Opportunities to Improve and Implement Patient Access Points in an Independent Orthopedic Practice

Business Plan Submission

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Project Summary:

In 2014 the practice realized the outreach options of direct patient messaging, scheduling, and patient reminders for appointments currently being utilized had become limiting in potential. It was also discovered that patient/referring office surveys documented a growing decrease in satisfaction of service, and lower scores both in patient response time to phone calls, and delayed scheduling of patients from referral sources. Around that same period in 2014, the group began experimenting with an Urgent Care option for immediate treatment of orthopedic injuries, but it did not have the desirable response and volume expected. That same year the practice experienced one of the worst losses of revenue since inception relating to the purchase of an EHR and bringing on four new providers that were slower to establish their practices compared to physicians in prior years. The physician owners and administration noted the increased risk and unsustainable pattern of not correcting these issues along with the risk and the possible loss of reputation to service and desired growth in the community.

There are many opportunities for quick access to orthopedic care. Online scheduling, Urgent Care Clinics allowing walk-in appointments, specialized scheduling and triaging of appointments, and portals for referring offices to track their referrals are just a few options. The practice was the first in the area to implement many of these different services. They have attempted to utilize several patient access opportunities to leverage technology and convenience to become a leader in patient response, and service to referring offices. The plan to improve these access points would be directly measured through an increase in office visits, revenue, and patient/referral satisfaction surveys.

This plan outlines the process of evaluating and implementing options to increase the availability, and ease of making appointments. The goal of the practice is to be more readily accessible to patients and referral sources the practice is currently serving, but also to increase market share where the practice has not reached patients and referral sources while maintaining and further improving on its efforts of customer service and patient care. It will be the Administrator's responsibility to develop a plan of action with the management team to evaluate all options that provide the Practice the best plan to improve access to the physicians along with the least amount of risk.

Executive Summary:

Patient access is one of the keys to a successful practice. Technology and convenience are changing the way patient access is defined in healthcare. No longer is it acceptable in the eyes of the customer to wait for appointments. The healthcare consumer evaluates not only the treatment provided by medical personnel, but also the ease of making an appointment, the customer service experienced while in the office, and aesthetics of the practice. Reviews of service and response on social media of a healthcare facility's patients' services similarly compare to that of restaurants or other retail stores. It is dependent on management to assist physicians in understanding the balance of retail type service, and not only meets but exceeds the patient expectations, and doesn't interfere with patient care and maintains all the privacy standards and regulations that healthcare to which facilities must adhere.

The practice is a privately owned 31-physician specialty practice providing healthcare services for most of all orthopedic specialties with approximately 24 advanced practice providers (APPs). The practice consists of six full time offices operating in multiple counties, and one part-time location in an underserved county area. They also maintain services in several ancillary areas to

include five physical therapy clinics, three MRI units, and multiple durable medical equipment locations. The practice is the second largest orthopedic service provider in a medium market with aspirations of competing and providing a quality brand recognized for service across the state. The group was formed in the late 90's through the merger of several smaller privately-owned orthopedic groups and has increased in number of physician owners. They are not affiliated with a hospital but mainly operate and practice within the main hospital system in the region. The practice has a strong history and a good reputation within the community, but internally has a history of being more reactive in the market, and not as willing to be early adopters of unproven technology. They maintain a very low debt burden and typically shy away from aggressive plans with an increased financial risk that has been unproven, or a less certain guarantee of financial return. The Mission Statement of the practice is: "Providing quality orthopedic care, with a focus on individual needs, positive outcomes, and excellent patient experience."

All but one of the physician offices are located within the campus of a hospital system. This hospital system has no ownership stock in the practice, however most of the elective and emergency surgeries of the practice are performed within this hospital system. The location of the offices within the hospital campus are in high traffic buildings leased from the hospital providing a lower operating cost compared to ownership of brick and mortar buildings or leasing from a more typical retail space. They also allow for greater convenience for the physicians to be more efficient during the day when going between the hospital/surgery center for surgeries, office, rounding, and ER coverage. Directions can be easier to provide over the phone as most of the community are familiar with the hospital campuses. However, the disadvantages are parking problems, longer walks to get to the office for the patients, decreased visibility for directional and building signage, and less control of services offered within the building that may compete with similar services offered by the hospital system.

The practice did initiate an orthopedic Urgent Care service in one of its site locations in 2014 that continues to see improvement in patient volumes. These services consisted of immediate treatment options for strains, sprains, and fractures for orthopedic evaluations Monday – Friday from 4 PM – 8 PM, and Saturday 9 AM – 1 PM. In 2018 the hours were increased from 8 AM - 8 PM during the weekdays. The expanded hours within this location have demonstrated an increase in patient access. Over the past several years the average has increased each year per day from 3 patients to 22 patients per day. The demographics of these patients appear to be led by the 18 – 35 age category, significantly improved payor mixes compared to the other clinic locations. There are currently no retail orthopedic Urgent Care centers operating within the practice area that are not tied to a facility on a medical campus.

Each office maintains its own appointment scheduling personnel. The software utilized to schedule is the same in all offices but there are different appointment types by physician and office, and there is not consistency among the offices in how certain appointment types are handled. It is possible for the patients to request an appointment online, but it requires a scheduler at a specific office to pick up the phone to call. Depending on the number of calls within an office, the appointments that are requested by fax, online, or through patient portal are only addressed during lower volume phone calls. On busy days, there is a possibility that the appointment schedulers working the phones may only be able to return calls the next business day or after phones are rolled to the answering service at the end of business. No other orthopedic office within the area that the practice operates offers online appointments without having to have an additional contact point from the office to schedule the actual appointment. Smaller offices share phone scheduling responsibilities with other duties such as patient check-in, registration, and front office collections. The phone system was upgraded in 2015, but the servers were not all

set up the same making comparative reports between sites limited. Some sites with higher volume calls are informed on occasion that referral sources and/or patients are getting busy signals on the appointment line. There are not any current viable options when the phones go down at each location.

The administrator and management team recognize the limitations of patient access and want to explore and implement options to expand upon services offered. It is the belief of the administrator and management team that the opportunity exists to take advantage of technology to improve the efficiency scheduling, offer greater opportunity to improve appointment turn around to the referral sources and further add more convenient financially secure site locations expanding the patient volumes and opportunities to grow the practice. The practice is managed by a Chief Executive Officer (CEO), Chief Operations Officer (COO), Medical Director, Controller, Clinic Directors and managers at the various physical locations and business office, a group of five physicians from each site which makes up its Physician Oversite Board (POB), and various physician and administrative led committee to make the decisions for the practice. These individuals will work together to review the information collected to select vendors based on scope of work, financial cost and return, and strategy to guide the practice to take advantage of the current opportunities that exist for patient engagement, access, and growth. The two areas of focus within the project will be improving access for patients to make appointments, and research and identify a retail space in an area to improve convenience for patients to be seen in the office. With the physicians' low debt ratio, access to funds is readily available within the normal operating budget and through specific project capital loans with the practice's financial lending institution.

After reviewing several potential vendors and current operational practices, the Operations Committee (made up of the COO, Clinic Directors, and five physicians from various site locations) determined that one of the vendors offered several opportunities to improve the current scheduling processes, improve scheduling efficiencies, and provide services to patients currently not available. The cost of such services could be covered if the new technology is used to fill the slots left by patients that cancel on the same day or within 24 hours. If the practice can fill 20 of these slots practice wide, then the cost for the system is cost neutral. Other opportunities are then available to take advantage of the technology to increase further financial return on the investment and patient service opportunity increase. The vendor guaranteed at 3:1 return in three months or initial investment of first three months returned (See Figure 1.1 below).

Summary Income Statement
(Patient Engagement System) Fig. 1.1

	Year 1	Year 2	Year 3
Revenue	$94,500	$126,000	$126,000
System Costs	($42,000)	($42,000)	($42,000)
Total Income	**$52,500**	**$84,000**	**$84,000**

The success of the orthopedic Urgent Care center located within one of the locations on the hospital campus prompted the idea to expand into an area of the community where the practice has low market share. Retail space brings several challenges including increased operational costs related to costs of owning or leasing retail space with greater community visibility compared to that which is on a medical campus. Based on the experience and current financial performance of the orthopedic Urgent Care, a proforma for a retail space orthopedic Urgent Care was developed. Based on the fact that most of these patients would be new to the practice, any

proforma that estimates the venture net neutral is looked at as a viable low risk option as it captures an increase in market share and doesn't account for downstream revenue within the practice (i.e. Physical therapy, MRI, surgery, and name recognition). (See Figure 1.2 below).

New Urgent Care (Retail Space)
Summary Income Statement Fig. 1.2

	Year 1	Year 2	Year 3	Year 4
NET MEDICAL REVENUE	$286,700	$322,700	$322,700	$322,700
TOTAL SALARIES & BENEFITS	$194,990	$194,990	$194,990	$194,990
TOTAL OCCUPANCY EXPENSES	$42,204	$42,828	$43,464	$44,112
TOTAL MEDICAL EXPENSES	$1,920	$1,920	$1,920	$1,920
TOTAL ADMINISTRATIVE EXPENSES	$83,322	$66,832	$66,832	$38,832
TOTAL EXPENSES BEFORE CLINIC SERVICE AGREEMENT EXPENSE	**$322,436**	**$306,570**	**$307,206**	**$279,854**
NET OPERATING INCOME	**($35,736)**	**$16,130**	**$15,494**	**$42,846**
Clinic Service Agreement Expense	($112)	$51	$49	$135
TOTAL CLINIC SERVICE AGREEMENT EXPENSE	**($112)**	**$51**	**$49**	**$135**
TOTAL EXPENSES	**$322,324**	**$306,621**	**$307,255**	**$279,988**
AMOUNT AVAILABLE FOR PHYSICIAN EXPENSES AND COMPENSATION	**($35,624)**	**$16,079**	**$15,445**	**$42,712**

Part I: The Organizational Plan

Summary Description of the Existing Business:

The practice has a focus on complete orthopedic care for the patient. By offering orthopedic specialists and general orthopedic surgeons, MRI with specific reads by musculoskeletal specialists, physical therapy managed by the practice, and Urgent Care options, the hope is the patient doesn't have the need to go anywhere else in their orthopedic care. Though the revenue of the practice is still based on volume of patients seen in office and surgeries completed, there is strong shift toward more quality-based revenue through bundled payments, surgery, and other forms of quality-based outcomes. For this reason, the office visits need to be productive, efficient, and yield a higher surgical hit rate so that the higher quality patients feel that their expectations for the visit have been met. The goal of the practice is to be the destination for orthopedic care, while continuing to improve upon its ease of access and customer experience.

The SWOT analysis below specifically focuses on the goal of recognizing access points and gaps to service within the practice. (See Figure 1.3 below.)

Strengths:
Fig 1.3

- Willingness of physicians to work patients in during the day

- Orthopedic specialist and generalists that are well respected and have a strong reputation in the community focused on good outcomes and experiences
- Trust in administrative team to evaluate, recommend, and follow through with a strategy to improve the overall mission of the organization
- Locations that service communities within a large county and surrounding county area located by or on campuses of the largest hospital system in the region.

Weaknesses:

- Every aspect of the phone delivery system to serve the practice (phone service vendor, reports, inconsistency in scheduling, inefficiencies and redundant staff at every site location, lack of manager to oversee the scheduling system, inconsistent rules and policies to schedule, busy phones, high turnover of scheduling staff)
- Internal disagreements in how patients should be assigned between individual physician, specialists, generalists, and site location.
- Dependent on phones for majority of all appointment scheduling.
- Low visibility and ease of access of the clinic locations.
- Slower to move and be proactive. Like to watch and be second generation adopters of change once all the kinks or bugs are worked out by others.

Opportunities:

- No other competitors in the area have systems with greater ability to provide ease of access.
- No other competitors in the area have offices off a medical campus.

Threats:

- One competitor is going to be the first to take advantage of new technology to provide greater access which is going to make the race to the top much more difficult for later adopters or those slow to change.
- Growth within the group has only occurred by adding new physicians, but those physicians within the group with an established practice have seen little change or are so busy that patients are not able to see them. Doing nothing will not change this pattern.

The strategy will focus on two phases: Improving patient access and entry into the existing business, followed by Improving patient access and entry into new lines of business. It is estimated that each phase will take approximately one year to implement, and patient access is the first phase that needs to be completed to allow phase two the opportunity of greatest success. The administrator, senior leadership, and the physician led committees determined that the group would not be successful with new ventures of patient access and engagement without addressing the gaps and service and weaknesses present in the existing business model. Adopting the new patient engagement system and utilizing the tools within the system will bring added financial benefit without significant costs if the estimations hold true of the break-even analysis with making minor adjustments in scheduling and implementing some patient engagement technology. The idea will be to create a patient engagement system that will touch several areas of patient scheduling process including: centralized scheduling, systematic process and consistent policies

of scheduling for each physician, establishing a procedure for patient entry into the practice and assignment to a specific surgeon or physician based on those processes, online scheduling for patients and referring sources, patient appointment reminder tools, electronic waitlist options for patients, and mass communication technology allowing for improved contact with patients to avoid unnecessary delays or inconveniences with scheduling and communicating office wait times.

In this phase, buy-in from the physician leaders will be key to adopting these new processes. In the end, the physicians will be the deciding factor in the success in making a positive and effective change. The CEO, COO, Director of Clinic Operations, and the physician led Oversight Board and Operations Committee will be the practice's key decision-making groups to build a product the physicians in the group will adopt. Communication and understanding of what the physicians feel they need and want to control will be important in building the technology and developing centralized scheduling policies and procedures. Each phase will need to be tested and verified to ensure that patient access is improving, and not creating additional barriers. Additional barriers are created when the technology is not working as intended or there is a perceived understanding by the stake holders (in this case the physicians), that the new limiting the overall goal to be achieved. This perception significantly decreases the effectiveness of implementing the plan.

The key relationships outside of the practice to implement the first phase are most heavily reliant on the technology vendor selected. The vendor for the patient engagement technology will need to ensure they align and meet the timelines of the practice so that progress continues to move in the direction of meeting the goals of increasing access points for patients within the practice. Regularly scheduled meetings, deadlines, delivery expectations, and proven testing will need to be placed on the detailed project plan to ensure that the communication in on target. The project plan should be reviewed each meeting to ensure all points are followed up on and accountability is assigned to ensure completion. A rollout of how the plan will be implemented will also need to be discussed, reviewed with the vendor, administrative team, physician led committees, and eventually the physician partners so that any potential concerns or problems are addressed before the final product is completed. After a successful roll out of phase I, the practice will be ready to support and begin working on plans to grow and compete in new lines of business focusing on more convenient patient access and growth.

Summary Description of the New Business:

As mentioned, the practice has been successful in their markets focused on services on or within medical based campuses. The emergence of convenient healthcare settings has been a source of new entry into the market area for more of the primary care-based patient treatments, however within the area of the practice, they have not witnessed entrance of orthopedic groups into this market. The practice has identified that their own patients are visiting Urgent Care settings for injuries that had typically been referred from the primary care physician offices, or self-referred. Many of these visits to the Urgent Care sites occur out of ease for the patient to walk-in without an appointment, convenient extended hours of operation, proximity of the clinic to home or work, and extended weekend operations. As it currently stands, the primary care based Urgent Care locations in grocery stores, large retail settings, or strip malls, are not having a significant impact of taking away from the practice as a whole, and recent marketing efforts have been focused on working with the different groups to develop a referral relationship for these type of clinics. There is a significant risk of an orthopedic Urgent Care being developed and added within the area that could be a direct threat to the practice. Especially if it was developed by an outside

orthopedic group from another city or state, or even a competitor within the area. Concern of this threat is creating the desire of the practice to be a new entry adopter of an orthopedic line of business that is placed in a similar area(s) to the model utilized by the primary care based Urgent Care groups.

The SWOT analysis from the initial phase review does possess some carry over to the phase II review and new business model. However, there is additional more specific analysis as it relates to the SWOT for the phase II. (See Figure 1.4 below)

Strengths:

Fig. 1.4

- Name recognition within the community.
- Administration with experience of many building projects, and the ready to use vendor contacts within the area to evaluate locations that have the highest significance and greatest impact to serve a potential underserved area of the practice.
- First orthopedic practice in the area poised to open a retail type store front option for patients to access.

Weaknesses:

- Cost of retail space is almost double of the practice's current experience of medical campus space, and contracts are more binding and harder to end in a retail space area if the venture is not successful.
- Landlords for retail space are not familiar with medical campus needs and retail buildings typically need greater support of electrical and other utilities, along with more considerable build out to make medical space useable.

Opportunities:

- Increase market share in an area that is not as prevalent within the practice.
- Perceived ease of access with added locations, increased visibility, and extended hours during the day and on weekends.

Threats:

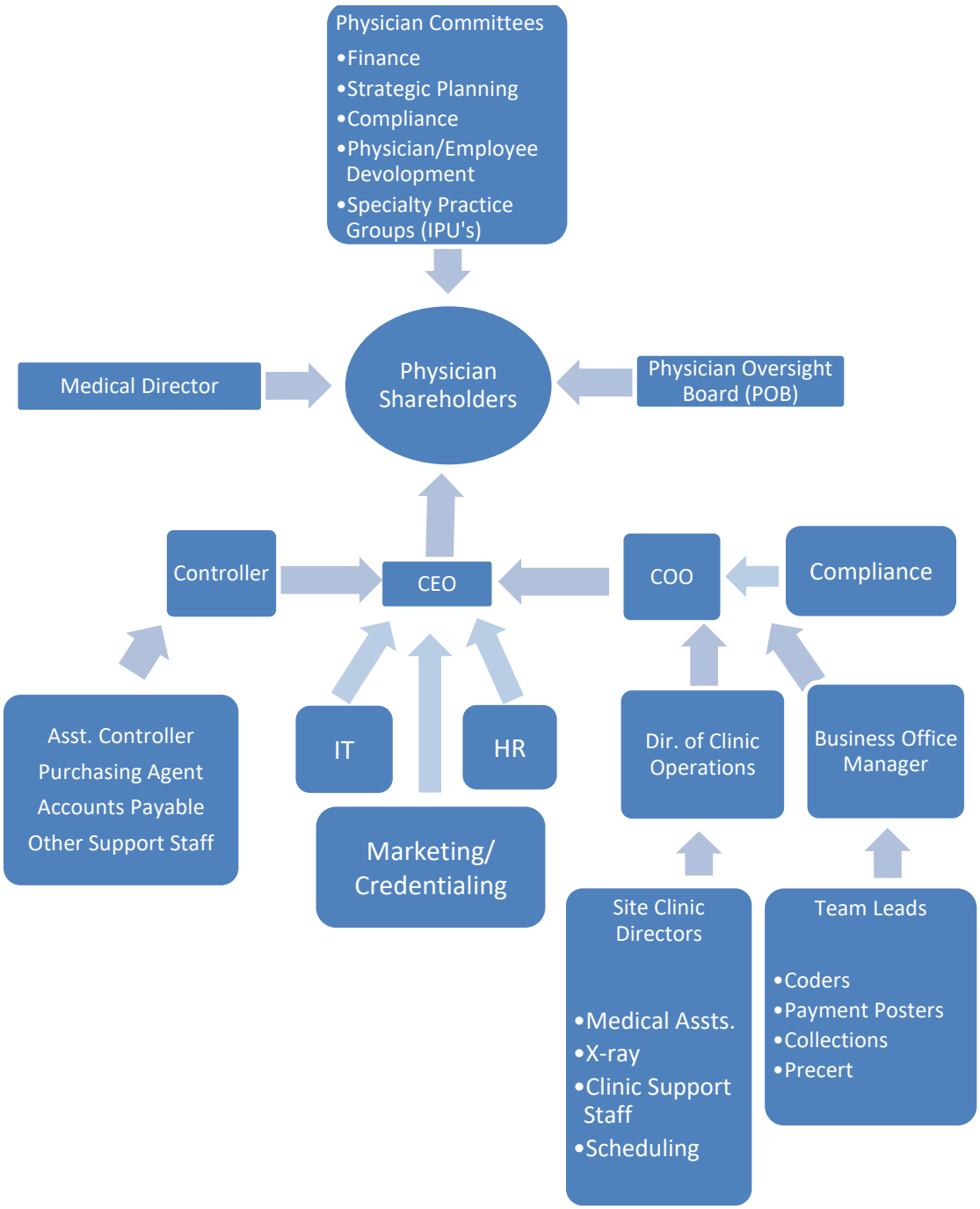
- Locked into a longer-term building location in terms of purchasing a building that may not be successful or leasing a space that does not provide the benefit expected.
- Doing nothing will give the advantage to another group.

Administrative Plan:

The strategy for phase II will consist of detailed planning and research. The overall operational structure of the new retail clinic space will be very similar to the current locations existing on a medical campus, however the need to take into consideration other outside forces and factors cannot be ignored. The cost estimations of a venture are estimated to be well over $500K, not including staff, equipment, and training needed to be prepared to open. Due to the cost of the potential project, the organizational chart for decision making will need to follow the by-laws and

decision matrix of the practice to approve moving forward with the potential project. The decision matrix (See Appendix A, pgs. 26 - 28), provides a quick decision guide to keep the project moving forward knowing where the approvals for the project are needed. In this case, the project exceeds more than what any one committee or group can approve. However, senior staff, physician board, and physician committees have the capability to work toward a plan design to present to the group for final approval. The organizational chart for the practice is listed below in Figure 1.5.

Practice Organizational Chart Fig 1.5



The new retail space clinic will be developed by the Strategic Planning Committee. The plan will then be presented at the Physician Board, and researched by the CEO, COO, and Director of Clinic Operations in preparation of being presented for full project approval at the Physician Shareholder level. If approval for the project is approved, then the Director of Clinic Operations will manage the project, working with the CEO, COO, Controller, and IT Dept to coordinate the appropriate areas of the project. This project has been asked to be completed on an expedited schedule upon completing development of the internal patient engagement platform.

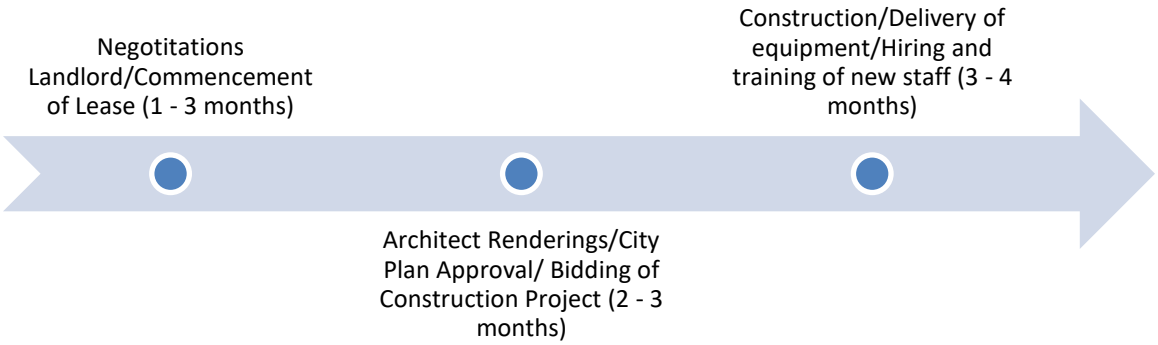
Operational Plan:

The scheduling system will be addressed in several ways: staff infrastructure, procedures and protocols, and IT infrastructure. It is estimated that the build of the scheduling program from the software vendor will take about six months. It is estimated that rollout of the scheduling system and training will take two months and centralizing the department and initiating training on the new scheduling protocols will take an additional four months. Total roll out of the project will be about one year from the time of signing the vendor contract for the scheduling and patient engagement platform. Communication of the project goals to support staff and all physician partners is viewed as the top priority in the success of building the infrastructure, and policies and procedures. During the vendor build of the product certain project items can continue to move forward in preparation of the new patient engagement and scheduling product.

The Director of Clinic Operations will coordinate with each Clinic Director, Physicians, and clinic support staff as to what the staff infrastructure will eventually become. Due to the high level of involvement by the physicians in their clinic schedules, it is the desire of the management team to seek direct feedback from the staff that are involved in the scheduling process every day to identify many of the challenges they need to overcome to be successful with quick entry of patients into the practice. The IT Department will coordinate a review of the phone system, servers, and carrier of services for the practice. The goal will be to have one system able to support the new scheduling software, and a centralized scheduling department near the time of completion by the vendor. Once the phone system can be tested with the new software, the Director of Operations in coordination with the Physician Committees, Physician Board, and eventually the Shareholders will be ready to approve scheduling and phone procedures and protocols utilized by every location. There is not an expected increase in costs or need to purchase additional equipment to complete the transition to central scheduling other than the expected cost of the new patient engagement and scheduling system. After successful completion of scheduling system rollout, online scheduling will be implemented on the practice website. This will be the final stage prior to completing preparation of the new retail orthopedic space.

The new retail space development is expected to take six to ten months to complete after the project is approved. Most of the time related to the project is expected to reside around identifying the best location of the retail office clinic space. It is determined that a realty broker would be used to evaluate locations within the main city of operations of the practice. Goals for the broker would be to find a highly visible location on a main road in the city, find an existing building that could be renovated, and assist with lease/rent negotiations with the potential landlord. The Physician Board would provide to options and present the final costs and options at the Physician Shareholder meeting for approval of the project. The project timeline will follow the approximate timelines below. (See Figure 1.6)

Fig. 1.6 Timeline of Retail Clinic Space Development



Some of the items within the timeline can overlap, or do not necessarily have to wait until the prior items are completed in entirety. For instance, once the negotiations are underway for the building, the architect can begin renderings of the clinic so that they may be submitted for approval as soon as the lease or terms are signed with the landlord. The unpredictable state of a city's building and planning commission's length of approval can lead to significant delays in the timeline. Being able to submit plans for construction, exterior signage, and even finding subcontractors to have ability to start the job are dependent on schedules that are outside of the practice's control. Keeping the next step moving as soon as possible will assist in avoiding some extended delays or making up for delays that may take longer than expected.

The addition of this retail clinic also poses some administrative questions surrounding management of the practice's Urgent Care operations. Currently the medical management and provider questions of the Urgent Care department are handled by different physicians on a rotating schedule. Time off requests are also managed by utilizing current APPs that have the desire to work additional hours outside of their normal obligations. However, these new clinics will create the potential need to cover five shifts and increase the number of patient medical x-ray reviews to levels that some physicians within the practice are unwilling to cover. It will be the duty of the Clinic Director of Operations to make a recommendation to the Physician Board to find a more consistent level of coverage and a physician champion to lead the new medical management of the care provided in the Urgent Care centers, and to hire enough staff to cover each shift as well as an extra extender to provide coverage during unexpected and planned absences of the APPs that work the Urgent Care Clinics. Even though the physicians like to take a "just enough" staffing approach to maintain a lower overhead cost on staffing, having enough staff to run the Urgent Care centers is most crucial to a successful operation. Without the staff to work the clinics the location will not be able to meet the proforma and expected outcomes.

Part II: Marketing Plan

Overview:

The marketing plan for the new retail space will have several administrative touch points for coordination. Although the practice has a marketing department which consists of outreach to referring offices, monitoring and pushes of social media updates with information about the practice, and other promotional material; the practice plans on using some outside resources to assist with more specific market analysis to ensure the investment of the project is as successful as possible. Those outside resources will consist of a population and growth study with ideal locations to place the practice by the realty broker. Market analysis of current patients and utilization of services in coordination with the CEO, COO, Director of Communications, and

Director of Clinic Operations to evaluate current patterns and trends of data within the practice (i.e. patient demographics, payor mix, and patient zip code analysis). Information from the city's Chamber of Commerce to include median incomes, growth maps, and other trends to compare to the practice's patient draw. The practice wants to ensure that a retail venture is evaluated from all areas to assist with finding placement of the retail space that will be utilized by the target demographic area of focus.

Market Analysis:

Marketing Analysis of the area (as hired by the practice from a realty broker) identified three areas within the Practice's main city of operations where consideration should be made for the most successful capture of new business. The following data table was taken into consideration when evaluating the best site. (See Figures 1.7a - d)

Figure 1.7a lists the total population market analysis for the county of the practice. Option A has the highest market population within the city, and the highest population to reach a new location within 10 minutes.

Fig. 1.7a Practice Market Analysis of Building Location

Primary Markets	Practice County	Option A	Option B	Option C
Total Population	465,546	82,787	21,755	43,839
Total Population within 10 min. of an existing Practice location	106,924	39,061	1,494	17,878
Incremental Population within 10 min. of New Location	-	43,726	20,261	25,961
Total Market Capture / Geographic Reach in Practice County w/ new location(s)	23%	32%	27%	29%

Figure 1.7b lists the existing patients of the practice in each of the areas for consideration. Option A is shown to have the lowest number of existing patients within the main county of the practice even though the overall market capture is the lowest of the three options.

Fig. 1.7b Practice Market Analysis of Building Location

Primary Markets	Practice County	Option A	Option B	Option C
Existing Patients	30,060	2,982	3,201	3,995
Current Patients within 10 min. of an existing Practice location	3,382	553	68	1,125
Incremental Existing Patients within 10 min. of New Location	-	2,429	3,133	2,870

Total Market Capture / Geographic Reach in Practice County w/ new location(s)	**11%**	**19%**	**22%**	**21%**

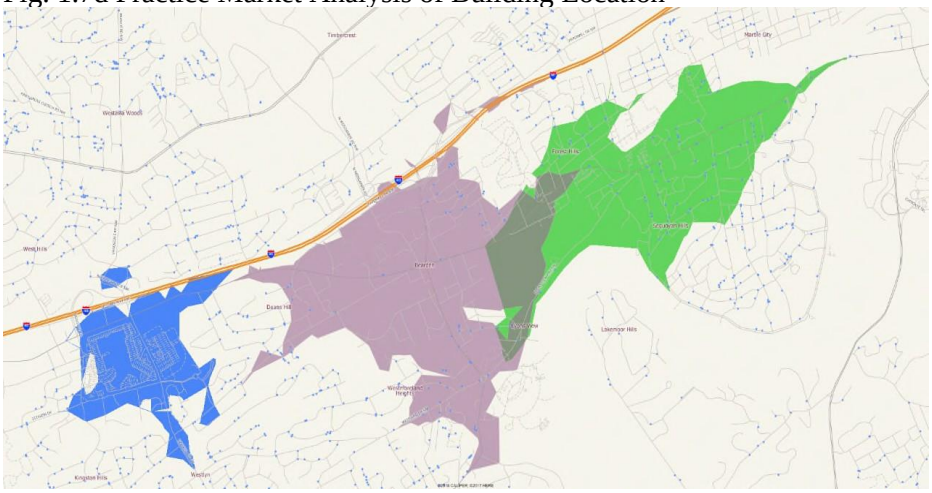
Figure 1.7c lists the main financial insurance payors of the practice. Each of the options the practice is considering for the new location all demonstrate good payor mixes for the practice.

Fig. 1.7c Practice Market Analysis of Building Location

Payor	Option A %		Option B %		Option C %		Total	%
Commercial	1,217	41%	1,396	42%	1,738	43%	22,126	37%
Medicaid	125	4%	41	1%	99	2%	2,647	4%
Medicare	590	20%	743	22%	717	18%	12,229	21%
Medicare Advantage	419	14%	346	10%	463	12%	9,040	15%
VA	18	1%	31	1%	50	1%	618	1%
Worker's Comp	73	2%	38	1%	79	2%	2,043	4%
Other	540	18%	744	23%	882	22%	10,676	18%
Total	2,982	100%	3,339	100%	4,028	100%	59,379	100%

Figure 1.7d shows a population heat map of Option A. After reviewing data from the previous tables, Option A provides a good payor mix of potential new patients and has a well-established population of potential patients in an area that the practice has no existing locations within a ten-minute drive. The lighter purple area within the map demonstrates the highest population area within Option A. This is the location recommended for the new location.

Fig. 1.7d Practice Market Analysis of Building Location

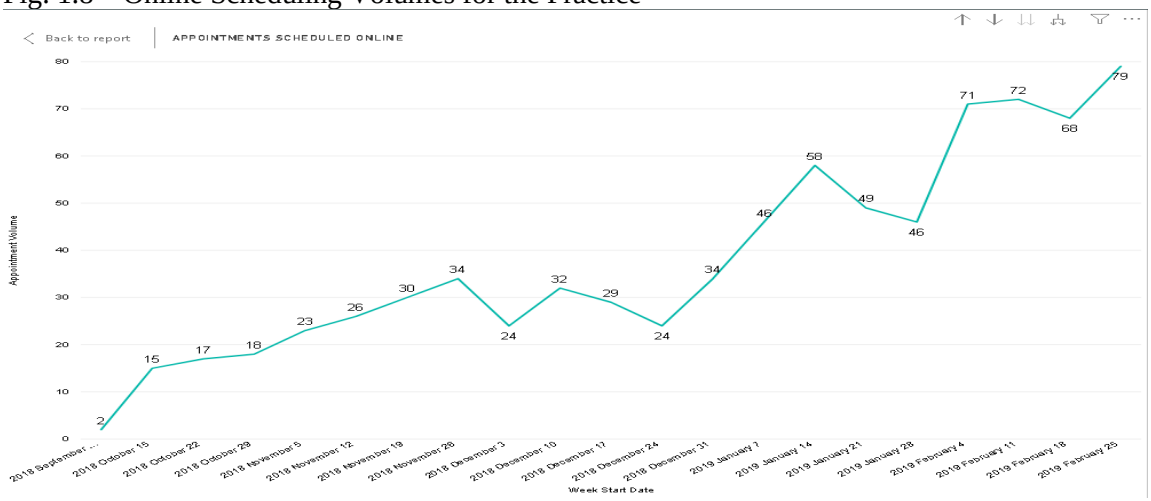


Marketing Strategy:

The market strategy will also consist of using current practice technology, online scheduling, radio advertisement focused on main demographics that use the Urgent Care, and billboards for advertising of services. Another option for consideration is adding other services within the new clinic that may not be available in the area to draw foot traffic into the building and to utilize word of mouth from existing patients. These services could be additional clinic space for existing physicians that want to add clinic time to their existing schedules, and/or physical therapy clinic space to allow urgent treatment of the acute Urgent Care injuries and another convenient location for patients to obtain some additional orthopedic services. Consideration needs to be observed to decrease the risk of cannibalizing current offerings of service from the practice.

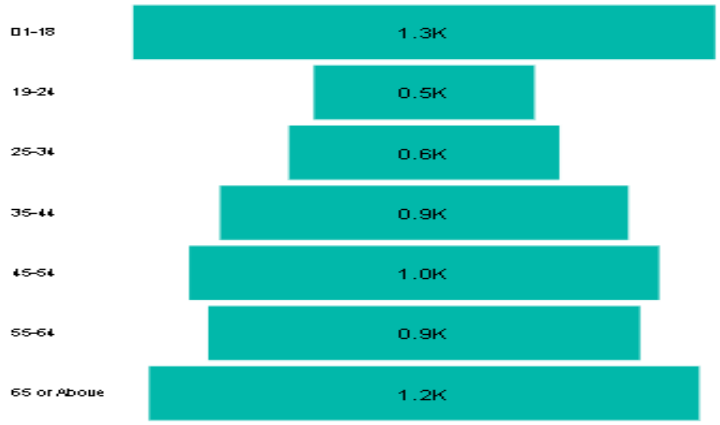
Online scheduling utilizing the new Urgent Care service demonstrates several key pieces of information to the practice. First the growth of online scheduling demonstrates the need of having a quick accessible option for patients to enter the practice without calling to speak to a person. The graph of Figure 1.8 demonstrates this need as it was rolled out for testing with some of the physicians in September 2018 into implementation of all physicians in January 2019.

Fig. 1.8 Online Scheduling Volumes for the Practice



Other data from the online scheduling system represented by the other ortho Urgent Care locations that practice within other main office settings also capture the demographic information of the main users of the Urgent Care services. Figure 1.9 represents the main ages of the patients being treated in the Urgent Care facilities. This helps the marketing department at the practice focus efforts on the primary group to capture that is currently utilizing the service. As notice in the graph below ages 1 – 18 are the highest utilizers of the service. Since most of this group would represent minors, the focus of the marketing campaign would be radio and online marketing of social media geared to parents of children ages 1 – 18. Geofencing of websites within schools, ball parks or recreational areas prone to orthopedic injury, hospital ERs, and restaurants geared toward younger families are all considerations for the Practice to focus efforts of making potential patients aware of the Urgent Care services to be offered.

Fig. 1.9 Demographics of Patients Utilizing Ortho Urgent Care at the Practice



Billboard location is another area of marketing that can produce instant visual results. The marketing department will plan on utilizing data from the main billboard contractor in the county focusing on close placement to the new retail location in an area with high visibility throughout the day. Typically, these high visibility billboard placements can be more costly, but recognition of services and knowing where the services are located are viewed as key strategies of the Practice to be successful in the retail venture.

Very few printed materials other than business cards for the current practice locations will be utilized. From more recent experience with the marketing department at the Practice, it is viewed that printed material consistently needs to be updated and typically does not have as great of an impact even though the costs can be lower to produce. Printed materials that patients hang on to are usually the size of a business card to keep in a purse or wallet with easy access to a phone number or website.

Implementation of Marketing Strategy:

The phases of implementing the marketing strategy will very closely match the roll out of the phases for the timeline for development as listed in Figure 1.6. The market analysis and comparison to current practice demographics of patient services must be completed during the months 1 – 3 and is dependent of selecting the location of the new clinic. Until this phase is complete review of buildings for renovation is on hold. Once the location is selected, the realty broker is then able to identify potential locations for the new clinic. After selection of a new clinic location is determined and construction can proceed, the other marketing items can begin falling into place.

In months 4 – 6 of the project, online notice of the new location can be added to the main website. Business cards of the service can be printed and handed out for distribution near the end of the construction. Physicians interested in additional clinic time that are either short on space or have a potential draw of patients to the area can have their practices evaluated to determine if the new location makes sense to add as an option to see patients. Due to the length of time needed to create a billboard and the contracts available for a specified amount of time, contracts for certain areas of high visibility may need to be obtained as soon as a contract expires to ensure that the practice can obtain the best billboard for visibility. It is also important to have negotiations for right of first refusal to allow continuation of the billboard space. This can ensure continued placement of the billboard once the contract expires.

As the project nears completion in months 7 – 10, electronic geofencing of the areas around the new location can be built and ready for visibility closer to time of opening and allow for quick access of scheduling with online searches when key words are used for internet searches on mobile devices and tablets within those areas. The actual patient and/or provider schedules will need to be built and tested to ensure accuracy of the appointment prior to opening the new clinic. Personal visits from the outreach staff within the practice will take place at referring medical offices that do not currently have similar services of ortho Urgent Care, and/or busy ER's within the area as an option for patients to avoid long waits of services that can occasionally cause overcrowding in the emergency room waiting areas.

Part III: Financial Documents

Summary of Financial Needs:

The Practice has a strong history of financial stewardship as well as a successful record in prior project management and investment of new services. It has already demonstrated success in two other Urgent Care locations and initial data demonstrates the need and viability of a new center outside of the normal venues for orthopedic Urgent Care. Expenses are closely monitored by the administration with regular reporting to the Physician Board at monthly meetings and to the Shareholders every quarter. The initial investment into a scheduling system focusing on patient engagement has minimal risk with the vendor promising a 3:1 profit ratio by the end of month three or full return on investment. At a minimum, this guarantee by the end of year three equates to $220,500.00 in additional revenue. There are other avenues of revenue with successful rollout of the project.

1. Increasing the total number of patients to fill unused patient slots of patients that cancel.

    - Breakeven for the project is 20 patients per month. Utilizing the scheduling staff in the new central scheduling department and designing procedures and processes to offer this option to patients will create a more consistent workflow to implementing and regular use of this option for patients. Every patient over 20 that is successful in utilizing this option is increased revenue for the practice.

2. Optimize scheduling efficiencies to allow greater number of calls completed during the day.

    - It is demonstrated through the new practice scheduling software that an efficient scheduler can complete 55 – 65 appointments in the normal day. Ensuring that all schedulers are working to that efficiency will ensure that time spent during the day scheduling is utilized to optimal level.

3. Scheduling by economies of scale will increase production and decreased missed calls within the department.

    - Prior to central scheduling, each office had staff that only schedule for the physical office they were located. By having fewer dropped calls, it decreases the risk of patients calling another practice due to inability to schedule an appointment by phone.

4. Consistent scheduling process streamlines information collected and allows for less variability in the amount of time needed to complete a scheduling call.

- Prior to central scheduling, each office scheduled patients with different parameters and collected different patient demographics to complete the scheduled appointment. The new reports in the phone system can be used to track number of abandoned calls, hold times, and average talk time. The new software vendor states that established patient visits should take less than 2 – 4 minutes to schedule, with new patients average 5 – 8 minutes. New reporting views will help to establish if any schedulers are out of line with the estimates and work toward identifying and correcting the individual staff members outside of the appropriate guidelines.

5. Online scheduling has the potential of decreasing staff time on phone while increasing appointments for the physicians and their APPs.

- Appointments being made directly into the scheduling system for the practice from online provides 24/7 access to appointment availability of the practice allowing patients the convenience to schedule when they can make appointments to be seen.

6. The new patient engagement system will utilize text, email, and phone to remind patients of appointments and allow automatic cancellations, and/or rescheduling opportunities without calling.

The Practice is aware that approximately 65% of the schedules each day are utilized during the day leaving 35% of the appointments unused. While it may be impossible to be 100% full of all appointments taken and every patient to arrive for a scheduled appointment, increasing the appointment utilization by 5% will increase the practice revenue just of the clinic by approximately $350K per year. This does not count additional revenue potentials from downstream sources such as ancillaries, and surgical opportunities.

The retail orthopedic Urgent Care location does present with the need for financial capital for the project. It is estimated that the costs to analyze the project ($20K) create the drawings (usually 6% - 8% if the construction costs $44K), build ($550K), equip ($200K), staff ($420K), and market the project ($75K) could exceed $1.3M. The Practice typically will elect funding for the architect, construction, and equipment through their selected financial institution in the form of a low interest loan with terms of 36 - 60 months. The Practice will elect to pay through cash reserves the project analysis fees from the realty broker, as well as any initial staff and marketing expenses.
As Figure 1.2 on page 6 estimates, the initial revenue for year 1 of the new retail space clinic indicates an estimated $36K loss in revenue followed by three years of positive revenue growth for a total of $38K in revenue. Although the revenue at the end of year three is positive, the initial early year estimates operate at a loss while the clinic ramps up in volume. Management of the construction project timeline, staying on budget, and other options may allow for an increase in revenue earlier than projected.

1. Adding ancillary services such as physical therapy to the clinic location provides additional sources of revenue to the project.

- It has already been determined that the selected option for the new clinic provides services to the area where the practice has a gap of services for the community within a 10-minute drive of existing locations. Adding space to accommodate some ancillary services that fit within the practice's model of care

decreases overhead to the Urgent Care balance sheet as well as providing additional offerings of service that the practice does not have in that area.

2. Adding physician clinics within the Urgent Care space for physicians looking to expand upon their current clinic time provides additional revenue to the project.

    - There are a few physicians within the practice that have expressed interest in adding additional time to their clinic availability at the new clinic location. Adding regular physician clinic to this space increases the supervision of the APPs that would be working the clinic as well as foot traffic to patients that can assist with the marketing via word of mouth of the new clinic.

Figure 2.2 (page 23) accounts for all expenses and potential revenue for just the orthopedic Urgent Care clinic. Retail space is already known to be higher than medical office space on a medical campus, but adding additional sources of revenue through ancillary services and additional physician clinics not only decreases the percentage of overhead the Urgent Care clinic will be taking on, but also increases the revenue opportunities for the practice. By accounting for the space for each of these services it is estimated that the building costs will be decreased from 100% to 33%. Making this change in building expenses decreases the first year's loss to $7.3K and estimates the retail based Urgent Care clinic to show a profit in year two.

Financial Documents:

Summary Income Statement – Three Year Projections:

Summary Income Statement
(Patient Engagement System) Fig. 2.1

	Year 1	Year 2	Year 3
Revenue	$94,500	$126,000	$126,000
System Costs	($42,000)	($42,000)	($42,000)
Total Income	**$52,500**	**$84,000**	**$84,000**

New Urgent Care (Retail Space)
Summary Income Statement Fig. 2.2

	Year 1	Year 2	Year 3
NET MEDICAL REVENUE	$286,700	$322,700	$322,700
	-	-	-
TOTAL SALARIES & BENEFITS	$194,990	$194,990	$194,990
	-	-	-
TOTAL OCCUPANCY EXPENSES	$13,927	$13,927	$14,297
	-	-	-
TOTAL MEDICAL EXPENSES	$1,920	$1,920	$1,920
	-	-	-
TOTAL ADMINISTRATIVE EXPENSES	$83,322	$66,832	$66,832
TOTAL EXPENSES BEFORE CLINIC			
SERVICE AGREEMENT EXPENSE	**$294,159**	**$277,669**	**$278,669**
NET OPERATING INCOME	**($7,559)**	**$45,031**	**$44,031**
Clinic Service Agreement Expense	($112)	$51	$49
	-	-	-
TOTAL CLINIC SERVICE AGREEMENT EXPENSE	**($112)**	**$51**	**$49**
TOTAL EXPENSES	**$29,4047**	**$277,618**	**$278,088**
AMOUNT AVAILABLE FOR PHYSICIAN			
EXPENSES AND COMPENSATION	**($7,347)**	**$45,082**	**$44,612**

Break-even and Financial Statement Analysis:

Urgent Care Centers have proven to be a good investment for the practice. It has allowed the practice to take advantage of unused space without adding costs taking advantage of some fixed expenses with exception of personnel to work the extended hours. In 2018 the Urgent Care locations had a profit of $466K. This also does not account for the additional revenues earned through ancillary locations and other downstream revenues and surgical volumes because of the visits through the Urgent Care setting. This new venture in a retail space will have a different and more costly start up.

There is not an existing location in which a service is being added. The cost of construction, clinic supply, and leased space are all new expenses on the project. Due to the new location being more self-sufficient and inability to use current staffing for some cost savings on personnel, there is also an upfront cost of hiring, credentialing, and training the clinical and administrative staff that will be working at the new location. Credentialing new providers on insurance at a minimum is 90 days before being eligible to submit claims. Realistically the practice is estimating about 120 days for complete state licensure, and credentialing on 75% of the practice's insurance plans. Given the unlikeliness that midlevel providers are going to wait four months to accept a job, the practice will have the burden of approximately 120 days of salaries during the

training and credentialing period before they can begin to generate revenue from seeing patients. The practice will also have the ramp up of patient volume.

By utilizing other services such as physical therapy, and adding clinics at this locations from current physicians, it can help drive volumes toward the clinic but the actual Urgent Care patient visits will be inconsistent in patient volumes for approximately six months to one year (based on the experience from the other Urgent Care locations previously started at the practice). All these things considered, profit in the first year is expected to be very low, or a potential loss. It is estimated that an average of ten visits are needed per day for the Urgent Care service in the retail location to be profitable. Based on prior experience, the clinic will potentially average three patients the first two months increasing to approximately ten patients on average in month ten of operation. Over the first twelve-month period, it is estimated that year one will represent a $7K loss in revenue for the Urgent Care retail location. However, based on prior experience at the practice from the other Urgent Care revenue centers, it is estimated that 50% of the patients utilize other services at the practice and approximately 20% of the patients will continue with surgical care at the practice. This additional volume will bring an increase in downstream revenue that will make up for the $7K loss and approximately greater than $50K in revenue at the other practice locations. It is also estimated that the new Urgent Care center will be profitable in year two further enhancing the benefit to the practice and additional growth to other revenue centers.

Business Financial History:

The Practice has been able to increase its presence in the mid-size city and gain additional market share with the addition of new specialists, physicians, medical services, and expansion of clinics over the past five years. Financial growth has increased each year over the past six years with the expansion of services. Urgent Care Clinics have already proven a value of quick entry into the practice for many patients and profitable. The demographic also shows that most people using the clinic have commercial insurance with higher reimbursement and younger families that have repeated visited the clinic upon discovering the convenience and value compared to an emergency room experience. As with the other Urgent Care locations at the practice, it is expected that the community will only increase in their use of Urgent Care centers and additional opportunity for growth is available at other locations within the practice area.

Part IV: Innovative Elements & Expected Outcomes

Healthcare is trending toward the retail conveniences of many other business. The next area of growth and increase in market share will go to those clinics that recognize the patient as not just a utilizer of health resources, but as a consumer of care focusing on efficiency in cost, convenience, and excellent healthcare treatment. Urgent Care Clinics offer the practice the opportunity to increase patient satisfaction through convenience in appointment times and location. It also allows the patient to have an opportunity for treatment at a lesser expensive and typically less risky exposure to care received in the hospital emergency room.

Retail space has been utilized by other health care providers with success over the past few years. Many cities have presence of such services in retail spaces like optometry and vision services, national dental chains, and more recently the emergence of Urgent Care family medicine clinics are growing in popularity. National retail chains focusing on pharmacy or grocery stores also have built Urgent Care Clinics to receive urgent treatment and grow their pharmacy services. Specialty providers have been slower to adopt Urgent Care centers. Just as these other businesses

have found success, other specialties will continue to move toward retail practices as an adjunct or additional line of business to their larger practice and surgical sites.

There are currently no other retail space orthopedic centers in the mid-size city where the Practice is operating. Being the first to adopt and add this line of business to their successful business model increases the opportunity to further grow its market share within the area.

Next Steps to Put into Action:

A successful business plan must be carried out to manage the expectation of costs associated with a retail venture. Not only is physician and administrative leadership key to keeping the project moving, but timing and roll-out of the project can create additional costs if not maintained to a firm commitment to schedule. A retail medical center is not much different from other retail spaces in that it is dependent on customer/patient recognition of the service to be successful. Therefore, patient engagement systems need to be in place and coordinated with a marketing plan to take full advantage of the new business to allow patients to recognize what services are offered, and when or where they can be utilized.

The physician owners will make the final decision to proceed with the new venture. For them to have a desire to proceed they will need to have confidence in the administration to produce a patient engagement system to support the new services, a proforma of all costs involved and potential return on investment, and a strong market analysis that provides the best opportunity to locate the retail space. Once approval is given to proceed with the project, the architect will complete rending of final plans so that the contractor can send to the city. Administration will negotiate the lease and terms to allow building to commence as soon as possible. Marketing will begin working to develop materials for patients in the clinics, referring locations, and set up geofencing in the neighboring areas to capture patients in search of medical care. Hiring of staff in preparation of credentialing and training will help to ensure the practice can begin to work toward profitability.

A patient engagement platform with a new retail Urgent Care clinic will allow the practice to:

- Expand current market share with greater convenience to their patients
- Create a lower cost setting for patients to obtain the orthopedic urgent needs
- Gain recognition for the orthopedic practice to be the first in the market with Urgent Care services to create a potential model that can be used for further growth of other Urgent Care centers.

Practice Financial Decision Matrix

Authority Limits

	Clinic Directors	Controller	Senior Leadership	CEO	Committees	Practice Oversight Board	Shareholders
Expenditures							
Employees & YR1 Physicians Registration, Travel, & Meal Expense	<$1K (with co-signature from senior leadership)		<$2.5K	<$5K	n/a	>$5K	n/a
General Medical Supplies	Establish Norms and monthly review (future process						
General Office Supplies and Expense Invoices	Establish Norms and monthly review (future process						
Advertising/Promotion/Public Relations/Charitable Contributions			<$1K (Bus Development Dir + R*1)	Co-sign with Bus	<$5K (Growth)	>$5K	>$100K
Capital Expenditures - New	<$1K R*1		<$10K , >$10K second sig., >$20K R*1 (Fin. Comm.)		<$50K (Finance)	<$100K	>$100K
Capital Expenditures - Replacements	<$1K R*1		<$10K , >$10K second sig., >$25K R*1 (Fin. Comm.)		<$50K (Finance)	<$100K	>$100K
Repairs	<$1K R*1		<$10K	<$10K	>$10K (Operations)	<$100K	>$100K
Consulting Fees	<$300, >$300 R*1		<$3K	<$5K		>$5K	>$100K
Dues Employees and YR1 Physicians-Professional Associations	<$200		<$1K				
Check Signature Authority (Policy in Place)		<$1K, >$1K second sig (CEO, COO) - Intacct					
Wire Transfers (Per Bank Policy)		Authorized signer only		Authorized signer		Authorized signer only	
Bank Transfers (internal)		Controller to provide avg					
Bank Transfers (external - ACH/My Loans/		Second Signature Req'd					
Recruiting Expenses			All Approved				
Refunds			COO approve anything > $500				
Invoice Review and Approval							
Contracts/Agreements/ Regulatory							
Banking/Loan/Letters of Credit						Board Resolution for all Loans/Credit Lines -	
Equipment Lease			<$3K	<$10K		>$10K	

*All decisions to be reported to the proper Committee Level

Practice Financial Decision Matrix

Facilities/Real Estate Lease				Sig & R*1			
Payor Contracts			<$50K (Bus Dev + R*1)			>$50K	
New Maintenance Contracts			<$5K (R*1)	<$25K		>$25K	
New Supplier Contracts	R*1	R*1					
New Product/Service Contracts					Review at applicable		
Insurance Renewal (GL, E&O, Wk comp, EPLI, Cyber)				Sig & R*1			
Annual Employee Health and Benefits Renewals				Sig & R*1			
Litigation and claims							
Engagement of outside counsel			<$2K + R*1	<$5K		>$5K	
Settlements/Judgements						President & Affected Party	
Employee - Benefits, Contracts, Expenses							
Employment Contract (Physician)						President	
Employment Contract (APP)			CMO				
Workers Comp Settlements			<$5K (HR Director + R*1)	<$50K		>$50K	
Free/Promotional/Giveaways			<$2K (HR and Bus Dev)	>$2K			
Senior Leadership and Managers Bonus				R*1			
Bonus and Incentive Awards (Outside of annual review)			<$500 (R*2)				
Employee Special Circumstances (Death Remembrance, Flowers, Illness)	<$100		>$100				
Personnel - Hiring and Salary Admin							
New Budgeted Position Approval (non-physician/APP)	<30K (R*2)		<$50K (R*1)			$50K to $200K	>$200K
New Non-Budgeted Position Approval (non-physician/APP)			<$50K (R*2)			$50K to $200K	>$200K

*All decisions to be reported to the proper Committee Level

Practice Financial Decision Matrix

New Position Approval (APP)			CMO/CFO and related physician			Urgent care	
New Physician							Majority Vote
Promotions/Salary Increases	R*1 for increases above set ranges						
Other							
Temporary Shutdowns due to inclimate weather			Along with President/CEO				
Policy/Procedure Additions/Changes/Modifications			R*1		Operations/Compliance/IPU		
Financial Statements/Balance Sheet		All					
Advocacy Correspondence/Representation			CMO				
Bi-Weekly Draw Adjustments		R*2			Finance		
Quarterly Distribution Approval					Finance Chair or President		
Shareholder Related							
Compensation Formula Changes (includes ancillaries)							2/3 Majority
Physician Termination							2/3 Majority
Clinical Policies			CMO with IPU and Compliance			CMO with IPU and Compliance	
New Physician Onboarding			Strategic Planning and CMO			Strategic Planning and CMO	
Merger/Acquisition							2/3 Majority
Changes to Decision Matrix							2/3 Majority
R*1 - Requires approval from 1 level up							

*All decisions to be reported to the proper Committee Level

Appendix A

Cash Flow Statement

Fiscal Year Begins 1/1/18 12/31/2018

Location Group: Urgent Care Locations

		Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Total
Cash on Hand Beginning of Month	352,722	352,722	375,232	411,164	426,360	455,216	479,988	523,194	570,117	601,480	642,616	723,969	778,091	818,502
Net Available		39,874	60,009	32,909	46,130	55,474	60,600	69,310	75,262	73,747	110,881	98,936	88,587	811,716
Net Operating Income (Loss)		23,075	37,096	15,521	29,551	25,468	43,920	47,961	31,888	41,699	82,807	55,095	41,151	475,232
Total Expenses Before Other Income & Expense		17,363	24,077	17,713	17,275	30,701	17,393	22,387	43,899	32,612	29,528	44,815	48,177	345,937
Net Operating Income (Loss)		22,510	35,932	15,196	28,856	24,772	43,206	46,923	31,363	41,136	81,353	54,122	40,411	465,779
Total Cash on Hand (before cash out)		375,232	411,164	426,360	455,216	479,988	523,194	570,117	601,480	642,616	723,969	778,091	818,502	818,502

YTD Income Statement – Profit and Loss Statement

As of Date: 12/31/18

Location Group: Urgent Care Locations

	Year to Date 12/31/2018	Year to Date 12/31/2017	Year to Date Difference	YTD % Difference	% of NMR 12/31/2018
Net Medical Revenue	811,716.12	525,329.09	286,387.03	54.51 %	100.00 %
Net Available	**811,716.12**	**525,329.09**	**286,387.03**	**54.51 %**	**100.00 %**
Salary & Benefits					
Salary and Wages	203,926.17	223,138.77	(19,212.60)	(8.61) %	25.12 %
Bonus	57,247.48	12,644.04	44,603.44	352.76 %	7.05 %
Benefits & Taxes	47,827.22	40,600.85	7,226.37	17.79 %	5.89 %
Total Payroll and Related Expense	309,000.87	276,383.66	32,617.21	11.80 %	38.07 %
Medical Expenses	16.68	3,340.77	(3,324.09)	(99.50) %	0.00 %
General and Administrative Expenses	27,466.27	72,506.60	(45,040.33)	(62.11) %	3.38 %
Operating Expenses Before CSA and Other	336,483.82	352,231.03	(15,747.21)	(4.47) %	41.45 %
Net Operating Income (Loss)	**475,232.30**	**173,098.06**	**302,134.24**	**174.54 %**	**58.55 %**
6110 - Clinic Service Agreement - Variable	9,453.56	6,856.50	2,597.06	37.87 %	1.16 %
Total Expenses Before Other Income & Expense	**345,937.38**	**359,087.53**	**(13,150.15)**	**(3.66) %**	**42.62 %**
Net Operating Income (Loss)	**465,779.00**	**166,241.56**	**299,537.18**	**180.18 %**	**57.38 %**