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CREATING AN EXPERIENCE MONOPOLY

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Mediocrity, n. – med-i-oc-ri-ty. The quality of being average or lacking in exceptional quality or ability.

I'm consistently amazed how often, when speaking with potential new client groups, that the response to my question, "What sets your group apart from other radiology groups?" is something akin to, "Nothing really. We do what most other groups do. We're all board certified or board eligible." With some additional prodding, the response might be kicked up a notch to something like, "Well, we *are* benchmarked to best practices."

But what does "benchmarked" really mean? It means that we, too, follow the leaders – that we, too, are . . . mediocre. In fact, if everyone benchmarked to best practices, there'd be no modern medicine, no radiology – we'd just be *really* good at praying for divine intervention.

In order to achieve a transformationally better future, it's anathema for your group to simply do what every other group does, even if it's doing what the best of everyone else does. Instead, your radiology group

should be devoting significant effort to creating a monopoly in terms of the experience that the group provides to its "customers:" hospitals, referring physicians and patients. The term I use to describe this experience monopoly is a Unique Hospital/Referral Source/Patient Experience™.

The reason why this is so important goes far beyond the immediate, and highly valuable, impact on the individuals your group's service affects, from patients to referral sources to hospital administrators. The importance goes all the way to the relationship between your group and the facilities at which it provides services, especially to the relationship preserved by way of an exclusive contract.

In order for you to get a better understanding of what I mean, and why it's important to you, I need to share some of the secrets of exclusive contracting and stipend support negotiation.

If you were to pick up any one of the popular books on negotiation they'd be crammed full of advice, almost all of which is totally useless in connection with negotiating agreements between radiology groups and healthcare facilities.

That's because traditional negotiating strategy applies to a contractual relationship that *concludes* upon the transaction. I refer to those kinds of deals as "Transactional Contracts™." Examples would be buying a car, agreeing on a price for real estate, or coming to terms on the price of a year's supply of widgets. Each of those negotiations builds up and then culminates – it culminates in a deal in which the parties exchange, say, widgets for dollars and then part ways.

But exclusive contract relationships between radiology groups and facilities are entirely different. They fall into a category that I've termed "Relationship Contracts™" – instead of culminating in a "closing," at which point there is an exchange of money for goods or services, and at which point the parties part

ways, this second set of contracting culminates in the creation of a *relationship* which then, as of the "closing," continues forward in time.

Because of this, radiology groups need to take a different approach, both in terms of the process of obtaining an exclusive contract relationship with a facility and especially in terms of the process of getting that contract renewed or extended or expanded.

In my practice, I've given this process a name, The Strategic Group Process™, but no matter what you call it, it recognizes the fact that the complexity of Relationship Contracts is such that instead of there being a time line . . . steps 1 through 4 carried out in sequence over time toward completion (like in the manner of a Transactional Contract) . . . Relationship Contracts require a process based approach that implements a number of substrategies, and their ensuing tactics, *concurrently*.

Among the substrategies that groups must implement are those aimed at positioning your group so that it is viewed by the hospital administration and the by medical staff as the only conceivable provider of radiological services. Creating an experience monopoly is one of those positioning strategies.

We know that humans tend actually to make most decisions on the basis of emotions, not intellect, and that they then "back fill," in a manner of speaking, their preliminary emotional decision with "facts" that they can use to justify their emotional decision to third parties.

I'm not suggesting that facts are not important. What I am suggesting, is that radiology group leaders must understand that negotiation is not simply about hard facts -- just who tells the better story, your group or a another radiology group, your group or the hospital, your group or the leader of the cardiology group, might mean who wins the economic battle.

The unique experiences of which I write are valuable both because of the real benefit they bring to their intended audience and because they tell the broader story that only your group can provide that package of experiences, experiences which other groups would never consider delivering even if they could understand their importance.

What your set of unique experiences consists of will depend completely on your circumstances.

For example, how does your group interact with referring physicians? What transpires upon a referral? How are reports delivered to referring physicians? Are there differences among referring physician in respect of preferences as to those reports and how does your group address them? What deliverables are provided to the referring physicians? What follow up exists?

Asking these and other questions in respect of the group's relationship with referring physicians, hospital administration and patients will help you design a truly unique set of experiences, an experience monopoly that will distinguish your group from all would-be competitors.

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