician Support:

1. ~~Betty Overstreet~~ to have Physician Sub-Specialty list and ~~outpatient~~ diagnostic inventory completed by March 31st. Ask

2. Physician benefit package needs to be developed.

3. Liaison position needs to be filled in April.

4. Physician purchasing company issue needs to be explored.

I am looking forward to the Board presentation on March 22nd, and will see you then. In the meantime, if I can answer any questions regarding the above items, please let me know.

Sincerely yours,

Kenneth I. Arfa

cc: Gary Brown
Richard Ekwall
Todd Hamilton

KIA/bd

April 8, 1988

Mr. Jim MacCallum
Administrator
Hillcrest Health Center
2127 SW 59th Street
Oklahoma City, OK 73119

Dear Mr. MacCallum:

Following is a recap of marketing activities at Hillcrest on April 6 and 7, 1988. It was especially productive to attain closure on the software issue for the Connection Card and I am very hopeful that Information Services will be able to provide the promised support.

Activities Conducted

- Start-up conference with Mr. MacCallum.

- Planning conference with Betty Chase and Lou Neimens. Subsequently drafted objectives and instrument for interviewing referring physicians. Obtained their review of instrument. Obtained list of target physicians. Also, discussed role of Dr. Mel Kolb. BMC's present need is for his technical assistance and advice regarding the open staff model. Their preference is to schedule his on-site visit for July, when Dr. Neller can be on-site.

- Conducted series of meetings with Mr. MacCallum, Mr. Thibeault, Mr. Weisman, Mr. Brown and Mr. Vanderwater re: Connection Card Software. The executive decision was to assign Information Systems the responsibility for developing the software with their recommended D-base code. Earlier, Mr. MacCallum decided to defer installation of the Advanced Revelation Physician Referral Software until such time as it can be demonstrated that automation is required (by volume of calls, complexity of referrals, and tracking requirements).

- Composed letter for Dr. Hughes signature requesting physicians to provide mailing lists for the Connection Card. Gary Brown obtained Dr. Hughes' cooperation in this matter.

- Provided report of remote physicians survey to Mr. MacCallum and Mr. Brown.

- Provided proposed job description of Data/Benefits Coordinator to Mr. MacCallum and Mr. Brown.

- Met with Ms. Wanda Lewellen re: a) assessment of project progress; b) non-health discounts package from recreational areas; and c) Connection Card orientation. "Training the Trainers" is scheduled for April 25. Employee orientation is scheduled for the following days.

- Met with Drs. Motz and King re: Women's Health Center, Baby Express, and Connection Card incentives for women.

- Met with Dr. Glinsky re: Physician Referral, Pre-registration, Women's Health Center, Employee Nurse Programs, Business Office Staff Training, Physician Marketing Committee Meeting Agenda, and communication with MEC and Board.

Follow-up:

<u>Pre-registration (Connection Card)</u>

1. Information Services to develop D-base code for the Connection Card with outside support as required to meet deadlines. PMCI and Marketing to define features for inclusion.

2. Marketing to provide copies of prepared materials and status report/schedule of remaining materials.

3. Marketing to confirm mailing house, embossing, and fulfillment arrangements.

4. Data/Benefits Coordinator needs to be recruited and placed. For the interim, Betty Overstreet will input lists. However, this must be limited or it will adversely affect the referral service.

5. Marketing to obtain Dr. Hughes' signature for letter to physicians re: mailing lists.

6. Marketing to prepare "Initial Ob/Gyn Screening" invitation for inclusion in package. This will be reviewed by the Ob/Gyn staff on April 13.

Physician Referral

1. Marketing to prepare media plan and budget.

Occupational Health

1. Vicky Matthews needs to make use of Jim Osborn's assistance re: vendor contacts.

2. Drop package MUST be produced.

Behavior Medicine Center

1. Betty Chase and Lou Neimens to review final interview instrument (attached).

2. Administration to schedule interviews per attached list and schedule, for April 27-28.

3. Todd Hamilton and Dr. Kolb to provide consultation re: Open Staff Model.

4. Dr. Kolb to consult on-site in July (tentative) per BMC request.

5. Interim Marketing Strategies recommendations to be submitted within 10 days of physician interviews.

Physician Support

1. Betty Overstreet to continue obtaining Physician Subspecialty list and outpatient diagnostic inventory.

2. Benefits for Physician Services Directory need to be drafted; Jim Osborn to review and edit/enhance draft re: group purchasing opportunities.

3. PMCI and Marketing to submit memorandum re: implications for the Network of the Rural Physicians Survey.

4. Administration should contract with Nicholas Hahalis, for 3 months, for physician liaison. Mr. Hahalis should initially identify specific "coding for reimbursement" concerns of doctors. This should be communicated to Sonja Hooks prior to May 2nd workshop. During Ms. Hooks on-site visit she should interview Mr. Hahalis and provide her assessment of his strengths and weaknesses to Administration.

Women's Health

1. Ob/Gyn meeting on April 13 to address:
   a) representation on Physician Marketing committee (PMCI recommends nominating Dr. Motz to Dr. Hughes)
   b) rename "Baby Express"
   c) review proposed "initial visit invitation" for Connection Card mailing
   d) endorsement of Women's Health Center plan to MEC and Board

Budgets

1. Per Mr. MacCallum's direction, PMCI and Marketing will prepare an all-inclusive marketing budget for FY 88-89 addressing all PMCI recommendations, as well as routine hospital marketing, PR, etc.

Miscellaneous

1. Given the expected lack of success in acquiring third party payors' subscribers lists, Hillcrest will, as an alternative strategy convene a meeting between Administration, Marketing, CompMed, and PMCI to establish cross sales strategies. PMCI's role will be to elevate the discussions

from the present level of interpersonal to that of inter-institutional dialogue for the purpose of establishing a de-facto marketing consortium.

2. Information Systems and Marketing should supply to the PRS Coordinator:

   a) better office lighting
   b) multi-line phone with headset
   c) auto-feed copy stand (with lighted magnification) to facilitate reading/inputting from printouts.

Jim, we are looking forward to returning on the week of April 25 (Cindy Martinez - Monday, and Todd Hamilton - Wednesday and Thursday). Thank you for your hospitality and decisiveness during my time on-site.

Sincerely,

Todd Hamilton

Todd C. Hamilton
Director of Client Services

Attachments
1. Letter to target physicians re: BMC interviews
2. BMC Interview Instrument
3. Interview Schedule
4. Physicians to be interviewed
5. Agenda for Physician Marketing Committee

cc: Gary Brown
Kenneth Arfa

MEMORANDUM

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To: Jim MacCallum, Pete Thibeault, Gary Brown & Staff

From: Todd Hamilton

Date: June 9, 1988

Subject: Trip Report June 6 & 7, 1988

****

Once again, I enjoyed my visit to Hillcrest Health Center. This visit focused on numerous details identified in Ken's previous correspondence.

Activities Conducted

- Briefing and Exit Conferences with Jim MacCallum.
- Submission of Draft ER Marketing Plan.
- Preliminary report and clarification of goals with Lou Neidens (BMC).
- Consultation with Gary Brown re: Budgets, Personnel Issues, Software/Hardware Requirements, etc.
- Meeting with Physician Steering Committee re: Project status, mailing lists, and patient enrollment.
- Observed Marketing Department's presentation to General Orientation.
- Meetings with Pete Thibeault, Eddie Wiseman, Gary McElwez re: Hardware/Software requirements.
- Conference with Nick Hahalis re: Practice Audits, Referring Physician Research, and Physician Services Directory.
- Meeting with Wanda Llewellen re: Connection Card Orientation and personnel issues.
- Meeting with Pete Thibeault, Barbara Reeves, Shane Burge, Bob Reynolds re: training staff to process enrolled patients.

- Meeting with Vicky Mathews re: Good Neighbor Clinic Guidelines and operational issues pertaining to occupational health sales and staffing, and Advisory Board.

- Meeting with Betty Overstreet re: Physician Referral activity, reports, and policies.

FOLLOW-UP REQUIRED

General Administrative

- Since new office space has been dedicated in the Medical Building, immediate attention must be given to telephone and computer linkages with the hospital.

- Since PMCI submitted the required budget report spreadsheet, Gary Brown needs to break out the figures and report them to PMCI by 6-17.

- Tracking reports have been developed by PMCI and are attached.

Connection Card Program

- As suggested at the Physician Steering Committee, admit packages should be provided to physicians offices due to the large numbers of "direct admit" patients. I would appreciate it if Pete could address this to Barbara Reeves for implementation by June 17.

- Pete also needs to monitor the Preparations by Admitting, ER, and lab for combined training re: Connection Card. Barbara, Shane and Bob agreed to set the training, with marketing and DP's assistance, within two weeks.

- Bob Reynolds also volunteered to draft the protocol for cholesterol screenings, and to send it to PMCI for review.

- Marketing is conducting Connection Card Orientation for new employees on the first Monday of each month. Since the card goes live soon, employees should begin enrolling during the next General Orientation. Additionally only 297 of the 600 HHC employees reportedly attended the initial training sessions. The remainder should be trained within a month.

- Administration, Personnel and Marketing have all endorsed filling the Data/Benefits Coordination position. This should be a high priority for Gary. The better candidates should be interviewed by other department managers, too.

- The enrollment software will reportedly be complete by June 10, excluding report writing. A copy should be submitted to PMCI for testing, since we have only received onsite demonstrations.

- Gary is collecting quotes for three PC's (ER, Admitting, Connection Line) upon which the card files will be stored and accessed pending installation of the LAN. These quotes should be called into PMCI ASAP for submission to Jim MacCallum.

Physician Referral/Telemarketing

- PMCI reviewed the correspondence which was sent to Physicians re: financial screening. Replies to that should be attached to Betty's Monthly report.

- A consolidated monthly report is attached. Please evaluate this in lieu of current multiple forms prior to the end of June.

- Mr. Thibeault decided that an external source for PRS software was needed. Current contenders are National Health Enhancement Systems or Advanced Revelation. An early decision would be welcomed, and will certainly enhance this exemplary program.

Occupational Health

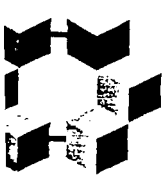
- The draft guidelines for Good Neighbor Clinics need to be reviewed by that committee. Gary should inform us of the schedule and the outcome.

- A temporary 3-11 shift Clinic Coordinator has been identified beginning July 1. Gary and Vicky need to work with her while continuing to recruit for full-time day shift coverage.

- The Drop Package components have been submitted for PMCI's review. Please proceed with scheduling printing.

- Vicky needs to write up by June 17 the competitive information obtained, and submit it to PMCI. Additionally, revisions to previously critiqued protocols need to be sent to PMCI.

- Before our next onsite visit, Vicky needs to have organized the nucleus of an Advisory Committee, per our discussion.



Physician Support Services

- The Directory is progressing nicely. Nick or Teresa need to notify us weekly re: status. Nick should also send us a proposed Table of Contents, and the corrected drafts (thus far), by June 17.

- The Admitting Department has been asked by Nick to continue collecting referring physician's data. Nick's analysis will chart the "from-to" of referrals as well as identifying the "from".

- The Physicians Support Business Plan and the automatic Connection Card enrollment need to be drafted prior to our next visit.

Emergency Services

- The draft ER Plan needs to be reviewed in detail by Gary and discussed with Dr. Askins and the ER manager. At our next onsite visit we need to have a meeting with those people to discuss the timing of implementation given the construction.

BMC

- On June 13 Lou Neidens and Betty Chase will draft the previously requested memo outlining Dr. Kolb's specific consultation function. This will be rushed to me, and I will immediately follow-up with Mel. The consultation will be conducted between June 15 and 30.

Summary

This was very productive trip, and also instructive, I think, for Denis D'Amico. I was pleased to see how receptive the HHC staff were regarding his association with PMCI.

Since our next strategy session will be offsite, we cannot specify the next onsite visit date, but will work that out by telephone.

Attachments

1. Sample form for collecting referring physician data in Admissions.
2. Tracking Reports
3. Highlights of BMC Physician Interviews

cc: Ken
Rich

VITA

Gary A. Brown

Candidate for the Degree of

Master of Business Administration

Thesis: DEVELOPMENT AND IMPLEMENTATION OF A PHYSICIAN SUPPORT NETWORK AT HILLCREST HEALTH CENTER: A CASE STUDY

Major Field: Marketing

Biographical:

Personal Data: Born in Ardmore, Oklahoma, August 16, 1959, the son of J. Delbert and Virginia Brown.

Education: Graduated from Putnam City High School, Oklahoma City, Oklahoma, in May 1977; received Bachelor of Science degree in Business Administration from Oral Roberts University, Tulsa, Oklahoma, in May, 1981; completed requirements for a Masters of Science degree at Oklahoma State University in June, 1989.

Professional Experience: Director of Marketing at Hillcrest Health Center, March, 1987 to November, 1988.