Developing Your 'Brand' and Marketing Strategy

Your "brand" is an important way to describe your practice to current and future patients. It's the thread that forms the basis of your organizational message and permeates your marketing plan and strategies to help your practice meet its marketing goals.

Chapter in Brief:

- *Your brand image should capture your practice's personality in graphics and messaging in a way that helps patients know what to expect, and these elements should be incorporated into all your marketing messages and materials.*
- *Your marketing strategy should be based on your brand identity or business positioning and will help you find the right tools and tactics to achieve your marketing goals.*
- *Use tracking and other tools to capture information about word-of-mouth referrals. Develop plans for generating referrals from patients, healthcare professionals, and others.*

Do you want your practice to be known as warm and caring, cool and clinical, or maybe some combination of both? A description of your practice's personality is called a "brand." By using your understanding of your practice gleaned from the research, self-analysis, and examination completed in Chapter 1, you'll be able to move to the next step in the marketing planning process: defining your brand and communicating that definition to both current and potential patients.

According to the American Marketing Association, a brand is a collection of images and ideas that often refers to a symbol such as a name, logo, slogan, and design scheme. People recog-

TREAT HEARTBURN AND BEYOND

Prescribe ACIPHEX to relieve heartburn & other symptoms of nonerosive GERD—regurgitation, belching & early satiety, because...

TREAT HEARTBURN AND BEYOND AcipHex® rabeprazole sodium

"There's more to my life than GERD"

20 Winning Seasons, 5 County Championships, 1 ACIPHEX tablet daily

Frank Johnson

GERD=gastroesophageal reflux disease

Hypothetical representation of a patient with nonerosive GERD.

INDICATIONS

ACIPHEX 20 mg is indicated for the treatment of daytime and nighttime heartburn and other symptoms associated with GERD in adults and adolescents 12 years of age and above.

IMPORTANT SAFETY INFORMATION

ACIPHEX is contraindicated in patients with known hypersensitivity to rabeprazole, substituted benzimidazoles, or to any component of the formulation.

As with all PPIs, patients treated concomitantly with warfarin may need to be monitored for increases in INR and prothrombin time, which may lead to abnormal bleeding and even death.

In adolescents, the related reported adverse reactions that occurred in ≥2% of patients were headache and nausea. The adverse reactions reported without regard to relationship to ACIPHEX that occurred in ≥2% of patients were headache, diarrhea, nausea, vomiting, and abdominal pain.

In adults, clinical trials revealed the following adverse reactions appearing in ≥2% of ACIPHEX patients and with a frequency greater than placebo: pain, pharyngitis, flatulence, infection, and constipation.

Symptomatic response to therapy does not preclude the presence of gastric malignancy.

ACIPHEX inhibits gastric acid secretion and may interfere with the absorption of drugs where gastric pH is an important determinant of bioavailability (e.g., ketoconazole, iron salts and digoxin).

ACIPHEX may reduce the plasma levels of atazanavir.

Rabeprazole has been shown to inhibit cyclosporine metabolism *in vitro*.

PLEASE SEE BRIEF SUMMARY OF FULL PRESCRIBING INFORMATION ON REVERSE.

Manufactured and Marketed by

Eisai

Woodcliff Lake, NJ 07677

Marketed by

PriCara®
Division of Ortho-McNeil-Janssen Pharmaceuticals, Inc.

Raritan, NJ 08869-0602

01AX1804R1 May 2009

ACIPHEX®

(rabeprazole sodium)
Delayed-Release
Tablets

BRIEF SUMMARY

Before prescribing ACIPHEX®, please see full prescribing information.

INDICATIONS AND USAGE

Healing of Erosive or Ulcerative GERD

ACIPHEX is indicated for short-term (4 to 8 weeks) treatment in the healing and symptomatic relief of erosive or ulcerative gastroesophageal reflux disease (GERD). For those patients who have not healed after 8 weeks of treatment, an additional 8-week course of ACIPHEX may be considered.

Maintenance of Healing of Erosive or Ulcerative GERD

ACIPHEX is indicated for maintaining healing and reduction in relapse rates of heartburn symptoms in patients with erosive or ulcerative gastroesophageal reflux disease (GERD Maintenance). Controlled studies do not extend beyond 12 months.

Treatment of Symptomatic GERD

ACIPHEX is indicated for the treatment of daytime and nighttime heartburn and other symptoms associated with GERD in adults and adolescents 12 years of age and above.

Healing of Duodenal Ulcers

ACIPHEX is indicated for short-term (up to four weeks) treatment in the healing and symptomatic relief of duodenal ulcers. Most patients heal within four weeks.

Helicobacter pylori Eradication to Reduce the Risk of Duodenal Ulcer Recurrence

ACIPHEX in combination with amoxicillin and clarithromycin as a three drug regimen, is indicated for the treatment of patients with *H. pylori* infection and duodenal ulcer disease (active or history within the past 5 years) to eradicate *H. pylori*. Eradication of *H. pylori* has been shown to reduce the risk of duodenal ulcer recurrence. {See ***CLINICAL STUDIES*** **(14.5)** and ***DOSAGE AND ADMINISTRATION*** **(2.5)** in full PI}.

In patients who fail therapy, susceptibility testing should be done. If resistance to clarithromycin is demonstrated or susceptibility testing is not possible, alternative antimicrobial therapy should be instituted. {See ***CLINICAL PHARMACOLOGY, Microbiology*** **(12.2)** in full PI and the clarithromycin package insert, ***CLINICAL PHARMACOLOGY, Microbiology.***}

Treatment of Pathological Hypersecretory Conditions, Including Zollinger-Ellison Syndrome

ACIPHEX is indicated for the long-term treatment of pathological hypersecretory conditions, including Zollinger-Ellison syndrome.

CONTRAINDICATIONS

Hypersensitivity to rabeprazole

Rabeprazole is contraindicated in patients with known hypersensitivity to rabeprazole, substituted benzimidazoles or to any component of the formulation.

Use of Clarithromycin and hypersensitivity to macrolide antibiotics

Clarithromycin is contraindicated in patients with known hypersensitivity to any macrolide antibiotic.

Concomitant use of Clarithromycin with pimozide and cisapride

Concomitant administration of clarithromycin with pimozide and cisapride is contraindicated. There have been post-marketing reports of drug interactions when clarithromycin and/or erythromycin are co-administered with pimozide resulting in cardiac arrhythmias (QT prolongation, ventricular tachycardia, ventricular fibrillation, and torsade de pointes) most likely due to inhibition of hepatic metabolism of pimozide by erythromycin and clarithromycin. Fatalities have been reported. (Please refer to full prescribing information for clarithromycin.)

Amoxicillin and hypersensitivity to penicillin

Amoxicillin is contraindicated in patients with a known hypersensitivity to any penicillin. (Please refer to full prescribing information for amoxicillin.)

WARNINGS AND PRECAUTIONS

Clarithromycin use in pregnant women

CLARITHROMYCIN SHOULD NOT BE USED IN PREGNANT WOMEN EXCEPT IN CLINICAL CIRCUMSTANCES WHERE NO ALTERNATIVE THERAPY IS APPROPRIATE.

If pregnancy occurs while taking clarithromycin, the patient should be apprised of the potential hazard to the fetus. (See *WARNINGS* in prescribing information for clarithromycin.)

Anaphylactic reactions associated with antibiotic use

Amoxicillin: Serious and occasionally fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. These reactions are more likely to occur in individuals with a history of penicillin hypersensitivity and/or a history of sensitivity to multiple allergens.

There have been well-documented reports of individuals with a history of penicillin hypersensitivity reactions that have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before initiating therapy with any penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillin, cephalosporin, and other allergens. If an allergic reaction occurs, amoxicillin should be discontinued and the appropriate therapy instituted. (See *WARNINGS* in prescribing information for amoxicillin.)

SERIOUS ANAPHYLACTIC REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE. OXYGEN, INTRAVENOUS STEROIDS, AND AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

Pseudomembranous colitis associated with antibiotic use

Pseudomembranous colitis has been reported with nearly all antibacterial agents, including clarithromycin and amoxicillin, and may range in severity from mild to life threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhea subsequent to the administration of antibacterial agents.

Treatment with antibacterial agents alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is a primary cause of "antibiotic-associated colitis".

After the diagnosis of pseudomembranous colitis has been established, therapeutic measures should be initiated. Mild cases of pseudomembranous colitis usually respond to discontinuation of the drug alone. In moderate to severe cases, consideration should be given to management with fluid and electrolytes, protein supplementation, and treatment with an antibacterial drug clinically effective against *Clostridium difficile colitis*.

Presence of gastric malignancy

Symptomatic response to therapy with rabeprazole does not preclude the presence of gastric malignancy.

Patients with healed GERD were treated for up to 40 months with rabeprazole and monitored with serial gastric biopsies. Patients without *H. pylori* infection (221 of 326 patients) had no clinically important pathologic changes in the gastric mucosa. Patients with *H. pylori* infection at baseline (105 of 326 patients) had mild or moderate inflammation in the gastric body or mild inflammation in the gastric antrum. Patients with mild grades of infection or inflammation in the gastric body tended to change to moderate, whereas those graded moderate at baseline tended to remain stable. Patients with mild grades of infection or inflammation in the gastric antrum tended to remain stable. At baseline 8% of patients had atrophy of glands in the gastric body and 15% had atrophy in the gastric antrum. At endpoint, 15% of patients had atrophy of glands in the gastric body and 11% had atrophy in the gastric antrum. Approximately 4% of patients had intestinal metaplasia at some point during follow-up, but no consistent changes were seen.

Concomitant use with warfarin

Steady state interactions of rabeprazole and warfarin have not been adequately evaluated in patients. There have been reports of increased INR and prothrombin time in patients receiving a proton pump inhibitor and warfarin concomitantly. Increases in INR and prothrombin time may lead to abnormal bleeding and even death. Patients treated with a proton pump inhibitor and warfarin concomitantly may need to be monitored for increases in INR and prothrombin time.

ADVERSE REACTIONS

Worldwide, over 2900 patients have been treated with rabeprazole in Phase II-III clinical trials involving various dosages and durations of treatment.

Because clinical trials are conducted under varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

Clinical Studies Experience

The data described below reflect exposure to ACIPHEX in 1064 patients exposed for up to 8 weeks. The studies were primarily placebo- and active-controlled trials in patients with Erosive or Ulcerative Gastroesophageal Reflux Disease (GERD), Duodenal Ulcers and Gastric Ulcers. The population had a mean age of 53 years (range 18-89 years) and had a ratio of approximately 60% male/ 40% female. The racial distribution was 86% Caucasian, 8% African American, 2% Asian and 5% other. Most patients received either 10 mg, 20 mg or 40 mg/day of ACIPHEX.

An analysis of adverse reactions appearing in ≥ 2% of ACIPHEX patients (n=1064) and with a greater frequency than placebo (n=89) in controlled North American and European acute treatment trials, revealed the following adverse reactions: pain (3% vs. 1%), pharyngitis (3% vs. 2%), flatulence (3% vs. 1%), infection (2% vs. 1%), and constipation (2% vs. 1%). The 3 long-term maintenance studies consisted of a total of 740 patients; at least 54% of patients were exposed to rabeprazole for 6 months while at least 33% were exposed for 12 months. Of the 740 patients, 247 (33%) and 241 (33%) patients received 10 mg and 20 mg of ACIPHEX, respectively, while 169 (23%) patients received placebo and 83 (11%) received omeprazole.

The safety profile of rabeprazole in the maintenance studies was consistent with what was observed in the acute studies.

Other adverse reactions that were seen in controlled clinical trials which do not meet the above criteria (≥ 2% of ACIPHEX treated patients and > placebo) and for which there is a possibility of a causal relationship to rabeprazole include the following: headache, abdominal pain, diarrhea, dry mouth, dizziness, peripheral edema, hepatic enzyme increase, hepatitis, hepatic encephalopathy, myalgia, and arthralgia.

In a multicenter, open-label study of adolescent patients aged 12 to 16 years with a clinical diagnosis of symptomatic GERD or endoscopically proven GERD, the adverse event profile was similar to that of adults. The adverse reactions reported without regard to relationship to ACIPHEX that occurred in ≥2% of 111 patients were headache (9.9%), diarrhea (4.5%), nausea (4.5%), vomiting (3.6%), and abdominal pain (3.6%). The related reported adverse reactions that occurred in ≥ 2% of patients were headache (5.4%) and nausea (1.8%). There were no adverse reactions reported in these studies that were not previously observed in adults.

Combination Treatment with Amoxicillin and Clarithromycin: In clinical trials using combination therapy with rabeprazole plus amoxicillin and clarithromycin (RAC), no adverse reactions unique to this drug combination were observed. In the U.S. multicenter study, the most frequently reported drug related adverse reactions for patients who received RAC therapy for 7 or 10 days were diarrhea (8% and 7%) and taste perversion (6% and 10%), respectively.

No clinically significant laboratory abnormalities particular to the drug combinations were observed.

For more information on adverse reactions or laboratory changes with amoxicillin or clarithromycin, refer to their respective package prescribing information, **ADVERSE REACTIONS** section.

Postmarketing Experience

The following adverse reactions have been identified during postapproval use of ACIPHEX. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure: sudden death; coma, hyperammonemia; jaundice; rhabdomyolysis; disorientation and delirium; anaphylaxis; angioedema; bullous and other drug eruptions of the skin; severe dermatologic reactions, including toxic epidermal necrolysis (some fatal), Stevens-Johnson syndrome, and erythema multiforme; interstitial pneumonia; interstitial nephritis; and TSH elevations. In addition, agranulocytosis, hemolytic anemia, leukopenia, pancytopenia, and thrombocytopenia have been reported. Increases in prothrombin time/INR in patients treated with concomitant warfarin have been reported.

DRUG INTERACTIONS

Drugs metabolized by CYP450

Rabeprazole is metabolized by the cytochrome P450 (CYP450) drug metabolizing enzyme system. Studies in healthy subjects have shown that rabeprazole does not have clinically significant interactions with other drugs metabolized by the CYP450 system, such as warfarin and theophylline given as single oral doses, diazepam as a single intravenous dose, and phenytoin given as a single intravenous dose (with supplemental oral dosing). Steady state interactions of rabeprazole and other drugs metabolized by this enzyme system have not been studied in patients.

Warfarin

There have been reports of increased INR and prothrombin time in patients receiving proton pump inhibitors, including rabeprazole, and warfarin concomitantly. Increases in INR and prothrombin time may lead to abnormal bleeding and even death. {See *WARNINGS AND PRECAUTIONS*}.

Cyclosporine

In vitro incubations employing human liver microsomes indicated that rabeprazole inhibited cyclosporine metabolism with an IC_{50} of 62 micromolar, a concentration that is over 50 times higher than the C_{max} in healthy volunteers following 14 days of dosing with 20 mg of rabeprazole. This degree of inhibition is similar to that by omeprazole at equivalent concentrations.

Compounds dependent on gastric pH for absorption

Rabeprazole produces sustained inhibition of gastric acid secretion. An interaction with compounds which are dependent on gastric pH for absorption may occur due to the magnitude of acid suppression observed with rabeprazole. For example, in normal subjects, co-administration of rabeprazole 20 mg QD resulted in an approximately 30% decrease in the bioavailability of ketoconazole and increases in the AUC and C_{max} for digoxin of 19% and 29%, respectively. Therefore, patients may need to be monitored when such drugs are taken concomitantly with rabeprazole. Co-administration of rabeprazole and antacids produced no clinically relevant changes in plasma rabeprazole concentrations.

Concomitant use of atazanavir and proton pump inhibitors is not recommended. Co-administration of atazanavir with proton pump inhibitors is expected to substantially decrease atazanavir plasma concentrations and thereby reduce its therapeutic effect.

Drugs metabolized by CYP2C19

In a clinical study in Japan evaluating rabeprazole in patients categorized by CYP2C19 genotype (n=6 per genotype category), gastric acid suppression was higher in poor metabolizers as compared to extensive metabolizers. This could be due to higher rabeprazole plasma levels in poor metabolizers. Whether or not interactions of rabeprazole sodium with other drugs metabolized by CYP2C19 would be different between extensive metabolizers and poor metabolizers has not been studied.

Combined Administration with Clarithromycin

Combined administration consisting of rabeprazole, amoxicillin, and clarithromycin resulted in increases in plasma concentrations of rabeprazole and 14-hydroxyclarithromycin. {See ***CLINICAL PHARMACOLOGY, Combination Therapy with Antimicrobials*** **(12.3)** in full PI}.

Concomitant administration of clarithromycin with pimozide and cisapride is contraindicated. (See *PRECAUTIONS* in prescribing information for clarithromycin.) (See *PRECAUTIONS* in prescribing information for amoxicillin.)

USE IN SPECIFIC POPULATIONS

Pregnancy

Teratogenic Effects. Pregnancy Category B: Teratology studies have been performed in rats at intravenous doses up to 50 mg/kg/day (plasma AUC of 11.8 µg•hr/mL, about 13 times the human exposure at the recommended dose for GERD) and rabbits at intravenous doses up to 30 mg/kg/day (plasma AUC of 7.3 µg•hr/mL, about 8 times the human exposure at the recommended dose for GERD) and have revealed no evidence of impaired fertility or harm to the fetus due to rabeprazole.

There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers

Following intravenous administration of ^{14}C-labeled rabeprazole to lactating rats, radioactivity in milk reached levels that were 2- to 7-fold higher than levels in the blood. It is not known if unmetabolized rabeprazole is excreted in human breast milk. Administration of rabeprazole to rats in late gestation and during lactation at doses of 400 mg/kg/day (about 195-times the human dose based on mg/m^2) resulted in decreases in body weight gain of the pups. Since many drugs are excreted in milk, and because of the potential for adverse reactions to nursing infants from rabeprazole, a decision should be made to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

Use of ACIPHEX in adolescent patients 12 years of age and above for short-term treatment of GERD is supported by a) extrapolation of results from adequate and well-controlled studies that supported the approval of ACIPHEX for adults {see ***CLINICAL STUDIES*** **(14.1, 14.2, 14.3)** in full PI and ***INDICATIONS AND USAGE***}; b) safety and pharmacokinetic studies performed in adolescent patients {see ***Pharmacokinetics, Pediatric*** **(12.3)** in full PI}. The safety and effectiveness of ACIPHEX for the treatment of GERD patients <12 years of age have not been established. The safety and effectiveness of ACIPHEX for other uses have not been established in pediatric patients.

In a multicenter, randomized, open-label, parallel-group study, 111 adolescent patients 12 to 16 years of age with a clinical diagnosis of symptomatic GERD or suspected or endoscopically proven GERD were randomized and treated with either ACIPHEX 10 mg or ACIPHEX 20 mg once daily for up to 8 weeks for the evaluation of safety and efficacy. The adverse event profile in adolescent patients was similar to that of adults. The related reported adverse reactions that occurred in ≥ 2% of patients were headache (5.4%) and nausea (1.8%). There were no adverse reactions reported in these studies that were not previously observed in adults.

Geriatric Use

Of the total number of subjects in clinical studies of ACIPHEX, 19% were 65 years and over, while 4% were 75 years and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

Gender

Duodenal ulcer and erosive esophagitis healing rates in women are similar to those in men. Adverse reactions and laboratory test abnormalities in women occurred at rates similar to those in men.

OVERDOSAGE

Because strategies for the management of overdose are continually evolving, it is advisable to contact a Poison Control Center to determine the latest recommendations for the management of an overdose of any drug. There has been no experience with large overdoses with rabeprazole. Seven reports of accidental overdosage with rabeprazole have been received. The maximum reported overdose was 80 mg. There were no clinical signs or symptoms associated with any reported overdose. Patients with Zollinger-Ellison syndrome have been treated with up to 120 mg rabeprazole QD. No specific antidote for rabeprazole is known. Rabeprazole is extensively protein bound and is not readily dialyzable. In the event of overdosage, treatment should be symptomatic and supportive.

Single oral doses of rabeprazole at 786 mg/kg and 1024 mg/kg were lethal to mice and rats, respectively. The single oral dose of 2000 mg/kg was not lethal to dogs. The major symptoms of acute toxicity were hypoactivity, labored respiration, lateral or prone position and convulsion in mice and rats and watery diarrhea, tremor, convulsion and coma in dogs.

PATIENT COUNSELING INFORMATION

How to Take ACIPHEX

Patients should be cautioned that ACIPHEX delayed-release tablets should be swallowed whole. The tablets should not be chewed, crushed, or split. ACIPHEX can be taken with or without food. {See ***PATIENT COUNSELING INFORMATION*** **(17)** in full PI.}

For prescription only

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Manufactured and Marketed by Eisai Inc.,
Woodcliff Lake, NJ 07677

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nize your brand through experience with the specific product or service or because they see it in some media.

In other words, a brand is the value or reputation your customer assigns to your business based on the customer's experience with the business. (To better understand these terms, see "Know the Lingo: Brand Buzzwords," oppposite.) Think about

Be careful to select a brand that is true to who you really are, not just who you want to be. Patients will quickly know if the brand doesn't match the reality; in those cases your marketing plan will fail.

some of the best-known brands, such as Disney and Coke, and the feelings they evoke: Disney says "fun" and Coke says "refreshment." That experience may come from marketing material such as a brochure, or it may evolve from personal contact and experience with the practice.

How to Choose Your Brand

Develop or refine your brand by reviewing your organizational identity. This is where the feedback from the internal research in Chapter 1 and your SWOT analysis will pay off by helping you to better understand what is unique and relevant about your practice. The patient research helps you understand how your practice is perceived relative to patient needs. Any changes you've made in response to the feedback should reflect what the practice has become and should be the basis for your brand identity.

Use patient research to help identify areas that need refining, enabling you to make improvements before spending—and perhaps wasting—money on ill-chosen marketing plans. This is the time to reflect on what you have learned and evaluate how it fits with the way you would like your practice to be perceived.

David Miller, a partner at Stoke, a Seattle brand-consulting firm (*www.stokestrategy.com)*, recommends conducting an "experience audit"—an assessment of what it's like to be a

Know the Lingo: Brand Buzzwords

It helps to be current on the lingo when working with marketing consultants. Here are the American Marketing Association's definitions for some terms associated with the brand-building process.

Brand choice: The selection of one brand from a set of alternative brands.

Brand contacts: Any information-bearing experience that a customer or prospect has with the brand, the product category, or the sponsoring organization that relates to the marketer's product or service.

Brand equity: The value of a brand. From a consumer perspective, brand equity is based on consumer attitudes about positive brand attributes and favorable consequences of brand use.

Brand lift: A measurable increase in consumer recall for a specific, branded company, product, or service.

Brand messaging: Creative messaging that presents and maintains a consistent corporate image across all media channels.

Brand personality: The psychological nature of a particular brand as intended by its sellers, even though people in the marketplace may see the brand otherwise (brand image). These two perspectives compare to the personalities of individual human beings: what we intend or desire, and what others see or believe.

For more information, see *http://www.marketingpower.com/_layouts/Dictionary.aspx?dLetter=B*.

patient in your practice—to determine what about your practice creates an impression on patients. An experience audit revealing that, for example, all the parking spots closest to the clinic entrance are reserved for physicians suggests that the practice doesn't position itself as a network that puts patient needs first. Otherwise, patients would get that priority parking.

The brand development process includes assessing the personality of the business. Is it relaxed? Fun? Aloof? Engaging? Conservative? Nurturing? A short phrase with specific and somewhat emotional language usually is enough. For example, rather than the flat "We provide good patient care," try "We provide timely and compassionate care to the entire family," "Family care in a

nurturing, supportive environment," or "We offer cutting-edge care quickly and effectively."

Be careful to select a brand that is true to who you really are, not just who you want to be. " Can a shy, retiring, technically oriented physician make a promise to offer engaged, personal health planning?" Mr. Miller asks. Patients will quickly know if the brand doesn't match the reality; in those cases your marketing plan will fail.

In a small business like a medical practice or clinic, the brand personality tends to be an extension of the owner's personality. "If you've been in practice long enough, you'll attract the patients who are a good fit," says Linwood W. Watson, MD, a family physician in Raleigh, N.C. "If your tone is militaristic or coldly scientific, you'll attract the patients who like those qualities. If you're more nurturing, you'll draw people who appreciate that style."

"Over the years, people have asked me why I went into family medicine; and I always said that I wanted to take care of common things in an uncommon way. I supposed that was my brand message," says Kenneth R. Bertka, MD, a family physician in Toledo, Ohio.

If the practice has multiple partners with widely ranging personalities, you'll find common ground on practice attributes that you all want to be known for, such as accuracy, professionalism, or excellent patient relationships.

For creative inspiration, visit the Websites of other practices in your community. The brand image for the practice of Dr. Wible, the Oregon physician who designed her practice with patient input, is folksy and friendly (see *http://www.idealmedicalpractice.org*.) Dr. Wible's biography that she makes available online is highly personal, illustrated with photos from her childhood to give prospective patients an opportunity to relate to the lifetime of experiences she shares in her description. The

site's design is colorful, casual, and handcrafted. The suggestion is that Dr. Wible will be as hands-on with her patient care as she is with the design of her Website.

When you have decided on a brand identity, test it, even if only informally. "At a minimum, you should test your proposed branding positions on friends, colleagues, and family to get feedback. One or two will likely resonate with most of them," says Agnes Huff, PhD, CEO of Agnes Huff Communications Group in Los Angeles.

What Do You Want to Say?

Your brand message will be reflected in all aspects of your marketing campaign, both visually and orally (see "Where to Use Your Brand for Maximum Effect," p. 37). For this reason, the next step centers on figuring out your message, which is what you want to say on behalf of your brand in your patient communications, while networking with physicians for referrals, or as you participate in media interviews.

"Over the years, people have asked me why I went into family medicine; and I always said that I wanted to take care of common things in an uncommon way. I suppose that was my brand message," Dr. Bertka says. That message stems from the brand positioning, the one thing you want people to know about you or your practice, network, or clinic. It is important to define your brand, whether it's a practice or an individual, because the brand reflects your positioning. The brand developed for one primary care practice might differ from another because of differences in the target audiences, the moods and images the practitioners want to evoke with their marketing materials, and the personalities of the physicians in the practices.

The message must be clear, simple, direct, and to some degree emotional. For example, the message for a practice promising compassionate care might be, "We treat our patients like family members." When working on message development, avoid the tendency to get bogged down in the details surrounding the prac-

tice. Instead, zero in on the emotion behind the brand, using language that motivates your target audience. A practice that prides itself on how well it communicates with patients to inform them or relieve anxiety might use a message such as "Our staff is specially trained to avoid medical jargon with patients to minimize confusion or misunderstandings."

Developing Your Message

Message development can be as complicated or as simple as you want to make it. You may want to position your practice as one that provides state-of-the-art care for chronic illnesses or, like Dr. Bertka, take a more subtle approach. Because of the high numbers of smokers where he practiced, he made sure all of his examining rooms featured posters with anti-smoking messages. "It told patients we were concerned about [smoking]," he says.

You also can hire outside consultants to develop and test your communications messages to make sure they resonate with target audiences. If you don't have the resources for that level of support, which can cost several thousand dollars, you will still do well developing messages on your own as long as you're methodical, thoughtful, and objective about it. The following six steps will help guide you:

1. Define the situation.

The process of defining the situation, what will be your overarching message, involves more than just claiming a position, such as "We are the best cardiologists in the country." Instead, share a specific fact, such as pointing out that all cardiologists in your practice have performed a high number of procedures or have trained at a top-ranked institution. Use the SWOT analysis from Chapter 1 to find descriptive language that applies to your practice. Your message will play up your strengths, not your weaknesses. But know your weak points, too, so that they can be improved or downplayed in your marketing plan.

Now tap into the research you've done to look at the practice from the perspective of your target audience. What do patients and others know about you already? What don't they know that's important? How do they feel about the practice? Add as much statistical research as appropriate about your specialty or prac-

Where to Use Your Brand for Maximum Effect

Once you've chosen your brand, be sure it is to some degree on everything that represents your practice, including the following:

- Logo
- Letterhead
- Signage
- Website
- E-mail signatures
- Patient forms
- Brochures or other literature
- Yellow Pages ads and any other paid advertising
- Staff apparel

tice area since it's important to leverage facts in your messaging rather than relying on anecdotes or gut feelings.

When Dr. Huff's firm helped Russell W. Nelson, MD, launch the Nelson Spine Institute in Thousand Oaks, Calif., it leveraged research with consumers to create a marketing tagline that reflects what mattered most to those with back problems: "Back to health. Back to living." You can see this line displayed front and center on his Website at *http://www.nelsonspine institute.com/nsi_bios_russellnelson.php*. Additional messages in Dr. Nelson's marketing materials reflect his years of experience and cutting-edge expertise. "We developed messaging to punctuate his 25-plus years of expertise and to position him as an innovator and researcher at the forefront of the science behind spine surgery," Dr. Huff says.

Combine what you have already learned about your audience and its attitudes with how you want your practice perceived to brainstorm some possible patient-friendly messages. (See "Are You Making This Communication Mistake?" p. 39.) These can

range from "I will treat your family like my own" to "We make healthcare painless." Include employees in this endeavor so that you get a diversity of ideas and have better staff buy-in at the end of the message development process.

2. Create draft messages.

Create as many draft or preliminary messages as you can, then review each carefully. What seems vague? What rings true? Are there a few that everyone likes—and a few that everyone dislikes? Liz Miller, vice president of GlobalFluency, an international marketing consulting firm, stresses using your patient knowledge as a guideline. "You should be listening to your patients carefully to know what will resonate," she says.

3. Test the draft messages.

After narrowing down the list to a few messages you think will work best, test your short list with your target audience either in a one-on-one conversations or with a group. You can do this yourself or assign the task to your most organized staffer. But you will get the most from the experience if you lead the discussion yourself, asking a colleague to record the answers as you present the messages and ask what the target audience members think of each. (See Chapter 5 for more information on getting the work done.)

Present the messages to them one at a time; then ask them the following questions:

- What does this message mean to you?
- Does this message motivate you?
- Is there anything about it that confuses you?
- Would this motivate you to take action?

Listen carefully to questions and comments while noting confusion or positive responses. Next, present all of the draft messages collectively and ask the target audience to select the one they think works best. Ask the following questions about the message selected:

- What do you like about that message?
- What don't you like about it?
- Is there anything missing?
- How would you phrase it differently?

Are You making This Communication Mistake?

Don't assume patients always know what you're talking about—literally.

Several years ago, Last Acts, an initiative working to improve the quality of care at the end of life, conducted focus group research with female caregivers of people who were dying in order to determine what or how much they knew about end-of-life issues. The goal was to identify language or phrases that might be used in a communications campaign on the topic.

It turns out the researchers overestimated the general public's familiarity with the language used in this highly specialized field. For example, researchers who referred repeatedly to "palliative care" in focus group settings were met with blank stares. This illustrated the gap between lay language and medical jargon and ensured that the program's messages wouldn't include the phrase "palliative care."

4. Refine the messages.

It takes time and patience to assure that your message motivates your audience—or that it doesn't. When you review the feedback from your message testing, you'll find that one or two messages rise to the top; or there may be universal confusion or a misunderstanding that sends you back to the brainstorming process. Assess where you are, and either refine the messages or move forward with the message that struck a chord.

5. Test the final message.

If you have had to start over or make substantial changes, test again. You need to be confident that your final message communicates appropriately and doesn't confuse or mislead.

6. Adjust the final message.

Adjust the message accordingly after testing. Once you've got it right, you're ready to weave the message into all of your communications vehicles and efforts so that it will be embraced by physicians, nurses, and anyone else who comes into contact with patients at your practice.

Creating Strategies for Your Marketing Plan

Now that you've done the background work—researching your practice, identifying your target audiences, analyzing your

strengths and weaknesses, establishing goals, then creating a brand and messages that reinforce that brand—it's time to develop a marketing strategy.

Your marketing strategy is essentially an umbrella statement that explains how you will achieve your marketing goals based on your brand identity or business positioning. Strategies vary

Dr. Wible achieved word of mouth marketing when she asked community members to help design her practice. By incorporating their suggestions into the practice's operating philosophy, she reached her patient roster goals within a year of opening because those first patients told others.

based on the nature of the practice and its goals. For example, some physicians might be exploring marketing in order to build awareness of a particular health issue.

However, most practices hope marketing generates patients. For these physicians, Mr. Buckley of PB Healthcare Business Solutions LLC advises practices to establish strategies for each target audience—referring physicians, patients, and payers—that can generate patient volume and revenue. These strategies include leveraging the physician's profile locally to position him or her as an expert in a regional, then national, marketplace, and using publicity to generate inquiries from prospective patients.

Generating Referrals From Patients

The easiest way to get referrals from patients is simply to ask for them. The strategy for this: "Ask current patients to recommend potential patients." Request names and contact information for friends and family who might be interested in your services; then follow up with marketing material designed to introduce the practice, and offer an incentive to work with you as their provider.

The smartest way for your practice to get referrals from

patients is by providing a service and experience that is so superior, surprising, or pleasing that patients talk about you without being asked to. The strategy for this approach: "Generate great word-of-mouth marketing by creating a patient experience that is so superior that patients talk about it outside the office."

"You never know how many people that patient you're seeing right then is going to tell about you," Dr. Watson says.

Dr. Wible achieved that word of mouth marketing when she asked community members to help design her practice. By incorporating their suggestions into the practice's operating philosophy, she reached her patient roster goals within a year of opening because those first patients told others.

"I began to get calls from multiple employees from the same business who told me that a colleague was recommending my practice in the break room," says Dr. Wible, who now has a waiting list that exceeds the number of patients she currently sees.

Dr. Baum, the author of *Marketing Your Clinical Practice*, says the strategy for generating good word of mouth is straightforward: "Exceed customer expectations, identify the needs and wants of your patients, and meet them," he says. Patients want access to the doctor, and they want "to be seen in a timely fashion," he says. In addition to meeting these needs, Dr. Baum works to make sure his patients have a positive experience in his office by, among other things, requiring the receptionist to use the patient's name at least twice in a conversation. "The most important words to use are your patient's name," he says.

Good word of mouth makes generating referrals easier, but it is important to give the concept a structure and a system, too. Dr. Baum also suggests that physicians can generate good word of mouth by calling key patients at home. These patients, he says, are not those you see the most or those who might demand the most attention. "Key patients [to call] are those who were just discharged from the hospital and have questions abut their diet, wound dressing, next appointment, or medication," Dr. Baum says. "They are the patients who were sedated when you did an

outpatient procedure and didn't see you before they left. They are the patients you sent for a CT scan and who are waiting to hear the results."

Mr. Buckley says this approach reflects the fact that today's patients are looking for more than competent care. "People… want a partner, somebody who will be their coach and help them accomplish their health goals," he says. Physicians who can understand that need and fulfill it are more likely to have the types of relationships with their patients that will generate referrals with ease.

Other ideas include publishing a regular newsletter and using forms and systems that let you track who is doing the referring and how new patients learn about your practice. Consider a special recognition level to help recognize and acknowledge those who refer a certain number of patients. These high referrers become, in a sense, your "business partners."

A well-rounded referral strategy starts with knowing how you compare with other practitioners (see "How Do You Compare?," opposite), then including the following:

- A request for referrals on patient update forms used at each visit ("We'd like more patients just like you. Please help us by providing the name and address of somebody you think might be interested in our services. Thank you!")
- A personalized thank-you note and an appropriate small gift, such as a box of chocolates, a set of golf balls, or a Starbucks gift card for patients who refer people who become patients
- Incentives for employees to ask patients for referrals (e.g., free lunch for the staff when you reach a target number of new patient referrals)
- Teaching employees how to ask for referrals
- New patient intake forms that ask patients how they heard about the practice and ask for the name of any individual who referred them to your practice
- Tracking systems such as Excel or the practice's contact management software that give you a way to thank those who refer

Generating Other Referrals

Next, develop strategies for other referral sources. For example, strategies for securing referrals from physicians, healthcare

How Do You Compare?

Today's emphasis on measuring healthcare quality, outcomes, and cost effectiveness has an impact on the number of patients who will come to your practice through managed care plans, according to Neil Baum, MD, author of *Marketing Your Clinical Practice*. While this isn't a classic marketing problem per se, the reality is that because your Healthcare Effectiveness Data and Information Set (HEDIS) profile will have an impact, the wise practitioner will be proactive to ensure his business compares well with others in terms of outcomes and costs. Dr. Baum recommends all physicians take the following steps:

1. In your HEDIS profile, look at length-of-stay and average charges for each diagnosis-related group. Then find out how you compare with your colleagues.
2. Review the HEDIS physician profile data in an analytical way.
3. Compare your patients' average length of stay, if applicable, with those of your colleagues, and try to shorten it.
4. Look at your consulting habits to identify areas for profile improvement.
5. To reduce costs, review the medications you are currently prescribing, particularly antibiotics. Newer-generation antibiotics are usually more expensive but often lack advantages that might make them worth the extra cost.
6. Make sure you absolutely need tests for diagnosis or treatment before you order them.
7. Talk with peers about cost-saving techniques and quality issues.

networks, or other healthcare providers might include this: "Leverage existing instructional materials from my work as a medical school instructor to educate other practices about what types of patient situations would benefit from a consultation with our practice," or "Increase visibility in local medical community to better identify referral sources with the greatest potential." (See "Six Referral Strategies," p. 44.)

Six Referral Strategies

These strategies will help keep your name in front of referral sources:

1. Add referral sources to your patient newsletter mailing list.
2. Meet every doctor who refers patients to you as well as every new doctor who starts or joins a practice. Take colleagues to lunch. Network at medical society meetings.
3. Build trust by demonstrating competence. Lecture in the hospitals of referring doctors or at large practices.
4. Make it easy and appealing for others to do business with you by being easy to work with.
5. Make certain that referring physicians receive copies of your notes, tests, and diagnoses.
6. Make it a two-way street. Refer patients to those physicians who refer to you.

Examine your current professional referral base. Which physicians, networks, or organizations are generating referrals? The practice administrator for physicians in a large group practice can look at the practice's referral data to identify patterns and opportunities. For example, an evaluation of referrals might indicate that a likely source of referrals has not provided any. Use this information as an opportunity to find out why. Add this to your knowledge of the local market to create a list of physicians or organizations that could be generating more referrals. At the same time, talk to doctors who are referring patients to you regularly to learn why and to ascertain what type of feedback they get from their patients about your care. Call them to say "thanks" and ask a few questions, or invite them to lunch for a more personal conversation. The information they will provide is valuable, so record it in an Excel file or use your practice's contact management software.

Use this research to compile a list of individuals or organizations such as networks you think will help you expand your patient base through referrals. Next, review the list and assess your familiarity with those on it. In smaller markets, it's likely you will be familiar with many names on the list, and that might

guide your outreach efforts. In larger markets, that is less likely to be the case.

You can reach out to these sources with branded educational patient handouts, lunch-and-learn sessions with potential referral sources, monthly sessions between your staff and referral sources, and testimonials that comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996's guidelines. (See "Making Sure Your Marketing Complies with HIPAA," below). If you know them better, call with a personal thank-you for the referrals or seek them out at the next county medical society meeting for an in-person expression of appreciation.

Making Sure Your Marketing Complies with HIPAA

Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations affect two areas of practice marketing: patient testimonials and promotional mailings to patients.

To comply, you must have a signed release form or waiver for testimonials, says Kate Borten, founder of The Marblehead Group, a healthcare privacy and information security consulting firm in Marblehead, Mass. (*http://www.marbleheadgroup.com/index.html*).

"The release form used must strictly comply with HIPAA privacy rules and specifications for authorization forms," she says. "The regulation is very explicit about what needs to be on the form and how it needs to be phrased." Practices covered by HIPAA should have a standard template available in their HIPAA materials. The American Medical Association also has forms on its Website at *http://tinyurl.com/nl4rmj*.

In addition, the new HITECH Act recently signed into law by President Obama makes it unlawful for practices to send marketing mailings to their patients when paid by a third-party source such as a pharmaceutical company without prior authorization. "It's okay to send a piece announcing a new wellness center or cancer clinic, but you can't send notices about third-party products or services if you are receiving direct or indirect payment for the mailing unless patients have given permission via an authorization form," she says. Prescription and biologic refills are the one exception to the general requirement for authorization.

Ms. Borten also cautions physicians to be careful about what they reveal about patients on blogs or social networking sites (see Chapter 3 for more on these topics).