Hospital & Community Marketing

Everything you need to know about
Hospital and Community Marketing

PHILIPS
Lifeline

Hospital and Community Marketing

Direct Marketing From Philips Lifeline

- Review key hospital referrers & how to capitalize on changes that are affecting the hospital
- Learn about partnering with community home health agencies
- Educate on a new referral audience – SNFs

CORE Referral Marketing Strategy

Hospital-Based Referral Audiences 80% Time	Core Messaging	Free-Standing Referral Sources 20% Time
• Discharge Planner/Case Manager • Social Worker • Rehabilitation Professionals	PIER Message • Peace of Mind • Independence • Early Intervention • Reassurance	• Home Health • Skilled Nursing Facilities • Free Standing Rehabilitation Hospitals

Referral Marketing Formula

The Right Customer • The Right Message • The Right Frequency

To be successful in serving more subscribers, we continue to refine how we communicate to key referral audiences. Our focus remains on healthcare providers, as they have direct access to at-risk elders needing the Lifeline service. The healthcare environment is constantly changing, and there are new pressures and challenges facing the key people to whom you market. This module will explain how these changes have strengthened the value that the Lifeline service provides as well as show you new areas where you can focus your marketing efforts.

This diagram illustrates a top-level view of our referral strategy. As you can see, the core strategy is to continue to build referral relationships with hospital-based audiences as well as expanding efforts to market in the community to stand-alone home health agencies and skilled nursing facilities.

Hospital-Based Referral Targets

Let's start by reviewing our hospital-based referral targets with a broader understanding of who they are, where to find them, and their day-to-day responsibilities. Your primary audience is those involved in the discharge of the patient back to the home: discharge planners, social workers, and case managers. An important secondary audience is rehabilitation professionals.

Discharge Planners –

Your primary target for hospital-based referral efforts

Who are they?

What are their responsibilities?

Which patients are referred to discharge planning?

All hospitals have a Discharge Planning Department. Individual discharge planners are assigned to units or on floors - for example, the stroke unit, ICU, Cardiology.

Certifications:

They are social workers, nurses, or case managers. Case Managers are certified with a CCM designation (Certified Case Manager). Social Workers are licensed with a LSW (Licensed Social Worker) or MSW (Masters of Social Work) designation. Nurses who perform discharge planning have an RN license.

Responsibilities:

- Responsible for 40 beds on average
- Active with about 20 patients at a time
- Assessments of new patients, which must occur within 24 hours
- Reassessment of active patients (with documentation in the medical record no less often than every two days)
- Daily multidisciplinary walking rounds on their assigned unit
- Maintain ethical and regulatory standards of care

Who is referred to Discharge Planning?

Usually individuals who fit "high risk" criteria, this is also the profile of a potential Lifeline subscriber:

- Elderly
- Those with catastrophic conditions
- Those with costly injury/illness
- Those who are non-compliant in following treatment plan
- Those in the acute phase of a chronic illness
- Those in the terminal phase of illness
- Diagnoses likely to require additional care post-hospitalization, i.e., stroke
- Any suggestion of abuse, neglect, domestic violence, substance abuse.

Discharge Planners (Continued)

Discharge Resources

In addition to their daily responsibilities, the discharge planner must also coordinate a host of services to support each patient being discharged to a home setting, such as adaptive equipment, oxygen, personal care assistants, meals on wheels, and, of course, personal response services.

As you have probably already experienced, these professionals can present a challenge for your referral marketing efforts. Lack of time, staff turnover, and shifting weekend coverage can make it difficult to get an audience with them. Plus, since the need for the Lifeline service may not appear as tangible as the other services they arrange, and as they may have concerns for the patient's ability to afford the service, it is critical to make a compelling "value proposition" for the Lifeline service and reinforce it on an ongoing basis.

The hospitals where discharge planners work are facing new challenges and pressures. The good news is that these challenges make the benefits that we offer more tangible. Let's look at these challenges.

New Challenges for hospitals and discharge planners –

Healthcare Changes Affecting the Discharge Process

- Shortage of nurses
- Higher discharge accountability

There are two key challenges that are putting overwhelming pressure on hospital-based referral professionals. First, there is a shortage of skilled nurses. Seventy-two percent of hospital CEOs reported nursing shortages. In addition, the government has instituted the Medicare Quality Initiative, which has led hospitals to focus on disease management. Prevailing themes are:

• To reduce length of stay in the hospital and
• To reduce readmissions – especially avoidable readmissions.

Evolving Role of the Case Manager – Higher Accountability

Case managers are being held to higher levels of accountability. Whereas in the past they were mostly concerned with a safe discharge, now they are measured directly on quality initiatives like reducing length of stay and readmissions. They are measured on whether their discharges are successful – or fail.

By being able to refer to their changing roles – the increased level of accountability – you can speak their language and offer a real solution to

• Keep seniors independent longer
• Reduce length of stay
• Reduce failure of discharge plans that result in readmissions.

The Value of the Lifeline Service for Discharge Planners

Meet all of these challenges straight on with strong benefit statements geared specifically for these professionals:

We supports their number one concern – safe discharge for the patient

The Lifeline service provides a safer home environment for the patient. The professional will feel more confident in yielding to patient/family wishes for earlier discharge. Lifeline with Reminders helps the patient and his or her family caregivers deal with often-complex careplans. All involved will be more competent in providing supportive care to the patient.

New Challenges for hospitals and discharge planners (Continued)

The Lifeline service can help avoid discharge failures by addressing the areas where they are held accountable – (and in doing so decrease their workload)

Through early intervention the Lifeline service:

Prevents unnecessary ED/hospitalization – keeps them out of the hospital system.

Reduces hospital length of stay – they arrive with fewer complications and can go home sooner.

Lifeline with Reminders helps them comply with their medication regimen, keeping them healthier and out of the hospital.

The Lifeline service can actually free up their time

The Lifeline service provides peace of mind to the patient and respite for the family. A discharge with the reassurance of Lifeline means fewer post-discharge telephone calls. (Discharge plans can often fall apart because family caregivers cannot manage the stress and responsibility.)

Rehabilitation Professionals –

Secondary referral target

Rehabilitation – Second Key Referrer

- Who are they?
- In many different areas of hospital
- Key Lifeline message – supporting the continuation of their hard work to the home in a safe environment

Rehabilitation professionals fall under three main categories:

Physical Therapists (Credentials – RPT, PTA) are concerned with the health of the patient via his or her physical conditioning as well as Gait Training (with or without mobility aids).

Occupational Therapists (Credentials – OTR, COTA) focus on "health by doing" – that is, maintaining independence through purposeful performance areas such as: activities of daily living, work-related activities, and leisure activities.

Speech Pathologists (Credentials – Certificate of Clinical Competence Speech Pathology – CCC/SP) focus on functional communication and successful swallowing.

The Value of the Lifeline service for Rehabilitation Professionals

Because these professionals are concerned about the ability of patients to function successfully in a home environment, messages to them should focus on supporting patients as they continue with the therapies on which they have been working.

With the Lifeline service:

- Patients have more confidence to continue to perform therapy routines necessary for their continued rehabilitation.
- Patients have the security of early intervention if they were discharged before reaching an independent level of functioning – they are safer in their homes.
- Patients are more self-reliant in their ability to perform activities of daily living when they have a safety net.
- Lifeline with Reminders can help patients remember when and how to use the adaptive equipment – again strengthening their recovery.

We recommend…

… that you focus your often-limited marketing time to Discharge and Rehabilitation professionals for the biggest return for your marketing effort. Other areas for referral activity are located on the updated "Mapping the Hospital" brochure available on CarePartners Connect.

Community Marketing

Partnering with home health agencies

Tapping into new referral audience – the SNF

Community marketing encompasses clinically-based referral sources as well as other organizations that touch the elderly population and can be referral generators. As always, our first focus is on clinical referrers. We will take a look at two rich referral areas – community-based home health agencies and Skilled nursing facilities– to give you a better understanding of the environments in which these professionals operate so you can effectively communicate how Lifeline can be a critical partner in meeting their needs.

What is Home Care

To market successfully to home care professionals at all levels, it is important to understand their environment, their needs, and how to approach and work with them. The goal of every contact with these professionals is to educate and reinforce how and why Lifeline can be a key component to the growth and success of a home care company on both clinical and business levels.

The Home Care "Environment"

In 1997 Congress changed the rules of reimbursing for home health. The effects have been dramatic:

- Home health benefits have decreased 60%
- Total cuts over 5 years equal $73 billion dollars
- Almost 40% of home health agencies report Medicare losses
- A loss of approximately 133,000 jobs in home care

Home care today is a highly under-resourced, over-stressed environment. If there is a positive side to this environmental change, it is that today the remaining home care agencies have transformed themselves into entrepreneurial, lean organizations that are dedicated to balancing business and patient care successfully. And with this change we have a more compelling message that these professionals will be receptive to hearing.

Home Health

- The Changing Home Care Environment
- Who's Who in Home Care
- Key Messages for Home Care
  - Connection
  - Reduced Costs
  - Competitive Edge

Community Marketing (Continued)

Who's Who in Home Health

In all agencies – large and small – there are three "arms" to their employee group.

1. Executive/Administrators/Medical Director

The role of these individuals is to look for business opportunities for growth and ways to keep the business profitable.

2. Clinical Staff – Management & Field

Nursing staff handles management responsibilities of the field staff as well as their own patient load. The field staff performs most of the visits in the patients' homes.

3. Marketing Staff (But they're not called "marketing"!)

The role of "marketing" the facility falls on individuals with titles like Patient Care Coordinator or Community Education Liaison. If you ask "who handles your agency's marketing efforts?," you will quickly uncover these people.

Approaching Home Care

It is important to keep in mind that professionals within a home care agency are very interested in keeping their agencies viable and profitable. No matter who you speak to, they will be receptive to your message – especially if you position yourself as:

A healthcare partner that can be an integral part of their patient care plan, while also helping the agency reduce the cost of care!

Home care professionals understand the need for partners. Presenting yourself as a fellow healthcare provider that is also affected by the changing healthcare environment will further reinforce your credibility.

Community Marketing (Continued)

The Key Message for Home Health

The key message for home health professionals, from which all other benefits messages flow, is this:

The Lifeline service offers the home health agency a way to stay connected to the patient and reduce the cost of patient care!

- **We can notify you if your patient is hospitalized.** (They are constantly faced with losing patients to a competing agency if the patient is hospitalized.) Third-Party Notify Service and Incident Reports can keep them connected to their patients, increasing their opportunity to retain a patient who has been transported to the hospital.
- **By being connected, you can reduce the need for unnecessary visits should your patient become hospitalized.** This can help them decrease payroll costs for non-billable visits by staff.
- **Our responder network reduces unnecessary hospitalizations.**
- **Early Intervention increases the chance that the patient will return home after an incident.**
- **The Lifeline service helps patients remain independent in their homes by extending your coverage 24/7.** You provide quality of care, and the patient can continue either to get home care or be readmitted to home care in the future.
- **Lifeline with Reminders keeps patients healthier and out of the hospital.** This saves medication-related visits or hospitalizations. Simple changes to reminders regarding the plan of care can be facilitated via a call from the nurse vs. a visit to the home.

Focus on the Partnership

You now have an arsenal of messages that are compelling for home care. When you meet with the different professionals outlined above, remember to stress that you are a partner to help them meet their goals. In the spirit of this partnership, be sure to let them know that while they are referring their homecare patients to your Lifeline program, you are informing key discharge professionals that the home care regularly refers the Lifeline service for added support for home care patients.

Referral Target –

Skilled nursing facilities (SNF) aka Nursing Homes

What's an SNF?

Why call on them

How to find them

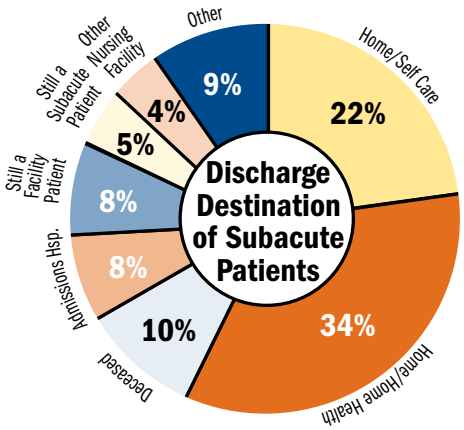
Who's In them?

What do you say to them?

Nursing homes are back! No longer are they seen as a last destination for elders who will spend the rest of their lives in 24-hour care. This is a re-emerging referral opportunity that can be a key referrer for your program.

What is an SNF?

Nursing homes have increased in importance due to the changes in Medicare hospital reimbursement which created the trend of discharging patients from the hospital more quickly. In today's healthcare environment, many hospitals are discharging patients not directly home but rather to nursing homes. It is often referred to as sub-acute care or short-stay programs. These nursing homes are referred to as skilled nursing facilities or SNFs. The primary goal of these short-stay programs is to rehabilitate patients and discharge them to home.



The typical skilled nursing facility has 120-140 beds. Since the early 1990s there has been an increase of other units in a SNF that are dedicated to short-term rehabilitation. SNFs provide 24-hour nursing care, rehab services, social services, help with personal care, and recreational activities. Nursing homes are the primary discharge destination site from hospitals for elderly patients – 82% of nursing home short-term stay discharges were referred by hospitals or the patient's physician (2 million patients in 2003).

Profile of a Short-Stay Patient

- Most short-stay patients are elderly - 67% are older than 65
- Most are discharged home (56%)

The Short-Stay patient is our Subscriber

So, why should you increase your presence in SNFs?

Skilled nursing sub-acute units present a significant universe of patients who are elderly and frail. On average, patients have spent 6 days in a hospital, followed by 26 days in a skilled nursing facility for an acute illness, injury, or exacerbation of a disease. Most are discharged home and have the means to pay for Lifeline.

Referral Target (Continued)

Why call on SNFs?

Simply because that's where potential subscribers are. Hospitals are releasing patients to SNFs when they no longer qualify for hospital stays but are not ready to go home yet.

So far Philips Lifeline has had great success in tapping into this resource. Our sales representatives report they are easy to access and will give you a welcome reception – they are actually very happy to see you! And so far, active contacts into these facilities by our Market Development Coordinators have resulted in 15% growth in referral activity.

The reason for this growth is that our "message" complements their goals.

- Facilitates a safe discharge
- Helps meet the facility's goals for filling beds with the right level of patients
- Messaging by medical specialty
    - Orthopedic patients: reduce the risk of falls with RSVP
    - COPD patients: early intervention for respiratory distress
    - Stroke patients: supports patients who may have difficulty with speech
- Lifeline with Reminders allows the discharge of a patient who otherwise may be held if he or she has problems with medication adherence

How to Find and Qualify a SNF – Best Practices to Save You Time!

Qualifying the SNFs you call on is essential to your success, as you should avoid calling on SNFs that are predominantly for Medicaid patients. You want a facility where 90% or more of the patients are covered by Medicare.

Your current referral sources can help you uncover and qualify SNFs in your area.

Ask your hospital Discharge Planning Department:
Where do you refer most of your elder patients for short-stay programs?
Is Medicare the primary funding source for these particular short-stay programs?

Referral Target (Continued)

Note:

Having the conversation with the hospital discharge planner is critical.

If you get a list of SNFs from the Discharge Department secretary, you run the risk of getting an extensive list of nursing homes that you have to quality through cold calls.

Given that 36% of SNF discharges are referred to home health – another approach is to ask your home health agency. Ask your home health agency:

What are the most active short-stay skilled nursing facilities in the area? Or
Which skilled nursing facilities refer the most elder Medicare patients to you on a monthly basis?

National chains are prime targets:
- Sunbridge: 240 Facilities
- Genesis: 300 Facilities
- Kindred: 290 Facilities
- Beverly: 400 Facilities
- HCR/Manor Care: 500 Facilities

Over half the nursing homes in the country are owned or managed by medium to large corporations or chains. Most of these corporations place a heavy emphasis on attracting the short-stay Medicare admission. Therefore, if you have one or more of their facilities in your key markets, it is likely that they are going to have active short-stay units.

Whatever the target, questions to ask when qualifying SNFs are:
- Do you have short-stay units?
- What volume of patients is discharged each month?
- Of those, how many are elderly patients?
- Are most of the elder discharges Medicare funded?
- What percentage of elderly patients do you discharge back home?
- What are the primary medical conditions treated on the short-stay unit?

The answers can tell you whether they are a good candidate for your marketing time.

In a recent test of SNF marketing in Pittsburgh, PA, Lifeline account manager Lisa Allen asked one of her referring home health agencies if there were any SNFs in the area and discovered several Manor Care SNFs. In her visit to the first one, she found success. With 70-90 discharges per month from the short-stay units, 25% would fit Lifeline's subscriber profile – that translated into 22 potential referrals per month.

Referral Target (Continued)

Key referral sources in a SNF

The **social worker** is your key referral source – in some of the larger facilities there may be a **nurse case manager** as well. You can find other key influencers on the Community Marketing Map available on CarePartners Connect.

Key Selling Messages for Lifeline

Lifeline Facilitates a Safe Discharge

Like hospital discharge planners, their key concern is to facilitate a safe discharge.

Envision the situation: They have had an opportunity to get to know the family and the patients, and they will know the quality of the patient's support system.

- Patients who don't have support systems
- Patients who don't function as well as they used to
- Patients who chose to go home against the recommendations of the SNF
- Managed care patients

Case in Point: For managed care patients, the LOS could be as short as 5-7 days. To quote one SNF case manager, "I cross my fingers when I discharge them so quickly."

Lifeline with Reminders Provides Critical Post-Discharge support

Supports adherence to medication regimens.
Supports follow-through with rehabilitation recommendations.

Case in Point: For the nursing managers in particular this is key. They may not feel a patient is ready for discharge because they are uncertain about medication compliance. Knowing that Reminders will help the patient adhere to the discharge plan will influence their decision to discharge the patient. (This is important to rehab professionals as well, since Reminders will help the patient continue with therapy recommendations.)

In addition, some short-stay patients decide to go home against the recommendations of the SNF staff. In those instances the social worker will feel better knowing that they have the Lifeline service.

SNF Best Practices –

Tips and Tools

Utilize current network to find SNFs

Be sure to qualify first

Know who you want to see

Know the discharge process

Use your discharge messages

- Learn your hospital's discharge process for SNFs – where patients are referred and the numbers each month. This information helps in building credibility when calling on a SNF.

- Gaining access to professionals in an SNF is usually easy. You can leverage your contacts from the hospital to gain access also. For example, "X, with the discharge department at Y hospital, suggested I call on you. She refers to Lifeline on a regular basis, and she would like the patients she refers to you also to be referred to Lifeline."

- Some hospital systems may have a long-term care division with physicians whose exclusive job is to round at skilled nursing facilities. They are another contact for you.

- Best time to call on SNFs is late morning.

- After developing relationships with SNF social workers, schedule an in-service for all social workers and rehab staff.

- Utilize SNF marketing flyer found on CarePartners Connect.