Turning Referral Leakage into Patient "Keepage"

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Patient Outmigration or what is commonly referred to as *patient leakage* is on the minds of most health system executives. They wonder why their patients seek care elsewhere, especially after they have spent millions of dollars attracting them through ad campaigns, the purchase of high-profile equipment and investing in employed medical groups that lose money in operational isolation. Perhaps we should reconsider our use of the term "referral leakage." "Referral leakage" implies that patients are somehow confined.

Confinement, however, was one of the prime reasons the public largely rejected HMOs. By contrast, to acknowledge patient consumerism and demand for choice, emerging payment models are often based on "attribution." Attributed PPO patients may choose to vote with their feet, and they often self-refer. The concept of referral leakage implies entitlement, but a sense of entitlement may be a part of the problem.

Fundamentally, referral leakage is a failure to be perceived as the best provider in a competitive environment. As inpatient volumes decline (thanks to our advances in taking better care of patients in the outpatient environment) system executives are intent on increasing market share to back-fill beds in their most expensive asset--the hospital. Here's the problem: every other system in the market is trying to do the same thing. Unless a market is growing demographically, relative system growth is a zero sum game. Therefore, systems must not only

convince patients to try them, but then to provide such superior service and value that those patients willingly stay-- all while others constantly try to lure them away.

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The process of creating patient loyalty can be thought of as "keepage"- a term which invokes *responsibility* rather than blame.

We sometimes think, perhaps too simplistically, that referral leakage is primarily a matter of provider and staff loyalty--that patients would stay within our system if only our providers referred patients to other in-network providers. We may also hold the belief that patients will surely go where their doctor refers them. No matter how loyal a physician is to a system, their highest priority is serving the patient before them, and adherence to that principle is a sound keepage strategy. The loyal physician may recommend an in-network provider when a referral is indicated, but if the patient wishes to go to an outside provider or system for any of the reasons discussed below, the physician faces the concern that if pressed too hard, they may lose the patient altogether.

Let's explore the root causes of what we call referral leakage and the associated strategies of keepage each suggests. They fall into six categories:

1. **False Attribution**
2. **Distance and Geography**
3. **Limited Access**
4. **Poor Service**
5. **Non-competitive Quality**
6. **Lack of Provider Familiarity**

False Attribution

When do we suppose a patient is "ours" to lose? When they have seen an affiliated provider? When they have had care, testing or a procedure within the facilities of the system? We need to make a distinction between "family" and "visitors." In some cases, systems should simply be grateful that a patient visited its facilities in an urgent situation due to convenience, but should not expect them to continue to receive care within that system when the patient is perfectly satisfied with their regular neighborhood provider. In other words, these patients should not be viewed as leaking, because they never were "ours" in the first place. Patients are often cemented to other systems for reasons as obvious as that their spouse works for the competing organization. Also, increasingly, patients are financially bound to other institutions by benefits plans that disincentivize out-of-network utilization with higher co-pays. This suggests the counter-strategy of incentivizing network utilization for employees through benefit redesign.

Distance and Geography

At some geographic distance from a system's facilities or affiliated provider offices, the inconvenience becomes more important than the quality of care. It is difficult to get a patient to come back to a facility eight miles from their home if they live right across the street from a hospital or doctor's office they perceive to be of equal value. Sometimes, the issue is not distance, per se, but psychological or cultural geographical boundaries--illogical though they may be--such as a mountain, a river or even a street that is associated with a change in socioeconomic status.

Generally, people will go further to get subspecialized care and procedures, making the geographic reach of a system relative to the seriousness of the condition. This problem requires a re-thinking of the service area from which keepage should reasonably be expected. A system should consider the proximity of its "centers of excellence" to other "centers of excellence" that compete for patients in its secondary and tertiary markets. A system must create a compelling reputation for quality and service to draw patients past the midpoint between such centers, for tertiary and quaternary care services.

Limited Access

Access is fundamental to keepage. It is difficult for a system PCP or other team member to refer their patient to an in-system provider who cannot see the patient for six weeks when an out-of-system provider may be able to see them that afternoon. If a system is concerned with leakage, it must improve the access of in-network specialists and facilities, including investing in weekend and evening hours and an adequate number of providers to meet demand. There is a cost to this investment, but it must be weighed against the revenues associated with keepage.

Poor Service

If patients have choices, they will simply not stick with a system where they believe they have been treated poorly. It only takes one episode of indifference, a rough or condescending tone, an unreasonable delay in a waiting room, a dirty bathroom, a botched bill or lack of compassion to cause some patients never to return. The corollary to observation is that rude and sloppy providers are known throughout the system. One cannot expect personnel in one part of the system to refer patients to providers elsewhere in the system that have reputations for poor bedside manner or follow-up.

The solution for this problem is to take patient satisfaction and its improvement seriously, and to require providers and personnel with poor service skills to attend remediation services. Ultimately, it means being willing to let go of individuals who cannot or will not improve, and to recruit their replacements. This may be done directly with employed providers, but systems should consider creating clinically integrated networks that have citizenship membership requirements and which provide and compel participation in similar remediation services.

Non-competitive Quality

Primary Care Providers and others will (and should) refer patients to the providers and facilities where they believe their patient will receive the highest quality care. If in-network referrals are to be expected, it is incumbent on the system to ensure, to the extent possible, that its specialists, services and facilities are second to none--at least in the local market. It benefits the system to institute a method of measuring the quality of its providers and facilities so it is able to objectively demonstrate that its quality outcomes are better than their competitors.

Lack of Provider Familiarity

This factor may be the most amenable to improvement. An increasing trend of primary care physicians staying exclusively in the office environment and using hospitalists for inpatient care means they no longer mingle with specialists in the course of daily life, as they once did on the floors and in the doctors' lounge. A physician who never comes to the hospital may simply not know who is and who is not "in-network" or what specialized services they provide. Systems themselves struggle with how to define whether a provider is "in-network", since doctors are often on the staffs of multiple hospitals.

This problem can be attacked by various means. The first is to create an accurate physician directory. Web-based directories can be updated in real time, which is essential, and they cannot be misplaced like old printed directories. In addition to creating awareness of the other in-network providers and the special services they offer, forums must be created to foster interaction between providers. This can be done in the form of a quarterly social. Organizations should create venues and mechanisms for the in-network doctors to get to know each other personally.

Systems may also leverage EMRs and health information technology to make it easy for in-network providers to find and refer patients to other in-network providers, by loading them into a pre-populated referral database.

Emphasizing Keepage

Systems must think carefully about which patients are actually theirs to lose, even as they work to improve the access, service and quality of their providers. Rather than focusing on referral leakage, which implies that system providers and staff are not referring patients to other network providers, systems should focus on keepage, or the fundamental principles that will make patients *want* to go where they are referred.

Much of the problem is a lack of awareness of, and relationship with, other providers in the network. Actively updated directories, referral databases that make it easy to refer in-network, and frequent provider mixers and other forums and channels of communication are high-yield investments to keep patients within the system of care.

Preventing patient outmigration requires data, analytics and strategic insight that can support health systems in three main areas:

Patient Retention

- Understand patient behavior in and outside of health care systems' networks across services and procedures, physicians and practices, and geographies
- Quantify and track patient retention with analytic web-based solutions
- Educate in-network providers about their referral patterns
- Accelerate awareness and communication of the systems current capibilities

Network Optimization

- Identify tactical opportunities to improve retention across service lines, providers and geographies
- Identify where patients are receiving care out-of-network, competitive analysis
- Improve physician awareness with reporting tools and routine communications

Network Growth Planning

- Evaluate provider groups prior to integration
- Identify the right markets and providers to build clinical integration networks
- Equipping health systems, especially ACOs, with the tools needed to optimize their referral networks is key to building a sustainable health care system.

Focusing on patient retention and reducing outmigration as a key tenet of the system's revenue growth can lead to securing a.) sustainable market position and b.) help move the enterprise toward expansion into new clinical and geographic opportunities directly supporting population health management and new risk-based reimbursement models.

About the Authors

Dr. Faber is a vice president within the clinical integration practice with The Camden Group. As a physician executive, he specializes in the development of accountable care organizations and clinically integrated networks, physician engagement, and health information technology.
Prior to joining The Camden Group, Dr. Faber served as Senior Vice President of the Rochester General Health System in New York, where he guided the development of the system's clinical integration

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Mr. Agnew has led negotiations for acquisitions, joint ventures, strategic partnerships, and reconfigurations for organizations such as Hospital Corporation of America, Bon Secours Health System, Baxter Healthcare, and VHA, Inc. His portfolio of transactions include transactions exceeding $2 billion in size, to engagements with smaller community hospitals designed to ensure financial stability and mission effectiveness of community providers. In addition, he has developed and implemented innovative health system strategies to improve both clinical and economic performance across the entire healthcare delivery continuum. He has successfully completed both sell-side and buy-side transactions of acute care hospitals.

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