Retail Health Clinics: Sustain or Close? A Case Study

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The operation of retail health clinics is a challenging endeavor for most healthcare professionals. Typically, healthcare professionals are not trained in retail sales or marketing, have little or no exposure to the critical success factors related to retail sales, and generally have difficulty in adapting what they know about healthcare management to the retail setting. This case study is an opportunity for healthcare practitioners and students to understand the unique characteristics and challenges of operating a unique aspect of primary care in the retail setting.

DECISION DILEMMA

Angela Tobias, the Director of Outpatient Services at Upper Midwest Healthcare System (UMHS) was in a real bind. She had responsibility for five retail health clinics (RHC) as part of her responsibilities and they were not meeting expectations. Within UMHS, each of the RHCs was expected to financially perform independently while contributing to the goals of the health system. They were expected to break-even at eighteen (18) months and then go on to profitability. After three years not one of Angela's RHCs was able to achieve its targeted financial performance and Angela was asked to bring a recommendation to her upper management team to refocus the RHCs, revise the financial expectations, or to close one or more of them.

The RHC were planned and opened during calendar year 2007. Angela's due diligence included conducting market research, building a budget, identifying qualified staff and coordinating lease agreements with a large retail chain prior to the targeted opening dates. The RHCs were each closely associated with its nearest system hospital, although they reported to Angela, not the hospital. Angela knew her job and perhaps her future with UMHS depended upon her successfully resolving the operating performance of the RHCs. She had six months to work with and needed to have a decision recommendation to give to her senior leaders by the end of the calendar year.

INTRODUCTION

The retail health clinic phenomenon began in the early 2000s as an alternative to the more expensive and inherently slower alternatives of hospital emergency rooms, urgent care centers, or physician office visit (Malvey and Fottler 2006). RHCs are identifiable by four characteristics including location within a big box retail store or pharmacy, a limited menu of services that do not require imaging or laboratory services, typical staffing by nurse practitioners, and affordable pricing structures (Bohmer 2007).

In 2005 Angela Tobias and the planning staff at UMHS were investigating ways to accomplish several objectives. Their first priority was to find a way to shift unnecessary visits from the Emergency Departments (ED) of their hospital system to other more appropriate venues. Over 30% of their ED visits were unnecessary because they were neither urgent nor emergent. Those visits could easily be accommodated in alterative outpatient settings. Angela also wanted to find a means to direct more patients to the hospital-based physician practice groups that were developing within the UMHS. Having hired over 80 primary care practitioners over the course of the previous 14 months, the UMHS needed to enhance their patient load and productivity as quickly as possible to reduce the subsidies that were being made. Angela was also accountable for positioning her outpatient services within the continuum of care. She knew that retail health was a fast growing segment of the care continuum and she did not want the system's competitors to gain an advantage over UMHS.

RHCs operated using several different models including leasing space as a tenant of a host retailer, functioning as a department within a larger retailing organization, and being a joint venture partner with a host retailer. Angela found a national retailer that had wanted to expand their RHC presence in every market where they could find a hospital or health system to partner with. The retailer only used the landlord-tenant model, therefore Angela developed lease agreements with five different stores within the chain. The five RHCs began operating within six months of each other in communities across the upper Midwest. The most distant were 160 miles apart.

OPERATING CHALLENGES

The stores were opened with great fanfare and excitement as more convenient and less costly options for care. The business plan that Angela had prepared called for the RHCs to break-even in 18 months, so a slow start-up was not unanticipated. Patient visits ranged from 3 or 4 patients per day to nearly a dozen at the busiest clinic.

The first challenge Angela encountered was staffing the RHCs. She knew that retail health care could not be delivered in the traditional way using a staffing model similar to a typical physician office. She needed to use nurse practitioners (NP) (advanced practice nurses) to staff the RHCs 12 hours per day, seven days per week. Finding sufficient numbers of qualified staff to cover the five RHCs would require 11 to 15 full-time equivalent NPs. Moreover, the NPs were required to be credentialed by the payers before the RHC could bill for and collect for services rendered. Angela was eventually able to find and hire sufficient staff; however in the early months the RHCs were not remaining open on a consistent basis due to variability in staffing and the start dates of the newly acquired staff. Angela worked to get the NPs credentialed but prior to having them officially sanctioned by all payers, several of the RHCs could only accept cash. That experience upset patients and Angela later determined that it hurt the long-term viability of some of her RHCs.

Angela understood that marketing and advertising were essential to a successful health care service. She had not realized that the nuances of retail marketing were just as applicable in the RHC as they were in any other retail setting. Angela was constrained by her lease agreements. She had not understood the significance of many of the terms and conditions of her leases. While her RHCs were co-branded with the retailer, she was unable to do any independent marketing or advertising on site. There would be no outdoor signage, no interior signage, and no special UMHS signage. Angela quickly came to understand that if someone did not know that her clinic was already in the building, they would never think to consider stopping there for health care services.

The location of the RHCs became another challenge for Angela. Four of her five stores were located in mid-sized communities with consistently high foot traffic. One of her RHCs was located in a resort community. The resort community retail foot traffic was consistent with the others; however, Angela quickly found that the propensity of travelers and vacationers to use a RHC was much lower than the more established communities. The location of the RHCs within the stores also varied. Angela had to accept the space that was available at the time she signed her leases. She found that other retail services such as optometry, photography, nail care, and retail health care were normally found near the checkout stands. Two of her RHCs were located in the rear of the store or near the pharmacy. Angela learned too late that the majority of customers enter and exit near the grocery section and may never pass by the RHC or even know that it exists.

From a health system perspective Angela was challenged to demonstrate that the RHCs contributed to corporate strategy and goals. UMHS has a standardized electronic health record (EHR) in each of its hospitals. While Angela was planning the rollout of the RHCs she included the cost for information technology in her planning. Unfortunately she was required to use the EHR that would be used in the hospital-owned physician practices. Like many health system's information technology platforms, the hospitals' EHR system and the physician practice management system EHR would not integrate. Angela was left with good data on the RHC patients but no way to demonstrate downstream revenue generation or identify those patients that ended up with admissions, procedures, or surgeries within UMHS.

Over time, the greatest challenge for Angela was clinic volume. The clinics failed to evolve as quickly as she had hoped and she knew she needed 20 to 23 patients per day at each of her RHCs to break-even. Many of the retail stores where RHCs are located have over one million people pass through their doors every year, yet most of her RHCs couldn't get above 20 patients per day. Moreover, Angela's staff would begin to complain when they reached that magic number of 20 – 23 patients per day since the staffing model was such that one NP and one support staff were all that were authorized to work. In some instances, only the NP was staffed in order to manage costs. Since volume was an indication of consumer awareness and satisfaction, Angela became very concerned that not enough patients were familiar with the RHCs or comfortable seeking care in a retail setting. She pondered how she could increase volume at each of her RHCs and not take business away from her urgent care business or be seen as competitive with the area physician office practices. She needed a way to be collaborative and build her business at the same time.

CRITICAL SUCCESS FACTORS

During Angela's Master's program in Health Care Administration she learned about critical success factors (CSF). She knew that if she could identify the CSFs associated with retail health care, she might be able to leverage those factors to make the RHCs more successful. Through a search of the literature and by interviewing a number of RHC operators, Angela learned that there were a limited number of CSFs that she needed to concentrate on. She found that patient visits, leadership commitment, marketing, store manager support, staffing, and location were the most commonly cited factors as the key determinants of success. Angela added an electronic health record to this list because she knew that without the ability to track patients through the system, she would not be able to demonstrate that her RHCs were making a contribution to the goals of the system. A number of other factors were revealed in her research but Angela determined that many of them were peculiar to a specific site and not generalizable across all of her RHCs.

DEVELOPING A RATIONALE FOR A RECOMMENDATION

Angela thought long and hard about the challenges she faced and the CSFs that she discovered in her research. She decided to develop strategies to employ the CSFs and leverage them against the challenges. If she could create a reasonable plan, one that she herself would likely approve, then she would try to sell

it to the UMHS leadership team in an effort to continue to provide the retail health services to the communities they serve.

Angela knew that the staffing issues were behind her and she had overcome that challenge. She knew that the credentialing issues would remain but if she were able to get all NPs within UMHS credentialed upon hire, then if and when they came over to work in her RHCs she could bill for them immediately. Staffing would not be an issue in the recommendation.

Marketing was a very different issue. Angela had discovered that a couple of the NPs had developed an excellent relationship with the store managers where they worked. They had learned how to leverage that relationship to get concessions on marketing and advertising that were not typically allowed. For example, sandwich board signs appeared on the sidewalks outside the retail stores. Directional signage was used in the parking lots, which of course had the dual benefit of advertising that a RHC did exist within the store. Promotional leaflets paid for by the clinic were used in a dual marketing effort to advertise back to school supplies and sports physicals. Angela knew if she and the other NPs could develop a similar relationship with the other store managers that the two successful NPs had, she could overcome the marketing problems.

Angela wondered if she could affect the location challenge. Certainly the stores were not going to move to different communities with different demographics, however one possibility might be to move the RHC to a different store in a more affluent market. The location within the store was also rather fixed in that the lease agreements were multiple year agreements. Moving them within the store would mean that more appealing space needed to become available which was unlikely. For those RHCs without the prime location within the store, it would continue to be a challenge to drive foot traffic past those clinics.

Angela knew that she would have to demonstrate that her RHCs were making a strategic contribution to UMHS goals. She needed to be able to drive referrals to and from UMHS physician practices. She also needed to be able to provide a relief valve for the EDs within the system and unload unnecessary ED visits to her RHCs. And, she needed to calculate downstream revenue by proving that patients originating in her RHCs were showing up in UMHS hospitals.

MAKING A RECOMMENDATION

Angela was troubled by the fact that among her five RHCs, four were getting close to a break-even and the other one was losing more money than all the rest. She felt with some more time and effort she could get four RHCs to break-even or even make some money. She also knew that without leadership commitment to an investment in IT, there would be no way to identify downstream revenue and prove the benefit to the system of this part of the continuum of care. Angela understood that it was a relationship business; that the NP at each RHC had to have a collaborative relationship with the store manager for that RHC to be successful. There would be no enhanced marketing or advertising without it and she probably couldn't develop the relationship for the NPs. Volume was dependent upon marketing and consumer awareness and developing that awareness was dependent upon the relationship between the provider and the store manager.

Angela was about to make a recommendation to her senior leadership team that she knew had to be in the best interest of UMHS. She wanted to ensure that her own integrity and reputation would not be compromised in making a recommendation. If she were to recommend that the system sustain operations of the RHCs, she knew she would be personally charged to make them successful. Failure to do so could damage her career and any future opportunities within the system. If she recommended that they close, it could be viewed as an indictment of her ability as a manager. Angela understood that there were CSFs that she could not change and there were CSFs that she could leverage to enhance the potential for success. She would soon be in front of her system leadership making a case for the decision.

This case was prepared by the authors and is intended to be used as a basis for class discussion. The views presented here are those of the authors based on their professional judgment and do not necessarily reflect the views of the Journal of Management Policy and Practice.

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