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Referral Growth Model

OUR POINT OF VIEW

You're treating a symptom.

When referral volume softens, the reflex is more outreach: more liaisons, more visits, more drop-ins. Activity rises. Volume doesn't. The problem is a misdiagnosis, not an effort gap.

Four Sources of Growth: This POV is about the first.

Deepen
Recapture demand you already have

Widen
Build presence where you aren't

Monetize
Commercialize capability you own

Invent
New capability to drive new demand

45%

of employed PCP referral revenue leaves the network

This is leakage inside a system's own employed base, where relationship is not the variable.
No amount of additional outreach reaches it.

Referral value leaks in three places.

Never Referred In

The referral you never saw. Physicians in your market send this volume somewhere else.

Driven by awareness, perceived expertise, and access reputation.

Referred, Not Converted

Won, then dropped. The referral arrives and dies in the queue, the callback, or the third-next-available.

The cheapest volume in the system to recover.

Treated, Then Lost

The initial encounter is captured, but the follow-on care is not. Imaging, procedures, and ongoing management go elsewhere.

Never appears in internal reporting. Invisible without claims data.

WHY IT PERSISTS

Everyone's problem. Nobody's KPI.

Referral leakage touches strategy, operations, marketing, finance, RCM, access, and clinical leadership. No clear owner means no accountability.

No Named Owner

The Deepen growth source belongs to the COO with the CMO: judged quarterly and reviewed monthly with the CFO and access lead. Most systems have never assigned it.

No Market Truth

Without all-payer claims, you can only count the referrals you received. You cannot see share, leakage, or opportunity.

No Revenue Spine

Without a referral-to-encounter-to-claim link, you can count referrals. You can never say what they earned.

Growth is the stated priority. The budget says otherwise.

85%

name growth a top strategic priority for their organization

68%

report budgets flat or down versus prior year — up 24 points year over year

BUILDING THE SYSTEM: THE ANALYTICAL MODEL

Build towards one shared KPI, with clear accountability

One number everyone rallies around, comprising the metrics each leader already owns.

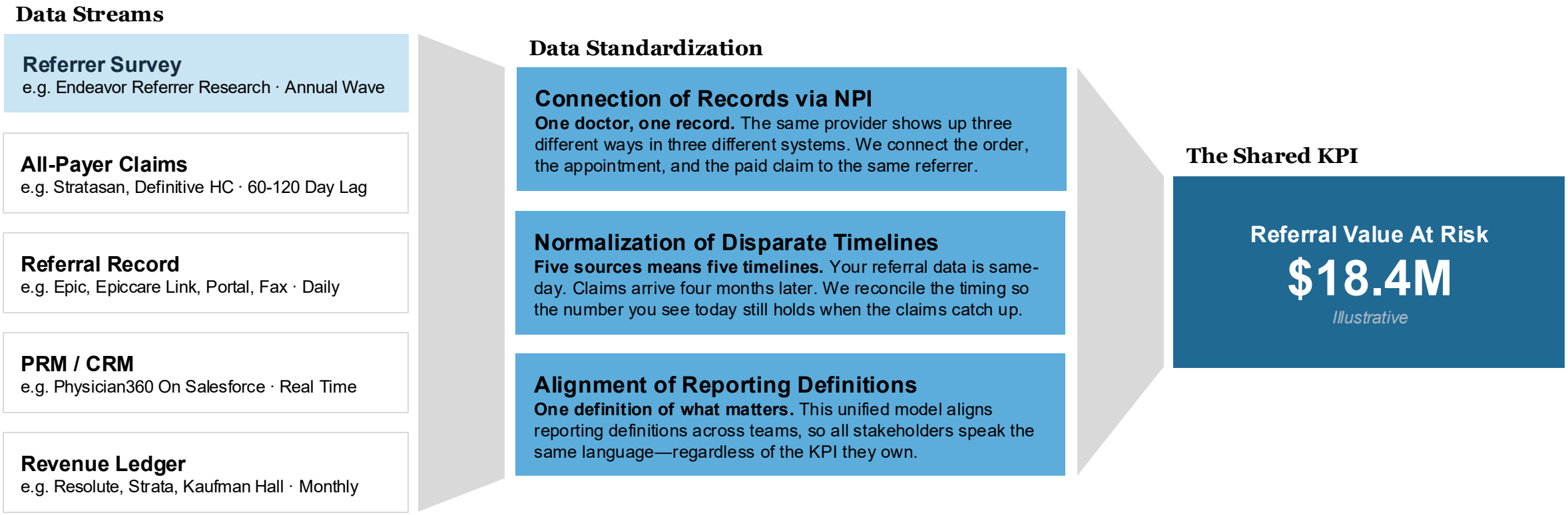
Shared KPI	**Referral Value At Risk** — $18.4M *Illustrative*				
Leakage Types	**Never Referred In**		**Not Booked**	**Treated, Then Lost**	
Referral Journey	**Awareness**	**Decision**	**Access**	**Treatment**	**Follow-Up**
Lead	Marketing	Physician Relations	Access Ops, under COO	Service Line	Often Unowned
Potential Metrics	Unaided Awareness Familiarity Reputation	Referral Share Splitter Count Preference Gap	Conversion Rate Time to Appointment Abandonment Rate	Closed-Loop Rate Note Return Time Episode Completion	Downstream Retention Repeat Referral Rate

Illustrative throughout. Dollar figure, metrics and owners are examples — all vary by system and are confirmed in the diagnostic.

BUILDING THE SYSTEM: THE DATA ARCHITECTURE

How Five Data Streams Become One Number

Combine all five data streams into a single metric, Referral Value at Risk.



Source systems named are examples. The architecture is software-agnostic.

NEXT STEPS

Find and quantify, before you fund.

The diagnostic names the leak, prices it, and assigns it. Eight to ten weeks, using data you already have.

STEP 1

Diagnose

Find the problem.

Referral leakage sized across the network, then conversion loss traced step by step in the service lines you prioritize.

STEP 2

Design

Build the system.

Build what makes the findings hold: data integration, leakage attribution, automated reporting, and clear governance and accountability.

STEP 3

Deploy

Fix what it finds.

Each leak gets the fix it calls for: access redesign where referrals stall, targeted engagement where share is split, closed-loop follow-up where downstream care leaks.

The first conversation is about which service lines to look at, and what data you can pull.

Thank you.

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