



RETHINKING MARKETING STRATEGY: THE HOSPITAL AS CUSTOMER

BY PATRICIA KROKEN, FACMPE, CRA, FRBMA

Reprinted from RBMA Bulletin January-February 2010

Over the past several years, radiology practices have found less security in an exclusive professional services agreement. In the old days, the hospital and group could engage in a relatively contentious relationship without any real threats to the practice's contract and it wasn't unusual to hear comments such as, "What are they going to do, replace all 12 of us?" In recent years that is exactly what a number of hospitals have done – terminated contracts that left physicians without privileges and without a livelihood. What the heck happened?

It all started with increasing internal pressure to improve physician quality of life for radiologists by reducing call demands, an opportunity met by the entrepreneurial zeal of emerging teleradiology companies. The concept of remote

interpretations then introduced a new business dynamic into the hospital/radiologist relationship. Hospitals reacted favorably to the responsiveness of the teleradiology physicians and their rapid report turnaround. In addition, many offered Web-based access to reports and images along with robust Q/A programs.

Nighttime coverage morphed into daytime options and radiologists discovered, often too late, they had just brought in another service option for hospital administration, conveniently credentialed and licensed. The teleradiology companies, which built their reputations on responsive service, also stepped up to the challenge of, "Do you think you could just place a couple of people here and read the rest of the cases remotely?" More frequently, the response was "Yes" and life began to change.

The hospital as a customer

In many cases, a key hospital (or chain) can represent more than 90 percent of a practice's professional component revenue. If it is gone as a line of business, the financial implications to a group are devastating. And yet, hospitals are too often perceived by radiology practices merely as demanding in terms of service, fixed on their own agendas (which may be a total mystery to the group), and fickle in terms of coming through with "former promises" to the radiology department. They are not viewed as the most important single source of revenue to the practice or the largest "customer" for the group.

Key customers will identify critical success indicators that must be met to earn or retain their business. What types of things would the hospital customer expect? If you speak with hospital administrators, some variation on the following would likely be articulated:

1. Reports are dictated promptly and results called for critical findings
2. There are minimal complaints from members of the medical staff, especially the emergency department
3. Radiologists sign reports promptly and don't require continued prodding
4. There is consistent (group-wide) participation in the Q/A overread program
5. Technologists aren't turned away when they approach a radiologist's reading station ("Take this to Dr. Jones, I'm too busy.")
6. There is cooperation with key technology initiatives such as speech-recognition dictation/transcription
7. Physicians participate on hospital and medical staff committees
8. There is prompt resolution of personnel and/or physician behavioral issues
9. The group participates in joint-venture activities and/or does not compete with the hospital with its own imaging center
10. The group adheres to the "administrative" provisions of the professional services agreement (often found under medical-director duties), including such requirements as:
 - a. Presentation of educational topics to medical staff and technologists
 - b. Participation in the development and implementation of quality-improvement/process-improvement initiatives
 - c. Participation and/or cooperation with hospital programs, including marketing, strategic planning, and business development
 - d. Contracting with key health plans with which the hospital participates

It has become a fact of life that while the radiology practice may have held an exclusive contract for 30 years, there is turnover in the hospital administrative staff. Every time a new pair of CEO, COO, or CFO loafers hit the ground, a new face reviews the status quo and determines where he or she will focus to make a difference. Usually that means the radiology professional services agreement is dusted off and reviewed one more time, problem areas are identified and prioritized for correction, and a strategic direction is established (or modified). And at that point, old promises or strategic directions are out the door. The more troubled the hospital, the more drastic the changes.

Turning the battleship

Hospitals appear to be receptive to groups who attempt to initiate a mutually beneficial relationship and if there has been a recent change in leadership (in either the hospital or practice), there is a natural opportunity to do so. This is the time for physicians to set aside past dealings and frustrations. This can represent a fairly long list and it may extend back decades, but it needs to be placed in the past as the group looks instead to the future.

For most hospital-based groups, their future success is linked inextricably to the success of the hospital's strategy and, as turnover occurs within the hospital administrative ranks, that strategy is apt to change. In addition, there are national hospital trends that move in and out of popularity and again, the strategy will change based on adaptation to these external forces.

Does this mean the group "sells out" in terms of its own strategic goals, or its pride and independence? No, but it does mean looking at radiology differently. Recent years have shown hospital administrators are willing to roll the dice when it comes to replacing even a long-standing radiology practice. Unfortunately even respected groups with 30-year contracts and strong medical community support have found themselves out in the cold. Rather than rely on the support (or battle) of contractual terms, the shift needs to focus on the development of strong, mutually beneficial business relationships.

In addition, unless the practice is proactively communicating with hospital leadership, assumptions about the

competence, capabilities, and participation regarding the group will come from external sources. Relying upon the assumption, “Of course they know us, we’ve been at this hospital for more than 25 years” is flawed at best and at the worst, fatal. Every change in hospital leadership represents both threat and opportunity.

To view this from another perspective, if any other business (whether a hardware store, leasing company, or equipment vendor) had most of its revenue come from a single source, what do you think their attitude would be toward that customer? How hard would they work to ensure that customer was happy with goods and services? How much attention would they pay to that relationship? How much would they focus on developing mutual goals so it would be difficult for the business relationship to end?

There are a few tough facts to face:

1. **Contract exclusivity is relative.** Yes, it should keep the hospital from engaging a competing radiology group while they are working with you. It will not prevent other physician specialties from moving into the imaging arena and any non-radiology group that plays the card of “look how much business we bring into the hospital” will win. Radiologists who feel they are “owed” that business solely by virtue of their professional services agreement will lose – and will alienate hospital leaders if the issue is pushed too forcefully.
2. **Hospitals are getting tougher on competing imaging centers.** Again, the rules of the old days were different. The radiology practice could develop an imaging center across the street from the hospital, siphon off lucrative outpatient imaging business by offering improved service levels and – while the hospital administration would be clear they were not in favor of this activity – there were seldom negative consequences. There is no clean answer to this situation since the political volatility will vary from one market to the next. Just be prepared for the issue to hit the table if this scenario applies to your group.
3. **You will be judged on the service issues mentioned earlier.** Normally problems are caused by a small proportion of the radiologists in the group. What this means, however, is the practice’s leadership needs to have the support of everyone else when meeting with hospital administration and committing to correct outstanding issues. A deliberate step to correct any of the service issues that constitute the majority of typical hospital-radiology agenda

items can lessen pressure in other areas and begin to establish collaboration.

4. **Establishing the hospital as a key focus of marketing efforts.** Marketing in radiology is typically associated with building imaging-center business, but some of the same tactics can work with hospital leadership. How can you set up a formal communications program to keep administration advised of new physicians and/or procedures, capabilities in the group (such as who has completed CAQ or MOC requirements), and promote each of the physicians and his/her strengths? Rather than assume essential information is communicated by the radiology-department manager, this enables the group to remain proactively “top of mind.”

The bottom line

Whether we like it or not, times have changed and the days of simply showing up and reading films, tolerating bad behavior by the group’s physicians, and offering only token compliance to hospital expectations are over. It is time for virtually every hospital-based practice to examine its situation in detail and deliberately become a valued partner in terms of meeting the challenging times ahead.

The teleradiology companies were developed on a model of service and responsiveness. While they have done much to alleviate the stress of call coverage, they have also changed the game and increased expectations regarding how the in-house radiology group should function. If radiologists simply conduct business as usual, knowing there are numerous service level complaints from the hospital, they are placing themselves at risk. No longer is it sufficient for the group to simply have high-quality physicians based on the criteria of education and diagnostic competence. Those are simply the baselines of the relationship, which warrant a full-blown marketing/communications strategy so we no longer see strong groups ousted because they failed in the care and feeding of a critical business relationship.



PATRICIA KROKEN, FACMPE, CRA, FRBMA

is a principal in Healthcare Resource Providers, a radiology business consulting firm. She is a regular contributor to industry publications and a frequent speaker on topics related to radiology practice management and HIPAA. Patricia can be reached at Healthcare Resource Providers, LLC, P.O. Box 90190, Albuquerque, NM 87199; 505.856.6128; pkroken@comcast.net.