

Physician relations programs: In today's operating environment, a whole new ballgame

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A radically changed hospital operating environment means that programs to build and sustain relationships with physicians have to be radically different too, say senior market planning executives and consultants. Every hospital needs to have a physician relations program, and it can't be simply about pleasant individual outreach to local doctors anymore.

What with market competition intensifying, hospitals pioneering new service lines, physicians creating specialty hospitals and outpatient services, and the medical profession's increasing geographic mobility; nothing can be left to chance, the experts counsel.

Our interviews with these experienced professionals turned up some fundamentals for success, case examples of strategies tailored to specific market challenges, and a closer look at the most difficult requirements for success.

The fundamentals

- ❑ The essentials to make a physician relations program work are sophisticated, detailed planning for the comprehensive upgrading of hospital-physician relations through attention to doctors' concerns and interests, identifiable goals, a strong support infrastructure, and carefully chosen outreach professionals.
- ❑ Support for the program must come from the very top and from across the breadth of the organization—and must certainly include the CEO and chief medical officer.
- ❑ The strategic plan must be developed through consultation with leaders of the clinical service lines.
- ❑ Since it's critical that program goals be concrete, measurable, and actionable, the plan must include creation or harnessing of survey instruments and other analytical tools. Hard data are increasingly crucial for good analysis and program success.
- ❑ The program's infrastructure is perhaps the most challenging and critical requirement for success, since it must ensure effective response to physician issues.
- ❑ All clinical departments and service line areas, particularly those with new or enhanced services, must be kept well informed of the program's ongoing work in order to present a unified face to physicians and patients, and ensure program activities are coordinated effectively.

- ❑ Physician relations professionals can come from different types of backgrounds, but must have a very strong understanding of clinical operations, combined with a sales perspective and experience.

Mapping out county-specific strategies in South Carolina

Those in the trenches agree on the fundamentals of success, but of course every hospital has its own individual situation and circumstances. Take, for example, the Medical University of South Carolina (MUSC) in Charleston.

This teaching hospital has had a physician relations program in place since 1988, but has made it “much more strategic and data-driven” in the past few years, says Lynne Barber, the organization’s marketing director. Barber, who spent nine years at MUSC before moving to Georgia because of her husband’s job, came back three years ago and has been responsible for the program’s planning and management since then.

“It’s been a very, very successful program here historically,” says Barber. “But in the old days, you didn’t have very good data. If you had data on the top referrers, it was spotty; so you weren’t sure you could trust the data.” As a result, she says, “It was basically all about meeting and greeting” and making sure the organization’s referring physicians were happy.

An early step in implementation of the long-range physician-relations strategy that MUSC has developed over the past few years was creation of a five-person statewide network of physician liaison professionals. This reflects MUSC’s broad patient catchment area, which extends all across South Carolina as well as neighboring communities in North Carolina and Georgia.

Further, Barber and her colleagues in the MUSC marketing department developed sales plans specific to each county in the state.

As part of that initiative, she reports, “We look at the revenue by county; market share, growth potential [population and age grouping], and household income for the county; level-of-outreach assessment by county, and percentage of revenue by payer mix” for each county. Then, based on these data and an analysis of what services each county has and doesn’t have, they define the types of services MUSC could develop in order to improve its referral stream in the individual counties, such as creation of an additional outreach clinic.

The targeted analysis and concomitant market effort are particularly critical in South Carolina, Barber says, because physician needs are particularly diverse in the area. Physician groups tend to be large and more specialized in the larger cities, but very small and general in smaller towns and rural areas. Physicians in these different types of groups have very different service needs and preferences.

What’s more, even though South Carolina runs very low on managed care—only about 10% of MUSC’s revenues come from managed care—both the Charleston market specifically and the state market overall are very competitive, Barber reports. And although MUSC is the state’s only academic medical center, “Our competition [for physician referrals] is not only hospitals in our state, but also other academic medical centers in the Southeast, like Duke and Emory.”

MUSC's strategic physician-relations program is also carefully coordinated with, and dovetailed into, the hospital's marketing and advertising efforts, as part of an overall marketing plan.

Tactics include distribution to every physician in the state of a bimonthly, contractor-produced physician practice magazine, plus other publications describing new developments in MUSC'S clinical service lines and medical technologies. The hospital is currently beefing up and enriching its physician Web portal as well.

Barber and her colleagues actively and thoroughly review regularly updated physician referral data to determine the success of their liaison program—and of overall physician marketing efforts—across the state. They not only look at currently affiliated physicians' referral patterns, but also “have a more intense protocol to work with... new physicians, because if you can connect with them to refer to our institution early, you can create a strong relationship,” Barber explains.

Overall, the results have been excellent, she says, and have only confirmed the strength of the strategic plan.

Promoting a new specialty services pavilion in New Jersey

Physician relations programs are essential for most hospitals, executives agree; but sometimes the impetus for an overhaul or initiative can be fairly specific as well.

It was clinical services development that spurred the physician relations strategy at The Valley Hospital in suburban Ridgewood, NJ, about 20 miles west of New York City and “the second-busiest hospital in New Jersey,” says Gail Callandrillo, vice-president for planning and market research.

“We started our program in early 2001 [because] we were about to open a new pavilion with ambulatory surgery and comprehensive cancer care,” Callandrillo explains. “We really wanted to promote that opening, and educate the medical staff about how convenient it would be for physicians to move their cases there, how seamless and easy we could make it for them.”

Other objectives, in addition to the overall goal of global improvement in relations with the 700 physicians on The Valley Hospital's staff were:

- ❑ *Determination to put a special emphasis on “splitters”*—area doctors who used multiple facilities for patients in their practices.
- ❑ *And provision of an introductory vehicle* for welcoming new physicians to the hospital's medical staff.

In other words, Callandrillo says she and her colleagues “had a broader perspective, of building relationships, building increased loyalty from docs practicing at multiple locations, and building volume to the new facility;”

Since then, they've had an “extremely busy” Physician Relations Director personally visiting between 280 and 320 physicians a year, a strategy that “has been wildly successful—the physicians love it,” Callandrillo reports. Specifically:

1. After the Director visits a physician's practice, the hospital sends a survey to the physician regarding his or her perception of the value of the program. Two years in a row now, physicians have rated the program a 4.47 on a scale of 1 to 5, Callandrillo reports.

2. What's more, the physicians the program has targeted as those who might bring cases to the new pavilion have increased the volume of their patient cases substantially. "So, we've had quantifiable proof that the intervention made a difference," Callandrillo says.

Another strategy was development of *a system for tracking problems*. "In the past," Callandrillo explains, "We'd hear things like 'The physicians don't like such-and-such,' or 'Dr. So-and-So doesn't like the wait times in the OR.' But our tracking system has allowed us to develop a database for this and the ability to track it. So we went from an anecdotal process to a quantifiably measurable one."

Still, even with all the measuring going on, Callandrillo concedes that it's hard to cite a specific financial return on investment for programs like theirs. "It's something we've struggled with," she explains, "because it's difficult to say for certain that the physicians who came to the pavilion actually increased their volume specifically because of the program."

"Would that have happened without this? Our CEO poses that question constantly. I can say it probably wouldn't have happened as quickly, or with as much ease, or with the good will we got, without the program."

And since it wasn't possible to determine with precision when the efforts of the Physician Relations Director specifically led to higher volume, Callandrillo and her colleagues decided that the Director's compensation package should be a mix, including mainly salary with some commission, rather than full commission,

Nationwide, a shift hack toward physicians as customers

All this activity going on nationwide reflects a general, recent shift in attitudes and perceptions over just the past two or three years, says Kriss Barlow, a senior consultant specializing in physician relations issues with the Hudson, WI-based Corporate Health Group.

"There's more of an acceptance now of acknowledging physicians as customers" of hospitals, says Barlow "Though physicians were originally seen as customers, during the heavy emphasis on managed care in the 1990s, hospitals spent a pretty focused decade thinking that life was about the contract," Barlow explains. "Now, with consumers and much more interest in choice on the consumer side, we recognize that physicians are still driving a significant portion of business, particularly on the inpatient side."

All this is to the good, she says, but adds that the downside is that some hospital organizations are jumping on the "bandwagon" without understanding what's required when setting up a physician relations program. She says there are two major gaps, in her experience.

- ❑ First, some hospitals are plagued by the *lack of a support infrastructure* for the physician relations program. Clearly, if a physician relations professional visits a physician's office, and that physician expresses a concern about something at the hospital, the hospital will need the support infrastructure to make any changes called for and document those changes. But

some hospitals have failed to do this, making themselves vulnerable to the charge that their physician relations programs are nothing more than meet-and-greet efforts.

- ❑ Another problem is *lack of coordination*. Marketing departments are under “tremendous pressure” from clinical service line leadership and senior management to promote clinical services, especially new and expanded services.

But often, Barlow notes, a consumer-oriented ad, or even a whole advertising campaign, will be launched before plans are made or carefully implemented to inform area referring physicians of the service change(s). Such missteps can leave dissatisfaction and confusion in their wake, she emphasizes. What’s more, Barlow says, it’s important for hospital marketing professionals to keep a few things in mind when it comes to the environment physicians practice in these days.

- ❑ *Many office-based physicians, particularly primary care physicians, aren’t even making it in to their local hospitals much anymore*, as hospitalist programs take care of the hour-to-hour monitoring of inpatients that the PCP might otherwise have rounded to see each day.
- ❑ *Practicing physicians are working longer hours* in order to make up for reimbursement losses from managed care and other insurance and reimbursement issues, so they’re more stressed and less happy in general.
- ❑ *And there has been an explosion in the building of specialty hospitals*. Since many doctors have invested in these and/or moved some of their business to them, it’s more important than ever for hospitals to do what they can to shore up relationships.

Senior management conviction seen as a key ingredient

Of course, no physician relations program will thrive without sincere and strong support from the top of a hospital organization, and that means not just the CEO, but also usually the chief medical officer and other physician leaders in the hospital.

Donna Teach, vice president for marketing and public relations at Columbus (OH) Children’s Hospital, says broad top management commitment is a given that colleagues need to understand. “Fortunately,” she is able to report, “our medical director has been a huge champion of what we’re doing in many areas that relate to enhancing physician relationships.”

For example, the Columbus Children’s medical director agreed with Teach that retention of currently affiliated physicians, and enhancement of relationships with them, were top goals. And to that end, Teach says, it’s extremely important to go beyond making physicians “feel happy” in some generalized sense—and *demonstrate that the hospital is doing practical things to improve their practice environment*.

In Columbus Children’s case, the hospital has been implementing its electronic medical record and computerized physician order entry information system over the past two years, with great success. “We’re very proud of our electronic medical records and CPOE, and have had wonderful physician acceptance of it,” Teach reports.

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So, in addition to the direct-contact work that her organization's two physician liaison professionals engage in, their work is reinforced by concrete initiatives the physicians can look to as advantages of affiliation with CCH. "We want to be perceived as delivering value to the practice," Teach emphasizes. "We're not the doughnut ladies or the giveaway people, like the pharmaceutical reps. Our whole goal is to enhance and ease their access to the hospital."

Like Barber at MUSC, and Callandrillo at The Valley Hospital, Teach says it's essential to stay mindful of the fundamentals. What should a hospital do if it wants to emulate the successful practices of these marketing professionals and their teams?

- Plan strategically.
- Get support from the top of the organization.
- Develop and use data intelligently and well.
- Hire carefully.
- Support your professionals with a response infrastructure.
- And turn feedback into marketing and relationship opportunity.

Enhancing physician relationships in today's stressful operating environment will be a challenge, Teach concedes, but it is also true that "This is a great time to be doing what we're doing. It just requires figuring out how and where you're going to be allocating your resources." And, though "physician relations is just one part of your overall marketing strategy... that and your internal marketing are [what] can hurt or help you the most." ■■■