The rise of health care consumerism has been a trend-spotting cliché for decades. Several generations of futurists have predicted that patients would wrest control of their health care decisions and finances from insurers, employers, and doctors, but progress has been halting at best—until now.

Suddenly, propelled by high-deductible health care plans and the Obamacare exchanges, the retail market for health care delivery seems to have arrived. Across the health care industry, we’ve seen ample evidence of new “retail purchasers”—patients shopping for lowest-price imaging exams; primary care purchasers opting for convenient care options; employees carefully selecting their own plans on insurance exchanges.

In this issue, we bring together insights and findings from across our research programs on what the new retail market will look like—and how health care provider organizations need to adjust their strategies and execution to position themselves for success.

Michael Koppenheffer
Executive Director
Research and Insights
Four challenges every health system leadership team is talking about

Where population health and consumer-driven care intersect

What do consumers want from primary care?

Hey, hospitals: It’s time to get real about being ‘patient-centric’

Patient access means something different to everyone—but all agree it’s essential

Channeling Chipotle with ‘have it your way’ scheduling

Traditional primary care, meet next year’s model

What do we really mean when we say ‘retail’?

What physicians fear the most about retail clinics

Are you ready for the specialization of primary care?

AT THE INTERSECTION  |  6
What kinds of organizations will thrive in tomorrow’s health care market? Those that follow three no-regrets strategies.

FOUR CHALLENGES FACING LEADERS  |  2
We’ve been having a lot of conversations with senior health care executives, and no matter the market, every leadership team has a similar set of concerns.

SPECIALIZING PRIMARY CARE  |  28
We’re asking PCPs to do a lot of new things all at once. Is it realistic?
Lately, I’ve been thinking about the conversations I’ve been having with senior health care executives. No matter what market I’m in—from Los Angeles to Cincinnati to Philadelphia—every health system leadership team has a similar set of concerns.

Specifically, all our discussions boil down to four big questions.
What is the business model for population health?

Health care executives know that population health is no longer a question of “if” or even “when,” it’s a question of “how.” With few exceptions, they’re already seeing flattening volumes in their traditional lines of business, including cardiac, orthopedic, and oncology services. They’re feeling price pressure from payers. They’re seeing ACOs form very quickly in almost every market. They know the industry is moving toward population health, and for the most part, they’re getting ready to move with it.

Their question is, “How can we get paid for it?”

Of course, CMS has put forth a number of pilots to try and address this, and the results are beginning to trickle in.

What do we know so far? Shared savings is simply not a great business model. It may be a good way to get your feet wet in population health without the full downside risk of capitation or owning the premium, but the upsides—for those who are good enough to generate the savings—are generally not enough to make up for the losses in volume. To make the economics work, health systems are going to need much greater numbers of lives under risk, much more aggressive risk contracts, or both.

At the same time, health systems will have to move aggressively to reduce their fixed costs. Few things will strain the financial health of an organization more than expensive underutilized capacity.

Have I assembled the right network components to be chosen by patients and payers?

Health system executives used to focus on building a care network that exploited pockets of profitability in the DRG payment system and capitalized on new technologies to drive growth in high-margin services. Because of that, most health systems have ended up with a somewhat random mix of assets, from acute-care hospitals to outpatient surgery centers to ambulatory clinics and more. Bigger was almost always better.

But now, health systems need a new way to look at their care network. If you want to attract both individual patients on exchanges and payers—either insurers or employers—you need to think about more than scale and the latest technology.

The question, “How big do we need to be?” is less relevant than the far more important question, “How good do we need to be?” Increasingly, the market appears to be rewarding scope (offering the full continuum of services, either yourself or with carefully selected partners) and geographic reach (being convenient and accessible for patients).

Let’s say you’re a health system that wants to work directly with an employer. Are you nearby their offices? Do you have a robust network of primary care access points in the areas where their employees live? What specific services would that employee population need, and can you credibly offer high-quality, cost-effective care in most or all of them?
The words “consumer” and “customer” haven’t been in the health care lexicon for long. Medicine has never been a retail market; the people paying for your services are payers, the people choosing your services are often physicians, and the people using your services are patients. The patients with insurance coverage almost always had it through their employers, and when they got sick or injured, they went to a nearby location that was covered by that insurance and recommended by their doctor. And someone else paid the bill.

Who exactly is the customer in that world? Two of the most fundamental tenets of market economics—freedom of choice and full exposure to pricing—have long been absent in this industry. But now that we’re seeing the “retailization” of the insurance market, people have more choice in where they get health care and more accountability for the financial implications of those choices. For the first time, the word customer actually means something.

Think about how well consumer products companies understand their customers. They provide a wide array of differentiated products at different price points to appeal to different customer segments.

Do we understand our patients as consumers?

And the first thing we’ve learned about our patients as customers is that we really don’t know them at all. Consider a patient with diabetes who signed up for coverage through the public exchange and is getting health insurance for the first time. If he works multiple jobs at odd hours, will he choose the lowest-price insurance option (i.e., lowest premium), or will he pay a bit more for a lower deductible or to access a more convenient provider network?

What about a young married couple that moves to a new city and decides to shop for a private insurance plan? Will they prefer a primary care physician near their house, or will they drive 45 minutes to an established organization with a brand reputation for high-quality care?

It’s not that we don’t know the factors at play—namely price, access, convenience, and quality—but we’ve only ever thought of them theoretically. We have almost no data on how consumers trade off these factors, or how they value one combination versus another.

Think about how well consumer products companies understand their customers. They provide a wide array of differentiated products at different price points to appeal to different customer segments.

Health care is pretty far from having that level of sophistication. Most health systems simply don’t have the consumer marketing expertise needed to understand how patients will make these trade-offs.
What are the **investments** we can make now that will help us under both fee-for-service and value-based incentives?

I think that’s the wrong question. It’s not just about volume or value. In many markets, it’s about both, and it will continue to be about both for the foreseeable future. Markets will not have clear tipping points at which health systems can seamlessly shift from one set of strategies to another. We’re going to have to live with the ambiguity and have organizations that are nimble and agile enough to sustain themselves amid that duality.

The real question is about what investments and initiatives make sense in both a volume-based fee-for-service world and a value-based world in which we’re paid based on cost and quality outcomes.

For example, improving access to care is critically important in both a volume- and value-based world. To win volume, you need easy, convenient, cost-effective access to ensure that you maximize the number of patients who are good candidates for acute-care services. In a value-based world, you need to have a broad suite of access points so you can proactively coordinate care for your most complex patients.

Another investment that makes sense in both worlds is ensuring that all patients get the full complement of necessary, evidence-based care for their age and clinical profile. In a volume-based world, this leads directly to increased revenue; in a value-based world, this kind of preventive care is essential to managing costs.

And of course, most important, it’s better for patients.

For more information on how to overcome these challenges, visit [advisory.com/hcab](https://advisory.com/hcab)

As vice president of health system strategy and executive education, David works with health systems to improve clinical quality, population health, revenue, and profitability during times of transition.
Where

population health and consumer-driven care

intersect

Three no-regrets tactics

BY: BEN UMANSKY
Here’s a simple question I ask myself all the time: **What kinds of organizations will thrive in tomorrow’s health care market?**

It’s a pretty important one for me—and you—to be able to answer, and I’ll share my prediction at the end.

On the one hand, you’d be on safe ground arguing that health care is becoming a retail industry. You could mention the rise of insurance exchanges, higher deductibles, price and quality transparency, and you’d reason that individual choice and responsibility are more important than ever. Then you’d note the proliferation of disruptive market entrants reshaping the choices individual consumers have: mobile health apps, freestanding diagnostics, and primary care at Walmart to name a few. There’s plenty of evidence to suggest that tomorrow’s market will be dominated by nimble, low-cost solutions.

But you could just as easily argue that population health management is the most salient market trend. You’d recall the continued migration to risk-based payment and the massive investments in care transformation hospitals of all types are making. You’d point out how important controlling the total cost of care is to securing preferred status with employers and insurers. And you’d suggest that the national wave of consolidation and integration is a signal that the future of health care is in big, integrated networks that can manage entire populations.

Is either view right? Could they both be right? And regardless, what should the majority of hospitals—neither agile enough for a retail world nor integrated enough for a population health world—do to prepare?

The truth of the matter is, retail medicine and population health are real, and probably around for the long haul. The good news for hospital leaders is that many of the strategies that will be successful in a retail setting will pay dividends in a world of population health management as well.

We identified three strategic objectives in particular that are relevant in both types of markets: **convenient access**, **lean cost structures**, and a **smart partnership strategy**.
Convenient access matters for more than patient satisfaction

Why this matters in a retail market: The most obvious feature of many “retail” health services is convenience. You can go to a CVS clinic after work or on the weekend, and you don’t need an appointment. Virtual options allow patients to interact with physicians and other providers without fighting traffic or spending an hour in the waiting room.

Our research shows that convenient access is one of the top priorities for discerning consumers, but it’s not just about improving the patient experience. More organizations are finding ways, whether through one-off payments or subscription services, to drive direct returns from improved access.

Why this matters for population health: Access has indirect benefits too, and one of the most important is its impact on patient engagement. When it’s easier for patients to get care, or even just information, when they need it, they’re more likely to follow care plans. That means better outcomes and lower total costs. Patients are also more likely to stay within your network if they can always access it, so you can be confident that the returns on your care management investments will accrue to you, not your competition.

Lean cost structures mean strategic flexibility

Why this matters in a retail market: On the surface, this one is obvious. Of course you’re in a better spot if your organization runs leanly; lower costs mean higher margins. But the imperative to control operational expenses is even stronger in a retail environment where price competition is rampant. It’s a lot tougher to match or beat your competitor’s rates when you have an overgrown fixed-cost base and inefficient operations to prop up.

Why this matters for population health: Investing in care transformation isn’t cheap, and there’s a real tension between keeping today’s prices low and finding the resources for long-run population health efforts. But the more you do to keep your own expenses under control, the more freedom you have to make new investments without

The most successful hospitals will be those whose doors are open widest...and whose relationships with the broader market yield value, not just leverage.
driving your prices to uncompetitive levels. It’s especially important to use scalable approaches to population health to get the most out of costly labor and technology.

3 A smart partnership strategy supports multiple ambitions

**Why this matters in a retail market:** Most hospitals don’t already have the network of low-cost, high-convenience facilities that the retail market demands. And it’s probably not wise (or even possible) to build all those facilities from scratch.

The right partnerships can fill some of those gaps. Perhaps it’s an academic center teaming up with a community hospital to offer a low-cost option closer to home. Or maybe it’s a physician network partnering with local urgent care centers to expand access. No matter the form it takes (and it’s not always M&A), a smart partnership can strengthen any organization’s appeal to retail consumers.

**Why this matters for population health:** Not even the biggest health systems can observe, let alone control, the entire continuum of care. But being a successful population health manager means being responsible for all of a patient’s care—even if someone else is providing it. So partnerships that reduce fragmentation—of data, of care pathways, even of incentives and accountability—are a big part of successful population health managers’ organizational identity. Organizations can stay legally independent, but they can’t stay isolated.

So who do I think will be the big winners in tomorrow’s market? They won’t be the big, or the small, or the medium-sized providers. They will be those whose doors are open widest, whose options are least constrained by uncontrolled expense, and whose relationships with the broader market yield value, not just leverage. Those are no-regrets strategies. I hope they are yours.

Are you prepared for tomorrow’s health care market? Find out at advisory.com/hcab

Ben is a practice manager with the Health Care Advisory Board research team. He spends much of his time exploring the impact of industry-wide trends on hospital and health system growth strategy.
What do consumers want from primary care?

10 insights from the Primary Care Consumer Choice Survey

BY: ALICIA DAUGHERTY

As referral networks tighten, primary care is increasingly important for winning and protecting population share. With the rise of retail and virtual providers, urgent episodic care (on-demand care) represents one of the best opportunities for attracting new patients.

Because many patients wait until they are sick before choosing a clinic, we conducted a survey to find out what’s most important to them when seeking care for an illness like the flu. Where a consumer receives care for her sore throat will likely influence where she receives her mammogram and knee arthroscopy. Here’s what we found.

ABOUT THE SURVEY

Unlike many other surveys, which allow respondents to rate all items as “important,” our MaxDiff conjoint methodology asked participants to make trade-offs among 56 different clinic attributes, providing insight into the relative importance of each attribute.

The survey asked consumers to assume they had the flu and wanted to receive care, but their usual provider was not available. Respondents were shown multiple sets of five clinic attributes. Within each set of five, they were asked to choose the one “most appealing” and the one “least appealing” to them. Each attribute was presented multiple times, resulting in a ranked list of utility scores indicating the relative value of each attribute.
1 Convenience is king
Prioritize immediate access. Six of the top 10 attributes were related to access and convenience.

2 Same-day appointments trump walk-in and wait
Consumers ranked “walking in without an appointment and being seen within 30 minutes” first among 56 attributes, but “walking in and being seen in one hour” ranked 39th.

3 Evening or weekends? Depends on age
24/7 access ranked fifth among all 56 attributes. But staffing a clinic around the clock is rarely feasible. So when should your clinic be open? Preferences for after-hours versus weekend access differed across age cohorts, with preference for weekend access growing with age.

4 Clinic near errands or work? They’d rather meet you online
Unsurprisingly, respondents preferred a clinic near home over a clinic near errands or work. What was surprising was that they also preferred email visits over a clinic near errands or work.

5 One-stop shop is worth the drive
When choosing between a clinic with lab, imaging, and prescriptions on premises, and a clinic located five minutes from their home, the majority of consumers preferred having ancillary services on-site.

6 Consumers prioritize convenience over credentials and continuity
Consumers ranked six access and convenience attributes over being treated by a physician, and four access and convenience attributes over being treated by the same provider each visit.

7 High-tech beats high-quality
Even when making a decision on where to go for less acute illnesses like the flu, 71% of respondents prefer a clinic with cutting-edge technology to one with quality scores in the top 10% for their area.

8 Don’t rely on your brand
Respondents ranked attributes related to reputation unexpectedly low. The highest-ranking reputation attribute, “a clinic affiliated with the best hospital in the area,” ranked 19th, and a clinic affiliated with a university hospital ranked 34th.

9 Talk about money—consumers will trade access for bill info
There was little that consumers preferred less than not knowing how much the visit would cost until receiving the bill a few weeks later: the attribute ranked 55 out of 56.

10 Know your target population—particularly their age
When defining value, younger cohorts (ages 18 to 49) preferred eliminating out-of-pocket charges, while 50- to 64-year-olds rated convenience factors—specifically walk-in availability, short wait times, and ancillaries on-site—as more important than a free visit.

To learn how to attract and keep your patients, visit advisory.com/mplc

Alicia’s 2014 research agenda includes consumer-centric strategy, ambulatory networks, employer partnerships, virtualization of care, and price transparency.
Hey, hospitals: It’s time to get real about being ‘patient-centric’

BY: ALICIA DAUGHERTY

The Advisory Board’s experts weighed in on Walmart’s move to open primary care clinics, and Alicia Daugherty’s comments provoked a stir. The Daily Briefing followed up with Alicia to get more context on her statement that “it’s time to get real about being patient-centric.”

DAILY BRIEFING

Why did you say it’s “time to get real” about focusing on patients?

ALICIA DAUGHERTY

Providers have talked for years—with the best of intentions—about being patient-centric, and in certain parts of the organization, such as nursing, they’ve made great strides.

But ultimately, hospitals have been limited in their investments. Why? Because at the end of the day, demand for hospitals’ services has been directed by physicians, not patients.

And since physicians have been the patient traffic controllers, provider organizations have naturally oriented their facility strategy, technology investments, and program planning around their needs. Around physicians’ desires.

But that’s changing. What we talked about with Walmart…that’s just one element of what we’re seeing shift in the market.

DB

Which suggests that there are many pressures making this an imperative for hospitals.

AD

Yes. I’ll give you three reasons. First, physician employment and alignment strategies are encouraging physicians to direct their referrals, when appropriate, to a preferred provider. That means the best opportunity to inflect that referral chain is increasingly at the point of primary care. And who directs patient traffic for primary care? Patients.

Second, patients are bearing more responsibility for their care costs. That naturally pushes them to shop around and even question their physician’s referral.

And third, patients have more places than ever to shop around.

DB

And that’s where the Walmart news fits in.
Exactly. New market entrants like retailers and online visit providers offer primary care services and begin to push into specialty care.

As a result, patient traffic is becoming more self-directed. Provider organizations now have both a mandate and an incredibly exciting opportunity to align their investments with their patient-centric values.

Ok—you’ve given us a picture of the playing field. What do providers need to do to compete?

First, understand what patients really want—not what we want them to want. Patients’ needs and preferences are changing, and providers need to understand what patients value and the relative importance they place on different components of value.

Our Primary Care Consumer Choice Survey looked at this, and we’ll be doing a deep dive analysis of the results at our upcoming meeting with strategists and business developers.

So what are the implications within an organization?

We also think it’s time to measure performance by people, not volumes. Providers need to reorient their performance dashboards to focus on how well they’re serving individuals, not generating clicks. For example, expanding market share metrics to measure not just share of volumes, but share of population and share of wallet. How many individuals are we reaching each year, and how much of their care are we providing?

That’s another big focus of our meeting, where we’ll also be previewing new demographic profiling and patient loyalty tools that will be available through the Marketing and Planning Leadership Council membership.

Shifting away from volumes-oriented thinking sounds like a major shift in the hospital value proposition.

That’s right. Reorienting strategy on patients will require everyone in the organization—planning, business development, marketing, and physicians, among others—to make difficult changes.

Business developers must figure out how to evaluate the value of online care delivery platforms. Physicians need to figure out how to expand hours and offer walk-in access. Planners will have to build strategy around patient groups, rather than physician specialties.

And that’s another imperative for leaders: it’s time to prepare the organization for major changes. We’ll be exploring how progressive organizations are doing this and developing consumer-oriented strategy at our meeting.

Learn how progressive organizations are developing consumer-oriented strategy at advisory.com/mlplc

As practice manager of the Marketing and Planning Leadership Council, Alicia leads research and tool development focused on growth strategy, new business innovation, and patient engagement.
There’s a raging debate going on in the Advisory Board offices right now between the people who think “patient access” is a critically important issue for health systems, and other people who think “patient access” is a critically important issue for health systems. Yes, you read that right.

At least in our corner of the industry, “patient access” is a leading contender for Health Care Buzzword of the Year. It’s coming up in many of our conversations with executives, policymakers, and physicians. But, like so many jargon phrases, everyone seems to mean something different by it.

The hospital’s front door

For some, “patient access” refers to the hospital department that’s in charge of registration, insurance verification, cash collections, and so forth.

The patient access department has always been an integral piece of how hospitals work, because the department touches every patient who comes through the hospital’s doors. If it’s possible, though, patient access has become even more important recently, for two reasons.

Patient access

means something different to everyone—but all agree it’s essential

BY: MICHAEL KOPPENHEFFER
First, our researchers have found that many patient access departments could do even better at their core functions. Across the past several years, Advisory Board studies have identified best practices for patient access departments that, if adopted, would result in meaningful improvements. Many of these practices work best with technologies that support patient access workflow, but we have found examples of tactics that all providers could pursue, regardless of their IT infrastructure.

Second, the shift in the insurance market toward high-deductible health plans means that an ever-larger portion of the overall hospital bill will be the patient’s responsibility to pay. The Advisory Board expects that the development of public and private exchanges will accelerate this trend. So, how well patient access departments manage patients’ financial obligations is going to have a growing impact on hospitals’ bottom line in the years to come.

The health system’s front line

As important as the patient access department is, though, the people who focus on health system strategy define patient access quite differently. To them, “patient access” represents everything that affects a patient’s ability to get the right care at the right time, in the right place.

The narrowest definition here focuses on centralized scheduling for ambulatory care sites, but as Advisory Board Consulting President John Deane wrote a few months ago, access is much more than scheduling: it encompasses operations, staffing, IT systems, facility design, and coordination between sites of care across the full continuum.

For instance, if a health care system has an effective centralized call center, but it doesn’t offer the hours or geographic location that meet a patient’s needs, its centralized scheduling abilities still won’t result in great access. Likewise, if the system doesn’t have the right mix of specialists, or enough providers to meet the demand for care, patient access will suffer.

One of the reasons that patient access has become such an important health system issue of late is that today’s patients are expecting a higher service standard with regard to access, with primary care in particular pushed to be a 24/7 offering, in person and virtual. Our 2014 Primary Care Consumer Choice Survey found that six of the top 10 clinic attributes that primary patients value are related to access and convenience.

So in some ways, “patient access” is practically a synonym for health care delivery strategy—and it’s no wonder that Deane made the case that patient access is a CEO issue.

The health care delivery model

If that’s not enough to convince you of how important patient access is, improving access to care was a stated goal of the Affordable Care Act’s Medicaid eligibility expansion and health insurance exchanges. But the ACA took it a step further. To make care accessible, patients—and the country as a whole—need to be able to afford to purchase health care.

And for the nation to be able to afford high-quality care, many observers believe that we will have to reconsider our physician-heavy care delivery model. Thus, we will need to rely more on nurses and advanced practitioners to deliver the full range of services they are qualified to provide—working at the “top of their licenses,” as leaders in health care education and policy describe it.

Michael is an executive director in Research and Insights. With 20+ years of experience, he is an expert advisor on health care product development, marketing, and technological innovation.

To learn more about Payment Navigation Compass, visit advisory.com/paynav
The Washington Post recently published an article on the explosion of “have it your way” fast-casual cuisine, deeming the phenomenon “Chipotlification.”

Chipotle’s model is straightforward—diners first choose between a burrito and a rice bowl, and then pass through a line choosing whichever toppings they desire to complete their meal. The approach, says the Post, capitalizes on consumers’ desire to have exactly “what they want in under five minutes.”

So what can medical groups learn from the Chipotle model?
How One Medical Group mirrors the approach

You could argue that One Medical Group has effectively “Chipotlified” primary care appointment scheduling. While One Medical does not offer appointments within five minutes, it does offer same-day access to a provider. The organization’s online portal allows customizable, “have it your way” appointment scheduling for patients.

To schedule an appointment online, patients first designate whether they would like to see their primary care team or any available provider. Once they have made this initial decision, the portal presents three further levels of customization:

“I want to be seen for...”

Patients select one of five potential appointment types. The appointments are broken out both by length (for example, “brief, 15 minutes”) and reason for the visit (for example, “physician exam and pap smear”). To improve self-scheduling accuracy, the portal provides examples of appropriate issues to be covered during each appointment type.

“I want to be seen on...”

Patients can choose either the first available appointment slot, or a specific date.

“I want to cover...”

A free-form text box prompts patients to list the top issues to be covered during the visit.

Truly patient-driven scheduling

The “Chipotlification” of primary care appointment scheduling means that patients are empowered to make trade-offs between seeing a specific provider versus being seen on an earlier date. Granting patients access to these tools is one way that practices can compete with the types of same-day access providers that we’ve profiled in the past.

Providers and schedulers win, too. The appointment scheduling process gives providers the details they need to anticipate the types of issues to be covered during the day’s appointments. Breaking visits into five distinct types gives practices the platform they need to build their own benchmarks for appropriate appointment lengths.

To learn more about how you can improve your patient scheduling, visit advisory.com/mgsc

Rivka leads strategic research in support of employed and integrated medical group executives through the Medical Group Strategy Council.
Traditional primary care, meet next year’s model

BY: LISA BIELAMOWICZ, MD

I recently took my kids to Walgreens, but it wasn’t to pick up a prescription or to stock up on candy. It was for primary care.

And if this experience represents the new standard for primary care delivery, traditional physician practices should be watching retailers like Walgreens very closely.

As I tweeted when we left the clinic:

Lisa Bielamowicz, MD
@LisaB_MD

Walgreens healthcare clinic: Saturday, 2 kids, scheduled appts, full exam room, no copay, out in 30 min. Hard for old model to compete.

11:38 am - 11 Oct 2014

How did our family end up at a drugstore for our primary care? To make a long story short, one of my kids woke up with a bad sore throat (pretty sure it was strep), the other one needed a flu shot, and our regular pediatrician doesn’t do weekend appointments.

So, we drove to a relatively new Walgreens Take Care clinic in the leafy Van Ness neighborhood of Washington, D.C., a few miles away from my house. Walgreens was apparently making an investment in form and function with this facility. The first floor was a retail space, and an escalator led up to the second floor, which was devoted to “deep health”—pharmacy, medical supplies, and a clinic area with two exam rooms.
We rode up the escalator right at our scheduled time slot and were ushered into a well-equipped exam room by a smart, affable nurse practitioner who administered the flu vaccine, performed the strep test, and had us on our way within half an hour. Though our reasons for seeking primary care were typical, our experience was anything but. Here are a few aspects of the visit I found remarkable, especially relative to conventional physician practices or even other retail clinics.

Centralized online scheduling
I was able to select a clinic location and a 15-minute appointment block for each child on the Walgreens online portal. The portal was simple and easy to use—and the Van Ness location had availability the same morning. I’ve been happy with my visits to walk-in retail clinics in the past, but compared to the risk of waiting for hours at a walk-in clinic, I’ll take scheduled appointments any time.

Price transparency
As it happened, I didn’t even have to hand over a copay for our visit. But if I didn’t have insurance coverage, the clinic posts a clear and comprehensive list of cash prices for their services, both on their website and in-person. I can’t remember ever seeing a price list at a physician’s office—as a patient, when I was a practicing doctor, or in my current professional life.

Broad range of services
Though we were there for other reasons, I was particularly struck that one of the service categories for the Walgreens clinic is “monitoring and management” for “ongoing health conditions.” Seeing how easy it was to find and make an appointment, you could easily imagine some patients choosing to visit a clinic like this for care of their chronic conditions like diabetes or hypertension.

Professional clinic facility
To a patient with limited health care experience, this Walgreens clinic could be indistinguishable from many primary care offices: fully-outfitted exam room, professional staff, electronic medical records. And it had some consumer-friendly services that most doctors’ offices don’t, like touch-screen check in. This professional clinic facility—a model deployed not just by Walgreens but other retailers, including the Little Clinic—was a far cry from the “NP in a closet” experience of the previous generation of retail clinics.

Extended hours
This clinic allowed me to take care of my family’s primary care needs when they first arose, rather than waiting until Monday to see if my son had strep. In addition, to take my children to the doctor during working hours requires me to take time off of work, and often means they have to miss school as well.
A wake-up call for primary care practices

My visit to the Walgreens clinic left me wondering how long typical primary care practices were going to be able to maintain their existing ways of operating, especially because it’s not just Walgreens moving into the health care delivery business.

The pharmacy chain CVS, which operates MinuteClinic services, has been signaling its commitment to a stronger health care identity by walking away from an estimated $2 billion in tobacco revenue and rebranding as CVS Health. The Little Clinic is expanding rapidly in grocery stores. And Walmart earned attention earlier this year by launching in-store comprehensive primary care clinics in Texas and South Carolina.

The reality is clinics like those that these retail giants have been launching deliver a better product than traditional primary care for many attributes that consumers value highly.

We recently ran a large-scale primary care consumer survey that found that when patients choose primary care providers, they are most concerned with access, convenience, and transparency—and not particularly attuned to brand or reputation. Or their relationship with their personal primary care physician.

Part of a larger shift in primary care strategy

If I were running primary care strategy for a health system today, though, I wouldn’t necessarily see this retail clinic disruption as solely a threat. For a variety of reasons—including the rise of population health management—we’re predicting that the generalist PCP model will become less prevalent, and the whole industry will move toward a more purpose-driven, customized model of primary care.

To be sure, primary care physicians and practices will still have a critical role. But in the health care marketplace that’s taking shape, we expect PCPs to be focused on the highest-value activities, such as managing complex chronic illnesses, directing care teams, and providing concierge-based care. Viewed in that context, retail clinic models like the Walgreens clinic are pieces of a larger puzzle, creating a more efficient and more effective primary care delivery system. Having said that, next time I need a strep test on a Saturday, I know where I’m heading.

To prepare for the future primary care model, visit advisory.com/hcab

Lisa is the Advisory Board’s chief medical officer and leading expert on physician strategy, serving as a strategic adviser to executives from the nation’s largest health systems and medical groups.
My visit to the Walgreens clinic left me wondering how long typical primary practices were going to be able to maintain their existing ways of operating...
“Retail” is one of the hottest buzzwords in health care right now. With CVS, Walgreens, and Walmart all investing in health care delivery models, it sometimes seems like there’s a new retail clinic on every street corner. My colleagues and I often get calls from Health Care Advisory Board members who want to talk about their “retail strategy.”
The way we look at retail health care, though, it’s far more than those in-store offerings that have gotten so much attention lately. Our research team is seeing two more profound applications of “retail” in health care—the emergence of a new retail insurance market and growth of retail shopping for care. For hospitals and health systems, these versions of retail prove much more disruptive than the clinic variety.

What the retail insurance market could look like

The retail insurance market was ignited by the launch of the public health insurance exchanges and continued growth of private exchanges across the past year. These exchanges give individual consumers substantially more control in selecting their health insurance coverage. Historically, employers have made coverage decisions on behalf of their employees. But the advent of health care insurance exchanges is putting these decisions directly in individuals’ hands.

Just think of how this could play out in the case of just one individual—me.

This year, as an Advisory Board employee, I had four options for my health insurance coverage, all from the same insurance company: an HMO-like plan, a PPO-like plan, a high-deductible plan, or no plan at all. This is similar to what many private-sector employees who get employer-sponsored health insurance experience—at most, a handful of plan options.

But if our company moved to a private health insurance exchange model—similar to Sears, Darden Restaurants, and Walgreen Co.—or if I decided to buy my coverage on a public exchange, then I’d have a much wider choice in insurance plans, with a range of features and prices. I would be comparing plans from several insurance carriers instead of just one. And, as an exchange shopper, I would be able to select a plan with the price, benefits, and provider network that suits my personal health care needs. After all, I’d be selecting coverage for one employee instead of nearly 3,000, so I could behave more like a retail purchaser.

This is a fundamentally different approach to purchasing health insurance than the traditional employer-sponsored model. It’s not just a theory, either; retail insurance shopping is already happening with eight million individuals on the Obamacare exchanges and another three million in private exchanges so far this year. We expect that this retail insurance market will continue to grow dramatically, with projections of reaching 87 million individual buyers by 2018.
The retail health care revolution isn’t just an insurance market phenomenon, however. More and more, patients are “retail shopping” for health care services, as they are increasingly likely to pay for those services out of their own pockets. Two related trends are driving this out-of-pocket spending growth: more enrollment in high-deductible health plans and rising deductible levels. We are already hearing from members in many markets about greater price sensitivity as a result.

Our analysis suggests that the growth in health insurance exchanges will result in even more out-of-pocket price exposure. The process begins when individuals pick their coverage at the start of the year, since they typically seek plans with low premiums—and are willing to accept high deductibles in return, often higher than $5,000. These high deductibles expose individuals to the cost of care across the year. In essence, the retail insurance market is fueling more retail shopping for care.

How market dynamics will change

So what’s the big implication for health care executives? Simply put: health care providers are no longer insulated from market forces. We see five major market changes as health care moves retail.

1. Growing number of buyers

Employers historically acted as “wholesale buyers,” selecting coverage on behalf of their employees; individuals are increasingly shopping for both coverage and care, resulting in more buyers and more intense competition.

2. Proliferation of products

While carriers previously offered plans with broad, open networks, they’re now turning to narrow networks to help keep premiums low. And individuals can choose among a wider range of plans to find one that fits their needs.

3. Increased transparency

Health insurance exchanges allow individuals to compare plans side-by-side, helping buyers make their decisions based on premiums, benefit design, and network composition. Individuals are also asking about the price of care, especially for services that fall within the deductible level, such as outpatient imaging.

4. Reduced switching costs

Health insurance exchanges enable individuals to evaluate their coverage decisions each year. It’s a lot easier for individuals to switch carriers and networks than it is for large employers.

5. Greater consumer cost exposure

Individuals are now paying more of the health care bill—both for insurance and care. Newfound price sensitivity will continue to drive retail purchasing behavior at the point of coverage and point of care.

What’s your retail strategy?
Learn more at advisory.com/hcab

Rob is a practice manager with the Health Care Advisory Board. He leads research on accountable payment strategy and major industry trends.
What physicians fear the most about retail clinics

BY: RIVKA FRIEDMAN

Walmart recently announced that it’ll launch self-branded primary care clinics in Texas, South Carolina, and Georgia. Visits will be priced at $40 for the general public, and just $4 for Walmart employees.

At this year’s national meeting, we asked hundreds of physician leaders what they think about the presence of such retail clinics in their neighborhoods—whether they see them as a potential partner or as a competitive threat.

With a few notable exceptions, the leaders we’ve spoken to feel very threatened by corporate retail operators, for three reasons.
They'll prune away the healthy and leave us with the sick

Medical group leaders fear that retail clinics will take away healthy volumes from traditional primary care clinics and leave the health system with primarily high-acuity visits.

According to these leaders, this would have an effect not just on margins, but also on physician engagement. Physicians like to balance complex cases with basic cases throughout their day and retail threatens to force them to see 15 acute, complex, and emotionally draining patients every day. Medical group executives worry that primary care physicians are not always receptive to this “ED-style” work profile.

They'll retrain patients to value convenience over relationships

Many leaders in this camp believe that retail represents a fundamental disruption of the health care industry, for the worse. They believe that by offering “radical convenience” and de-emphasizing a personal relationship with a provider, retail is retraining patients to value different competencies.

This echoes what we heard from the leader of a major urgent care chain—although health systems value care continuity, patients increasingly don’t.

They'll make us a downstream commodity

Medical group executives fear that if this is true, and retail operators do not intend to limit their scope of services, then the medical group’s entire delivery model is in danger. These executives believe that retail clinics will secure patients, expand their scope of services to include higher-acuity primary care services and lower-acuity specialty care services, and become direct competitors to the medical group’s core competencies.

In response, some medical group leaders want to fight to take back this territory. “Why let [retail] get anything?” said a CEO in the Midwest. They are building out their own self-branded retail clinics, often going around big-box companies and partnering with local businesses.

Yet others suggest that medical groups could allow retail clinics to occupy a piece of the health care ecosystem. They believe they could, in essence, concede low-acuity visits to retail clinics while aggressively strengthening the medical group’s core competency: physician relationships with patients.

Pseudonymed Collier Provider Network, a 700-provider system based in the South, has done just this. Collier manages 100,000 lives under risk and recently entered a partnership with 13 area Walgreens clinics to relieve pressure on primary care offices. Their partnership enables patients to be seen rapidly and is cost-effective for the network, as low-acuity needs are managed outside the office and shared savings reimbursement is not affected.

Prepare your practice to compete against retail clinics. Learn more at advisory.com/mgsc

Rivka works with medical group executives on a wide range of issues including hospital-physician integration, medical staff performance management, access expansion, and care coordination.
Are you ready for the specialization of primary care?

BY: ROB LAZEROW
Think of all the new things we are currently asking PCPs to do: become a medical home. Manage high-risk patients differently. Offer on-demand access. Conduct e-visits.

Is it realistic for a PCP to do all of this at once—let alone effectively? Absolutely not.

Our research team spent the past year exploring the attributes of the clinician network that hospitals and health systems will need in the future. As you might expect, we found changes in care models and staffing needs looming in practically all specialties and settings. But nowhere were the changes more pronounced than in primary care.

**Revising assumptions about the physician market**

When we interviewed senior health system executives, we found that most were still building out their physician networks based on three outdated assumptions about the market.

First, they are assuming that the physician shortage is inevitable, despite the fact that new care models, technology, patient cost shifting, and provider-driven population health are all inflecting both provider-supply and patient-demand curves.

Next, they still assume that all roads to the patient run through the physician, even though new access points, narrower networks, higher deductibles, and the proliferation of mobile health apps are all reshaping how patients shop for care. In fact, the choices that patients make about their health insurance during open enrollment will drive both where and how they receive care across the year.

And finally, they are assuming that primary care remains a homogeneous set of services that are delivered by generalist PCPs. And when we asked about primary care transformation, we generally heard about progress in transforming all primary care practices to medical homes. Yes, all of them—at least that’s the plan.

**Segmenting PCP networks**

By contrast, we are seeing progressive organizations starting to segment their primary care networks and assign discrete roles to specific providers. They are saying farewell to the generalist PCP model and embracing the specialization of primary care.

As we study how organizations are restructuring their primary care networks, we tend to see four new primary care identities emerge.
one

Super PCP

Especially in rural areas and markets with limited supply of certain physicians, organizations are asking a subset of their PCPs to deliver an increasing range of services that have traditionally been the domain of specialists. For example, the University of New Mexico’s Project ECHO is upskilling PCPs so they can safely and effectively deliver specialty services. And so far, the quality of care delivered by these PCPs is just as high as their specialist counterparts.

Even if you are not in a rural area, this might be a worthwhile tactic to help specialists in your network practice at the top of their training—not to mention capitalize on the beneficial labor cost differential if your network employs the physicians in question.

But the key is that not every practice needs to become a medical home—primarily just the ones treating your rising-risk patients. And when designing the medical home staffing model, organizations need to carefully craft each care team member’s role to manage labor costs and enable panel growth.

For example, Stanford Hospitals & Clinics clearly delineates the roles of PCPs, nurses, and medical assistants. PCPs principally serve as care team directors and focus on developing the care plan, managing the practice team, and collaborating with specialists.

two

Complex care manager

When developing a population health strategy, one of the first steps is to deploy a high-risk care management model to support your sickest patients since they account for an outsized proportion of health care spending. We have seen several approaches, but some organizations are choosing to re-panel their highest-cost patients to dedicated high-risk clinics. For example, the PCPs practicing at AtlantiCare’s Special Care Center focus exclusively on managing the system’s sickest patients. Specialization is critical to the model.

There are several ways that hospitals and health systems can task a subset of their PCPs with providing on-demand access. For example, North Shore Medical Group (part of Partners HealthCare) collaborates with MDVIP to offer patients a personalized concierge option. And Sentara Healthcare partners with MDLIVE to bring real-time e-visit capabilities to the system. In each case, a select number of physicians staff the programs.

three

Care team director

While high-risk care management is the right approach for your sickest patients, few systems can afford to replicate this expensive model for their healthier patients. So for the rising-risk population, the patient-centered medical home model offers a more scalable approach.

four

Concierge care provider

Patients are increasingly seeking on-demand primary care and e-visits, often prioritizing convenience and affordability as they actively shop for care. Although non-traditional competitors are investing in storefront clinics—including CVS, Walgreens, and Walmart—hospitals and health systems are beginning to compete more aggressively in this new market for on-demand care.

There are several ways that hospitals and health systems can task a subset of their PCPs with providing on-demand access. For example, North Shore Medical Group (part of Partners HealthCare) collaborates with MDVIP to offer patients a personalized concierge option. And Sentara Healthcare partners with MDLIVE to bring real-time e-visit capabilities to the system. In each case, a select number of physicians staff the programs.
The PCP network of the future

As hospitals and health systems advance their care management capabilities and compete in the new retail market, they will continue to need their primary care networks to deliver a wide range of services.

Based on our research, we expect that most successful organizations will combine the four identities outlined here to build a tiered primary care network. Beyond crafting the network itself, leaders will also need to address the challenge of helping PCPs find their role in this emerging structure. But at the end of the process, health systems will have managed a significant cultural and clinical transformation—the specialization of primary care.

Are you ready for the specialization of primary care? Learn more at advisory.com/hcab

Rob works directly with hospital members on location, educating leadership teams about major market developments and the implications for provider strategy.
Additional Resources

The Advisory Board Company has a range of Performance Technologies grounded in the best practices covered in this Expert Perspective and designed to help you with the specific retail challenge areas facing your organization. These technologies are developed to provide data-driven insights through web-based analytics platforms and paired with dedicated support teams and collaborative cohort networking.

More than 60% of U.S. inpatient admissions flow through our technology platforms, logging more than 1.6 million user sessions annually.

Address your specific retail revolution challenges with...

Crimson Market Advantage
Gain visibility into your physician referral networks with Crimson Market Advantage. advisory.com/cma

Crimson Medical Referrals
Retain and grow your referral revenue through the data and insights of Crimson Medical Referrals. advisory.com/referrals

HealthPost
HealthPost offers you and your patients a user-friendly online scheduling system. Enhance your consumer-driven growth strategy. advisory.com/technology/healthpost

Consumer Marketing Initiative
The Consumer Marketing Initiative is our newest offering designed to expand your overall consumer reach, improve targeting, and better nurture new and existing patient relationships. Contact Jordan English at englishj@advisory.com.

Payment Integrity Compass
Payment Integrity Compass helps ensure your financial future by enabling you to negotiate top-tier contracts and hold payers accountable. advisory.com/pic

Crimson Medical Group Advantage
Optimize your medical group care teams for better patient access with Crimson Medical Group Advantage. advisory.com/cmga

Payment Navigation Compass
Payment Navigation Compass allows you to optimize point of service collections in a patient-centric manner and provides accurate estimates of patient obligations. advisory.com/paynav

iRound for Patient Experience
In today’s consumer-oriented health care market, you can’t afford to deliver a subpar patient experience. iRound for Patient Experience can help you consistently deliver excellent service. advisory.com/iRound
The rise of health care consumerism has been a trend-spotting cliché for decades. Several generations of futurists have predicted that patients would wrest control of their health care decisions and finances from insurers, employers, and doctors, but progress has been halting at best—until now.

Suddenly, propelled by high-deductible health care plans and the Obamacare exchanges, the retail market for health care delivery seems to have arrived. Across the health care industry, we’ve seen ample evidence of new “retail purchasers”—patients shopping for lowest-price imaging exams; primary care purchasers opting for convenient care options; employees carefully selecting their own plans on insurance exchanges.

In this issue, we bring together insights and findings from across our research programs on what the new retail market will look like—and how health care provider organizations need to adjust their strategies and execution to position themselves for success.

Michael Koppenheffer
Executive Director
Research and Insights