Referral Networking for Women's Health Interventions

John H. Fischer II, MD, discusses why it's important, what works, and what doesn't.

What is the first step in identifying potential referral partners?

Many of the strategies that work in building a uterine fibroid embolization (UFE) referral network are the same that work well with other procedures. The specialties most likely to provide referrals must first be identified, which, for a UFE practice specifically, include gynecology, family medicine, and primary care physicians. After that, look for physicians who are in close proximity to your practice, in the same geographical area, or on staff at the same hospital. Close proximity is important, especially when getting started.

Are there any characteristics that might lend a particular practice to being more open to referring patients for intervention?

It is difficult to predict. My own experience has been that female gynecologists tend to be more likely to refer, but I have certainly received a lot of referrals from male gynecologists, too. In general, for UFE, I have found better success in working with the more recently trained gynecologists.

What about in terms of the type of practice, such as those located within the hospital versus outside?

When getting started, it's easier to work with a practice or physician who is on staff at the same hospital. This is also beneficial in terms of providing a team approach to the patient's care. However, it is certainly not necessary to work only with practices in your hospital or network. I would estimate that half of our referrals or more are from gynecologists who are not on staff at our hospital.

I have certainly seen a shift toward more cooperation and sharing of information, primarily because I think patients are demanding additional treatment options.

You noted that the gynecologists who have been trained more recently are more likely to refer patients for UFE; have you noted any changes in the perception of these interventional options among the overall gynecology community in recent years?

More recently trained gynecologists may be less comfortable performing complex open or less invasive fibroid surgeries and, therefore, are more likely to refer to us. As a group, it seems like gynecologists are more educated about UFE and more accepting of it as a viable alternative to hysterectomy in selected patients, but there is still a lot of variability from one practice to another, and from physician to physician. There are those who discuss UFE as a treatment option with every patient they think may be a candidate and refer patients regularly, and those who only discuss the procedure with patients who inquire about it. There's a very broad range of perspectives on referring for UFE, but in general, over the 12 years that I have been offering the procedure, I have certainly seen a shift toward more cooperation and sharing of information, primarily because I think patients are demanding additional treatment options.

Are certain procedures in your practice easier to gain referrals for than other women's health interventions?

Sure—probably 95% of the women's health interventions we do are UFE. We do other procedures less frequently, such as pelvic congestion syndrome treatment/ovarian vein embolization, postpartum hemorrhage embolization, fallopian tube recanalization, and various other things, but those tend to make up a small portion of our practice, and the referrals for those procedures are probably more a result of having a busy UFE practice and have grown out of established relationships with the gynecological community.

What are your primary talking points when discussing your practice's abilities to offer UFE procedures?

First and foremost, we let them know we will provide primary clinical care for their patient. We admit and discharge all of our patients, taking care of them in the hospital; in the majority of cases, the referring gynecologists will not see the patient while she is in the hospital for her procedure. We manage all postprocedure issues, pain being the primary concern in these patients. Once we get the referral, we handle everything from insurance authorization to the completion of the service, and, in the rare occasion that complications arise, we do our best to manage those complications ourselves. Only in the cases in which we believe the patient needs a gynecologic intervention that we can't offer do we ask for assistance from our gynecologic colleagues.

I can't stress enough how important this is in the process of developing referrals.

Although things have changed significantly in the last few years, radiologists aren't traditionally known for providing primary clinical care of the patient. I believe the inability and/or unwillingness to provide primary clinical care of the patients is where the majority of radiologists fail in their attempts to establish a successful UFE practice.

What kinds of resistance do you encounter from gynecologists? Is there ever a fear of losing patients when you say, "We're going to take them into the hospital and provide all the clinical care?"

For physicians who refer to us regularly and are familiar with our practice, no. We have a fairly robust network of physicians, not only on staff at our hospital, but also outside of our hospital in the Houston and Southeast Texas region, who refer to us on a regular basis. The physicians who are not on staff at our hospital appreciate that service, as do those who are on staff. We provide regular communication, including telephone calls and follow-up letters, keeping referring physicians informed of their patient's course of care. This is important because the referring physicians want to remain informed, and it's also best for the patients if they are. But, I don't believe there is a fear of losing the patient, because we can't provide primary gynecologic care to these patients. In our practice, we have also developed a very healthy "two-way" referral pattern with gynecologists in our referral network. Sometimes we send as many or more patients to our gynecologists than they send to us, especially patients who were self-referred and are not appropriate candidates for one of our procedures. Not only is this good patient care, but it also helps to relieve concerns a referring gynecologist may have about losing patients. I believe healthy collaboration and satisfied patients can, over time, net positive results and growth in both the gynecologic and IR practices.

I try to stress that for any patient group, fibroid patients included, no single treatment option is the best solution for every patient.

When there is resistance, is it a lack of response, or is there a fundamental disagreement with the procedures you are presenting? If so, how do you address these barriers?

I try to stress that for any patient group, fibroid patients included, no single treatment option is the best solution for every patient. I see all of these treatment options as additional tools in a toolbox used to treat fibroid patients. There are also more attractive, less invasive gynecologic treatment options, such as laparoscopic, hysteroscopic, and robotic surgery. For some patients, traditional open surgery is still best. It depends on the patient, and in my discussions, I try to stress our belief in patient education and exploring each treatment option, regardless of whether we will ultimately treat the patient.

We won't do a UFE or any other procedure just because we can; we will only offer it if we honestly believe it is what's best for the patient. If you approach patient care in this way and make sure you get this point across to the patients' referring physicians, you will gain more respect and credibility from them, and they will be more likely to refer patients to you.

Is it helpful to explain in detail the various therapeutic options you can provide? How much do you share on each specific type of procedure you offer?

We talk not only about the procedures we offer but also about those we do not provide. It would be hypocritical of us to bring a fibroid patient in for consultation, especially those who are self-referred, and not talk about the other options available for which she might be a candidate, even if we don't offer it, because that's essentially what we are expecting of our gynecology colleagues.

For instance, if a patient comes in with a single small intracavitary fibroid and heavy bleeding, she is usually best treated with a hysteroscopic resection of that fibroid, not embolization. In this case, we present the other options, and we either refer the patient back to the original referring physician, or if they were self-referred, we send them to someone within our referral network we know has expertise in less invasive gynecologic surgical procedures. Not all gynecologists offer laparoscopic, hysteroscopic, or robotic procedures, especially with frequency. Although we are not doing the procedure, by referring patients for it, we place our own reputation on the line and must make sure that whomever we refer them to takes good care of them and the patients have good outcomes.

What kind of surgical networking must you have in place in case a patient needs to undergo surgery?

It is a very rare situation that we would need to send somebody for emergent hysterectomy after UFE, with the rare case most likely being due to a serious infection. But even in these rare cases, the gynecologist will usually treat them with aggressive antibiotics for at least a day or two before they even consider surgery. Out of the well over 1,000 patients we've treated in the last 12 years, this has happened in only a handful or fewer patients. On the rare occasion it does, we rely on our pre-existing relationships with our local gynecological colleagues. They may call me for a patient of theirs who is having severe bleeding and needs an embolization that day. In turn, if a patient of mine or a patient from another physician who is not on staff at the hospital needs a hysterectomy because of a UFE complication, gynecological assistance is usually only a phone call away.

What kinds of approaches haven't been successful when trying to establish a referral partner?

Expecting anybody else to take care of your patient during the preprocedural, periprocedureal, or postprocedural time periods. The last thing a referring physician wants to do is deal with patient issues related to a procedure they did not perform. There is a big difference between asking for assistance once you realize that you have done everything you can and a patient needs surgery or another procedure you can't offer (after you've done everything you can in terms of admitting a patient, getting him or her on IV antibiotics, consulting the appropriate services, etc.) versus punting the care of and responsibility for the UFE patient back to the referring physician because you do not want to deal with it. This approach is not conducive to building a referral base or successful practice.

I attempt to visit our top referrer's offices at least once a year and provide information and updates about our practice.

The local gynecologic community must have confidence that you will provide appropriate primary care for the patient, and they won't have to deal with issues resulting from a procedure they didn't perform.

Do you invite the potential referral sources to your facility for instructional cases, seminars, or lunches?

We have not actively invited referring physicians to our practice, but if someone expressed a desire to come and visit the practice or to see a procedure, I would be more than happy to accommodate him or her. However, we do make visits to their offices. I attempt to visit our top referrer's offices at least once a year and provide information and updates about our practice. This is generally well received and provides a great opportunity to solidify the referral base, introduce new procedures such as MR-guided focused ultrasound, discuss research projects, and present new data regarding UFE.

When you go to present a new therapy at the gynecologist's office, do you network at all with industry beforehand to discuss talking points? Or is it something you do on your own?

We have occasionally held lunches at referring physician offices or potential referring physician offices that were sponsored by industry, but more often we've made visits on our own or in conjunction with the hospital marketing department. Regardless of whether it is a sponsored event, it doesn't change the approach or my message.

To what degree do you discuss specific embolization technologies that you use, such as different coils or materials? Is that of interest to gynecologists in your experience?

My experience has been that when I share details about the catheters or embolics used, there may be a curious interest, but referring physicians are much less interested in the technical aspects and more interested in how we are going to manage their patients. They want to know what they can expect from me and how their patient will be cared for, or, if there is a complication, how that will be handled. I think those factors are much more important to them than the technical aspects of the procedure.

How do you handle your follow-up interaction with referring gynecologists?

We see all of our patients for follow-up 1 or 2 weeks after the procedure, and send a follow-up letter to their gynecologist whether they were referred by them or not. We also see most patients between 9 and 12 months after the procedure and send letters to their gynecologist after this encounter.

Aside from the gynecology community, what other types of practices can be helpful in generating referrals?

I think a lot of people overlook family practice or primary care physicians who, especially in more rural areas but also in urban areas, provide a significant amount of well-woman care and routine pap smears for their patients. Therefore, they're the ones who often diagnose fibroids and may be the first line of care for many patients' fibroid-related issues. They are another group of physicians who should be considered by anyone who is trying to build a practice.

Are there any specific ways you tailor your pitch to primary care physicians?

It requires a slightly different approach in that a lot of them are used for referring only to gynecologists for fibroid-related issues. Therefore, many primary care physicians must be educated regarding the potential benefits of the fibroid treatment options offered to their patients by interventional radiology. Also, some family practice physicians, especially those who have provided well-woman care for a patient for 10 or 15 years, may be concerned that referring a fibroid patient to a gynecologist may result in losing that portion of the patient's care.

For these physicians, there may be less of a concern about referring to a radiologist than a gynecologist because after we do a UFE procedure, we send the patient back to the primary care physician for her well-woman care.

It takes a long time and a lot of effort to build a good reputation, but a short time and very little effort to destroy one.

What roles do other members of your staff play in the networking process?

In many ways, their roles are more important than mine because they are usually dealing directly with the patients, and a key to successful networking and building a practice is having satisfied patients. Whether or not a patient was referred, if she goes back to her gynecologist or primary care physician and talks about what a wonderful experience she had, how nice the staff was, and how well she was treated, that physician is much more likely to refer future patients than if the patient had described a negative experience.

From our coordinator to our physician assistant, to the radiology techs and nurses, we try to stress a patient-centered approach. This includes offering the best possible care, being courteous, and making the patient feel comfortable. It takes a long time and a lot of effort to build a good reputation, but a short time and very little effort to destroy one.

Is there any specific training that you or your staff goes through in that regard?

We are fortunate that we haven't had much turnover in our staff, so we haven't had to train multiple people, but more than specific training, it mostly comes down to common sense and courtesy, along with offering quality patient-centered care. We try to be mindful and respectful of the patient's time. We try not to make patients wait too long when in the office or take too long to return patient calls. Sometimes delays are out of our control, but it's important to minimize patients' waiting times as much as possible and provide patients with information and realistic expectations when there are delays. We also try to accommodate them as best we can for appointment time requests. All of these things can make a huge difference in patient satisfaction. ■

John H. Fischer II, MD, is a partner in Singleton Associates, P.A., a Clinical Assistant Professor of Radiology at Baylor College of Medicine, and practices in the Department of Radiology at St. Luke's Episcopal Hospital in Houston, Texas. Dr. Fischer may be reached at (832) 355-4110; jfischer@sleh.com. For more information, visit www.fibroidfocus.com.