Retail's Healthcare Offensive

"Envision and Think In Terms of the Future State"

Sabrina Hannigan

TransformationalOutpatientPharmacy.com

Drug retailers have reached a kind of critical mass forcing vertical or horizontal integration to maintain profit growth and shareholder value expectations. Both strategies ultimately intrude on healthcare revenue drivers at the expense of the patient and healthcare delivery system. It is difficult to imagine that this desperation is patient-centric, and if healthcare fails to act, the future state belongs to retail.

Some years ago, I laid out the next retail strategies for pharmacy executives of a Philadelphia hospital. Retail pharmacy consolidation had run its course and retailers needed to look to healthcare for additional profitable low hanging fruit, and ways to solidify ownership of customer prescriptions. Similarly, wholesalers squeezed out of the retail pipeline would need to create their own pharmacy markets. It was the right time for hospitals to defend revenue drivers, and transform outpatient pharmacy operations.

Results belied the energy of meetings in Philadelphia and other cities. It seems desire for transformation far outweighed commitment. I blame myself for being inadequate to the task of convincing clients and LinkedIn connections of outpatient pharmacy's importance to the health of the industry. There are no simple solutions, especially now as retail expands their assault of the healthcare industry on two fronts.

One Goes Vertical, One Goes Horizontal in Search of Profit

Major drug chains continued vertical and horizontal integration strategies in 2018. One chain chose vertical integration to strengthen cost containment and delivery-side stranglehold of patient lives. The other chose horizontal integration to reposition prescription sources closer to the pharmacy and drain off healthcare dollars, historically through leases, fees, or other costs to operate.

Although retailers self-identify as healthcare companies, they avoid investment to transform pharmacy operations or provide therapeutic outcome products/services. With the exception of adding technology and process to control labor cost and underpin profit, and the loss of a personal patient relationships, the prescription filling process has remained unchanged for at least the last 60-70 years.

The future state, however, is not the one unfolding now. It is the next state, perhaps the last state, for major drug chains. The question is will healthcare define the future state, or will it become the future state of drug stores?

So What Does This Mean For Hospitals?

Retailers left open the door open to transformational outpatient pharmacy solutions. Having said this, however, retailers continue to create reimbursement barriers, technology barriers, benefit from failed therapeutic outcome, and bleed cash from the healthcare sector. The chain drug battle for share of the prescription and healthcare dollar threatens to dismantle underpinnings of a patient-centric industry.

Hospitals still have a window to re-imagine outpatient pharmacy operations, improve patient ownership, therapeutic outcome, return on capital, and market coverage. However, hospitals cannot compete with retailers utilizing the same pharmacy model, nor are patients best served by the retail model. This includes healthcare organizations aligning with chain drug stores for the purpose of distributed care or market share.

Point-of-care access is the 'Holy Grail' for drug retailers. Fortunately, as it turns out, hospitals own a piece of point-of-care and better positioned to expand this ownership within

healthcare. More good news … retail integration strategies should significantly diminish retailer's fair trade argument and provide a way forward for hospital ownership of therapeutic outcome products, and challenging pharmacy rules and regulations detrimental to outpatient pharmacy operation.

Additionally, patients seek local acute and primary healthcare. This self-evident observation controverts the chain drug claim for importance of national (or international) prescription access. The good people of North Dakota, for example, get along very well without chain drug store pharmacy. Community hospitals, systems, and networks can upend the retail stranglehold of therapeutic drug revenues by providing localized and highly integrated outpatient pharmacy operations.

Exhibit 1
Core Pharmacy Mission

Exhibit 1 identifies core drivers for pharmacy operations. While applicable to all pharmacies, retail drug chains eventually sacrificed some patient-centric drivers to underpin profit growth and grow stockholder value. These orphaned drivers provide healthcare the foothold to imagine a new future state for patient-centric pharmacies.

Market – Prescription holders seek out a local pharmacy for product and service, meaning pharmacy is primarily a patient destination. This fact provides hospitals with low-cost options for positioning transformative in-market pharmacy and medical service centers.

The major drug chains sacrificed low-cost combination destination/convenience locations for high-cost, high-visibility corners. While this tactic might allow a chain to out-position competition, and perhaps improve front-end store maturity rate vis-à-vis top-of-mind awareness, the move did not improve patient access or lower cost to the patient than might otherwise have been achieved.

Product – Hospital readmission, ADEs, emergency room capacity, asset value realization, etc., risks argue for patient-centric, therapeutic outcome, drug, and disease management products. Retail does not offer these products because they bear no risk (or opportunity) for the absence of these products. Hospitals and the healthcare industry own these risks, and more importantly, able to leverage the risk to provide successful pharmacy operations.

While retailers provide MTM for profit, and/or by third party agreement, true health and medication management to lower cost and minimize patient drug use does not exist. Consider the notion that retail pharmacies benefit from continued drug use, and PBM agreements can include a 'gag clause' preventing pharmacists from lowering patient cost. These, and many other, notions should dispel any delusion that patients benefit from commoditized healthcare product.

Strategy – A successful outpatient pharmacy strategy includes owning the patient market, superior product and services, and above all else, developing patient-centric efficient operations. Owning the patient market has at least two requirements: own recovery and health of a patient, and provide necessary in-market access to product and services.

To be successful, hospital outpatient pharmacies must provide a superior product to current and future retail products. It is not enough to be competitive, or to provide a better product to what retail offers today. Organizations do not succeed if competition can quickly reproduce product or services. The future state must not be a choice between equivalents, but of difference.

Finally, a transformative strategy will not work unless hospitals pursue transformative pharmacy design and operation. Outpatient pharmacy, on and off campus, must provide on-demand prescription delivery, recovery related services, and seamless connection of medical services. Chain drug location strategy is not optimal for distributive health products and services.

Industry – "Envisioning the future state, and thinking in terms of that state", anticipates infrastructure requirements for economies of scale and marketing. Local, regional, and national healthcare alliances could improve healthcare through reciprocal prescription coverage agreements, and sharing information on patient services and drug use.

Retailers drive efficiency and uniform product by centralizing management. Similarly, outpatient pharmacy operations need to provide uniformly efficient operations, if not products and services. Shared central management of outpatient pharmacy operations provides a means by which product remains superior and operations efficient.

Branding reinforces product and/or service identity to patients (and potential customers). Competing with nationally known

retail brands requires an equally pervasive healthcare industry brand. An example I offer to clients is the mock brand shown in Exhibit 2. The brand name

Exhibit 2
Sample OneRx Brand

"OneRx" compares with CVS, Walgreens, Rite-Aid, Fred's, etc. named brands. The brand name creates scale and, hopefully, patient expectation for quality, price and differential product.

The logo helps differentiate the brand by labeling it "An Outcomes Pharmacy", similar to "The Pharmacy America Trusts" (Walgreens), and the more subtle, Love CVS portrayed as a heart and the CVS brand name.

Why Transform Healthcare and Outpatient Pharmacy?

This is a fair question reflecting on emerging integration strategies of retailers, especially with respect to horizontal integration. First, we need to rule out the notion that integration efficiencies will make their way into patient pockets (when has that ever happened, right?). In the absence of expanding profitable product lines, these efficiencies are required to underwrite growth in stockholder value. Second, these strategies do not change ownership (and accountability) for patient outcome.

Retail-healthcare alliances move point-of-care prescription access closer to retail locations. It is unlikely that retailers will bear the cost of the alliance, perhaps opting for leasing or fee arrangements with participants. Nor is it likely that the arrangement will be revenue neutral for healthcare overall as these clinics directly compete with primary care providers and other small clinics. A number of articles in recent years point to the detrimental impact of commoditized care for minor illness and injury.

Apart from self-inflicted injury, alliances anchor services to retail locations that are not tactically optimal for health centers. Chain drug high cost properties are unnecessary for destination driven products. Hospital-centric outpatient pharmacies, clinics, and medical services require better locations, lower costs, and larger footprints that those of the chain drug store.

The simple fact is that retail needs healthcare more than healthcare needs retail. Tactically placed hospital-centric outpatient pharmacies can ally with other healthcare entities to provide in-market access, improve therapeutic outcome, and improve population health. In addition, these centers provide a mechanism to reclaim healthcare revenues leaching into the retail sector and stockholder portfolios.

The Next Step for Hospitals

The way forward requires a good measure of self-reliance. First, because transformation by definition means something is new. Second, because it is going to take commitment and time. Finally, investing in the future state is better than spending money on expensive consultants. Having said this last piece though, do not hesitate to ask for input when required.

Exhibit 3 suggests one way to get started. All of healthcare is now, or will be, challenged by retailers looking for new sources of profit and the means to own and control customer medications. Therefore, it makes sense for hospitals, and the industry as a whole, to cooperate in creating the future state. It is simple. Either you create your future state, or you will be part of someone else's.

Exhibit 3
Getting Started

Organize committees and discussions with stakeholders. Begin discussions by examining the current state of therapeutic outcome, cost, and causes. Visualize the future state if you do nothing. What are retailers doing and towards what future state are they moving? What happens if you continue along your current strategy? Ideate the future the way you need it to be. What do you need to get there? What rules, regulations, and legislation must change? Create action plans.

Clearly, Exhibit 3 oversimplifies the process. Hospitals and healthcare entities will start the process at different points. For example, Amita Health serving west and northwest suburbs of Chicago is ready-made for in-market outpatient pharmacy and medical centers. These entities have the critical patient mass to sustain point-of-care, hospital-centric outpatient pharmacies. (As a sidebar, these entities are also prime targets for a retail defined future state.)

Do your homework. Quite by accident, I learned a former client was negotiating to take-over local in-store retail clinics on the recommendation of consultants. The strategy was to divert patients to clinics and take some of the burden off emergency rooms, and provide disease state care. It is a good strategy, but a poor solution to use the in-store clinic footprint given capacity, operating requirements, and marginal labor cost.

Summary

Retail continued to pursue vertical and horizontal integration strategies in 2018 looking for new ways to own, control, or create prescription ownership. Nevertheless, the door remains open for hospitals to create superior pharmacy products consistent with their healthcare mission.

Hospitals can leverage point-of-care ownership (and risk) with primary care physician alliances to create a superior pharmacy and therapeutic outcome delivery system that will positively affect capital architecture. The transformation will require commitment, innovation, technology, and fair representation in state pharmacy rules and regulation.

Retail-healthcare alliances are not optimal for healthcare, nor are drug store operating models, products, or services. Retail market, location, product, and service strategies tune to maximizing profit, top-of-mind awareness, and minimizing patient risk exposure. Hospitals markets are local, require tactical placement of medical/pharmacy centers, and must mitigate patient risks with superior products and services.

Creating the future healthcare state will require time, commitment, and eventually, industry-wide cooperation. The time to begin is now with transformation of outpatient pharmacy operations to mitigate therapeutic outcome risk. Tactically combining distributive healthcare with outpatient pharmacy locations provides low-cost, high quality patient care at the right place.

Footnotes

[1] None

About the Author

Sabrina Hannigan is a retired major drug chain executive with over three decades experience in site analysis and operations optimization. Upon retiring, she contracted with a healthcare consulting firm to consult on a broad range of operational topics specific to build-out of an outpatient pharmacy service.

As an independent consultant, Sabrina recognized that retail solutions were not transferable and created an outpatient pharmacy business model incorporating methods and processes experienced over forty years in manufacturing and retail.

Sabrina is passionate about the future of healthcare and envisions hospital-centric solutions for improving therapeutic outcome and population health. Towards this end, she continues to develop new processes and methods for outpatient pharmacies.