WHITE PAPER

HEADING TO THE MALL FOR HEALTHCARE?

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Retail has been a topic of discussion in healthcare for some time now[1]. This has included improving the culture of healthcare by adopting some attributes from retail as well as reorienting space to provide an experience that meets the dynamics of retail criteria (e.g., convenience). More recently, retail has been strictly associated with retail clinics located within retail establishments (e.g., CVS, Wal-Mart). Despite this attention in articles and seminars, it has generally been difficult for a retail mindset to gain traction in most healthcare organizations. Patient-centered care has also entered the lexicon but the connection of the patient to retail has been lacking.

Yet, a retail orientation is destined to be more broadly implemented than as just an "inside-out" component in a drug store or department store chain, as this Paper will show.

A number of factors are converging that should provide the impetus for healthcare services to occupy what has traditionally been classified as non-service retail space. Changes in the economy, shifts in consumer spending patterns, an aging population and the rise of ecommerce are all leading to innovative placements of future healthcare delivery sites. This Paper explores some of the nuances of what the Healthcare Practice Group at Cushman & Wakefield expects to be some future trends in healthcare and retail space. It explores some of the historical barriers to entry along with some of the contemporary and shifting enablers. What is changing? Why should healthcare organizations care? How is this consistent with healthcare reform trends? These and related questions are explored herein.

Cushman & Wakefield, Inc.
1290 Avenue of the Americas
New York, NY 10019-6178

RETAIL SITE SELECTION & LOCATION ANALYSIS

To address this larger topic, it is first necessary to understand some of the underpinnings of the retail industry. Retail development traditionally followed the resident population; people shop where they live, leading to the mantra location, location, location. The growth of the suburban lifestyle after World War II prompted the development of thousands of enclosed regional malls, neighborhood strip centers and big box power centers. Across the country, these retail destinations were built with common attributes:

- Proximity to population centers
- Access and visibility to major roadways and transit
- Located where a large parking field could be developed

Lifestyle changes and the recent global economic downturn have changed a retailing formula that retailers and consumers have followed profitably for almost three generations. In short, they were designed to make it easy for consumers to shop. Each of these changes is explored in more detail.

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The first change is a new group of consumers who choose to live an urban lifestyle rather than a suburban one. This has fueled a resurgence of the world's major cities. In the U.S., this "Sesame Street effect" is being driven by the convergence of the 77 million-strong, aging baby boomer generation (those born between 1949 and 1966) who no longer have children living at home and want to experience all of the cultural institutions that "downtown" has to offer. Their children—the echo boomer generation (those born between 1983 and 1999)—are choosing to follow a similar path in toward urban areas where they are choosing to raise their children. Growth in the ten largest metropolitan areas has swelled by 11.1% since 2000. Population growth ranged from a low of 4.4% in the New York City Metropolitan Statistical Area (MSA) to an astounding 30.9% in the Houston MSA. In those cities growing by more than 20% (Washington, Atlanta, Dallas & Houston), population growth in the 0-19 year old category averaged 21%. The result of this migration back to the cities is that many suburbs are left with significant vacancy in the traditional retail hubs. Some predictions hold that as much as 15% of existing regional malls are vulnerable to closing over the next five years as this demographic shift continues, coupled with internet sales and slow economic growth[2]. Barnes & Noble mentions "the maturity of the market for traditional retail stores" as one of the risk factors in its latest SEC filings.

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These urbanites have also fueled another trend in retailing—globalization. One of the legacy issues of the most recent economic downturn is a renewed focus on the profitability and operations of each unit rather than market share. As a result, brands have realized that they need both the urban populations and new markets worldwide to drive growth. Clearly, this represents a classic form of diversification (markets). As a result, foreign brands that traditionally would enter markets through the major suburban shopping malls are now looking to the high traffic streets to open their first units in the U.S. market. These changes are adding to the increase in prominent retail spaces that are available for alternate uses as demand patterns change.

The final way that the retail market has changed in relation to healthcare delivery opportunities and related uses is the advance in technology and its integration into daily shopping behaviors. There are several reasons for the rise of online commerce[3], including:

- Changes in lifestyle (discussed on the previous page)
- Economic conditions where consumers have become increasingly price sensitive and are more apt to use the Internet rather than a big box store to compare prices
- Convenience for time-starved consumers who are working longer hours to meet the demands of their increasingly demanding jobs. No longer is it necessary to hop in a car to see what is available nor to visit the store to make your purchase.

Middle market retailers that fueled traditional experience in the suburban environment are now suffering disproportionately.

The Internet Age (perceived through the lens of retail as bricks and clicks) has driven another trend known as omni-channel retailing, wherein retailers are integrating their marketing across physical and virtual outlets to create a unified brand image for today's consumers. The result is that retailers need smaller square footage and fewer physical stores (bricks) creating a "showrooming effect" for commodity products that are increasingly bought over the Internet (clicks).

Finally, the physical retailing experience is being changed by retailers creating direct-to-consumer options that allow for immediate gratification for a U.S. population that is increasingly spending more on essential needs (results of lingering economic downturn) and less on wants. Under the old suburban model, people were incurring increasing amounts of debt to buy splurge items that were premium in nature. A 2010 Booz & Co. study[4] affirms this trend, indicating that 55% of the U.S. population has adopted these practices of trading-down to lower priced goods[5]. Thus, the middle market retailers that fueled traditional expansion in the suburban environment are now suffering disproportionately.

In summary, a combination of economic, lifestyle and consumer behavior changes are creating a new paradigm in the retailing environment, the result of which is that retail storefronts have become more accessible for alternate uses. This allows traditional retail customers to be viewed increasingly as potential patients in this new world of retail and healthcare. As such, healthcare providers are actively wrestling with the notion that healthcare will increasingly be value-driven and less subject to the nuances of a fee-for-service business model. Like retail, such a mindset change will reduce overall spending on expensive, esoteric (and elective) healthcare services and will drive increased spending on what is perceived as essential services , at least for a significant part of the population. This shift in demand for value is already driving changes in healthcare business models wherein care is offered in more integrated and less fragmented settings under one roof (one-stop care), while ensuring greater throughput (efficiency).

HEALTHCARE MANDATES

Many dynamic shifts are upon us in healthcare; some more obvious than others. This will be the subject of another Cushman & Wakefield White Paper (Changing Rules of Healthcare Real Estate) and will not be covered in detail here. However, a key driver that is important to understand related to retail is the shift from hospital-based inpatient care to freestanding outpatient or ambulatory care. In order to understand the future of ambulatory healthcare services, we must look to past practice and delivery models. Additionally, we should define past ambulatory care office models as a baseline that helps describe how future retail mall use for medical care may differ from current use by medical professionals, as well as in the perceptions of patients/customers.

The history of ambulatory healthcare services starts with the country doctor and his/her small universal practice that provided cradle-to-grave care. In recent decades, that model evolved to favor private medical professional groups providing primary and/or specialty care in a single office or as small tenants in larger medical office buildings (MOB). Although the model had changed, the fundamental economics were much the same across the sole practitioner and small retail provider models: centrality of location in population centers, identity, and ease of access for both the provider and the patients.

A pivotal corner was turned in 1986—little noticed at the time—when, for the first time, hospital-based ambulatory visits[8] exceeded hospital patient days (admissions x average length of stay). Some within the industry at the time argued—unsuccessfully, yet, in hindsight, accurately—that the core business of healthcare had changed. A key reason to suggest this was the recognition that payment for such services were different than payments for hospital care. Further, this brought hospitals more directly into competition with private physician offices, many of which were located on hospital campuses. For example, competition for certain tests became fierce between cardiology practices and hospital heart programs.

Over the course of the evolution, teachable moments abounded relating to the hospital/physician dynamic and how they worked out deals to determine which patients were seen, where and for what. The flaws of what would prove to be an inherently byzantine system were further exacerbated by the fact that many hospitals are not-for-profit organizations that face increasing scrutiny relative to such legal issues as private inurement and other related healthcare regulations (e.g., anti-dumping and EMTALA).

This shift to ambulatory care was visibly driven by the capacity and ability to do more surgeries on a same day basis (i.e., ambulatory surgery) which has had the effect of significantly reducing the number of patients occupying an inpatient bed. While it took years to evolve, it is now to the point where fully 80% of all surgeries in many specialties can be done on an ambulatory basis. But it goes well beyond surgery. Many if not most technologies traditionally restricted to the hospital are now cheaper and more amenable to delivery through ambulatory settings. Slowly but surely, the tether between these services and the hospital setting has been loosened. The pace of change has been checked, in part, by the fact that many of these services have continued to be offered in settings—hospitals—convenient to physicians rather than those settings most convenient for consumers (i.e., where they live and work). It seems clear that, over time, this shift to ambulatory has enabled consideration of retail locations.

But before discussing retail opportunities, a few more key issues are in order:

- **Bend the cost curve.** At the heart of all health reform after expanded coverage for the uninsured is bending the cost curve. This has now become a national economic issue and is no longer just a health issue. To accomplish this, it is widely acknowledged that attitudes must change and less costly delivery options be developed (e.g., patient-centered medical homes).

- **Shift away from gatekeeper physician model.** Early efforts at the managed care model failed to take hold outside of select isolated areas largely because of the politics surrounding a primary care gatekeeper. This model involved a primary care physician who exercised authority over other medical referrals. More specifically, it required the gatekeeper physician to authorize access to a specialist. This created all kinds of dynamics most of which were not helpful. Outside of a Kaiser-like closed panel physician model, this approach has not been well received.

- **Disruptive innovation[9].** It can be argued that shifting healthcare toward retail is an example of disruptive innovation. It draws inspiration and a path from outside the industry. It has been largely panned in past efforts by traditional healthcare. Now, it may well represent a more cost effective approach to deliver healthcare to large segments of the population at lower total cost (including cost to the consumer of getting to the care) than past models. A more recent example of this is the growth of so-called "retail clinics" by the likes of CVS Caremark[10], one of the fastest growing components of healthcare that is only recently beginning to involve partnerships with traditional healthcare providers (e.g., Sharp Health).

- **One-stop, convenient care.** This has long been recognized as a more efficient model but has been hard to develop because of the inability to form large multispecialty groups except in some isolated, mostly rural areas in the U.S. (e.g., Rochester, MN, Temple, Texas and Urbana, Illinois).

It can be argued that shifting healthcare toward retail is an example of disruptive innovation.

FITNESS IS NOW PART OF HEALTHCARE DELIVERY

There is no secret that most of the medical industrial complex[11] of the past has been focused on sickness care after symptoms appear. Moving upstream in the disease process, while intuitively appealing, has not produced tangible results except in a few limited areas. In fact, some findings suggest that various forms of prevention (e.g., disease management programs) or detection are seemingly worse than the disease. The Boomer generation seems more ready to embrace an upstream wellness mindset than any previous generations. This has given rise to burgeoning dietary supplement companies that tend to cover weight loss and immune support supplements (e.g., GNC), dramatically expanded health clubs (24 Hour Fitness, LA Fitness, etc.) and organic foods, along with other lifestyle modifications. Many of these wellness initiatives have found expression at some level in retail outlets.

But to really understand the importance of this is to redefine health. Health is no longer considered the mere absence of disease. Health is now more focused on quality of life and the ability to pursue physical and mental activities later into life. As such, a great barrier to innovation to healthcare has been seemingly removed—the impact of third-party insurance.

The concept of insurance exceeds the scope of this article but suffice to say that it is truly one of the more important elements of the Patient Protection and Affordable Care Act (AKA ObamaCare). The idea that group risk can play a positive role in covering healthcare costs is proven. However, it is also proven that there have been many unintended consequences of third-party health insurance. For one, the consumer has been too far removed (until recently) from pricing as they have not even necessarily known what was paid for certain care[12]. But another unintended consequence has been the willingness of the consumer to pay out-of-pocket for healthful things. This can include a myriad of commodities and services like healthier food, fitness and now even more traditional healthcare services. The burden that has been removed relates to the fact that many if not most healthcare providers in the past were reluctant to try a new modality or service if it was unlikely to be "covered" by insurers.

Many trials and tribulations have resulted from trying to innovate only to find that insurance companies would not cover a bold attempt to address certain problems. In some cases, their reluctance to pay for services was warranted. But in others it may well have retarded otherwise worthy attempts to find new ways to better treat or diagnose various illnesses. The willingness of people to recognize that health is more than just insurance-covered services may well allow for more daring attempts to innovate than has been the case in the past. By comparison to the traditional provider, organizations that have integrated payment into the health delivery model have had relatively little problem making this transition (e.g., Kaiser with their "Live Well and Prosper" tag line).

But most providers are not yet in such a model that includes a financial risk component and a population health focus will be a challenge for them. A retail mindset can help to make this shift. From a consumer perspective, the shift to retail is already reflected in such things as medical fitness and dietary supplements, which are sold in a retail context.

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THE NEW NORMAL IN RETAIL INCLUDES HEALTHCARE

A healthcare organization has already become an anchor tenant in a retail mall[13]. One of the primary enablers for this may be softening lease rates and occupancy concerns of owners. In the past, owners were generally not receptive to healthcare tenants delivering healthcare services. Major objections have included:

- **Lack of prestige** in drawing other retail tenants (i.e., you don't buy a Tiffany bracelet and an iPod after getting a colonoscopy). Retailers are incredibly sensitive to their surroundings. Healthcare services have never been regarded by retail landlords as attractive or high-end. Some emerging healthcare brands may have a chance to change their perception.

- **Unwillingness to mix business models.** Most retail leases are triple net[14], with rents based, at least in part, on gross receipts of the retail tenants, creating an environment in which they are all in it together. If the mall does well, the retailers do well and the rents reflect that based on the sales of the retailers. Ambulatory and physician clinical care services tenants do not operate under this model. The only thing that comes close is multi-specialty groups, where they are in a corporation (or foundation) together and share common finances. Such clinics, as they are often called, have proven a number of things that are now influencing greater consolidation in healthcare, especially among physicians. Among those tenets that have been proven is that multi-disciplinary care can be superior to other forms (e.g., especially in such areas as cancer care). A second observation is that primary care can work better in a multi-specialty setting (that often involves specialty subsidization of such care since primary care has been chronically underpaid). Finally, and important to this Paper, these clinics have proven that branding can be as important in healthcare as it is to its retail cousins. Names like Mayo Clinic, Geisinger Clinic and a handful of others are household names in certain regions and even internationally. Their brands have created recognition among physicians and patients. Their buildings have supported one stop, multi-specialty care. While they have not yet gone retail, it seems inevitable that this will occur.

BUT THINGS HAVE CHANGED…

As vacancy rates have risen, rents have fallen. Malls in general have struggled with sharply increasing vacancy rates. Since the recession of 2008, there have been numerous shocks to consumer confidence. A corresponding stagnation and decline of rents have accompanied this period, with a number of the largest retailers struggling mightily, most notably General Growth Properties which finally emerged from the largest real estate bankruptcy ever after spinning out numerous unprofitable ventures in November of 2010[15].

It is worth reflecting on recent C&W research related to market performance in retail:

As of the end of the third quarter 2012, the pace of U.S. retail market fundamentals improved with increased momentum. According to the U.S. Census Bureau, retail and food service sales for the third quarter alone totaled more than $1.2 trillion increasing 1.3% from the previous quarter, well ahead of analysts' expectations. Midrange and discount retailers such as Target, Kohl's and the Gap experienced a significant pickup in third quarter sales while performance slowed for luxury segments.

Although traditional big box retailers are downsizing their footprints in mammoth-sized locations, they are reformatting their store concepts and increasing their demand for new, smaller locations in order to accommodate increasing consumer demand in urban areas. In July, Target opened its first three City Target locations in Seattle, Los Angeles and Chicago, and plans to open in excess of 75 additional locations in urban areas throughout the country. Additionally, Walmart plans to open an additional 283 of its scaled-down Neighborhood Market locations over the next three years, while other retailers such as Best Buy,Cabela's,JC Penney and Office Depot have similar plans to open smaller, more efficient locations.

Although consumer confidence is 41% below 2007 highs, it is up 30% from consumer confidence levels one year ago marking the largest year-over-year gain since Q1 2010. Coupled with employment gains, and improved retail sales, retail vacancy in the U.S. dropped year-over-year from 7.6% to 7.3% as of the end of the third quarter of 2012. Overall rents began to stabilize dropping just 0.5% year-over-year, the smallest year-over-year decline since Q1 2009. Although overall U.S. rents continue to decline as a whole, there are several major retail markets that experienced year-over-year rent increases, including Honolulu and Miami. Nationally, retail construction activity remained sluggish compared to historical levels allowing vacancy rates to continue to improve; however, a few large retail markets are now experiencing a pickup in retail development activity.

Despite U.S. economic uncertainties and lingering cautiousness among investors, retail investment fundamentals continued to improve, albeit slowly. According to Real Capital Analytics (RCA), the distressed pipeline of retail assets fell to $26.1 billion during the third quarter, marking the lowest level since the first quarter of 2010. As for investment sales, a drop in portfolio transactions during the third quarter caused a slowdown in the momentum of total sales volume in the retail sector. Despite the slowdown, year-to-date volume totaled $33.8 billion, enough to outpace the volume reported during the same period in 2011 by 5%. Investor demand remained primarily focused on regional malls and urban storefront properties. Notably, the third quarter marked a record high for price paid for a retail storefront property as the retail portion of the St. Regis Hotel on Fifth Avenue in Manhattan sold for a reported $15,121 per square foot.

Market fundamentals for the U.S. retail market are expected to continue to slowly improve. As unemployment figures and personal income levels improve, consumer confidence will strengthen leading to a pickup in consumer spending. The limited supply of newly vacant space and the improvement in the U.S. economy both will have a direct impact on retail leasing fundamentals over the next few years. The trend of falling vacancy rates and rising demand that has occurred so far in 2012 is expected to continue and produce notable rent growth in an increasing number of U.S. markets. Over the next year, as retail vacancy rates continue to fall and construction deliveries remain restrained, the average rental rate for U.S. markets is expected to increase for the first time since 2008 while main street rents in gateway cities continue to post strong, albeit likely slowing gains.

In the short term, U.S. retailers will continue to focus their expansion plans on proven markets and high-density locations, which bodes well for established retail properties and corridors in top tier markets such as New York, Chicago, and San Francisco where rent growth has been strong. Overall, market conditions for the retail sector will reflect the moderate improvement expected in the U.S. economy. This all has implications for healthcare.

In view of these key market trends, there is nothing to dissuade the view that healthcare may figure more prominently in the retail world of the future. From the healthcare organization perspective, a key barrier to entry into retail has been relatively high lease rates. At a time when MOBs might average $20-$22 per square foot (PSF), retail space was almost double that and generally was dominated by small floor plates. It was hard for healthcare CFOs to justify the difference. But several things that have changed make it more likely that there will now be a broader crossover, including:

- Repurposing existing retail boxes.
- New emphasis in healthcare on throughput (retail equivalent of sales PSF).
- Foot traffic with no appointment (dramatically missing from traditional physician office models).
- Consolidated medical services (both hospital and physician).
- Consumer demand for a better experience (visiting a traditional doctor office can send chills down many spines).

REPURPOSING EXISTING RETAIL BOXES

Strip retail has been a prime candidate for dialysis and specialty care conversion for quite a while, with those decisions based on demographics and smaller space need models. DaVita is a prime example, with a service model that calls for 6,000-15,000 square feet with as many as 20 patient beds, DaVita finds many of their facility needs match perfectly with functionally obsolete strip centers. Attributes that have served them particularly well are parking abundance, visibility/identity, proximity to public transit, and the base physical conditions typical in those centers, which is essentially a concrete box with limited windows and high water and sewage capabilities. Wellness Centers, Clinical Care and Ambulatory Care are also a prime example of great natural fit for shadow anchor space in larger malls (vacant exterior locations ranging in size for 15,000 to 45,000 square feet). Typically these vacancies are former electronic goods stores, office suppliers etc. Mercy Medical Center in Baltimore has re-opened several shuttered grocery stores as highly productive suburban ambulatory centers[16]. (see www.bigboxreuse.com)

THE NEED FOR EFFICIENCY

Many healthcare organizations remain in the throes of difficult physician practice acquisition and the need to at least break-even financially. One of the oft-mentioned solutions is to convert these practices quickly to so-called productivity based performance. This usually takes the form of relative value units (RVUs[17]) as a basis for compensation. A more detailed explanation of this approach exceeds the purpose of this Paper, but suffice it to say that most healthcare organizations are far from break-even on most purchased physician practices, despite shifting away from paying for any goodwill. Anything that would improve productivity would be welcomed.

More often than not these purchased practices are already in a small space (MOB)[18] that is relatively inefficient in comparison to a larger footprint where there might be central registration and a common waiting area with other practices. While this would seem relatively simple, it is not. Many independent physicians are entrepreneurs and take this seriously. One of the things that attracted them to private practice in the first place was the ability to control their surroundings and lead their practice. Converting them overnight to employed status rarely goes well.

The result is that too few purchased practices are actually moved to larger, more productive space. One reason that this "purchase and move strategy" is not often used is that there are relatively few examples of such space. Those organizations that have taken the risk to develop such space would seem to have an advantage over others that might be trying to buy the physician practice. This assumes that those physicians that are open to an employment model understand the potential for growth and adjacency (in this case to other retail outlets). Truth be known, too many small physician groups really want a subsidy to stay where they are, even though there may be little to no growth potential in their current location and configuration. It comes as a surprise to some people that many physicians do not seem to care much about growth but are more focused on doing more for their existing patients. The health system on the other hand has little choice but to care more over time about growth and throughput. Where branded competition exists, growth may be existential, especially when considering that future growth will not come from the inpatient side of the equation.

RETAIL HEALTHCARE COULD LEAD TO A BETTER HEALTHCARE EXPERIENCE

Finally, it is all about improving the healthcare experience. Understanding the potential that a retail approach to care represents can unleash enormous potential to improve the experience for many healthcare customers in the future. A few key points:

- **Foot traffic and no appointment care.** While there is a difference between retail foot traffic and impulse buying on the retail side, foot traffic in healthcare can be important as well. Adjacency has long been recognized in academic medical clusters as an important attraction; no different than in retail malls. What has been missing in basic primary care is the potential that adjacency represents for convenient care. When patients realize that they can accomplish many more tasks during that trip to the doctor, it becomes differentiating from other traditional options characteristic of single purpose medical space. One-stop care can shorten wait times between appointments and is a real time saver to the patient and their family. The classic prototype patient to plan around is the mother (women are responsible for most healthcare decisions) with two children (one an infant in her arms). She is seeking a convenient experience that caters to her needs. Multi-tasking that is convenience-driven is what is required. If it is possible to add "no appointment required" on top of this (i.e., flexible scheduling), so much the better. Healthcare organizations should start to take foot traffic into consideration in their future location planning for ambulatory services.

- **Consolidated medical services and Branding.** Dramatic consolidation characterizes current actions in the healthcare industry. As a result, there are fewer and fewer (but larger) providers and insurers. The hospital and physician components are rapidly combining and the financing component of integrated delivery systems (i.e., health insurance) is looking for provider partners. In most major metropolitan markets today, branding is becoming a key driver with only 3-4 names gaining recognition on a crowded stage. This competition is expected to become heightened under any future reform plan. The result will be greater emphasis on innovation, including new delivery models such as retail mall sites.

- **Consumer demand for a better experience.** The prevalence of poor healthcare experiences is ubiquitous and must change. Often these experiences may have nothing to do with clinical decisions but reflect more on poor service or facility configuration. How realistic is it to expect this to change if care continues to be offered in the same old way in the same old locations? Providers are slowly embracing the concept of patients as customers. As this occurs, it truly can represent a breakthrough in that new experience models can emerge[19]. Embracing a retail mindset in healthcare begins with embracing the patient and their family as customers. Note that it is not just the patient. Sometimes the patient is not even capable of making their own decisions. Healthcare is more of a family affair and demands a delivery model that understands this. With very few exceptions, hospital waiting rooms are not made for family meetings. The search for better experiences is expected to emphasize new things, foremost of which is convenience (with resulting lower cost). It is no coincidence that the drug stores are finding great success with their retail clinic concept. Other providers need to recognize this for what it is—a pure retail play driven by convenience and the need to satisfy the complicated demands of the prototypical mother with two children.

Summary

Small medical malls are not new but mixing medical into existing retail malls is new. This is expected to occur more frequently in the coming years and at an accelerated pace. A variety of factors have combined to make this increasingly attractive both on the landlord side and the provider side. Whether conversion of an old retail box or development within a larger mall, the option to visit a healthcare provider while doing other typical errands is upon us. This has dramatic implications for existing providers that are campus-centric and for other healthcare organizations that are interested in growing under health reform. It also has significant implications for those of us in healthcare real estate looking to help our clients bend the cost curve and grow their services.

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3. For this paper, ecommerce and mcommerce will be considered synonymous
4. *"Forever Frugal? U.S. Consumer Survey Confirms Persistent Frugality,"* 2010
5. An important reference for this topic is another Booz & Co. work Bernstein and VanderLinde-Kooper (editors), *"Health Care's Retail Solution: A Consumer-Focused Cure for the Industry"*, published in Strategy and Business, 2008
6. "Patients" is used in this Paper to make the point of shifting customers. However, it is thought that healthcare organizations that are increasingly competing against traditional retail entities are likely to eventually adopt a more of a "customer" orientation, reflecting a healthcare customer that is demanding more of a retail experience.
7. Even the Affordable Care Act is struggling with exactly what these services are and are not.
8. As reported in Hospital Statistics provided annually by the American Hospital Association
9. A term coined by Clayton Christensen. See The Innovator's Prescription, (McGraw Hill, 2009)
10. See for example Japsen, "More Health Clinics Pop up Inside Retailers," New York Times, January 9, 2012
11. A term coined many years ago by the former editor of the New England Journal of Medicine Arnold Relman (N Engl J Med., 1980 Oct 23;303(17):963-70)
12. Steven Brill, *"Bitter Pill: Why Medical Bills are Killing Us"* Time Magazine, March 4, 2013
13. One Hundred Oaks Mall in Nashville, TN is an interesting case study where Vanderbilt University went at risk and entered into a lease – purchase agreement for an entire 880,000 sq. ft. retail mall and converted it to medical use. The jury is still out on the success of this but it is well worth watching how this plays out.
14. Defined as a lease agreement on a property where the tenant or lessee agrees to pay all real estate taxes, building insurance, and maintenance
15. Note it had entered bankruptcy in 1980!
16. As reported by Sam Moskowitz, former COO at Mercy Medical Center at the BOMA MOB conference in Atlanta, 2012
17. Relative value units are a measure of value used in the United States Medicare reimbursement formula for physician services. For each service, a payment formula contains three RVUs, one for *physician work*, one for *practice expense*, and one for *malpractice expense*. Before RVUs were used, Medicare paid for physician services using "*usual, customary and reasonable*" rate-setting which led to payment variability. Source: *Wikipedia*
18. Sometimes this space is owned by the physicians that sets up other difficult issues including acquiring space the organization does not really want, or possibly leasing the space from the physicians which sets up Stark related compliance issues.
19. Mason and Adamson, "Transforming Healthcare Delivery into an Experience-Based Brand, Spectrum, July-August 2011

For more information, contact:

Scott A. Mason, D.P.A., FACHE
Executive Managing Director & Leader of the Healthcare Practice Group, Americas
T (202) 471 3598
scott.mason@cushwake.com

Matthew B. Winn
Leader of Retail Services, Americas
T (404) 853 5309
matt.winn@cushwake.com

Eugene McGrane
Associate Director, Healthcare Practice Group
T (925) 951 5023
eugene.mcgrane@cushwake.com

Cushman & Wakefield, Inc.
1290 Avenue of the Americas
New York, NY 10019-6178