LHC DYNAMIX

# ADVANCED **GROWTH**

## Workshop **Participation** Guide

**DAY 1** | Introduction/Selling Skills

LHC GROUP
GROWTH ACADEMY
2020

## AGENDA

## INTRODUCTION

### The Right Mindset for success in Healthcare sales

- I can... IF...

- Growth mindset versus fixed mindset

- Self-coaching

## SALES PROCESS

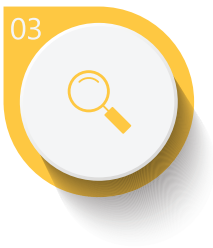
### WHY HAVE A SALES PROCESS?

Reasons for a Sales Process

**ROADMAP**
It gives us a roadmap of what to do and when to do it.


**CONSISTENCY**
It helps us to have more consistent success with our sales calls.


**IDENTIFICATION**
It helps us to identify why things go well on a sales call and why they go poorly.




**REPEATABLE**
It gives us a repeatable process.


**PROCESS DRIVEN**
It allows us to focus on process rather than results.


**ROOT CAUSE ANALYSIS**
It helps us to understand the root cause of poor performance.


**Discussion:**

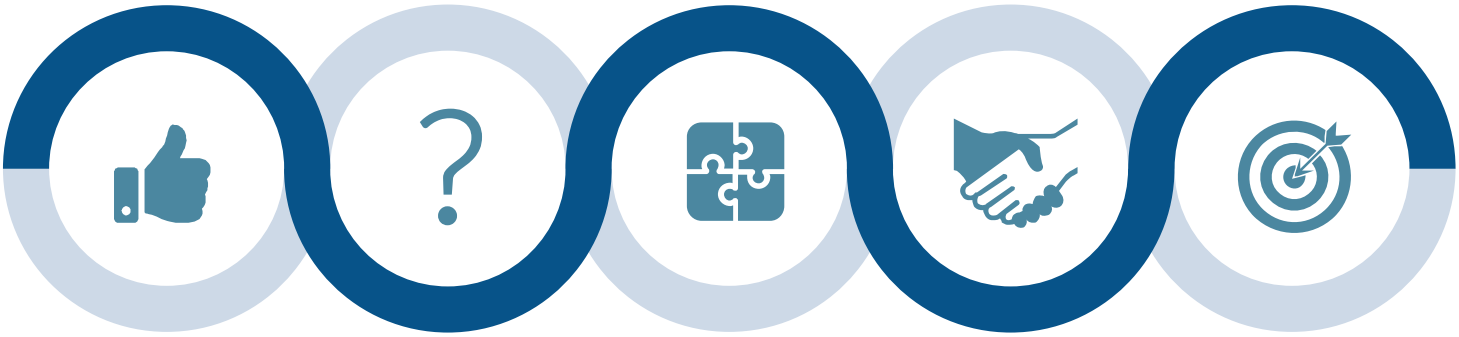
Solicitor:

Servant:

Consultant:

Why is a consultative approach so important in healthcare sales?

## THE FIVE STEPS TO REFERRAL GENERATION



**INTRODUCTION AND CONNECTING**
Building a foundation of trust

**NEEDS ASSESSMENT**
Discovering their needs

**SOLUTIONS**
Customized solutions that solve discovered needs

**CLOSING**
Directly asking for the logical next step

**NAVIGATING APATHY, HESITATION, AND OBJECTIONS**
3 types of a "NO"

### Discussion:

What if we skip the Introduction and Connecting Step?

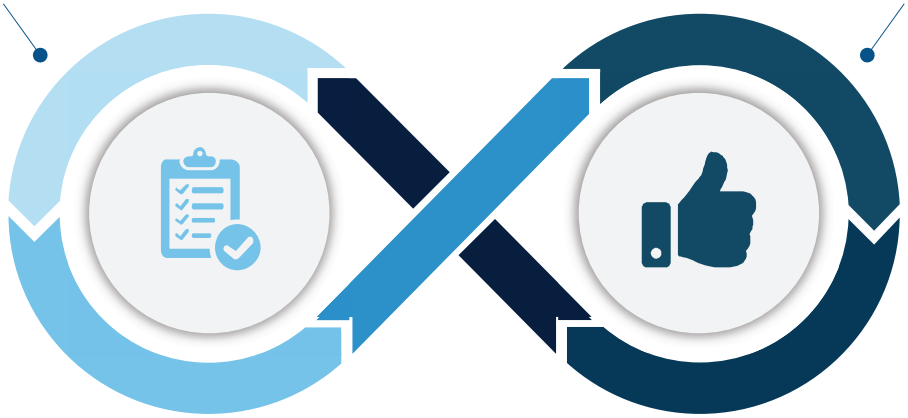
What if we succeed in Connecting but skip the Needs Assessment?

Why is a fake "YES" so bad?

## SALES PROCESS: ONGOING

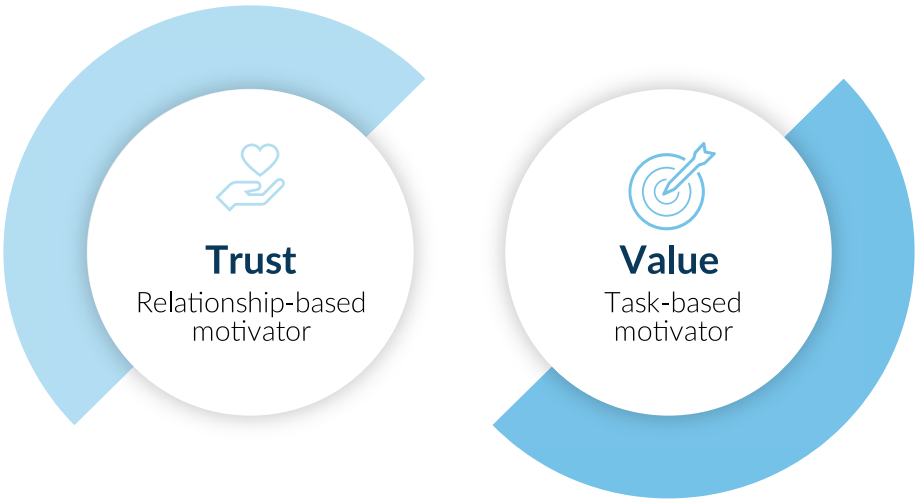
### Reinforce
Reinforcing the referral source's decision to refer

### Avoid ongoing apathy
Proactively increasing customer satisfaction



## GET READY TO CONNECT

### Trust and Value




**Discussion:**

What does trust look like? How can you tell that they trust you?

## TRUST

### Discussion:

When developing trust with a referral source, you must demonstrate 3 key behaviors.

- Reliability
- Integrity
- Care

## TRUST

### Discussion:

Scenario: You make your first call to a new internal medicine office. It just so happens that the referral coordinator has a few minutes to talk to you before lunch. Quickly into the conversation, they tell you that they most likely won't use you because they are owned by a health system that has their own home health and hospice.

Based on this scenario, here are three important questions to ask on trust and value:

› What's the cost for this referral coordinator to refer?

› What's the value at this point for the referral coordinator to refer?

## VALUE

### Cost versus Value

Decision-making: Balance of cost versus value

1. Cost
   - What do I have to lose?
2. Value
   - What do I have to gain?

### Creating Perceived Value and Building Trust

Three things that you must do **BEFORE the call** when creating perceived value and building trust:

1. Research the account
   - Know what to research
   - Know how to research

2. Set 2 to 3 goals
   - Set primary and backup goals
   - Expand or Compete?

3. Prepare value-added introduction
   - Why you are there?
   - How you will conduct yourself?
   - What's in it for them?

## Creating Perceived Value and Building Trust (continued)

Two things that you must do **DURING the sales call** when creating perceived value and building trust:

1. Create a positive first impression
   - Wait your turn
   - Be respectful of their policies
   - Friendly welcome
   - Similar body language
   - Use their name
   - Professional appearance

2. Open with value-added introduction
   - Why you are there
   - How you will conduct yourself
   - What's in it for them

## Activity:

**Value-added Introduction Practice**

Write down your Why/How/What value statement for a call you're planning to make next week. Pair up and practice this with a partner. Provide feedback to your partner. Repeat as time allows.

## OUR REFERRAL SOURCES

| CONTACT / ROLE | NEEDS / CHALLENGES |
|---|---|
| **ACCOUNT TYPE: HOSPITAL** | |
| **CEO/President/Administrator** – Operations, contracts<br>**COO/CNO** – Operations and quality concerns for the entire hospital<br>**Chief of Staff** – Medical Care oversight<br>**Hospitalist** – see patients in the hospital only, speed up discharge<br>**Information Desk/Operator**<br>**Unit /Department Secretary**<br>**Chaplain**<br>**Case Management/Discharge Planners/Social Services** – patient advocate, responsible for coordinating discharge and post-acute services<br>**Departments** – ER, ICU, Telemetry, Med/Surg, Cath Lab, Respiratory, Oncology/Hospice<br>**Population Health** – committee or coordinator | › Length of Stay (LOS)<br>› Diagnostic related grouping (DRGs)<br>› Hospital acquired conditions (HAC)<br>› Reduction in 30 day readmissions<br>› Staffing<br>› Safe discharges<br>› Outcomes/Image<br>› The referral process – easy access without complications<br>› Timely response for care coordination<br>› A “one stop shop” approach<br>› Service consistency<br>› Quality patient care<br>› Geographic service area<br>› Weekend and after five coordination and SOC<br>› Having the hospice conversation |
| **ACCOUNT TYPE: PHYSICIAN OFFICES*** | |
| **Physician** – writes the order for home care or hospice<br>**Physician Assistant** – patient care<br>**Nurse Practitioner** – patient care<br>**MTM Pharmacist** – medication therapy management program, meet with all the complex cases<br>**Patient Care Coordinator** – supports patients with complex needs<br>**RNs/LPNs** – patient care, sometimes coordinates/ influences referrals<br>**Referral Clerk** – the person who calls in the referrals for home care or hospice<br>**Medical Assistant** – administrative, billing, referral coordination<br>**Referral Coordinator** – manages referrals, insurance authorization<br>**Office Manager** – administrative, scheduling, understand patient mix, billing<br>**Gatekeeper** – receptionist, patient check-in, VERY important! | › Increase revenue/protect bottom line<br>› Phone calls<br>› Too much paperwork<br>› Increased focus on hospitalizations and re-hospitalizations<br>› Difficult patients take up too much time<br>› Referral process takes too much time<br>› Patients don’t take/understand their medications<br>› Efficient communication<br>› Time and money<br>› Having the hospice conversation<br>› Bereavement for office staff close to patients who have passed |

| CONTACT / ROLE | NEEDS / CHALLENGES |
|---|---|
| **ACCOUNT TYPE: SKILLED NURSING FACILITIES** | |
| **Administrator** – operations, census, compliance, oversight of all building operations, quality of care<br>**DON** (Director of Nursing) – compliance, cost control, delivery of care<br>**ADON** (Assistant DON) – resident care, medication management<br>**MDS Coordinator** – Medicaid billing, level of care changes<br>**Education Coordinator** – staff education, inservices<br>**Medical Director** – compliance, quality of care<br>**Primary Care Physicians/ARNPs** – different from the Medical Director, these MDs continue as the PCP<br>**Social Worker/Admissions/Marketing** – resident advocate, family support, marketing, move-ins<br>**Billing Clerk** – billing, Medicaid Room and Board<br>**RNs** (don't forget the nights and weekends) – resident care, resident advocate, family support<br>**Activity Director** – resident activity<br>**CNAs** – resident care/assistance with ADLs | › Re-hospitalization rates<br>› Referrals come from hospitals<br>› Staffing<br>› Time<br>› Quality results<br>› Having the hospice conversation<br>› Placing GIP or respite patients for hospice<br>› Bereavement for other residents when hospice patient passes |
| **ACCOUNT TYPE: ASSISTED LIVING FACILITIES** | |
| **Owner/Administrator** – operations, census, compliance, oversight of all building operations, quality of care<br>**Director of Clinical Services (RN)** – identifies decline in residents, medication management, resident advocate, family support<br>**Caregivers** – assist residents with ADLs<br>**Admissions/Marketing** – resident advocate, family support, marketing, move-ins<br>**House Physician/Nurse Practitioner** – different from a Medical Director, often treats many residents in the Community. Can be multiple groups coming onsite to see residents | › Keeping residents in their home – aging in place<br>› Keeping the back door closed<br>› Lack of a coordinated process to transfer residents back to assisted living post-hospitalization<br>› Continuity of Care<br>› Containing costs<br>› Appropriate staff to support and accommodate residents needing more complex care<br>› Staff retention<br>› Limited clinical staff on-site<br>› Limited expertise in caring for high acuity situations<br>› Maintain and/or improve resident and family satisfaction scores<br>› Resident recruitment<br>› Regulatory compliance<br>› Don't know how to identify home health or hospice patient<br>› Bereavement for other residents when hospice patient passes |

| CONTACT / ROLE | NEEDS / CHALLENGES |
|---|---|
| **ACCOUNT TYPE: INDEPENDENT LIVING FACILITIES** | |
| **Owner/Administrator** – operations, census, compliance, oversight of all building operations, quality of care delivered by service partners<br>**RN** – resident advocate, family support and resource | › Aging in place<br>› Occupancy – keeping the units full<br>› Keeping community healthy<br>› Bereavement for other residents and staff when hospice patient passes |
| **ACCOUNT TYPE: GROUP HOMES** | |
| **Owner** – wears many hats, very involved in resident care<br>**Caregivers** – resident assistance with ADLs | › Keep residents in place<br>› Manage residents needs with least staff possible<br>› Reduce anxiety and 911 calls<br>› Bereavement for other residents and staff when hospice patient passes |
| **ACCOUNT TYPE: LTAC (LONG TERM ACUTE CARE HOSPITAL)** | |
| **Administrator** – operations, census, compliance, oversight<br>**Social Worker** – patient advocate, coordinates discharge<br>**Therapists** – resident therapy<br>**Medical Director** – Medical Care oversight, compliance<br>**Nurse Manager** – patient care, patient advocate, family support | › Manage length of stay<br>› Discharge patients following optimal 25-day stay<br>› Reduce re-hospitalizations |
| **ACCOUNT TYPE: CLINICS (DIALYSIS, CARDIAC, TRANSPLANT, PAIN, ETC.)** | |
| **Social Worker** – patient support, coordination of services<br>**Nursing staff** – patient care<br>**Physician** – Medical Care oversight | › Patients are able to make their appointments<br>› Improved outcomes<br>› Keep patient out of hospital<br>› Bereavement for other patients and staff when hospice patient passes (especially in dialysis clinics) |
| **ACCOUNT TYPE: OUTPATIENT REHAB FACILITIES** | |
| **Administrator** – operations, census, compliance<br>**Social Worker** – patient advocate, coordination of services, referrals<br>**Therapists** – patient care/therapy | › Patients able to make their appointments<br>› Keep patients out of the hospital |

| CONTACT / ROLE | NEEDS / CHALLENGES |
|---|---|
| ACCOUNT TYPE: **HOME HEALTH CARE AGENCIES** | |
| **Administrator** – operations, census, compliance<br>**DON** – compliance, cost control, census, quality of care<br>**Social Worker** – patient advocate, coordination of services<br>**Marketing** – census growth | › Assist with patients they can't serve. Be their first backup.<br>› Improve outcomes by discharging terminal patients to hospice. |
| ACCOUNT TYPE: **INTERNAL CUSTOMER** | |
| **My LHC Group Team** | › Help with managing service failures<br>› Get orders signed<br>› Provide communication with referral partners |

*Physician Specialties

## ACTIVITY

### Referral Source

You will be given an assigned a referral source.  Identify the decision-makers, the influencers, goals, and challenges within the referral source.

- Decision makers/influencers
- Goals
- Challenges

- List one to three takeaways that you plan to implement in your market.

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See you on Day 2!

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