

# Compounding Some New Medicine for Sicko-ness A Modest Recipe for Retail Clinics 2.0

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## *It's About Care and Caring*

The retail/in-store clinic movement is more than a highly beneficial strain of “disruption” to the general primary health care delivery system. It should also be a significant catalyst and test-bed to improve community health status. This strategy entails straightforward e-collaboration with a robust referral care network bundling-in harmonized wellness, early disease detection and disease management services and enabling tools. Add a hefty dash of customized customer rewarding flowing from opt-in health risk appraisal completion. Then, follow with sequential adherence-based economic incentives fulfilled through one-on-one behavioral target marketing, using customized couponing triggered by HRA findings, seasonal drivers, and respondent demographics. Reward triggering based on benchmark attainment within disease management protocols would also be enabled.

A win-win system arises building new loyal families in touch with new teams of wellness providers. It's only opt-in and HIPAA immune, and is freed from the babble generated by a zillion committees, taskforces, and “working” groups intent on cyber transacting everything.

To the extent that progressive local and regional players are included, the smoother the political sailing. For example, a Blue Cross plan could co-venture production of selected services. Local VNA and health departments make excellent staffing partners. With insurance coverage arising, the customer is the beneficiary regardless of the chosen production function.

## *Why Retail Clinics as the Locus for Change?*

Incumbents in the retail clinic space grow because their business case is compelling, enterprises are sufficiently capitalized and customer experiences are highly scored by all relevant satisfaction metrics. These operations are still in their infancy and face normal start-up woes including uncertain ROIs and break-even points, sub-optimal layouts, staffing, information capture and work-flow patterns, “without the doc” risk-averse service menus, voluntary script dispensing/selling firewalls, and low ball pricing.

Thus, there is plenty of wiggle room to house additional functionality during the growth phase. As competition increases, investment drivers include the need for continuous product improvement and differentiation as well as for satisfying large customer cohorts shifting from latent to expressed demand for diagnostic, immunization and screening services. In-store worker-focused risk assessments add icing to the convenience cake, especially by filling in off-peak appointment slots, smoothing work-flow and reducing queues and wait times. (Workers' rewards must be nondiscriminatory per US Department of Labor regs compared with customers' rewards.)

Like Lipitor, the “daughter products” released after its ingestion are more beneficial than the original dose. Sensible protocol-based and decision-supported adult primary care is

the core retail clinic output platform now in place. Providing appropriate consumer-assisting programs builds upon these sunk investments at low marginal cost.

Within many urban and rural communities, the default locus for free “medical advice” has primarily been the neighborhood pharmacist. The retail clinic can expand this tradition with one-on-one assistive and practical care in terms of full primary prevention services which are disease- or body-part specific.

Many screening and testing services have been battle tested in drug stores, at health fairs and convention lobbies and within assorted clinics of all stripes. More recently, based on strong empirical evidence from workplace wellness settings, providing customized incentives and rewards is essential to “get people to the last mile” to initiate behavioral change. This might become an especially compelling strategy with the deployment of emerging home-based disease management products incorporating remote monitoring. Incentives could take many forms from reward programs to price discounts on in-store goods and services.

Service demand can be continuously driven by demographic (gender and age) thresholds per US Public Health Service guidelines. Such info is captured within the HRA completion process to trigger sentinel announcements (i.e., 50<sup>th</sup> birthday) and invites along with customized coupons to promote visiting the clinic and the store. Intervention opportunities also arise seasonally. Examples include the promotion of back-to-school and vacation-prompting vaccinations, flu season shots with pneumonia piggy-backed on, spring and fall seasonal allergies, national body part (i.e., Breast Cancer) of the Month campaigns.

### ***Convenient Primary Prevention Would Gain Equal Footing with Convenient Care***

Given pervasive techno-chaos within the overall healthcare industry, it takes business discipline and standardization to corral and harmonize the appropriate set of processes and technology. Just consider the hundreds of options flowing from web-based and traditional programming in risk assessment and personal auditing and tracking programming including health risk appraisals, HSAs and derivative financial products, mini personal health records, electronic medical records, chronic disease management with remote monitoring, behavioral targeting and one-on-one relationship marketing and loyalty card systems.

Each of the above now operate under different parentage – from health departments, governments, self-insured large employers, progressive unions, managed care organizations, classic insurers, marketing services firms and increasingly, by customers themselves. Most have or will become zero-priced commodities. The good news is that all are adjunctive and congruent to enhancing the retail clinics’ care and caring missions.

The retail clinic could initially assume employers’ traditional role in health risk appraisal to get incentive packages, monitoring and benchmarking locked and loaded. Then, many follow through tests and procedures are internalized in-store with out referral if and when appropriate. It’s like installing training wheels for the emerging PHR and EMR systems. These convergent systems are typified by early developer groups like WebMD while Google is rumored to be building a PHR system.

Such positioning is not glitzy PR to deflect the opening blows by the AMA which wrongly perceives negative competition from nurse practitioners. The reality is all PCPs (and more importantly, their patients) will be universally better off if they begin to mimic some of the critical convenience, staffing and pricing success factors put in place by the retailers.

The docs are far from being disintermediated; they can be emancipated from the routine sniffles and scratches while remaining wired in, utilizing their time and skills more appropriately and productively. Ditto for our under funded public health clinics which will face huge workflow and staffing problems as prevention and wellness eventually obtains public and private core financing.

Recent AMA opening moves challenging the emerging retail clinic industry's usurpation of physician roles and functions were inevitable. It's fuming again but will lose the battle because (1) their, economic self-interest becomes more visible than their patients', (2) the inherent cost-effectiveness of the approach is readily apparent to customers (especially where services are insured), and (3) business groups, governments, employers, public health associations and insurers all welcome price and quality competition wherever and whenever they find it.