Building a Referral Base

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Referral bases are a source of immediate and continued revenue, but how they are developed and maintained has changed significantly in the past 2 decades. This article addresses referral bases and their continued maintenance as of 2006, covering cosmetic and medical practices, with a special emphasis on the cosmetic aspect. It also examines whether various referral practices are applicable based on the growth stage of the practice.

Physician-Based Referrals

When I entered the world of private practice in 1992, significant erosions of the traditional referral system were already becoming evident. For example, at that time, managed care was beginning to impact dermatology, which changed referral patterns. Previously, physicians could feel confident referring their patients to a specific dermatologist. However, due to the constraints of managed care (ie, copayment amount and whether the physician participates in a particular insurance plan) patients are no longer assured of being treated by the named dermatologist.

Referral patterns in the past typically have been based on collegial associations, such as seeing patients in the hospital or socializing with other physicians. Although some remnants of these associations still remain, hospital consults, for example, have become less common as patients are released from the hospital as quickly as possible. As a result, face-to-face contact between the referring physician and the dermatologist is limited. That is not to say that collegiality does not exist, but it does not seem to exist in the same manner as in previous years.

Dermatologists do not require hospital services as much as they did when lasers cost hundreds of thousands of dollars and ownership rested largely with major hospitals employing the resources and staff necessary to operate them. Since many dermatologists now own their own lasers, they do not need to use operating rooms in local hospitals for laser procedures, thus closing another avenue of meeting referral doctors.

All this leads to a newer, less formal method of gaining access to referral relationships, in which patients have more influence. Although collegial referral patterns remain intact for many physicians, these patterns seem to be diminishing with the increased presence of managed care.

Also pertinent is the fact that cosmetic procedures, though certainly germane to the medical profession, frequently are initiated without direct consultation with an internist or family physician. Conversely, many family physicians and internists are opting to treat their dermatology patients. These same physicians, as well as obstetricians, gynecologists, and other "noncore" cosmetic practitioners, are branching out into cosmetic procedures, which may be another reason for eliminating the expenditure of time and effort necessary to cultivate this area of referrals.

Let us now consider some referral sources that have emerged over the past several years. I have been tracking referral sources for new patients since my practice opened. It has been interesting to note the changes in referral patterns. As of 2005, referral sources ranked in order were: (1) family members, (2) friends, (3) signs (billboards, signage on the building), (3) Yellow Pages, (4) insurance companies, (5) radio advertising, (6) physician referral, (7) newspaper advertising, (8) internet advertising, (9) outside lectures, and (10) magazine ads. For the year 1997, referral sources were ranked as follows: (1) friends, (2) family members, (3) physician referral, (4) insurance companies, (5) Yellow Pages, (6) newspaper advertising, (7) radio advertising, (8) magazine ads, (9) signs, and (10) outside lectures.

These rankings would certainly change based on the amount of time and money allocated to each area; what is typical for my practice may be quite different for another practice. Nonetheless, these data indicate that family and friends have been consistent referral sources, while the role of physicians in this area has decreased since 1997.

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Insurance companies presently rank ahead of physicians, though that was not the case in 1997. It also may be a reflection of less rigid HMO penetration in the cosmetic market, with less direct referral necessary at this time. The change in signage ranking from 1997 to present may be largely due to decisions made to improve signage because referrals from that source were lacking. Internet advertising is ranked low, which indicates that it is not a strong source in terms of trust compared with other sources such as family and friends.

The most important message this analysis concludes is that friends and family are strong referral sources—potentially the best source! Although one cannot pay to increase referrals from these sources, there are many ways to assure better returns.

In-house Referrals

It has always been my contention that the least expensive and most effective form of advertising comes from within your practice, beginning with smiles from the reception staff and benefiting from the nursing staff's professional care, a tidy office, and, most important, the interaction between physician and patient.

While no office can assure 100% patient satisfaction, it is an important goal. I try to see my practice as a patient would by attempting to put myself in his/her shoes, from parking to checkout. Although this can be a difficult task, it is not impossible. Another option is to send a friend to the office as a "mystery shopper." You may discover a thing or two you did not expect.

Consider your phone system and the interpersonal skills of the reception staff, as these may be significant assets or liabilities to the practice. One rule of thumb for my practice is that if the phone lines are maxed out more than several times a day, it is time to add another phone line. We currently have 15 incoming lines, which are very expensive, but at approximately $40 a month per line, the additional lines are preferable to a busy signal and a lost patient.

Once the patient is in the office, reading material and an informed staff are key points to patient satisfaction. If you perform procedures such as fillers or liposuction, patients need to know that you have the capabilities and expertise to provide these services. Brochures are helpful, but informed and interested staff members are even more effective. Incidentally, staff members who have experienced such procedures and are happy with the results are one of the best forms of advertising.

Being able to meet the patient's needs in a timely manner is an absolute necessity, especially in the cosmetic arena. My staff is instructed to schedule cosmetic patients when the patients wish to be scheduled—period. This is a hard and fast rule. An example of such attention comes from an experience I had 2 weeks before writing this article. I received a call from an out-of-town patient as I was preparing to leave the office on a Friday afternoon. She asked if I could see her for Botox® and Restylane® injections, as she was in for the weekend to visit family. Although my staff asked me if this was OK in a somewhat concerned manner, I thanked them and told them I could do the procedure later that afternoon.

This is the type of customer service that cosmetic patients expect and deserve. It also should be noted that cosmetic procedures are something that women (and men, to a lesser degree) discuss among themselves. Rather than selecting a dermatologist at random, they tend to choose after a comparison of alternatives and also by word of mouth. This is why a good customer referral base is imperative and another reason that friends and family play such a significant role in referrals.

Advertising-Based Referrals

Advertising, essentially shunned prior to 1990, has become commonplace as times have changed. When I started in practice, it was unusual for physicians to advertise in the newspaper or on the radio or television, but now it is almost the norm. Perhaps the determining factor is that it is no longer possible to purchase an expensive piece of equipment and profit from it without some form of advertising.

Before equipment prices began to rise from thousands to hundreds of thousands of dollars, it was reasonable to introduce new procedures without much fanfare. Now the stakes are much higher, and it has become an economic necessity to use appropriate marketing strategies before and after the purchase of expensive equipment. Failure to advertise adequately or promote a new product or laser can lead to staggering losses.

Other Referral Sources

Most of the other referral sources available are far more expensive than the ones already discussed. However, they are important enough to deserve mention.

Newspaper advertising has been a changing source of patient recruitment, especially since less people read the paper on a daily basis. Sadly, what once was a common activity has been replaced by snippets of CNN and Internet news delivery. That is not to say that newspapers do not draw an audience, but the population drawn is somewhat older than average and not as

interested in cosmetic procedures. Newspapers are still a good source for medically related advertising, but whether they will perform well based on a return on investment must be considered.

Magazine advertising is a viable option, especially in cities with widely read magazines. For my practice, it has not been a major referral source; however, it does serve a purpose, depending on the venue and issue being promoted.

Radio advertising has declined in its ability to draw attention over the past several years, as more listeners are choosing satellite radio and as commercials have proliferated. Although I still advertise on the radio, I am selective in my approach. Negotiation is of paramount importance, and promotions should be a part of any radio package if it is to be successful. Arguably, promotions are the most effective part of any well-negotiated radio package, as they are actually heard by the majority of listeners if they are good.

The Yellow Pages are a continuous source of patient referrals but can be quite costly. While a good advertisement is imperative, it is important to provide additional reasons for patients to choose your practice (ie, family, friends, word of mouth, and convenience), so that Yellow Pages advertising cements the relationship instead of making it. It is easy to spend quite a bit of money on this type of advertising, so make sure it is indeed worthwhile based on your referral tracking. If it is not, it may be due to poor ads, poor placement, or ads that are too small.

Lectures can be a mixed blessing. While most companies selling products or services push this method, it is very dependent on weather, time of year, and other variables. If a dermatologist enjoys doing lectures and it fits his or her lifestyle, it might be an excellent source of referrals. On the other hand, if public speaking is challenging for a particular physician, it is best to avoid it.

Insurance referrals are negligible when cosmetic procedures are considered. However, acne and eczema patients presenting to your practice may be accompanied by mothers who are interested in having cosmetic procedures. It is my belief that the medical and cosmetic sides of a practice work hand in hand.

Conclusion

While no single method of building a referral base will work in every city and practice style, this article has addressed some of the concepts that have worked in my medical/cosmetic practice. Additionally, it addresses changes in delivery of healthcare and the implications these changes have on referral patterns. ■