The Consumer-Oriented Ambulatory Network

Converting Patient Preference into Durable System Advantage
Health Care Advisory Board

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Table of Contents

Executive Summary .......................................................................................................................................6

Essay: The New Health Care Consumer ..................................................................................................7

Preserving Share Through Affordability ..................................................................................................21
  #1: Attracting Price-Sensitive Consumers with Competitive Offerings .............................................27

Driving Volumes with On-Demand Access ............................................................................................35
  #2: Generating Direct Revenue from Access Points .............................................................................40
  #3: Converting Initial Visit to Future Revenue .....................................................................................50

Unlocking Value Through Tailored Service ............................................................................................63
  #4: Embracing Premium Payment Models .............................................................................................70
  #5: Accommodating Excess Primary Care Demand .............................................................................79

Appendix ..................................................................................................................................................85
The Health Care Advisory Board has developed a suite of resources and publications to help hospital and health system executives pursue different strategic identities. A selection of relevant publications and webconferences are provided here. All of these resources are available in unlimited quantities through the Health Care Advisory Board membership.

### Available Within the Health Care Advisory Board Membership

#### Resources to Support Any Provider Identity

#### Four Emerging Provider Identities

- **Best-in-Class Acute Care Destination**
  - Indispensable specialist network and a collaborative operating model

- **Consumer-Oriented Ambulatory Network**
  - Integrated ambulatory network with consumer-oriented access points and price points

- **Full-Service Population Health Manager**
  - Assumes delegated risk from payers and/or employers

- **Financially Integrated Delivery System**
  - Assumes full risk by offering health plan to subscribers

#### Resources to Meet Member Needs

- **The Sustainable Acute Care Enterprise**

- **12 'Must-Do' Strategies for Protecting Future Margins**

- **Playbook for Population Health**

- **High-Risk Patient Care Management**

- **How to Win Lives as a Successful Population Health Manager**
  (webconference)

To order copies of these and other Health Care Advisory Board publications, please visit our website: advisory.com/hcab/publications
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Crimson Continuum of Care combines business intelligence technology with dedicated implementation support and best practices to provide credible, severity-adjusted performance profiles to physician and hospital executives. Crimson Continuum of Care enables the hospital-physician collaboration needed to advance quality goals and secure cost savings.

Partner with Physicians in Pursuit of Higher Value Care

Health system leaders must execute against new performance standards and adapt to shrinking Medicare margins. Integral to these efforts is partnership with physicians to pursue higher value care.

Crimson Continuum of Care helps hospital leaders and physicians:
- Secure hospital-physician alignment in performance improvement efforts
- Gain a unified view of cost and quality data across all care settings
- Advance quality by reducing unnecessary practice variation
- Reduce costs to adapt to shrinking Medicare margins

Crimson Continuum of Care supports the hospital-physician alignment needed to identify and tackle opportunities of quality improvement and cost reduction across inpatient, hospital outpatient, and physician clinic care settings.

Crimson Continuum of Care

- **Inpatient**
  - Provide physicians access to visually intuitive, severity-adjusted performance profiles
  - Compare performance on the full range of cost and quality measures and reduce unwarranted variation in practice patterns

- **Outpatient**
  - Gain visibility into ED, observation, and ambulatory surgery performance data
  - Reduce inappropriate utilization in the ED and outpatient surgery; better manage length of stay for observation patients

- **Ambulatory**
  - Track aggregate and physician-level performance on PQRS quality measures for employed physicians
  - Drill down to individual cases to identify gaps in patient care

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The Consumer-Oriented Ambulatory Network

Executive Summary

Study in Brief

To thrive in the consumer-oriented ambulatory market, providers need to develop a coherent ambulatory network that generates growth by meeting three consumer demands: service affordability, on-demand access to care, and a more tailored service approach. This study outlines how to construct and operate a competitive, coordinated, high-performing ambulatory network that captures patient preference and drives sustainable growth.

10 Lessons for Meeting Consumer Demands for Ambulatory Care at a Durable Advantage to the Organization

1. **Consumer preferences for affordable, on-demand, and tailored health care services are driving market innovation.** New pricing models, alternative access points, virtual care channels, and other consumer-friendly developments are disrupting the health care market. Opportunities and threats alike confront providers as they develop consumer-facing strategies.

2. **Traditional growth paradigms have prevented health systems from profitably responding to consumer demands, but new perspectives clarify the opportunity.** Matching service offerings to consumer preferences can appear unwise if viewed in the context of a siloed business line. Savvy hospitals and health systems will understand how consumer preferences can be converted to a broad range of growth opportunities, including market share, premium pricing, and downstream value.

**Preserving Share Through Affordability**

3. **Pricing wars are difficult for hospitals and health systems to avoid but almost impossible for them to win.** A health system’s priority should be to choose its battles carefully and eschew global price cuts where possible. Limited price reductions that the most price-sensitive consumers can self-select into are a more promising option.

**Driving Volumes with On-Demand Access**

4. **Healthy volumes at convenient care access points like retail clinics or urgent care centers depends on directing in-network patients to those sites.** Hospitals and health systems can strengthen volumes by referring patients from overcapacity primary care clinics to convenient care alternatives, and prove value to continuum stakeholders by showing how the convenient care site complements and benefits other providers.

5. **Supporting on-demand care sites with accessible primary care referral points allows those sites to drive long-term patient acquisition efforts.** Retail clinics used as system entry points require nearby primary care support to effectively connect patients with ongoing primary care. Retail clinics lacking primary care support will be ineffective system entry points for new patients.

6. **A hardwired referrals protocol maximizes the likelihood that an initial visit to a convenient care site will be converted into a longer-term relationship.** Patients are won on convenience and timeliness. Providers should establish referrals processes that ensure both in-network and out-of-network patients leave care sites with appointments and next steps in place.

7. **Strategic partnerships can expand the ambulatory network via convenient care sites or virtual care access.** Effective partners will be those offering models that explicitly advance growth goals. Priorities include focusing on in-network referrals, new patient volumes, and revenue sharing.

**Unlocking Value Through Tailored Service**

8. **Concierge care models represent an opportunity to earn additional revenue from patients demanding more customized service.** Charging patients increased rates for tailored service offers current consumers more palatable delivery options and attracts new customers seeking more customized care. If converting an entire panel to concierge care is unpalatable, consider whether a hybrid concierge model could be a viable alternative.

9. **Pay-per-use primary care service offerings, especially virtual care options, are an increasingly promising way to meet patient preference for customized service while driving new revenue.** Such services both benefit patients and improve operations at an overcapacity practice.

10. **Virtual care and other remote transactions expand primary care supply—and hence facilitate the capture of excess demand.** Remote interactions for basic care are the cornerstone of a model in which a significant proportion of ongoing management shifts to virtual channels. In the near term, systems can minimize the disruption to physicians by slotting virtual care into existing downtime. In the longer term, it is necessary to rectify financial disincentives by compensating physicians directly for virtual care delivered or indirectly through panel size-based productivity formulas.
The New Health Care Consumer
Patients Independently Select a Subset of Ambulatory Services

The drumbeat of a consumer movement in health care has been sounding for some time, yet the data continues to indicate that physicians remain hugely influential in care decisions. Why the disconnect? Reconciling these seemingly contradictory phenomena requires recognizing that not all care is chosen in the same fashion. In particular, there are specific services, predominantly in the ambulatory arena, for which patients direct their own health care independently based on their individual preferences and needs. Patients feel particularly confident deciding when and where to access clinical support for lower-acuity illnesses, diagnostics, and moderate clinical issues.

As a result, patients are actively choosing providers that offer these services in a different, and more attractive, way. For these consumer-directed services, standard growth strategies such as physician referrals or in-network status are not as effective. Traditional health care providers are at risk for market share losses if they do not offer services that are competitive in the eyes of the consumer.

Patient Involvement in Accessing Care

<table>
<thead>
<tr>
<th>Least Consumer Involvement</th>
<th>Most Consumer Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma Care</td>
<td>Preventive Care</td>
</tr>
<tr>
<td>Non-elective Complex Care</td>
<td>Moderate-Acuity Illness Care</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>Low-Acuity Illness Care</td>
</tr>
<tr>
<td>Elective Surgery</td>
<td>Imaging Diagnostics</td>
</tr>
<tr>
<td>Low-Acuity Illness Care</td>
<td></td>
</tr>
</tbody>
</table>

Physician input, guidance significantly influences care and access decisions

Patients comfortable directing own care based on personal judgment

Estimated market size for consumer-directed services $235B

Health systems that aspire to capitalize on changing consumer preferences will need to establish a consumer-oriented ambulatory network that not only offers attractive services but also drives growth and clear value to the system.

Such a network will include a variety of convenient, consumer-oriented entry points that seamlessly connect patients to the next level of care. In this ideal network, patients flow bi-directionally from site to site, based on preference and clinical need, followed by clinical records and a unified care plan. A coordinated network of assets seamlessly triages patients needing more advanced services into the appropriate downstream site of care.

Ambulatory sites may not all be independently profitable, but each drives growth by bringing in new patients and offering capacity relief to other ambulatory sites. Patients could access advanced clinical support through a variety of delivery channels—including virtual visits or urgent care sites. In-person visits become the minority access point for non-interventional clinical needs.

### Ambulatory Growth Strategy

- Sites of care are attractive to discerning consumers
- Individual sites are seamlessly connected to cascade patients to next level of care, if needed
- Network evolves as consumer preference changes

**Source:** Health Care Advisory Board interviews and analysis.
Among Many Consumer Demands, Three Are Most Pressing

Consumer preferences are varied and numerous, and it can be difficult for providers to prioritize their improvement efforts. Savvy providers will supplement consumer preference data and other market research with sound business reasoning.

For example, a patient demand is more pressing if patients can discern clear differences between sites that offer it and those that do not. In addition, opportunity lies in areas where there is the potential for rapid improvement. Most important, demands are critical if offering no response exposes health systems to competitive threats.

Based on these criteria, three consumer demands rise to the top: affordability, on-demand access, and tailored service. Tailored service is defined as customized care delivery and service approaches matched to specific patient needs.

Providers must clearly understand the drivers behind each demand and position services in a way that meets these consumer preferences.

Competitive Ambulatory Assets Meet Patient Demands

Top Priorities for Meeting Consumer Preference

<table>
<thead>
<tr>
<th>Affordability</th>
<th>On-Demand Access</th>
<th>Tailored Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reasonable price compared to similar options</td>
<td>• Immediate availability</td>
<td>• Comprehensive visit length</td>
</tr>
<tr>
<td>• Clear pricing to streamline payment</td>
<td>• Broad range of hours open</td>
<td>• Provider interaction matches expectation</td>
</tr>
<tr>
<td>• Guidance on which sites are most affordable</td>
<td>• Rapid completion of service</td>
<td>• Delivery options tailored to specific need</td>
</tr>
</tbody>
</table>
• Geographic proximity to home, work, errands |
As patients become responsible for a greater share of health care spending, they also become more attuned to the prices of the services they consume. In particular, price-sensitive patients who choose high-deductible health plans (HDHP) become more sensitive to price at the point of care.

As a result, patients shop around for lower prices. Patients are sometimes assisted by health plans offering financial incentives to select lower-priced options, such as the Anthem SmartShopper program. Regardless of the root cause of price shopping, price comparisons highlight the often significant differential between health system price and less costly independent providers, frequently putting the health system at a disadvantage. Even more dangerously, cost-sensitive patients are more likely to postpone care or avoid care altogether. These patient behaviors slow growth in the market overall, making it more critical to capture the patients that are accessing service.

Affordability

High-Deductible Plans Reinforce Patient Affordability Concerns

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Purchasers Encouraging Patient Price Sensitivity

High-Deductible Health Plan Enrollment

<table>
<thead>
<tr>
<th>Year</th>
<th>Individuals with Deductible of $1,000 or More</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>7%</td>
</tr>
<tr>
<td>2005</td>
<td>10%</td>
</tr>
<tr>
<td>2010</td>
<td>18%</td>
</tr>
<tr>
<td>2012</td>
<td>25%</td>
</tr>
</tbody>
</table>

Price Sensitivity in Action

- **23%**
  - Consumers report they are postponing care after enrolling in a CDHP

- **17%**
  - Consumers report they are sacrificing care after enrolling in a CDHP

- **3,561**
  - Number of imaging scans Anthem redirected from costlier to less costly sites through the SmartShopper program

Independent Providers Meeting Consumer Preference for On-Demand Service

Retail Clinic Visits
Annual Visits, 2007-2012

Patient Reasons for Visiting Retail Clinics Over Other Sites of Care

As convenience and immediate access become baseline expectations in other service industries, patients increasingly expect these attributes for clinical care. These demands are most pressing for lower acuity conditions that require care immediately yet are not severe enough for the emergency department (i.e., respiratory issues, sore throat).

Retail clinics have capitalized on the on-demand access opportunity. Convenient care sites continue to attract patients, largely because of their quick service, walk-in accessibility, and long hours.

In contrast, the traditional health system offers one truly on-demand site—the emergency department—which is costly and does not provide immediate service for less severe clinical issues.

Now that patients see their on-demand preferences met through convenient care sites, the expectation for health systems to offer competitive sites will only increase.


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When patients do access care within a primary care office, the interaction often does not meet expectations. For complex issues, patients desire longer appointment times with more meaningful clinical explanations. For shorter check-ins, patients prefer a simpler, quicker, even remote interaction, over a time consuming in-person visit. Most providers have not yet established a delivery model that is more tailored to patients, clinical needs, and care delivery preference.

Even when providers believe they offer high-value clinical service, patients disagree. Data indicates a discrepancy between the physician’s perception of the clinical interaction and the patient’s perception. This difference in opinion indicates the current primary care service standard is subpar in terms of meeting patient preferences. Furthermore, it signals a distressing reality—that providers are not aware of the problem and therefore may not be actively transforming operations to capture patient-consumer business.

Tailored Service

### Patients Seeking More Meaningful Clinical Interactions

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Incumbent Challenges Stalling Health System Action

Even when providers are aware of service issues, health systems face meaningful barriers to change.

First, financial incentives reinforce a status quo model of service delivery. Put simply, high prices are the foundation of profitability for services like imaging. Offering affordable options seems to directly undermine system profitability goals.

Second, many systems assess a business’s value and performance in isolation. New endeavors in the ambulatory space, such as retail clinics or urgent care centers, may not look favorable as stand-alone businesses. Furthermore, physicians may perceive new ambulatory access points as threats to their own primary care business rather than opportunities to expand the care delivery footprint.

Lastly, resources may be scarce. If the system is facing a physician shortage or financial pressures, it is difficult to justify incremental improvements of an existing service.
Innovators Positioned to Siphon Off Business

The near-term urgency for health systems to change is the presence of disruptive innovators. Companies and corporations are stepping in to meet consumer demands—and they are doing so at a profit. Health systems that do not respond to changing market conditions are positioned to lose out on a growing revenue stream and risk losses in patient loyalty.

Convenient care clinics continue to explode nationwide as operational expertise has improved and patient comfort with the sites has increased. The volumes that could shift from traditional providers to convenient care sites are significant. Taking a very conservative estimate, between 18% and 27% of primary care business could be delivered by a nurse practitioner (NP), either in a competitor primary care clinic or a convenient care setting such as a retail clinic. Today, 36% of ED visits are for non-urgent needs—needs that could be managed at urgent care or retail sites.

Competitors are capturing market share and consumer mind share at a time when patient loyalty is critical.

Source: CDC/NCHS, “National Ambulatory Medical Care Survey, National Hospital Ambulatory Medical Care Survey,” 2009-2010; “Primary Care Physician Shortages Could be Eliminated Through Use of Teams, Nonphysicians, and Electronic Communication,” Health Affairs, 32, no. 1 (2013); Merchant Medicine, www.merchantmedicine.com; Health Care Advisory Board interviews and analysis.
Competitors Plan to Offer Services Beyond Basic, Low-Acuity Care

Not only are disruptive innovators directly competing for basic primary care and non-urgent emergency department visits, many are preparing to broaden the service scope to include advanced clinical services and care management. Though this will relieve pressure on the current primary care system, health systems not chosen as preferred partners are positioned to lose downstream volumes from new patients as well as more complex downstream services.

BigCo, a pseudonymed corporation, currently offers basic care through traditional retail clinics. In the future, BigCo intends to handle a wide variety of care, including chronic care management, in-house through its NP staff and remote delivery channels. As a provider, BigCo intends to play both hub and spoke roles within health care networks. As a spoke, BigCo will partner with organizations it defines as high value, serving as an integrated part of an ambulatory network. As a primary care hub, BigCo will offer a more comprehensive suite of services directly and refer patients to selected health system partners only when necessary.

Competitors Plan to Offer Services Beyond Basic, Low-Acuity Care

Nontraditional Competitors Expanding Clinical Reach

Partnering as a Primary Care Spoke

- BigCo delivery channels are additional spokes for convenient care
- Providers collaborate to efficiently care manage patients
- Ideal system partner prioritizes high-quality, low-cost care; likely operates under risk contracts, population health management principles

Leading as the Primary Care Hub

- BigCo delivery channels are main source of care
- Selectively refers complex care to provider partners aligned around providing high-quality, low-cost care
- Excludes providers not aligned with population health management principles

Case in Brief: BigCo¹

- Large corporation with >1,000 retail stores
- Extending primary care access through virtual and in-store delivery channels
- Care will be financed through preferred arrangements with payers, packaging profitable products with primary care services and benefit plan savings derived from employee utilization

¹ Pseudonym.
The central challenge for providers is creating and offering a consumer-oriented network that converts patient-consumer preferences into robust, sustainable growth.

Traditional health care providers are typically able to create a consumer-preferred offering. However, too often providers offer consumer-oriented services that do not confer specific advantage to the organization through revenue, new patients, or downstream services.

Other organizations are entrenched in an outdated school of thought, where change seems antagonistic to organizational goals.

Successful growth requires a new perspective. Providers must match each ambulatory asset to a specific and appropriate growth channel—for example, using retail clinics to expand market share or deploying urgent care centers specifically for stand-alone profitability.

Matching assets to growth channels will reinforce the specific value of each network piece, making performance improvements and business decisions clearer.

### The Business Case for Meeting Consumer Demands

#### Converting Patient Preference into Durable Advantage

**Profiting from Catering to Consumer Preferences**

<table>
<thead>
<tr>
<th>Affordability</th>
<th>On-Demand Access</th>
<th>Tailored Service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Old Perspective</strong></td>
<td>Lower price equates to less profit per case, lower profit for services as a whole</td>
<td>Convenient care sites are questionable stand-alone business ventures</td>
</tr>
<tr>
<td><strong>New Perspective</strong></td>
<td>Strategic pricing leads to higher patient utilization, more market share capture</td>
<td>Convenient access points attract new patients and generate profitable downstream referrals</td>
</tr>
</tbody>
</table>

Source: Health Care Advisory Board interviews and analysis.
Successful consumer-oriented ambulatory services meet patient demands for affordability, on-demand access, and tailored service—while driving tangible value to the health system.

The three sections in this study each focus on a specific consumer demand, and include commentary on the specific assets and services most frequently affected by that precise consumer expectation.

Specific growth channels, shown by the circled numbers in the chart, provide guidance on how the health system can succeed by meeting the specific consumer demand.

Throughout, this study is information on how to assess the performance of ambulatory sites, how to make sites more attractive to consumers, and how to drive growth across the network as a coordinated whole.
The Consumer-Oriented Ambulatory Network
Converting Patient Preference into Durable System Advantage

Maintaining Share at Risk

Preserving Share Through Affordability

1. Attracting Price-Sensitive Consumers with Competitive Offerings
   - Target price reductions to price-sensitive consumers
   - Promote price translucency

2. Generating Direct Revenue from Access Points
   - Win consumer preference through competitive site placement
   - Drive visits by directing in-network patients to new site

3. Converting Initial Visit to Future Revenue
   - Support on-demand care sites with accessible referral points
   - Secure next step with hardwired referrals protocol
   - Pursue strategic partnerships to drive value

Growing as a Coordinated Network

Driving Volumes with On-Demand Access

4. Embracing Premium Payment Models
   - Deploy a concierge care model in response to market demand
   - Establish pay-per-use service offerings

5. Accommodating Excess Primary Care Demand
   - Leverage remote transactions

Unlocking Value Through Tailored Service

III

Source: Health Care Advisory Board interviews and analysis.
Preserving Share Through Affordability

1. Attracting Price-Sensitive Consumers with Competitive Offerings
   • Target price reductions to price-sensitive consumers
   • Promote price translucency
Assessing Price Sensitivity in Your Market

Affordability is perhaps the most obvious patient demand that traditional providers are ill-positioned to meet. Consumers in many markets nationwide are becoming more price-sensitive due to an increase of high-deductible health plans, health plans offering incentives for low-cost site selection, and the emergence of accountable care organizations.

From the patient perspective, affordability concerns influence where and when patients access care. From the physician or health plan perspective, there is an incentive to support patients in choosing lower-priced options to reduce total care costs.

Markets that are not yet exhibiting indicators of price sensitivity are likely to do so in the future. This is due to the increasing personal ownership of health care costs, which is further reinforced by purchasers seeking to reduce care costs without impacting care quality.

Signals of a Price-Sensitive Market

<table>
<thead>
<tr>
<th>Guiding Indicators</th>
<th>Yes</th>
</tr>
</thead>
</table>
| Patients
| Do you receive weekly or daily price requests from patients? |
| Do high-deductible or consumer-driven health plans account for more than 10% of covered lives in your market? |
| Is there a significant number of uninsured patients in your market? |
| Payers
| Do patients often cite price as a reason for cancelling appointments? |
| Are payers or benefits managers calling patients referred to hospital sites in an attempt to reschedule at cheaper facilities? |
| Is a significant part of your patient population covered by large and/or self-insured employers? |
| Market Conditions
| Are there physician-based ACOs forming in your market? |
| Are freestanding imaging centers or ambulatory surgery centers surviving and/or thriving in your market? |
| Has there been any media coverage of price differences between health care providers in your market? |

Source: Health Care Advisory Board interviews and analysis.
Affordability Concerns Stemming from Rising Deductibles

HDHPs directly expose patients to, on average, more than $2,000 in out-of-pocket expenses before insurance begins paying for clinical care. For services priced under the deductible, patients are fully exposed to variations in cost between providers. As deductibles rise, patients will be more likely to distinguish between low- and high-cost providers.

Although most high-revenue hospital services exceed the average patient deductible, certain high contribution margin services, like diagnostic imaging, are increasingly paid for out-of-pocket. As a result, hospitals and health systems are facing heightened price competition for many profitable services. With no response, higher-priced sites are likely to see a substantial number of cases shift to lower-priced providers as more consumers select based on cost.

For a provider to remain competitive in a price-sensitive market, service prices must be both low enough to attract target populations and comparable to the lowest price in the market.

---

Patient Cost-Consciousness Impacting Profitable Ambulatory Services

Services Falling Within the Deductible

What does it mean to be ‘affordable’?

1) High-deductible health plan.
2) $2,086; based on KFF report of average HDHP deductible.
3) Suture of deep wound, not skin cut.

Price sensitivity results in two distinct consumer behaviors. First, patients opt for the lowest-cost site of care, often despite previous health system loyalties. Second, patients elect to delay or avoid care altogether due to affordability concerns.

Both of these patient behaviors undermine system growth, regardless of payment model. Under fee-for-service, both out-of-network care and avoided care erode system revenues. Under accountable payment models, care delays or avoidance may exacerbate clinical conditions, elevating total cost of care over time.

In response to these two consumer threats, providers can reduce prices, to attract price-sensitive consumer business and encourage utilization from those at risk of opting out.

**Price-Sensitive Consumer Behaviors**

<table>
<thead>
<tr>
<th>Choose Lower-Priced Sites</th>
<th>Avoid or Delay Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>$430K</td>
<td>58%</td>
</tr>
</tbody>
</table>

Estimated annual losses from one case per week shifting from HOPD\(^1\) to IDTF\(^2\)

Patients avoiding any health care visit in 2012, an 8.6 percentage point increase from 2009 levels

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1) Hospital outpatient department.
2) Independent diagnostic treatment facility.


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Global Price Reductions Risky for Health Systems

For most systems, the natural reaction to price sensitivity is to decrease prices across the board; however, global price cuts ultimately diminish health system growth. Even if systems lower prices enough to maintain current volumes, a significant portion of the service line profit may be sacrificed in the process.

Pinkman Medical Center, a pseudonym, reduced its diagnostic imaging prices by half to attract volumes from lower-price independent diagnostic testing facilities (IDTFs). In doing so, Pinkman has created a losing proposition. The reduced prices remain twice as high as freestanding center prices. Moreover, expected volumes are too low to return total revenues to baseline levels.

Health systems competing with freestanding providers on price are at a significant disadvantage due to drastic differences in cost structure. As a result, direct competition over price is usually disproportionately damaging for the costlier health system. Therefore, minimizing the impact of or avoiding a price war is critical to health system survival.

Case in Brief: Pinkman Medical Center

- Hospital located in the Northwest
- Radiology department losing significant volumes to less-expensive IDTF in region
- Reducing prices by 50% to attract patients

Storing up for Winter

“We’ve prepared to take the hits, saving up a reserve and then putting ourselves on a self-imposed diet to ride it out until volumes materialize.”

VP, Ambulatory
Pinkman Medical Center

| Prices for MRI at Pinkman Medical Center¹ |
|------------------|------------------|------------------|
| Before | After | IDTF |
| $3,000 | $1,500 | $600 |

Amount placed in “reserve” to support imaging until volumes materialize

$800K

Expected increase in imaging volumes as a result of price cuts

10%-15%
Securing a Place in the Lower-Priced Playing Field

Some health systems have the option to invest in low-cost competitors rather than engage these providers in one-on-one price competition. By trading competition for collaboration, Meechum Health, a pseudonym, is expanding its imaging footprint in the region. Meechum is partnering with ImageCo, a pseudonymed freestanding provider, to open new lower-cost service sites. Through these sites, Meechum is able to capture the new patients it would have lost in a price war with ex-competitor ImageCo.

Meechum’s joint venture with ImageCo leverages both organizations’ strengths by combining Meechum’s reputation and referral potential with ImageCo’s expertise and favorable cost structure.

Although establishing a second, lower-price service delivery structure was a viable approach for Meechum Health, many providers are less keen to abandon profit-center services. Moreover, opportunities to partner may not be a viable option for all systems due to unavailability of partners or regulatory conditions.

### Partnering to Expand the Imaging Network

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Meechum</th>
<th>ImageCo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Referrals</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Regional Reputation</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Speed to Market Entry</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Operational Expertise</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Price Competitiveness</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

### Case in Brief: Meechum Health

- Multi-hospital system in the West
- Entered a joint venture with independent radiology provider to grow imaging share as market volumes shift toward less expensive freestanding facilities
- Expecting significant volume, revenue growth through new patient acquisition and market share capture from competitor hospital outpatient imaging

### Sharing in Substantial Returns

- **37** Anticipated number of JV² sites to be placed statewide
- **$1.5M** Positive annualized cash flow from two JV sites currently in operation
- Expect double-digit volume growth over the next 5-10 years

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1) Pseudonym.
2) Joint venture.

Source: Health Care Advisory Board interviews and analysis.
How to Profit in an Era of Partial Price Sensitivity

Instead of pursuing blanket approaches to counter price sensitivity, such as global price reductions and competitor partnerships, systems can create different pricing options with the intention of attracting patients who are price sensitive. Many patients, including those on traditional PPO plans, remain sheltered from the high costs of services within a deductible. These patients remain insensitive to price and will likely not be actively shopping for lower-priced options. In contrast, price-sensitive patients have an incentive to more actively seek less-expensive options.

There are two steps to creating a tailored pricing option. First, providers need to establish a less-expensive service option. Second, providers need to make information available for price-sensitive patients seeking affordability. By selectively offering lower-priced services, providers can regain volumes emigrating toward cheaper competitors, while growing the overall market by unlocking demand from patients at risk of avoiding care. A tailored pricing strategy helps maximize revenue for as long as price-insensitive consumers remain in the market.

Reduce Prices to Attract the Price-Sensitive

1. Attracting Price-Sensitive Consumers with Competitive Offerings
   - Offer Less-Expensive Service Alternative
   - Selectively Promote Price Differential

Three Key Questions

1. How do we identify price-sensitive patients from price-insensitive patients?
2. What services do we offer at a reduced price to attract interested consumer subsets?
3. How do we enable price-sensitive consumers to select into affordable options?

Legal Note
Market conditions, health plan interest, and other factors influence the ability to offer differentiated pricing strategies. Please consult legal counsel prior to establishing any targeted pricing initiative.

Source: Health Care Advisory Board interviews and analysis.
Targeted discounts for consumer-selected services improve margins when any portion of the population is price sensitive, because discounts encourage price-sensitive patients to use services, without forgoing revenue from patients agnostic to price. In contrast, global discounts erode margins by failing to attract enough incremental volume to offset the drop in price.

The model presented here tests the revenue impact of a 30% discount on a health service commodity, such as a diagnostic test, varied by the percentage of price-sensitive patients in the market. If a smaller percentage of the population is price-sensitive, for example 10%, reducing global price results in a 26% revenue loss for the provider.

In contrast, as the percentage of price-sensitive consumers in a market grows, the negative impact of global price cuts does wane. This is due to more patients opting in to the service, and more consumers choosing the site. At the same time, a targeted approach yields a healthier bottom line in all cases, making it the savvier strategy regardless of the market composition.

1. Targeted discounts consistently yield incremental revenue gains when any proportion of the population is price sensitive
2. Global discounts consistently create revenue losses until >80% of the market is price sensitive
3. As prevalence of price sensitivity increases, global discounts become less damaging and targeted discounts become more lucrative

Source: Health Care Advisory Board interviews and analysis.

1) Model assumes standardized annual utilization rates for 100,000 patients for a commodity health care service, priced at $500 per use (i.e., $350 with 30% discount).
2) The model also assumes no retaliation from competitors in the market, though this would not alter the revenue fluctuations resulting from global versus targeted discounts.
3) Please consult legal counsel before engaging in targeted pricing strategies.
Selective Discounts Grant Price-Sensitive Patients a Choice

For providers to make targeted price cuts a reality, they must create innovative service approaches that grant patients the choice to opt in to a lower cost option. One way to selectively promote lower-priced options is to offer opportunities for consumers to exchange certain preferences, like convenience or location, for a lower price.

CarePilot is a Colorado-based scheduling service that allows providers to post appointment bookings online for a range of consumer-selected services, with discrete prices set based on the date and time of the appointment.

Instead of a provider or purchaser actively steering patients to lower-cost service options, CarePilot puts the patient in control. Patients willing to trade convenience for cost can access services at less appealing time slots or sites.

CarePilot also reinforces growth by enabling providers to book underutilized timeslots throughout the month. Such a tailored approach ensures that discounts are available to patients actively seeking lower-cost options.

Case in Brief: CarePilot
- Colorado-based company contracts with 300 providers to offer available medical appointments for variety of procedures
- Providers promote off-peak appointment times priced at 10% to 30% discount
- Patients must pay up-front through health savings account, credit card, or PayPal; may submit claim to insurance later


1) Please consult legal counsel before engaging in targeted pricing strategies.
Selective Discounts Offered Only to Those Interested

The targeted discount program at MedStar is designed to identify price-sensitive patients at or before the point of service.

StarPass, an urgent care service discount program, grants consumers access to discounted services for a nominal annual fee. Patients without a subscription to StarPass pay full price for urgent care visits.

Because StarPass is not widely advertised to the broader consumer base, only patients valuing discounted care, such as HDHP and uninsured patients, self-select into the program. In this way, the real value of the program is not in the up-front fee, but rather in its ability to selectively target discounts to price-sensitive consumers at risk for avoiding care due to cost.

It is important to note that StarPass is not an insurance product. Consumers on any insurance plan can purchase the pass, but it is most relevant for those without insurance, on HDHPs, or experiencing a gap in coverage. The discounts apply to out-of-pocket payments and do not count toward a patient deductible.

Case in Brief: MedStar Health

- Ten-hospital health system located across Washington, DC and Maryland
- “PromptCare” urgent care facilities serve patients with acute, non-life-threatening conditions at a lower-cost site of care
- “StarPass” program provides self-pay and HDHP beneficiaries with urgent care at a discounted, but still profitable, rate

<table>
<thead>
<tr>
<th>Discounted Care for StarPass Subscribers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No StarPass</strong></td>
</tr>
<tr>
<td>Self-Pay</td>
</tr>
<tr>
<td>Individual Annual Subscription Fee</td>
</tr>
<tr>
<td>Additional Family Member</td>
</tr>
<tr>
<td>Visits Allowed per Year at Discounted Rate</td>
</tr>
<tr>
<td>Visit Without Diagnostic Services</td>
</tr>
<tr>
<td>Visit with Imaging^1, Lab and/or Procedures</td>
</tr>
<tr>
<td>Visit with Limited Services (e.g., suture removal)</td>
</tr>
</tbody>
</table>

Benefits to Discount Model

- Captures greater proportion of personal health spend
- Reduces the risk of care avoidance
- Appeals to patient demand for price transparency
- Forges greater loyalty to system brand

1) X-ray.
2) Assumes patient has not exceeded deductible at point of care. StarPass price only valid for patients not submitting claims to the insurer, in which case the patient balance would be the contracted rate instead of the StarPass discounted rate.
3) Note: Please consult legal counsel before engaging in targeted pricing strategies.

Source: Health Care Advisory Board interviews and analysis.
Informing Key Stakeholders of Price Changes

New pricing strategies can fall short if the information does not reach key stakeholders. Despite patients becoming more autonomous decision makers, physicians must still inform inquiring patients about affordable in-network options.

At Danton Health (pseudonym), the organization negotiated lower commercial imaging rates to compete with local providers, but failed to communicate the pricing changes to physicians. As a result, physicians continued referring cost-conscious patients to less costly out-of-network facilities.

After new volumes failed to materialize, Danton aggressively educated physicians through in-person meetings, at quarterly check-ins, and through an email campaign (see the appendix page 86 for a sample email from Danton). Danton Health is in the process of restructing pricing for laboratory services, outpatient rehabilitation, and other ambulatory services, with plans to communicate those changes to physicians at the outset to secure in-network referrals in the future.

Averting Patient Loss at the Point of Referral

Physicians refer price-sensitive patients to less expensive out-of-network sites

Danton Health restructures outpatient pricing to recapture business

Physicians unaware of change in pricing, continue to refer patients out-of-network

Educate, Monitor Referring Physicians

- Hold in-person meetings with employed physicians to create two-way communication about referral patterns and decisions
- Deploy email campaign and discusses pricing changes at quarterly visits
- Monitor physician behavior through referrals tracking tool, private-payer claims data

Case in Brief: Danton Health¹

- Large health system located in the Southwest
- Restructured outpatient imaging prices to compete with lower-cost sites; currently revising lab, outpatient rehabilitation services in same manner
- Initially witnessed no change in physician referral patterns, now educating physicians through in-person meetings, email campaigns, and quarterly visit discussions on pricing changes for outpatient services

¹ Pseudonym.

Sample email available in the appendix, page 86

Source: Health Care Advisory Board interviews and analysis.
Using Liaisons to Communicate Competitive Prices

Cavill Hospital (pseudonym) is keeping employed and independent physicians—and in turn, patients—abreast of pricing changes to laboratory services and diagnostic imaging through physician liaisons. Liaisons arrive with collateral crafted by Cavill’s imaging staff, outlining the competitive advantages and favorable pricing patients receive compared with other providers in the market. Cavill anticipates substantial volume increases as a result of proactively communicating its market-competitive prices to physicians.

Cavill Hospital, like Danton Health, recognizes that rising consumerism does not entirely remove clinicians from patient decision making. Patients often ask providers where low-cost care can be accessed in the region—providing an opportunity for physicians to advise patients on which in-network options are low cost. Informed physicians stand a better chance of keeping patients in-network for consumer-selected services, which is why systems like Cavill and Danton focus on communicating pricing changes to the clinicians educating patients on their access options.

**CT Price Before Liaisons**

<table>
<thead>
<tr>
<th></th>
<th>Cavill Hospital</th>
<th>Other Hospitals’ Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT Price</td>
<td>$2,000</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

**CT Price with Liaisons**

<table>
<thead>
<tr>
<th></th>
<th>Cavill Hospital</th>
<th>Other Hospitals’ Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT Price</td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

**Marketing Campaign**

- Imaging department creates collateral outlining competitive advantage of program
- Liaisons visit with each referring physician office to update on prices, distribute collateral

**Case in Brief: Cavill Hospital**

- 400-bed hospital located in the North
- Launched awareness campaign for physicians after reducing imaging prices

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1) Pseudonym.

Source: Health Care Advisory Board interviews and analysis.
Preserving Share Through Affordability

Providers aiming to preserve market share through affordable pricing should keep three key insights top-of-mind.

First, even if price sensitivity is absent in the market today, it will likely be present in the near term. The growing popularity of HDHPs and urgency for purchasers to reduce care costs make price-based decision making a near certainty, despite current conditions.

Second, health systems need to deploy a tailored pricing strategy that offers lower-priced options for price-sensitive patients to opt into. Global price reductions place hospitals at a significant disadvantage, often destroying irrecoverable value in the process.

Third, to maintain multiple pricing options, providers should engage in price translucency rather than full-out transparency. Ideally, price-sensitive patients will be able to self-select into discounts, based on personal preference and values, however providers should also be aware of the various options for services available in the network.

1 Attracting Price-Sensitive Consumers with Competitive Offerings

Few markets will remain sheltered from consumer price-sensitivity
Both activist purchasers and disruptive innovators seeking out a viable market niche are driving consumer cost-sensitivity within markets. As the pressure on purchaser finances magnifies, few markets will remain price insensitive.

Avoid global price cuts in favor of selective discounting; use price reductions to attract price-sensitive consumers
Engaging in a destructive price war or deploying global price reductions is a risky proposition. Providers should instead deploy selective discounting strategies—making a more favorably priced option available for subsets of consumers actively seeking lower prices to self-select into.

Promote price translucency over full price transparency
Reducing prices has limited impact if key stakeholders are not aware of the newly competitive price. However, full transparency around price negates the strategy to selectively discount. Educate key stakeholders on the lower-priced options, including physicians and patients, to inform price-sensitive patients about lower-priced service options and enable self-selection based on personal preference.

Source: Health Care Advisory Board interviews and analysis.
Driving Volumes with On-Demand Access

2. Generating Direct Revenue from Access Points
   • Win consumer preferences through competitive site placement
   • Drive visits by directing in-network patients to new site

3. Converting Initial Visit to Future Revenue
   • Support on-demand care sites with accessible referral points
   • Secure next step with hardwired referrals protocol
   • Pursue strategic partnerships to drive value
Current On-Demand Offerings Not Measuring Up to Patient Demands

For patients seeking quick, convenient access to care for low-acuity, time-sensitive conditions, a lack of on-demand options can lead to worse clinical and financial outcomes. Patients may delay or even forgo treatment, resulting in an unnecessarily elongated illness. Worse still, illnesses not addressed in a timely fashion can evolve over time to more acute conditions.

Unfortunately, traditional ambulatory settings are either too inconvenient or too overpowered for straightforward, on-demand needs. Primary care offices, though contributing to overall network access, still require appointments and carry considerable wait times. In contrast, emergency departments (EDs) offer walk-in access exclusively, but are expensive for moderate conditions and have excessive wait times for patients with lower-acuity conditions.

Current Solutions Less Suitable for Immediate Access

Traditional Care Sites Overpowered, Inconvenient

<table>
<thead>
<tr>
<th>Low Acuity</th>
<th>High Acuity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Office</td>
<td>Emergency Department</td>
</tr>
</tbody>
</table>

- Appointment required, may be unavailable
- Inconvenient hours
- Long wait times, service frequently delayed
- On-demand service
- Long wait times for non-emergency treatment
- Extremely expensive

Definition of On-Demand Access

- No appointment needed
- Extended hours, or open anytime

<table>
<thead>
<tr>
<th>43%</th>
<th>3 hours</th>
<th>1.5 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients who do not have access to same- or next-day PCP appointments</td>
<td>National average wait time at EDs</td>
<td>National average wait time at freestanding EDs</td>
</tr>
</tbody>
</table>

The market is responding to fill on-demand access gaps. Retail clinics, urgent care centers, and virtual access channels all appeal to consumers’ preferences for immediate care. But few providers are strategically employing those assets to drive sustainable benefits to the system. Far from executing a deliberate strategy, many systems are reacting to market innovators by opening consumer-oriented sites without clearly connecting them to organizational goals.

To derive the full benefit of new access points, systems need to take a more intentional approach, aligning site function with system ambitions for growth. Questions of whether and how to invest in such services should be addressed only after establishing a clear connection between the asset and system goals.
Many systems nationwide have faced a conundrum of how to establish and run immediate care sites to the advantage of the health system.

Tusk Health, a pseudonym, failed to think strategically about how a retail clinic would drive value to its network. Initially, Tusk established two goals for its clinic: to off-load low-acuity cases from the ED and to generate new revenue. The clinic has met neither goal. Tusk placed the site too far from the ED to absorb volume and the clinic was located in a service area that attracted primarily uninsured patients.

Tusk Health failed to outline a strong strategic vision for the site and failed to adjust its strategy after years of inadequate returns.

On-Demand Access Points Often Failing to Advance System Goals

**Goal:** Establish retail clinics to off-load low-acuity services from ED, drive new revenue

- Retail clinic located too far (5+ miles) from ED, patients unwilling to reroute to retail clinic
- Results show no ED volume reduction, no profit
- Retail clinic primarily serves uninsured patients

**Case in Brief: Tusk Health**

- Health system located in the Southeast
- Of insured patients using clinic, few lack PCP; few need specialty or follow-up care
- After failed operations, retail clinic goal adjusted from ED capacity relief to mission-based care delivery

**No Financial, Downstream Value Captured from Convenient Care Clinic**

- 10+ Years health system has operated retail clinic
- $0 Profit from clinic

Source: Health Care Advisory Board interviews and analysis.

1) Pseudonym.
On-demand care sites can contribute to health system growth in two ways: through immediate profit accrued at the point of service, and by converting patients to necessary downstream services or ongoing system relationships. Importantly, in-network referrals drive value in both a fee-for-service environment and under risk-based payment.

Immediate, or service-specific profit, is calculated by multiplying access point visits by the contribution margin per visit. Downstream profit is calculated by multiplying access point visits by the referral or downstream conversion rate, then by the downstream contribution profit for each conversion.

Two key variables underpin immediate and downstream returns. One variable is the number of visits to the on-demand access point, which powers both terms. Therefore, attracting volumes to the site is paramount to system growth. The second variable is the downstream conversion rate for patients requiring follow-up, measured as the proportion of access point visits converted to in-network utilization.
Win consumer preference through competitive site placement

Attracting Patients with a Convenient, Visible Location

Profitable consumer-selected sites are able to attract consistent volumes across the year—due to the fact that immediate care site use fluctuates seasonally. While many factors influence the clinics’ ability to execute on that objective, diligent site placement is a central consideration for maximizing potential profitability.

Providers should keep in mind a number of other considerations, beyond traffic and visibility, when developing new ambulatory sites. Several other considerations are listed in the graphic.

Norton Healthcare, a midsized health system in Kentucky, discovered a tight link between site visibility and profitability. The organization spent considerable energy seeking high-traffic, unobstructed space for its new urgent care center. Within just a few years of opening its doors, the time invested in placement paid clear dividends. Because of its location, Norton’s urgent care center attracts twice as many annual visits as the average provider, presenting meaningful opportunities to capture new patients for the system.

### Immediate Care Site Placement Considerations

**Plentiful Volumes**
- Growing affluent population
- Large proportion of younger consumers (18-54)

**Favorable Payer Mix**
- High marital/familial concentration
- Commercial-heavy payer composition
- Self-funded employer presence

**Reliable Consumer Traffic**
- Retail adjacencies
- High-traffic, busy intersections
- Emergency department nearby

### Doubling Average Volumes Through Competitive Placement

<table>
<thead>
<tr>
<th>Urgent Care Center Visits per Year by Location</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="#" alt="Graph showing visits per year by location" /></td>
</tr>
</tbody>
</table>

- Average Location (Open 5-28 yrs) 12,000
- Location Off Main Road (Open 3-4 yrs) 24,000
- Largest Location (Open 25 yrs) 25,000

**Case In Brief: Norton Healthcare**

- Five-hospital system based in Louisville, Kentucky
- Due to highly competitive urgent care and retail market, challenging to attract incremental volumes
- For one of newest locations, focused on selecting high-trafﬁc site to attract volumes

Source: Health Care Advisory Board interviews and analysis.
Pulling in new consumers through site placement is an important first step, but an effective “push” strategy can be helpful to boost volumes as well. In particular, physicians can be an important volume driver through appropriate referrals.

Unfortunately, physicians need to refer to on-demand sites to maximize site volumes. Physicians often resist sending excess cases to convenient care sites for fear of losing business and alienating patients from their panel. Prevea Health in Wisconsin allayed these concerns by sharing volumes data with their physicians.

Initially, Prevea showed its primary care physicians that urgent care centers were accommodating excess demand, not siphoning off scarce patients. In fact, the data demonstrated that new patient referrals were originating in urgent care, demonstrating its value as a source of new patients. Prevea primary care physicians now view urgent care as a source of new business, as well as a capacity relief valve for established patients.

Volume Data Allays Concerns, Encourages PCP Referrals to Urgent Care

Sharing Volumes Data Encourages Physicians to Refer to Urgent Care Centers

Mutual Benefits from PCP-Urgent Care Referral Channels

- Right sizing daily volumes across both sites of care
- Improving patient satisfaction by lowering PCP appointment delays, wait times
- Preventing lost volumes due to primary care inaccessibility

Source: Health Care Advisory Board interviews and analysis.
Prevea communicates the value of urgent care on a monthly basis. Prevea’s regional service line directors collect and share data feeds on urgent care volumes with PCPs, including new patient traffic and primary care referrals. Updated figures are emailed to physicians, serving as a reminder of urgent care’s value to the primary care office. The data also reinforces that each individual site, while important, is critical to drive broader network performance.

Beyond providing a snapshot of volumes flowing through urgent care, the monthly feeds also inform care management plans for chronic disease patients. Physicians can identify the frequency and reason for patient visits to urgent care, leading to refinements in their approach to patients misusing or overusing urgent care. This in turn strengthens physicians’ acceptance of urgent care services and improves care continuity for patients already using them for on-demand needs.

Formalized Process Reinforces the Site’s Value Within the Network

**Prevea Health’s Data Sharing Process**

1. Collect and track urgent care volumes data
2. Share volumes data with physicians monthly

**Sample Monthly Volume Report**

- Daily urgent care center volumes
- New urgent care patients
- Primary care referrals from urgent care

**Case in Brief: Prevea Health**

- 240-provider physician group headquartered in Green Bay, Wisconsin
- Regional service line directors share capacity and volumes data with physicians to encourage referrals to the urgent care center when the offices are overcapacity
- Urgent care centers accrue new volumes from redirected patients and Prevea physicians remain at capacity with daily volumes
Another strategy to reduce physician resistance to on-demand sites is to staff the sites with familiar practitioners. Russo Health, a pseudonym, sources nurse practitioners (NPs) from local physician offices to run its retail clinics. Because the retail providers are trusted, physicians are more comfortable sending surplus cases to the site.

Russo uses its system-wide electronic health record (EHR) to keep care coordinated. Shortly following each visit, physicians can access the patient file and use clinical elements noted there to inform subsequent care plans. For Russo, the additional step to interconnect retail clinics with physician offices improves care coordination by keeping all clinicians informed of in-network encounters.

Familiar Staff Encourage PCP Referrals to Convenient Care Sites

Elements Required to Leverage Immediate Care Clinic as Alternative Care Site

Clinics at Capacity
Primary care offices refer excess same-day appointments to retail clinics

Trusted Staff
Retail clinic NPs sourced from within the system, trusted by physicians

Coordinated Care
Records follow patient throughout sites

Case in Brief: Russo Health

- Multi-hospital system based in Southwest
- Operates retail clinics; primary care physicians refer patients to convenient care sites when overcapacity
- Urgent care centers and emergency department receiving higher-acuity cases as a result of convenient care clinics

Toward a Shared Goal

“Physicians need to be at capacity to accept the retail clinic into the network.”

Clinic Director

Source: Health Care Advisory Board interviews and analysis.
Attracting Patients More Rapidly with a Virtual Care Offering

Progressive organizations are thinking beyond the physical care site and strategizing how to quickly reach consumers interested in virtual care. For example, Underwood Health, a pseudonym, is deploying a virtual care platform to capture tech-savvy patients in regions where it does not already have a physical presence.

Underwood purchased consumer data to inform its market entry strategy and discovered that its target regions were populated by younger, healthier patients preferring quick, remote access. Consumers new to Underwood, as well as established patients, can now access face-to-face virtual visits for a nominal fee. The services are advertised via web banners viewed on a patient’s computer or smartphone.

One benefit of pursuing a digital strategy over a physical site is speed to market. Underwood can move from contract to launch in 15 weeks with a virtual care offering, whereas new bricks-and-mortar facilities can take well over a year to complete.

Virtual Visits Represent the Ultimate On-Demand Access

**Tech-Savvy Patients Attracted to Virtual Care**

1. See virtual care advertisements
2. Log in to virtual access portal
3. Conduct synchronous virtual visit

**Patients in market areas with no physical site of care**

**Virtual Market Capture Strategy**
- Tailoring web banner campaign to targeted consumer demographic (tech-savvy, healthy, busy)
- Marketing smartphone accessibility to mobile users
- Virtual copays lower than on-site copays for ED, urgent care centers; $45 for consumer paying out of pocket

**Case in Brief: Underwood Health**

- Multi-hospital system located in the East
- Entering new markets with virtual strategy to capture consumer segments preferring site-less care delivery
- Patients can engage providers via webcam, send secure photos, and submit biometric tests for clinicians to review in real time

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1) Urgent care centers within 30 miles if physical care center needed.
2) Pseudonym.

Source: Health Care Advisory Board interviews and analysis.
Beyond strategies to capture individual patient volumes and excess volumes from primary care, systems can also contract directly with wholesale purchasers. UMC Physician Network Services (UMC-PNS) in Texas contracts directly with self-funded employers to drive traffic to its Express Care Clinics. Employers are charged a discounted rate for employee retail visits, and employees have either a discounted copay, or no copay for the care.

The benefits of the agreement accumulate across all three parties. Employees and employers save money on primary care visits, and UMC-PNS operates both clinics at a profit, realizing over 6,500 visits annually as a result of the contract.

Furthermore, once employees visit the clinic for low to moderate acuity conditions, UMC-PNS is better positioned to retain these patients for in-network follow-up care, driving downstream business to the physician network.

**Case in Brief: UMC Physician Network Services**
- 127-provider medical group associated with University Medical Center Health System, based in Lubbock, Texas

**Source:** Health Care Advisory Board interviews and analysis.
Physician acceptance of alternative sites of care depends also on the cultural signals implicit in organizational structure.

Retail clinics under the purview of business development, for example, may be less likely to be accepted within the network; physicians might view the sites as competition. In contrast, clinics managed as part of the medical group tend to gain favor with physicians, since they can more directly influence the clinical operations of the site.

On the other hand, some medical groups that manage retail clinics as part of primary care may not push sites to be maximally profitable, especially if traditional primary care practices are considered loss leaders. This is short-sighted; convenient care sites should strive to maximize performance and profitability, regardless of where they are positioned in the organizational structure.

Oversight Contributes to Perception, Attitude, Function of Clinics

Comparing Common Oversight Models

Key Benefits of Medical Group Oversight

Clinical Coordination
- Medical group able to oversee, modify on-demand services to best support network’s clinical needs

Network Integration
- Retail staff can rotate through physician offices to build trust and tighten referral channels between care sites
- Clinicians can establish standard, acceptable retail referral protocols

Retail clinic perceived as threat, competitor to medical group—without physician buy-in, clinic less likely to hit profitable volumes

1) For owned or leased retail clinic models only.

Source: Health Care Advisory Board interviews and analysis.
Uneven Performance Common Across Sites of Care

**Breakeven Volumes per Day**

_For Retail Clinics and Urgent Care Centers*

<table>
<thead>
<tr>
<th>Visits per day</th>
<th>Annual Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>$0</td>
</tr>
<tr>
<td>10</td>
<td>$500,000</td>
</tr>
<tr>
<td>20</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>30</td>
<td>$1,500,000</td>
</tr>
<tr>
<td>40</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>50</td>
<td></td>
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<tr>
<td>60</td>
<td></td>
</tr>
<tr>
<td>70</td>
<td></td>
</tr>
</tbody>
</table>

**Limited service menu limits patient traffic**

15 Average visits per day at a retail clinic
51 Average visits per day at an urgent care center

Assumptions available in the appendix, page 87

Ten Common Conditions Account for the Majority of Care Delivered at Retail Clinics

- Upper respiratory infection
- Sinusitis (sinus inflammation)
- Bronchitis
- Sore throat
- Immunizations
- Inner ear infections
- Swimmer’s ear
- Conjunctivitis
- Urinary tract infections (UTIs)
- Screen blood tests


1) Assumptions listed in appendix, page 87.
2) Profit includes imaging, medications delivered on site.
3) Retail clinics open 365 days per year, urgent care centers open 365 days per year.

Generating Throughput Required for Convenient Care Sites to Break Even

Higher volumes are favorable for any consumer-selected access point. But the number of visits required to break even—and the difficulty in reaching that number—differs across convenient care sites. The contrast is most apparent between retail clinics and urgent care centers. Advisory Board interviews and analysis suggest that retail clinics require between 18 and 23 visits per day to break even, yet the average throughput across the country is closer to 15 visits per site per day. As a result, many retail clinics operate at a loss. This is driven in part by an inability to attract new patients, but also by physician resistance to sending established patients to the retail site for basic care needs that cannot be immediately completed in primary care.

Urgent care centers require significantly more visits to break even, yet most urgent care operators attract volumes at or above what is required to break even, with some recording as high as double-digit operating margins within a few years of opening. This is due to urgent care’s ability to serve a broader spectrum of conditions than retail, as well as its reputation for high-quality care among physicians.
Retail clinics and urgent care centers do not differ only in their breakeven requirements. The potential upside of each is very different, too. Urgent care centers are capable of producing substantial profits. Retail clinics, however, are typically low-margin businesses. As it stands, almost 80% of retail clinics owned by health systems are failing to break even, largely because they fail to attract sufficient volumes. But site-specific profitability is only a single part of the power formula for growth. Revenue accrued from referring new patients into the network, or directing patients to needed downstream care, can be just as valuable as independent profitability.

Margins Strong for Urgent Care, Weak for Retail Clinics

Stand-alone Profitability Varies Across Sites of Care

**Urgent Care Center Profitability**

- Revenue: $2,672,582
- Costs: $2,284,426
- Best-in-Class Profit: $857,531
- Typical Profit: $388,156

**Retail Clinic Profitability**

- Revenue: $644,400
- Costs: $420,995
- Best-in-Class Profit: $223,405
- Typical Profit: ($41,068)

**Average profit margin for urgent care centers:** 9.6%

**78%** Health systems surveyed with retail clinics failing to break even

Acquiring New Customers, at Low or No Cost, Is the Value of a Retail Clinic

If access points are effective in generating referrals and long-term relationships, stand-alone losses may be better viewed as patient acquisition costs.

The model presented here demonstrates that per-patient cost to acquire can be reduced by increasing new patient volumes to the site or improving the downstream conversion rate to another needed service. Both enhance the site’s value by increasing the frequency and total number of downstream conversion opportunities.

Organizations can justify continued investment in assets that are breaking even or showing modest losses—if the businesses generate significant downstream utilization or value in patient lives under risk.

Customer Acquisition and Patient Conversion the End Goals for Retail Clinics

Source: Health Care Advisory Board interviews and analysis.

1) New patients defined as those not interacting with the system in 24 months.

Retail Clinic Patient Acquisition Cost
Per Patient, Visits Held Constant at 16 per Day

Proportion of Retail Clinic Patients Who Are New to the System
- 15% New
- 20% New
- 25% New

Cost to Acquire

Conversion Rate
Converting Visits into Profitable Volumes for the System

Mercy Medical Center in Des Moines, Iowa, has a network that attracts new patients and has seamless referrals between sites.

Because Mercy is the sole owner of its retail clinic, it controls all operations. As a result, staff are able to refer new patients and patients needing additional care in-network. To reinforce relationships with Mercy's employed physicians, retail clinic NPs staff physician offices one day per week, which also helps overcome any physician discomfort with the clinic.

At the point of referral, Mercy supports on-demand care sites with multiple timely options. Over 100 PCPs and 35 urgent care centers surround the retail clinic, many of which reserve same-day access slots to accommodate referrals. As a result, Mercy can refer patients into a follow-up appointment within 30 minutes of a retail visit, meeting patient demands for immediate access while ensuring downstream in-network service use.

Components of Timely Appointment Conversion at Mercy Medical Center

- **Support on-demand care sites with accessible referral points**
  - **Advanced Access**: Most employed PCPs maintain same-day access slots for on-demand care
  - **Multiple Site Options**: Mercy has 100 PCP providers at 35 locations, multiple urgent care centers in region

- **Secure next step with hardwired referrals protocol**
  - **Referrals Protocol Control**: As clinic sole owner, Mercy controls clinic operations, prioritizes in-network referrals for follow-up care
  - **Staff Alignment**: Retail NPs staff physician offices one day per week to develop trust, reinforce network coherence

Source: Health Care Advisory Board interviews and analysis.
Co-located Site Converts Patients to Ongoing Management

Before Mercy Medical Center developed a comprehensive strategy for seamless referrals, Mercy used co-location between urgent care and PCP offices to build new primary care panels twice as fast as stand-alone practices.

Because new PCPs staff each urgent care center, new patients become familiar with their future physician in advance. After an initial visit, a PCP refers a patient into the co-located practice, scheduling a timely appointment at the same clinical site for routine care. This makes follow-up care convenient for the patient.

Co-location is one reliable way to build a coherent ambulatory network. For a more comprehensive list of considerations for co-location, please see the appendix, page 88.

Co-locating Urgent Care Center, PCP Office for Convenience, Efficiency

Co-located Services Offer Patient, Practice Benefits

- New patients meet primary care provider at urgent care service
- Patients are immediately referred into the same primary care physician’s panel

Time Required for New Physician to Build Panel by Practice Site

- 1 Year
- 2-3 Years

Operational considerations for PCP, urgent care co-location in the appendix page 88

Case in Brief: Mercy Medical Center

- 643-bed hospital located in Des Moines, Iowa; part of Mercy Health Network
- Operates six urgent care centers co-located with primary care practices
- Mutual referrals increase new patient visits, decrease wait times, improve patient satisfaction

Source: Health Care Advisory Board interviews and analysis.
Surrounding retail clinics with nearby primary care clinics is important for triaging new patients into the network. In lease models where a health system assumes full control over clinic operations, staff can prioritize referrals in-network, but only if those options are convenient for patients. This makes PCP proximity key to acquiring new patients through an owned retail clinic.

Clinic proximity is also important for retail partnerships where the health system is an affiliate partner. Medical directorship models like CVS MinuteClinic compensate health system physicians for clinical oversight, but referrals are not triaged directly to the partner health system. Retail clinic NPs triage patients to the most convenient provider for ongoing care, often an office close by the retail clinic. Without available primary care proximal to retail, systems are at risk for losing new patients to better positioned competitors. PCP proximity also benefits providers not chosen for retail affiliation in regions with a CVS MinuteClinic presence, because staff often recommend the closest provider to new patients, without allegiance to the co-branded system.

**Nearby Network Support Required to Convert Patients**

**Retail Clinics Refer Patients to Closest PCP Office**

---

**Lease-Model, Owned Clinic Offers Most Control Over Referrals**

- Health system can preferentially refer patients in-network through direct scheduling or interconnected IT
- Clinic staff will choose most convenient clinic for patient—making PCP clinic proximity key to completing referral
- *Ex. Walmart, local lease model*

**Affiliate-Partnerships, Medical Directorships Offer No Referrals Control**

- Affiliate health system does not receive preferential referrals
- Clinic staff will choose most convenient clinic for patient—making any nearby PCP a viable choice for referral
- *Ex. CVS MinuteClinic*

---

**Without primary care presence, on-demand clinics cannot convert patients to ongoing relationship**

**Affiliated retail clinics do not prioritize affiliate partner, sending patients to any convenient PCP**

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Source: Health Care Advisory Board interviews and analysis.
Even with the right components in place to capture downstream referrals, an inefficient referrals conversion process can jeopardize valuable opportunities. Norton Healthcare, a Louisville-based health system, found that disjointed protocols within its system-wide call center undermined timely referrals from urgent care to orthopedic providers, a top follow-up need among patients.

Norton’s call center threatened the integrity of orthopedics referrals in three ways. First, the call center was unable to match patients with the right subspecialist, resulting in patients seeing the wrong physician for their condition. Second, the call center did not consider patient proximity in deciding on a location. Because Norton’s orthopedic footprint is diffuse, patients were often asked to travel long distances for a short appointment. Finally, variability in scheduling processes at each practice created delays between the central call line and front-office staff. As a result of the inefficiencies, Norton was at risk of losing patients to competitors.

Central Call Line Unable to Schedule Right Visit, Right Time

Challenged in Providing Correct and Timely Orthopedic Referrals

35 orthopedists¹ have different subspecialties
Six practices, very geographically distributed
Clinics have variable scheduling processes

Challenging referral chain increases error, decreases referrals

Case in Brief: Norton Healthcare

- Five-hospital system based in Louisville, Kentucky
- Operates 12 urgent care centers seeing 171,000 visits per year
- 20% of patients referred to a PCP or specialist from urgent care; orthopedic referrals are the top follow-up need for patients

¹) All orthopedists are employed by the system.
Dedicated Process Strengthens High-Priority Referral Chains

To tighten connections for high-priority referrals, Norton created a dedicated call line for orthopedic scheduling. A single scheduler staffing the line has access to the calendars of all 35 employed orthopedists. This allows the scheduler to schedule a timely appointment with the correct subspecialist. As a result of the new protocol, patients receive appointments with the appropriate orthopedist, usually within 24 hours of their urgent care visit.

Norton measured the impact of the new referrals strategy by tracking changes in orthopedic volumes originating from 12 urgent care centers. As of this writing, Norton has realized over 245 completed orthopedics referrals every month—orthopedic volumes that would otherwise be at risk due to gaps in the previous conversion method.

Protocol for High-Value Orthopedic Follow-Up Appointments

Single scheduler maintains centralized orthopedic referral phone line

Scheduler is familiar with subspecialty care, can access all 35 orthopedists’ calendars

Patient receives follow-up appointment with correct subspecialist within 24 hours

Keeping It Simple Keeps Patients in Network

“Instead of 12 urgent care centers searching for which scheduler to contact, one dedicated assistant finds an appointment at the right place, right time, with the right doctor—it’s all about keeping it simple.”

Bill Ritchie
VP Outpatient Services, Norton Healthcare

>245

Monthly orthopedic scheduled appointments from urgent care produced through dedicated phone line

1) Scheduler confirms plan eligibility, copayment, and pre-authorization, and enters information into electronic medical record; timeliness of appointment based on patient’s condition, urgency of care.
2) Appointments from 12 urgent care centers.

Source: Health Care Advisory Board interviews and analysis.
Prevea Health uses a centralized scheduling platform to ensure continuity between care sites. The system ensures that each patient can receive a timely follow up appointment at the point-of-care. Patients are highly satisfied to have all needs met at the initial visit, instead of having to personally own the scheduling step. Within a year of implementing the platform along with an after-hours triage line, the proportion of new referrals from urgent care to Prevea PCPs and specialists rose ten percentage points.

Prevea tracks downstream activity from new patients entering the system through the ambulatory network. New patients are assigned a unique system identifier that registers any in-network utilization occurring across the year. Tracking patient activity helps Prevea understand the value of each on-demand access point to new patient acquisition and ambulatory growth.

**Centralized Scheduling the Gold Standard for Service Coordination**

**Percentage of New Urgent Care Patients Converted to Prevea PCP or Specialist**

<table>
<thead>
<tr>
<th>Year</th>
<th>Conversion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>30%</td>
</tr>
<tr>
<td>2012</td>
<td>40%</td>
</tr>
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</table>

**New referrals after implementing centralized scheduling and after-hours triage line**

**Quantifying the Downstream Contribution**

New patient receives unique identifier; enables quantification of downstream utilization, revenue

**Case in Brief: Prevea Health**

- 240-provider physician-group headquartered in Green Bay, Wisconsin
- Attracting and referring significant percentage of new patients from its five urgent care centers through centralized scheduling and the after-hours triage line
- Tracking new patient utilization across the year to calculate referral value

Source: Health Care Advisory Board interviews and analysis.
Capturing the Specialty Episode from Competitors Without PCP Conversion

Few providers are interested in, or capable of, converting patients with an existing out-of-network PCP to an in-network PCP. But for specialist referrals, consumers are much more willing to access care outside of their existing health system.

As long as the in-network alternative meets consumer demands for timeliness and convenience, providing a specialist referral is a low-resistance way to capture share from the competition. This is particularly true for urgent care centers, where downstream specialty care is more often needed.

Stamper Hospital, a pseudonym, attracts urgent care patients to its specialist network by securing follow-up appointments faster than the incumbent system. Schedulers will call a patient’s health system to ask for appointment times, which are usually weeks away. Then, Stamper offers a much earlier in-network slot, winning the patient’s episodic business by providing faster service.

Patients Less Loyal to Specialists

Offering Patients an Easy Choice

Composition of Physician Referrals from Urgent Care

National Average by Specialization

Case in Brief: Stamper Hospital

- Multi-hospital system located in the Midwest
- Offers competitor patients in-network specialist appointment at the point-of-service; patients remain with their PCP

1 Pseudonym.
Providers can also use virtual visits as an opportunity to address unrecognized care needs and arrange needed downstream care.

Jona Health, a pseudonymed integrated health system, is incorporating self-funded insurance plan data and centralized scheduling into its virtual care platform to fully capture unmet care needs. The data allows clinicians to pinpoint patient risk factors and conduct screenings to manage care. If a patient requires follow-up, centralized scheduling enables clinicians to make immediate appointments for an in-network specialist.

Enriching on-demand virtual care delivery with expanded capabilities to streamline follow-up care will also help differentiate health system virtual visit platforms from those of independent virtual visit providers.

**Virtual Visits Evolve to Provide Valuable Point-of-Care Patient Services**

- **Conducting Immediate Virtual Care**
  - Addressing low-severity and administrative patient needs

- **Fulfilling Outstanding Care Needs**
  - Identifying and addressing risk factors, unmet care needs

- **Converting Downstream Business**
  - Accelerating in-network referrals via centralized scheduling platform

**Case in Brief: Jona Health**

- Multi-hospital system located in the East
- Using system-owned health plan data to inform real-time interventions during virtual visits and to determine follow-up care steps
- Syncing centralized scheduling with virtual platform to enable immediate referrals

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advisory.com
Pursue strategic partnerships to drive value

Keys to Growth-Oriented Clinic Partnerships

The performance goals for on-demand access sites vary by system. Some systems may need on-demand sites for primary care or ED capacity relief, whereas others may be interested in new marketing opportunities. Still others are interested in the new revenue, or seeking to engage with new consumers who lack PCPs. Outlining the specific ambition and goals for convenient care sites is a critical first step in establishing sites that advance those goals.

Keeping those goals in mind, organizations must create a dialogue with potential partners to outline which organizations will offer which competencies. Beyond establishing a high-value partnership, a key component of success in the future will be identifying and meeting the evolving needs of patients.
Attributes of a High-Value Partnership

Today’s high-value retail clinic partnerships prioritize easy triage of appropriate in-network referrals, drive revenue, and serve as capacity relief valves for overburdened primary care clinics.

As the ambulatory network evolves, the value proposition of partners will also change. Health systems may seek partners interested in tighter collaboration on care management—for example, through coordinated teams—or partners willing to pilot virtual visits out of the retail clinic. In the much longer term, partners that can integrate traditional consumer data with clinical information may be the most valuable. Organizations should establish partnerships that advance specific goals today, and keep an open dialogue with partners to ensure that the network is advancing current goals and well positioned to advance future initiatives.

Constructing a High-Performing Clinic Partnership

Today’s Priorities

- In-Network Referrals
  - Enabling sites to capture downstream referrals

- Financial Investments, Returns
  - Sharing revenue, allocating financial risk

- Bidirectional Patient Flow
  - Utilizing clinic as integrated delivery system component

Future Priorities

- Care Coordination
  - Developing integrated care management teams

- Virtual Delivery
  - Providing asynchronous visits, virtual support

- Consumer Analytics
  - Integrating pharmacy, consumer data

Source: Health Care Advisory Board interviews and analysis.
Three main categories of partnerships are present in today's market. First, a branded affiliate program is a model in which the health system is co-branded with the retail clinic. This is best for organizations seeking a low-risk, low-reward access site, or marketing exposure. The second category is termed a clinical partnership, in which the health system and retail partner engage around unified care goals. ACO partnerships are one example of this model, because these partnerships may include shared care teams or care management objectives. This new model is higher-risk, because the model is more complex than simple branding. It is moderately rewarding, because financial gains are typically split between partners. Lastly, a full control clinic is a lease model or owned clinic run independently by a provider. The corporate partner serves simply as a host site for the clinic, but offers no clinical support. This is the highest-risk but highest-reward model, because the provider accrues all of the clinic profit and is well positioned to triage patients needing additional care or services into the health network.
Driving Volumes with On-Demand Access

There are two ways to derive value from on-demand access sites. First, sites can generate initial revenue on their own. This channel can be strengthened by siting clinics to attract new patients and triaging existing patients to the convenient care site for on-demand needs. To improve the acceptance of clinics into the network, show physicians data that reinforces the value of the clinic to the network.

Second, on-demand access points can foster future business and longer-term patient relationships. To track performance in this respect, measure access points’ contributions to growth through new patient acquisition cost and daily volumes at ambulatory sites. To improve referrals integrity, hardwire a conversion protocol for high-priority referrals, with an ambition to make all appropriate referrals seamless. Strive to rapidly fulfill patient needs in the moment and ensure that follow-up care is performed in-network.

Generating Direct Revenue from Access Points

Win consumer preference through competitive site placement
Physical site placement is critical to successfully pull volumes into convenient care sites. Move beyond a bricks-and-mortar approach, deploying virtual assets in tech-savvy markets where remote care will be highly appealing.

Drive visits by directing in-network patients to new site
Ensure high volumes by referring patients from overcapacity clinics into convenient care alternatives. Prove value by showing how the site complements and benefits PCP practices.

Converting Initial Visit to Future Revenue

Support on-demand care sites with accessible referral points
Retail clinics used as system entry points require nearby primary care support to effectively refer eligible patients into ongoing care. Retail clinics lacking primary care support will be ineffective system entry points for new patients.

Secure next step with a hardwired referrals protocol
Patients are won on convenience and timeliness. Establish processes that ensure in-network and competitor patients leave care sites with appointments and next steps intact.

Pursue strategic partnerships to drive value
Select partners offering models that explicitly advance growth goals—focusing on in-network for appropriate patients, new patient volumes, and revenue sharing.

Source: Health Care Advisory Board interviews and analysis.
Unlocking Value
Through Tailored Service

4. Embracing Premium Payment Models
   • Deploy a concierge care model in response to market demand
   • Establish pay-per-use service offerings

5. Accommodating Excess Primary Care Demand
   • Leverage remote transactions
Consumers are increasingly demanding customized service for ongoing and routine care. Today’s standard is inflexible both in terms of delivery setting and duration. A typical visit requires patients to physically travel to a clinic and engage with a physician for a 15- to 30-minute in-person interaction regardless of the reason for the visit.

Increasingly, patients seek different delivery options such as email or virtual visits. Many patients would prefer shorter, remote transactions over coming into the clinic for low-severity care. Consumers also prefer variable in-person interaction lengths, shorter or longer, based on personal preference or clinical complexity. Consumer demands range across a broad spectrum and may depend on personal values, clinical need, or simple preference.

Regardless, the current service standard does not offer options that flex with, and suitably match, the type of clinical interaction that patients prefer for their varied clinical care needs.

**Consumers Seeking Elevated Service Level, Experience**

**Standard Visit Provides Too Much for Some and Too Little for Others**

**Many Patients Preferring Short, Remote Appointments…**
- No remote interactions are offered, though physical exams are not required for some care
- Ongoing management still occurs with in-person visits, even when recurring or frequently the same

**75%**
Patients want physicians to provide online services for test results, scheduling, email, and medical record access

**Today’s Standard Offering**
- Appointment times too short to fully resolve complex issues, engage in meaningful dialogue
- Total health care review happens only on an annual or biannual basis

**85%**
Patients want in-person communication with their physician for most medical conditions

**…While Others Require More In-Person Access to Physicians**

**Definitions of Tailored Service**
- Options to precisely match interactions with care needs

The inflexibility of the current care delivery model presents an opportunity for innovators interested in transforming the patient-clinician interaction.

PINGMD, a technology start-up company based in New York, offers a mobile app and online platform for patients to communicate with physicians through digital channels. Patients can send secure text, video, or picture messages of their symptoms to clinicians, who respond in nearly real-time over the platform or app.

Over 60% of patient messages are for symptoms that can be managed remotely. For conditions that cannot be diagnosed or managed remotely, the patient is instructed to visit the clinic for an in-person consultation.

PINGMD’s model also meets the consumer preference of on-demand care, but the remote delivery provides additional value to patients less interested in visiting the clinic.

PINGMD Mobile App Offers Remote Transmission of Patient Symptoms

Real-Time Patient Access to Physician, Care Providers

- Patients submit clinical questions via mobile wizard¹ or web application
- Photo or video attachments provide detail on ailment²,³
- Physician or care provider recommends next care step

Case in Brief: PINGMD

- Health care technology startup located in New York, New York
- Online platform enables efficient care network communications through secure text, picture, and video messaging; mobile app notifies user when communications are sent, received, and resolved
- Platform reports 100% improvement in customer satisfaction

¹ Proprietary
² Documented exchanges reduce physician liability; patient acknowledges disclaimer describing proper platform use.
³ 100% HIPAA compliant secure communication, 100% of the time.

Source: PINGMD. www.PINGMD.com; Health Care Advisory Board interviews and analysis.
In addition to connecting patients with clinicians, the PINGMD application enables remote consults between clinicians as well.

For more complex patient symptoms, physicians can securely forward the patient’s information to other physicians, the broader care team, or specialists for additional insight. Substituting telephonic or in-person consults with digital interactions saves physicians time and streamlines care coordination. It also eliminates the need for patients to attend unnecessary in-person follow-up visits. The application packages a record of the encounters into an easily exportable file that integrates with most electronic health records.

PINGMD estimates that over half of its digital consults replace office visits, which at scale would signal a prominent shift in how providers enable patients to access care in a more customized way.

### Platform Virtually Connects Providers Across the Continuum

#### Preventing Wasted Time from ‘Phone-Tag’ with Specialists, Care Team

#### More Streamlined Care Coordination Across Networks

- Providers conduct case consults or referrals virtually using group chat
- Improves communication and efficiency between providers
- Prevents readmissions through collaborative care follow-ups
- Automatic documentation ready for export to medical record

---

**Ping closed**

A pink for this ping has been generated and is now available in the patient profile on the website.

---

**Messages often replace unpaid patient encounters such as post-ops, prescriptions, discussion of lab results, etc.**

1. Messages often replace unpaid patient encounters such as post-ops, prescriptions, discussion of lab results, etc.
2. Not required, mean response time for physician to patient is 60 minutes

---

**Source:** PINGMD, PINGMD.com; Health Care Advisory Board interviews and analysis.

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<thead>
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<th>Time</th>
<th>Description</th>
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<td>30 min</td>
<td>PINGMD messages replace office visits⁴⁴</td>
</tr>
<tr>
<td></td>
<td>10 min</td>
<td>Median response time between care partners on PINGMD²⁴</td>
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<tr>
<td></td>
<td>50%</td>
<td>Physicians saving 15-60+ minutes per day with application</td>
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</table>

⁴⁴: Physicians saving 15-60+ minutes per day with application
More and More Care Successfully Handled Remotely

As remote technology becomes more sophisticated, patients will be able to access more clinical care digitally.

But most providers have not maximized the use of existing technology for all possible care today. Virtual care delivery is typically used for lower-acuity clinical needs and basic diagnoses, whereas it has the potential to be used for ongoing care as well. Progressive organizations are expanding virtual care to include follow-up care for existing conditions—such as chronic disease check-in visits—and post-surgical check-ins for low-risk patients. Though feedback on the model is early, many patients view remote check-ins as an appealing alternative to frequent office visits.

In the future, nearly any condition that does not require a physical intervention could potentially be handled successfully through remote channels. However, patient preferences for care delivery will still remain divergent. Though remote care is appealing to some, other patients still do place a premium on longer, in-person interactions, making it imperative for providers to offer options to stay competitive.

Maximize Virtual Channels for Tailored Care Delivery

“...[A] significant part of health care is essentially a content business. Today, that content (or knowledge) primarily resides in the inconvenient and expensive domains of physician office visits.”

Thomas Lee
CEO, One Medical Group
Meeting different consumer demands for customized service delivery can create opportunities for system growth. At the risk of oversimplifying a complex market, the current primary care environment can be compared to a typical market shortage scenario. As the graph here displays, a shortage manifests for two reasons. Either the current price for a service is artificially below what consumers are willing to pay, or the supply of that service is too scarce to satisfy demand. Improving either of these factors alleviates the shortage, moves the market toward equilibrium, and improves supplier—in this case, health system—revenue.

For primary care, there are two ways health systems can adapt care delivery to profitably eliminate the shortage. First, charge a premium to the population segment willing to pay for higher-end primary care services, e.g., through concierge care and virtual access. Second, expand primary care supply to accommodate excess patient demand. Because primary care physicians are scarce, systems must increase capacity without increasing labor—such as through virtual care channels.
Deploy a concierge care model in response to market demand

Creating a Premium-Priced Service Offering

The practice of charging a premium for enhanced primary care is gaining traction in the market. Though concierge models have typically involved offering a high-dollar service to a small group of wealthy patients, new lower-fee concierge models have emerged that appeal to a wider variety of patients.

From the physician perspective, concierge care delivery is attractive. Physicians care for fewer patients and receive higher compensation due to the retainer fee revenue. From the health system perspective, the biggest drawback to concierge care is the downsizing of patient panels that must occur for physicians to provide the enhanced level of care. A medium-fee concierge practice may have a panel size of 400 to 600 patients, in contrast to 2,500 patients for a typical employed PCP. Most health systems find the idea of losing the downstream revenue from the dismissed, non-concierge patients unpalatable. Therefore, low to medium-fee models with larger panels are more attractive for health systems seeking to implement concierge care at any level of scale.

Source: Health Care Advisory Board interviews and analysis.

1) Note: Please consult appropriate legal counsel prior to establishing premium payment or concierge care models.
For health systems, there is a trade-off between the revenue gained from delivering concierge care and the downstream revenue forgone from smaller panels. As panel sizes decrease, patients excluded from the practice may be lost to the system, jeopardizing downstream revenue. The model at right estimates the financial implications of establishing a moderate-fee concierge practice for an independent physician and a health system. The model takes a conservative viewpoint, assuming that patients who do not enroll in concierge care will not continue to access care at the health system. To make the case for the concierge practice, a health system would need to raise the retainer fee by 20% to 40% simply to offset downstream hospital revenue losses; to drive new profit, the fee must be higher. Though this is not impossible, systems should account for financial differences.

Concierge care can be attractive for health systems. If there is PCP capacity, the non-concierge patients can be integrated into those practices. A smaller panel may also be attractive for near-retirement or disengaged physicians, who may be considering leaving medicine entirely.

**Balancing Panel Size Loss with Revenue Gain**

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<thead>
<tr>
<th>Physician Value Clear...</th>
<th>600-patient panel</th>
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</thead>
<tbody>
<tr>
<td>Panel size reduced to 300-600</td>
<td>$900,000¹</td>
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<tr>
<td>Additional practice revenue</td>
<td></td>
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<tr>
<td>Extended patient interactions</td>
<td>$200,000</td>
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<tr>
<td>Increased patient satisfaction</td>
<td>($275,000)</td>
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<tr>
<td>Enhanced schedule flexibility</td>
<td>$825,000¹</td>
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<tr>
<td>Panel size reduced from 2,000 to 600</td>
<td></td>
</tr>
<tr>
<td>Physician revenue sharing model difficult to outline</td>
<td></td>
</tr>
<tr>
<td>Physician not engaging in broader population health management efforts</td>
<td></td>
</tr>
</tbody>
</table>

### Finances

<table>
<thead>
<tr>
<th></th>
<th>600-patient panel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital value of 2,000 patients</td>
<td>$2.58 M</td>
</tr>
<tr>
<td>Lost hospital value (1,400 patients lost in practice downsizing)</td>
<td>($1.27 M)</td>
</tr>
<tr>
<td>Retainer fee needed to break even on lost hospital value</td>
<td>$2,126 per patient</td>
</tr>
<tr>
<td>Profit</td>
<td>$0; Must raise retainer fee to add value</td>
</tr>
</tbody>
</table>

---

¹ Assumes annual retainer fee of $1,580 per patient; does not subtract portion of retainer fee allocated to concierge company for corporate support.

² Note: Please consult appropriate legal counsel prior to establishing premium payment or concierge care models.

Source: Health Care Advisory Board interviews and analysis.
Medium-fee concierge models, such as MDVIP, can improve practice economics for the participating physicians and meet patient demands for more customized care.

MDVIP practices offer a suite of additional wellness and preventive services, full-hour appointments, and around-the-clock physician access in exchange for the retainer fee. Patients also benefit from access to MDVIP’s Medical Centers of Excellence hospital-partner network. These additional enhancements are on top of clinical care billed to insurance.

MDVIP has met patient demands for customized clinical service. Patient satisfaction, membership renewal, and quality indicators are consistently high.

For health systems in regions where PCPs are more abundant, a moderate-fee model is a lucrative way to drive new revenue and meet patient demands. However, many health systems find it challenging to downsize even some PCP practices to 400 to 600 patients. In markets where PCPs are particularly scarce, such downsizing of panels may not be feasible.

MDVIP Concierge Practice

- >94% Annual membership renewal rate for MDVIP patients
- 79%, 72% Lower hospital discharge rates per 1,000, for MDVIP-enrolled Medicare patients, non-Medicare patients

Using results from comprehensive wellness evaluation and diagnostics, physician and patient customize wellness plan to address risk and proactively identify and meet patient health goals

Medical Centers of Excellence network expedites referrals, offers urgent access to all MDVIP doctors

300- to 600-patient panels provide extended appointments, exclusively physician-led care

Case in Brief: MDVIP

- Wholly owned subsidiary of Procter and Gamble
- Patients pay $1,500 to $1,800 annual membership for wellness program; practice bills Medicare and insurance for traditional patient services
- Patient panels capped at 600 patients per physician


1) Note: Please consult appropriate legal counsel prior to establishing premium payment or concierge care models.
Hybrid Concierge Model a Viable, Less Exclusionary Alternative

Capture New Revenue Without Restructuring Entire Practice

Hybrid concierge is a variation on traditional models where a portion of patients are enrolled in the concierge model, while the remainder stay within the practice as traditional patients.

There are three key benefits to hybrid models. First, practice bottom lines benefit from the additional revenue stream. A physician can earn an additional $200,000 by converting roughly 10% of his/her practice to concierge care. Second, patients uninterested in concierge medicine are not excluded from the practice—sustaining some of the downstream revenue for the system. Finally, the practice sources its concierge patients from within the preexisting panel, saving time and resources otherwise required to recruit a new concierge practice.

Hybrid models depend on several factors. Physicians must have strong relationships with their patients to enroll part of the practice into concierge care. If patients do not see the surplus value, they will not opt to pay the fee. In addition, physicians must offer high-quality care to both populations, regardless of payment model, to avoid any legal scrutiny.

Cross-Subsidizing Primary Care

“If we could make the concierge practice financially successful, then the revenue would be used to support what we all know is an underfunded part of American healthcare: primary care....Our system has raised the level of quality for everybody.”

Deeb Salem, MD
Chairman Department of Medicine, Tufts University School of Medicine

Health System Investment per Physician FTE

<table>
<thead>
<tr>
<th>Hybrid Concierge</th>
<th>Sample Hybrid Concierge Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Only part of the panel is converted to concierge model</td>
<td>• 100 patients per 1,100 patient panel</td>
</tr>
<tr>
<td>✓ Model maintains larger panel size, patients can opt out of fee and stay in practice</td>
<td>• $2,000 annual retainer fee</td>
</tr>
<tr>
<td>(1) $170,600</td>
<td>• $200,000 additional revenue per physician</td>
</tr>
<tr>
<td>(2) $29,400</td>
<td></td>
</tr>
</tbody>
</table>

Sample Hybrid Concierge Practice

1) 2013 Medical Group Strategy Council benchmarking data, n=44. Comparison includes all clinical staffing costs, clinical occupancy costs, medical group overhead, health system overhead allocation, and practice management expense.
2) Investment calculated by sample calculation described to the right of the bar graph; sample practice.
3) Note: Please consult appropriate legal counsel prior to establishing premium payment or concierge care models.

Source: Press M, “Improvement Happens: An Interview with Deeb Salem, MD and Brian Cohen, MD,” Journal of General Internal Medicine, March 2012; Health Care Advisory Board interviews and analysis.
Tufts Medical Center has operated a hybrid concierge practice for nearly a decade. Retainer fees from concierge patients cross-subsidize care for a larger pool of traditional patients. In fact, the bottom line for the entire primary care service line is boosted by the $2,000 concierge fees paid by a minority of patients. Panel sizes are, on average, 1,200 patients per physician, with a quarter of patients opting in to concierge.

The same physicians care for concierge patients and traditional patients, and they offer a uniform level of clinical care. In Tufts’ model, physicians see concierge and traditional patients in two different offices, though this is not required for hybrid concierge care to be successful. Hybrid concierge models operated in the same clinic typically set aside specific time slots for concierge patients, to avoid having patients wait for service if the clinic is not on schedule.

Hybrid concierge models can be more palatable to physicians that are skeptical of concierge care, do not want to exclude patients from their practice, or are not ready to commit to downsizing their practice.

Capturing New Revenue from Existing Patients

Hybrid Concierge Program Successful at Tufts

- Panel comprised of 275 concierge and 900 traditional patients
- Physician splits time between concierge patients and traditional clinic
- Retainer fees make Tufts’ primary care service line profitable

Case in Brief: Tufts Medical Center

- Pratt Diagnostic Center is a hybrid-concierge practice operated by Tufts in Boston
- Retainer fees cross-subsidize traditional care

Determinants of Concierge Viability

| Patient income, ability to pay retainer fee | Length, quality of physician relationships |
| Demand for enhanced access, services | Physician willingness to convert panel, accept 24/7 on-call status |

$550,000
Annual revenue from retainer fee

1) Annual retainer fee per patient is $2,000.
2) Note: Please consult appropriate legal counsel prior to establishing premium payment or concierge care models.
Converting Full Panels to Elevated Service Through “Concierge Lite”

The lowest premium payment models, where retainer fees are hundreds rather than thousands of dollars, are particularly attractive options in markets where even minor reductions in panel size are infeasible. With the reduced fee, providers are able to convert entire practices into concierge models, with few patients opting out on account of high prices.

One Medical Group, a low-fee concierge network, targets younger, healthier patients with its enhanced access model. Patients are allotted same-day appointments, online access to medical records, and email consultations. Because patients often prefer email consultations to in-person visits, One Medical physicians can manage larger panels while still guaranteeing in-person visits.

A major consideration for health systems considering low-fee concierge care is whether there are enough eligible patients to populate the clinic. Many concierge practices report losing roughly 5% of patients per year, so systems must assess whether it is more viable to repopulate by converting existing patients (hybrid concierge) or attracting new patients (full concierge—all fee levels).

Trading Smaller Fee for Narrower Customization, Larger Panels

One Medical Group Care Model

- Same-day appointment booking online through One Medical mobile app
- Physician email consultations for minor illnesses and ongoing health management
- Coordinates tests, treatments, specialist referrals, and hospitalizations

Sample Concierge Retainer Revenue

<table>
<thead>
<tr>
<th>Finances</th>
<th>1,500 Patient Panel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retainer fee</td>
<td>$200</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$300K</td>
</tr>
</tbody>
</table>

Must create entirely new panel of paying patients or recruit new patients to fill slots of patients opting out of concierge model

Case in Brief: One Medical Group

- 90-physician network practicing in San Francisco, New York, Boston, Chicago, and Washington, DC; investments from Google Ventures and other venture funds
- $149 to $199 annual membership allows access to same-day appointments, email consultations, and online electronic medical records
- Email consultations, technology allow panel sizes to be closer to traditional practices

1) Please consult appropriate legal counsel prior to establishing premium payment or concierge care models.
Not all patients are willing to pay annual fees for concierge care, but many are willing to pay a premium for specific services. Virtual care enables patients to avoid the inconvenience of an in-person visit for conditions that can be managed through virtual care.

Sentara Healthcare, an integrated delivery system in Virginia, invested in a private telehealth provider, MDLIVE, to offer low-cost virtual consults. For slightly more than an office copay, patients can request appointments through the MDLIVE website. An operator then determines whether an e-consult is appropriate based on the reported condition, and if so collects the out-of-pocket payment up-front. For an established Sentara patient located in Virginia, the operator forwards the request to the person’s own Sentara physician, who is compensated for the visit. The physician has 15 minutes to reply before the case is redirected to a pool of MDLIVE physicians on standby.

Sentara is driving growth by providing attractive services to patients willing to pay out-of-pocket, instead of waiting for health plan reimbursement to catch up to consumer demands.

**Case in Brief: Sentara Healthcare/MDLIVE**
- Multi-hospital system headquartered in Norfolk, Virginia; owns equity stake in MDLIVE—a telehealth provider of online, on-demand health care delivery services and software
- Provides access to virtual care for any patient; Virginia-based web visitors triaged to co-branded virtual product to labeled “Sentara—Empowered by MDLIVE”
- Phone, web, and email visit services include general health, select and pediatric health, as well as mental health consults
Incentives to Spur Virtual Care Adoption

Physicians need the right incentives in place for virtual care adoption. Sentara initially decided to embed per-case payments into the employed physicians’ salaries. But because the payments were effectively invisible to the physicians as an indiscernible part of the salary, the signal value of the virtual care incentive was lost.

In response, Sentara decided to separate out MDLIVE payments from salaries, rewarding physicians explicitly for each virtual visit he/she completes. Though per-visit payments are modest, their rapid pace and convenience make them easy to slot in throughout the day, during downtime or after business hours, without complicating physician workflows. As a result of the adjusted incentives, more Sentara physicians are offering virtual visits.

Sentara’s commitment to provide consumers with low-cost virtual access is reinforced by the virtual care requirements for newly employed physicians. Incoming physicians are required to enroll in MDLIVE—both to accelerate the rollout of the platform and to increase panel size through new patient virtual visits.

Moonlighting as Virtual Providers

<table>
<thead>
<tr>
<th>Sentara Medical Group Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Elective participation during downtime, after-hours</td>
</tr>
<tr>
<td>• Physicians paid separately for virtual visits to reinforce MDLIVE contribution to physician compensation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sentara Reimburses Synchronous E-Consults Separate from Physician Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician’s Daily Schedule</strong></td>
</tr>
<tr>
<td><strong>Normal business hours</strong></td>
</tr>
<tr>
<td>9:00 AM</td>
</tr>
<tr>
<td>9:30 AM</td>
</tr>
<tr>
<td>10:00 AM</td>
</tr>
<tr>
<td><strong>After hours</strong></td>
</tr>
<tr>
<td>6:30 PM</td>
</tr>
<tr>
<td>7:00 PM</td>
</tr>
<tr>
<td>7:30 PM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Traditional Compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separate MDLIVE Check</td>
</tr>
</tbody>
</table>

Source: MDLIVE, www.MDLIVE.com; Health Care Advisory Board interviews and analysis.
Scaling Up Virtual Visits from Established Patients to New Consumers

At scale, virtual visits present an opportunity to convert consumer demand for remote services into a long-term patient relationship with the health system. Franciscan Health System, a multi-hospital provider in Washington, is collaborating with Carena, Inc. to offer virtual care options to existing and new patients. “Franciscan Anytime” is a low-cost, after-hours virtual and home visit product targeted at employees, intended to reduce costs for the self-funded health plan. In 2013, Franciscan expanded the service to established patients and launched a virtual urgent care product to attract new patients into the system.

Franciscan has two goals for growing via virtual urgent care first, then plan to accrue revenue from the out-of-pocket payments of patients demanding remote services. The second goal is to channel new patients from the virtual platform into downstream sites, including connecting patients with PCPs or needed specialist care.

By meeting consumer preference for remote access, Franciscan plans to acquire more than 1,450 new patients in the first year of the partnership.

### Expanding from Covered Populations to the General Public

<table>
<thead>
<tr>
<th></th>
<th>Employee Base</th>
<th>Current Patients</th>
<th>General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Substitution</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Access Extension</strong></td>
<td>![Person Icon] “Franciscan Anytime”</td>
<td>![Clock Icon] “Franciscan After-Hours”</td>
<td>![Monitor Icon] “Franciscan Virtual Urgent Care”</td>
</tr>
<tr>
<td><strong>New Service Provision</strong></td>
<td>![Plus Icon] Improve access to reduce costs (avoidable ED visits, treatment delays)</td>
<td>![Clock Icon] Extend availability of care for established patients through after-hours service</td>
<td>![Monitor Icon] Provide care on the patient’s terms to attract new volumes, extend Franciscan brand reach</td>
</tr>
<tr>
<td><strong>Patient Cost</strong></td>
<td>![Dollar Sign Icon] $19-$35 per virtual visit, $85-$90 for home visits, Free telephonic care</td>
<td>![Dollar Sign Icon] $35 per virtual visit</td>
<td>![Dollar Sign Icon] $35 per virtual visit</td>
</tr>
</tbody>
</table>

### Case in Brief: Franciscan Health

- Seven-hospital integrated delivery system based in Tacoma, Washington
- Partnered with Carena, Inc. in 2010 to provide virtual care and house calls
- Expanding Franciscan Virtual Urgent Care to general population as new patient acquisition strategy; aiming to generate >1,450 referrals to the system in first year

Source: Health Care Advisory Board interviews and analysis.
Limited New Capacity in Expanding Existing Clinical Model

The second way to address the market shortage is to expand the primary care supply to accommodate excess demand. Historically, systems created capacity by accelerating office throughput, extending clinic hours, and hiring more primary care physicians. But in many markets, these traditional levers are largely exhausted, and at best, offer incremental and insufficient returns. Furthermore, expanding capacity of an unsatisfactory model is unappealing to patients.

For example, patients desiring in-person care are dissatisfied with shortened appointment times. After-hours or weekend care slots are often unduly costly and simply offer more of the same in-person, scheduled format. Finally, PCP numbers have dropped substantially, creating a worsening labor shortage as time progresses.

To expand supply, systems will need to uncover new levers that gainfully create space in the day from existing clinical resources.

### Limited New Capacity in Expanding Existing Clinical Model

- **Increase Patients per Hour**
  - Scheduled visits already truncated to 10-15 minutes
  - Patient dissatisfied with degree of medical attention

- **Extend Hours**
  - Costly to keep clinics open beyond normal business hours
  - Physicians are already overworked with daytime schedule

- **Expand Physician Supply**
  - Physician supply becoming increasingly restricted
  - High labor cost to employ additional physicians

**53%**

percentage of PCPs at full capacity

21.7 hours

Time it would take a physician to meet all daily clinical needs for representative panel

68,500

Expected PCP shortage by 2025

Virtual Visits Create Space in the Day—and the Panel—for In-Person Service

E-Visits Offer Potential for Capacity Gains, Especially with High Utilizers

Typical PCP Workload

Workload with Remote Check-Ins

1 Square=1% of Physician Time with Patients

Virtual care, aside from its potential as a premium payment offering, can also create primary care capacity for established patients seeking ongoing care. The illustration at right demonstrates the effect of shifting a portion of chronic disease management check-ins to virtual visits, and the impact on overall office capacity. Assuming controlled chronic disease patients visit the primary care office four to five times annually, converting two visits to shorter, remote interactions creates new clinic capacity. In a typical practice, this shift can release up to 30% of the physician’s time, to be backfilled with new, in-person visits.

The value of virtual care substitution differs between the health system and the physician. For the health system, more visit capacity equates to larger panels, representing patients that need downstream care. However, if physicians are not paid for the virtual visits provided, the time represents lost practice revenue—because physicians do not accrue the downstream value of the lives served in the panel. To reconcile these perspectives, physicians must be reimbursed for virtual care provided.
The reimbursement landscape for virtual care remains challenging. Few insurers offer meaningful payment for virtual care.

Many private payers are bypassing health systems to provide beneficiaries with virtual access directly. WellPoint, the largest managed care company within the Blue Cross Blue Shield Association, partnered with virtual provider American Well to offer virtual primary care and specialized services to its policyholders. Cigna chose vendor MDLIVE to offer virtual care options to covered employer groups.

Public payers remain focused on reimbursing virtual care for specific, needy populations, such as rural or at risk patients. Many states are passing statutes to mandate Medicaid—and in some cases private payer—coverage for select virtual services provided to rural and underserved populations. This excludes elective encounters for patients with ample physician access or encounters for ongoing chronic disease management—precisely the visits targeted for practice capacity expansion discussed on the prior page.

### Public and Private Payers Compensating Virtual in Limited Circumstances

#### Outlook for Commercial Reimbursement

**Private payers** are partnering with non-health system innovators to offer covered virtual services for select groups of beneficiaries

**WellPoint/American Well**
- Scaled across 12 states
- Covering real-time video, telephonic, and secure chat visits for non-urgent care consultations

**Cigna/MDLIVE**
- Covering several large employer groups
- Offering video and telephonic consults with internal medicine, primary care, and pediatric physicians

**UnitedHealth Group/NowCare**
- Scaled across 22 states
- Covering real-time video and telephonic interactions for non-urgent care consultations

#### Outlook for Public Payer Reimbursement

**Public payers** (i.e., Medicare and Medicaid) are reimbursing for a limited number of services delivered to remote, underserved populations

### States Mandating Telehealth Coverage

For Limited Access Populations

- **Medicaid and Private Payers Only**: 56%
- **Medicaid Only**: 28%
- **Private Payers Only**: 10%
- **No Mandate**: 6%

42 states have active laws as of October 11, 2013, for real-time virtual interactions between Medicaid patients and “distant site” physicians

---

1) Terms of the mandate vary from state to state, though nearly all include a provision to require telehealth coverage for rural and measurably underserved populations covered by public or private insurance.
Though health plans are not eager to reimburse physicians for virtual care, virtual visits can still be implemented in clinics open to creative solutions. The Massachusetts General Ambulatory Practice of the Future is piloting the exchange of in-person chronic disease management appointments with virtual consults. Instead of dedicating space to these visits, the clinic schedules them in available downtime.

MassGeneral found that scheduled 60-minute check-ins for chronic disease cases often concluded in 40 minutes. In response, the practice began conducting virtual care consults between scheduled visits.

The model benefits physicians and the system. Physicians provide virtual access to patients without overloading daily workflows or sacrificing lucrative in-person appointments. For the system, increased panel sizes translate into more potential downstream revenue. For patients under risk contracts, virtual check-ins are a less costly way to provide ongoing management. Though the virtual visits are still in pilot phase, early results are promising.

### Daily Schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00</td>
<td>In-Person Clinical Visit (Chronic Disease Intake)</td>
</tr>
<tr>
<td>9:30</td>
<td>Virtual Consult (Chronic Disease Follow-Up)</td>
</tr>
<tr>
<td>10:00</td>
<td>Virtual Consult (Chronic Disease Follow-Up)</td>
</tr>
<tr>
<td>10:30</td>
<td>In-Person Clinical Visit (Chronic Disease Intake)</td>
</tr>
<tr>
<td>11:00</td>
<td></td>
</tr>
</tbody>
</table>

### Case in Brief: Massachusetts General Ambulatory Practice of the Future

- Primary care innovation pilot clinic located in Boston, Massachusetts
- Uses multidisciplinary care teams and technology to support both in-person/in-practice visits as well as virtual visits; virtual visits replace in-person visits for disease monitoring/management, weight management, blood pressure monitoring, etc.

### Offers Virtual Follow-Up Option for Ongoing Chronic Disease Management

- Both phone and video virtual visits are conducted for chronic disease management and follow-up
- In-person clinical visits booked for 60 min, typically run 30-40 min
- 10-20 min virtual consults slotted into excess time throughout the work day

Source: Health Care Advisory Board interviews and analysis.
Compensation Models Must Reinforce Virtual Value

Conducting virtual visits during existing downtime is a near-term solution, but aligning system-level and physician-level incentives is essential for long-term sustainability.

At Group Health in Seattle, physicians are reimbursed one-fourth of one RVU for secure messaging over the patient portal. This direct compensation model encourages practices to offer remote consults to patients who are interested in a virtual visit option.

At Dean Health System, physicians are compensated based on panel size and patient engagement with the online patient portal. A portion of the physician incentive corresponds to total panel size. This indirect incentive encourages physicians to find ways to enlarge their panels through virtual platforms.

---

**Group Health Designates RVU-Value for Virtual Care**

Physicians reimbursed one-fourth of one RVU for secure messaging over MyGroupHealth patient portal

**Dean Includes Panel Size in Bonus Incentive**

PCP Compensation 2011

- 60% Productivity
- 55% Other
- 20% Incentive Elements
  - Panel Size
- 35% Sample Metrics:
  - Patient IT utilization
  - Efficient prescribing
  - Patient satisfaction
  - Quality

---

**Case in Brief: Group Health**

- Integrated provider and payer network located in Seattle, Washington
- Operates scheduling and triage system, including e-messaging patient portal

---

**Case in Brief: Dean Health System**

- Integrated delivery system including a multispecialty clinic network and health plan, located in Madison, Wisconsin
- Business model focusing on value-based care has been a priority since 2004

---

1) Relative value unit.
2) Total greater than 100% due to bonus elements.
3) Percent of patients active on the MyChart patient portal.

Source: Health Care Advisory Board interviews and analysis.
Unlocking Value Through Tailored Service

Health systems can employ two strategies to grow by meeting patient demands for more customized service. First, systems can increase per patient direct revenues via premium payment models—such as concierge care and virtual care paid for out-of-pocket. Second, systems can increase the supply of clinical care to satisfy demand for basic primary care services. By offering virtual visits for conditions that do not warrant an in-person visit, systems can make room for new patient volumes while delivering benefits to existing patients and physicians.

Individual markets may respond more to one strategy over another, depending on specific patient preference, physician relationships, and system goals. Health systems have an opportunity to operationalize a mix of tactics from each strategy to win share and grow the organization.

4 Embracing Premium Payment Models

Deploy a concierge care model in response to market demand
Charging more for tailored service offers current consumers more palatable delivery options and attracts new customers seeking more customized care. Recognize the (under) valuation of primary care and seek opportunities to right the shortage in a profitable way.

Establish pay-per-use service offerings
Enable consumers to pay for desired services—such as virtual visits—that both benefit the patient and improve operations at an overcapacity practice.

5 Accommodating Excess Primary Care Demand

Leverage remote transactions
Expand supply through remote interactions for basic care, building to a model in which a significant proportion of ongoing management shifts to virtual channels. In the near term, minimize the disruption to physicians by slotting virtual care into existing downtime. In the farther term, rectify financial disincentives by compensating physicians directly for virtual care delivered or indirectly through panel size bonuses.

Source: Health Care Advisory Board interviews and analysis.
Appendix
The Consumer-Oriented Ambulatory Network

- Danton Health Pricing Change Email to Physicians (page 86)
- Profitability Comparison Among Immediate Care Sites (page 87)
- Considerations for Co-located Urgent Care, Primary Care (page 88)
- Evaluating Corporate Retail Partners (page 89)
- Comparison of Non-Traditional Concierge Models (page 90)
Danton Health Pricing Change Email to Physicians

At right is the email that Danton Health, a pseudonymed health system, sends referring physicians to alert them of pricing changes for diagnostic services. This is part of the system’s broader initiative to educate physicians on pricing changes, and in turn to keep price-sensitive patients in-network for downstream referrals.

Subject: Danton¹ Imaging Services Announces Lower Out-of-Pocket Costs for CommCo¹ Insurance Members

Dear Dr. Smith,

CommCo Insurance customers will now benefit from lower out-of-pocket costs when receiving outpatient imaging services at a Danton facility. This change comes as a result of Danton’s recently renegotiated contract with CommCo, which makes our rates competitive with stand-alone imaging sites and will result in lower co-insurances costs for CommCo members.

This change will significantly improve patient access to affordable imaging services, including X-ray, CT, MRI, mammography, and more, and is effective (retroactively) for services provided on or after April 1, 2013. While CommCo members who have a set copay (such as Danton Employee Plan or State Employee Health Plan members) won’t see any change to their out-of-pocket costs, our renegotiated contract ensures Danton’s rates are competitive with stand-alone imaging sites, reducing the overall cost of services for all parties.

Similar negotiations with other health plans are currently under way. See below for specific example of lower out-of-pocket costs for patients with co-insurance.

<table>
<thead>
<tr>
<th>CT Head Without Contrast</th>
<th>Previous CommCo Co-insurance for Danton Outpatient Imaging Services</th>
<th>New CommCo Co-insurance for Danton Outpatient Imaging Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Charge</strong></td>
<td>$2,310.00</td>
<td>$2,310.00</td>
</tr>
<tr>
<td><strong>Contracted Rate</strong></td>
<td>$1,097.25</td>
<td>$462.00</td>
</tr>
<tr>
<td><strong>Patient Coinsurance, Assuming 20%</strong></td>
<td>$219.45</td>
<td>$92.40</td>
</tr>
</tbody>
</table>

¹ Pseudonym

Source: Health Care Advisory Board interviews and analysis.
## Profitability Comparison Among Immediate Care Sites

<table>
<thead>
<tr>
<th></th>
<th>Retail Services¹</th>
<th>Urgent Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average Annual Revenue</strong></td>
<td>$340,000</td>
<td>$2.5M</td>
</tr>
<tr>
<td><strong>Average Charge per Visit</strong></td>
<td>$60</td>
<td>$184</td>
</tr>
<tr>
<td><strong>Average Reimbursement per Visit</strong></td>
<td>$60²</td>
<td>$114</td>
</tr>
<tr>
<td><strong>Average Profit</strong></td>
<td>$0-$75,000³</td>
<td>$379,000</td>
</tr>
<tr>
<td><strong>Margins</strong></td>
<td>-3% to 1%</td>
<td>3%-14% (9.6% average)</td>
</tr>
<tr>
<td><strong>Patients per Day to Breakeven</strong></td>
<td>17-23 visits</td>
<td>30-40 visits, varies by model</td>
</tr>
<tr>
<td><strong>Time to Breakeven</strong></td>
<td>12-36 months</td>
<td>12-18 months</td>
</tr>
<tr>
<td><strong>Start-up Costs</strong></td>
<td>$150,000⁴</td>
<td>$1.3M-$3M</td>
</tr>
<tr>
<td><strong>Staffing</strong></td>
<td>3-4 FTEs (1-2 NP, 1-2 registration staff)</td>
<td>5-10 FTE (1-2 physicians, 0-2 NP, 2-3 MA, 1 X-ray technician, 1-2 registration staff)</td>
</tr>
<tr>
<td><strong>Services Provided</strong></td>
<td>10-12</td>
<td>30+</td>
</tr>
</tbody>
</table>

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1) Hospital-owned clinics, not corporate partnerships or retailer-owned clinics.  
2) Cash price.  
3) Profit dependent on clinic volumes, varies by season.  
4) Start-up costs listed if building clinic for full operational control.

In weighing whether to co-locate urgent care centers with primary care practices, there are four key factors providers should account for in their decision. First, organizations need to assess whether physicians are willing to flex their time between the two care settings. Second, to drive traffic to both sites, organizations may need to provide additional marketing to new patients to help them understand the value of a co-located model compared with freestanding competitors. Third, operational considerations like clinic placement and IT interconnectivity should be evaluated before finalizing co-location. Fourth, reimbursements for urgent care delivery versus primary care delivery should be outlined and established prior to initiating a site.

**Considerations for Co-located Urgent Care, Primary Care**

<table>
<thead>
<tr>
<th>Providers</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians willing to practice in both settings</td>
<td>May require additional marketing to unattached patients compared to freestanding urgent care center model</td>
</tr>
<tr>
<td>Comfortable with extended care team model</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operations</th>
<th>Financials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinics located in high-traffic, high-visibility location</td>
<td>Favorable reimbursement differential available for dedicated on-demand service</td>
</tr>
<tr>
<td>EMR connectivity within clinic, preferably across sites</td>
<td></td>
</tr>
</tbody>
</table>

Source: Health Care Advisory Board interviews and analysis.
## Evaluating Corporate Retail Partners

<table>
<thead>
<tr>
<th>Health System Autonomy</th>
<th>Benefits</th>
<th>Challenges</th>
<th>Future Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Branded Affiliate (CVS-MinuteClinic)</td>
<td>• No financial risk throughout</td>
<td>• No control over strategy, operations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Small fixed revenue stream from medical directorship</td>
<td>• Retail partner refers patients to downstream care regardless of whether systems are clinical affiliates</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Exclusive regional partnership</td>
<td>• Limited ability to coordinate care with other ambulatory sites if IT is not coordinated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Prominent signage</td>
<td></td>
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<tr>
<td></td>
<td>Clinical Partnership (Walgreens ACO)</td>
<td>• No financial risk at start-up; shared risk under ACO model</td>
<td>• Movement into chronic disease management may be unpalatable to physicians</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Corporate partner may fund care coordination, integration efforts for certain patient populations</td>
<td>• Ability to capture shared savings through partnership unproven</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Access to pharmacist expertise</td>
<td></td>
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<tr>
<td></td>
<td>Operational Control (Walmart)</td>
<td>• Can encourage appropriate in-network referrals, and establish care coordination protocols</td>
<td>• Health system assumes full financial risk for clinic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Heavy in-store traffic provides high exposure to patients, site is convenient</td>
<td>• Build-out expensive, space options limited</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Store is a destination for multiple consumer needs beyond health</td>
<td>• Inflexible contract terms for operations, signage, hours</td>
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<td></td>
<td></td>
<td></td>
<td>• Clinic may attract less-favorable payer mix</td>
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<td></td>
<td></td>
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<td>• Clinics rarely break even</td>
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<tr>
<td></td>
<td>Full Control (Local Business)</td>
<td>• Can encourage appropriate in-network referrals, and establish care coordination protocols</td>
<td>• Partner may be less strict about operations, signage, hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Partner may be less strict about operations, signage, hours</td>
<td>• In-store traffic provides patient exposure, convenience</td>
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<tr>
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<td></td>
<td></td>
<td>• Preexisting consumer trust in local brand</td>
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</tbody>
</table>

### Health System Financial Risk

- Low
- High

**Source:** Health Care Advisory Board interviews and analysis.
At right is a comprehensive comparison of two nontraditional concierge medicine models discussed earlier in the section. Tufts’s hybrid concierge model converts a minority of the panel to the concierge model without dismissing a substantial number of traditional patients from the practice. One Medical’s concierge model charges a considerably lower fee than traditional or hybrid concierge models, aiming to attract a younger, healthier population willing to pay for a limited set of enhanced services.

<table>
<thead>
<tr>
<th></th>
<th>Tufts Hybrid Concierge Model</th>
<th>One Medical</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Concierge Patient Encounters</strong></td>
<td>4-6 patients/day</td>
<td>16 patients/day</td>
</tr>
<tr>
<td></td>
<td>Visit length: 45-60 minutes</td>
<td>Visit length: 30 minutes</td>
</tr>
<tr>
<td><strong>Traditional Patient Encounters</strong></td>
<td>10-12 patients/day</td>
<td>No traditional patients in practice</td>
</tr>
<tr>
<td></td>
<td>Visit length: 8-15 minutes</td>
<td></td>
</tr>
<tr>
<td><strong>Retainer</strong></td>
<td>$2,000/year</td>
<td>$149-$199/year</td>
</tr>
<tr>
<td><strong>Annual Revenue from Concierge Retainer Fee</strong></td>
<td>$550,000/year</td>
<td>$300,000/year</td>
</tr>
<tr>
<td><strong>Billing/Collections</strong></td>
<td>Insurance, patient obligations, retainer for non-covered services¹</td>
<td>Insurance, patient obligations, administrative fee; no Medicaid.</td>
</tr>
<tr>
<td><strong>Panel Size Before Transition</strong></td>
<td>1,500</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Current Panel Size</strong></td>
<td>1,175 (275 concierge patients, 900 traditional patients)</td>
<td>1,500</td>
</tr>
</tbody>
</table>
| **Noncovered Services Provided to Concierge Patients** | • On-time appointments  
• Separate concierge medicine office  
• Physician availability 24/7 by personal cell phone, email  
• Physician-coordinated appointments with other specialists within the system  
• Concierge physician visits hospitalized patients regularly, reviews care | • Same-day appointments  
• Email consultations  
• Coordinated tests, treatments, specialist referrals, hospitalizations  
• My One mobile app for appointment booking, prescription refills, emails |

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¹ Non-covered services typically include a wellness plan, extra health coaching, electronic services.
