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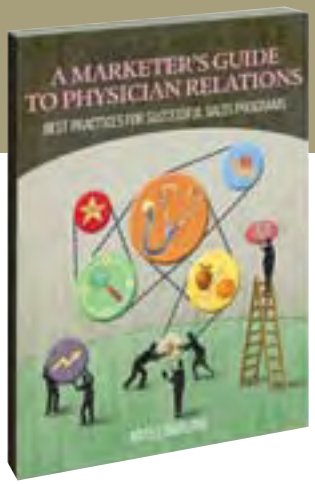

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CHAPTER 4

Measurement

The ROI of physician relations

Costs are up, reimbursements are down—even the public is taking notice of the rising cost of healthcare. There are many reasons for the current cost dilemma, but it's having an impact on the nation's hospitals in the same way: They are under tremendous pressure to continue to grow in the most cost-effective manner. Healthcare leaders are cautious about investing money in programs and new employees to staff them. They want assurance that the investment will increase usage and revenue. That's especially true with programs such as physician relations that are outside the patient-care arena. In that case, the organization's leaders want to make sure that the program's benefits will substantially outweigh the program's cost.

Physician relations programs are growing in number and intensity in the market because they have the ability to meet leaders' expectations for a positive return on investment (ROI). Hospitals have discovered that investing in these

programs and people can have a significant impact on referral growth in key areas. By carefully developing a measurement model, best-practice organizations clearly show how the representatives' interactions with physicians result in increased referrals and provide evidence of solid referral growth. It is clear method of demonstrating that this program was essential to making it happen.

Beyond doing what's right, those organizations that are willing to demonstrate their contribution to the bottom line are able to create good momentum for the physician relations program. (That's another best practice that we'll talk about later in the book.) This allows the organization to grow new business and add new physicians and gives these best-practice organizations new insight into how best to deliver care and be more competitive.

Measurement models also allow organizations to collect and analyze data and, based on the information, make adjustments and refinements to the program. There is nothing easy about setting up systems of measurement for physician relations programs. Best-practice organizations are usually blessed with one or more of the following attributes:

- They have access to good state data
- They're nimble enough to be able to create ways to extract the right data
- They're driven to measure data by the pressures related to the program

- They're experienced enough to have set up solid systems and tools that allow extraction of the right information to make the case

Measuring for retention or growth

What we are able to measure depends on who we are targeting. Organizations that have found the loyalty and contentment waning among their most active medical staff members focus first and foremost on retaining existing business. Physician relations representatives create good customer service strategies and work to understand the doctors' concerns, to gain their involvement, and ultimately to enhance their satisfaction. If you are working with physicians who give you all the referrals they can, for example, your goal is to increase satisfaction, get them more involved, and stabilize or slightly increase their referral volumes as their business grows. It is a very important group, but since they are already giving you the bulk of their business, there's simply not much more to grow. Organizations with a retention strategy measure two main objectives:

- Physician satisfaction, including the number of issues or problems raised by the group of loyal referrers

- Volume of business, to ensure that there is no erosion and, if possible, some small amount of growth

Although many of the techniques in this book are helpful for organizations pursuing a retention strategy, our main focus is on those organizations that

are engaged in physician relations as a growth strategy. For these organizations, the measure of success is new business in the door.

Best-practice organizations are intentional about using physician relations to earn new referrals. They target physicians who split their referrals between their facility and the competitor or those who do not currently send referrals their way but could. The goal is to use education and connections to encourage physicians to send patients to the facility.

To accomplish those goals successfully, best-practice organizations take the following actions:

- They determine to which competing organizations the target physician is sending patients
- They identify ways to differentiate their facility to earn these referrals
- They have the ability to track and measure whether the physician's referral volume has changed
- They make certain that they are working to grow the right kind of referrals
- They establish conservative metrics that all internal stakeholders agree show the program's contributions

Organizations with new physician relations programs generally rely on metrics or mathematical formulas to determine ROI. But best-practice organizations take the time to really understand the process for their facility. They glean market intelligence from the field and combine it with internal data and trends to get an accurate, detailed picture of the referral milieu. This process takes time and persistence to accomplish.

"The reality is that there needs to be a little leap of faith as organizations move forward with their sales measurements. The essential piece is to make sure that the organization is directionally correct and make sure not to let *perfect* get in the way of *good*," says Terry Humphrey, an experienced sales leader who now works for HCA Healthcare in Nashville.

Using data to gauge results

To understand best-practice organizations' approach to measurement, it is valuable to understand their philosophy and technique for getting to the numbers. In Chapter 1, we discussed the need to grow the right business and to use data sources to understand the potential for growth clearly. From the measurement perspective, it's important to examine baseline contributions—to look at the before-and-after pictures, if you will. As you cull through the data, identify physicians to target for growth by starting with the strategic areas in which you have a strong potential to grow business and where you are certain you have specialists who are similarly motivated.

Once you have developed a target list, dissect each physician's individual referral contributions over the past three years to evaluate his or her personal growth trend. Some organizations like to count referrals only, generally recognized as inpatient encounters. Others look at revenue and volume for their inpatient encounters. Some measure inpatient and outpatient data, focusing the sales effort on a select group of diagnostic/testing procedures when there is a mixed portfolio. Each facility must decide for itself exactly what data it will measure. One caveat: Don't measure on revenue alone. The payer system within healthcare is extremely complex, and the physician relations representative has no control over reimbursement rates. The role of the representative is to encourage the physician to send patients—generally within a certain diagnostic category for starters and then across the continuum—to your facility. If that is your goal, that's what you should measure.

Once you decide what to measure, step back and dig into some of the data that will frame your measurement profile. The process is tedious but essential if you are going to establish clear targets and strong forecasts. The data includes the following:

- **Payer mix.** First, look at the current payer profile. Does the physician you are considering have the right mix to enhance your organization's profitability? Of course, I'm not saying you should turn patients away or refuse referrals because of poor payer mix. But if you are going to proactively encourage new business, you must evaluate this. Second, evaluate whether more business to your facility is feasible given the payer complement within the practice. If Dr. Smith is referring all of his

patients to your hospital except for those covered by an insurance plan that you do not accept, there's probably not much room for growth from him.

- **Individual referral trends.** Although many facilities like to categorize physicians according to their practice group, it is important to evaluate the referral trends at the individual physician level. It's not safe to assume that they all follow one routine—even though the senior partner may sometimes tell you that they do! You should also determine whether there are splits within the individual physician's referral routines. If Dr. Smith, a family practice physician, sends a large number of patients to one hospital for cardiac care but only a handful of orthopedic cases, there's probably room for growth from this physician.

- **Physician demographics.** Evaluate demographics at the physician level. If Dr. Smith's patients all come from a geographic area that is closer to a competing facility, there may be room for some growth from the physician with the right approach from the physician relations representative. The forecast for this physician should be conservative.

Try to work with three years of trended data—or as close to three years as you can get. More data means a clearer picture of referral routines. This level of data scrubbing and analysis will give you the clearest sense of the ideal target and what type of referrals he or she may send your way.

Sue Pietrafeso, director of outreach programs at Sunrise Health Systems in Las Vegas, describes how her organization developed a measurement system. "When we initially started the program, our efforts to identify our target goals for sales were quite simple—it was all about market share. We didn't have a lot of depth of understanding at the time about the complexity of really understanding how to move the referral business until we got into it," she says. "So, for example, we would look at the trends for each of 25 cardiovascular surgeons in town and develop a projection around how much cardiovascular surgery business we could move based on that limited review. As we got more sophisticated, we started to recognize that we had to also look at the whole group and the dynamics those aspects would have and the accompanying strategies that would be needed to influence that level. What came to us after a few quarters was that sales efforts had to start further back in the referral chain than that—with the cardiologists, and even before that with internal medicine. All that has to be teased out as best as you can depending upon the data you have access to and really understanding where to gain influence and traction in redirecting existing referral patterns."

Tracking primary care referrals

Collecting data about primary care physicians (PCP) is a significant challenge for many organizations because many do not adequately document their referrals to the specialists. They know the name of the cardiologist who referred the patient and the name of the hospitalist who admitted the patient but often fail to capture the name of the doctor whom the patient sees

regularly. It's likely the physician relations representative has spent years convincing this physician to refer patients to the cardiologist on your staff.

When organizations dig into this, they are amazed to see that their biggest referring physician is "none." This struggle has been further compounded by the rise in popularity of hospitalists. Best-practice organizations that employ hospitalists track, measure, and monitor the input of PCP information to their records.

Many organizations are staffed by private-practice hospitalist groups. In this case, such a mandate is a bit trickier to accomplish, and it falls back to admissions to gather information about the referring physician.

You can make a dramatic and immediate difference in your program if admissions consistently asks for and reports on the patient's PCP. From the standpoint of the physician relations representative, it is certainly much easier for the representative to visit a doctor when he or she can first evaluate a record of the type and number of patients he refers to your specialists for hospitalizations.

Those organizations that have a multilevel strategy spend time with the PCPs and "pull" the referrals through the specialists who use their facility. It is hard to create the pull if you are uncertain of the track record or the impact. Referral data not only benefits the physician relations program but also improves the quality of patient care. When patients return to their PCP, sending the physician a note indicating what occurred and the ongoing

treatment needs not only improves physician satisfaction but also ensures the continuum of care.

"What the whole process of understanding the referral chain has done is changed the kind of dialogue my sales staff has with primary care physicians," Pietrafeso says. "Instead of going down the path of asking 'How does my hospital work for you?' we focus on 'Who do you refer to, how does it work, and why does that work for you?' We now more clearly understand it isn't just one piece but the entire referral spectrum that must be influenced to see change. And the team now has physician relationship diversity so they can fully appreciate the needs and sensitivities of all of the participants in the referral process."

Gather market insights from the field

Data is one way to evaluate the best targets and to create accurate forecasts. The other vital component is the market insights gleaned from field intelligence. Once the field representatives have created a list of potential targets, best-practice organizations use anecdotal information from the field to cull it.

For example, an organization might remove a target from the list because he or she has a close relationship with someone on the board of a competing hospital or there is a quality or safety concern. They might decide to tread carefully with a target because of political concerns or because the physician has had a poor experience with your facility in the past or might cause friction with one of your other physicians. They might put a question mark next to a

physician about whom little is known. And, finally, they would of course go forward with those physicians who are desirable to the organization.

So who makes these assessments and on what grounds? Some of the very best lists are the result of a one-hour meeting with the top few members of the leadership team. If the leaders have been in the community for a long time and are willing to look over the list, this is a great approach for streamlining. For some facilities, members of the C-suite are the best resource for this task.

Although it's difficult to get them all in the same room at one time, most will be willing to peruse a list and offer insight if they know the physicians. The chief medical officer or vice president (VP) of medical affairs is another good resource. Those who have come up through the ranks and have long-standing relationships through the entire medical community are invaluable in steering the physician relations representative in the right direction. It's most important to tap these sources for the physicians who are not practicing at your facility, since it's not likely you have a lot of intelligence on them. Obviously, it is easier when they are splitting business because you have quality indicators and peer review to support the opinion of those who give input.

Long term, the most effective approach for gathering information is to glean the details from the physician relations record once regular visits have begun and the physician is in the database. The representative will know how quickly the physician tends to make changes, what the physician's current referral patterns are, and the physician's conditions for making a transition. Regardless of the source, layering the solid trended data with the intuitive

market intelligence makes for a more fully developed target list and the opportunity for better forecasting of results.

Strategy for forecasting

Best-practice organizations work hard to create accurate forecasts for estimating volume potential as a result of the physician relations program. They understand that although it is not an exact science, the methodical planning and predictive process can make a real difference. Forecasting offers the following benefits:

- **It forces preplanning.** The process of creating a forecast allows the internal team to evaluate past market trends, detail expected changes, and predict the future.

- **It sets realistic expectations for the team and for leaders.** Physician relations representatives perform better when they are accountable for specific results. Reality is a very healthy manager. Likewise, leaders benefit from seeing up front what they can expect to garner as a result of the physician relations effort.

- **It stimulates internal communications.** The forecast allows those services that are targeted for growth to step back and evaluate the capacity and their ability to manage the impact of growth. They are also given fair warning that they will need to provide the tools that will help the representatives build relationships with the referring physicians, such as clinical outcomes data and time for physicians and leaders to go

with the representative and share details about the service. The forecast defines the agenda and spells out how much growth is anticipated. It is also a good reminder that there must be focused effort on this service and the field function for that to happen. It is a delicate reminder of the intent for the relationship strategy.

- **It gives leaders validation for their support of the effort.** The forecast reminds leaders that there is real dollar value in the program and that the program leaders are willing to commit proactively to an outcome. In an environment where dollars are tight and outcomes often imprecise, there is great value in the ability to predict and to meet those predictions.

Forecasts should be done yearly, when the business plan and targets are updated. On a quarterly basis for the first year or two, the representative and his or her leader may wish to tweak it. I am a strong proponent of not allowing too much overhaul—tweak is the operative word here—unless there are major, unanticipated market changes. There are two reasons for this. First, it is possible to overplan, which robs the representative of time in the field. Second, some sly physician relations representatives will never leave it alone and keep trying to "play" the forecast purely for purposes of their incentive-compensation advantage.

Forecasting techniques

There are several different approaches and methods for forecasting. Again, the exact formula isn't the most important thing—rather it is about finding a sound method that will work for your organization.

Forecasting is a mathematical model that relies on historical data and those variables (e.g., referral patterns) that you believe you can change. The forecast should be driven by trended data at the physician level. The market variable is intelligence based on past visits from the representative. (If the forecast is for a brand-new program, there will be no strong field intelligence and, thus, is little more than just a good guess. That doesn't mean you can't or shouldn't go through the process, however.)

It's a good idea to walk through the forecasting process in great detail. That way, when you go to do the actual measurement, the formulas are in place, and it becomes a straightforward mathematical computation.

Here's the suggested model for when you have solid admitting data at the individual physician level:

1. Start with your target list of physicians and your desired areas for growth.

2. Look at revenue and volume numbers for the last three years for each individual physician level. Predict what his or her overall revenue and volume would be with no change.

3. Document any market changes that are likely to occur and predict, based on the methodology of the CFO, the impact.

4. Use that information to determine the baseline number of expected growth for each physician without sales.

5. Hone in on revenue and volume numbers in the strategic areas you are targeting. Check to see if they are in keeping with the physician's overall trend. Make adjustments if needed.

6. Based on the annual percentage of assumed growth and the variables (items 3–5), estimate the percentage of growth potential. List it both as a percent and as an actual number of referrals.

One caveat: If you are unable to track PCP referrals accurately but you are aware that you will be using visits with the PCPs to increase their awareness and ultimately referrals into a specific physician group/service line, this can be accounted for in the forecast. If you are a small facility with only one or two specialists, it works to just increase their referrals by a larger percentage to note your impact on the overall referral market. If you are a large hospital/academic medical center and assume that there will be many specialists in the department or section who benefit from the physician relations program, look at an overall section total that is larger than the individual forecast numbers add up to be. This might sound tedious, but if each representative is focused on a group of 250 or so physicians and this is an annual exercise, perhaps that puts it in perspective. It is much easier to stay focused on advancing the

relationship when you know exactly how much of an impact you are projected to have on the referral numbers.

Ed Dougherty, the VP of physician network development at Lehigh Valley Hospital in Bethlehem, PA, worked with Program Director Nancy Heacock to demonstrate the ROI for their physician sales effort. They have refined the data of measure each year, but they started with gaps in the primary care data. After full analysis, Dougherty determined that it was "comparably muddy data." But it was a starting point, and a forecast in the early stages, for most healthcare facilities, is a tool to focus the effort and estimate the potential. Take Dougherty's advice, and be careful of "analysis paralysis" when it comes to forecasting.

Activity measures

Most facilities measure activity in addition to results. Many weight each one so that 60%–70% of the performance management tool weighs results with the remainder giving credit for the ability to meet or exceed the activity measures. The weight for the results needs to be proportionate to the confidence in the data to measure it. And many start with a much higher activity weight because they can measure it and because it encourages consistent field activity, which, after all, drives results.

Nonsales healthcare experts sometimes debate the validity of rewarding a physician relations representative for activity—in other words, as they see it, for "just doing their job." They argue that every job includes tasks that

are necessary to accomplish the main goals of the job and that setting up a meeting is not worthy of rewards for excellent performance or for incentive compensation. But today's representatives face significant challenges when attempting to get face-to-face visits with physicians in their offices. Some offices ban representatives altogether.

Pharmaceutical companies hire the best and the brightest salespeople to enhance communication and make connections with physicians. As healthcare facilities follow suit and flood the practices with more and more representatives, it's only going to get more difficult to schedule a meeting and have quality time with a physician. As competition for face time increases, a few things will happen:

- Those who do not bring value to the physician and his or her staff will not be invited back
- Those who say they are there to learn about the physician's needs but who simply tell and sell will be first to lose their slots
- Programs will need to make certain they consolidate their impact on practices, so those facilities that have a large number of service-specific representatives calling on the same physician will need to rethink their tactics
- Some will say, "We tried a physician relations program, and it did not work"

With so much market turbulence, those representatives who have stayed focused on solid messages, a strong work ethic, good techniques, bringing value, and staying consistent will be rewarded with the opportunity to make an adequate number of appointments per week. And those who are actively involved in supporting their efforts believe strongly that the activity should be measured.

So how do you measure it? Best-practice organizations have worked hard to make the model, method, and measures very clear and easy to understand. "At the end of the week or the end of the month, people are going to look at the combination of how many practices did we touch as an initial barometer and in how many practices did we do something that could impact positive change in our direction," Dougherty says. "From my experience in sales, I know there is a correlation between the amount of activity and revenue. Activity leads to results. It would have been unnatural to attempt to have a program without some metrics, so we decided to measure both activity and revenue to start, and although we started with heavier emphasis on the activity side, we now weight 65%–75% of what we accomplish on the actual outcomes. And our outcomes targets will change depending upon the hospital and the market area and medical staff associated with each."

The measurement of activity relies heavily on careful assessment of the types of activities that are known to grow the referral base and the careful definition of those actions. The most common activity measure is the number of face-to-face appointments with targeted physicians per week. Nationally, the average for this is about 12–15 visits per week.

When counting the number of appointments, pay careful attention to the criteria of an appointment. Remember, these appointments are not easy to get, and salespeople do see the world from their own angle, so make certain that you clarify what an appointment is and what it is not. For example:

- It is not an appointment with the physician if you see only the office staff

- It is an appointment if you come with a plan for your time together, which includes actions and expectations for the meeting and closure to a next step

- It is not an appointment if you catch Dr. Smith in the parking garage and ask how things are going

- It is an appointment if you arrange for Dr. Smith to meet with the cancer center director about advancing their referrals to this service area

Beyond the number of face-to-face visits, other common measures include physician-to-physician meetings, meetings with office staff, physician attendance at a suggested continuing medical education (CME) or other education event, and physician participation in a medical staff event/special meeting. The trick here is to find things that are known to encourage the target physician to learn more or relate more to your organization and the physicians who practice there.

For the majority of your activities, select categories that can be sustained for a minimum of a year. The next step, again, is to again clarify what counts in each of the categories. Define the criteria as tightly as you can. Then, assign a suggested frequency to the activity. You can determine how many times per month or per quarter you expect the activity to occur. For the representative, this detail creates the road map of activity that needs to be integrated into their sales plan—the tactical action plan for their target physicians.

With this level of detail, a good representative should be able to map out his or her daily and weekly tasks, to accomplish the desired activity. If they are accomplishing all these activities, if they are the right people for the role, and if they have been given products and services that are right for the market, then their only obligation for ensuring results is a solid plan for advancing the relationships through messages and differentiation. (We'll talk about that more in the chapter on differentiation.)

Tracking activity and results

The tracking of activity and the integration of results continue to be areas of interest for many programs—old and new alike. They are all seeking the best, most efficient way to track results and to have the kind of reports that demonstrate the impact for senior leadership.

Best-practice organizations have a system to track their activity and results. Some organizations build them internally, while others purchase and customize contact management systems. As the interest in physician relations grows,

database companies are introducing more and better products. Developing a tracking system is not just about acquiring the right software, notes Allison McCarthy, principal of Barlow/McCarthy in West Dennis, MA. The software is a tool and not a magic bullet. The actual performance success of any tool depends on how its functionality and customization effectively document the relationship process and outcomes.

Physician relations professionals all too often select software without thinking about their overall process. In the end, they're dissatisfied because the system or tool doesn't flow naturally into their day-to-day functions or achieve their desired objectives. To avoid this problem, ask the following questions in the early stages of development:

- What information must be captured?
- What other system has this information (e.g., credentialing, recruitment, finance, etc.) that we could integrate into the tracking system?
- What information do we need to collect from the field?
- What does the system need to do (e.g., maintain calendars or integrate with existing calendar functions, integrate with organizational e-mail systems, document physician meeting discussions, assign next steps, track sales plans and implementation progress, trend physician responses to survey questions, capture and trend issue resolution)?

- How will staff access the system (e.g., through laptops or PDAs, via the Internet or remote server access)?

In addition, consider the types of lists and reports that should be routinely generated:

- Targets by specialty, credentialed versus noncredentialed, ZIP code, competing hospital status, etc.

- Qualitative feedback on important trends or issues, such as results from one-on-one discussions with a target physician group about the reasons for its steep decline in referral volume

- Sales staff performance reports, including number and type of visits conducted, CME sessions arranged, and hospital orientations provided, measured against performance expectations

- Activity reports that demonstrate the sales efforts made on a target group of physicians so that a side-by-side assessment with referral volume, revenue, and contribution margin trends can be made to determine the cause-and-effect relationship of the effort

An organization that has multiple marketing or promotional tactics working in tandem creates the most powerful marketing message. In these advanced programs, other functions also may be integrated with the tracking system. Examples include:

- Documentation of marketing communication efforts that show which physicians received a direct mail piece, for example, so that representatives can reinforce the message in their face-to-face meetings

- Interface with other areas of the physician strategy, such as physician recruitment, so that the physician relations team can use information on a physician candidate to build and implement their retention strategy with that physician

- Integration with the call center so that representatives can use the information captured by your physician-to-physician line to assess the effectiveness of the referral made as well as encourage additional referrals to that service

Beyond these factors, other aspects must be considered, including the size of the physician relations program, its budget, the computer literacy of the staff, and the organization's security concerns.

With all that preparation in place, the organization is now well positioned to select a software tool to meet its needs. Through this preliminary planning work, the hospital, health system, or clinic can identify the software program that will be the best fit, versus having the tool drive what information is collected and reported. Although many organizations choose vendor-hosted tracking software or systems, there are still many that develop homegrown systems to track their physician relations initiatives.

OhioHealth, a multihospital organization in Columbus, OH, developed a unique contact management system three years ago that meets the needs of its sophisticated physician relations department. Kurt Stull, director of physician relations, and Troy Miller, manager of strategic planning at OhioHealth, built the system based on specific requests from stakeholders. "We wanted to combine a physician database with an off-the-shelf contact management system and an issue-resolution system. No such software or technology with those parameters existed," says Stull.

Previously, OhioHealth had an access-based contact management system and had built issue resolution functionality through the hospital's Lotus Notes system. However, those functionalities did not interface and were ineffective.

"Through our homegrown system, we have these various pots of information that can now 'talk' to each other," says Stull. "We have the ability to collect physician profiles and, at the same time, record physician visits and issue-resolution information."

Stull says the advantages of developing a homegrown system include flexibility, full customization, and a central repository for information that can be accessed by anyone with a username and password for the system. In the case of OhioHealth, Stull says they have encountered no disadvantages during their experience. "However, organizations have to commit to making this successful, to respond when needed, [and to] provide the manpower and budget commitment that's necessary in maintaining the system," he says.

Regardless of your organization's size and physician relations goals, tracking capabilities are essential in demonstrating the value of those efforts to that entity. The organization can then make informed decisions about how this tactical approach fits into the broader mix of hospital-physician strategies and which efforts are yielding the best results.

ROI, measurement models, and methods

Measuring the impact of a physician relations effort is the result of many parts of the infrastructure coming together. Assuming you are confident that the physician relations team is at or above its activity targets, this should translate into measurable new referrals—that's the goal, right? The consistent theme among all the best practices is that they measure impact. All have a method of providing quantitative outcomes, and they monitor change. They collect the field intelligence and study success in the form of growth or flat and declining volumes, as an indication of the need for a change of course. Having said that, the outcomes measures that are currently employed by best-practice organizations are as innovative as their leaders. In the simplest terms, the measurement models today are broken into two different types—physician-specific and service-line.

Physician-specific impact

A physician-specific measurement model is certainly the most logical, the easiest to justify, and the most straightforward. It is the way to go, as long as your organization does a good job of capturing the name of the primary and referring physicians.

At the beginning of the year, the organization analyzes data and develops the forecasts. The growth forecast, including the rationale behind it, is shared with key members of the leadership team—most notably the CFO. The internal stakeholders agree which physicians to target and how much "credit" the physician relations team will get for results. It is crucial to determine this last point up-front. Negotiating for it after the fact is always disheartening if you have a financial leader who is skeptical of the impact of your program. He or she will make all sorts of excuses and give all kinds of reasons for the increase that have nothing to do with the program.

The moral of the story is that you must preplan. Put a stake in the ground about what you will produce and how you will demonstrate results. The next step is to work with the IT team to create a special quarterly report that shows revenue and volume changes for the target group. As part of this report, it is also good to look at overall trends in the strategic service areas. The physician relations team may need to adapt the plan to make sure that the organization is getting the right growth in the right direction overall—it's all part of being a team player and being proactive.

Finally, evaluate the actual quarterly data against trended numbers and the forecasts. Report this information to leadership alongside the activity report. Include information about any new physicians you have added, along with data about their referrals.

At the end of this process, you'll want to determine whether you need to adapt the field efforts for the next quarter. Some programs look at the data

monthly, which is great if you can get it and use it. The cautionary note, of course, is that splitter growth can have some immediate results, but the work that is done with new business rarely shows results so quickly. Concentrate on the overall trend rather than feeling high or low every time the program experiences a little blip.

Michael Thomas, VP of strategic planning and marketing at East Texas (Tyler) Medical Center Regional Healthcare System, prefers monthly updates. "We review every referral by every doctor in our employed groups," he says. "We know which doctor sent what business to each specific destination. But beyond this analysis, an important difference is that we also look at referral patterns by physician. It's about working to understand through the data where you have a chance to change a referral."

Service-line trends

For many organizations, the breakdown in this method occurs because they have their representative focused heavily on the primary care community and they cannot effectively track their admissions. Organizations that have three to four strong service lines that they are promoting might just measure those specialists. The built-in assumption is that the representative pulls the referral from the PCP through the specialist to the facility.

Others do some forecasting and evaluation at the physician-specific level, especially to help motivate and coach the physician relations representatives to meet their growth obligations, but rather than use the physician-specific data as the ultimate measure, they opt for a service-specific model. When programs

are in the start-up phase or when they are internally at odds about whether to trust the data, the next best option is to focus on growth in the target service lines. The way this works is that new business is measured in the top three to five service lines that the physician relations team has been asked to focus on for growth.

As you get further out from measuring the actual interaction, there are a few more challenges. The first is trying to figure out what growth within the service line should be attributed to this effort. This is a concern of other organization members that the physician relations program will get more credit than it deserves. Some are conflicted about the fact that a generalist physician relations representative will have an impact on many other services because of the relationship and consistent presence in the office, so the program does not get all the credit it should.

Responding to those who question whether the physician relations program is responsible for growth: There is never a perfect answer for the source of every single referral. In fact, changes may be the result of several different events or messages that resonate together. But, in the case of this effort, we also know that many of those other messages and events were in place long before the sales effort, so their contributions should already be a part of the mix.

Again, the method for creating program measures is to look at past patterns and then to compare and give credit. It must be negotiated on the front end. If there are other new and different happenings that contribute, negotiate that also. For example, the cardiac service line has been growing by 25 cases each

year for the last three years. We assume that with the addition of our new EP physician, we will double that volume even with nothing being done.

With this discussion and the projection, then the physician relations program will measure and take credit for growth this year that is more than 50 new cases. It becomes clear that for some organizations, there needs to be a great deal of negotiation. Taking a conservative approach and clearly defining the contributors on the front end can go a long way in saving you from the measurement blues on the back end.

So, how do we reply to the representative who says, "If we only measure these three to four service lines, all the good work we are doing to be responsive to the needs of the practice outside the scope of these areas goes unnoticed, or at least isn't credited to us."

To overcome this challenge, some have opted to add some anecdotal commentary to their reports, calling out the areas where the representatives have been focused, telling stories, or documenting specific physician changes. Others will look at the service lines but also take partial credit for overall growth—much harder to negotiate with some CFOs—and still others will assume that if they are growing cardiac, they are also going to see increases in pulmonary and rehab programs. In this case, they just state assumed overflow credit without putting an actual number to it.

The challenge of exactness and allocating credit in measurement is twofold. There is getting credit for the program, which we have discussed. But the

bigger challenge occurs when incentive compensation for the representative is reliant on these measures. Assuming that you have come to terms with all of the naysayers, here's how to set up this approach:

1. Look at the trended data in the top three or four strategic service areas that you have targeted for growth. As part of your data analysis, evaluate the specialists who are contributing and at what level, explore which ZIP codes the business comes from, and determine any "external factors" that may influence the service growth over the next year. This might include additions or retirement of a specialist, changes in managed care, the competitor campus across the street, etc.

2. Determine how much growth is expected based on past trends. Consider any variables that will affect this growth, and present a projected growth number for the service.

3. The measurement process is similar to the physician-specific model in that, on a quarterly basis, you will ask for a service-line report that shows new referrals.

4. If you have added new physicians to the service as a result of the physician relations effort, it is also appropriate to track and measure the new physicians on board.

5. Although the measurement report is on total service lines, the program leadership needs to dissect the data at the physician level to understand how the growth occurred and to adapt as needed.

The easiest part of the measurement is the analysis. The challenges seem to come with getting the rules set up internally, ensuring that the right data is reported in a timely manner, and managing the physician relations representatives who have a tremendous desire to make certain they get credit for everything they feel they deserve.

At the end of the day, none of the models are perfect. Joe Paine, the CEO of CHRISTUS Schumpert in Shreveport, LA, has a refreshing slant on this issue: If there is growth occurring, he says, the last thing we should do is to fight with each other over who should get credit for it. Rather, focus on the real opportunity, which lies in replicating the success and working to grow even more.

A measurement snake pit to avoid

Sometimes service-line leaders will step forward with their budgets and ask the physician sales representative to project the line's growth potential as a part of budgeted dollars. Base your projections on data trends, market variables, and field intelligence. Don't fall into the trap set by their saying they are budgeted to grow 10% and they need you to contribute 5% of that. (Physician relations' 5% will of course be the *second* half of the 10% growth projected, so the internal team will get the credit if there is 5% growth only.)

Proceed with eyes wide open, and clearly understand and question, if necessary, the factors they considered in their growth projections. Often the 10% is based on how much the organization needs to spend rather than on

tangible actions. It seems like the smartest approach to look at the actual numbers and then work to negotiate how much of the service-line's budgeted numbers the program can contribute, as well as how there will be tracking and results reporting for them.

How do you share the results, and how often?

Good reports are of no value if they are not understood or not shared with the right stakeholders in the right context. Best-practice organizations understand the value of a quality report, and they find ways to showcase their program and the impact that physician relations has within their organization.

Departmental activity reports

The program should look at activity reports on a weekly basis. If a representative falls behind in the desired number of visits, then an additional previsit planning report is in order. Obviously, there is a need to assess whether the issue is time management, inability to get the appointments, too few targets, or a lack of understanding about how many calls it takes to get more than the baseline number of appointments. With a previsit worksheet, the leader can work with the representative to make certain that they are able to get all their calls scheduled. The weekly activity summary does not have to be formal. The leader just needs to see whether calls are being made, to whom, and with what objective. And if a tracking system is in place, these summaries can be generated easily.

Monthly and quarterly summary reports

Program leaders generally provide the senior leadership with an end-of-the-month summary. The most effective format I found is a one-page summary that includes a quarterly summary of new referrals or of revenue and volume, generally demonstrated in year-over-year comparisons. The rest of the report is the same monthly and quarterly activity, including the total number of field visits, the percent of visits to each targeted physician type, and key topics for strategic messages to each. Include market intelligence from the field and a summary of the top complaints that the representatives hear from their target physicians. Some also create a line graph to track and trend the top issues.

Finally, include strategic services/key messages or targets planned for the following month. Including next actions will, from time to time, trigger a leader to share additional information on the topic with the representative if the leader knows the rep plans to have it as a central message point. The report is short and easy to understand. Leaders can read it quickly and feel in touch. And it allows an opportunity for senior leadership team members to ask questions and delve deeper.

Reporting the quantitative results is best done with a breakdown of key categories and a roundup of totals. Charts and graphs that visually detail forecasts versus actual results or trends and impact are always informative. Those who are the best at measurement are often the most focused on generating awesome results. It's your opportunity to put the physician relations team in a position to prove its success.

Pushing the envelope

As programs mature in their ability to measure those things important to assessing sales impact, they will begin to search out more advanced tracking and monitoring methods. To enhance activity reporting, many programs begin to break out sales activity by service line. This permits one to assess whether sales resources are being appropriately allocated based on the organization's strategic goals and objectives. Not all service lines are created equal, and therefore it is important to assess periodically whether sales is supporting those areas deemed to offer the greatest growth potential. If the organization's strategic plan calls out cardiovascular and oncology as key growth areas for the year, then sales should focus more effort and resources in these areas. Breaking out sales activity by service line provides a quick check that resources are being directed into the appropriate areas and in the right amount.

Another common sales activity breakout is retention versus growth. For those programs that have both target groups, breaking out sales activity into these categories provides another quick check on whether the program is slipping back into heavy retention instead of focusing resources on growth opportunities. Both of these activity breakouts can be monitored on a monthly basis along with overall sales activity, but at the very least they should be evaluated quarterly so that midterm adjustments can be made if necessary to keep the program on track and aligned with the organizational goals for the year. As discussed previously, making or exceeding forecasts is the true measure of program success.

Some sales programs take an extra step to show their impact on growth by comparing volume among their targeted physicians to a comparable group of non-targeted physicians. In statistical lingo, this is similar to setting up a control group or, in the case of drug testing, a placebo group. In this case, sales resources are directed toward the targeted group of physicians, and no resources are directed to the non-targeted group.

For this comparison to be meaningful, it should be done by service line or physician specialty. Here's how it works: Let's say that the organization identifies cardiology as a strategic service line for the coming year. As a result, sales targets cardiologists believed to offer the greatest growth potential and directs resources and field visits toward this group. When it comes time to measure results, volume growth of the targeted group is compared with all other cardiologists who were not targeted by sales. If the growth on a percentage basis of your targeted group is greater than your nontargeted group, then that's a good indication that sales had a positive impact.

Of course, as with any approach, there are limitations. Your nontargeted group consists primarily of physicians with low growth potential by design; however, one can argue that at least some of the above-average growth is the result of sales and would not have occurred without the effort. Finally, some programs are actively engaged in measuring the holy grail of marketing and sales—namely, a measure of the financial ROI. Most industries, including healthcare, have struggled with this issue from the beginning of time. The basic problem is that it is extremely difficult to identify cause and effect when it comes to sales and marketing. Did the patient come to your facility

because he or she saw your TV advertisement, or because a neighbor highly recommended you?

The inability to determine cause and effect is one of the reasons why direct marketing and sales campaigns have become so popular in recent years. When someone responds to a direct marketing campaign, you know that the interest was sparked by the campaign, so most CFOs have no problem attributing any dollars associated with that customer to your marketing effort. You also generally know what it cost to execute the campaign, so you have what you need to measure ROI (gain/cost).

I know we all wish measurement was that easy with physician relations. It's not, but there are still some ways to do it. Regardless of the methodology employed, the most important step is reaching some type of agreement with the CFO prior to determining what portion of growth will be attributed or credited to sales. This will always be a negotiation process based on assumptions that are agreeable to all the parties involved. Some have elected to compare volume growth in your targeted physician group to a group of nontargeted physicians in the same specialty.

As we discussed earlier, the nontargeted group serves as a control group. If cardiology volume increased 10% among your targeted physicians and only 5% among nontargeted cardiologists, then sales should be credited with some portion of the growth.

This is where your agreement with the CFO comes into play. If the CFO has agreed to credit sales with half the incremental growth, then some type of average contribution margin for cardiology cases is applied to this volume, and you suddenly have the gain attributed to sales.

While many hospitals still struggle with accurate cost accounting, at the very least your annual budget identifies direct costs of the sales programs, and most organizations have some method of allocating indirect costs to departments. Now you have the cost component, and ROI simply becomes the financial gain achieved against the cost to achieve this gain. Although not a perfect solution, many other industries don't get much closer to a true measure of ROI than this.

And, of course, we have the whole question of how to account for growth in outpatient services and its contribution to sales ROI. Few programs to date have fully incorporated the outpatient component, although those attempting to do so are using the same principles described above for the inpatient setting.

Using measurement to enhance the program

The organizations that continue to push forward and look for more, better, and different ways to grow their programs and enhance their own growth are those that dissect their measures and constantly look for better ways to use the data and better ways to do the job.

Like them, you can look through the different reports and ask yourself some of these tough questions to determine whether there is more that can be done to enhance the physician relations effort. Ask the following questions:

- Are representatives getting in the door and having good dialogue with physicians but not getting new business?
- Do the same issues stay on the report month after month?
- Are the representatives learning field intelligence that we can better harness to position our competitive advantage?
- Have we hit a plateau with our growth trends?

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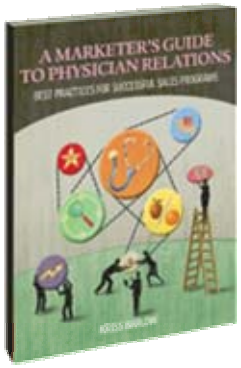
A Marketer's Guide to Physician Relations: Best Practices for Successful Sales Programs

By Kriss Barlow RN, MBA



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