

PHYSICIAN ENTREPRENEURS: GOING RETAIL

BUSINESS STRATEGIES
TO GROW BEYOND
TRADITIONAL PRACTICE MODELS

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About the authors

Max Reiboldt, CPA

Max Reiboldt, CPA, managing partner and CEO of The Coker Group, has been involved with healthcare consulting most of his career and has experienced first-hand the incredible changes within the business of medical practice. This uniquely equips him to handle financial and business issues faced by healthcare providers.



From his extensive work with physicians and health systems, Reiboldt understands what motivates physicians and what sustains the motivation of those who are in transition. He also knows what health systems need in order to maintain their viability in a highly competitive market.

He has a keen knowledge of managed care's effects on medical practice management and is proficient in employing practical responses to the fiscal realities of market demands. Reiboldt is uniquely qualified to work with organizations of all sizes to provide sound solutions to everyday and long-range challenges.

Reiboldt oversees Coker's services and coordinates and supervises multiple projects. He personally engages in consulting projects with physicians and health systems nationwide. His expertise covers employee and physician employment and compensation, physician/hospital integration and affiliation initiatives, business and strategic planning, mergers and acquisitions of practices and healthcare companies, practice operational assessments, ancillary services development, PHO/IPA/MSO development, fair market value assessments, practice appraisals, succession planning and buy/sale analysis, and negotiations for acquisitions and sales. Reiboldt also performs financial analyses for healthcare entities and buy/sale agreement planning arrangements for medical practices.

Recent projects to which Reiboldt has contributed expertise include a major health system's turnaround of its employed physician network of practices; a successful negotiation of practice sales; establishment of an equitable buy-in/buy-out agreement for numerous practices; review and implementation of a heavily productivity-based compensation plan for both hospital-owned and private physician groups; coordination of the successful strategic planning process of several client specialty practices; consultation regarding the best economically viable alternatives for practices confronted with major operational decisions and challenges; and management of numerous high-level planning sessions for hospitals and practices, including board presentations and retreats.

A popular speaker at practice management seminars and workshops, Reiboldt is frequently engaged to speak by professional associations such as the Medical Group Management Association (leading their annual conference on compen-

sation), the American Academy of Medical Management, the American Medical Group Association, the Southern Medical Association, and many state organizations on financial topics, physician compensation, strategy and planning, personnel management, and a variety of other topics. He serves on the editorial board for the newsletter *Physician Compensation Report*, a publication produced monthly by HealthLeaders Media.

Reiboldt is a published author and contributor to the American Medical Association's 25-book series, *Practice Success!*, and frequently writes for magazines and other periodicals. He is also on the advisory board of *Physicians' Legal Handbook for Doctor's Digest*, a bimonthly digest covering practice management issues.

A graduate of Harding University in Searcy, AR, Reiboldt is a licensed certified public accountant in Georgia and Louisiana and a member of the American Institute of Certified Public Accountants, Healthcare Financial Management Association, and American Society of Appraisers. He has also gained executive fellowship credentials in practice management from the American Academy of Medical Management.

John P. Reiboldt, MBA

John P. Reiboldt, MBA, joined The Coker Group in 1999. He is the manager of Coker Capital, the division of the firm that focuses on a variety of financial solutions for healthcare organizations. Reiboldt's various projects include valuations and appraisals, mergers/acquisitions/divestitures, pro forma financial statement compilations and analyses, expert witness testimonies, and other areas of financial and operational analyses for healthcare organizations of all sizes and structure.



Reiboldt works with healthcare organizations of all sizes and in many different sectors within the healthcare industry. Although his focus is financial, he is equally adept in areas that include operations and special-projects management. Complementing his strong financial foundation, he also completes projects such as feasibility analyses, strategic planning analyses, and day-to-day operational analyses.

He has authored and co-authored numerous books and articles on various topics of importance in the healthcare industry and has written articles for the *Journal of Medical Practice Management* and the *Practice Directory*. He has spoken for organizations such as the Medical Group Management Association, American Academy of Medical Management, and the American Urology Association and is a regular contributor to the CokerConnection©. He has also been quoted in numerous healthcare industry publications.

Reiboldt holds an undergraduate degree in economics from the University of Mississippi and a Masters in Business Administration, with a concentration in finance from the Robinson College of Business at Georgia State University in Atlanta.

Mark Reiboldt

Mark Reiboldt is a senior analyst at The Coker Group, where he manages the firm's extensive research operations. He specializes in research development, strategic data collection and planning, and general management consulting services.



Through his experience working with a variety of organizations, including Fortune 100 companies and other major corporations, Reiboldt has acquired experience in using advanced management strategies and scientific research methods to achieve the highest level of results for clients.

He conducts extensive research and analysis on a variety of issues related to the healthcare marketplace, and he provides analysis for industry organizations in strategic planning and other operational and management initiatives.

Prior to joining Coker, Reiboldt was a project manager in the consulting division at Trammell Crow Company, where he worked on multi-billion dollar merger integration projects for Fortune 100 clients in the financial services and

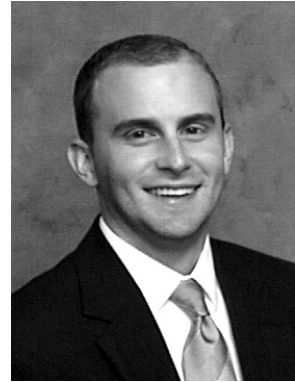
wireless telecom sectors. There he gained valuable experience managing multi-million dollar subprojects of some of the largest corporate mergers in the global marketplace. Also during this time, he gained experience in using advanced measuring tools in large-scale program management initiatives. Reiboldt received a BA in political science from Georgia State University in Atlanta. As a student, Mark completed numerous internships, including one in the Congressional Office of Rep. Andrea Seastrand (R-CA).

He has contributed to a number of books, in addition to publishing numerous articles and white papers covering a variety of issues for many organizations. Reiboldt has been published in *The Hill*, a popular newspaper in Washington, D.C., as well as trade journals and healthcare industry publications.

Reiboldt has also traveled the world to work on projects with international NGOs in Africa, the former Soviet Union, and Central America in a variety of voluntary and professional roles. He serves on the Board of the Technology Association of Georgia (TAG) Healthcare Society and is a research associate at Working With Congress. Reiboldt also manages Coker Realty LLC, the commercial real estate investment arm of The Coker Group.

Justin Chamblee, MAcc, CPA

Justin Chamblee, MAcc, CPA, is a senior consultant with Coker Capital, The Coker Group's financial consulting division. Licensed as a certified public accountant with the Texas State Board of Public Accountancy, and a member of the American Institute of Certified Public Accountants, Chamblee helps Coker's clients in a variety of financial areas and ventures, including valuations, appraisals, mergers and acquisitions, pro formas, expert witness testimonies, and financial assessments. His strong background in accounting, financial analysis, and problem-solving gives him insight into clients' unique financial needs and goals.



Prior experience includes PricewaterhouseCoopers, LLP, where he worked as an associate/senior associate and assisted in the completion of financial statement audits for multi-billion dollar publicly traded companies. This included the review of documents to be filed with the Securities and Exchange Commission; working closely with executives, such as the controller and director of financial reporting, to resolve issues; working as an audit team member to solve complex accounting issues and meet deadlines; performing technical research; and coaching staff.

Chamblee attended Abilene (TX) Christian University, where he obtained a bachelor's degree in business accounting, as well as a Master of Accountancy.

Kay B. Stanley, FACMPE

Kay B. Stanley, FACMPE, an associate partner, joined The Coker Group in 1988. Beyond consulting, The Coker Group has an established role in publishing practice management publications, guidebooks, and operational manuals, and Stanley heads this initiative.



Stanley's skills in project management, writing, and editing and her attention to detail make her ideally suited to her various roles within The Coker Group, including the firm's marketing, education, training, and publishing efforts. She also uses her skill and experience to work with clients in publishing and communications initiatives, including marketing, newsletter, Web, and survey development.

Stanley's responsibilities involve development, production, and sales of Coker's books, manuals, and monthly newsletter, the *CokerConnection*©. Major past and current publications are *Practice Success!*, a series of medical practice management guidebooks for the American Medical Association, and various projects for professional associations, including the American Academy of Dermatology, American Academy of Pediatrics, the American Academy of Physical Medicine and Rehabilitation, and the Renal Physicians Association.

In 2006, she served as contributor and project manager for the Jones & Bartlett book *Physician Ancillary Services*. Based on that work, Stanley was engaged by the Medical Group Management Association to develop and

facilitate a five-week Web-based learning program titled “Driving New Revenue Sources.”

Stanley has more than 20 years of experience in administration, personnel, and editorial management. She is a member of the Medical Group Management Association at the local, state, and national levels, and speaks at workshops on current issues in practice management.

Currently, she is a member of the Georgia Chapter’s Education Committee. Stanley is Fellow of the American College of Medical Practice Executives, and she has served on the Educational Advisory Council for the American Medical Association’s Business Solutions Group and the Advisory Board for Aspen Publishers’ *Medical Group Practice Legal and Administrative Guide*.

A member of the Healthcare Financial Management Association since 2003, Stanley immediately joined the Scroll team and has served in leadership capacity for several years. For two years, she served as Committee Chair/Editor of the *Georgia Scroll*. She is now serving in a two-year appointment to the Board of Directors for the Georgia Chapter, heading up the various Communications Committees. She also participated in 2006 and in 2007 in the HFMA National Leadership Conference as a representative of the Georgia Chapter.

Recently, Stanley represented The Coker Group in a medical missions program serving the medically deprived population in Guatemala.

Keith Solinsky

Keith Solinsky currently serves as Chief Operating Officer and principal with The Coker Group. He is an executive with more than 17 years of experience in the healthcare industry. As COO, Solinsky directs the firm's day-to-day operations and oversees the Practice Management division.



When working with Coker's clients, Solinsky specializes in many consulting areas, including physician/hospital joint ventures, pro formas, revenue cycle analyses, MSO network development, hospital assessments, and start-ups. He is known as a strong leader who is able to develop the trust and loyalty of those around him. His hands-on approach has made him successful at retaining employees by creating a work environment that encourages teamwork, appreciation, and success.

Prior to joining Coker, Solinsky was the COO of X-ray Medical Group, Inc., XMG Radiation Oncology, Inc., and Grossmont Imaging, LLC, in La Mesa, CA. Solinsky specializes in private practice and ancillary service start-ups, operational assessments, and strategic planning for medical practices and ancillary ventures located across the nation, and he has extensive experience with hospital joint ventures. An engaging and knowledgeable presenter on a wide range of healthcare topics, Solinsky also speaks to many national organizations.

In addition to working with The Coker Group, Solinsky's coast-to-coast experience includes employment as a CEO of a radiology practice, vice president of business development for an outpatient imaging and surgery center organization and billing service, director of primary care development and operations for a hospital, and area administrator in the dialysis industry.

His extensive background and education in finance and accounting has served him well in healthcare. He has been responsible for developing a \$100 million operational budget and creating numerous financial pro formas, monthly financial analyses, and statistical analyses. Solinsky has previously spoken for the American Medical Association, the Southern Medical Association, and Radiology Business Management Association, and he is on the faculty of the American Academy of Medical Management.

Introduction

by Max Reiboldt, CPA

“Going retail” within the healthcare delivery system demands the consideration of a variety of viewpoints. There is the position of the consumer/patient, who because of specific service features will purchase care directly from the provider/business owner. There is also the provider, who considers retail with a desire to construct a facility that allows service delivery and provides direct contact with—and marketing to—the public.

For payers, there is interest in the services providers offer that they too can market to their constituency (i.e., the businesses and, ultimately, the consumer) with accessibility and high traffic. Finally, the federal government—the largest single consumer and payer of healthcare—is interested in providing the greatest amount of services for the least amount of reimbursement to associated organizations.

If all of these goals can be accomplished within a more functional retail setting, it provides definite advantages. Aspects of care such as accessibility, convenience, quality, low cost, high traffic (i.e., where the consumer can also purchase other commodities besides healthcare), and, of course, service are all components of the “going retail” concept.

In this book, we delve deeply into the dynamic changes that are taking place in the United States relative to the healthcare delivery process. It is not too strong to call these changes revolutions in care delivery. Part of this dynamic change is the overall shift in thinking about the actual delivery process, one that moves away from the traditional “one office visit at a time” paradigm characteristic of ambulatory care. When moved to the context of a setting akin to a retail environment, all of the players within the healthcare delivery system (i.e., providers, consumers, payers, and the government) are genuinely focused on helping the healthcare experience become more effective, efficient, accessible, and patient-centered.

As pressure continues to mount for both providers and insurers of healthcare to be more responsive to the consumers’ point of view, and as those same consumers try to justify the cost of their healthcare along with the corresponding copays, utilizing a retail approach for care delivery is both appropriate and necessary.

Starting with the concept of patient choice, convenience, and satisfaction in today’s healthcare market, *Physician Entrepreneurs: Going Retail* explores the effect of the consumer-directed healthcare initiatives on the care delivery system. From there, we closely analyze the retail mindset and what that experience means exactly to the consumer, the payer, and, of course, the provider, primarily the physician. Additionally, we examine the best service line approach among the various specialties when considering market competition and overall feasibility, and we explore how to measure the return on investment.

Next, we move into the implementation strategies relative to adding a retail service line to the provider's service mix, and we include information on how to overcome potential pitfalls and obstacles that the provider may encounter when adding a retail service line. We also consider the issue of transparency in marketing and presenting to the public, payers, and other pertinent parties. Finally, we investigate the partnering among various groups—including hospitals, physician practices, and other entities—in such retail initiatives.

Within the United States, demographic trends—such as the changing age of the population, technology, and the cost of healthcare—are promoting the move toward a more retail-oriented marketplace. These precepts include such things as convenience, control, customer service, and overall accessibility, coupled with reasonable price. Many of the consumers have sufficient money and will not hesitate to obtain alternative services or to find different ways to obtain healthcare, especially if it means better service for the dollar.

Physicians should therefore be interested in entering the retail market, both with their services and with product sales and other specific ancillary offerings not necessarily thought of as a part of their traditional service mix.

Quick tests for blood pressure, cholesterol screening, and other healthcare status indicators are also likely to become more popular. Still other types of services and therapies such as massage, biofeedback, acupuncture, and “boutique” medicine are a part of this overall continuum of care. Additionally, pay-for-performance initiatives will continue to grow in popularity. This form of reimbursement will fit nicely within the retail concept.

The concept of “one-stop shop” retail-like settings makes more and more sense as price transparency continues to be a major push within the overall provision of healthcare in the United States. It gives consumers, payers, and providers the opportunity to see what a particular healthcare facilities offers, how much a service costs, and the level of quality delivered by the physicians performing those services. Getting the information out in a straightforward way with as many details as possible about price, quality, and comparisons fits the retail concept.

Technology is also a major player in this dynamic situation. Historically, the healthcare industry has been behind other industries in automation. This is quickly changing as improvements in technology, such as information access and recordkeeping, make significant strides for both the provider and the payer.

These advances will allow a limited amount of self diagnosis, home testing, and access to data (all retail-oriented concepts), which brings invaluable information and processes into the continuum of care. As providers and payers work together to share information relative to their care delivery processes through enhanced communication channels, the ability to improve upon clinical performance, outcomes, and overall cost efficiencies grows, and, consequently, higher quality healthcare is possible.

Thus, the concept of retail is an overarching theme of offering related products and services to stimulate additional spending. It is timely for today’s medical practice experience, and this book puts into action the strategies for realigning medical practice initiatives in the context of the retail experience.

A revolution in healthcare

by Mark Reiboldt

If you have picked up a news article or watched coverage on television lately, there is a good chance that you have seen something about the revolution taking place in our nation’s healthcare delivery system. Some call it healthcare reform, whereas others prefer a wider view of the movement and call it healthcare transformation. In essence, it all boils down to the fact the system needs to change. Regardless of what you call it, the result is the revolution.

Although some of the parties involved—policymakers, payers, physicians, and patients, to name a few—are waiting for a single major change that will lead this revolution, many are now figuring out that there is no one global solution to “fixing” healthcare and no quick cure for the root causes that create the large-scale problems.

The solution will be the result of a series of many small changes, one component of which we address in this book—the industry shift from a model of set procedures and rigid systems to one that is much more dynamic and

consumer driven. As patients, we are all consumers of healthcare services, making the healthcare market vast; however, in the past we have had no leverage as consumers. We went to the doctors we were told to go to, paid fees that were negotiated by third parties or in some cases the government, and ultimately had very little impact on the services that we were receiving.

Now let's take that model and try to put it in the context of shopping for other goods or services that are in high demand. For instance, what if my employer told us we could purchase our household items only from a certain grocery store, Dave's Grocery Shop? For many years, I shop at Dave's, primarily because when I purchase my items at this store, I pay only a percentage of a total fee (sometimes forgetting that a set amount is deducted from each paycheck). This is nice because, quite frankly, this is all I know.

One day, however, I notice that a Wal-Mart Supercenter has just been built down the street from my home. Out of curiosity and due to a commercial that I saw on television, I check out some of the prices at Wal-Mart, just to see what they charge for some of the same goods that I purchase at Dave's. From my research, I find out that Wal-Mart is charging much less for their products; in addition to this, the selection seems to be much greater than Dave's. In order to get more information, I go up to Wal-Mart one day and ask to meet with a store employee so that they can walk me through their items and prices.

I am blown away by the service, selection, and prices of Wal-Mart. What they said in their television ad is completely true. Now I begin to wonder just how

beneficial it is for me to be shopping at Dave's, especially since the amount that my employer is taking out of my paycheck continues to grow.

Obviously, this example is a hypothetical one and probably somewhat comical; however, the type of situation illustrated here is exactly how our healthcare system has been structured for many years. But now people are beginning to realize just how inefficient this type of system is, especially when the goods and services we are talking about are the most important and vital to our society.

The grocery store example also brings up a number of other issues, such as the fact that finding information on healthcare prices is more difficult than logging in to a computer and checking retail prices at Wal-Mart. However, thanks largely to consumer demand, price transparency is becoming a basic tenet of our healthcare system. We will talk more about this in Chapter 7.

At this point, we should make one clarification: In this book, we are not writing solely about consumer-directed or consumer-driven healthcare. We should point out, though, that this is a key component in the healthcare revolution, and it has a significant impact on why healthcare is affected by retail strategies. Although we talk about this issue next, we view consumer-driven healthcare as a component of a much larger shift that is taking place.

What is consumer-driven healthcare, and how does it affect me?

Consumer-driven healthcare—also referred to as consumer-directed healthcare—is a concept that adopts the larger concepts of consumerism, a belief that the free choice of consumers should dictate the economic structure of a society. This means that consumers should drive the demand for goods and services based on their wants, needs, and purchase power. Within this definition, consumers also need adequate information in order to make informed decisions as to how they distribute demand and consumption.

Consumerism in healthcare is simple, yet for many years this idea has been completely foreign to industry stakeholders. Consumer-driven healthcare is the idea that patients, as consumers of healthcare services, should drive the market. To make this happen, consumers must also be able to influence the price of goods through demand and operate in a price-transparent environment. This ensures that they can make informed decisions as to where and how their health dollars will be spent.

There are many components of consumer-driven healthcare, including a variety of specific strategies and plans that have been implemented, such as Health Savings Accounts (HSA) and other pre-tax, investment-like accounts that consumers can use in order to move away from a system that would otherwise be driven either by a third party or by the government.

What does retail healthcare mean?

Now that we have discussed the larger shift that is taking place in the U.S. healthcare system, we can now get into more specifics about some of the smaller changes that are being made.

The term “retail healthcare” has many different implications and a variety of meanings. When some hear retail, they immediately think about MinuteClinics in retail chains such as Wal-Mart, CVS, Walgreen, etc. Others view retail as referring to traditional provider organizations (e.g., practices, hospitals, etc.) that adopt more mainstream strategies in a competitive environment.

Instead of looking at retail as a static concept, we should look at it as a spectrum or continuum, with different extremes on both ends. One extreme would be the idea of small primary healthcare clinics, often times staffed by non-MD clinicians, which are housed in the retail stores as mentioned earlier. These clinics typically provide basic healthcare services and in many cases are targeting indigent or minority populations, as well as the uninsured. The other extreme are some of the non-traditional strategies that traditional healthcare organizations are adopting, such as more dynamic marketing, branding, and promotions.

One key result of the many changes in the healthcare system is that it has become a much more competitive environment. The days of a family practitioner opening his or her practice and suddenly being bombarded with patients are long over. Even specialty providers are finding it tougher to remain com-

petitive in the marketplace. As a result, new strategies are being adopted, and those who embrace these strategies are staying alive, while those who hold fast to the old system are being “picked off” every day.

However, that being said, even those market players who embrace change and adopt new strategies are still finding it tough to keep their heads above the water. Due to the nature of the system, it is not a friendly environment for market players; therefore, only the best and brightest will be able to prosper in the long term.

This is not meant to scare off new market entrants or to deter existing players from investing in change. This is simply the way that healthcare has unfolded and, like any marketplace, innovators will prosper and nay-sayers will most likely be proven wrong.

Although many players have struggled to survive in this evolving environment, it is good for consumers because competition, as a cornerstone of the U.S. economy, ultimately brings quality, affordability and consumer interaction into the picture.

Dynamics of the retail revolution

In the previous section, we touched on some of the components of the health-care retail revolution, but it is essential for consumers and providers to understand the dynamics of this evolving marketplace.

One of the most important factors in the transformation of the nation's health-care delivery system is the aforementioned move away from a third-party or government-driven system to a system that is driven by consumers. Patients are becoming more involved in where they obtain their healthcare services, the quality of those services, and ultimately the price of those services. Just like they shop for groceries at the most affordable store with the best selection, patients are already "shopping" for their healthcare services in order to make sure that they are getting the best care at the best price.

The key component around this idea is quality. For many years, quality has not necessarily been a cornerstone of providing healthcare services. Perhaps it has always been assumed that providers ethically provide the best quality of care to all patients, regardless of who is paying (or even if patients cannot pay). However, data shows that this is not the case. Study after study shows a progressive decline in the quality of healthcare services that patients are receiving. Meanwhile, costs continue to increase and the burden rests on patients, their employers, and providers.

According to a recent report on a study conducted by the management consultancy firm McKinsey & Company, "Traditionally, employers selected health-care products for their workers and paid for most of the services and other costs. Increasingly, however, those costs are being passed on to individuals, who now decide what products to buy, as well as where, when, and how to buy them."¹ Many consumers are finding that taking their healthcare into their

own hands is much more beneficial than doing it when premiums finally become too much.

Ultimately, as consumers become more involved in the decision-making process, quality is going to be the key determinant in where the consumer goes for healthcare services. There is a distinction here that separates quality-based retail strategies in healthcare from other markets, because in those markets, price is the primary determinate. Although price in healthcare is also important, when people are looking for healthcare services, quality services will almost always outweigh price.

The influence of the insurance companies

The healthcare industry, being the complex beast it is, has numerous players and parties that sometimes interact together and other times work against each other. For example, the insurance companies, operating as third-party payers, make the healthcare system unique compared to other industries, but in many ways this makes healthcare inefficient from an economic point of view. In the past, payers and providers have negotiated prices of healthcare services, but the prices were ultimately set by the insurance companies. Therefore, one very influential party set market prices with very little input from the provider of the services, and with no influence from the consumers.

What makes this even more incredible is that the demand will continue to grow in this marketplace in comparison to other sectors, where demand fluctuates much more drastically. But although demand for services increases, the

supply will decrease, due to both the restrictions that have been placed on providers and the market inefficiencies involved.

As it becomes more and more difficult to be successful as a provider, the supply shortage will only get worse. Additionally, the price inelasticity will continue to exacerbate the problem. With that description, it is not difficult to understand why there is very little economic efficiency within healthcare.

The burden on providers

From a provider's point of view, it almost seems as though they have been left in the dark as the system continues to pass them by. Furthermore, the lack of leverage held by providers is enough to drive many of them out of the marketplace altogether. The challenge has changed from thriving to surviving in many ways. This is not to say that all providers are struggling to exist in their practices or services; in fact, many are still doing very well in terms of growth, success, and market effectiveness. However, due to inefficient economics and a flawed system, the burden is now on the providers—even though they hold very little leverage, a necessary component for succeeding in highly competitive and volatile environments.

Luckily, the dynamics of control over prices are changing. According to the McKinsey study, “as the industry becomes more retail oriented, payers face severe competitive threats.”² Those providers who embrace change can be a part of that threat to insurance companies, but even more importantly, they can discover how to thrive in a volatile and competitive marketplace.

Yet, just because the market dynamics present a challenge for providers does not mean it is impossible to achieve high positive growth and financial success. It is simply becoming more apparent that providers cannot achieve this success via the traditional system.

The solution: Providers have to adopt new strategies, embrace new methods, adopt new technologies, accept change, and be willing to take the necessary steps to thrive in a competitive environment.

Patient choice changes the provider's dynamics

Even though providers have had little leverage, in the past there was a sense of comfort in the traditional system, where the revenue and growth opportunities did not necessarily depend on the consumer. That is why in the newly emerging retail revolution, some providers feel threatened by the idea of consumers making informed decisions about their healthcare. But it is evident that those providers that embrace a changing marketplace will ultimately be the players that thrive in the near future.

What does this mean then to embrace new strategies and adapt to an evolving marketplace? Primarily, it means that providers, as an important element in the industry dynamic, must understand what is happening in the marketplace and, most importantly, understand how it affects them—and the bank account. In an industry where there are already so many challenges to achieving financial success, not also adapting and evolving is simply unacceptable.

Another example may help us understand just what it means to adopt new retail strategies, and it's one that takes place every day in medical practices throughout the country. The issue revolves around the acceptance of credit cards. For many practices, the traditional third-party payer system and managed care meant that accepting payment methods from consumers (i.e., patients) really only related to the reimbursement process. Because private pay patients were so few and far between, accepting only certain credit cards as payment for their services was not a major issue.

Many patients are now adopting new payment options, such as a HSA, in which case the patient will often use a credit or debit card to pay the bill at point of service. This means that after an exam, the patient goes to the exit counter in the practice and pays the entire fee for the visit, which is immediately withdrawn from the patient's account and transacted into the practice's account. A supplier provides its services and a consumer purchases its services—transaction complete. But what is the practice to do if that patient approaches the exit counter and then realizes that the practice does not accept the particular credit card that sponsors the patient's HSA?

This scenario occurs every day in practices around the country. Not only could the practice potentially lose revenue if they do not accept the patient's credit card, but they also miss the opportunity for immediate payment at point-of-service. Under managed care, it can take some providers up to 120 days to get paid for their services. The provider that gets paid at point-of-service encounters fewer issues related to coding, billing, and collections, saving time, money, and resources along the way. Unless providers are willing to consider

new strategies or alternatives, they could seriously miss out on revenue opportunities.

Retail marketing and healthcare

Although Wal-Mart and other retail stores may find it beneficial to start their own small clinics in existing stores, many medical practices are realizing that there is a great deal of profit available from the roads that retailers have already paved—marketing ability and branding. But some practices have not developed any sort of branding plan and essentially have no form of marketing, with the exception of some basic literature and a sign in front of their facility.

For many providers, especially physicians, marketing is a necessary evil that they would avoid if at all possible. To the credit of healthcare professionals, in the traditional system marketing was not a major concern for providers. It was an issue to address but was by no means something that could make or break a practice.

In today's environment, however, marketing in healthcare, just like in any other industry, is the lifeline for growth and success. Attempting to thrive without a dynamic marketing strategy for providers is like deciding to open a coffee shop across the street from a Starbucks and refusing to do any marketing. You are likely doomed for failure.

Still, what does it mean to adopt retail marketing strategies? Should physician practices be doing more radio and television advertising? Is Internet market-

ing going to show significant return on investment (ROI)? How much is a billboard or an advertisement in a magazine truly going to help patient volume grow?

These are all valid questions, and answering them is not easy. One of the first challenges in regards to marketing that practices and hospitals have to face is obtaining a valid understanding of their target marketplace. Once this is done, they can then start thinking about ways to penetrate the market directly, rather than depending upon their relationships with third parties to do all of the market development for them. (Read more about marketing a practice in Chapter 7.)

Market trends and medical practices

There is no doubt that in today's medical practice marketplace there are plenty of barriers to success, and these new challenges for practices and physicians are fairly global in their impact. However, the primary benchmark for success in the marketplace is financial viability. Of course doctors want to be successful in terms of providing the best level and quality of care for their patients, but doing so does not necessarily mean financial success for the practice.

For medical practices, remaining profitable is a daily struggle, and many physicians feel overwhelmed by the barriers to financial fortitude, regardless of how hard doctors and practice employees work and the level of care they give.

But before we can truly assess the challenges that practices are facing from a financial standpoint and look at the measures that physicians and administrators are using to remain effective in the marketplace, we have to analyze these market trends as a whole and ultimately examine the trickle-down effect that they are having on individual practices and physicians.

The current state of the nation's healthcare system is in a downturn, specifically related to the costs of medical care for both the patient and provider. Insurance coverage is becoming—and will continue to be—the most pressing issue related to the nation's healthcare system. More people are living without coverage now than ever before in the last half-century, and the numbers do not look any better for the future.

Healthcare expenditures are up, and coverage levels for individuals are down. Moreover, while it is costing more to provide healthcare, there has not been an equitable market adjustment in compensation for those who provide it. Further, statistics show that spending on healthcare when measured against gross domestic product (GDP) has increased significantly in recent years. In fact, in 2004, while the spending for the GDP increased 5.6%, spending for healthcare increased 8.2%.³ This has occurred without adjustments in inflation and the market for costs of providing care and fluctuation in coverage costs.

The physician struggle

A recent survey conducted by OPEN, American Express' small business division, identified the top areas of concern currently facing healthcare providers in the U.S. The general theme of those issues, which is addressed in more detail in

the following sections, is that many providers are experiencing difficulties managing the dual role of practicing medicine and running a small business.

In fact, another survey of 633 physicians in 2004 by American Express showed that about half of the respondents spend at least one full day each week managing the business end of their practice. Some respondents stated that they spend up to three days on these issues.⁴

It also revealed that issues such as revenue, cash flow, and staffing are some of the problem areas for physicians in managing the business side of their practices, with the most challenging issue being managing malpractice insurance coverage. All of these issues relate to the financial stability of a medical practice. Many respondents stated in the survey that if they had known what they know now about managing a practice before they started, they never would have pursued practicing medicine.

This led to the realization that medical schools need to better prepare students for the business side of practicing medicine. Ninety-four percent of respondents stated that it is extremely important for medical schools to teach business and management skills to their medical students.⁵

Physicians and non-physician providers are dropping out of the medical profession at alarming rates. The rising cost of malpractice insurance has reached a point where it is causing many practices to place “Out of Business” signs on their front doors.

For example, many OB/GYN practices, the provider specialty that has borne the brunt of frivolous lawsuits, are being driven out of practice. Likewise, provider organizations in rural areas are fighting to keep their doors open, primarily due to rising costs of maintaining practices and insufficient reimbursement for medical services in government payer programs.

The consumer struggle

As medical practices close their doors, patients go without access to health-care, now more than at any other point in the last half-century. As the Baby Boomer generation continues to approach retirement, it is becoming a serious question of whether there will be sufficient quality healthcare coverage for all of the nation's seniors.

Larger corporations are also struggling to provide coverage for younger generations. Many major companies are decreasing the level of health benefits they provide because the premium costs are becoming too much of a burden to manage adequately. Meanwhile, small businesses and their employees are missing out on health benefits at alarming rates thanks to the already high costs of adequate plans, making it impossible for them to afford adequate coverage for their employees. This exacerbates an already challenging, competitive environment for top employees.

The National Federation of Independent Businesses has teamed with policy-makers to establish what is known as Association Health Plans—health plans constructed for groupings of small businesses across state lines—so that these

smaller organizations can supply adequate coverage of quality healthcare for their employees at reasonable prices.

The government piece of the puzzle

The Medicare reimbursement system is an issue of primary concern in and of itself. The Department of Health and Human Services and Centers for Medicare & Medicaid Services have proposed reimbursement cuts to Medicare for the past three years and have said they will be forced to continue recommending cuts to providers.

Overall, the amount providers pay to treat Medicare patients is higher than the amount they are reimbursed for those services. This comes at a time when the number of Medicare patients is increasing to a level that is beyond the capability of the current system.

The silver lining

Considering all of these facts related to the current state of healthcare in the United States, it would seem that the nation's healthcare system is doomed for failure. If nothing else, it would seem that the future of U.S. healthcare looks dim.

In fact, that could not be further from the truth. The United States is currently at a point where it can redirect the future of its healthcare, changing the system to a point where it will not only be able to implement quality care for today's patients but also plan for future generations to have affordable access to quality healthcare.

Top ten issues confronting medical practices

As stated earlier, revenue cycle management, cash flow models, collections processes, accounts receivable methods, compensation structures, and other financial issues are imposing a significant burden on physicians and the medical practices that they manage. The stress of these issues is translating into an underlining negative effect on the quality and level of care at which healthcare services are provided, because many physicians are forced to spend more time managing their practice instead of focusing on and tending to patients.

The following are the top ten issues of most concern to physicians, as indicated in surveys from American Express. Although there is no magic remedy for improving the future of U.S. healthcare, the following sections go beyond the negatives of today's healthcare system and focus on how to develop a healthcare system that is market-driven and patient-centered—a key to success for healthcare in the future.

1. Personnel considerations. There is an old school vs. new school dichotomy related to personnel in the medical and dental practice setting. The “old school” refers to the time when the physician was the leader, revenue belonged to the physician, salary and benefits that belonged to employees were administered by the physician, and communication within the medical practice was informal and verbal.

This structure has evolved dramatically in recent decades, and the “new school” of medical practice management can be identified by a number of factors, including:

- Marketplace is the driver
- Revenue belongs to the organization
- Employees are small fish in big sea
- HR administrators control salary and benefits
- Communication is formal and written

Blending the “old school” and “new school” can often be a difficult task, presenting more hardships for the practices as they are forced to evolve and remain competitive in their marketplace. However, the following 12-step program can help organizations blend the two philosophies more smoothly:

- Step 1 – Recognition
- Step 2 – Acceptance
- Step 3 – Communication
- Step 4 – Integration
- Step 5 – Organization
- Step 6 – Introspection
- Step 7 – Motivation
- Step 8 – Cooperation
- Step 9 – Representation
- Step 10 – Standardization

- Step 11 – Gratification
- Step 12 – Appreciation

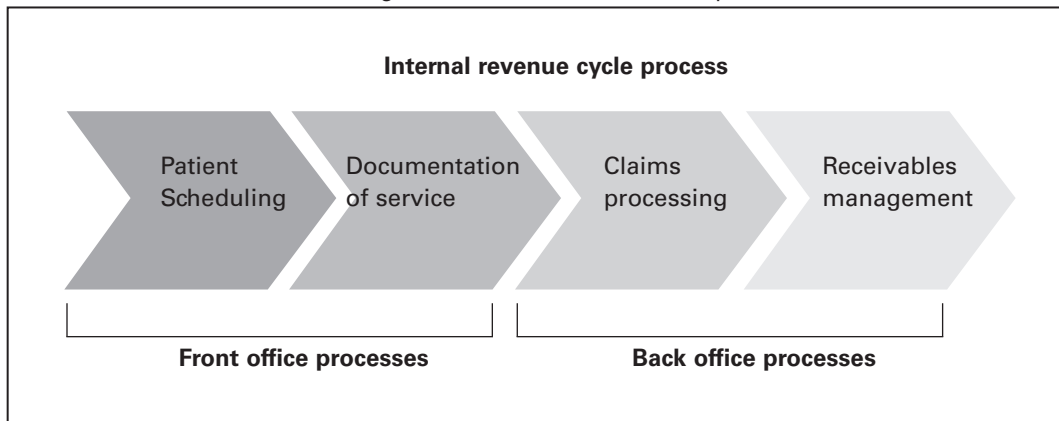
Although these steps require effort, time, and focus on behalf of the physician and the medical practice staff, the end result is much more productive and profitable and will allow the medical practice to remain competitive within the marketplace.

2. Billing and collections. The first concern that comes up in this arena for physicians is how to take control of this process. Some of the first signs of trouble that often develop include shrinking cash flow, a dropping collection percentage, growing accounts receivable, frustrated staff, increases in patient phone calls, and denial of claims increases.

There are also some key performance indicators related to billing and collections that can allow a practice to maximize its productivity, ultimately increasing generated revenue. These include:

- Gross collection rate
- Net collection rate
- Days in A/R
- Adjustment percentage

After learning these key performance indicators, providers must also understand the process behind billing and collections in order to maximize their effectiveness within the process. (See Figure 1.1.)

FIGURE 1.1 The billing and collections process

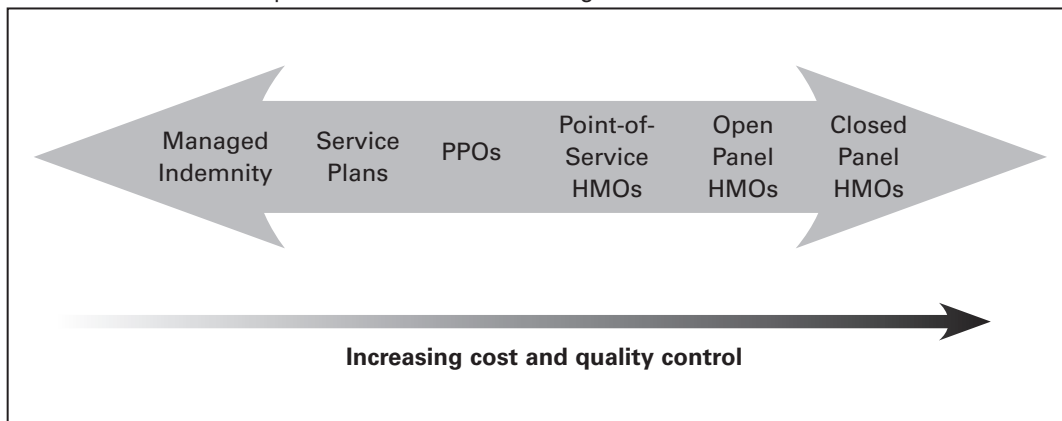
Finally, the healthcare management professional must understand the psychology behind collections, which can often be more powerful than the process itself. For example, although it is much easier to write a collection letter than to call a patient concerning a delinquent account, the collection call is far more effective—a letter can be ignored, but a call cannot.

When done correctly, it is also a less expensive collection technique. According to the *Consumer Credit Grantor's Guide to Credit Granting, Billing, and Collecting*, “in a professional collection agency situation, the first collection letter will bring back some kind of response from 5–15% of the time. This means that 85–95% of the letters are wasted money.”⁶

3. Managed care contracting. Managed care is an organized effort among the payers and providers of healthcare to contain costs while providing quality healthcare services. Although this used to be an alternative delivery system, it is now the dominant health insurance coverage in the United States.

Since its inception, managed care has placed a significant burden on the administrative and management side of practicing medicine and has ultimately driven many from the medical field completely. Figure 1.2 represents the various component forms of managed care. These models vary with the level of control and the restrictions placed upon both the provider and the patient.

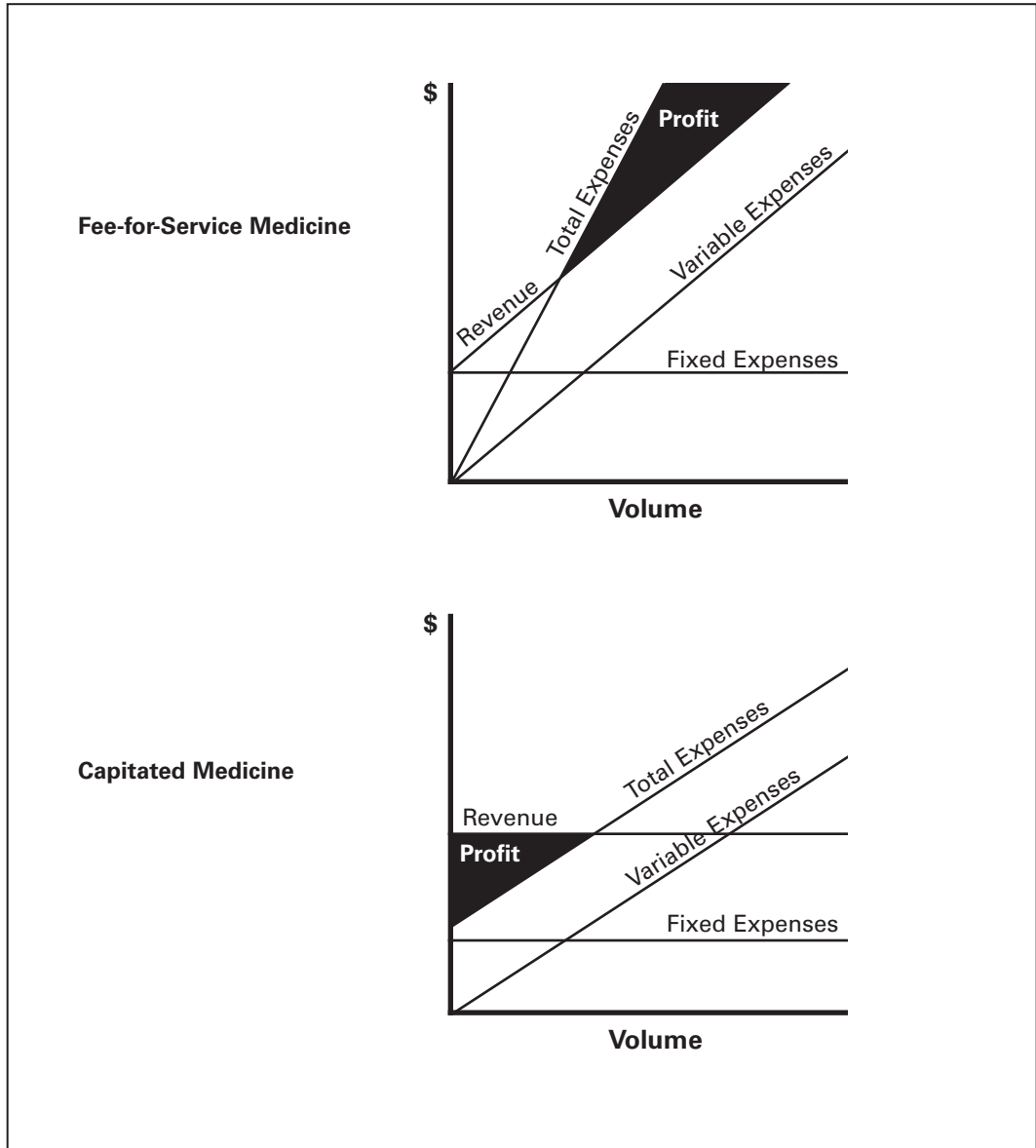
FIGURE 1.2 Components of managed care



The managed care system has presented various methods of reimbursement and payment, all of which add more complexity for providers within the billing and collections process. Moreover, this is a system in which the providers have little input as to the amount they are compensated for certain services, regardless of what the market projects.

The two graphs in Figure 1.3 depict the revenue (collections) versus expenses within a fee-for-service and capitated environment of reimbursement. In the fee-for-service model, as patient encounters increase, revenue decreases likewise.

FIGURE 1.3 Revenue models in fee-for-service and capitated reimbursement environments



Thus, profit increases incrementally with production. Because so many costs are fixed, profit increases when revenue does.

A capitated reimbursement environment produces the opposite effect, in that revenue is essentially fixed. Hence, in a fee-for-service setting, more revenue is better; in a capitated environment, more production/encounters are worse. This varied reimbursement structure leaves the physician confused—should he or she see more patients (yes, if in a fee-for-service setting; no, if in a capitated environment)?

This conundrum presents yet another reason why a market- or consumer-driven system is a more profitable solution for providers. Healthcare organizations can play a role in their pricing, rather than leaving it up to a system of inadequate reimbursement that oftentimes barely covers overhead and expenses.

4. Regulatory compliance. Compliance with requirements such as HIPAA, OSHA, CLIA, etc., can often be stressful, but they are a necessity in healthcare in order to ensure certain levels of quality and efficacy. The key to compliance is proficiency. Compliance yields greater profits and ensures that a practice will be competitive within the marketplace.

5. Leveraging technology. The reluctance to accept technology, coupled with the complexities of capturing information and the high cost, has made advancements in this area a slow process. However, there is no way around this issue for physicians. Despite the cost, time, and focus factors associated with imple-

menting technology, the long-term benefit and likely return on investment outweighs any initial struggle or stress.

Whether it is enhanced practice management or electronic health record (EHR) software, physicians must embrace and implement technology into their businesses. It is likely that the government will eventually mandate EHR. Many believe that if the government requires it, they will first provide a free solution. This is accurate; however, the product that the government has created and makes available for free is of low quality and has proven to be extremely inefficient and costly for those practices and hospitals that have implemented it. Consider making the purchase, and work closely with a commercial vendor to find the right EHR program for your needs and goals.

6. Physician employment and compensation. The design of a physician compensation program involves numerous factors, including selecting the appropriate competitive market(s) for benchmark comparisons; determining the desired mix between base pay, incentive/bonus awards, and benefits; and defining the performance criteria that will be used for base pay adjustments or awards.

Compensation programs based primarily on productivity arrangements are most prevalent now, yet non-productivity-based incentives are becoming more prominent. Furthermore, compensation models are in a state of flux in response to changes in the market environment. Many current plans have been in place for fewer than five years, and most practice administrators expect to modify or redesign their plan every few years.

Compensation plan adjustments do not have to be regarded as an ongoing chore. When a regular review of the plan is established, it can often motivate the provider to greater productivity and less cost.

7. Financial management. Financial management can be a life-or-death issue for many practices in today's healthcare marketplace. Some of the key concerns include:

- Operational control
- Pricing/fee structure
- Cost evaluation
- Procurement of capital
- Measurement of incremental performance (departments)
- Profitability analysis
- Return on capital analysis

8. Expanding the practice. Just as every small business has to embrace various marketing strategies, a medical practice must also confront the options related to expansive penetration within the marketplace. Today's healthcare environment demands a developed referral strategy to maintain existing patients and build a patient base.

In addition, particular trends, such as the willingness of patients to pay for more choices, will place more demand on physicians to improve customer service (e.g., better bedside manner) because a consumer-driven system allows those consumers to be more selective.

9. Developing ancillary services. Ancillaries can refer to anything that generates revenue and is offered alongside the provider's primary means of productivity. Within the walls of its practice, a group can offer any product or service that fit its medical staff's specialty knowledge areas. This is a strategic advantage for the provider because by developing ancillary services, practices can maximize productivity and increase revenue within defined operations.

Ancillary services also present numerous benefits for the patient. They allow the patient to receive more care and services from one organization, improving continuity of care and simplifying the process for the patient. The following are some factors to consider in relation to ancillary services:

- The rate of decline in third-party reimbursement for standard services
- The finalized "Stark" regulations, which have broadened the ability to offer ancillary services
- The ability to diversify services and increase revenues
- The ability to take more control over all aspects of patient care
- The ability to improve the delivery of care, which often also connotes greater quality and efficiency
- The ability to complement and augment the "bottom line"

10. Developing a strategic initiative. A strategic initiative focuses on a number of factors and addresses a number of goals, such as:

- Instituting an effective strategic planning process
- Clarifying the core business of the practice

- Clearly defining goals and objectives
- Obtaining buy-in at all levels of the organization(s)

In strategic planning, certain key steps ensure that the solutions are profitable and not a waste of time or resources. Those steps include:

- Develop and review the practice’s mission, vision, and values commitments
- Scan the internal environment (SWOT analysis)
- Scan the external environment
- Identify strategic priorities and establish goals and objectives
- Develop action plans to outline strategies and tactics
- Monitor results
- Identify additional needs
- Suggest changes

With all of the day-to-day challenges confronting practitioners, they often do not have (or take) the time to plan longer-term (i.e., strategically). This further exacerbates their problems. The only issues being addressed are day-to-day “brush fires,” not longer-term strategies that will remedy the ongoing issues of managing a small business.

Connection between providers' challenges and retail

Now that we have identified the biggest challenges for providers, how do we put this in the context of retail healthcare? More importantly, how can retail strategies help providers mitigate or overcome some of these challenges?

In an open-market system such as the one in the United States, when imbalances arise, the market will inevitably address them. This may not happen overnight; in fact, it could take a downturn in the economic situation for the market to balance. Eventually, however, balance will come into play.

For a number of years, the healthcare sector has not operated as an efficient, market-driven industry. In many ways, it would be difficult for healthcare to function the same way as the retail industry, for example. However, in order for the market to balance out (which it will eventually have to do because of the inefficiencies involved), strategies from other industries can be adopted to help in the balancing effort.

Consumer-driven healthcare (CDH) is the perfect example of this. CDH is a market-driven solution, rather than another subsidized or government-driven measure. One missing component of this movement, however, is the providers. At this point, providers have not embraced any one strategy or school of thought. Many have stayed on the fence, hoping that either the marketplace or the government will address healthcare, which will then allow them to go back to doing what they were trained to do and make a good living doing it. This is simply not going to happen.

Whether it will be setting up more healthcare clinics in retail environments or physicians considering other retail-driven revenue strategies to help their practices remain competitive, the trend toward a market-based and consumer-driven healthcare system is radiating throughout the healthcare industry. The key market players and industry stakeholders are looking at new ways to ensure financial success.

If long-term change and improvements are ever going to take place within our nation's healthcare delivery model, all parties—providers, businesses, government, and patients—will have to embrace the retail revolution.

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Developing a retail mindset

by Kay B. Stanley, FACMPE

What do retail enterprises and medical practices have in common? Both rely on consumers—customers or patients—for their businesses to be profitable.

What is the difference in the way retail businesses approach customers and the healthcare provider's traditional approach to patients? The retail mindset takes an aggressive approach. The objective is to do whatever it takes to get customers in the door, provide the product or service that they desire at a favorable price, and serve them so that they want to return. This is a service mentality that focuses on the customer experience.

On the other hand, physicians generally take a passive approach to the consumer. After completing many years of education and training, the typical physician will hang out his shingle, join a hospital staff, meet a few colleagues in the doctor's lounge, place an advertisement or listing in the Yellow Pages directory, and then wait for the patients to come. As addressed in Chapter 1, the emphasis on marketing is in many cases considered a dreaded task and is

minimized by most practitioners. Although physicians generally care for their patients to the best of their ability and strive for favorable outcomes, they are likely to assume that the patient's expectations will be met.

Meanwhile, as more consumers are being exposed to significant cost sharing and transparency, they are becoming more proactive in their healthcare decision-making. In a recent McKinsey Consumer-Driven Health Plan survey, health plan enrollees indicate that they are increasingly conducting discussions with physicians on cost. More and more, they are independently evaluating treatments for a "very serious" health issue.¹

In the new marketplace, healthcare providers can't afford to be passive. As discussed in Chapter 1, patient satisfaction, choice, and convenience drive today's healthcare market. The purpose of this chapter is to provide helpful tactics and critical information on the aspects of service that get patients in the door and keep them as loyal consumers for all their healthcare needs.

The customer experience is so important in healthcare that many hospitals and institutions, like the Cleveland Clinic, are adding positions at the corporate level with titles such as Chief Experience Officer. This newly created role is designed to ensure that all aspects of the patient experience meet the highest standards and to make sure that the organization does whatever possible to make the environment and experience enjoyable (relatively speaking, of course) and not intimidating.

Whatever we can do to make patients feel at home and to feel like people—rather than just numbers—will go a long way in delighting patients and improving outcomes. The patient experience, in reality, is everyone’s job. The challenge is to change people’s behavior in an environment that typically is structurally centered on functional expertise, not on patients.

Staff training in customer service, enhancements to access through scheduling strategies, and providing a convenient location and pleasant environment are areas of opportunity for providing an inviting experience for patients.

Defining the retail mindset

In the purest sense, “retail” means selling something that others make. That’s why shopping centers with a couple of anchor department stores, a few clothing chains, some specialty shops, and a food court with notable fast-food services are called retail malls. Even though the various stores and chains may compete with each other, they come together in one locale to meet the needs of the consumer.

Similarly, retail outlets that feature off-retail pricing may be grouped in a strip shopping center or complex, such as an outlet mall. The objective is to bring under one roof or in one common location—conveniently located and easy to access—goods and services that will produce revenue and drive profitability for a confluence of enterprises.

The elements of the retail mindset

Due to patient expectations, medical practitioners must view the delivery of healthcare in the same way. Borrowing from retailers, physicians are compelled—as a result of consumer demand for convenience—to deliver a line of services representing a convergence of specialties, providers, procedures, and even products. Offering other amenities, such as access to food within medical office buildings, bring in and meet the needs of patients and their families while they are seeking healthcare. These concepts will be covered in more detail in the sections that follow.

Customer service

Q: Why do people buy coffee and beverages at Starbucks?

A: It is the *Starbucks Experience*.

The healthcare consumer demands quality care, first and foremost. Beyond quality, in the new retail practice paradigm, achieving patient loyalty requires consistently offering great service and meeting the needs and comforts of the consumer.

As mentioned earlier, another idiosyncrasy of retail thinking is to provide an enjoyable experience to the consumer. In its initiative to provide “Legendary Service,” Starbucks, the nationally recognized coffee store chain, trains every employee on how to provide a level of service that develops “enthusiastically satisfied” customers all of the time.

In its store training program, there is this passage: “By providing Legendary Service, you create long-term, ‘regular’ customers that make our jobs more enjoyable, and help build the business. Statistics show that a satisfied customer will remain loyal for up to 5 years. An enthusiastically satisfied customer will remain loyal for over 12 years.”²

Starbucks teaches that the benefits of its experience are three-fold: for the employee, the customer, and the business.

Using the Starbucks philosophy, the medical practice or health entity that provides legendary service and creates a positive experience will offer the following benefits:

- **For the employee.** The employee will work in an enjoyable workplace where they are treated with respect and dignity and where they play a part in contributing to the practice’s success.
- **For the patient.** When the practice employees deliver enthusiastic service and quality products, healthcare consumers will enjoy a welcoming environment and will return for medical care.
- **For the business.** The positive healthcare experience will contribute to the business objectives and guiding principles, which will ensure its continued success.

Training in delivery of exceptional service will be an essential component of the success of the new practice model that competes successfully in a demanding marketplace.

Pleasant environment

Part of the revolution in healthcare delivery is to create a place where healthcare consumers feel comfortable and at ease. It is safe to say that patients will experience some anxiety and discomfort when concerned about their health. In an environment where both employees and patients are treated with respect, much can be done to allay insecurities and uneasiness. The medical practice should also strive to achieve a comfortable and relaxed atmosphere where privacy and security expectations are met.

Colors, décor, furniture, and fixtures are just as important in the physician's office or in a hospital setting as they are where a person buys coffee or meets with friends, if not more so.

Staff training

A staff that is passionate about both the work they are doing and the quality of care they provide are the most important elements to the success of the practice. Overall, happy employees create happy healthcare consumers. A positive attitude is contagious.

Under the retail paradigm, practices must hire the right people. At Starbucks, the employees create the Starbucks Experience by displaying the following qualities:

- They smile.
- They work as a team.
- They are enthusiastic.

- They are proactive.
- They enjoy helping people.

Training employees to deliver legendary service begins with learning how to treat each other with respect and dignity. Starbucks employees have a way of communicating with each other throughout the company and with customers called “Star Skills.” Star Skills are as follows:

- Maintain and Enhance Self-Esteem
- Listen and Acknowledge
- Ask for Help

When one employee catches another person doing something right, he or she gives the coworker a card with a note acknowledging the act. The award cards reflect the character traits Starbucks strives for in its baristas by delivering the following messages:

- Welcoming—Offer everyone a sense of belonging.
- Knowledgeable—Love what you do. Share it with others.
- Considerate—Take care of yourself, each other, and our environment.
- Involved—Connect with one another, with the company, with your community.

These character traits, when extended to coworkers and customers, make up the Starbucks Experience.

Starbucks training stresses that its people must go beyond basic service (e.g., speed, service, quality product, and cleanliness) by exceeding the customer's expectations.

Legendary service is behavior that makes a positive, lasting impression on the customer. It creates meaningful experiences; allows you to build a relationship with customers; creates compelling, positive word-of-mouth; and makes a business transaction more personable.

Likewise, the medical practice with a retail mindset can exceed its patients' expectations through:

- **Atmosphere.** Creating an inviting office environment that is pleasant and comfortable.
- **Personalization.** Knowing patients' names.
- **Individual relationships.** Having a conversation.
- **Focusing on the patient.** Adjusting to meet patients' needs, and responding appropriately when issues come up.

Now, let's apply that to some practice scenarios:

A patient walks into a very busy practice with a crowded lobby where many people are waiting, and more are arriving.

The receptionist working at the check-in desk says, "Good morning, ladies and gentlemen. We are running a little behind this morning due

to several emergencies. Our doctors and staff are working hard to catch up while spending adequate time with each patient. They will be seeing you as soon as possible. If you feel that you cannot wait, please come to the desk and we will reschedule your appointment. Thank you for your patience.”

By informing the patients of the delay and what to expect, and thanking them for their patience, the receptionist is providing an experience that exceeded the patients’ expectations.

In another scenario:

A patient is at the checkout counter to pay his bill for a physical exam. The clerk says, “Your co-pay is \$35.00.” The patient writes a check and hands it to the clerk. The clerk says, “Thank you,” and the patient leaves.

The clerk is courteous, does the job, and the transaction is complete. Although collection is achieved, to create an exceptional experience, the clerk can instead say:

“Thank you, Mr. Johnson. Is there anything else we can do for you? We appreciate your choosing our practice. Please let us know if we can do anything better in the future. Please take this card, fill it out, drop in the box by the door as you leave, or mail it from home at

your convenience. We would like to know how we can improve our services and make your experience more pleasant.”

The physicians and providers, the patients, and the employees comprise the practice. It is the atmosphere, personalization, individual relationships, and focus on the patient that make the difference in whether the practice delivers expected or exceptional service. Employees must be trained in how they make the practice experience special.

Starbucks achieves its winning results through this type of staff. They attain a level of expertise in the coffees and beverages they serve, but that’s only the beginning. They learn that people—the employees themselves, as well as the customers—are the most important part of the Starbucks experience. They learn how to offer help and support their fellow baristas, to enjoy people, and to have fun.

Why does Starbucks have high expectations of all baristas? “To ensure that we create an enduring company that enriches people’s lives—baristas and customers. High-quality baristas help build the financial foundation for a strong company.”³

Access

Access can mean a lot of things in the retail world, but mostly it means being able to provide consumers with what they want when they want it. Certainly, retail shopping malls, major discounters, and other shopkeepers study their demographics and keep hours that serve their customers’ needs.

Some even stay open 24 hours, seven days a week, to demonstrate their perseverance in serving the consumer.

In a medical practice, access means being available when the healthcare consumer needs your services. It can be a phone call to make an appointment, the ability to get an appointment at a suitable time, or providing the information the patient wants and needs in a timely manner.

Nothing frustrates a patient more than to call a doctor's office and get a series of messages through a phone tree with options that do not fit the need. (My personal favorite is "You have reached the offices of Drs. Who, What, Where, and When. If this is a medical emergency, hang up and dial 911.")

For example, suppose a patient calls for a question to be answered, and one of the phone tree options is to speak with the nurse, but the call goes to the nurses' voice mail because she is with the doctor. The patient then has to leave a lengthy explanation or purpose of the call for the nurse to address. When the nurse does not return the call for several days or leaves a message on the patient's answering machine to call if the question still needs to be answered, then the practice is not accessible and the patient's needs are not met.

In this example, healthcare has been withheld or delayed. Delivery of quality care has been aborted—it did not happen. Based on traditional consumer behavior, the patient will seek healthcare elsewhere, regardless of the physician's education, training, skills, and likeability.

The retail mindset must use every communication avenue available to provide access to the patient. E-mail, for instance, is a simple way to connect with the patient. However, many physician practices miss the opportunity to use this vehicle for fear of malpractice or a preference to see the patient in the office. Yet the Internet is a simple and inexpensive way to provide access and is an apparatus that many retailers use proficiently. With proper barriers on the types of questions that can be answered through e-mail and necessary security parameters in place, practices can learn to use this tool effectively to increase patient access.

Appointment scheduling

Appointment scheduling can also be simplified through your Web site, and it offers patients another way to access the practice easily—particularly those who are put off by a phone tree. For example, put yourself in your patient's place:

You are at work and have only a few minutes at break time to call for an appointment for a routine checkup. Would you rather go through five or more options, after which you are asked to be put "on hold" before you are able to schedule a routine appointment, or would you rather go to a Web site after office hours and send an e-mail asking for an appointment, stating dates and times you are available?

Beyond e-mail, more sophisticated scheduling tools and programs are available for use through the Internet. Based on the premise that access is fundamental to offering exceptional service, and in an effort to emulate retail practices,

open access is a scheduling technique that allows for more flexibility and reduces the likelihood of loss of productivity. With this method, a certain percentage (based on patient flow data) of appointments are reserved for those who call ahead; the rest are left open for same-day or next-day treatment.

How many appointments you keep aside for those who call ahead depends largely on what kind of practice you have and the type of patients you see. For example, pediatric practices will likely need a greater number of appointments available for same-day callers because parents want their children to be seen right away. An orthopedic practice may need more open availability on Monday after their patients have gone to emergency departments over the weekend, and they may find it profitable to increase the percentage of reserved appointments later in the week.

Patients who continually “no-show” or come in late can cause a decrease in revenue and interrupt the patient flow for everyone. Open access scheduling can help reduce no-show rates and keep patient backlogs down. More and more practices are finding this type of scheduling model extremely efficient with overall higher patient, staff, and physician satisfaction.

Wave scheduling, another technique, may be more effective and beneficial for some specialties and physicians, and others do well with straight line scheduling. The method of choice should fit the overall needs and convenience of the patient population and maximize the opportunity for access to the physician. Hours of operation, a subset of scheduling, is another facet to consider when

patterning after retail. Offering extended hours and weekend availability is again only suitable for some specialties and in some locales.

For primary care, a beach or a resort setting is an ideal place to start and end each day later in an effort to accommodate sunburns, contact dermatitis, upper respiratory infections, and minor injuries sustained by vacationers. Imagine what a boon it is for the practice that can choose to rely heavily on cash or credit card collections rather than third-party payers. The patient who walks in that door and leaves with a prescription for relief or just peace of mind is a consumer who has received exceptional service.

Location

“Location, location, location” is the common and almost hackneyed phrase used in real estate. It also applies to healthcare, especially when considering where a practice is located in relation to other healthcare providers. A careful choice of location can maximize the growth of the business and sustain the loyalty of the patient base.

As in the example of the retail mall where many goods and services are brought together in a common locale, healthcare is often offered in conjunction with hospitals, medical office buildings, and free-standing surgical, treatment, diagnostic, and other procedural centers. Access to food and even lodging for patients from outside the area or for family members who accompany the patient is an essential aspect of access. Patients with serious illnesses who need ongoing testing or treatment benefit greatly from the centralization of care and services.

Nevertheless, some specialties benefit from being located in shopping centers or free-standing buildings over medical office buildings. Think about how important it is for the pediatrician's or the family practitioner's office to be in a location where parents can drive up near the front door, where parking is readily available and free, and where the doctor is located down the street from the neighborhood schools and nearby the workplace.

Another primary aspect of location is in choosing what community to serve, and then choosing the location that will provide you with your targeted patient base. Before successful retailers locate, they study the characteristics of the population, especially its size, growth, density, and distribution and statistics regarding birth, marriage, disease, and death. The lesson from retail is to know the demographics of the community and then provide what the individuals in the community want and need.

Again, take a look at Starbucks. Starbucks stores are located in well-traveled areas, typically positioned at the end of small shopping strips or inside supermarkets or other retail outlets, and even in hotels. The same considerations apply when deciding where to locate a medical office. Again, the primary objective is accessibility to the targeted consumer.

Office design

Office design with a retail state of mind encompasses pleasant surroundings through décor and furnishings, but it also includes work flow for the employees and patient flow for the consumer. It starts at the parking facilities and winds its way through every facet of the practice that the patient encounters.

It's necessary to remove as many obstacles and hurdles to delivering exceptional patient service as possible.

Retailers like Starbucks would think about the following:

- Access to abundant parking or public transportation lines
- Ability to move safely and with ease from mode of transportation to office setting
- An adequate amount of comfortable seating
- Ease of egress and regress
- Convenient access to restroom facilities
- Neatness and cleanliness of the work areas and the overall facility

Office design that considers all of these aspects from an employee and patient perspective help to develop a patient experience that exceeds expectations.

Keeping patients front and center

More patients are using publicly reported quality measures to assess healthcare providers, particularly hospitals. They have preconceived ideas about providers and set expectations of the care they will receive.

Retailers are constantly asking customers for feedback on their experience. To learn what these customers think, they use surveys, loyalty cards, focus and advisory groups, and suggestion and comment cards. They adjust buying and align every aspect of their stores through the information gathered to cater to their top consumers.

Medical practices should do no less to connect with patients and gain their perspective on healthcare. Ask questions to learn what improvements are needed. Comment cards should be highly visible for patients to take and randomly inserted in patients' bills. The information can be used to make helpful changes and added to the agenda when training staff members to improve their performance and effectiveness.

The entity that is serious about listening and responding to its consumers becomes empowered to act in its customers' interests. It is essential to keep in mind the end goal—to get the patient to return to the practice.

In *Loyalty Marketing: The Second Act*, Brian Woolf, a global leader in loyalty marketing, writes about what he regards as one of the world's best retailers, Superquinn, a highly successful supermarket chain with a philosophy is that the customer is all-important.

When Feargal Quinn, the founder of Superquinn, opened his first supermarket in Dublin, Ireland, in 1960, the guiding principle he instilled in all employees was—and still is—to get the customer to return. In fact, the “Boomerang Principle,” as it has since been dubbed, is now a well-recognized mantra in many parts of the retail world. Superquinn hires friendly people with a ready smile. Employees are taught to recognize and greet customers by name and to make eye contact with them.

According to Woolf, “Superquinn is a company where people are important. Employees are called colleagues.” He goes on to explain that each aspect of the

store, from the beef to the produce, and each department is given a human face; pictures of farmers and employees hang on the walls in order to give customers a sense that their purchases matter and that they will be taken care of. He adds, “Store managers have an unusually high degree of responsibility and authority. The company’s suggestion system readily rewards upward-flowing ideas.”⁴

Following the Superquinn pattern, the medical practice can elevate its staff through various recognition measures and award programs. Celebrate achievements, anniversaries, birthdays, and other important events to create and enhance camaraderie. Such habits such as this go a long way toward developing a genuinely positive experience for the employees and the patients.

Furthermore, Superquinn is not only obsessed with its customers; it also has a passion for providing quality goods and services. It is both customer- and product-centric. Superquinn wants to listen to its customers. In regular meetings with customer panels in different stores, Quinn simply asks what they think about all aspects of the company. His role, he explains, is to sit back and listen. He doesn’t try to justify the company’s position. He is, as he says, “seeking to hear what he doesn’t want to hear.”⁵

Another reason this retailer is the best is that it is a very open, very accountable company. The senior management team shares with all employees how the previous week’s trading and customer results compare with the week’s target and with peer performances at both department and store levels within the company. This means that all employees receive both a horizontal and vertical perspective of their department: sales, profits, and customer information.

The bonus program is based on a combination of the store's profits and changes in the "Best Customers" count because they found that changes in a store's returning customer numbers directly reflected changes in the basic loyalty elements—service, cleanliness, in-stock conditions, etc.—of that store.

In emulating the Superquinn example and mission, compensation, bonus, and reward programs can be used strategically to promote positive behaviors and a "super" patient experience.

Who are your patients?

In spite of all the staff training and customer service initiatives that create an exceptional patient experience, patient segments differ. Thus, it is important to know what each segment wants and what is important to them.

Most practices will have a mixture of the following types of patients:

1. **Comfort seekers** want to feel welcomed and comforted by staff and desire significant contact with family and friends. They value convenient scheduling and delay notifications. This group tends to be younger, with children and lower incomes.
2. **Amenity seekers** have higher incomes and are willing to pay for comfort. Strongly influenced by hospital or provider reputation, they are more likely to ask their physician for a referral to a particular hospital or specialist.

3. **Control seekers** are interested in efficiency and information. They are most willing to challenge a doctor's recommendation. This segment has less interest in entertainment and Internet access, and they often have lower incomes.
4. **Just the basics** patients are most concerned about location and convenience. They have less frequent and less intense provider encounters, and they are most likely to have high deductible health plans.
5. **Physician-reliant patients** are heavily dependent on physician recommendations. Some members of this segment delay a hospital or specialist visit after receiving their doctor's diagnosis. This group is the least likely to be influenced by patient experience factors.

For all segments, the most valued element of experience is being kept informed.

CASE STUDY Internal medicine practice goes “concierge”

Many physicians are taking control of their individual situations and creating more time for themselves and their patients by turning to personalized medical practices, or “concierge” medicine.

Three years ago, with two senior physicians considering retirement, an internal medicine group decided to change the way they approached practice.

Reimbursement had flattened, and the two older physicians were having a difficult time sustaining the volume necessary to maintain an acceptable income level. At the time, the practice had a total of six physicians and a patient volume of approximately 25,000.

The new approach was to convert to a concierge-style practice, where patients pay a flat fee for comprehensive services and enhanced preventive healthcare. The physicians would serve as gate-keepers and be totally involved in the patient’s health.

First, the senior physicians transitioned to treating patients who paid a flat fee to enroll in the program. Six weeks later, another physician converted to the new practice model, followed by the fourth member of the group two months later. Another physician joined the prac-

tice, and the seventh in the group is now in the process of converting.

Targeting the older patient or patients with at least one chronic illness that requires ongoing care management, each patient undergoes an annual comprehensive physical. Because it is preventive care, third-party payers will not reimburse for the initial physical. Sick visits that are covered by the patient’s plan are filed for reimbursement as in a traditional medical practice.

The goal was to reduce patient volume to 600 patients per physician, with each physician seeing 8 to 10 patients per day instead of 20 to 25 in the traditional internal medicine model.

Patients who can afford the retainer fees of this practice receive:

- More personalized attention
- Guaranteed same-day appointment
- Paid parking
- Longer consultations, 30-minute appointments
- Annual comprehensive physical

- Coordination of care with specialists
- 24/7 availability of their physician via office phone, email, fax, cell phone
- Access to prescription services and refills
- Web site access to medical record information and the physician through enhanced Web services via their own patient portal

The physicians in this group began to experience positive income and life-style changes almost immediately. Overhead decreased through attrition—from 46 to 22 employees. The practice culture made an immediate 180-degree switch from one based on the traditional model of productivity (i.e., increase volume, add dollars, and yield productivity) to one that provided more customer service and catered to patients.

The success of the personalized medical practice depends largely on the attitude and level of service provided by the staff. Although the physicians were focusing more on customer service and were enjoying a reduction in work load and the experience of providing comprehensive, high-level care, the staff was

being asked to ratchet up its attention to the patient to provide an outstanding “patient experience.”

Their workload increased immensely. More work and fewer workers means employees are unhappy, unless unusual measures are taken. At first, the solution seemed to be more training in customer service to improve skills, but still, that fell short.

In response, the doctors began to take a serious look at the problem and seek solutions. They reached a turning point in the way they viewed their employees through a study of other well-run customer-service-oriented companies, such as Disney and Southwest Airlines, whose approach to their employees is similar to those of Starbucks and Superquinn, as discussed earlier.

All four companies push the model that the employee comes first, the customer is second, and the shareholders are third in the list of importance in the organization.

Furthermore, the philosophy cannot be delivered merely in words; it must be demonstrated in concrete actions. To get employees to deliver exceptional customer service and a legendary patient

experience is simple as this: Reward employees who do great work.

The practice began to listen to its employees. The physicians started recognizing their employees' needs to be appreciated. They started providing time and attention through weekly educational sessions and presenting a high-quality work environment.

In the annual review process, the physicians traditionally focused on hard skills (e.g., how well do you know your job, and how well do you perform it), but soft skills such as attitude, friendliness, going the extra mile, overcoming difficulties, and meeting challenges in the area of responsibility—with coworkers, patients, and employers—are also evaluated and recognized.

As in the Starbucks model, employees are rewarded when they are “caught doing something good.

Three years into the concierge

model finds a staff with a great attitude and high morale. Attendance has improved immensely so that now there are almost no absentees, whereas in the past at least one employee called in absent per day. Turnover is rare.

This year, the annual holiday party is being upgraded to an event at a fine restaurant, and the physicians will give recognition to each individual who works in the practice for special efforts demonstrated throughout the year. In addition, the employees will have an opportunity to share in practice profits at year end by receiving a holiday bonus.

The successful retail approach is based on having satisfied employees who know how to and willingly deliver an excellent patient experience. No medical practice that merely offers a quick and impersonal remedy can expect to compete.

Conclusion

Those involved in the delivery of healthcare in a marketplace driven by proactive consumers can gain much by taking a look at successful companies. In this chapter, two widely differing yet tremendously successful companies—Starbucks and Superquinn—are presented as examples for medical practices to follow. Both companies emphasize the importance of people, both employees and customers, to reach their business goals.

In its simplest form, the lesson learned is that happy employees who are trained to deliver to customers what they want at a level of excellence create loyal patrons who return again and again. Their businesses prosper, and so do all the contributors.

Endnotes

1. "Delivering a Distinctive Patient Experience," Bachelor Gulch, CO, June 27–29, 2007.
2. "Legendary Service Facilitator Guide," Starbucks Initial Store Training Program. p. 2.
3. Ibid., page 22.
4. Woolf, Brian. "Loyalty Marketing: The Second Act." October 2001. Online, www.brianwoolf.com/books/samples/read.asp?id=2. Accessed 8/9/2007.
5. Ibid.

Planning for your retail strategy

by John P. Reiboldt, MBA

Just because the Minute Clinics and RediClinics out there focus on a specific type of primary care medicine does not mean that you have to alter your focus to fit into that model. Retail medicine can be applied to virtually any type of practice. In fact, although business models can be structured off of competitors' and prior models, it is important for any business owner to note that simply setting up a model similar to your competitors' does not guarantee success.

The most important thing is to develop a service that is needed in your community and fill a gap that is currently not being filled. Even the most ingenious business model/initiative is worthless if it does not give the consumer something he or she needs. Probably the most difficult thing for someone from a "traditional" healthcare delivery background to do is to stop thinking like a medical practice and start thinking like an entrepreneur.

Generally speaking, for medical providers (physicians, etc.), the mindset has become “build it, and they will come.” And that is great—based on our traditional healthcare delivery system. But remember that we are focusing on retail-based medicine. There are no insurance panels to sign up with—in fact, you are likely going to be competing directly *against* insurance companies. There are no “patients”—they are now “consumers.” And there are many other changes you will be facing that are not common in the traditional medical practice.

Determining your retail strategy

Before you do anything—before you can even start to plan, complete an analysis, draw a conclusion, or procure financing—determine what your retail strategy will be. In some cases, this is easy, although it may not be as straightforward as it sounds.

Most physicians reading this will say, “Well, I am a dermatologist, so my retail strategy will be focused on skin care products,” or something along those lines. And that is a very valid point. At the heart of the matter, this is medicine, so you cannot—for ethical reasons, legal reasons, and many other reasons—stray too far from your knowledge base. For example, it would make no sense for a dermatologist to open up a retail-based open-heart surgery clinic.

But many of the people who are opening retail-oriented clinics are not physicians at all; instead, they are entrepreneurs who see a need for health-

care-related services. A good example of this is a gentleman who opened up what is now one of the most preeminent “medi-spas” in a large, progressive metropolitan area. He had not a lick of medical training himself, nor had even worked in the healthcare field before. But when he talked with friends and his clients at the time, he realized there was a tremendous need for these services.

Once he determined his strategy and the services he would offer, he did enlist the services of physicians who could provide him with the necessary and appropriate clinical expertise, but the idea was his.

Many of the “traditional” retail-based clinics like MinuteClinic and RediClinic were not started by physicians but by business people. Even Wal-Mart and many of the large drug stores are getting into the game, and those certainly are not physician-driven services. The point is that retail medicine provides the opportunity for non-healthcare providers to take their business-world expertise and apply it to healthcare initiatives. As noted earlier, this is why determining the retail strategy may not be as straightforward as it might seem.

There are two ways to look at retail medicine:

1. Retail medicine as a mindset, as described in Chapter 2
2. Retail medicine in practice

Both of these can influence your strategy. Retail medicine as a mindset is to take the lessons from retail (many of which have been discussed before) and apply them to a traditional medical practice. This may include transparent

pricing, open access scheduling, formal marketing and promotion strategies to achieve volume growth, focusing on the quality of the service, and others. The bottom line, though, is that the mode of the delivery system still exists: Consumers of the service are not necessarily the payers of the service.

Retail medicine in practice, though, is quite different. Of course it is all of the concepts we just noted, but more importantly, the provider of the service is trying to market his or her service as one that is inherently “better” to a consumer, who makes a decision based on objective and subjective factors. The consumer is ultimately the payer of the service.

This distinction is important because it determines which strategy to implement. For cardiologists with a retail mindset, for example, this may mean that they continue in their current specialty and continue to bill third-party payers. At the same time, they may implement more of a retail approach to their practice in actively marketing to the public, having transparent pricing, and posting their quality outcomes to the public in order to show their “success” rate and other factors.

On the other hand, a cardiologist who wants a more retail-oriented practice might notice that in the market, third-party payers are not paying for the preventative care that he or she believes to be necessary, but many baby boomers are willing to pay for that type of care out of their own pockets. The physician opens a “cardiac retail center” where people can come and have a full battery of tests and services performed. The cardiologist may even add

complementary non-cardiac related services to entice people to come. He or she would bill directly to the patient, based on packages and pre-set rates that have been clearly identified.

This is only an example, but it illustrates the difference in the retail mindset and retail in practice, and it is an example of how a physician looks outside the box in his or her own specialty to offer retail-based services.

It would be virtually impossible to run through every type of medical specialty and say, “In orthopedics, XYZ can be offered as a retail-based service; in gastroenterology, ABC can be offered as a retail-based service.” It is not that easy, and it requires a detailed understanding of every type of specialty and all of the ins and outs that go into that specialty before you can identify a retail strategy. The fact is, even some really good ideas with strong market support have flopped.

For example, take the full-body scans that appeared on the market back in the early 2000s. People were doing full body MRIs to find possible illnesses before the illnesses had the ability to cause irreparable harm to the body. The scans were preventative medicine, so they were fee-for-service: X scan costs Y dollars. One major company even used a prominent sportscaster whose life had been saved from detecting an illness early. Now there are few, if any, organizations that focus solely on preventative MRI scans. What seemed like a good idea ultimately failed.

It is important to note, though, that taking on the retail mindset does not

mean that your life will be easier, or that it will necessarily equal success. MRI and imaging centers in general were some of the early pioneers of retail-based medicine in the way that they operated. They were perfect for it because they were relatively physician neutral (i.e., they did not have to rely on the intimate relationship between a patient and a physician), and they could be managed much like a service line in a manufacturing company. There was no such thing as “bedside manner” in an imaging center, only throughput.

So why didn’t this idea succeed? Because the physicians still had to rely on the third-party payer system and consequently were subject to tremendous cuts from Medicare and other payers. Although their operations may be retail-esque, how many U.S. supermarkets do you know that have strict government price controls placed upon them?

Thus, before you do anything else, determine the type of strategy you want to focus on. This does not mean that a cardiologist must focus on something related to cardiology, nor does it mean that an airplane engineer cannot start a retail-based healthcare service or product. Niches exist for every type of product and service available, and healthcare, as unique as our delivery system is, is no different. The key ingredient is finding the right niche for you.

Getting into the retail mindset

If you cannot get into the retail mindset, then you will not be able to put retail-based medicine into practice. Any first year MBA student will be able to tell you about the “Four P’s” of marketing: Price, Product, Placement, and Promotion. Although not necessarily groundbreaking or “outside the box,” these are time-tested, proven principles—they are simple, but they work.

First off, let’s define the Four P’s:

- **Price.** In simple terms, price is the amount you will be charging consumers for your product. In a retail-based environment, especially one that has matured and is highly competitive, this is largely driven by outside forces (e.g., consumer demand, competition, and cost of living where you are located, etc.). Some prices are going to be elastic—meaning that you can raise your prices a lot and you will not lose very many consumers—and others may be inelastic, where even a small price increase will cause the loss of many consumers.
- **Product.** Product is the “what” that you are selling, which can be a whole service line, not just a single item. For example, Wal-Mart doesn’t offer just one product but a variety of items, all at “everyday low prices.” But still, the “product” is virtually anything you could ever want or need in one stop.
- **Placement.** The most straightforward definition of placement is the location where your product receives the most traffic, eyes, etc. For a company such as Johnson & Johnson, “placement” may mean where

its products are located on the shelves of supermarkets. Companies actually pay for better shelf space to ensure that the maximum number of people will see their product. For a company such as Starbucks, it may mean where your facility is physically located. Starbucks wants its stores to be in places that are highly visible from the road and highways and easy for consumers to get in and get out.

- **Promotion.** This refers to how you are going to show your product to consumers. Typical modes of promotion include print (handouts, bulletins, etc.), media (television, newspaper, and magazines), the Internet (search engine optimization, Web sites, online advertising), and a variety of others.

The beauty of the Four P's is that they all flow into each other. For example, the type of "product" you are selling will likely determine the type of "promotion" that you undertake. Consider a consulting firm that offers a specific knowledge base in a small niche. This type of product (which is a service in this example) is very personal and specialized to one aspect of a market. In this case, a 30-second television advertisement on the Super Bowl would probably not be of much benefit. Instead, the best marketing approach might be some print advertising mailed directly to the target market. It's also important, in this case, that the consulting firm develop personal relationships with clients and potential customers.

The Four P's are very new concepts to the healthcare. Because of this, it may be helpful to compare the Four P's from a traditional healthcare delivery system to those within a retail-based system.

FIGURE 3.1 Application of marketing principles

Systems	Traditional healthcare	Retail-based healthcare
Price	Usually set by third-party payers.	Determined by the service and market prices. Other factors may include location, special services, etc.
Product	Based on the provider(s) expertise/specialty, and generally focused on "services."	May diversify and add a variety of complementary services. Focus is on this diversification.
Placement	Typical provider locations: medical office buildings, near hospitals, etc.	Distinguish itself from a typical provider of medicine to show the additional "value" from retail-based medicine. May locate in high-end "resort" locations or complementary offerings (such as supermarkets).
Promotion	Sign up with as many insurance plans as possible, and get privileges at local hospitals. Specialists may go out to meet referring physicians. For the most part, no formal marketing strategy exists.	Direct-to-consumer marketing is very important. The type of marketing will cater to the targeted consumer. Common promotional activities might include magazines, search engine optimization, "educational" marketing, and sometimes television.

Clearly, there are significant differences in retail care versus traditional healthcare delivery. Probably the biggest one is that a traditional healthcare delivery system is more passive, and providers wait for patients to come to them when they need services. A retail healthcare system, however, is dynamic: the providers go to the market and tell consumers why they need their services. The whole concept is a general shift to the mindset that a physician is the provider of scarce services that have significant value.

Planning is key

Before you make it to the stage where you're considering the Four P's, you must first complete your due diligence, planning, and pre-planning. Determine what service(s) you are going to take to market, and then determine whether the market needs or wants what you will be providing.

Call to mind some of the most successful retailers in the world: Starbucks, McDonalds, Wal-Mart, etc. They do not make one single move—whether it is opening a store, adding a product, or making storefront changes—before analyzing the feasibility of what they are doing.

Take Starbucks again as our example. They have strict standards and requirements that must be met before they open up a new store anywhere in the country. Not just anyone can pay \$2.00 or more for a coffee and \$4.00 for a latte. Also, consider how many \$2.00 coffees and \$4.00 lattes must be sold before you can make a profit (a lot!). That is why Starbucks looks very closely at a market before entering it: the demographics, the median income levels, and whether the area receives high daily traffic.

But how do they know this? They plan. Planning is the first step into retail medicine, and to plan, you must define a few key items:

- What service/product will I offer?
- Who is my target market?
- What is my geographic market/service area?

Create an operational framework

Once you have addressed these questions, you will be able to move into your planning phases. First, lay out an operational framework that outlines how your new entity will operate. Many people believe the first thing to do, right off the bat, is to run a feasibility analysis and make financial projections. Although that is very important, a general operational layout must be considered first. Financial projections are essential, but you have to have a good understanding of how the business will operate before you make any other projections, as these will largely drive your financial analysis going forward.

Start high and work your way down in terms of operations. Think of the biggest, best, most glamorous facility that you want, and factor in excellently trained employees. Then, as you run your financial models, scale back as needed. Beware, though, because often once entrepreneurs have their minds set on something, it is difficult to break free from this “vision.” Starting up and working your way down will be the job of the feasibility study.

Conduct a feasibility study

Much has been written on feasibility studies—their need, their purpose, and how to complete one. However, the best advice anyone can give you is to get help. Go out and get an expert to do it for you. It will save you time and probably money over the long run, and if you go with an experienced person, it will lend credence to your project and give you extra peace of mind that you have left nothing to chance.

Without going into too much detail, the feasibility study does just that: It determines whether your project is feasible, from a financial, market, and operational standpoint. You must have done your due diligence and research before you reach this point in the process. When the consultant starts asking questions about whom you will be serving, what products you will be providing, and the operational foundation, you should have answers.

The feasibility study will take the three points just discussed and develop a document that answers the following questions:

- Based on the services you want to offer, does your market (i.e., where you are locating the business) make sense?
- Based on the operational structure you have defined, does this project make financial sense?
- Based on the business (i.e., the type of service or product you are providing), does this project make financial sense?
- Are your operational goals, the business, and financial considerations all in concert?

In addition to addressing these concerns, the feasibility study can be used for other purposes, especially financial projections. They will let you see, based on your assumptions (e.g., operational considerations), what your required investment will be and when you will realize a return on your investment. They also can be used as a guideline (but technically not a budget) for your operations during the initial planning period.

Have your statements on hand

There are three key financial statements that will get you through just about any planning process: a profit and loss statement, the balance sheet, and the statement of cash flows. Each statement serves its own purpose both in the planning process and in the ongoing management of the new endeavor.

Some medical practices run their financial statements on the cash basis of accounting, where revenue is equal (or very close) to collections and expenses match the checks that were written. Most are on the modified cash basis that considers depreciation and amortization—expenses that are not actually cash outlays.

For a more advanced operation, however, you will want to perform your financial accounting on the accrual basis, where revenue is realized when it is earned (for example, if someone gives you a down payment of \$200 for a service, you don't actually realize that \$200 as revenue until you perform the service), and expenses are realized when they are incurred (same principle as revenue), rather than when they are paid. Technically speaking, accrual accounting is more accurate, but your method of accounting will probably vary based on a variety of factors, including the size, type, and complexity of the business.

The profit and loss statement (P&L) provides the relationship between revenue generated by the organization and expenses incurred by the organization. In the simplest terms, the difference between the two is net income, or whatever is left over, but that definition is inadequate in today's business world. If your

business is product/sales-based, then you will also want to have a category called cost of goods sold (COGS), which gives you—ironically enough—the cost of producing the goods you sold.

P&L formula

$$\text{COGS} - \text{Revenue} = \text{Gross Profit}$$

$$\frac{\text{Gross Profit}}{\text{Revenue}} = \text{Gross Profit Margin}$$

COGS less revenue equals gross profit, and gross profit divided by revenue is your gross profit margin. Generally speaking, the higher these numbers, the better. A P&L encapsulates a period of time—like a movie—during which this equation develops; this could be a month or even a year.

Under the cash basis of accounting, the P&L serves as the cash flow statement, but under accrual accounting, the cash flow statement is very important. For financial reporting purposes, you can show a loss on the P&L for a time, but if you continue to lose cash, then you are not solvent.

The clearest way to lay out the cash flow statement is by the indirect method, which breaks cash down into three primary categories:

- **Cash flow from operations (CFO).** The cash flow generated by your business from general day-to-day operations, or your core business.

- **Cash flow from investing (CFI).** The cash flow generated and expended by your organization on investments. This is most commonly associated with the investment in capital expenditures (e.g., equipment).
- **Cash flow from financing (CFF).** The money received and paid for financing activities, mostly associated with debt principal (interest on debt is realized on the P&L).

The great thing about this statement is that you can develop your operations and apply them to the P&L and then use your statement of cash flows to understand how much capital you will require (whether it is debt or equity).

If a P&L is a movie, then a balance sheet is a photograph, capturing one period in time (e.g., “As of December 31, 20XX,” as opposed to a P&L, which would be “For the Twelve Months Ended, December 31, 20XX”).

The balance sheet is where the cash flow statement and the P&L all come together. Balance sheets serve as the foundation for a company’s financial statements. They are very important for showing items such as how much debt a company has in comparison to its assets (i.e., its liquidity), the efficient use of assets, cash available, collections (accounts receivable), etc.

The real genius and hard work—the art, if you will—related to these statements is deriving the assumptions that serve as the basis for this information. This is where seasoned, experienced advisors earn their weight in gold.

Analyze the market

Another key component of the feasibility study is the analysis of the marketplace. This not only looks at the composition of the consumers in your market but also performs a competitive analysis of the market and determines whether someone else already offers a similar product or service there.

Knowing this information is important for a number of reasons. For example, say you are opening a high-end “medi-spa” that focuses on a variety of cosmetic services. If this is the case, you have a couple of options to consider when defining your market. Are you going to draw your market largely from where you are located, or are you going to be a “destination” service at a resort location where people travel for these procedures? Or will you be a combination of the two? Regardless, you can see why this must be defined before you can measure your market, as the results from a market study would vary significantly based on your focus.

An actual example of this is a very successful physician who already had an excellent name as a top OB/GYN in the community and was highly respected for providing excellent care. In addition to her traditional OB/GYN practice, she created a health spa that focused on traditional spa treatments, such as massage therapy, yoga, pedicures, and manicures. She also provided a number of medical treatments, such as microdermabrasion, a wide range of medical-related cosmetic services, and many, many other medical services. All of these were fee-for-service at pre-set prices.

The spa was attached to her OB/GYN practice—an extremely well-planned and marvelously designed facility with wooden floors and a very “feng shui” feel—with the idea that women coming in for their traditional OB/GYN visits would drive business to the spa. In addition, the physician did a variety of outside marketing in all forms of media, as well a traditional public relations initiative.

But what the physician did not do is consider her market. If she had done the proper due diligence, she would have realized that the primary makeup of the consumers in the marketplace (e.g., household income, per capita income, age distribution, etc.) were nowhere near what would be needed to support such an endeavor. Furthermore, if the physician had done the proper analysis, she would have realized that the people who could afford to have those procedures done were going to the very high-end centers in the metropolitan area less than an hour and a half away. The result was failure, caused by a failure to plan properly.

This is an unfortunate example, and it is one that is far too common and could easily have been prevented. The physician was proud that she had financed the whole operation out of her own pocket and did not have to borrow one dime to get it up and running. However, if she had gone to a bank and borrowed the money, the banker or loan officer would have likely asked to see her financial projections and her market study and asked who was advising her on this deal. Sometimes being unaware of what you do not know is the most dangerous thing.

There is no magic recipe for identifying a market you should be in versus one you shouldn't—a lot of this comes down to plain old common sense. For example, you probably don't want to offer a retail-based service for children if you are located in a retirement community. And, along the lines of the OB/GYN example, if you have high-priced, “executive” level services, you should probably be located in an environment frequented by these types of people.

At the same time, though, look at trends and learn about your community; think about where your community is going and less about where it currently is. This may let you get your foot in the door in a community that might be out of your reach in five years.

Conclusion

The key is planning, planning, planning. Planning is the airplane structure frame, operations are the engine, and each is not much use without the other when you want to fly. So, for those who skip right to the back, it is pretty straightforward:

1. What are you going to offer? Determine your retail-based strategy.
2. To whom are you going to offer it? What is your target market (age, demographics, etc.)?
3. Where will you be offering your service? What is your target geographical market (local, national, international)?
4. What is your competition? Complementary services?
5. How do you envision the organization running? Plan for the operations.

6. Does your operational vision mesh with the target market? Will it generate financial returns? What will it take to get it to where you want it to be? Determine the feasibility.
7. Get professional help. Be open to admitting that you don't know everything and that your way may not be the best way.

Measuring the return on investment for retail initiatives

by Justin Chamblee, MAcc, CPA

What is the one reason physicians enter into retail initiatives? They are not bored or just looking for change; rather, they perceive a need in the healthcare market and believe they have a product or service that can fulfill this need. As with an investment made in the stock market, the overall objective of pursuing this initiative is to reap some benefit from the time and effort spent—in other words, to see the investment perform.

So then, the question arises: “What does the term ‘perform’ mean?” The definition of performance can vary with each investment and even fluctuate from one individual to the next within the same investment. Performance also does not always have to take on monetary value, yet it always intrinsically holds some type of value.

For instance, quality of life could be a performance measurement—there is no monetary value associated with this type of performance, but there is value. Although many performance measurements exist, most retail initiatives are

undertaken in order to realize some sort of financial benefit. In other words, physicians seek return on their investment. Whether this comes within one month, one year, or even five years from the onset of the initiative, an investment will not be made without the possibility of realizing profit.

One may then ask, “How do I know if an investment will be profitable?” Unfortunately, there is no crystal ball to answer this question. We are left only with thorough research and analysis as tools for making informed decisions and evaluating the viability of potential future initiatives.

Finally, we arrive at the purpose of this chapter. It might be impossible to predict the future, but it is possible to complete the necessary research and consider a potential investment’s performance in comparison to other alternatives in the market. We will accomplish this by first laying the groundwork and then walking through the necessary steps to evaluate the potential performance of a retail initiative.

How do you measure performance?

As discussed earlier, performance is essential to any investment and can be measured in a number of different ways. There is no clear-cut, right, or wrong method to performance measurement, and typically this process is tailored to each individual investment. However, an entity should consider criteria such as its industry, size, age, geographical location, capital structure, and future goals and objectives to determine the appropriate performance metrics to use, as well as the comparable companies to use as benchmarks.

For example, it would not be appropriate for a small, private, single-owner company to use earnings per share as a key profitability metric, as only one person owns all the outstanding shares. In the same manner, it would not be appropriate for a company in its first year of operations to be compared to a company that has been in business for more than 20 years. These are only a couple of examples, but they provide an appropriate foundation for choosing the proper performance measurements.

Next, we focus further on performance benchmarks. As stated previously, it is essential that a company choose relevant benchmarks in determining overall performance and profitability. Here are some of the most common profitability measures:

- Earnings per share
- Return on assets
- Return on equity
- Earnings before interest, taxes, depreciation, and amortization (EBITDA)
- Gross profit margin
- Net profit margin
- Free cash flow
- Return on investment (ROI)

Some of these are targeted to a specific type of company, but a number of these measures translate very well across companies and industries of various

sizes. Net profit margin and ROI, for example, can be applied to almost every company and investment, which makes them very useful measures.

Return on investment

The following graph illustrates the most basic calculation for determining the ROI:

$$\text{ROI} = \frac{\text{Benefit} - \text{Cost}}{\text{Cost}}$$

Although this calculation appears quite simple, the difficulty is in defining the inputs. This challenge is sometimes viewed as a benefit of this model because there is a lot of leeway in how it can be used. However, this lack of definition also can lend itself to manipulation in order to obtain desired results. For example, an investor may choose to exclude certain costs in the calculation in order to artificially increase the ROI. Thus, when using this calculation, it is imperative that a thorough review of the inputs be performed to ensure the calculation is as accurate as possible.

Now that we have discussed the calculation in general, it is important to understand the calculation's inputs—specifically, what should be considered a benefit and what should be considered a cost.

Benefits

Benefits are typically comprised of revenues generated from an initiative. Some revenue benefits are easier to pinpoint than others. For example, if a physician starts a new retail clinic in an area grocery store, benefits will include the revenues generated from this clinic. The benefit here is very easy to identify because the new initiative is a completely separate entity from the physician's other activities. But consider a situation where a physician extends his practice hours in both the mornings and the evenings to better accommodate patients. In this instance, it may be more difficult to identify benefits directly, as the practice likely does not track the time services are performed.

The physician may experience an overall increase in revenues, but he or she cannot assume that this is entirely the result of extended hours. These increases may be a result of other factors, such as a change in payer mix or an increase in reimbursement. In such a situation, revenues associated with extended hours should be estimated as best as possible and then be considered as the benefit for purposes of calculating the ROI.

Costs

As described earlier, although they are sometimes difficult to pinpoint specifically, the benefits to be used in the calculation most often revolve around the actual or estimated revenues associated with a new initiative. The cost portion of the calculation is not so straightforward because there can be a number of costs associated with a new initiative. In basic terms, these can take the form of either initial/start-up costs or ongoing costs.

Start-up costs will vary by initiative. For example, development of a new retail clinic could result in numerous start-up costs, including leasehold improvements, purchases of equipment, and legal fees. On the other hand, extending a practice's hours could have minimal start-up costs, such as recruiting—if additional staffing is needed—or other minor, one-time costs.

Almost all initiatives will have ongoing costs that typically require spending additional money to continue generating revenue. In the example of the retail clinic, these would include personnel costs, facility costs, supplies, and other fixed costs associated with operating the clinic. In the example of the practice extending its hours, this may only include additional personnel, supplies consumed, utilities, etc. As with determining the benefits, it is more difficult to identify specifically all costs associated with the latter initiative. Thus, all of the costs specific to the activity should be identified with other attributable costs and estimated as accurately as possible.

Calculation and evaluation

Once both the benefits and costs are specifically identified, ROI can be measured. This is completed by entering these variables into the calculation. For example, let's assume that benefits are \$10 and costs are \$8; thus, the calculation would take the following form:

$$\frac{\$10 - \$8}{\$8} = 25.00\%$$

The ROI is 25%. Clearly, this is a very simplistic example of the calculation, but it illustrates the ease of the actual ROI calculation once the inputs are identified. The point of any investment is to maximize the return by creating a greater disparity between the benefits generated and the costs incurred.

Risk vs. return

The ROI will always vary per initiative and must be considered alongside the returns of other investments in the marketplace. There are a number of factors involved in this process, and one of the most important to consider is an evaluation of the investment's risk. There is assumed to be a direct relationship with risk of an investment and associated returns. If an investor is willing to assume substantial risk, the ROI should be sufficient enough to compensate for the assumption. Continuing with this idea, an investor given two investments with comparable returns will most likely choose the less risky of the two, as they will not be willing to assume additional risk for the same return.

There are several key items to remember relative to assessing the risk associated with retail initiatives. First, risk is evident in any endeavor, and it is impossible to completely eliminate risk without foregoing the opportunity. Second, since risk cannot be eliminated, it must be considered as the key factor in the decision to enter into a retail initiative. Ultimately, in assessing risk, we recommend a thorough analysis of the strengths, weaknesses, opportunities, and threats (S.W.O.T.) associated with a potential opportunity. Some of the factors to be considered as part of a S.W.O.T. analysis follow.

Strengths

- Expertise in field
- New, innovative product
- Location
- Solid customer base
- Cost advantage
- Efficiency advantage
- Strong brand or reputation

Weaknesses

- Lack of marketing expertise
- Location
- Saturated market
- Payer mix
- Availability of resources

Opportunities

- Developing market
- Strategic alliances
- Weak competition
- Clinical efficiencies
- Reduction of expenses

Threats

- New competitor
- Substitute product
- Governmental regulation
- Reduction in reimbursement
- Taxes

This analysis does not quantify the risk associated with the initiative in monetary terms, but it will provide a detailed understanding of the dynamics of the market where the risks become evident. Considering this information along with the ROI will assist in making an informed decision.

Finally, it is imperative that the ultimate decision be based upon the assessment of the two forces alongside other investment alternatives in the marketplace. Despite the fact that many people have an entrepreneurial spirit and a positive outlook toward a new opportunity, there are times where the risk and return are not in alignment and there are better investments to consider.

The pro forma projection process

Up to this point, we have laid the foundation for understanding the evaluation process. Specifically, we have discussed the benefits and costs associated with the ROI calculation, as well as the consideration of risk. Further, Chapter 3 discussed the process of considering a number of retail initiatives and understanding the needs of the market in order to identify the most appropriate retail initiative. However, we have not discussed how the potential retail initiative is further developed to project its potential performance. This is called the pro forma process, or the creation of a business plan.

The pro forma process is a very detailed projection of an entity's future financial performance. It involves a projection of revenue and expenses as well as cash flow. It is typically performed for a period of three years and involves the overall formation of the business, at least on paper. In order to walk through this process, we will continue with the example of the creation of a retail clinic mentioned earlier in this chapter. We have also broken down this process into four steps:

- Step one: Business development
- Step two: Revenue projection

- Step three: Expense projection
- Step four: Cash flow projection

Step one: Business development

The first task that must be completed in the pro forma process is developing the business. This entails answering questions such as where will this business be located, and operationally, what will it look like? These are the more qualitative items, but they are imperative in later projecting revenues and expenses. Specifically, as it relates to a retail clinic, the following questions must be answered:

- How will the clinic be structured legally?
- Who will the investors be and what percentage of ownership will they obtain?
- Will the clinic be freestanding or located within a grocery store/drug store/etc.?
- How many square feet will the clinic need, and what will the layout be?
- What will be the clinic's hours, and how many days per week will it operate?
- Will the clinic be staffed with nurse practitioners or physicians?
- Will the clinic partner with local hospitals?
- What equipment will be required?
- What services will be provided?
- What will be the fee structure?
- What insurance will be accepted?

The questions in this step can seem endless, but they are necessary before the final decisions are made. This process will begin the formation of the clinic's operations, which will later drive its revenues and expenses. For example, the fee structure, hours of operation, and list of services provided will be used to assist in projecting revenues, whereas the staffing structure, space requirements, and equipment needs will assist in determining the initial start-up costs and the ongoing expense structure. Once there is reasonable consensus as to the framework of the clinic, the process can move forward with the projection process.

Step two: Revenue projection

As stated previously, a number of factors are to be considered in developing the revenue projections. Unfortunately, for a retail clinic this projection process is complex as a result of the number of procedures performed, reimbursement rates, insurance companies, etc. Therefore, the decisions made in step one are critical to this process—even minor changes to the clinic's structure, such as moving the proposed location of the clinic, can have significant impacts on the revenue projection.

To dive into the details of the revenue projection process, the following must transpire:

1. **Fee schedule.** Because retail clinics will mainly perform office visits, it is reasonable to use only the office visit CPT codes for projection purposes. Thus, a standard charge amount must be assigned to these codes. As there will likely be a number of self-pay and uninsured patients visiting

the clinic, it will be necessary to take this into consideration in setting the fees.

Consider the following fee structure (the numbers included throughout the remainder of this chapter are for illustration purposes and are not intended to reflect actual recommendations or expected results):

CPT Code	Charge
99211	\$33.75
99212	\$56.25
99213	\$78.75
99214	\$123.75
99215	\$180.00

2. **Weighted average charge per encounter.** It would be too cumbersome to project patient visits by CPT code and multiply this by charges per procedure in order to arrive at projected charges. Instead, it is more simplistic to use a book or other source that contains estimations of the percentage of overall charges each CPT code will represent and then project revenues based upon a weighted average charge per encounter.

For example, consider the following table:

	99211	99212	99213	99214	99215	Total
Distribution	1.28%	6.45%	42.96%	40.43%	8.88%	
Charge	\$33.75	\$56.25	\$78.75	\$123.75	\$180.00	
Weighted Average	\$0.43	\$3.63	\$33.83	\$50.03	\$15.98	\$103.91

This weighted average charge per encounter of \$103.91 is then applied to all projected patient visits.

- 3. Encounters.** Once the fee schedule is set and a weighted average charge per encounter is calculated, estimate the number of encounters. Typically, this is performed on a daily basis. In addition, it is assumed that the encounters per day will be low at the onset of operations and increase thereafter. The rate at which the encounters per day will increase is highly subjective, but it could be based upon research of other retail clinics.

Additionally, assuming that no other space or providers are acquired, there is ultimately a limitation to the number of patients that can be seen. It is important that the patient encounter projections stay within this parameter. For illustration purposes, let's assume that the clinic begins seeing 10 patients per day at the beginning of year one and ultimately reaches 50 patients per day, which becomes the norm.

- 4. Days worked.** In order to extend the encounters per day to an annual figure, it is essential that the clinic's work schedule—specifically, the days of operation for the clinic—be defined. This data, along with the estimated encounters per day, will allow the calculation of total patient encounters per year. For illustration purposes, let's assume the clinic is open 20 days each month.

5. **Total gross charges.** Once encounters per year and weighted average charge per encounter are derived, total charges can be estimated. This is done by multiplying the weighted average charge per encounter by the encounters per year. We have provided the calculation in the following table to continue our illustration.

Charge Summary - Year One

Month	1	2	3	4	5	6	7	8	9	10	11	12	Total
Encounters	200	220	242	266	293	322	354	390	429	472	519	571	4,277
Weighted Average Charge per Encounter													\$103.91
Total Charges													\$444,396

Charge Summary - Year Two

Month	13	14	15	16	17	18	19	20	21	22	23	24	Total
Encounters	599	629	661	694	728	765	803	843	885	900	900	900	9,307
Weighted Average Charge per Encounter													\$103.91
Total Charges													\$967,025

Charge Summary - Year Three

Month	25	26	27	28	29	30	31	32	33	34	35	36	Total
Encounters	900	900	900	900	900	900	900	900	900	900	900	900	10,800
Weighted Average Charge per Encounter													\$103.91
Total Charges													\$1,122,198

6. **Adjustment rate.** Using information regarding the payer mix along with current reimbursement rates, the contractual adjustment rate can be estimated. Benchmark data, such as that provided in the Medical Group Management Association’s “Single Specialty Cost Survey for Single Specialty Practices,” can be useful in estimating this figure. For purposes of this illustration, let’s assume the average adjustment rate is 35%; thus, 65% of charges are collectible.

7. **Total collectible revenue.** Using the estimated adjustment rate and the estimated gross charges, the total collectible revenue can be calculated. Based upon the information calculated earlier, we arrive at total collectible revenue.

	Charges	Adj. %	Adjustments	Net Revenue
Year One	\$444,396	35.00%	\$155,539	\$288,858
Year Two	\$967,025	35.00%	\$338,459	\$628,566
Year Three	\$1,122,198	35.00%	\$392,769	\$729,429

Although it is assumed there will be a small percentage of bad debt, these figures should be a reasonable estimation of future collections of the clinic. Unless the clinic accepts strictly cash payments, it will not collect this revenue at the time of service and should expect some timing differences to result. However, for purposes of this explanation we will assume that this estimation of revenues is reasonable.

Step three: Expense projection

There are two main types of expenses that must be estimated. These include the aforementioned initial start-up costs as well as ongoing clinic expenses. The initial start-up costs will mainly consist of capital expenditures, but they can also include some operating costs incurred prior to any revenue being generated. It is important to identify all of these costs. Some of the main initial start-up costs include the following:

- Medical equipment
- Furniture and fixtures
- Information technology
- Leasehold improvements
- Operating expenses (advertising, personnel, rent, utilities, etc.)

This process is typically performed in detail on an asset-by-asset basis. The following table provides a small portion of such an asset listing:

Medical Equipment	Quantity	Individual Price	Total Price
Adult Scale	1	\$187	\$187
Audiometer	1	\$3,500	\$3,500
Autoclave	1	\$3,807	\$3,807
Biohazard Trash Hamper	4	\$200	\$800
Blood Draw Chair	1	\$300	\$300
Cautery Unit	1	\$604	\$604
Centrifuges	1	\$2,000	\$2,000
Defibrillator	1	\$3,250	\$3,250
Digital Thermometer	2	\$6	\$12

For purposes of the ongoing illustration, let's assume that the total initial start-up costs are \$300,000. Once initial start-up costs are determined, an ongoing expense structure must be defined. The main costs here will fall into the following categories: personnel, occupancy, variable, and fixed. Partner compensation is not considered an expense, as it is ultimately dependent upon the profitability of the venture. Again, these four expense categories will be based mostly upon the decisions made in step one.

For example, personnel costs will be influenced by both the staffing structure and the location of the clinic. Additionally, the facility costs will be determined by the space leased, and the variable expenses will largely be based upon the projected productivity of the providers. Here is an example of a table to use for such a projection:

Expenses

	Year One	Year Two	Year Three
Personnel			
Salary - Staff			
Salary - Employed Physician			
Contract Labor			
Payroll Taxes			
Retirement Plan - Employee Benefits			
Ins: Group Health			
Total Personnel			
Occupancy			
Rent			
Repairs and Maintenance			
Utilities			
Total Occupancy			
Variable			
Bank Service Charges			
Laboratory Expense			
Medical Supplies			
Office Supplies			
Total Variable			
Fixed			
Advertising			
Continuing Education			
Depreciation Expense			
Dues and subscriptions			

Expenses (cont.)

	Year One	Year Two	Year Three
Fixed (Cont.)			
Janitorial			
Licenses and Permits			
Ins: General Business			
Malpractice Insurance			
Meals & Entertainment			
Miscellaneous			
Professional Services			
Recruitment			
Reference Materials			
Telephone			
Travel			
Uniforms			
Total Fixed			
Interest Expense			
Normal Operating Expense			

In the preceding table, we have not illustrated the projection of every expense category, but for purposes of this illustration, we will assume an expense to collections ratio of 50% in the following expense structure:

	Year One	Year Two	Year Three
Collections	\$288,858	\$628,566	\$729,429
Expense Percentage	50%	50%	50%
Clinic Expenses	\$144,429	\$314,283	\$364,714

Based upon the illustration below, the costs for the clinic include \$300,000 of initial start-up costs, \$144,429 of expenses in year one, \$314,283 in year two, and \$364,714 in year three.

	Start-Up Costs	Year One	Year Two	Year Three
Collections		\$288,858	\$628,566	\$729,429
Clinic Expenses	\$300,000	\$144,429	\$314,283	\$364,714
Profit before Taxes	(\$300,000)	\$144,429	\$314,283	\$364,714
Profit Margin		50%	50%	50%

Using the revenue information from step two and the expense projections in step three, we can prepare a very basic profit and loss statement for the clinic. Later, we will use this data to calculate the ROI for this illustration.

Step four: Cash flow projection

Because a cash flow projection is not necessary in estimating the ROI for the retail clinic illustration, we will not spend too much time discussing this item. However, it is still essential to the overall pro forma and business development process. The cash flow projection involves consideration of the initial start-up costs along with any additional working capital needed to fund the operation in its early stages. It also allows an investor to better understand the initial capital needs as well as when the venture might begin producing positive cash flows. The revenue and expense projections discussed in steps two and three are essential to this process.

It is unreasonable to assume that a retail clinic will be profitable from day one. Therefore, in addition to funding the initial start-up costs, funding will be necessary to facilitate the day-to-day operations for at least a little while. Although we have illustrated the revenue and expense projections on an annual basis, it is sometimes necessary to do so on a more detailed level to better understand these cash needs from month to month.

Once the total amount of necessary capital is estimated, the capital must be obtained. There are a number of methods for obtaining this funding, but it typically comes from cash investments by the owners or a combination of long- and short-term borrowings from a financial institution. If it is the latter, the interest costs must be considered in the expense projection process with the principal repayments as part of the cash flow projection process.

Different from the measurement of ROI, the cash flow projection is also a critical indicator of an initiative's viability. Opportunities may not be worthwhile if it takes too long for the entity to begin generating positive cash flow or if the upfront capital needs are too great. Clearly, from an investment perspective, the sooner positive cash flow generation can occur, the better.

Summary of pro forma process

The four steps just discussed provide the detailed process an investor must perform to seriously consider a potential investment opportunity. In addition, these are the steps for obtaining the data necessary to estimate a return on investment.

As this process is time-consuming, we recommend first taking the steps outlined in Chapter 3 to identify the most realistic retail opportunities and only then engaging in such a detailed analysis.

Return on investment calculation revisited

Now that we have determined the costs and benefits for our retail clinic, we can calculate the ROI for this potential opportunity. Using revenues as our benefit and expenses as our costs, we calculate the return on investment. We have performed this calculation for the end of each year and provide a summary following the individual calculations.

Year One

- Benefit: \$288,858
- Costs: \$300,000 + \$144,429 = \$444,429

$$\frac{\$288,858 - \$444,429}{\$444,429} = \mathbf{(35.00\%)}$$

Based upon this calculation, if the venture is terminated after year one, it will result in a return on investment of negative 35%. This is largely because the initial start-up costs cannot be fully absorbed in only a year's time.

Year Two

- Benefit: $\$288,858 + \$628,566 = \$917,424$
- Costs: $\$300,000 + \$144,429 + \$314,283 = \$758,712$

$$\frac{\$917,424 - \$758,712}{\$758,712} = 20.92\%$$

The return on investment calculation after year two yields different results. Because the initial start-up costs are fully absorbed, the clinic is able to produce a favorable return.

Year Three

- Benefit: $\$288,858 + \$628,566 + \$729,429 = \$1,646,853$
- Costs: $\$300,000 + \$144,429 + \$314,283 + \$364,714 = \$1,123,426$

$$\frac{\$1,646,853 - \$1,123,426}{\$1,123,426} = 46.59\%$$

As is evident from the calculations for years one, two, and three, the return on investment continues to increase, and it will continue to increase as long as the clinic remains profitable.

Conclusion

As illustrated throughout this chapter, there are a number of factors to consider in evaluating the potential return on investment for retail initiatives. Understanding the basics and using a structured approach for the analysis will ensure that the information is sufficient to make well-informed decisions.

Every investment opportunity is different, and the analysis necessary for one could vary significantly from another. For this reason, the return on investment will not be the same for each opportunity, and at times it could indicate a negative return. At the end of the day, it is essential to perform some sort of analysis, consider the ROI and associated risks, and make an educated decision about whether the investment chosen provides a desired level of return at a reasonable level of risk.

Implementation strategies for a smooth transition

by Keith Solinsky

The appropriate implementation of any new service line within an existing medical practice requires the organization to work through certain challenges, and depending on the specific retail setting being entertained, the practice will have a lot of changes to consider. First and foremost, they must have the resources (time, acumen, personnel, and finances) to develop this new retail line adequately.

Time

It is extremely common for those starting a new business or business line to underestimate the time required to plan, construct, and implement it. Planning—including writing a business plan and/or pro forma and, if necessary, getting financing—can be time consuming. In addition, if acquisition of new equipment is involved, it is important to allow for the manufacturers' lead time in shipping such equipment and to understand that delays with the architectural process and construction permits during the planning phase are highly likely.

Often within a physician organization, there is also a struggle to reach a consensus on key issues related to equipment selection, design, and financing, greatly increasing the time for a project to reach completion. If a hospital is involved in the venture, particularly as a joint venture partner, it is important to anticipate that their normal bureaucracy will add significant time to the overall process.

Finally, consider whether the practice partners and your existing staff have the time necessary to manage the development phase of this new business. If your administrator or manager is already working at capacity, everyone involved will need to understand the potential negative impact this may have on current day-to-day operations.

Acumen

Acumen means knowledge. Just because your administrator or manager is quite adept at directing the operations of your practice, this doesn't mean he or she will have the skill set to develop a retail venture. The "Peter Principle"¹ is not uncommon in these situations, and thus some physician assistance may be needed.

Consider hiring an outside consultant to assist with this kind of project. Consultants oftentimes provide the needed experience and expertise to more adeptly plan and develop these kinds of retail ventures. But we would add the following caveat as well: Consultants will sometimes try to build you the Notre Dame when you only need a nice, small church.

For example, we are familiar with a situation where a consultant was hired to build an imaging center for a practice and hospital joint venture. Upon our arrival into the situation, the construction project was significantly over budget and behind schedule. The reason: The consultant was overbuilding the center.

First, he didn't look at the demographics of the area where the center was being constructed. The community was working class, but the imaging center interior design was being done by a high-end firm from Los Angeles. Not only was their plan unattractive, it did not make financial sense. The surfaces they were choosing were too extreme and not durable.

The patients from this community would have taken offense to such a clinic and truthfully would not have taken care of it. Consequently, we went in and completely changed the interior design, keeping a similar look but using less expensive, more durable materials, which saved the entity approximately \$500,000. The board, hospital administration, physicians, and community were very proud of the end result.

Personnel

When opening a retail service line, one of the most important components to success is having the right personnel. The best practices provide something different than the competition, and at those facilities, there is little doubt that the customer is always right.

Consider this: Nordstrom is a household name in its home city of Seattle. It developed this reputation in part through its total commitment to customer satisfaction. For example, patrons have been able to return items to Nordstrom, even items that were not originally purchased there, and they were accepted with no questions asked. If a store does not have a particular size of a garment, the company will have it shipped directly to a customer's home at no charge. It is this kind of service that epitomizes the Nordstrom brand.

This level of service can be quite successfully introduced into a retail clinic. Going so far as to hire a consultant to provide customer service training may be necessary. This training should include role playing as patients. If you have not or cannot walk in the shoes of the patient, then it is difficult to empathize and provide the level of customer service patients expect. The goal should be to exceed these expectations for customer service.

It all starts with finding and hiring the correct personnel and giving them the tools to thrive. Where do you find this kind of staff? First, it is important to look outside the box. Hiring staff members with clinic experience would be ideal; however, they may come into the organization with preconceived ideas about providing customer service in a medical setting. It may be advantageous to hire individuals who have worked in a service-oriented industry (e.g., waitresses, high-end retail clerks, etc.), as they often have a better understanding of how to provide top-notch customer service. They can be taught the specifics of working in a medical practice and will incorporate the Nordstrom view of service into your office environment more quickly.

Additionally, it is important to interview candidates appropriately for the practice. Make sure that the individuals interviewed have a consistent work history, and have not had different employers every six months. Start the interview process by asking simple, generic questions to allow the interviewee a chance to relax. Ultimately, it is recommended that you ask questions that delve into the candidate's personality and work habits. Ask open-ended questions that get the person talking freely. Ask questions related to working relationships and how they handle conflict. Don't be afraid to probe.

Another issue to consider when hiring personnel is that you should avoid nepotism. Although it may sound like a good idea, hiring family and friends of current employees often creates problems. Also, check professional references, not personal ones. It is important to call the employer directly and ask to speak to the supervisor, or at least the human resource department.

Unfortunately, due to fears of potential lawsuits, many employers will divulge little, if anything, about prior employees. However, one key issue that they will often divulge is whether the person is eligible for rehire. If the prior employer says no, then this should tell you all you need to know. You may want not want to hire this person. It is important to trust your instincts in this process. If you have any questions regarding an individual and his or her fit with your office culture, do not hire them. Your instincts are right far more often than they are wrong.

Finances

Developing a retail service line will take cash, and it is important for a practice to determine how it intends to acquire the funds. In Chapter 4, we discussed the financial feasibility process, and you should refer to that as we discuss the necessary financial strategies for a retail clinic. If you have a strong pro forma, then having the practice secure the necessary financing from a financial institution makes sense. However, all the partners of the new venture need to be prepared to personally guarantee any debt incurred.

Other considerations

Questions a physician owner and entrepreneur should ask before beginning a retail enterprise include:

- Will the service require the practice to add an additional provider(s)?
If so, what level of provider?
- Does the service require additional physicians, or can a mid-level provider be used?
- Should the practice add the service to its existing entity?
- What are the advantages/disadvantages of creating a separate legal entity?
- Does the practice have enough resources (i.e., personnel, space, and money) to adequately embark on a retail venture?

There are many retail services of which private medical practices can take advantage. Some will require only limited clinical and non-clinical staff, while

others may require additional providers. However, in most instances, the providers can be mid-levels (e.g., physician assistants or nurse practitioners). This is especially true when the retail venture is a walk-in clinic or urgent care facility located within a retail establishment.

Retail services such as optical shops, common to ophthalmology practices, and hearing aid sales and service, common in otolaryngology, will require additional specialized personnel (an optometrist and possibly an audiologist).

Buy-in

Getting a consensus among staff members is very important when developing a retail service line. All of the partners must understand and be willing to accept the financial responsibility of the venture, but the staff also must see it as an exciting opportunity.

To ensure everyone's commitment to the project, get as many personnel as possible involved in the planning process to make them feel like their opinion matters and that they are a vital part of the process. In addition, the partners need to see good cost data that clearly shows that the venture makes financial sense. At that point, they will usually be behind the project 100%.

Finally, it is important to let everyone within the practice know how their patients will benefit and how they personally will benefit from the retail service. Even if it is simply convenience for everyone, that may be enough.

Do you need a separate legal entity?

When starting a new venture such as a retail clinic, the decision regarding whether to include it under an existing professional practice is not always clear. Some practices may choose to add the retail service to their current operations, and others may choose to form a separate legal entity. The following are some issues that need to be considered:

Ownership

1. Will all the partners of the professional practice be partners in the new retail venture?
2. Ownership also means potential personal liability. If debt needs guarantors (equipment leases, construction loans, property leases, etc.), then most lenders will require each partner to guarantee the entire debt. Are all the partners able and willing to accept that responsibility?
3. Will there be any outside investors or partners?

If the answers to questions one and two are no and the answer to question three is yes, separate legal entity and council will be required. If the answers to questions one and two are yes, and the answer is no to question three, remember that there are no regulations that require a separate legal entity.

Additionally, if the retail clinic is part of the professional practice, then all future partners will automatically become partners in the retail clinic. Some practices consider this a good philosophy because they feel that all partners must be equally invested in the long-term success of all of their organizations.

However, in some cases, they may not assume the same personal financial responsibility (debt guarantees) as the original partners.

Typically, there are no requirements by financial institutions for new partners to guarantee any debt previously incurred by the practice. Is it fair for new partners to have equal ownership as original partners yet less financial liability? That is a question that will need to be decided upon during discussions related to the appropriate legal structure of any new ancillary ventures.

Advantage of adding a retail clinic under your professional practice

By adding a retail clinic under your professional practice, there is good potential for minimizing efforts in the credentialing of the clinic as well as payer contracting. Under some circumstances, the professional practice may not be required to perform any additional credentialing or contracting, and the service will be covered under existing agreements.

Review all contracts to ensure that the practice will receive adequate and appropriate reimbursement for the new services. Also remember that the providers and billing and collections personnel must be trained in the appropriate coding and documentation of this new service.

Regulatory considerations

Although unlikely, specific state regulations (Certificates of Need, or CON) may also affect the decision regarding whether to establish a separate legal entity for a retail clinic. Not all states have CON requirements. However, in those that do, these regulations need to be reviewed for their potential effects

regarding the venture. Remember too, that in some states, the retail service may require a CON only if the service is being provided by a new legal entity, and an existing professional practice may not have the same requirement.

Conclusion

Successful implementations of retail clinics require time, business acumen, personnel, and financial resources. If those are at your disposal, then there is no logical reason why your organization cannot open a retail service line in an organized, systematic manner. The process will be stressful no matter what, but the amount of stress can be reduced with careful planning and implementation.

Endnotes

1. "The Peter Principle": The theory that employees within an organization will advance to their highest level of competence and then be promoted to, and remain at a level at which they are incompetent. *The American Heritage® Dictionary of the English Language: Fourth Edition*. 2000. Online at www.bartleby.com/61/4/p0220400.html. Accessed 10/22/2007.

Potential obstacles and pitfalls with the new addition

by Keith Solinsky

There are many obstacles and pitfalls when implementing a retail business. These can include anything from unrealistically expecting your clinic to be open and ready to see patients in 30 to 60 days to not knowing what the patient population expects from you as a retail clinic. The following are four major obstacles to successfully implementing any retail venture.

Lack of support

A four-man executive committee of a 10-partner specialty practice purchased a CT and MRI due to persistent lobbying of the group's senior physician. However, one of the executive committee members wasn't in support of the purchase, and neither were the remaining partners. In addition, the practice administrator did not have the financial acumen to prepare a detailed pro forma estimating the revenue, expenses, profit/loss, or return on investment for this equipment. After one year of operations, the practice was legally obligated to

pay full lease payments (deferring the first six months of payments), in addition to the approximately \$20,000 per month for equipment maintenance costs.

The practice was performing only four exams each per day on both the MRI and CT. A review of the referrals to these internal imaging services revealed that only three of the 10 partners were regularly referring patients. Consequently, the practice, with approximately \$80,000 in equipment expense each month, not to mention the cost for the staff (salaries and benefits) dedicated full-time to these modalities, was only generating approximately \$20,000 in revenue each month.

This is an example of a practice that made a significant financial decision without the support of the entire practice. Ultimately, all of the providers are financially responsible for the debt associated with practice equipment, so it is in every partner's best interest to speak up if they have concerns (ultimately "put up or shut up" if they don't express any objections to such a venture), and to make sure that they are using the new services their practice is providing.

Contracting issues encourage cash only policies

Many practices make one common mistake when they add service lines to their organization: They assume that the commercial insurance payers will automatically reimburse them for these services. However, as the healthcare

industry continues to struggle with overutilization of services, commercial payers are becoming more strict about whom they contract with to provide specific services. Consequently, it is highly recommended that prior to going down the path of setting up additional service lines, organizations get confirmation—in writing if at all possible—that their top payers will reimburse them for these services.

These payer difficulties are encouraging more and more healthcare providers to establish a “cash only” policy. Providers have become frustrated with the many issues related to accepting assignment on behalf of patients for Medicare and all other commercial payers. Therefore, they are now requiring patients to pay up-front for services (cash or charge), and then file for their own insurance reimbursement, as was common in the 1970s and 1980s.

In addition, some physicians are setting up boutique or concierge practices where patients are paying a flat monthly fee for increased appointment times, more in-depth preventative care, and better customer service. Again, insurance is not accepted for these services. Common fees go from \$200 per month per person and up. Physicians who own these practices often have fewer patients, which allows them to increase their level of service and improve the quality of their personal lives.

Competition

When considering venturing into the world of retail medicine, it is extremely important to consider your competition. It is difficult for a private group to compete against the likes of Wal-Mart, CVS, and Walgreen. These retail giants have the luxury of tremendous foot traffic and name recognition, and they will use those assets to their competitive advantage.

In the urgent care marketplace, competition can be defined as after hours services provided by primary care practices, emergency rooms at your neighborhood hospitals, and other urgent care clinics.

Any organization that sees your new retail venture as competition may develop a new attitude about your organization. In some instances, practices that previously referred patients to you may choose to no longer do so for fear that they will not get their patients back. Additionally, your local hospitals may make life more difficult for your physicians if they see your retail venture as direct competition.

Marketing

Today, patients have greater expectations from their healthcare providers. They want better appointment availability, shorter wait times, and exceptional customer service from their doctor's office. And they expect the best quality services, especially in the retail arena.

How should you market retail services? First, determine what sets your retail service or clinic apart. Do you provide any guarantees for your patients? For example, you could provide same-day appointments or the convenience of having laboratory and radiology services on-site.

Second, it is important for physicians to market the services they provide to other physicians in the community. This can be accomplished by personally visiting their offices, sending out brochures to colleagues' offices, or making a presentation at the local hospital.

If you have a retail or ancillary service that could benefit from referrals from retail clinics, market to them as well. For example, if you own an imaging center that offers evening hours and there is an evening-hours retail clinic at the Walgreen on the corner, your center could benefit by visiting them and letting them know how you can assist them with their patients. In this type of relationship, everyone benefits, both the clinics and the patients.

Finally, traditional marketing methods of print advertising, radio spots, television commercials, and direct mail may be beneficial, depending on the services. As these methods are often more costly, it is important to understand the local marketplace to determine whether these methods will provide a financial benefit.

Ultimately, failure to understand the importance of implementing a marketing plan may prove detrimental to the long-term success of a retail service (see the next chapter for more about marketing).

Unrealistic financial projections

Six months after starting a retail service line, a group of physician partners became concerned when their cash flow decreased dramatically. After asking some questions and doing some detailed financial analysis, it was determined that the losses were due to their new retail service line.

Upon hearing this, the partners started inquiring about the due diligence performed by their administrator. The administrator could not locate the financial assessment and pro forma performed prior to developing the business. Ultimately, it was determined that the financial projections were never completed.

It is very important for every practice to prepare a pro forma or budget for every new service line they undertake. Each has specific intricacies that must be evaluated prior to investing any cash. In addition, if the practice is expecting the insurance payers to reimburse for the service, the administration needs to verify that the payer will contract with them. This is not an unreasonable expectation from any board, and it is actually their responsibility to ensure that this kind of due diligence is completed.

An administrator was hired to manage a hospital and professional physician practice joint venture retail service line. Upon his arrival, he reviewed the financial pro forma that was prepared by the hospital and a consultant retained by the professional physician practice.

Immediately, the administrator became concerned. The financial pro forma was not realistic at all. The expected growth and profit was quite large, and based on these expectations, the administrator knew a difficult task was at hand. Unfortunately, although the administrator had voiced his concerns from the outset, the pro forma had been approved by the hospital board, so there was no changing it.

Ultimately, after one and a half years of diligently working to meet the pro forma projections, the administrator decided that it was in everyone's best interest if he resigned. The joint venture found someone else who could "think out of the box." One year later and now onto its third administrator, the joint venture is still not meeting the projections in the original pro forma, and the board is unhappy.

Ultimately, every person who is asked to manage to these expectations is being set up to fail, and the turnover in management makes the problem that more difficult. Pro formas are goals, but making them realistic is key to the success of any venture, particularly retail ventures. Personnel want to feel good about coming to work every day; having unattainable goals is very demoralizing and will encourage staff members to stop trying.

It is also important not to make the pro forma too easy to attain. In those circumstances, individuals become complacent and start to feel entitled, especially if bonuses are being paid for reaching the goals set by the pro forma. The ideal pro forma is attainable, but only if your staff stretches a bit.

Detailed financial pro formas, projections, and/or budgets are a critical part of the development process for any practice or service line. It is imperative that these are completed in advance and are approved by the necessary governing body to ensure that all parties involved in the ownership/management of the entity are on the same page.

Conclusion

Pitfalls are inevitable with any new business venture. When considering adding a retail clinic or a retail service line to your practice, watch out for the issues discussed in this chapter. Each of these would be deemed significant if a practice fell into it, so beware.

Leveraging transparency and marketing to promote new service lines

by Mark Reiboldt

Now that we have discussed the macro-level move toward retail in healthcare, strategies for measuring ROI, and how to follow the new market trends, we should look at some specific methods that providers can use to make these shifts work to their own advantage.

Thinking outside the box

Let's start simple before we dive too deep into various ideas and strategies and look again at the big picture to find ways that providers can be more competitive in a changing marketplace.

The first step is to change the way that decision-makers in practices think. Consider a simple case study:

Dr. Smith has recently left his practice in the Midwest U.S. and will be starting a new internal medicine practice with three other doctors. He

and his partners have gone through all of the legal and administrative processes to get to a point where they can launch a practice. They have leased office space, hired clinical and administrative personnel, and finalized all tax and legal paperwork that says they can function as a business.

The doctors have also had help in developing a compensation plan and selecting and implementing an IT system, have developed a proper business plan with pro forma projections, and have completed the appropriate operational measures in order to make sure that their new business opens and operates professionally.

The grand opening is approaching and everything is ready to go, but one important thing is missing: patients.

In today's competitive environment, a practice must initiate more aggressive marketing strategies in order to reach consumers and get them to purchase the services offered.

Practices have a more direct line of communication from provider to consumer in today's marketplace, and consumers have more choices in the services they use. Therefore, a practice's advertisement can have a much greater impact on patients who would have otherwise settled for something else.

One of the biggest components of the new retail-based healthcare system is the idea of transparency. In any other industry, prices drive demand and demand

drives supply. As a result, prices fluctuate based on the market dynamics. In healthcare, however, most people cannot tell you what it truly costs for a checkup with their primary care physician. Moreover, people in need of highly specialized healthcare services usually have no clue what the costs are for a surgery (unless they look at the statement from the insurance provider, which most do not do).

In addition to not knowing what their healthcare services cost, many people also do not know even what their portion or contribution to the payment is, meaning that they do not know how much is being deducted from their paycheck to cover health insurance through an employer.

In order for people to care about where they get their healthcare services, they must understand the economic variables behind the process. The trend, then, is shifting toward more transparency in healthcare prices. Think back to the hypothetical situation mentioned previously. One of the ways that the new practice can attract patients is by promoting the economic benefits of their services as opposed to the practice down the street. Transparency also means that more quality indicators are available for consideration, so promoting better quality services can also help drive patients their way.

Just five to ten years ago, if a practice advertised that its prices were lower than others, it would make no difference to the consumer. In fact, it could be construed negatively because many consumers would associate lower prices with lower quality.

However, in today's evolving market, when a consumer sees that they can pay a lower price for their healthcare services and still receive a high quality of care, they are much more inclined to consider this new option as an alternative to their current provider. This especially holds true when the consumer has children in need of regular care, which can be extremely costly for the family.

Usage of retail health clinics

A *Wall Street Journal*/Harris Interactive poll conducted in March 2007 examined some of the numbers related to the usage of retail health clinics, as well as the concerns associated with these new provider settings. According to the poll, 5% of the 2,441 adults in the U.S. who responded said that they or someone in their immediate family had used a retail health clinic, such as the ones that are opening in retail and pharmacy chains throughout the country (CVS, Costco, Target, etc.).

In the same poll, 42% said "health insurance covered all or a portion of the costs" associated with their visit to a retail health clinic, while 36% said that insurance did not cover any of the costs. Approximately 22% responded that they did not have health insurance at the time of their visit(s).

Overall, the usage of these clinics is still relatively low, but when you consider that retail healthcare is still in its infancy, it is not surprising to see slower adoption rates. However, the fact that 42% of those polled in this study said that insurance covered all or part of the costs associated with their visit to

a retail health clinic is a sign that private payers are embracing the shift to a more retail-centered approach to healthcare delivery.

Another key trend is that 22% of those polled said that they did not have any health insurance—therefore, we could potentially conclude that a retail clinic was a viable and affordable alternative to traditional healthcare services for the uninsured.

Quality in retail health clinics

Another key component of retail healthcare is the quality of the services received. A number of people assume that health services in a retail setting, such as a clinic in a drug or grocery store, will innately be of a lower quality. Some people may assume that the providers working in those settings are not as good as others working in a traditional setting, or that since many of the providers staffing these facilities are physician extenders, such as nurse practitioners or physician assistants, they are sacrificing quality for price or convenience.

The *Wall Street Journal*/Harris Interactive healthcare poll also addressed some of these quality concerns. There was both positive and negative feedback from questions related to the quality of care received in a retail health clinic.

In terms of quality, 64% said “they would be worried about the qualifications of the staff at a health clinic not run by medical doctors.” Although this is a significant percentage, this number is down from 71% in the previous version of this poll, conducted in October 2005. Further, 71% of those polled

in the 2007 version said that “they would be worried that serious medical problems might not be accurately diagnosed,” which was down from 75% in the 2005 poll.

On the other end of the spectrum, 83% said that “they have been satisfied with the convenience provided by such clinics” and “90% are satisfied with the quality of care.” Further, 80% said that they were “satisfied with the cost, which typically ranges from \$25 to \$60 per visit.”²

These positive responses show that a significant percentage of those polled in the study were confident in the quality of care they received from retail health clinics. The majority of the negative responses were geared toward the possibility of retail clinics not being staffed or monitored by physicians, as well as the possibility that these types of clinics would have some inadequacies in terms of diagnosing major illnesses. This is not surprising, since retail-based clinics, such as the ones being opened in grocery and pharmacy stores, are not meant for major illness diagnostics.

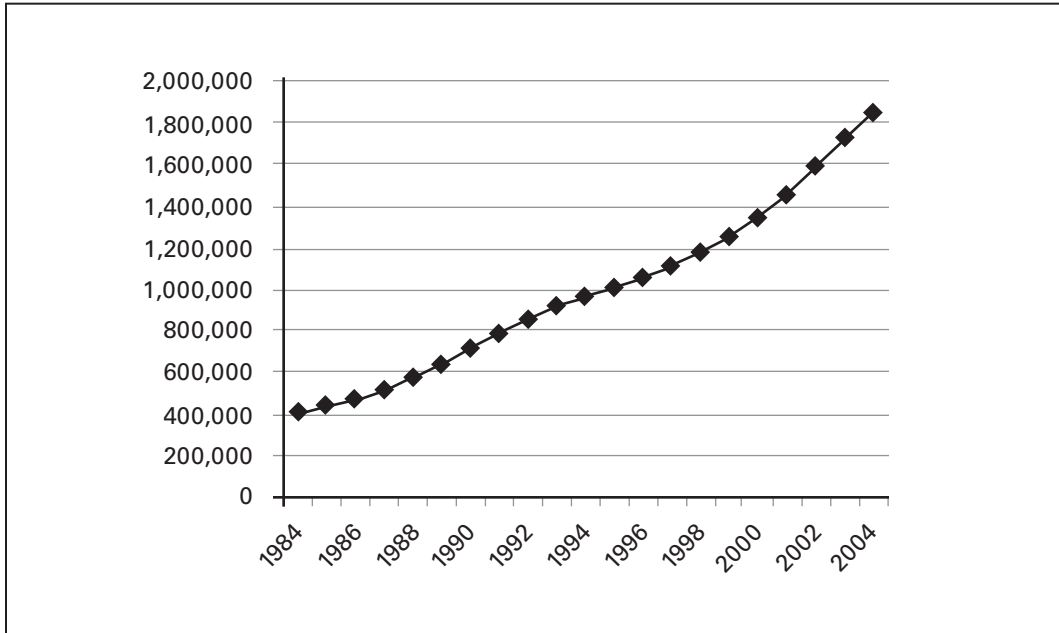
But this poll could also indicate a desire by consumers to access care for more serious conditions with the same ease that they encounter with retail health clinics, but from qualified and well-reviewed physicians. This is an important idea to keep in mind.

Economic trends in healthcare

In understanding some of the micro-level strategies affecting and changing the nation's healthcare delivery model on a daily basis, it is also helpful to look at some of the larger economic trends that have affected the evolution of the healthcare industry over the previous two decades.

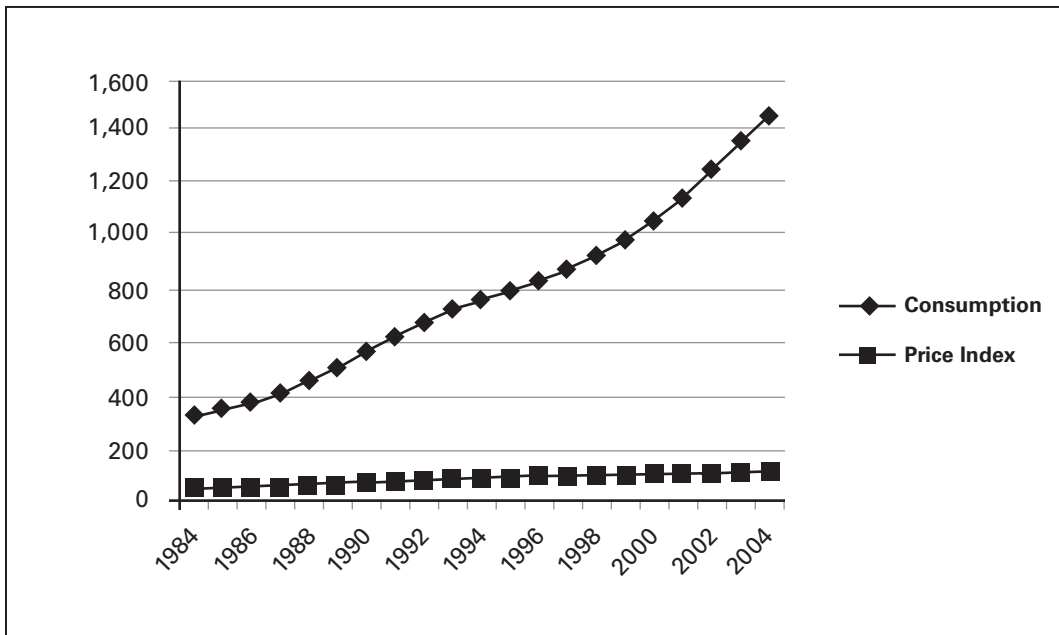
The healthcare industry has experienced more growth from an economic perspective in the past five years than it has in some 10-year spans over the past half century. Healthcare spending has increased dramatically, and has done so at rates higher than income increases, as shown in Figure 7.1.

FIGURE 7.1 National healthcare expenditures for 1984 to 2005



In 2005, people were spending more money on services from their physician than the amount spent on hospital services. This trend is positive because hospital services are typically geared toward more serious healthcare needs. However, even though spending on physician services has increased, many physicians are still finding it difficult to remain profitable, regardless of these spending increases and increases in the consumption of healthcare services. (See Figure 7.2.)

FIGURE 7.2 Comparison of personal consumption expenditures for healthcare services and the Healthcare Price Index from 1984 to 2005



Furthermore, the price of healthcare services has achieved relatively slow growth over the past 20 years, despite spending increases. Population numbers for the most part have steadily increased since 1984, and income has increased as well, but Americans still are finding it more and more difficult to navigate the economics of the healthcare system.

From the data and the general trends occurring in the marketplace, we can make a number of conclusions, but the bottom line is that the trends related to the healthcare industry show two overall themes:

1. Patients are finding it more difficult to pay for healthcare services.
2. Providers are less likely to remain profitable while providing their services under the traditional model.

These trends have ultimately driven the ideas of consumerism and retail strategies into the realm of healthcare. The market is playing a more active role in the healthcare delivery system today than ever before, but as seen by some of the adoption rates discussed earlier, it is happening at a relatively slow pace, and there are still a number of barriers that must be negotiated before retail healthcare moves into the mainstream.

Now that we have established that retail healthcare is not a fad, we must now look at some of the specific ways that this trend can shift market dynamics, from how the single physician practice will be affected by a retail-centered healthcare delivery system to how they can thrive in this changing environment.

Marketing

Providers are using modern marketing strategies developed and proven in other industries that are aimed at increasing market share and limiting competition. As practices begin to sell services and try to attract general consumers rather than health plans, marketing is beginning to evolve within the health-care industry.

One key marketing strategy that healthcare providers have embraced is the idea of selling and promoting an image to the general population. The days of a doctor in a lab coat being the primary image of a medical practice is long gone. Furthermore, a doctor's image goes well beyond his or her peers. In today's marketplace, practices and physicians are building a reputation that promotes their experience, expertise, and specialty to the general public.

Instead of authoring studies and research in industry trade journals, physicians are reaching out to the mainstream media community in order to publicize their expertise and create awareness of their services amongst consumers. Practices are building images that communicate a variety of messages to the general public. In some areas, these messages may be geared toward community-based quality health services, whereas in other specialties the message may simply be focused on price and convenience.

Oftentimes in today's marketplace, many consumers do not go to a doctor in response to a healthcare need but instead seek out specialty services, and pro-

viders of these services are competing with a variety of marketing strategies that combine communications, image, and price point.

Introducing the Seven P's

The target market for physicians has expanded, but the supply of services within the marketplace has also increased. The Four P's of marketing (Product, Pricing, Promotion, and Place), detailed in Chapter 3, are becoming more prominent as providers work to remain competitive within the marketplace. However, as the healthcare industry in general continues to evolve, the Seven P's (adding People, Process, and Physical Evidence) are also beginning to play key roles within this changing environment.

People are becoming vital to the healthcare marketing process in a way that is different from any other industry. People, or the consumers, are purchasing healthcare directly from the provider of services, whereas in the past many of the Four P's were negotiated or managed via a third party. Providers must embrace this.

Process is important because providers are beginning to realize that economics play a role in how they provide healthcare services. For example, Medicare may force providers to limit their time with patients and even limit the amount of new Medicare patients altogether, as a result of declining reimbursement under an inadequate system.

Physical evidence is more applicable to healthcare than perhaps any other industry, yet the realization of this is still very limited. A good example is the data mentioned in the *Wall Street Journal*/Harris Interactive poll discussed earlier in this chapter. Only 5% of the sample in that study have embraced retail healthcare, even though an overwhelming majority of those who have received care in a retail setting were convinced that the quality of care received was good for minor illnesses.

The issue of physical evidence in a marketing sense is really related to the idea of risk. When people purchase gasoline, they are not overly concerned with the details related to how the gasoline was refined—that purchase decision is typically based almost entirely on economics. However, in healthcare, consumers are going to have to be convinced that what they are purchasing is indeed high quality. It is up to a solid marketing plan to assure the consumer on this point, craft an image of openness about outcomes, and push the image of the practice beyond its local community.

Marketing plan and strategic plan overlap

Many marketing strategies fail before they ever get off the ground due to the lack of adequate planning. Businesses are re-evaluating their approach to marketing, realizing that more investment is required on the front-end of planning in order to see the returns on the back-end.

Many managers, administrators, and decision-makers in general think about the strategic planning process and are immediately overwhelmed. The process, however, does not have to be overly complicated. In fact, it is typically more

effective if it can be kept simple. Strategic planning, if approached efficiently, can be the deciding factor in whether a marketing strategy is effective.

In thinking about strategic planning, a decision-maker or a group of decision-makers must first outline their overall goals and objectives for the business, including leadership, financial goals, organization and operations, personnel, message, and the general image and branding of the business. All of these things play a unique and significant role in developing and implementing a marketing strategy, and there is a good chance that these aspects of their organization have evolved and changed over time, just as the marketplace has evolved into a relatively different place.

Soft vs. direct marketing

Two broad categories of marketing typically exist in any program focused on sales, marketing, and/or general business development.

1. **Strategic marketing.** Strategic marketing typically focuses on an organization's place in a given marketplace and how it competes therein. Ultimately, the focus of strategic marketing is to gain a competitive advantage in the marketplace. This is primarily driven by research data in order to make more appropriate decisions about the strategic goals of a marketing plan.
2. **Operational marketing.** Operation marketing relates more the execution of the strategies, which ultimately aim to attract and retain customers by satisfying them and meeting their expectations. This also includes the determination of the marketing mix that we addressed earlier in the discussion about the Seven P's.

There are also two subcategories of marketing that relate to operational marketing from an implementation aspect but that are also driving factors in the strategic component: soft and direct marketing, which play vital roles throughout the entire marketing spectrum.

There are a couple of factors that differentiate direct marketing from soft marketing. Direct marketing is, for the most part, just what its name describes: strategies that are directed toward a target market with the overall goal of gaining customers and, subsequently, market share through sales of a particular product or service. It usually aims to send a business' message directly to the consumer from the provider and is done without the use of intervening media. Additionally, direct marketing attempts to drive marketing success (i.e., sales) that can be correlated to a specific sales initiative.

Direct marketing is the most effective and most common form of marketing that consumers typically see, and it is more conducive to tracking returns on marketing investment. And although the concept of direct marketing seems fairly basic and clear, its presence is still somewhat novel within the healthcare industry.

A different approach that is linked to direct marketing is one commonly referred to as soft marketing. This idea typically employs indirect or subtle marketing strategies that attempt to sell a product or service without promoting it or directly reaching out to the consumer with a "sales" approach.

A good example of soft marketing is that done by Apple. Often Apple computers or other products are used by characters in movies, and not by accident. Apple pays a significant amount of money to get its brand out into the marketplace, and as a result, the company generates unimaginable sales of high-priced products, even in a declining economy.

However, soft marketing pertains to more than just product placement or subliminal advertising. For example, various organizations, such as Fortune 1000 corporations, think tanks, and trade associations, have conducted a significant amount of research to investigate new trends in retail strategies related to healthcare. *The Wall Street Journal* and other major media publications frequently publish stories and research reports that discuss the new trends of a retail-driven healthcare delivery model. Finally, practically every day a major network, local news station, or even national media outlet features stories that communicate the growing trend of retail strategies being implemented in healthcare.

These stories, features, and discussions may not even relate directly to the healthcare retail revolution, but the focus on other trends and developments within the industry may indirectly swing the marketplace, the players, and the key stakeholders therein toward a favorable impression of retail.

Advertising

Advertising, which is similar to marketing, is much more focused. It is a key component of effective marketing in a competitive environment. As new advertising mediums and strategies become available, more and more healthcare provider organizations are embracing these opportunities.

For example, the population of healthcare consumers is aging, meaning that the demand for specific services is increasing. As incomes also increase and technology improves, providers can take advantage of this demand and create advertising that caters to it. Additionally, with advances in advertising, a more targeted approach is possible at a reasonable price.

It is much more common now to see medical practices and even individual physicians advertising on billboards and in the phone book (the two most traditional places for these businesses to advertise), and also in local magazines, the newspaper, and especially on the Internet. In order for a medical practice to compete with the new retail clinics, they are investing the dollars in advertising in locations that will not only help attract new patients but also will act as a customer relationship management tool, helping them retain their patients by exhibiting quality and competitiveness within the marketplace.

Healthcare marketing and the Internet

As previously mentioned, the Internet is a major outlet for advertising. Building, maintaining, and promoting a Web site is one of the most important marketing and business development strategies that a practice can implement, particularly as retail concepts become more mainstream within the healthcare industry. People need health information on almost a daily basis, and the Internet has proven to be the number one resource.

The days of practices marketing themselves through the good words of their existing patients are all but gone. In the old marketplace, people would ask their friends, relatives, and work associates about which physicians were best for different needs. Today, the first stop is typically Google, WebMD, or some other online-based search tool. Even if people do ask for recommendations on providers from friends or family members, their next move will be to get a second opinion or follow-up information from an online resource.

Whether it is general advertising of a practice's Web site through search engine optimization, banner advertisements on third-party Web sites, or resource information banked in a central repository for others to view, the Internet is exponentially decreasing the size of the healthcare marketplace, and all of the barriers to communication and information flow are coming down in the process.

Healthcare businesses are gradually learning to embrace the changes they are facing in this evolving marketplace. For example, building a Web site used to

be something a practice did only if there were some extra marketing dollars left over. Today, a Web site is an essential tool that serves numerous functions for a business. Not only does a Web site publicize the name of the business and promote its services to potential new customers, it can also aid in the drive for efficiency and accessibility, as patients are able to complete new patient forms, questionnaires, and informed consent brochures, which are being made available through downloads.

Some practices are creating secure channels using online tools—such as e-mail, chat groups, and other forms of messaging—to communicate with patients about a number of items, including test results, appointment confirmations and reminders, and even treatment or diagnosis. Although some argue that this could diminish the value of the face-to-face interaction between a provider and patient, most are finding these outlets necessary in order to remain competitive, adjust for efficiency and volume, and boost sales.

Whether it is through online advertising, an enhanced and informative Web site, or secure communication portals, the Internet will prove to be a pivotal component of the healthcare industry's evolution into a more retail-based system.

Utilizing traditional media

Another marketing and advertising strategy that is gaining in popularity and yet is still relatively new in healthcare is the use of media. Again, the technology revolution and the Internet's impact on the marketplace have contributed to new opportunities to use media in advertising.

In the past, media has typically referred to the use of radio, television, or some other form of audio or visual advertisements that often have an unclear penetration rate and subsequently deliver a hard-to-determine ROI. In the current marketplace, it is not uncommon to see television advertisements for retail chains, such as CVS or Wal-Mart, that feature a newly established retail clinic. This is a major selling point for their services.

The differences between CVS or Wal-Mart and a local medical group that offers similar services advertising in this format are the scale, level, and investment that are made in this strategy. Wal-Mart can afford to include its retail health services in its television ad because, for one, it is already advertising the stores using this medium, so it is only natural to advertise a service within their stores that may help draw patients. Second, Wal-Mart is going to receive a much more significant return on its advertising/marketing investment by promoting numerous services and products.

By comparison, a practice may spend a great deal of money to advertise services but may not penetrate its desired market effectively. Wal-Mart will have the dollars to penetrate a marketplace efficiently through repetition and numerous marketing “hits,” whereas a practice that does the same will likely have low return on their investment.

For a practice, then, the key to a marketing plan is to identify where the business’ strengths are, in order to translate marketing efforts into results. After finding the strengths, it’s necessary to analyze the appropriate cost and benefits associated with those strong points, in order to identify the most economically

efficient targets in which to invest the marketing dollars. In other words, businesses must invest their marketing dollars where they are going to be most effective. Trying to compete with major chains that have literally millions (and billions, in some cases) of dollars in resources behind them is neither effective nor efficient for a medical practice.

However, this is not to say that these practices cannot compete. They have a great advantage over some of the major chains, which is what will ultimately allow them to remain competitive. The key, however, is for the providers to sell those benefits to the most effective targets and not worry about competing with the major players.

This does not mean that media cannot be used for marketing healthcare services. Indeed, media can play a very effective role for even the smallest business in a retail-driven healthcare market, and more and more healthcare businesses are using media in their own controlled marketing strategies. For example, many practices are featuring video and/or audio interviews with their providers on their Web sites. The providers discuss key issues of importance to their patients and potential customers. Featuring the videos allows the practice to control the content, monitor the interest, and penetrate a target market of viewership, all without significant cost.

A similar strategy that providers use is publishing video recordings of procedures online (obviously with the appropriate permissions and fulfilling the necessary regulatory requirements). These help to communicate expertise in a

given area, and they illustrate how a procedure works and what it will be like if and when a new patient comes in to see the provider.

Again, there are a number of effective strategies that can be considered and adopted; the key is understanding that the goal of these strategies is to help providers remain competitive and reach their target market, and not necessarily compete with the millions of dollars that others may put against them in a competitive ring.

Conclusion: Response to the changes

Not all providers are thrilled with some of the changes that are occurring in the healthcare landscape, and it is safe to say that many of the key players within the healthcare industry are not the most adept at change.

For example, despite affordability, incentives, and an overwhelming amount of positive ROI and quality-of-care data related to information technology (such as electronic health records [EHR], personal health records [PHR], practice management systems [PMS], pictorial archiving communications systems [PACS], e-prescribing, computerized physician order entry [CPOE], etc.), adoption of such systems remains extremely low. Only a small percentage of the overall marketplace has adopted some form of advanced technology to help them provide better care and make more money.

Of course, there are concerns about privacy and security of data, and some providers are waiting until all of the kinks are ironed out before making an

investment. However, the overriding reason that many providers have not implemented an advanced IT system is that they are not interested in changing the way that they have been practicing medicine.

This same attitude pervades the discussion about a healthcare system that is becoming more retail based. And in many ways, it is almost scary for providers to consider the level of change that they may be forced to accept. Some will brush off the idea of retail-centered marketing as something that is below the high standards and professionalism of the industry—however, economics and the marketplace always have a way of humbling those who resist the trends. Ultimately, when providers start to feel the pain in their pocketbooks, embracing retail strategies will become more appealing.

Recently, an article in *The Wall Street Journal* by Benjamin Brewer, MD, discussed the idea of retail health clinics from the point of view of the doctors and the pressure that they are dealing with as a result of this new market force. Dr. Brewer uses an example of a group of doctors in a small town fighting larger groups that want to install a retail health clinic in drug stores. The doctors claim that these clinics are “cherry-picking the best business [...] Easy and profitable visits for sore throats and sinus infections break up an otherwise grueling day of time-consuming patients ill with diabetes, dementia and heart disease.”³

Frustration relating to an evolving marketplace is inevitable, and the healthcare industry’s approach has typically been to regulate the situation in a man-

ner that limits change or simply to hope that the stakeholders will essentially “take their ball and go home.”

Dr. Brewer goes on to express the opinion that some parties’ efforts to combat retail health clinics constitute a “disservice to uninsured patients who can’t easily access or afford health care.” He also adds, “When all else fails, improve the product.”

This is the attitude that the healthcare industry at large should consider. Ultimately, the marketplace will change the trends; however, ensuring that the trends evolve efficiently will depend on the level of acceptance by key industry stakeholders early on.

I would go a step further than Dr. Brewer and say that the idea of retail-based healthcare is not only about providing affordable access to care for the uninsured, although that is a major advantage of this trend. Affordable and easy access to healthcare should theoretically be available to all consumers, whether they are rich or poor, insured or uninsured, because ultimately that is the duty of the market to provide the services that consumers demand.

If the physicians’ approach to this is to attempt to block it with hostility or to regulate the thing to death, then they will ultimately waste time, energy, and dollars attempting to perform a function that can only end in failure.

This is not to say that all providers must accept these changes happily and willingly, but looking at the issue realistically, if they want to remain competitive,

if they want to become more successful, and if they want to maximize their economic efficiency, they will ultimately have to embrace the evolving marketplace and consider new ways that they can excel and use the market to their advantage.

Endnotes

1. "Most are Satisfied With Care at Retail-based Health Clinics," *Wall Street Journal*/Harris Interactive Healthcare Poll, March 29, 2007. *The Wall Street Journal* (restricted access). Online September 2, 2007.
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Partnering with other groups or hospitals: Taking a lesson from retail

by Max Reiboldt, CPA

As we consider the entire retail initiative within healthcare, it is essential to review the various alternatives for healthcare providers (and possibly even payers) to collaboratively participate in the development and operation of healthcare services in a retail setting.

Types of collaborative structures

The collaborative arrangement between a physician group and a hospital or health system is one of the most prominent in healthcare today. Hospital and physician transactions are undertaken for both entities within the purview of an overall strategy. Hospitals, for example, need physicians to provide the professional services required by law and the community. Physicians, although capable in many instances of completing their services without the use of a hospital, for the most part not only require but also want local hospitals to supplement their practice.

Hospitals have historically provided all inpatient services and most outpatient services, including surgical, diagnostic, therapeutic, and rehabilitation. However, over the past 20 years, physicians have grown much more aggressive in their development of service offerings and now include many of the services that were previously confined to hospitals. In fact, only inpatient services have remained largely untapped by physician groups.

Therefore, hospitals and physicians understand that they are often working in both a collaborative and competitive manner. The concept of affiliation and further collaboration is not only logical but also results in the best quality of care for the patient and in the best financial outcomes. There are many vehicles for affiliation:

- Joint ventures
- Hospital recruitment support
- Networking entities (primarily for managed care contracting) such as PHOs/IPAs
- Gainsharing
- Management services organizations
- Direct employment of physicians (both W-2 and 1099)

In the context of the retail initiative, similar arrangements can be made. For example, a hospital and physicians could be equity holders in a separate legal entity that in turn would own and operate the retail initiative. There could also be a joint venture in which both entities (the hospital and physicians) have separate legal entities that are involved in the specific initiative. Finally,

there could be a management relationship where the hospital (or some other entity) may provide independent management services for the physicians who own the retail initiative. Of course, a similar structure could be effectuated in which both the hospital and physicians are equity owners in a retail initiative that is managed by another party.

Other forms of affiliation

Although hospitals and physicians would be the most obvious affiliation, there are other possibilities. For example, there are several for-profit companies that have been formed to reshape the healthcare landscape through the fast-growing trend of “convenient medical clinics.” These bring low-cost medical services to consumers in a convenient, one-stop-shop setting (akin to a retail mall).

Again, the development of these service lines are through independent, for-profit venture companies, physician groups, health systems, hospitals, and other interested parties (even private investors). Often the retail-oriented venture is founded by entrepreneurs within the retail industry who have information technology experience, and it is structured so that at least one member of the venture within the management structure has a direct connection to retail or a large retail chain business.

Such a paradigm allows for easier development of exclusive partnerships, and often the independent venture member (unlike the local hospital and physicians) has a goal of developing many locations through multiple regions and geographical areas.

The aggressive nature of the for-profit venture firms in such retail initiatives can create challenges for the local/area hospitals and physician groups looking to develop their own retail initiative. That is true not only because these ventures potentially block an affiliation within a retail entity, such as a drug or grocery store with an onsite pharmacy, but also because the hospital and physician entities typically do not have the business plan to expand through multiple locations, regions, etc. Furthermore, they are often unwilling to invest the capital that this would entail.

However, the possibilities for viable affiliations are virtually endless. Clearly, within any structure there must be a professional component that will vary with the makeup of the retail healthcare service offering (i.e., physician, nurse practitioner, etc.), and of course these entities do not have to be owned by healthcare providers at all. Those providers can simply be employed or contracted for the professional services. But keep in mind that entities with professional expertise included in the equity or ownership tend to be more successful over the longer term.

Payers also may be involved in this entire process. As strange as it may sound on the surface, many insurance companies are intrigued by this form of healthcare service and may even be willing to be a part of the venture in some (or all) of these initiatives. Needless to say, this would change the entire paradigm, in that the payer (or at least one of the payers) would also be an equity investor in the retail initiative. Although unusual, this is not as farfetched as it might seem. There is the precedent established in the staff model health maintenance

organizations, in which the third-party payer employs physicians and is also the provider of care. Such initiatives should not be overlooked within the realm of possibility.

At the core of success within initiatives like these are the predictable factors that make any partnership successful: proficient and efficient administrative structure and oversight, high quality of professional care, a physical venue that attracts the targeted customer base, and ultimately, an acceptable return on investment from both a financial and strategic view.

Reasons for affiliation

As we started to discuss in the previous section, the reasons for affiliating in retail initiatives are numerous. It helps to gain competitive advantage, control costs, provide access to capital, and—perhaps the most important reason of all—maintain a high quality of healthcare delivery.

It also positions the investing parties within the targeted customer base for the future, which can be extremely valuable considering that the hospital and physician affiliation often face serious external threats from both new and existing competition. The extent of managed care and lower reimbursement rates from both commercial and governmental payers are also reasons to form such an integrated entity, as is the ability to solidify the areas of services offered and reach out to the patient base. Needless to say, an attitude of partnership—both legally and emotionally—must exist.

In terms of gaining competitive advantage, this depends upon the structure of the joint venture. For example, it is possible that the joint ownership could be between a hospital, a physician group, and an outside investor. Although the outside investor would primarily want a direct and justifiable return on their investment, the hospital and physicians may be willing to accept a lesser return (at least initially) in exchange for the overall competitive advantage of fulfilling the continuum of healthcare delivery through services that they would provide over and above those delivered at the retail setting. Nonetheless, any competitive advantage that can be gained from forming such an affiliated entity (large or not) will serve the needs of those involved, particularly physicians and hospitals.

Be aware that there is some risk when hospitals and specific physicians form an affiliation that excludes certain physicians within the community (even though there is almost always a justifiable reason for them not being involved). In reality, such investments between hospitals and physicians should be only one component of many other strategies relative to integration within any strategic plan. Additionally, a high level of receptivity in the community for both physicians and the local hospital in the retail healthcare delivery initiative is often extremely valuable, if not an imperative, to success.

Expense control is another major reason for considering an affiliated model. In theory, certain forms of centralization and consolidation should result in a net savings of operating expenses. This sounds simple in theory, but it is much more difficult in practice. Nonetheless, it makes more sense to partner in such initiatives rather than compete or go it alone.

Improving quality of care should never be neglected. Most hospitals and physicians genuinely place quality care front and center in these ventures. Moreover, as different forms of reimbursement that depend on quality (including pay for performance) become more and more in vogue, quality will be a key component of the measurement and reimbursement system.

As emphasized earlier in Chapter 3, the appropriate feasibility study and business plans should be completed with an outline and a clear designation of the resources and capital that will be necessary to carry out the venture. Finally, a timeline and responsibility assignments for implementation should be also completed. Ask the following prior to the establishment of the joint venture or jointly owned entity:

1. What is the best organizational model or form for structuring the joint relationships?
2. What is the most effective way to work through the changing relationships between the venturers (assuming that they have done little, if any, previous joint venturing together)?
3. What capital should be invested—both now and in the future—and in what areas?
4. What will be the actual ownership/equity structure?
5. How does the retail joint venture effort influence the work that is currently being provided by those investors within the service area/community? In other words, how much potential dilution would result?
6. How are the investors to be compensated (through wages, earnings, distributed earnings, or both)?

7. How is the leadership and governance organized and carried out?
8. How is the corporate “culture” to be developed and defined?
9. What is the organization’s support relative to information technology, internal services, policies and procedures, and overall communications?
10. Are there long-term growth and expansion plans, or is this just an initial venture to which the organization commits only one time and then evaluates later for future expansion?

Informal partnering

Others argue that given the competition, market dilution, capital access, and overall quality of care effectiveness, partnering is the best scenario. Doing so informally (without any legal affiliation) also may be a strategy for the development and success of the retail initiative. The same players as we discussed earlier in this chapter are involved in this scenario. For example, physicians and hospitals could be loosely affiliated in a retail initiative in which the hospital may be the formal and legal owner of the venture, yet they may contract with physician groups to supply the professional services that are required.

Also, as noted earlier, every such retail initiative will need the physician (or some form of healthcare professional) to be involved in the delivery of care. Therefore, in essence these individuals are partners either through a professional services contract or full employment. Moreover, in many retail initiatives, such as the express care clinics that are staffed primarily by non-physician providers, a physician legally must provide clinical oversight to that midlevel provider, usually in the form of medical directorships.

This is yet another way that physicians, hospitals, and private investors can create informal partnerships in those retail initiatives. A medical directorship is established through a contractual agreement wherein the specific responsibilities and clinical guidelines for those functions are laid out for the physician. That individual must be compensated at fair market value, which is best established through an independent analysis (usually performed by an unrelated expert consultant/appraiser).

Regulatory concerns

It goes without saying that all physicians, hospitals, and even private independent investors must be completely in compliance with governmental regulations—both state and federal. This is sometimes overlooked in the enthusiastic approach to developing a retail initiative, under the assumption that it is analogous to other retail ventures without the regulatory ramifications that exist within healthcare. The involvement of competent healthcare attorneys and consultants should be a part of the overall planning and development of the joint retail venture.

Of course, some care should be given to the compensation packages that are provided to the physicians and other professionals within the retail venture. Whenever physicians are compensated—in particular, by a hospital—it must be at fair market value. Whether that is a medical directorship, employment, or contractual payment for professional services, all compensation must be at a value that is deemed to be appropriate within the marketplace for the services and overall functions being provided.

If this is not the case, it is most likely in violation of several regulations. The best approach is to engage an independent appraiser (usually an experienced healthcare consultant who has such expertise) to perform an independent study and conclude the fair market value compensation structure and dollar amounts. Usually those reviews conclude a reasonable range of compensation after a definition of the specific job responsibilities and functions of the applicable professionals.

Needless to say, these arrangements should be made permanent and fully documented in a contractual agreement. If employment (e.g., W-2) is the structure, an employment contract is warranted. If the professional provider is contracted for services, a professional services agreement (PSA) is appropriate. The PSA will document the terms and conditions of the services to be provided and the expected compensation. Both contractual arrangements will also outline other predictable components of the agreement, such as termination, non-compete, duties and responsibilities, etc.

Formal affiliations or partnerships also should be documented, with the form depending upon the legal structure. For example, if a separate legal entity jointly owned by the investors was formed, the typical operating agreement, articles of incorporation, bylaws, etc., would be the governing documents memorializing such relationships.

Affiliation issues and strategies

Regardless of the collaborative structure, there are going to be key issues that must be addressed and ultimately resolved prior to (and in some instances during) the formative stages. These include the following:

- **Due diligence.** This is the “homework” that is needed to form the entity. In fact, it may include the feasibility study used to justify the venture and provide the guidelines for the formation of the jointly owned entity.
- **Investor equities.** If it is a legally formed and jointly owned initiative, the capital and equity investments required will need to be addressed.
- **Compensation.** Staffing and the compensation of those staff, both professional and otherwise, must be firmly outlined, addressed, and agreed upon among the partners.
- **Management and governance.** Certainly the definition of management and governance responsibilities, functions, and parameters, both day-to-day and big picture, must be defined going into the process.
- **Administrative infrastructure.** The partners must agree on the administrative infrastructure (here meaning the healthcare information technology) of the jointly owned entity—not only who will provide this, but how it will be done. Within a retail initiative, this would include the day-to-day accumulation of performance data from a P&L standpoint and would entail billing (especially if the initiative bills to third-party payers) and overall performance considerations. Of course, it could also include some form of electronic health record. Although not

imperative (at least not yet), effective electronic health record clinical charting systems are clearly the wave of the future for both efficiency and maximization of operating results.

- **Ancillary services.** In effect, most retail initiatives could be considered “ancillary” to the core business that healthcare providers give to their customers (i.e., patients). However, within many retail settings additional spin-off services could result, such as diagnostic evaluations and appropriate referrals to other services that the health system or physician investors (and even independent for-profit investors) could provide. Obviously, these must be done within the parameters of regulatory guidelines for such referrals.
- **Marketing strategies.** A clearly defined marketing plan should be created. This will be based on the vision and mission of your organization, as well as your strategic goals.
- **Contracting and reimbursement strategies.** It is likely that any jointly owned retail initiative will have to work with third-party payers. Whether this is the government through Medicare and Medicaid programs or commercial third-party insurance-oriented payers, a strategy must be developed for negotiating the reimbursement. This information should be included as part of the overall business plan development.

There are other areas to consider as the parties collaborate in retail entities, but these areas are by far the most far-reaching and important. The deliverables will include the identification of capabilities, a determination of future opportunities, and the establishment of goals and priorities, all of which ultimately create a path to a desired future outcome.

Conclusion

Working together in the development of any healthcare initiative is becoming more the norm than the exception. Whether it is hospitals and physicians working together; physicians working with other physician groups; physicians and hospitals investing with independent, private for-profit investors; or a combination of all of these players, the retail healthcare initiative is becoming a large part of the integration/collaboration strategy for all three groups.

Strategic alignment in such initiatives makes a lot of sense for economic, quality of care, and operational reasons. As for physicians and hospitals, it is a great ingredient for continuing to improve their overall relationships as co-providers of healthcare within the communities they serve. However, like any other partnership, there is a lot to learn about such collaboration, and the actual affiliated entity must be the result of considerable thought, planning, and, in many instances, a sense of compromise among the investors.

In a commonly owned entity, there is usually a majority owner, although this is not necessary (in other words, they could equally own the entity with certain governance and voting rights addressed in order to not stalemate decisions). All of these things must be considered and evaluated, looking at their merits and the overall realities and practicalities of the situation and relationships.

In the final analysis, working together to develop retail initiatives often will be the best scenario for all the parties involved. Ultimately, this is going to be the most successful model as the retail healthcare entities continue to develop.

Conclusion

by Max Reiboldt, CPA

While exploring the many components of healthcare within a retail setting, and as we conclude this book and summarize key thoughts, it seems that what we are really talking about is making the delivery of healthcare more convenient without sacrificing quality of care to the patient.

Convenience has become a significant part of the delivery of services in the United States. Healthcare, perhaps being the last to follow in this mode, has finally woken up. The consumer wants convenient, one-stop shopping. The success of our retail industry via major shopping centers, malls, and the like are living evidence of this fact. Even the consumer purchasing basic commodities related to his or her health is used to convenience.

For example, anyone can drop by the local drug store on the way home from work to pick up a prescription and over-the-counter medication—and do some shopping for other items—all within a short period of time. No one misses work, there was no long wait in the physician's office, and there

were no real inconvenience to the employer (or for that matter, the provider). Although no-frills seems to be the order of the day, this doesn't mean sacrificing quality.

One of questions we explored in this book is whether this is a fad or whether it is here to stay. We have considered the dynamics that are going on within the healthcare industry today, such as consumer-directed healthcare and the overall concept of delivering service lines in a streamlined and convenient manner. But retail in healthcare still falls within a definite “the jury is out” mentality in America, and it remains to be seen if this method of providing care will continue to grow or reach a certain apex of interest and then wane.

Additionally, the following issues will need to be considered:

- Third-party reimbursement in retail clinic settings
- Medicare in retail clinics
- Retail-based medicine and consumer medicine
- Structure and ownership of the retail clinics
- Retail clinics and healthcare reform
- Legal and regulatory issues in the retail clinic
- Legal liability implications for retailers
- Urgent care vs. retail care
- Leveraging information technology and how retail clinics will be affected by automation

There is a genuine and significant need to develop a business plan that will address these issues. We believe that growth will continue in this area as long as quality and the patient and caregiver contact are maintained.

In an article from HealthLeaders Media Online entitled “Six Innovations to Increase Productivity, Cut Costs, and Extend Coverage,”¹ the author Richard L. Reece, MD, discusses key trends and developments that will improve and transform our health system. These innovations cover technological, managerial, and governmental perspectives, but they also emphasize entrepreneurial and consumer input and involvement.

In the article, Reece cites a pertinent quote from Pankaj Gupta, MD, medical director of an insurance company who, in a May 20, 2007, Letter to the Editor in *The New York Times* wrote, “It’s about time that the sleeping giant (the healthcare industry) wakes up, smells the coffee, and learns from other giants (like the manufacturing industry): process improvement, incentivization, and health competition are drivers of change to control costs in the current healthcare system.”²

Reece goes on in the article to point out what he sees as the six innovations that need to be at the core of our healthcare delivery system going forward. These include the following:

1. Facilitating patient and physician information exchange as a key of productivity
2. Introducing new, more focused, and more productive medical specialties

3. Taking lessons from retailers: hidden in plain sight and DIG (demand-first innovation and growth)
4. Becoming transparent, with bundle services and bundle billing arrangements
5. Having chief information officers
6. Having tax-deductible insurance for everyone to extend coverage with strings attached

Although not all of these innovations are directly related to the retail concept, the retail concept clearly applies many of them. Taking the lessons from retailers is significant and comes down to a mindset about how to do business. Looking at trends and preferences of customers “from the outside in,” as Reece points out, is going to be required. Healthcare providers must adopt a similar approach to succeed financially and competitively.

Any new undertaking like this, or even just a new mindset, requires a lot of risks and even some trial and error before it matures to the level of long-term sustainability. This is characteristic of many of the initiatives that have been tried thus far, and undoubtedly there will continue to be mistakes made as the system is refined. But it is truly exciting to realize that different ideas are being tested that will facilitate our ever-busy lifestyles in America without sacrificing the integrity of our healthcare delivery system in any way.

Physicians, hospitals, private investors, and pharmaceutical companies—no matter who is the actual provider—can all join into this process, be a part of the solution, and share in the economic gain.

Endnotes

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