OCCUPATIONAL MEDICINE

What, When, Who, and How to Offer 'Freebies'

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Historically, marketing occupational health services has often meant producing various commodities with your clinic's name on it: pens, hats, mini-flashlights, refrigerator magnets, note pads, even t-shirts. Cute, perhaps—but these trinkets cost money, took time to distribute, and quickly faded from the recipient's mind, if not their possession.

Should your clinic's outreach strategy include "freebies?" If so, what should they be, how should they be distributed, and who should receive them?

What to Offer

Free goods and services should fall into two categories: something of educational value or something that allows recipients to "feel" or experience your clinic.

Educational offerings might include episodic e-mail blasts about new workplace regulations or other current topics, regular e-mail tips, or efforts to leverage a program's website as an informational source.

In turn, your clinic might develop a monthly e-mail briefing at, say, $49 a year. If marketed aggressively, it could be a revenue source in its own right (e.g., 200 employer subscribers a year at $49=$9,800 in gross revenue). Such a product is:

- A low-cost way to make a prospect a "mini-client" of your clinic. A prospect may not be ready to move their business over to your clinic, but may be comfortable with a $49 subscription. Hence, you remain on the prospect's radar screen, emphasize your clinic's mastery of occupational health, and are poised to move the company into the client column at a later date.
- Renewable, as a subscription keeps on giving. A $49 "close" can easily grow to a $490 close over 10 years.
- A way to begin or build a relationship with a prospect. When all else fails, the salesperson can always fall back on the following offer: "I would like to offer you a complimentary one-year subscription to our *Occupational Health Update*. I am confident that you will find it valuable and it would allow us to begin a relationship with your company."

The second approach for offering a freebie involves a hands-on, active experience with your clinic. For example, you can provide a free mini-annual physical to decision makers from high-priority prospects.

If time is set aside for one physical exam per week, your 50 highest-profile prospects can gain a hands-on experience in your clinic every year.

When you provide low-cost or free services, you are not losing revenue but incurring costs per unit of complimentary service. The free one-year subscription is a no-brainer: an incremental e-mail subscription costs your program virtually nothing (to say nothing of prospective paid renewal revenue). Provided that you schedule complimentary physicals during traditionally low-volume hours in your clinic, that cost is minimal, as well.

When and to Whom?

A free subscription or analogous low-cost product is best reserved for the moment it becomes evident that a close is unlikely. Rather than merely a "Thank you, perhaps sometime in the future," you can now offer the one-year "getting to know us" free subscription. The free subscription option is applicable to virtually any prospect, regardless of their priority or future volume potential.

The "free physical" option applies primarily to your "A" prospects. Such an amenity is best offered to prospects that have not closed the door but are not quite committed,

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HEALTH LAW

transfer, unless the ED is closed to ambulance traffic. And even if they are closed to ambulance transfers, they cannot refuse a patient who is being transferred by private vehicle.

Effective Provider-to-Provider Communication

There are other ways to communicate important facts germane to the patient who is changing venues to the emergency department.

When I work in the ED, I don't necessarily want to hear from an urgent care provider who is transferring a patient to my care. I simply don't want to be biased by their concerns.

What I do expect, however, is a written record of the history, exam, radiographs, and lab results, as well as a written statement identifying the UC provider's concern. "This 67-year-old diabetic patient presents with abdominal pain out of proportion to exam findings and I am concerned about the possibility of ischemic bowel."

If you feel more comfortable communicating directly with the receiving physician, more power to you, although don't let yourself be the recipient of any abuse.

When I transfer a patient, I call *after* the patient has already left the urgent care and I keep my communication fact-based: "I just sent you a 48-year-old man with a good story for acute coronary syndrome. His EKG, CXR and troponin are normal, as well as his d-dimer. He has hypertension and a family history for coronary artery disease and should be there is about 10 minutes."

This leaves the emergency physician no out; the patient is on his way.

Compare this method with "I'm thinking about sending a patient who may have angina. Everything else is normal but I'm not sure what else to do. Would you mind if I sent him your way?"

You get the picture. If you are constantly getting pushback from the ED, choose another receiving hospital or, if you have to use the particular ED, quit calling. After all, you are sending them a patient who will augment their income; why should you be abused?

Epilogue

You know the old saying, "what goes around...." Well, you guessed it. A short while after placing one of the calls I confessed to previously, I was on the actual receiving end of one of these scenarios.

A bus load of handicapped kids *were* involved in a minor accident and they all arrived unexpectedly—"unexpected" only because I did hang up on the University of Chicago EM resident who called on the patch phone. And I did say "bite me!"

Lesson learned. ■

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or to the highest-priority prospects that for the moment have little interest. The offer is usually made toward the end of the sales call when the disposition of the call is apparent.

How to Make the Offer

It is not what you say; it is how you say it. When offering a complimentary service, you need to go beyond simply offering the product/service by mentioning its value; give an honest appraisal of why the prospect should accept the free commodity.

That is, you should quantify both the dollar value of the product or service and the functional value (e.g., what's in it for the prospect) in the same breath that you are offering the complimentary service.

Your clinic should be well past the trinket era and focused on providing complimentary services of genuine value and/or offer a true hands-on experience to prospects.

Developing a plan on what to offer, who to offer, when to make the offer, and how to verbalize the offer can provide your clinic with a cost-effective yet excellent marketing tool for converting both near- and non-prospects into clients. ■

CODING Q & A

to answer this is this: *If the patient has been seen in the urgent care or occupational medicine clinic in the past three years (not counting drug screens), then the patient is **established**.*

If the urgent care and the occupational medicine clinics are incorporated separately, you may be able to count most new patient visits to the urgent care center as new patients, even if the patient has been previously seen in the occupational medicine clinic.

One exception must always be considered: If the patient has been seen for evaluation and management by the same physician (whether it be in a private practice, emergency department, occupational medicine clinic, or any other setting), then for three subsequent years the patient is an established patient for that particular physician in any practice setting. ■

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