FACTORS INFLUENCING THE DECISION TO CLOSE OR SUSTAIN OPERATIONS OF COMMERCIAL STORE-BASED RETAIL HEALTH CLINICS

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This work is dedicated to my children, Roger II, Adam and Nellie and to my grandchildren, Emma, Catherine, Sarah, Patrick II, George, Matthew, and Felicity in the hope that my example of dedication to this educational pursuit will motivate and encourage them in their education and their lives' work.

Now as he thus made his defense, Festus said with a loud voice, "Paul, you are beside yourself! Much learning is making you mad!" But he said, "I am not mad, most noble Festus, but speak the words of truth and reason."

Acts of the Apostles: 26:24

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But the excellence of knowledge is that wisdom gives life to those who have it.

Ecclesiastes 7:12

ABSTRACT

FACTORS INFLUENCING THE DECISION TO CLOSE OR SUSTAIN OPERATIONS OF COMMERCIAL STORE-BASED RETAIL HEALTH CLINICS

by Patrick M. Hermanson

Retail health clinics were developed around the year 2000 to address a narrow segment of health service needs represented by non-emergent, non-diagnostic ambulatory care. Retail health clinics' limited menu of services target a niche market of health care consumers interested in access, convenience and low cost. Services are provided by advanced practice professionals (APP), normally nurse practitioners (NP). Retail health clinics are usually integrated into "big box" retail stores such as Walmart or Target, large pharmacy chains including CVS and Walgreens, or grocery store chains such as Kroger (Pollert, Dobberstein, & Wiisanen, 2008).

The purpose of this research was to identify and describe critical success factors (CSFs) used to achieve and sustain viability by retail health clinics operating in one large national retailer organization. The primary objective was to clarify the use of CSFs in this setting and determine how similar perceived CSFs were in clinics that remained open versus clinics that were closed. Another objective was to determine what other criteria retail health clinic operators use to make decisions related to operations. A final objective was to develop information and insight for potential clinic operators to predict success when planning retail health clinics.

A literature review was performed, survey data collected, and interviews conducted to identify CSFs and metrics associated with decisions to close or sustain operations of retail health clinics. The findings indicate that the CSF model is not a commonly used tool for retail health clinics to manage facility performance. There was commonality, but a lack of consensus on the part of the retail health clinic operators in describing CSFs. It was anticipated that leadership

commitment, marketing, and location would be identified as important CSFs for both closed and open retail health clinics. Decisions to close clinics were primarily volume and financially driven and mostly unrelated to the use of CSFs.

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DEFINITION OF TERMS

Critical Success Factor (CSF): Critical success factors are those things that must go well to ensure success for a manager or an organization, and, therefore, they represent those managerial or enterprise areas that must be given special and continual attention to bring about high performance.

Retail Health Clinic: A retail health clinic is a limited scope health care facility located in a high traffic retail outlet. It is staffed by advanced practice professionals and designed to provide affordable, accessible, non-emergent care. A retail health clinic appeals to consumers with limited time and who prefer convenience and low cost over appointments with primary care providers.

Advanced Practice Professional (APP): An Advanced Practice Professional is a Nurse Practitioner or Physician Assistant having education beyond the basic nursing education and certified by a nationally recognized professional organization.

Nurse Practitioner (NP): A Nurse Practitioner is a Masters prepared advanced practice professional nurse with privileges to practice semi-independently in treating patients. A NP is not required to have direct supervision by a physician.

Physician Assistant (PA): Most States require that a Physician Assistant work under the direct supervision of a physician. PAs may be the principal care providers in rural or inner-city clinics where a physician is present only occasionally. A PA requires more frequent and direct supervision than a NP

MANUSCRIPT I

Case Study - Retail health clinic: Sustain or close?

Decision Dilemma

Angela Tobias, the Director of Outpatient Services at Upper Midwest Healthcare System (UMHS) had responsibility for five retail health clinics as part of her responsibilities. The retail health clinics were planned and opened during calendar year 2007. Angela performed her due diligence by conducting market research, building a budget, identifying qualified staff and coordinating lease agreements with a large retail chain prior to the targeted opening dates. The retail health clinics were each associated with the closest system hospital, although they reported to Angela, not the hospital.

Within UMHS, each of the retail health clinics was expected to perform financially while contributing to the goals of the health system. They were expected to break-even at eighteen (18) months and then go on to profitability. After three years not one of Angela's retail health clinics was able to achieve its targeted financial performance and Angela was asked to bring a recommendation to her upper management team to refocus the retail health clinics, revise the financial expectations, or to close one or all of them. Angela needed to have a decision recommendation to her senior leaders by the end of calendar year 2010.

Introduction

The retail health clinic phenomenon began in the early 2000s as an alternative to the more expensive and inherently slower alternatives of hospital emergency rooms, urgent care centers or physician office visits (Hoffmann, 2010). Retail health clinics are identifiable by four

characteristics including location within a big box retail store or pharmacy, a limited menu of services that do not require imaging or laboratory services, typical staffing by nurse practitioners, and affordable pricing structures (Blair, 2005).

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

Retail health clinics operate using several different models including leasing space as a tenant of a host retailer, functioning as a department within a larger retailing organization, and being a joint venture partner with the host retailer. Angela found a national retailer that wanted to expand their retail health clinic presence in every market where they could find a hospital or health system to partner with.

The retailer only used the landlord-tenant model; therefore Angela developed lease agreements with five different stores within the chain. The five retail health clinics began operating within

six months of each other in communities across the upper Midwest. The farthest apart were 160 miles distant.

Operating Challenges

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

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

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

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

From a health system perspective Angela was challenged to demonstrate that the retail health clinics contributed to corporate strategy and goals. UMHS has a standardized electronic health record (EHR) in each of its hospitals. While Angela was planning the rollout of the retail health clinics she included the cost for information technology in her planning. Unfortunately she was

directed to use the EHR that would be used in the hospital-owned physician practices. Like many health system's information technology platforms, the hospitals' EHR system and the physician practice system EHR would not integrate. Angela was left with good data on the retail health clinic patients but no way to demonstrate downstream revenue generation or those patients that ended up with admissions, procedures, or surgeries within UMHS.

Over time, the greatest challenge for Angela was clinic volume. She knew she needed 20 to 23 patients per day at each of her retail health clinics to break-even. Her staff would begin to complain when they reached 20 patients per day since the staffing model was such that one NP and one support staff were all that were authorized to work. In some instances, only the NP was staffed in order to manage costs. Since volume was an indication of consumer awareness and satisfaction, Angela was concerned that not enough patients were familiar with the retail health clinics or comfortable seeking care in a retail setting. She pondered how she could increase volume at each of her retail health clinics and not impact on her urgent care business or be seen as competitive with the area physician office practices. She needed a way to be collaborative and build her business at the same time.

Critical Success Factors

During Angela's Master's program in Health Care Administration she learned about critical success factors (CSF). She knew that if she could identify the CSFs associated with retail health care, she might be able to leverage those factors to make the retail health clinics more successful. Through a search of the literature and by interviewing a number of retail health clinic operators, Angela learned that there were a limited number of CSFs that she needed to concentrate on. She

found that new businesses concentrate on financial ratios, management and leadership team characteristics, and market factors in order to manage successfully (Lumpkin & Ireland, 1988). She understood that the volume of patient visits; leadership commitment, marketing, store manager support, staffing, and location were some of the key factors that would be the determinants of success. Angela added an electronic health record to this list because she knew that without the ability to track patients through the system, she would not be able to demonstrate that her retail health clinics were making a contribution to the goals of the system. A number of other factors were revealed in her research but Angela determined that many of them were peculiar to a specific site and not generalizable across all of her retail health clinics.

Developing the Rationale for a Recommendation

Angela thought long and hard about the challenges she faced and the CSFs that she discovered in her research. She decided to develop strategies to employ the CSFs and leverage them against the challenges. If she could create a reasonable plan, one that she herself would likely approve, then she would try to sell it to the UMHS leadership in an effort to continue to provide the retail health services to the communities they serve.

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

Marketing was a much different issue. Angela had discovered that a couple of the NPs had developed an excellent relationship with the store managers where they worked. They had

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

Angela wondered if she could affect the location challenge. Certainly the stores were not going to move to different communities with different demographics. A possibility might be to move the retail health clinic to a different store in a more affluent market. The location within the store was fixed in that the lease agreements and the agreements were multiple year contracts. Moving within the store to more appealing space would mean that something else needed to become available which was unlikely. For those of her retail health clinics without the prime location within their store, it would continue to be a challenge to drive foot traffic past those clinics.

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

Making a Recommendation

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

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

Teaching Note: Retail health clinic: Sustain or Close

Case Study Overview

Over the past five years Angela Tobias, the Director of Outpatient Services at Upper Midwest Healthcare System planned and opened five retail health clinics. In addition to her other duties, she was chosen to be the lead administrator responsible for retail healthcare within the system. Angela did an excellent job with her due diligence by conducting market research, building a budget, identifying appropriate staff, and initiating partnership arrangements with a large national retailer. After three years none of Angela's retail health clinics was meeting expectations. Angela was under pressure to turn their performance around or she would have to close one or all of them and the system would have to recognize a significant loss on this venture. Angela is called upon to make a recommendation to her senior management team in regard to sustaining or closing the retail health clinics.

This case can be used as a business case for students learning about planning, marketing, and operations management. It has particular relevance for those students interested in business to business relationships and the impact that relationships have on success.

Research Methods

The case presented here is an extract of a larger study of retail health clinic success factors. It stems from a single qualitative case in which one provider contracted for several retail health clinics in similar retail stores across two states. The information was gathered from an interview with an operations executive accountable for several retail health clinics. The names of the executive, the clinics and the retailer have been disguised to honor their interest in anonymity.

Learning Objectives

The objectives of this case study are to:

1. Identify the critical success factors necessary to ensure start-up retail health clinic success.
2. Identify and analyze the key metrics required to properly manage a retail health clinic.
3. Understand the behaviors and relationship issues required to ensure retail health clinic success.
4. Propose and defend a recommendation for moving forward or not.

Questions

1. What critical success factors should Angela have considered in her planning and which are still relevant in making a recommendation for continued operations? Identify three to five critical success factors that will impact her recommendation to senior management.
2. From a purely business perspective, what are the key metrics that should be monitored and reported on a regular basis for a retail health clinic?
3. What management behaviors are required in a retail setting that may be different from the traditional healthcare setting?
4. What relationships are important to the success of retail health clinics? Describe how Angela might capitalize on improved relationships to make her clinics profitable.
5. Propose and defend a recommendation that Angela should consider.

Answers to Questions

1. Any of the following categories could be addressed. They are the most common critical success factors applicable to retail health clinics and must be considered when planning and managing retail health care. They include: visits or financial results, location, marketing, staffing, and leadership commitment. Mission is rarely mentioned as a critical success factor in retail health care as these clinics are often done as strategic initiatives designed to capture market share or contribute patients or volume to the larger system.

2. Retail clinic operators report that they focus a great deal on volume statistics including total monthly visits or encounters, revenue per visit, and visits by type. Key metrics also included revenue and expense categories with particular attention paid to net income. Other metrics identified are staffing costs by provider type (PA or NP), hours available, number of referrals within the system, and patient satisfaction.

3. Most clinic managers, like Angela Tobias are not on-site managers. They oversee clinics from a hospital-based office or other off-site location. They are often responsible for other aspects of healthcare operations besides retail health care and are not trained in retail operations. Healthcare managers must learn retail to be successful in retail health care. They have to learn and practice a different kind of marketing, they have to engage and attract patients that may not have considered seeking healthcare in a retail setting. And they have to create an experience for patients that make it convenient, less expensive, and more effective than going to an emergency room or a physician's office. This different way of thinking about health care is a challenge for healthcare managers that have been used to having the business come to them.

4. Retail health clinic providers must be intimately involved with the retail store employees and management. They need to attend their meetings, know them by name, and assist in making

the retail clinic become a virtual department of the retail store. Retail health clinic managers report that those providers that are actively engaged with the retailer's staff have higher numbers of in-store referrals to their clinics than those that don't. In addition the providers that develop a collaborative relationship with the retail store managers are more likely to get concessions on marketing restrictions and other assistance necessary to attract patients.

5. Angela must decide if the four stronger clinics can achieve break-even or better within a relatively short time frame. If she determines that through the use of several very specific strategies she can make them profitable or demonstrate a significant contribution to the system goals, she should recommend that they be sustained, at least through a sufficiently long period for her to implement her changes. She should recommend that the clinic located in the resort community be discontinued as soon as possible. There appear to be too many negative issues related to that clinic that will continue to make it unlikely that it will ever turn a profit.

Epilogue

Angela did recommend that they clinic in the resort area be closed. UMHS decided that the joint venture relationship was not working primarily because the joint venture partner did not have the same commitment to the success of the clinic that UMHS had. Angela did not have control over the staffing of the clinic so it was often closed due to lack of staff. The unpredictable nature of the clinic hours made it even less attractive for the local residents and put strain on the relationship with the retail store manager. Angela hoped to continue operations of the other retail health clinics and by making renewed efforts to market the clinics and enhance the service offerings she hoped to attract more patients.

Disclaimer

This case study was prepared by the author and is intended to be used as a basis for class discussion. The views presented here are those of the author based on his professional judgment. The names of individuals and organizations described in this case study have been disguised to preserve anonymity.

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MANUSCRIPT II

Challenges and Critical Success Factors Influencing Commercial Store-based Retail Health Clinics.

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Retail health clinics are a recent addition to the spectrum of outpatient, ambulatory care venues available to health care consumers in the United States. The retail health clinic is an innovation attributed to Dr. Doug Smith, a Minnesota physician who, after an experience staying late one evening to provide an acquaintance's son some immediate care, decided there had to be an alternative to the extended waiting times in urgent care clinics and emergency rooms (Hoffmann, 2010). After over 10 years of growth and development of retail health clinics, the number of clinics has plateaued and many clinics have closed.

This study considered the challenges and critical success factors that retail health clinic operators must address in a discernment process leading to decisions to close or sustain operations of their retail health clinics. The purpose of this research was to identify and describe the critical success factors used by retail health clinics operating in collaboration with a large national retail organization to achieve and sustain viability.

Background. Retail health clinics were developed around the year 2000 to address a narrow segment of health service needs not well met by other outpatient providers. They offer a limited menu of services and serve a niche defined by non-diagnostic treatment and services. Retail health clinics were originally organized to target self-pay patients (Kolar, 2008). They

have matured to the point that they now accept third party insurance payments while retaining the appeal of low cost services for uninsured or underinsured populations.

Retail health clinic services are provided by advanced practice professionals (APP) who are primarily nurse practitioners (NPs) although occasionally physician assistants (PAs) can be found in retail health clinics. The providers are typically overseen through contractual arrangements with independent physician practices. Rarely stand-alone facilities, retail health clinics are most commonly integrated in some way into "big box" retail stores such as Walmart or Target, large pharmacy chains like Walgreens or CVS Pharmacy, or a grocery store chain such as Kroger (Pollert, Dobberstein, & Wiisanen, 2008).

Malvey and Fottler (2006) described the retail health clinic phenomenon as the third revolution in health care in the modern era following the passage of Medicare and Medicaid legislation in the 1960s and the implementation of the prospective payment system in the mid-1980s (p.168). Early assessments of the innovation predicted exponential growth of retail health clinics. Sturm (2006) predicted that the retail health clinic was no longer a fad but had become a trend that health care providers and health systems should pay attention to and get involved in. Kolar (2008) and others have predicted significant growth, having gone from fewer than 50 in 2005 to more than 900 in 35 states by 2008. Kolar (2008) expected them to exceed 2,000 nationwide by the end of 2008 (p. 46). Laws and Scott (2008) affirmed the rapid growth of retail health clinics. They reported the number of clinics has grown from about 60 in 2006 to nearly 1000 by 2008 and clinic operators have grown to more than forty separate operating companies (p. 1293). There were an estimated 1200 retail health clinics in the United States by December 2009 (Pollack, Gidengil, & Mehrotra, 2010). By 2010, the number of retail health clinics had peaked and begun to level out. An article in Medical Economics indicated that some clinics were

beginning to be closed for business reasons (Retail clinic chain closes 30 locations, 2010). By May 2011, there were 1242 retail health clinics operational in the United States (Charland, 2011).

Challenges facing retail health clinics. Retail health clinics under lease agreements with "big box" retailers such as Walmart face several constraints not present in free standing urgent care or walk-in clinics. Lessees are bound by agreements that specifically address marketing opportunities including limitations on how interior and exterior signage can be used. They are also limited to a space allocation provided by the store and a specific location within the store that may not be optimal.

The retail health clinic model calls for the use of advanced practice professionals that are seeking a fulfilling career and an appropriate work life balance. The limited menu of services and the routine nature of the cases seen in a retail health clinic are challenges for the operator to maintain qualified permanent staff. The retail setting also challenges the operators in terms of keeping those same professionals enthused about working long hours nearly every day of the year, including weekends and holidays.

Other challenges for retail health clinics include a perception problem of being able to deliver quality care in a discount retail setting, breaking even or making money in an environment that is designed to provide low cost options for the consumer and getting and keeping NPs credentialed so insurance carriers can be billed. Financial challenges are a constant issue for retail health clinics. Without a strategy to support retail medicine to achieve its other objectives, the system's retail health clinics will continue to struggle with the financial challenges inherent in the model.

Comparison with other ambulatory settings. Retail health clinics are part of a continuum of care for outpatient services. Urgent care centers, walk-in clinics, physician offices with expanded hours and open schedules, and fast-track services in hospital emergency departments all serve the non-emergent, usually non-procedural patients. The outpatient, ambulatory venues all face similar challenges. Managing them to success requires attention to similar critical success factors as well. Wodinsky, Sharobeem and Pancratz (2009) found that for urgent care centers to be successful they needed to pay attention to financing many months of deficits, budgeting for sufficient marketing and advertising, staffing with midlevel providers, expanding their hours, and working with insurance carriers to ensure they can accept all payers (p.88). Several similar critical success factors were identified by Sheehan and Zeigler (2010) for a wound care clinic that included physician oversight, physician referrals, staff support, a proper environment, service specific equipment, and marketing (p.95). In a white paper written for Meritage Healthcare Strategies, LLC, Evans and Sewing identified a dozen common factors that most medical fitness centers exhibit (p.2-5). Many are common to the factors cited above and include leadership commitment, staffing, location, pricing, marketing, customer service and communication.

Purpose. The purpose of this research was to identify and describe the critical success factors used by retail health clinics operating in collaboration with a large national retail organization to achieve and sustain viability. The primary objective was to clarify the use of CSFs in this setting and determine if perceived CSFs related to commonly used operating indices. A secondary objective was to determine if operators use other criteria separate from CSFs to make decisions related to continued operation of retail health clinics. The final

objective was to be able to provide potential clinic owners and operators with information and insight necessary to better predict the success of developing retail health clinics in the future.

Methods. Identifying the factors that influence decision making in closure or sustainment decisions for retail health clinics required a conceptual model that would surface perceived success factors on the part of clinic operators. A three step approach was developed to identify and categorize the success factors.

Step one was a literature review which revealed that success factors have commonalities but vary substantially from industry to industry. Several factors such as leadership commitment appear common across all industries. Based on the literature review, step two was the development of a survey document for use with clinic operators that remain open for business. The survey was drafted, reviewed and tested to ensure that it would identify those success factors most important to retail health clinic operators. Potential bias within the survey was guarded against by submitting it to experts in the field and the researcher's committee for review. The third step was the development of an interview guide that mirrored the electronic survey. The interview guide would be used with clinic operators that have closed their clinics.

The electronic survey was sent to a sample (n = 140) of the retail health clinics located in stores owned by a large national retail organization across the country. The survey included items related to demographics, operational data, and critical success factors. The respondents (n = 24) provided quantitative and qualitative data on operations and success factors. An initial announcement of the survey was followed by three written reminders and some phone calls intended to increase the response rate.

The interview guide was used with clinic operators that had closed clinics. Some of the operators were able to represent both closed and open clinics. The operators responded to a number of questions related to perceived critical success factors and challenges faced in operating retail health clinics.

Sampling strategy. Purposive sampling was used for this study by choosing the participants on the basis of predetermined criteria. Participants were retail health clinic operators previously or currently in a lease arrangement with a large national retail organization. The sampling strategy was designed to include the entire subset of retail health clinics associated with that retailer's stores in the United States. The sample was dependent upon the availability of and access to the retail health clinic operators that have partnered with the retailer's stores. The researcher attempted to include the full subset of retail health clinics under contract with the large national retail organization, however there was incomplete participation. Of the 140 clinics represented in the sample, 24 respondents completed the survey. The 24 respondents indicated that they represented at least 90 retail health clinics, the majority of which were not in the chosen retail organization's stores. The number of respondents represented 20% of the selected retailer-based retail health clinics originally identified for the study.

The telephone interview sample was also a purposive sample. Participants were the retail health clinic operators sponsoring clinics in the selected retail organization that were identified during the course of the electronic survey. Returned letters and solicitations to participate in the electronic survey revealed a number of clinics that had closed. Those clinic operators were contacted by phone and all agreed to be interviewed. Six clinic operators representing 20 closed retail health clinics took part in the interviews.

Data collection and variable description. Data was collected via an electronic survey using Survey Monkey and through telephone interviews conducted by the researcher. Several nominal variables were used in the survey. They included a staffing variable which identified the type and number of staff members assigned to the retail health clinic during its hours of operation and a service offering variable which identified by the menu of services provided by each retail health clinic. The survey respondents provided the 10 most common services provided by their clinics. Prices and costs of operation were interval variables and described the charges for the most common subset of service offerings and costs of operations which were grouped into categories.

Critical success factors are criteria that may be used by the clinic operators to make decisions about whether to keep the clinic in operation or to close it, i.e. sustainability. Perceived critical success factors, a nominal variable, were identified and categorized according to their importance to the clinic operations.

The limited response to the electronic survey and the amount of missing data made the analysis of some data questionable. The open-ended questions related to perceptions of critical success factors and the challenges facing the retail health clinics provided sufficient information to support a qualitative analysis.

Results.

Open clinics. The survey of clinic operators with clinics that remain open identified the top five (5) critical success factors as leadership commitment, financial performance, location, staffing, and physician support. Table 1 depicts the frequency of mention of the perceived

critical success factors that retail health clinic operators identified as determinants of their success.

Table 1. Top-rated critical success factors

Perceived CSF	Rated #1	Rated #2	Rated #3	Rated #4	Rated #5	Total
Leadership support	2	5	2	1		10
Number of visits	1	1				2
Financial performance	1	2		1	5	9
Staffing	1		1	6	1	9
Location	6	1	1	1		9
Provider acceptance	1	1				2
Part of a system	1					1
Breaking even	1					1
Mission	1	1				2
Patient satisfaction / community support	1		1		3	5
Physician support		1	6			7
Availability (open every day)		1	1	1		3
Convenience		1				1
Visibility		1				1
Retail store support			1			1
Scope of services			1	1		2
Insurance participation			1	1		2
Quality of care		1	1		1	3
Marketing				2	1	3
Room size				1	1	2
Focus on retail					1	1

Source: Survey of retail health clinic operators

Respondents were asked to list the top 5 critical success factors for their retail health clinic. There was no specific definition provided to the respondents as they were asked to describe their definition of the CSFs. The definitions below represent a synthesis of the respondents' description of the prioritized success factors.

1. Leadership commitment. Leadership commitment was the designation of a senior executive with the responsibility and authority to oversee the performance of the clinic and who had personal accountability for its success.
2. Financial performance. Financial performance was related to meeting budget for encounters, work relative value units (WRVUs), and revenue.
3. Location. Location was defined as internal and external. Internal location referred to in-store location and external referred to as the area that the retail store was located in.
4. Staffing. Staffing was defined as the ability to recruit, credential, and staff the retail health clinic for all hours that the clinic was intended to be open.
5. Physician support. Physician support related to the backing of physicians within and outside of the sponsoring entity such that referrals would be facilitated.

Survey descriptive statistics.

The staffing variable reflected 91% utilized 1.0 full-time equivalent (FTE) to 6.0 FTE NPs in the clinics, 27% utilized 1.0 FTE or more physicians, 36% used part-time or full-time Medical Assistants, and 86% utilized from 1.65 FTE to 3.0 FTE receptionist staffing.

The majority (72%) of respondents held Master's degrees, 11% had a high school diploma, 11% held Bachelor's degrees, and 6% held Doctorates.

In general, retail health clinics provide physician medical direction and oversight to the NPs and PAs working within the clinics. Most states provide prescriptive authority to NPs while very few provide it to PAs. Fifty four percent of the clinics in operation contract physician oversight to independent physician practices. Twenty five percent of the clinics utilize

physicians within their system to provide oversight and 21% use the same physicians that supervise the NPs and PAs to provide clinic oversight.

Referral arrangements are required to provide a continuum of care to patients. Eighteen percent have contracts with the local hospital. Twenty three percent refer directly to physician under contract with the clinic. Sixty five percent refer back to the patient's primary care provider, 64% refer to any available provider and 22% reported no formal relationship for referrals. The numbers sum to over 100% because respondents identified multiple referral resources.

Clinics in the survey were open from three (3) to 84 months with the most frequent response being a bi-modal distribution around 24 and 12 months. Ninety six percent of clinics were open at least 359 days per year and most kept similar hours. Most were open six hours on Sunday, 12 hours on Monday through Friday, and 10 hours on Saturday.

Charges reflected differences in location and whether or not the clinic was part of a system. The minimum charges ranged from $20.00 to $53.00 per visit. The maximum charges ranged from $67.00 to $100.00 per visit. The mean charges were from $39.44 to $70.00 and the standard deviation from 7.924 to 19.046. There was insufficient data to describe the cost structure of the retail health clinics.

Closed clinics. Table 2 depicts a frequency of themes derived from interviews with retail-based clinic operators that had closed clinics. The themes are issues that were related to the management decision to close the retail health clinics.

Table 2. Interview theme frequencies

Theme	Respondent #1 1 clinic closed	Respondent #2 6 clinics, 5 closed	Respondent #3 5 clinics, 1 closed	Respondent #4 10 clinics closed	Respondent #5 2 clinics closed	Total
Marketing	3	5	5	4	5	22
Store relationship	1	4	6	5	4	20
Staffing	3		5	5	2	15
Credentialing / insurance part.	5	1	1	4	2	13
Volume	3	4	2	3	1	13
Location	2	2	5	2	2	13
Financial losses	3	3		3	2	11
Part of a system	2		1	5		8
Break-even	3	1	1	1	2	8
Relationship with physicians	2		1	2	3	8
Leadership support	2		4		1	7
Downstream Revenue	1	1	2	1		5
IT	2		1	1	1	5
Competition					4	4
Quality perception	1	1	1			3
Seasonality			1	1	1	3
Cost Structure	1					1

Source: Personal interviews with retail health clinic operators

The top five (5) critical success factors identified through the telephone interviews with clinic operators that closed clinics were:

1. Financial performance. Overall financial performance includes meeting budget for encounters, work relative value units (WRVUs), revenue and being able to calculate and demonstrate downstream revenue within the health system.

2. Relationship with the host store. The relationship with the host store referred to the personal relationship developed between the provider(s) and the store manager as well as the relationship that the provider(s) had with the store associates.
3. Volume. Volume was the number of visits or encounters per period. A threshold of 20 to 23 encounters was frequently cited as a minimum.
4. Location. Location was defined as internal and external. Internal location referred to in-store location and external referred to as the area that the retail store was located in.
5. Marketing. Marketing was primarily related to in-store and outdoor marketing on the host retailer's site.

Discussion. Critical success factors and challenges facing retail health clinic operators were identified through the literature review, the survey, and the interviews. A thematic analysis of the data revealed common and similar CSFs that were considerations in the decisions to close or sustain operations of retail health clinics. Of the top five (5) critical success factors cited in both open and closed clinics, financial performance and location were common to both. An organization will sustain operations of a clinic if it is profitable in and of itself or if the clinic is related to a broader system strategy and contributes to the success of the sponsoring entity. One finding common to closed clinics was that they rarely had electronic health records (EHR) that were integrated with the sponsoring hospital's or health system's EHR. The inability to track downstream revenue inhibited the ability of clinic operators to demonstrate a contribution to system success.

Location was a second common perceived critical success factor for both open and closed clinics. In-store location was seen as critical due to the fact that there were constraints on

marketing and advertising allowed on premises. It was reported that retail shoppers frequently were not aware that the clinic existed. Operators indicated that patients' use of their clinics was often an ancillary reason for visiting the store. Retail health clinics are also dependent upon the physical location of the retail store and therefore are not sited based on demographics. Stores out of close proximity to schools and workplaces reported a lack of volume in the use of services such as back-to-school sports physicals and employment drug screenings.

Closed clinics ceased operations primarily due to financial considerations. None of the clinics that closed were profitable as stand-alone businesses. Most clinics could not track downstream revenue; the revenue that initial encounters at the retail health clinic resulted in further treatment or procedures somewhere else in the sponsoring organization's system. One clinic manager reported downstream revenue was incidental at best. The majority of visits to her retail health clinic were appropriate and therefore those patients would not require or result in a referral to other system resources. Clinics that closed were impacted by a number of other CSFs such as staffing, volume, and the relationship with the host retailer. These factors are all related in that they contribute to financial performance. The key theme emerging from the interview data was the relationship with the local host store. There was near consensus that the clinic providers that failed to engage and develop a close personal relationship with the store manager and the store associates were not likely to be successful in building volumes to break-even or make a profit. The corporate retail health care executive team reported that those clinic providers that engaged the store associates on a personal and regular basis could bring their clinic to break-even in eighteen (18) months.

Conclusion. Three objectives were set forth for this research. The first was to clarify the use of CSFs in the retail health setting and determine if perceived CSFs related to commonly used operating indices. A second objective was to determine if operators used criteria other than CSFs to make decisions related to continued operation of retail health clinics. The third objective was to be able to provide potential clinic owners and operators with information and insight necessary to better predict the success of developing retail health clinics in the future.

A survey and interviews of retail-based retail health clinic operators provided some evidence of the use of CSFs in managing their clinics to success. Several of the self-described perceived critical success factors influencing decision making related to clinic sustainability or closure could, and frequently are related to common business metrics. For example, volume in visits or encounters and staffing were both described as CSFs but used more routinely as monthly reporting metrics. The CSF model is not a common tool used to evaluate the strategic value of retail health clinics.

The second objective was to determine if operators use criteria other than CSFs to make decisions related to continued operation of retail health clinics. Interpretation of the results would indicate that the primary determinant of success for retail health clinics was financial performance. Mission and community need were absent from the study. Factors such as quality, physician support, and community awareness had little apparent effect on sustainment decisions. Demonstrated profitability or contributions to the hospital or system strategic objectives were the predominant criteria for clinic sustainment or closure.

The third objective of providing potential clinic owners and operators with information and insight necessary to better predict the success of developing retail health clinics in the future was accomplished. The survey and interview data are rich with ideas and concepts that would

contribute to successful operations. The respondents emphasized the importance of a collaborative and engaged relationship with the retail host site manager and staff. They also were clear that retail health clinic success was dependent upon integration with the strategic goals and objectives of the sponsoring entity. Respondents identified ways and means of increasing effective marketing and advertising and they shared the importance of careful staff selection, engagement and retention in order to make their clinics successful.

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RESEARCH

A. Problem Statement

Research Question

Retail health clinics were developed around the year 2000 to address a narrow segment of health service needs not well met by other outpatient providers. Retail health clinics offer a limited menu of services and serve a niche defined by non-diagnostic treatment and services. They were originally organized to target self-pay patients (Kolar, 2008). The evolution of retail health clinics has resulted in acceptance of third party insurance payments while retaining the appeal of low cost services for uninsured or underinsured populations.

Malvey and Fottler (2006) described the retail health clinic phenomenon as the third revolution in health care in the modern era following the passage of Medicare and Medicaid legislation in the 1960s and the implementation of the prospective payment system in the mid-1980s (p.168). Early assessments of the innovation predicted exponential growth of retail health clinics. Sturm (2006) predicted that the retail health clinic was no longer a fad but had become a trend that health care providers and health systems should pay attention to and get involved in. Kolar (2008) and others have predicted significant growth, having gone from fewer than 50 in 2005 to more than 900 in 35 states by 2008. Kolar (2008) expected them to exceed 2,000 nationwide by the end of 2008 (p. 46). Laws and Scott (2008) affirmed the rapid growth of retail health clinics. They cited the fact that the number of clinics has grown from about 60 in 2006 to nearly 1000 by 2008, and the clinic operators have grown to more than forty separate operating companies (p. 1293). There were an estimated 1200 retail health clinics in the United States by December 2009 (Pollack, Gidengil, & Mehrotra, 2010). By 2010, the number of retail health

clinics had peaked and begun to level out. An article in Medical Economics indicated that some clinics were beginning to be closed for business reasons (Retail clinic chain closes 30 locations, 2010). By May 2011, there were 1242 retail health clinics operational in the United States (Charland, 2011).

The failure of the retail health clinic phenomenon to meet expectations of growth and the incidence of closure of many clinics has provided an opportunity to investigate why this has occurred. The research question is: What factors influence the decision to close or sustain operations of retail health clinics?

Experimental hypothesis

The study is primarily qualitative in nature and therefore no formal hypotheses were formed as would be expected in a quantitative study. The research is based upon an understanding that certain factors influence decision making in healthcare business settings. It is presumed that there are critical success factors peculiar to the retail health clinic setting that influence decision making to close or sustain operations. Stated as hypotheses:

$H_{0:}$ There is no difference in critical success factors for clinics that remain open when compared with clinics that closed.

$H_{a:}$ There is a difference in critical success factors between the clinics that remain open when compared with clinics that closed.

Assumptions

The study sample was derived from the population of retail health clinics in the United States. The sample chosen was the approximately 140 retail health clinics associated with a large retail organization with stores across the country. The sample was chosen as a convenience sample because the names and addresses of all of their retail-based retail health clinics were available to the researcher. The following assumptions were made after a literature review:

- Leadership commitment, marketing, and staffing would be the primary success factors;
- Location would be an important determinant of success;
- Visit volumes would be high due to low cost and convenience;
- Retail health clinics would be an attractive alternative for the uninsured; and
- Retail health clinics would be a low cost channeling strategy for provider systems.

Delimitations

The study initially focused on the clinics associated with one major national retail organization. The retail health clinics in those stores are all lessees and therefore operate independently of the retailer. The retailer does exert common lease restrictions on all of its retail health clinic lessees. The study was delimited by the choice of the retail-based clinics as the study sample. The selected retail-based clinics constitute approximately 11% of the total retail health clinics in the country. They are unique in their relationship with the large national retailer and thus cannot be easily compared with other retail health clinics. A second delimitation was the decision to review critical success factors that influence decision making. An alternative approach could have been to solely consider financial results or the number of encounters as

definitions of success and determine which clinics close or stay in business based on those criteria.

Limitations

The most important limitation of this study is the difficulty in generalizing the results to other settings. Retail health clinics are unique among other outpatient, walk-in clinics in they have service constraints due to the design of the model. Specifically, they lack sophisticated imaging and laboratory services. Retail health clinics may be different enough from other ambulatory settings that the results of this study are not generalizable beyond the scope of retail health care. The clinics specific to this study are unique among the population of retail health clinics due to the specific limitations and requirements that the retailer imposes on its' lessees.

The response to the electronic survey reflected 17% of the clinic sample. This limitation reduces the power of the results. The researcher can draw inferences and extract themes from the data; however the electronic survey alone lacks sufficient reliability and external validity to draw specific conclusions. Similarly, the inability to identify a complete sample of closed retail health clinics formerly associated with the large national retailer is a limitation of the study. Five clinic operators were interviewed that had closed 19 clinics.

Golafshani (2003) reported, "To improve the analysis and understanding of construction of others, triangulation is a step taken by researchers to involve several other investigators or peer researchers' interpretation of the data at different time or location" (p. 604). Two forms of triangulation were used to validate the results of the study. Several studies of other outpatient clinic settings were identified in the literature review in an attempt to compare CSFs used in the analysis and management of those clinics with retail health clinics. The studies were reviewed

for commonality among the critical success factors cited or discussed. It was found that staffing issues were cited nearly twice as often as any other factor. The next most frequent success factor identified among the studies or reports related to financial issues. Other common CSFs were cited approximately an equal number of times in the studies. They were location, leveraging information technology, marketing and leadership commitment. The similarities of the success factors identified from the literature review with the open and closed clinics common success factors demonstrate that staffing, financial performance, and location are as applicable to other outpatient, ambulatory clinic settings as they are in retail health clinics.

A second form of triangulation was conducted to test and validate the results. Five recognized experts were contacted and asked to comment on the differences between the success factors taken from the electronic survey and those identified through the interviews for both open and closed clinics. The expert panel responded favorably to the identified success factors and made specific comments supporting the criticality of financial performance, especially for the clinics that closed. They were in agreement that a tie to the hospital's, the health care system's, or other ownership model's strategic objectives was paramount in determining if a clinic was to continue to operate or to close.

Significance of the Study

Retail health clinics evolved around the year 2000. The rapid growth of this new model of care over the first half of the decade was referred to as a new revolution in healthcare (Malvey and Fottler, 2006). The projected growth of retail healthcare did not materialize as predicted. Investigating the success and failure of retail health clinics and understanding the factors

influencing the closure or sustainment of these clinics will be vitally important to new operators 74considering opening clinics as well as those currently in the business.

Clinic managers or operators that understand the factors that influence the decision making process to sustain operations or close a retail health clinic will be able to apply lessons learned from this study to their individual setting. They may be able to use critical success factors as accelerators or levers to enhance operating results to maximize outcomes while understanding the negative influence of failure to achieve certain metrics important to decision makers.

B. Literature Review

The Critical Success Factor Model

Critical success factor (CSF) analysis was originally developed by Ronald Daniel and has been used in business since the 1960s (Meibodi & Monavvarian, 2010). Daniel believed that CSFs could be used by management as filters through which they could view and analyze information aggregated by their information systems. John Rockart, a professor at Massachusetts Institute of Technology, Sloan School of Business, was later quoted to say that key success factors (KSF) are, "those things that must be done if a company is to be successful" (Freund, 1988, p. 20). This somewhat vague definition is used because no two businesses are exactly alike. One study of critical success factors for small businesses showed that different management practices or strategies were associated with small firm performance across major industry types (Gadenne, 1998). In other words, depending upon the industry there were different and distinct management practices and evaluation tools used.

Critical success factors and key success factors can be viewed as equivalent terms. Boynton and Zmud (1984) used a definition of critical success factors as, "those things that must go well to ensure success for a manager or an organization, and, therefore, they represent those managerial or enterprise areas that must be given special and continual attention to bring about high performance" (p. 17). It is commonly understood that critical success factors should be limited to those essential things that are critical to an organization achieving its mission.

Rockart (1979) defined four sources of critical success factors as: a) the structure of the particular industry; b) the competitive strategy, the industry position, and geographic location; c) environmental factors; and d) temporal factors (pp. 86-87). The structure of the industry refers

to those particular characteristics that are peculiar to an industry the way intensive care is to acute care medicine or the way hub and spoke routing is to the airline industry. The competitive strategy, industry position and geographic location are intuitive and can be conceptually overlaid on the retail health clinic business quite simply to illustrate applicability. An example of an environmental factor for retail health clinics might be the effect the economy has on unemployment and health insurance coverage. The higher the rate of unemployment, the higher the likelihood that retail health clinics would be attractive alternatives to more expensive care delivery venues. Likewise, the location of the retail health clinic in an urban, suburban or rural setting could significantly impact its success. The fourth source of critical success factors in the retail health clinic market is temporal critical success factors. Temporal factors pertain to those issues or situations that are temporarily significant and require only occasional special attention. An example might be the loss of a single provider at one location. The lack of staff would become a CSF until management could resolve it. Another example could be the effect of seasonality in certain diseases or conditions such as influenza or respiratory syncytial virus (RSV) (Rockart, 1979).

Using Rockart's (1979) prime sources of CSFs and the model developed by Sirus and Moghaddam (2007), Meibodi and Monavvarian (2010) concluded that there would be specific success factors and competencies in any organization under study. A modified version of their findings is presented in Table 3.

Table 3. Prioritized critical success factors based on Friedman test scores

Friedman score	Critical success factor
7.7	Plan to place individuals in suitable situations
8	Effective monitoring and evaluation of employee performance
8.41	Employee satisfaction
9.25	Knowing when to replace old resources with newer ones
11.24	Employee training
12.25	Leadership skill
12.59	Management qualification and experience
13.23	Making relations with key suppliers on added value
13.75	Making more customer loyalty
14.4	High value and quality of product
14.4	Feedback of customer services (customer satisfaction)
15.04	Existence of definite and accessible operational goals
15.16	Protecting organization brand and trying to familiarize others
15.29	Leadership guaranty and obligation
16.39	Definite organization vision and mission
18.37	Technology proportion with market demand

Source: Meibodi, L. A., & Monavvarian, A. (2010). Recognizing critical success factors (CSF) to achieve the strategic goals of SAIPA Press.

The Meibodi and Monavvarian (2010) study cited over twenty critical success factors which somewhat contradicts Rockart's assertion that CSFs be limited to the essential few that can predict organizational success. Using relative strength of the scores shown in Table 3

however, the Meibodi and Monavvarian (2010) list of factors could be narrowed to the essential few in order to predict or manage toward success.

Chawla et al. (2007) view critical success factors as "events, circumstances, conditions or activities that require special attention because of their significance" (p.2). Their study used a survey instrument to measure the importance of 40 success factors taken from business literature. Those factors were grouped into six major categories or segments. The segments included quality and marketing, financing needs, supplier issues, employee issues, industry and marketing trends, and market demographics. The purpose of their study was to identify differences in critical success factors by business legal structures.

The Chawla et al. (2007) study cited several other authors that reflected on critical success factors. Montagno, Kuratko, and Scarella (1986) for example, looked at banking and found that factors such as caring, confidence and insight were important and aligned well with planning, leadership and organizing. Lumpkin and Ireland (1988) identified management team experience, financial strength, as well as market and personal factors as key criteria when they studied small business incubators.

Critical success factors vary across industries and organizational structures. The studies demonstrate that in virtually every industry a few critical factors, when monitored and managed, have the capability of moving a business toward success.

Common Critical Success Factors

There are as many CSFs as there are companies that use them. Freund (1988) wrote that CSFs were most effective when developed from the top down (p. 22). Hines (2009) identified several CSFs for rural health clinics in Alaska and Washington. The rural clinics in Hines's

(2009) study were similar in size to the retail health clinics in this study. The CSFs in Hines's (2009) study included: organizational mission, revenue maximization, community involvement, customer service, technology, business collaboration, personnel maximization, quality leadership, recruitment and retention, quality control, and a safe and healthy working environment (pp. 57, 58). In the Meibodi and Monavvarian (2010) study the researchers found that the most important critical factors were effective employee placements, effective monitoring and evaluation of employee performance, employee satisfaction, innovation in products or services, and knowing when to replace old resources with newer ones. Murdoff (2009) cited the scope of practice for nurse practitioners, the existence of the corporate practice of medicine limitations, ethical issues such as conflicts of interest, and barriers to access that include socioeconomic issues as CSFs. There is a great deal of diversity in the identification of CSFs. The common characteristics are the self-identification of CSFs and the ability of the organization to use them to guide decision making.

Urgent Care and Other Ambulatory Clinic Critical Success Factors

Critical success factor analysis is similarly used to describe the drivers of success in urgent care facilities. Several studies identified success factors as common to urgent care, yet there is no exact subset of CSFs that fit all urgent care facilities. Morrison (2007) reported that his research has shown there to be seven key areas of CSFs that include people, resources, innovation, marketing, operations, and finance. In a paper done for their consulting clients, Clayton and Clemans (2008) cited key factors determining success for urgent care facilities as staffing the clinic consistently with one or two providers, location, accreditation or credentialing, volume, and physician compensation. They pointed out that the most important of these factors

was how the clinic was staffed. Kirchner, Cody, et al (2004) used a similar approach in their review of rural Veterans Administration community-based outpatient clinics. They found that critical success factors included an emphasis on teamwork, relationships between disciplines, an infrastructure to support collaboration, the proximity of staff, the use of joint medical records, a long-term commitment to quality, interdisciplinary training, and a leadership bias for change. Their analysis is heavily weighted toward staffing and the interactions of staff within the clinic.

In a study on outpatient wound care clinics Sheehan and Zeigler (2010) identified six critical success factors necessary for a good business plan. They listed physician oversight and supervision, physician referrals, outpatient nursing cooperation, an environment with proper equipment available, future procurement of a bariatric chair, administrative support, and physician practice support. A similar list of critical success factors was developed by Evans and Sewing (2006) in their white paper on medical fitness centers. They included 12 CSFs that included top management commitment as number one and qualified staff as number two.

Three other studies approached the concept of success factors in urgent care or similar facilities slightly differently and grouped success factors under broader categories. O'Meara, Burley and Kelly (2002) found that there were 12 essential elements determining success which they grouped into two major themes. Training, education, and support and the rural context as it relates to social capital were the two themes. Included within these themes the authors discussed infrastructure elements that included such items as hours of availability and communication systems and personnel elements that included the value of general practitioners as well as staffing with a variety of nurse practitioners and allied health professionals. Ortiz, Meemon, et al (2009) study looked at efficiency and effectiveness of rural health clinics. They found that three factors were important to clinic success including the percentage of revenue coming from

Medicare, whether or not the clinic participated in an integrated system, and how the clinic leveraged information technology. In a focus group study Ortiz and Busby (2011) reported that the most frequently mentioned factor contributing to clinic effectiveness was the provision of quality services, followed by effective community relationships and having cooperative and satisfied staff.

Retail Health Clinics

Retail health clinics are a recent innovation in the provider market. One of the earliest references to retail medicine was an article that predicted that the location of a primary care clinic in a retail setting would be a growth model for primary care (Hayden, 1989). It did not occur exactly as predicted. Primary care physician offices did not materialize in shopping malls or other retail sites. However, a more convenient, service restricted model for treating common, easily treated illnesses and preventive services emerged as the retail health clinic in the late 1990s and early 2000s.

Retail health clinics are frequently sponsored or hosted by large retail companies. Table 4 shows the ownership (operators) of the retail health clinics in operation as of May 2011 (Charland, 2011).

Table 4. Retail health clinics in operation in the United States May, 2011.

Operator	Number
Minute Clinic	462
TakeCare	357
The Little Clinic	118
Target Clinic	6
RediClinic	29
FastCare	28
Baptist Healthcare at Walmart	7
Cigna CareToday	10
Aurora Quick Care	10
Christus Health at Walmart	10
DR Walk-in Medical Clinics	8
Lindora Health Clinics	9
Eastern Maine Healthcare at Walmart	6
Heritage Valley Health at Walmart	6
Alegent Quick Care	5
Geisinger CareWorks	5
Access Health (Formerly QuickHealth)	4
Cox Health at Walmart	4
Lancaster General Health Express	4
MedPoint Express	4
Mercy QuickCare	4
Northwest Care Express at Walmart	4
St. Vincent Health at Walmart	4
Atlantic ImmediCare	3
Family Quick Care	3
Intermountain ExpessCare	3
MedCheck Express at Walmart	3
Mercy Health of OK at Walmart	2
Owensboro Medical at Walmart	3
Pikeville Medical at Walmart	3
Sutter Express Care	3
Walmart Partners with < 3 clinics	56
Other operators with < 3 clinics	34
Total	1242

Source: http://i.walmart.com/i/if/hmp/fusion/Clinic_Locations.pdf

One large national retailer sponsors 126 of the 1255 retail health clinics or approximately 10% of the total. Only Minute Clinic and Walgreens have more retail health clinics than the

chosen retailer. The TakeCare clinics listed in Table 4 are the clinics at Walgreens.

Retail health clinics are typically organized in two ways. They are either owned by retail store hosts such as in the case of Target stores or they are owned by health care providers such as hospitals or health systems that lease space from the retail host as in the case of Walmart stores. All of the operators of retail health clinics at the selected national retailer are lessees and operate their clinics as independent contractors. Their contracts with the retailer bind them to numerous conditions related to such things as the use of the retailer's brand and maintaining standard hours of operation. Size and layout are standardized as well. All of the clinics operators are required to use a standard branding convention in titling their clinics.

Retail health clinics are designed to be models of efficiency. They are normally staffed with advanced practice professionals (APP); usually a nurse practitioner since he or she normally has prescription authority (Costello, 2008). Waiting times are short, overhead is low, and charges are minimal compared to other alternatives (Gallegos, 2007). Efficiency does not always result in profitability. It is not uncommon for retail health clinics to have difficulty breaking even or even losing money as the margins are low and objectives other than direct profit sometimes influence the operation of a clinic. In a report prepared for the California HealthCare Foundation, Scott (2007) reported that retailers were creating space for retail health clinics for three reasons: to attract new customers, to assert their position in the market for health and wellness offerings, and to strengthen their pharmacy prescription and over the counter medication sales. One operator identified market presence and the opportunity to influence referrals to its tertiary care facility as justifications for an operating loss on its clinics. (B. Huerta, personal communication, May 17, 2011).

Retail health clinics began as an alternative to more expensive and less convenient ambulatory care models. An online survey in 2007 demonstrated that the rapid growth in retail health clinics has been due to convenience and cost advantages (Harris Interactive, 2007). An earlier Harvard Business Review article appealed for disruptive business innovations in health care that allow for procedures to be done in less expensive and more convenient settings, for technology to become smaller and less expensive, and for care to be delivered by the least expensive personnel (Christensen, Bohmer, & Kenagy, 2000). It was the convenience and cost factors that made the retail health clinics popular and fueled the growth of this disruptive innovation. Primary care providers, particularly Pediatricians, came out against the clinic model and lobbied for standards in order to influence the quality of care provided, control their proliferation, and maintain the fundamentals of the medical home concept (Bachman, 2006; Corwin et al., 2006).

The 1255 retail health clinics exist in 42 states across the country. Ninety-eight operators provide clinic services at 41 different retailers (Charland, 2011). Rudavsky, Pollack, & Mehrotra, (2009) found that approximately 10.6% of the U.S. population lives within a 5-minute drive from a retail clinic and close to 30% live within a 10-minute driving distance. The five states with the highest population living within a 10-minute retail clinic catchment area include Nevada (79.9%), Minnesota (54.4%), Illinois (57.7%), Florida (50.7%), and Maryland (55.6%). There are 340 retail health clinics located in those five states.

A representative from the large national retailer suggested that the urban, rural or suburban nature of the market demographic was not significant in terms of the financial success of the retail health clinic. Rather, success was determined by the following four things: a) an operator that has a designated champion within the organization, b) having physician buy-in

where physicians oversee and monitor the care delivery, c) basic grass roots marketing, and d) in-store involvement (S. Shepherd, personal communication, May 9, 2011). A designated champion is a high level executive that has individual accountability for the success of the clinic. That person needs to have enough influence in the organization to commit time and resources to support the clinic. Grass-roots marketing was described as face-to-face marketing to organizations and individuals that can direct patient referrals to the clinics. Hotels, casinos, and other retail businesses are good target markets as they may not have access to convenient care venues or would be interested in less expensive alternatives. In-store involvement was described in terms of the familiarity that the clinic personnel have with the retail store employees and management. Those providers that take the time to know the store employees by name are more likely to get referrals than those that don't.

Summary

Retail health clinics filled a need for convenience and affordability within the health care delivery system. Retail health clinics were a disruptive innovation that lowered costs and focused on health care needs that did not require the technology, the expertise, or the facilities of traditional health care institutions. Retail health clinics' limited scope of service means that they cannot deliver sophisticated diagnostic imaging or laboratory services. They can however, accommodate the minor injuries, illnesses, and preventive care that do not require a physician's expertise or the technology associated with an emergency department of a hospital.

Retail health clinics are formed and operated for a number of purposes including increasing market share for tertiary services through referrals, acting as a draw for other in-store services such as prescriptions and over-the-counter medications, and creating a profit center on

its own. Critical success factors associated with retail health clinics are peculiar to the clinic itself and to the operator, be it a health care system or an independent retail health clinic business.

C. Recommendations for Future Research

This study focused on success factors of retail health clinics affiliated with one national retail organization. The unique relationship between the retailer and its clinic operators and the limited participation of retail clinic operators in the electronic survey (n = 24) and in the personal interviews (n = 6) offers the opportunity to further investigate the drivers of retail health clinic success in the larger population of retail health clinics.

A comparison study of clinic models by retailer would provide insight into the determinants of success caused related to the various models. Future research should be conducted on the broader population of retail health clinics to determine the relative success of store-owned clinics versus lessee-owned clinics within the retail outlet.

Future studies investigating retail health clinics' linkage to a sponsoring entity's strategic plan and describing the effect of the relationship between the clinic owner and the retail store employees could enhance understanding of CSFs in the retail health clinic business model.

APPENDICES

APPENDIX A

CMU
CENTRAL MICHIGAN UNIVERSITY

Adult Consent Form

Study Title: Factors Influencing the Decision to Close or Sustain Operations of Commercial Store-based Retail Health Clinics.

Research Investigators' Names and Departments:

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Introduction: This survey is part of a dissertation project in partial fulfillment of the requirements for the degree of Doctor of Health Administration at Central Michigan University. It will be used to identify critical success factors used by retail health clinics operating within a large national retail organization to achieve and sustain viability.

The survey will ask retail health clinic operators for data and perceptions regarding the important factors related to successful retail health clinics. I am available at any time to answer questions or concerns you may have about participating in the study.

Study Purpose: The purpose of this research is to identify the critical success factors used by retail health clinics operating within one large national retail organization to achieve and sustain viability. The objectives of this study are threefold; to determine if and how retail health clinics use the critical success factor model in decision making related to the ongoing viability of the clinics, to identify the criteria that are commonly used in decision making, and to provide potential clinic owners and operators with information and insight necessary to address critical success factors useful in developing and operating successful retail health clinics in the future

What will be done with the study: The study will be used as part of a dissertation. Data and information will be gathered through the use of an electronic survey tool. Follow up telephone interviews may be necessary and if so, a separate consent form will be completed at that time.

Study duration: The overall study is intended to take no longer than six months to complete. Participants can expect to spend approximately 30 minutes completing a survey instrument.

Potential risks of participating in the study: There are no expected risks to participants in the study.

Benefits of participating in the study: Participation in the study will contribute to the body of knowledge in existence related to the application of the critical success factor model in various businesses. In this case the use of critical success factors has not been extensive in health care. Additional information on the use of critical success factors will assist owners and operators to function more efficiently. It will also position new retail health clinics to become profitable more rapidly.

Confidentiality: Confidential, personal information will not be disclosed to anyone beyond the investigator and his advisor. In all other instances, any data under the investigator's control will only be presented in a manner that does not reveal the subject's identity, except as may be required by law.

Compensation: No compensation or fees will be paid to participants in this study.

For further information regarding questions about the research or research subjects' rights, please contact:

Patrick M. Hermanson
406-750-0439
herma1pm@cmich.edu

You are free to refuse to participate in this research project or to withdraw your consent and discontinue participation in the project at any time without penalty or loss of benefits to which you are otherwise entitled. Your participation will not affect your relationship with the institution(s) involved in this research project.

If you are not satisfied with the manner in which this study is being conducted, you may report (anonymously if you so choose) any complaints to the Institutional Review Board by calling 989-774-6777, or addressing a letter to the Institutional Review Board, 251 Foust Hall Central Michigan University, Mt. Pleasant, MI 48859.

My signature below indicates that all my questions have been answered. I agree to participate in the project as described above.

_____ _____

Signature of Subject Date Signed

A copy of this form has been given to me. _____

Subject's Initials

_____ _____

Signature of Responsible Investigator Date Signed

APPENDIX B

INTRODUCTION

The following survey is being conducted as part of a research project investigating the critical success factors for retail health clinics. Your participation is voluntary and confidential. All data will be reported in the aggregate and no individuals or organizations will be identified with any of the data.

Completion of this survey should take no longer than 30 minutes provided you have operational data at hand.

The survey is in three parts. You will be asked for operational data, information on critical success factors, and demographic data. Please be as specific as possible in your responses.

Thank you for taking the time to participate in this survey.

Patrick M. Hermanson, FACHE

OPERATIONAL DATA

The following items pertain to operational data including volumes, charges, staffing, and days & hours of operation. Please be as specific as possible in your responses.

1. What prompted you to work in a retail health clinic?

O This is my preferred career choice
O It was an exciting opportunity
O I wanted to see what it was like
O My supervisor encouraged me to do so
O I needed a job
O Other (please specify)

_____

2. What is your role in/with the retail health clinic?

□ Nurse Practitioner
□ Physician Assistant
□ Clinic Supervisor or Manager
□ Medical Director
□ Clinic Owner or Operator Executive
□ Other (please specify)

_____

3. What is the name of your sponsoring entity? (The organization that owns your retail health clinic)

_____

4. How many other retail health clinics does your sponsoring entity have?

□ 0
□ 1-3
□ 4-6
□ 7-9
□ >10

5. How many full-time equivalents (FTE) work at your retail health clinic by employee category?

Physician FTE_____
Nurse Practitioner FTE _____
Physician Assistant FTE_____
Registered Nurse FTE _____
Licensed Practical Nurse FTE_____
Medical Assistant FTE_____
Receptionist FTE_____
Other FTE_____
Total FTE_____

6. Please describe any arrangements that you have for physician oversight of your retail health clinic services.

_____

7. What formal relationships do you use to accommodate referrals to higher levels of care?

□ Transfer agreement(s) in place with local hospital
□ Refer directly to contracted physician practice
□ Refer to patient's primary care provider
□ Refer to any available provider
□ No formal relationship
□ Other (please specify)
_____

8. How long has your retail health clinic been in operation?

_____

9. How many days per year is your retail health clinic open for business?

_____

10. How many hours of service does your retail health clinic provide by day?

Sunday _____
Monday _____
Tuesday _____
Wednesday _____
Thursday _____
Friday _____
Saturday _____

11. Please describe (up to) the top 10 services that your retail health clinic provides, and estimate the percentage of business by visits that each represents (actual numbers preferred).
Example: Immunizations = 20%

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

12. Please provide the average charge per encounter for the services listed in the previous question.

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

13. Please name your top 5 payors and their percentage of your total revenue.
Example: Blue Cross = 15%

Self-pay _____
Payor 2 _____
Payor 3 _____
Payor 4 _____
Payor 5 _____

14. How many visits or encounters did your retail health clinic provide during calendar year 2010?

_____

15. How many discreet individual patients were served during calendar year 2010?

_____

16. Please describe the percentage of your patient population by race / ethnicity.

American Indian or Alaska Native _____
Asian _____
Black or African American _____
Hispanic or Latino _____
Native Hawaiian or Other Pacific Islander _____
White _____
Other _____
We don't keep these records _____

17. Please describe any seasonality or other fluctuations in volume that your retail health clinic experiences.

_____

18. Please describe the average monthly cost of operations for the following categories:

Personnel salaries and benefits _____
Physician oversight _____
Other contracted services _____
Lease expenses _____
Supplies _____
All other _____

19. What was your adjusted operating income for the year 2010?

Adjusted operating income % _____
EBIDTA % _____

CRITICAL SUCCESS FACTORS

You will now be asked to identify and list the top 5 critical success factors (CSF) that you believe are essential to your retail health clinic's ability to sustain itself over time. Please be specific as

to the definition of each CSF. You will later be asked to rank the CSFs according to your estimate of their importance.

Critical success factors are criteria for which satisfactory results will ensure successful competitive performance for the organization. They are those performance criteria that must go right for the business to flourish. Examples might include among others, leadership commitment, mission, financial performance, location, favorable contracting or demographic characteristics.

In thinking about critical success factors please do not limit yourself to the aforementioned examples.

20. In your own words please provide an overall definition of success for your retail health clinic.

_____

21. Please list in rank order (1 being most important) the top five (5) critical success factors (CSF) for your retail health clinic.

1. _____
2. _____
3. _____
4. _____
5. _____

22. Please provide specific definitions for each critical success factor.
(One example might be: Leadership Commitment is the designation of a senior executive with the responsibility and authority to oversee the performance of the retail health clinic and who has personal accountability for the success of the clinic.)

1. _____
2. _____
3. _____
4. _____
5. _____

23. Please describe in rank order (with 1 being the most challenging) the top 5 challenges you encounter in operating your retail health clinic.

1. _____
2. _____
3. _____
4. _____
5. _____

BUSINESS METRICS

You will now be asked to describe the top five (5) metrics that you track on a monthly basis to measure the success of your retail health clinic.
Business metrics are measurements used to gauge some quantifiable component of a company's performance. Metrics may include such things as return on investment (ROI), earnings before interest, depreciation, taxes, and amortization (EBIDTA), visits per day, patient satisfaction, charges per visit, patient churn rate, etc.

24. Please list in rank order (1 being most important) the top five (5) metrics that you track for your retail health clinic.
1.
2.
3.
4.
5.

25. Please provide the following demographic information. This information is voluntary but necessary if any follow up is required. All information provided in this survey will remain confidential and only reported in the aggregate.
Name:
Company:
Address:
Address 2:
City/Town:
State:
Zip:
Email Address:

26. If the name and or address of your Retail Health Clinic is different from the address provided in Question #25, please provide it here.

_____

27. In what year were you born?

_____

28. What is your highest degree earned?
O High School Diploma
O Associates Degree

O Bachelor's Degree
O Master's Degree
O Doctorate
O Other (please specify)
_____

29. Please indicate your gender.
O Female
O Male

30. What race do you consider yourself to be?
O American Indian or Alaska Native
O Asian
O Black or African American
O Hispanic or Latino
O Native Hawaiian or other Pacific Islander
O White
O Other

31. Are you interested in receiving the results of this study? Results will be sent to the name and address indicated in Question #25.
O Yes
O No

If you have any questions or concerns about completing this survey, please email me at herma1pm@cmich.edu.

Thank you for your participation.
Patrick M. Hermanson, FACHE

APPENDIX C

Retail Health Clinic Questions / Telephone Survey

1. Name & contact information:
2. Sponsoring entity:
3. How long has the clinic been in operation?
4. # of sites the sponsoring entity owns / manages:
5. How many FTE's by type work in the clinic?
    - MD
    - NP
    - PA
    - RN
    - LPN
    - Receptionist
    - Other
6. How do you provide for physician oversight?
7. What relationships exist for referral to higher levels of care?
8. How many days per year is the clinic open?
9. What hours per day is the clinic open by day of the week?
    - Monday
    - Tuesday
    - Wednesday
    - Thursday
    - Friday
    - Saturday
    - Sunday

10. What are the top 10 services provided by volume? (% of the total, if available.)

11. What is the average charge per encounter for the services identified above?

12. What are your top 5 payors and % of the total for each?

13. What was your total # of visits for your last calendar year?

14. How many discreet individual patients were served in the last calendar year, if known?

15. Do you keep patient data by race or ethnicity? If so, please provide it.

    White
    Black
    Hispanic
    Native American
    Asian
    Pacific Islander / Eskimo

16. Do you experience seasonality in volume and why?

17. How do you measure financial success? If you can break out clinic profitability please provide it.

18. What would be your definition of success for your clinic?

19. What are the top 5 critical success factors for your clinic? (Examples include location, volume, senior management support, hours of operation, payer mix, etc.)

20. Please define what you mean for each of the CSFs above.

21. What are the top 5 challenges your retail clinic encounters?

22. What are the top 5 metrics you use to track the performance of your clinic?

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