A Physician's Guide to Financial Freedom, Autonomy, and Complete Control of Their Practice

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ISBN 13: 9798657043051
Library of Congress Control Number: 2020907957
LCCN Imprint Name: Jacksonville, Florida

I dedicate this book to my amazing wife, Zarita "Cherry" Thompson, and my four children, Chaz, Christian, Coley, and Azha. I am truly blessed with two angels and three champions. It is because of their sacrifices and support that I am able to realize my dream of making a difference in the world by helping others. Cherry has devoted her life to me and our children, giving us the joy of being members of a loving, happy family. She is just as proud of her titles of nurturer, wife, and mother as I am of mine as father, husband, and founder of MMC®. Together, we have found balance.

Cherry, I am not worthy of you, but I am eternally grateful for your love and I am honored to be your husband; I know I married up. Thank you for everything, but most of all, thank you for saying yes. I love you, baby.

Revolutionize: To change something radically—to cause a radical change in something such as a ***method or approach***.

—Encarta Dictionary

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INTRODUCTION

In this handbook, I am going to show you a ***no-risk*** solution that will enable you to practice medicine without the everyday hassles of insurance bureaucracy, limited time with patients, excessive patient loads, and financial worries. There have been numerous industries that have faced similar challenges. Cash flow dilemmas, burnout, and hopelessness are not exclusive to the health care industry. To prove how this concept works and how it shares the same fundamentals as the Affordable Care Act (ACA) or Obamacare, I share my experiences of revolutionizing the golf and health club industries, acquiring casual and non-user customers to balance out the demographics of the traffic as well as balancing out the books, and how I've adapted those principles to the health care industry. My objective is to increase revenue and solidify customer/patient loyalty. Today, I am 100 percent committed to revolutionizing the health care payment system

using the same principles, which I have developed over the past thirty-plus years. I know that at first glance it will be hard to rationalize the parallels, but if you just keep an open mind and read this short handbook, I promise you it will be a eureka moment.

Since the inception of my company, Mulligan Marketing Concepts® (MMC®), in 1991, my team and I have worked with more than nine hundred membership-based businesses and raised almost a billion dollars in revenue for our clients by penetrating new segments of the market, bringing affordable health and fitness as well as affordable golf to everyone across America. In total, I have been directly responsible for selling more than one million memberships and tens of millions of memberships indirectly over my thirty-eight-year career. My marketing concept of targeting the casual and non-users to offset the revenue concept has completely changed the health club industry and is changing the golf industry forever. If you have purchased a golf or health club membership in the past fifteen years, there is a good chance my fingerprints are on it.

MMC® profiles consumers for golf courses and health clubs based on their buying patterns and spending habits. My team looks for consumers who have purchased within the golf and/or health categories and then prequalifies them through a criteria-based formula. My goal is simple: focus on identifying, engaging, and locking up long-term relationships with

untapped segments—casual and non-golfers for golf courses and the deconditioned for health clubs—to grow their businesses.

In the 1980s, health clubs were popping up on every corner, and in the 1990s, golf courses followed suit. There was too much inventory (supply) and not enough health-conscious consumers and golfers (demand) to support all the new businesses entering the marketplace. The so-called experts in these industries were throwing up their hands, surrendering in total defeat.

Not me! I knew these businesses were focusing on the wrong consumer and following an unsustainable model that had been designed decades ago. I remember hearing as a young man, "Follow the herd and they will lead you straight to the slaughterhouse." I also remember hearing, "If you want to be successful, do what everyone else won't." It's time health care providers stop following the herd.

In short, both these industries made two devastating mistakes:

1. They both focused all of their efforts on locking up relationships with customers who had already raised their hand and said, "I want your product." The challenge with this approach is that there are only X number of customers who fit into this profile. Every business in this field is doing its very best to take a bite of this pie. Unfortunately, there are not enough slices to

feed the masses. Failing to penetrate different segments of consumers to balance out the membership base, that is, frequent, infrequent, casual, and non-users is, in essence, teeing up the business to fail from the very beginning. The foundation is lopsided and, inevitably, will fall.

2. The business owners raised the barrier-to-entry so high that it is only affordable to the top X percent of their market. They follow the model of "get as much money upfront" as possible, charge the highest membership dues possible, and keep the membership base as low as possible. This theory sounds fantastic because under this illusion you can provide the very best experience to every customer/member. Unfortunately, this model only works in the very beginning, but when your market starts to be saturated with competition, this model falls like a house of cards. These experts forgot that business is a marathon, not a sprint.

Today some, if not most, health care providers (especially the direct primary care providers) are facing the same challenges. I am a huge fan of the Direct Primary Care (DPC) model and I know it is the future of health care. Unfortunately, the experts have shaped their businesses on the antiquated membership models of the past. The physicians following this model are struggling with the same issues that golf course owners

and health club owners were facing when MMC® entered the space. Substantial cash flow, monthly receivables, daily revenue, growing the business with new customers to outpace the churn rate, and a sustainable business model have been plaguing the DPC since its conception.

Primary caregivers need a sustainable model that will generate immediate cash flow, operational revenue, as well as a respectable return on their investment. Today's model is not meeting these needs.

In this handbook, I am going to provide you with an option to grow your business beyond your imagination. With my model, you will see fewer patients per day, provide more personalized care per patient, and be rewarded handsomely for your efforts. I will address the problems and provide the solutions and, don't worry, it won't cost you a dime.

My company is a no-risk, self-funding, performance-based business, which means we put our own money where our mouths are, and if we don't grow your business, you won't pay us one dime. We invest our own money to launch your campaign, so there is absolutely no risk involved for you.

Feel free to visit our other websites—www.golfmarketingmmc.com and/or www.healthclubmarketingmmc.com—and watch some of the testimonial videos to hear what our clients have to say about the success of MMC®'s campaigns before continuing, so you can erase the thought that this sounds like it's too

good to be true or maybe it's a get-rich-quick scheme. Some of our nine hundred clients thought the same thing at first but after partnering with MMC®, they immediately realized that it is just shattering decades of antiquated systems with innovative thinking.

PS: Please take a few minutes to write a review for my book, and post it on as many websites and platforms as possible with a direct link to where your friends and followers can buy *A Physician's Guide to Financial Freedom, Autonomy, and Complete Control of Their Practice.* Also, be sure to register with my company and personal websites—www.mmctoday.com, www.hotelmarketingmmc.com, and www.chuckthompson.guru (not dot com)—for freebies and updates. If you wish to contact us at MMC®, you may call 904-217-3762, call toll free 877-620-8135, or email me at chuck@mmctoday.com. For comments or any other correspondence, please use my personal address at chuck@chuckthompson.guru. Thank you, and enjoy the book.

1

INSURANCE COMPANIES ARE GETTING RICH, WHY NOT PHYSICIANS

For decades, few careers had as much long-term potential, job security, and longevity as a career in medicine. With a growing population, increased numbers of chronic illnesses, and a greater focus on preventative care, physicians are in greater demand than ever before, and that demand will keep growing in the coming decades. Besides, advances in technology and its application to medical treatments will continue to offer exciting new avenues for physicians to treat and interact with their patients.

Despite all the opportunities the health care industry presents, the industry as a whole has never faced more challenges—for physicians, hospitals, and patients alike.

Research shows that health care costs state and local governments approximately $300 billion

annually, representing almost one-third of state budgets. Industry experts have labeled health care's rising cost as "a huge threat to the US economy," with lawmakers on both sides of the aisle continuing to debate the best way to ensure people have access to health care without bankrupting the country.

Beyond the problems that the industry at large faces are the problems that individual physicians are dealing with. According to a survey conducted by the American Medical Association (AMA), burnout among physicians was as high as 48 percent in some specialties, specifically critical care and neurology. The burnout rate among family medicine doctors was 47 percent, among obstetrics and gynecology 46 percent, and 45 percent in emergency medicine.

Much of the blame for rising burnout rates lies with the ever-increasing administrative elements of a physician's daily routine. For example, a 2016 study funded by the AMA, and cited in the *Annals of Internal Medicine*, discovered that physicians only spend a total of 27 percent of their day on face-to-face care of their patients, and 49.2 percent on Electronic Health Records (EHR) and desk work. Even when a physician is seeing their patients, only 53.9 percent of their time in the examination room is spent on direct clinical care, with 37 percent spent on EHR and desk work.

As a result, with doctors' visits shrinking to fifteen minutes or less, doctors often don't have time to properly address patients' questions and concerns. All too

often, doctors must choose between spending additional time with a patient or moving on to the next one for the sake of billable hours. For an individual who has spent the better part of a decade—more if in a specialized field—going to school, saddling themselves with hundreds of thousands of dollars of debt, enduring sleepless nights, and having made countless other sacrifices out of a desire to help people, making that choice day in and day out can be excruciatingly demoralizing.

The picture doesn't look any better for patients in the United States. With average health care costs surpassing $10,000 per person in 2016, more and more individuals are finding themselves choosing between their wallets and their health. In fact, a survey by West Health found that 40 percent of Americans skipped a recommended test or treatment and 44 percent didn't go to the doctor when they were sick or injured because of the cost. Imagine the agonizing choice some patients are forced to make, choosing between their own health, or the health of a loved one, and their ability to feed their family.

Even when cost is not a deterrent—either due to their financial situation or insurance—patients still feel the pain of dealing with the medical industry. As doctors become overloaded, patient wait time increases. Insurance requirements often mean changing doctors and this happens many times against patients' wishes.

Worse yet, these problems that are impacting the health care industry are reaching a point where they're on the verge of creating a perfect storm, which will have disastrous consequences. Throughout the industry, many physicians are trying to cut back on hours in an effort to combat burnout. Some reports show that one out of every three doctors is sixty-five or older and approaching retirement. What is most disturbing is a study commissioned by the Association of American Medical Colleges (AAMC) released in 2017 that projects a shortage of over a hundred thousand doctors by 2030. Shortage of available doctors is already forcing hospitals to make difficult decisions regarding the type of care they can or cannot provide, let alone when that shortage reaches over a hundred thousand.

The evidence is clear: While the medical field may offer an almost unparalleled degree of job security, the above factors demonstrate the need for drastic changes in how the industry—and the physicians who comprise it—approach day-to-day business.

Unfortunately, agreeing on the need for change is just about the only thing that most people can agree on. Many different possibilities have been put forth, some tested and nearly all vilified by one group or another.

Talk about fixing the US health care system rarely takes place without bringing up Canada and its universal health care. In fact, universal health care is so ingrained in Canadian culture and life that 85 percent

of Canadians feel that its elimination would "result in a fundamental change to the nature of Canada."

Accepting it as part of their culture, however, does not mean that all Canadians are happy with how the system works on a daily basis. In fact, according to a Gallup poll, 41 percent of Canadians were dissatisfied with the current system. While that's a far cry from the 72 percent of Americans dissatisfied with US health care, it still shows that the Canadian system has its own pain points.

Chief among those pain points is the amount of time patients must wait to receive specialized care. Commonplace tests such as an MRI can take months to receive, unlike in the US direct care model, where a patient can usually receive one within a few days, or a couple of weeks at the most. While it is true that patients with serious illnesses or injuries are fast-tracked and seen immediately, if something is deemed non-serious or non-life-threatening, those patients can end up waiting a very long time.

Even when the issue is "non-serious" or "non-life-threatening," that doesn't mean it's a pleasant experience to wait for months before receiving a diagnosis or treatment. Nothing exemplifies this as much as an article the *New York Times* wrote about Dr. Brian Day, a former president of the Canadian Medical Association. In that interview, Dr. Day said that Canada "is a country in which dogs can get a hip replacement in under a week and in which humans can wait two to three years."

While the need for a hip replacement may not be considered "life-threatening," try telling a patient dealing with the chronic pain of every step that it's not "serious." Try explaining to that patient why they should have to endure that pain—pain that is likely to keep getting worse—for two or three more years before they can get it fixed.

For physicians, the Canadian health care system is a mixed bag. Many doctors cited the ability to focus on treatment as a plus. Compared to the US health care system, it's easy to see why that is listed as a positive. In the United States, all too often doctors are forced to play the role of an insurance agent as much as a healer. Every treatment must be considered through the lens of an insurance agent. What insurance company does the patient use? What plan do they have? What coverage and copays? How much can they afford out of pocket?

Again, the evidence is clear: While the Canadian model of universal health care offers some advantages over the American direct-pay method, it also comes with some severe drawbacks that impact both doctors and patients. Just like the American system of health care, the Canadian model is poised to experience worsening conditions. A 2017 survey of the Canadian Medical Association found that 29 percent of doctors planned on reducing hours over the next couple of years, up from 20 percent for their American colleagues.

Unfortunately, this is a pattern that repeats in many health care systems around the world. Costa Rica is another country that is often cited as an example of a successful universal health care system and, in fact, the quality of Costa Rican health care has received consistent praise. The UN ranks Costa Rican health care in the top 20 worldwide and first in Latin America, and the country compares favorably with the quality of care offered in the United States, even exceeding it in some rankings.

In many ways, Costa Rican health care is a mirror image of the Canadian system, with one big exception: private care is completely legal. For the majority of individuals, public care constitutes the primary medical care they receive and they deal with all the pros and cons that go with it, just as the Canadians do. The overall quality of care is quite good and costs are nonexistent—public care costs absolutely nothing for citizens. However, wait times can exceed weeks for even basic care appointments.

For those who want immediate care, they can opt for treatment at a private clinic or hospital. Going this route, however, can cost $75 to $85. Although that may not seem like a lot, when the average Costa Rican makes between $1,000 and $1,400 a month, $85 isn't exactly cheap.

While these may be just two examples of health care systems around the world, when taken together with the American system of direct pay, they well illustrate

the problems facing health care today. In a direct-pay system, costs are increasing at a crippling rate, while doctor satisfaction is at an all-time low thanks to less time spent interacting with patients, more time spent on paperwork, and being forced to play the role of glorified insurance adjusters.

On the flip side of the coin, universal health care systems offer doctors the increased satisfaction that comes with being able to focus more on patients rather than on paperwork. At the same time, doctors are plagued with the inability to treat patients—including those in pain—in a timely fashion. Even more than under the direct-pay system, the backlog of patients can be overwhelming and may lead to burnout.

In both health care models, the future of physician availability looks bleak. With projected shortages in up-and-coming doctors, existing doctors retiring or scaling back to combat burnout, wait times, care quality, and doctor/patient satisfaction are sure to suffer.

Unfortunately, efforts to promote meaningful change in the United States have yielded mixed results at best. By far, the most ambitious effort to overhaul the US health care industry is the Affordable Care Act (ACA). President Obama's defining legislative achievement, the ACA was the single biggest expansion of health care coverage, combined with regulatory overhaul, since Medicare and Medicaid became law in 1965.

In theory, the ACA had some admirable goals and made progress toward achieving them. For example,

while it has since been repealed, the ACA originally had a mandate requiring everyone to have some form of health insurance. While the individual mandate may not have been popular, prudent, or pragmatic, from a strictly economic standpoint this system cannot be paid for and supported solely by the segment of the population who needs it most *and* remain affordable for all. For this system to remain affordable, those who don't need it at the moment must also help pay for it.

Another area where the ACA made significant progress was in making preventative health care affordable, even eliminating copays completely for the fifty procedures recommended by the US Preventive Services Task Force. Again, from an economic standpoint, this makes sense: make it as easy as possible for people to maintain their health and prevent illness, thereby saving patients and the industry the costs of treating serious illnesses that could have been avoided.

Unfortunately, while it may have had admirable goals behind it, the ACA is a classic example of how good intentions can be undermined by the wrong people implementing them. Politicians rarely have the business or medical expertise necessary to fully understand and address the myriad issues the health care industry is facing, and the many complaints about the legislation and ensuing legal challenges it has faced are evidence of that.

For many patients, one of the biggest disadvantages of the ACA is "losing" the doctor they may have been

going to for years or even decades. While the ACA itself never stipulated which doctor a person could or could not go to, changes in the cost of care—in an effort to balance out the cost by lowering it for the sick and raising it for the healthy—sometimes resulted in doctors being unwilling or unable to work with insurance companies' revised payment plans and options. Patients all over the country have experienced this issue: losing access to the doctors they have been seeing for years or decades.

Another significant disadvantage of the ACA is the amount of personal information required for a person to enroll—something customers and critics alike often feel is too invasive. Add in the ever-present threat of data breaches—such as the one that exposed seventy-five thousand patients' information—and it's easy to see why people are not comfortable with the amount of information the ACA requires them to provide.

Even worse, the ACA does little to improve the issues, with doctors spending too much time on paperwork rather than on patients. On the contrary, the extra bureaucratic overhead of the ACA often creates an even greater workload for doctors and *reduces* even more the amount of time they spend treating patients.

When taken together, these factors have led some doctors to close shop and abandon their profession altogether. In the aftermath of the ACA being passed, a survey revealed that as many as 62 percent of physicians believed the law would lead to more of their

colleagues retiring early, while 75 percent felt fewer individuals would pursue a career in medicine.

Even things being touted as benefits of the ACA are often anything but. For example, writing for *Trusted Choice*, Sandy Baker says that "the passage of Obamacare means doctors are likely to experience an increase in the number of patients they see."

There's just one problem with that statement: with doctor's visits already shrinking to less than fifteen minutes, and nearly half of the physicians in some categories already experiencing burnout, how does *increasing* patient workload improve things?

Remember the perfect storm of circumstances that would create a disastrous scenario? When you combine a health care system with skyrocketing costs, overworked doctors on the verge of burnout, increased numbers of patients, increased bureaucracy and red tape, an aging population, aging health care providers, an increasing number of doctors considering early retirement, and a projected shortage of hundred thousand doctors within the next few years, it becomes clear that the US health care industry is facing a time of unprecedented challenges.

It's little wonder then that people are beginning to experiment with alternatives, such as health care sharing programs, direct care, and concierge medicine. As with the more mainstream options, however, these too have pros and cons.

In the case of health care sharing programs, these programs revolve around a community or group of

people—usually faith-based—that all pay into a pool or fund that is then used to help pay the medical expenses of the various members or contributors. While there have been success stories, with some families saving tens of thousands of dollars a year, the downsides of this kind of arrangement are equally obvious. Each contributing member or family is reliant on the administrators of the fund to ensure that the money is responsibly managed and used. Because of the faith-based nature of health care sharing programs, there is often a commitment to or agreement with a statement of faith. Often, certain medical treatments deemed against the group's beliefs are simply not covered.

Concierge medicine is another alternative that many people are increasingly looking at, and for obvious reasons. For doctors, the appeal of this method is the promise of being able to reduce the number of patients they see in exchange for relatively high monthly retainers that make the model financially feasible. With true concierge doctors charging an average of $182 per month per patient, it doesn't take very many patients to create a very lucrative practice. For the patients who can afford this, the benefits are compelling, most notably the ability to see the doctor at a moment's notice, day or night.

There are, however, a number of factors that have limited the widespread adoption of this model. First and foremost are the high fees. Because concierge

medicine requires relatively high monthly retainers to make it worthwhile, it automatically limits the number of patients a doctor can realistically expect to gain.

While individuals and families on the upper end of the economic spectrum may not think twice about a couple of hundred dollars a month per person, for your average middle-class family, it represents a significant investment—especially when it doesn't cover emergency room visits or major health issues that still require some kind of insurance plan.

Additionally, critics continue to voice concerns that widespread adoption of concierge medicine, *in its current form*, could lead to lower-income families being left without viable medical options. As you'll see in this handbook, however, with my program, concierge medicine can be adapted to serve all segments of the patient spectrum.

Despite the myriad challenges the medical community is facing, not the least of which is how to evolve and move forward, there is an option that combines some of the best elements of the different systems we've discussed, while minimizing the negatives.

To better understand this system, however, we need to take a step sideways and look outside the medical profession for inspiration. Why? Because the challenges the medical profession is currently facing are not unique to it alone. In fact, these problems have been faced by other industries before and successfully met head-on.

2

WHY THE "EXPERTS" HAVE FAILED TO BUILD A SUSTAINABLE MODEL

While different countries try to implement successful, modern, and balanced health care systems, most of them, by and large, have failed miserably. The US ACA (Obamacare) actually came the closest to succeeding. The basic premise of the ACA model was to have non-users and those who rarely needed care to subsidize the cost for those patients who need constant care. One of the biggest blunders of the ACA (as we all know) was the rollout. There were and are many issues with the structure, but had the program been launched correctly through its marketing efforts, many of those structural issues could have disappeared.

In short, neither politicians nor physicians are in the best position to realize real change for the industry: the former, due to a lack of real-world knowledge of

the industry and the latter, because of being ingrained with how the industry "should" function. What the ACA needed was effective marketing cultivated from years of experience of getting the non-users to offset the cost for heavy users.

To understand this concept better and how it can could have (don't worry, I will give you the new solution later in this handbook) worked perfectly for the health care industry, both short- and long-term, we have to look at other industries that experienced similar issues, for example, businesses that needed to balance out their books as well as their flow of traffic by penetrating new segments of their market, namely casual and non-users to generate additional revenue that would subsidize the heavy user. The greatest examples of industries that faced this dilemma would be the health club industry and the golf industry. Let me explain.

In the early 1980s, the health and fitness craze went into full swing, eventually turning into a booming industry. By the 1990s, the industry had been overbuilt with a health club on every corner. The competition was brutal, and the owners were losing their shirts. This was my first introduction to working with doctors. A lot of health clubs were owned by doctors, attorneys, and other business people with no experience operating a health club, who were looking for tax shelters and a way to cash in on the boom. For most owners, the "boom" was short-lived. In a nutshell, there were

way too many clubs in town targeting the same finite demographic who were health and fitness conscious.

I identified the problem and immediately started working on a solution. Health clubs are busiest on Mondays, Tuesdays, Wednesdays, and Thursdays, between the hours of 4 p.m. and 8 p.m. During the day, as well as on Fridays, Saturdays, and Sundays, you can shoot off a cannon in most clubs and not hit a single member. Basically, there was a lot of wasted real estate with huge overhead. No matter if there was one member or a hundred members working out, the owner still had to keep the lights on for sixteen hours a day, which equated to wasteful spending. I was determined to fill up the club during non-prime time hours, and I knew just how I was going to do it.

I had been reading about consumer profiling and knew if I could build a profile on psychographics (buying patterns and spending habits of the local consumers), I could target the deconditioned segment, which was 90 percent of the local market, instead of focusing on the health and fitness conscious, which was less than 10 percent of the market at the time. Today, consumer profiling is quite common, especially in the digital world. Amazon and Google, as well as numerous online retailers, are constantly gathering data on your buying and spending habits to help them sell you more products. Consumer profiling allows a company to identify their prime prospect. Once I was able to clarify what my product was and then identify my

prospects, I just needed the best vehicle, media, platform, and so on, to deliver my message and engage my customer. Simply put, identify, engage, and lock up long-term relationships with new members acquired from untapped segments.

To understand my concept of penetrating untapped segments and letting the casual and non-users balance out the patient/member load, I want to show you more examples, but this time I want to go deeper into the industry's business model so you can see the undeniable parallels it shared with the health care industry. I know some of you are thinking, "How on earth are there any similarities in these two industries?" Well, I will show you.

The 1990s were the Golden Age of golf, a time when golf was more popular than ever. Tiger Woods had risen to fame in the '90s and, with him, had brought an influx of new, younger golfers into the game. Golf was suddenly being talked about in the same circles as the hottest NBA and NFL teams. In short, golf was "cool". With that sudden rise in popularity, there was an explosion of new courses being built, existing courses being renovated—whatever it took to cash in on the sudden interest in the game.

Unfortunately, as with most things that go up, they eventually come back down. Starting in 2003, and even today, in 2020, as I am writing this book, many golf courses have become virtual ghost towns, with many filing for bankruptcy and closing shop. There was

plenty of blame thrown around, with some blaming the economy, others blaming younger generations—especially the millennials—and some even blaming Tiger Woods, as if the popularity he brought to the game had spurred the industry to be overbuilt.

The downturn didn't just impact the courses themselves. Many retailers were forced out of business or forced to focus on other sports as a result of the decreased interest. Course owners and managers were losing their livelihood, not to mention their status in the community.

It was in this environment in 2006 that MMC® entered the golf industry with a revolutionary marketing concept that would shake up the industry and completely change how courses went about attracting new golfers. This marketing concept wasn't created in a vacuum, or brought to the world of golf merely in the hope that it would succeed. This approach had already been wildly successful in the health club industry, an industry that shares many parallels with the golf industry, just as the golf industry shares many parallels with the health care industry.

We've all heard the saying, "They can't see the forest for the trees." This perfectly described the golf industry. Most owners and course managers look at the game through rose-colored glasses, nostalgic for the "good ol' days" when most courses were profitable no matter how poorly they were operated. Even worse, when individuals in the industry realized the need for

change, they often focused on the wrong things, or went about change the wrong way. Everyone was trying to change the game, when all that needed to change was their thinking.

As an outsider looking in, free of all the emotional attachment and nostalgia, it was easier for me to see what the real problem was: The game was perfectly fine—it was the antiquated thinking and marketing that needed to change. Unfortunately, this was a need the industry just wasn't prepared to meet. Golf courses had always been the original Field of Dreams: If you build a beautiful facility with all the bells and whistles, golfers will come.

In 2008, things began to look even grimmer. While the '90s were an economic heyday, with fortunes easily made and spent, the turn of the century started to see an economic slowdown that would end in the Great Recession. During this time, Tiger's fan club realized that watching golf was more within their budget than playing golf regularly. Golfers who were still playing were dropping the number of rounds they played. Meanwhile, the most avid, dedicated golfers were dying off as a generation. By the time the recession was in full swing in 2008, golf was in real trouble. This was golf's perfect storm.

To make matters worse, owners were relying on their golf pros and managers to grow their business—in the midst of a mass exodus—using old, outdated methods. While golf pros may be trained in PR and

operations, not to mention knowing the ins and outs of the game, marketing had never been a prerequisite for running a successful golf course.

One of the biggest challenges for golf pros to overcome, in the quest to attract new business, was the purists, who wanted to make sure the game didn't change in any way. These were the people preaching: "We must stick to our old way of doing business. We are special because we are golfers. Don't give golf away, and don't leave money on the table. Just wait, it will get better." All of these statements are simply a code for, "We are scared to death to change because we may make things worse and are desperately afraid of losing our jobs." The reality is that nothing good was ever accomplished by being afraid of change, and the closure of thousands of golf courses is a testament to that.

Does this sound familiar? In many ways, the fate of the medical industry rivals that of the golf industry. For centuries, being a medical professional has been one of the most surefire ways to be successful. Even more than golf, medical practice was the ultimate Field of Dreams. Hang up a shingle, and the patients would come. Just like the golf industry, however, the medical industry is facing a crisis.

As outlined in the previous chapter, the medical industry has been facing a perfect storm of issues that are threatening the profession as a whole. Previous generations are aging and in need of increasing levels of care, doctors are overworked, many practices

are closing as a result of a lack of enough qualified doctors, and, to make matters worse, the coming decades are predicted to experience the greatest deficit of medical professionals we've ever seen.

Just like golf course owners, many doctors are too afraid of change, too afraid of trying something new to embrace better ways of doing things. As a result, just like golf courses, medical practices continue to suffer, doctors continue to be overworked, and patients continue to miss out on the time and focus they want to receive from their doctor.

In the case of the golf industry, how did MMC® solve these problems? We realized that the key to thriving in these difficult times was to grow the game by penetrating new segments of consumers. Just like there are multiple generations that must be targeted, there are four different types of golfers as well: core golfers, avid golfers, casual golfers, and non-golfers (consumers who have purchased within the golf category). This was a completely new concept to many of the industry "experts." In their mind, there was only one group of golfers—people who play golf, that is, golfers. It was this ignorance that made it nearly impossible for golf courses to adapt to the changing climate.

Let's look a little closer at how the golf market breaks down:

Core golfers: Core golfers are those who play at least fifty to a hundred rounds per year. Most core golfers have built relationships with other golfers/members

over a period of many years and tend to stay loyal to their home courses, unless their rates go up and leave golfers feeling as if they can't beat the system by playing enough rounds per year/season to justify the cost.

Core golfers don't spend a great deal of money at their home courses. They don't spend money on range balls; they chip and putt because it's free. Core golfers don't buy logo balls, logo caps, or logo golf shirts. They don't buy clubs, shoes, gloves, or sleeves of balls from the pro shop either, because they know every discount golf outlet in town where they can buy similar merchandise for half the cost. Core golfers don't spend on food and beverages at the course; they bring bagged sandwiches and keep six-packs chilled in the trunks of their cars. Core golfers don't go out of their way to promote the course, because they don't want to have to wait a couple of extra minutes to tee off or set tee times in advance. Core golfers are saving every penny they have to play one more round of golf. This group is addicted to the game and in most cases, is on a fixed budget.

Avid golfers: Avid golfers are those who play twenty-five to fifty rounds in a year/season. These golfers are non-committed and will play their rounds wherever they get the best deal on green fees, which means they will divide their rounds, and therefore their revenue, over several courses. This group of golfers loves the Internet and gives its "loyalty" to the deal of the day. Avid golfers don't spend money on range balls; they chip and putt because it's free. Avid golfers don't buy

logo balls, logo caps, or logo golf shirts. They don't buy clubs, shoes, gloves, or sleeves of balls from the pro shop, because they know every discount golf outlet in town where they can buy similar merchandise for half the cost. Avid golfers spend very little, if anything at all, on food and beverages at the course; they stop and get fast food on the way to the course. They may buy hotdogs and beer, but that's about all they will spend in the snack bar. Avid golfers don't go out of their way to promote a course. They promote the "deal of the day" and the website or company that gave them that deal; the course's name is only briefly mentioned when giving directions.

Avid and core golfers know the ins and outs of spending the least amount of money while getting the most value. Avid golfers are those who want all the same prime tee times (Saturday and Sunday mornings) as core golfers, and they will do everything they can to beat the system.

Casual golfers: Casual golfers are consumers who play eight to twelve rounds in a year. These golfers, on average, play where their buddies play and have very little knowledge about the ins and outs of the golf business or Internet deals on green fees. Casual golfers are the future of the golf industry. These consumers should be the focus of every golf course, retailer, golf professional, and so on. Casual golfers play the least and spend the most. Casual golfers don't break out the calculator and run the numbers, don't go online

to find the best deals, don't try to beat the system, and don't know the system. Casual golfers spend money on range balls, and they practice. Casual golfers impulsively buy a course's logo balls, logo caps, and logo golf shirts. They buy clubs, shoes, gloves, or sleeves of balls from the pro shop because they don't know any of the discount golf outlets in town. They spend on food and beverages at the course; they buy burgers, hotdogs, and steaks because they have come for the experience and want to enjoy the day as well as the amenities offered. Casual golfers drink at the bar and buy beer from the cart girl. They go out of the way to promote the course because the day they spent there was the best time they had all month; they tell their friends, coworkers, and anyone else who will listen. Casual golfers aren't saving every penny they have to play one more round of golf like core and avid golfers do; they spend like one-day millionaires because they golf only a few times a year. This group can be termed consumers, and in most cases (if profiled correctly), they have disposable income.

Non-golfers: Non-golfers are those who have shown an interest in the game through their buying habits—a few rounds, equipment purchases, apparel purchases, subscriptions, and so on. These golfers play less than six rounds a year, and some have never played a single round in their lives. They have to be identified through a consumer profile and are far more difficult to engage, but once they are, they move easily into the casual golfer segment.

As you can see, the casual and non-golfer spends far more on a daily basis than the core and avid golfer. This will hold true for patients too.

To survive in a changing market, course owners needed to cultivate relationships with casual golfers—as well as convert non-golfers into more casual golfers—who would be more likely to spend money in a course's profit centers. Because these segments of the market aren't heavily invested in playing dozens of rounds a year, they have the money and the willingness to spend in the profit centers. Unfortunately, in a near-sighted attempt to keep the status quo, course owners and managers are still focused on the core and avid golfers—the very golfers that spend the least amount of money, but play the most golf.

These segments/groups are a mirror image of the health care industry. There are four segments of patients based on age who, as a group, require certain levels of care based on their age. Non-users, casual users, avid users, and heavy users comprise the average doctor's patient load, with avid and heavy users being the biggest groups. Balancing out a physician's patient load with all four groups can achieve the same results we have achieved in the health club and golf industries.

I knew that, for golf courses to succeed in this new reality, we would need to identify the casual and non-users, engage them with a lower barrier to entry and lock them up in long-term committed relationships with the property. Doing this would redistribute the

revenue stream by collecting less cash upfront from the golfer, but would increase the operational revenue collected daily and monthly drastically, which would far exceed the amount of revenue owners were used to under the traditional model.

For example, most golf courses charge an initiation fee when you first join and then an annual membership fee that is normally broken down into a monthly fee. The "initiation fee" is normally the fee that is used for discounts to attract new customers, like "enroll today and get 50 percent off the initiation fee." This is a marketing tool quite common in membership-based businesses, including health clubs. Unfortunately, the marketers using this tool fail to realize that only a small, finite group of consumers in today's economic climate can afford those huge monthly fees. And a lot of those who can are still afraid to commit until they are confident they will, first, use the product enough to justify the cost and second, will enjoy it enough to make the time for it. In essence, they are narrowing their market even further and pushing away 99 percent of the potential customers/revenue.

My approach was to design three levels of golf membership, starting with an entry-level membership (with limited days of use) with a lower barrier to entry and all other services (outside of a basic golf membership) à la carte. I want to point out that this system did not discount green fees or membership dues; it simply grafted in new membership category for casual and

non-golfers and redirected the revenue stream to the profit centers, for example, bag storage, car rentals, pushcart rentals, food and beverage, driving range, outings, weddings, banquets, catering, car storage, annual car passes, merchandise, equipment, and so on. Golf courses collected less upfront but far more over the term of the membership.

Next was a mid-level membership with no limitations on the number of days of use—the golfer paid more upfront and also followed the same à la carte system. In most cases, under this membership plan, these golfers paid as much or even more than the golf course was receiving from existing golfers under its current rate structure.

The final membership was the full all-inclusive membership that was similar to what courses already offered. This was the membership level everyone would secretly aspire to. These were the golfers who golf once or twice a week; want to play during prime times and reserve the tee times well in advance; want people to know their names when they walk into the pro shop; want to play in all the course's events and leagues; don't want to be charged additional fees; want to walk into the clubhouse and get immediate attention and recognition; want to attend the social functions, and so on. This quality of service, attention, and unlimited access commands a premium membership fee.

Golf course owners and managers who partnered with MMC® using our system found themselves with

hundreds of thousands of dollars of immediate cash on hand to help fund the transition, hundreds if not thousands of new customers and, most importantly, a much larger, sustainable revenue stream.

The point of including the information above, and giving you a window into the golf industry, is to make the point that the golf and medical industries don't just face similar problems—they also need similar solutions. In medicine, there are different categories of patients with different needs and different billing requirements, broadening the earning potential for the physician. Similarly, medical professionals are often focused on acquiring the wrong patients/customers.

Too many individuals in the health care industry are stuck in the old way of doing things. Unfortunately for them, and their patients, the old way of doing things is changing. Costs are rising, education is becoming more expensive, regulation is increasing, and the patient load is growing at a rate that is nearly impossible to keep up with.

In addition, I talked above about how there are different groups of patients. Rather than treating all patients the same, doctors need to understand that each type of patient represents a different level of investment, time consumption, and earning potential. That's not to say or in any way imply that the quality of care will be different, only that different groups of patients have different needs, and are willing to pay accordingly.

Like the health club and golf industries, many different things have been tried in an attempt to fix

health care. As this chapter has demonstrated, however, simply being an amazing physician does not make one a natural marketer, any more than being a certified golf professional does. Similarly, being a successful politician or bureaucrat does not make someone an expert on the challenges and potential solutions that pertain to the health care industry. No matter how noble President Obama's intentions, and those of his team, they were just not equipped with the knowledge of how to sell/market this new model to the American consumer.

To put it in medical terms: sometimes you need to see a specialist. When it comes to addressing the problems the industry is facing, doctors need to look to a specialist in the field of patient acquisition and customer interaction. Most importantly, you need a specialist who has already helped two other industries facing similar problems navigate through the "solutions" that didn't work to embracing the solution that will.

There are no shortcuts, but there are accelerated learning tools, and in the next chapter, I'll show you a model that has great potential if the powers that be will only reach out and ask for help to tweak what they already have. Remember, it is the pioneers who get slaughtered, and it is the settlers who prosper. Let's settle down together and design a sustainable model that enriches all parties involved.

3

A SUSTAINABLE MODEL WHERE EVERYONE WINS

Shortly after the beginning of the ACA, doctors who were desperate to find a way to survive and improve their health care practices researched ways to work around it. Some found the best way was through Concierge Care and Direct Primary Care (DPC). Concierge Care and DPC are very similar in their goals. Providers want to gain more autonomy for their practices and time for their patients.

Concierge Care is the gold standard and requires a high monthly payment—around $150 a month—while patients maintain their health insurance. Concierge Care allows doctors to cut their patient loads, ranging from two thousand to two thousand five hundred down to four hundred to six hundred patients. The average patient for Concierge Care lives in an affluent community and is fifty-five years or older. With a patient load of four hundred to six hundred, Concierge Care doctors

can pull into their practices $60,000 to $90,000 a month in membership dues; that's $720,000 to $1,080,000 a year free and clear without billing insurance companies. Again, it can be quite the balancing act when it comes to the dual fee system if a practice chooses to split the baby by offering both payments from the insurance companies as well as a cash payment directly from the patient. This is not at all impossible; it just needs to be thoroughly thought out. The key is to be sure that all services and procedures are billed at the same rate.

A more affordable option to concierge services is the DPC system. DPC has grown to such an extent that there is a group called the Direct Primary Care Coalition working in Washington, DC, which lobbies for improvements to health care rules to benefit the DPC providers and patients. Among the improvements are those that allow big and small corporations, and their employees, greater access to DPC services, drastically cutting costs for both employer and employee in many cases. In fact, DPC is already proving so effective that the ACA specifically mentions it as an acceptable way of receiving medical care without health insurance, unlike Concierge Care.

Recognizing the benefits of this model, many states have passed legislation to specifically indicate that DPC practices do not form a type of insurance. This frees up DPC offices from complying with the endless paperwork, laws, and red tape that go with being an insurance provider.

How exactly does DPC work? What are some of the benefits, to both provider and patient?

No insurance requirement:

One of the single biggest advantages of DPC is the ability for doctors to focus on patients without dealing with health insurance. In traditional Fee-for-Service (FFS) models, nearly half of a doctor office's staff is there just to deal with patients' insurance requirements.

With DPC, however, doctors don't accept insurance or work with it in any way. Instead, DPC providers charge a much lower monthly fee, ranging from $10 to $99, based on the age of the patient and the individual practice. Patients are still encouraged to have insurance but, rather than having expensive insurance that covers regular medical bills, they can opt for a very inexpensive, high-deductible "catastrophe plan." For their regular medical visits, tests, and treatments, they're covered under their monthly DPC membership fee.

Time with patients:

DPC relies on similar numbers of patients (four hundred to six hundred), with most DPC practices hovering around the low-end of the spectrum, which is a byproduct of ineffective marketing, sales acumen, and poor packaging of products and services—not the model itself. This is something I will address later in this handbook. With fewer patients to see, the level and quality of health care improve. DPC providers are

learning how to maintain high-quality care, 24-hour notice for appointments, and allotting ample time for each patient. How does a DPC model allow for more time with each patient?

According to the American Academy of Family Physicians, the average doctor is seeing 93.2 patients a week, or nineteen per day. The non-profit group Physicians Foundation found that just over a quarter of doctors are seeing between twenty-one and thirty patients a day. Add in the 49.2 percent of a doctor's time spent on Electronic Health Record (EHR) and desk work, and you realize that half of the doctor's time is spent on red tape. This half day could be better spent with patients (or on a golf course . . . joke!). Seriously though, simple math tells you that a patient could receive almost twice the time with the physician under the DPC model.

Under DPC, there is no daily requirement for how many patients need to be seen, so a smaller active patient base gives the doctor more time with each patient, as well as the flexibility to schedule much needed and unexpected appointments. As an example, Brian Forrest, MD of Access Health in NC opened his DPC practice in 2002. One of the things he proudly touts about his practice is that he's never taken a dollar of insurance money. What's even more impressive is that Dr. Forrest only sees an average of twelve patients a day, with an absolute maximum of sixteen.

That may not seem like a big drop from the nineteen to thirty patients most doctors see on an average,

but remember, most doctors also spend 49.2 percent of their time on paperwork—much of it related to proving and validating to insurance companies the need for a certain treatment. Take out that time and spend it on two-thirds the number of patients and, suddenly, you begin to practice medicine the way you always dreamed of: helping people, not insurance companies.

And what would the result be? The University of North Carolina Medical School and North Carolina State University MBA students conducted a study and found that patients who chose a local DPC practice spent 85 percent less while enjoying doctors' visits that averaged thirty-five minutes per visit—compared to just eight minutes for a standard FFS practice. Imagine how much more rewarding your practice would be if you were able to achieve those results.

How does it work?

This raises the question: How exactly does DPC work? Our research shows that the new primary care model will look something like this:

Monthly membership fees (*these rates are not set in stone; these are just sample ideas of possible rates for reference):

- Young adult, 18–33 years old, $19/month
- Adults, 34–44 years old, $29/month
- Middle age, 45–60 years old, $59/month
- Seniors, 61+ years old, $99/month

The real profit margin of this new health care business model is in the children to thirty-three and the thirty-three to forty-four categories. These groups are the casual and non-users but will absolutely pay an entry-level membership fee to know they are covered. This is exactly what MMC® has been doing since 1991 in health clubs (and golf since 2006) by profiling, engaging, and acquiring the difficult-to-reach demographic to offset the heavy users. The incredible thing about MMC® is, because we have worked with over nine hundred golf courses and health clubs, we've been able to understand this membership model better than anyone else, including the ins and outs required to make it work with just a few minor tweaks in any given practice.

Health clubs and golf courses both want to try to charge a monthly premium for their membership: a premium, all-inclusive membership that covers everything from tee time to cart rental. Health clubs and golf courses used to charge exuberant rates before MMC® came along. Health clubs, for example, used to charge $99 a month whereas golf courses charged $100 to $1,000 a month. What they discovered is that only a few people can afford that, hence only a few businesses could sustain that model. MMC®'s model with regard to health care is to balance out the patient load by having more than 80 percent of the membership comprise non-users and casual users.

In the health club business, one of your up-sales is personal training—you are drawn in on an affordable membership, but when you hire a personal trainer it will cost you $50 or more an hour, providing the club with a huge profit center. The juice bar, tanning beds, apparel, supplements, vitamins, special classes, nutritional counseling, and a host of other products and services are up-sales and add-ons to their membership. The same thing is true in golf. Using the range, eating in the club's restaurant, buying beverages, lessons, clinics, tournaments, leagues, scrambles, cart rentals, banquet facilities—all of these products and services are incredibly profitable when you lower the barrier to entry, focus on the casual and non-users, sell products and services ala carte to the volume . . . and everyone wins.

The same is true for medical practices. Physicians will see far fewer patients because the fact is, only four hundred, six hundred, or eight hundred patients will be heavy to moderate users, with the majority of their membership fees coming from the casual and non-users whom they rarely, if ever, see. Again, it's not the idea of just having a smaller patient load, it's the idea of having a smaller patient load that you're seeing, so you can spend more time getting to know that patient who needs your help, while still having a large group of patients offsetting the cost and contributing to the bottom line.

With my new introductory membership, I needed to assure course and club owners that they were not

giving the course away, but using the introductory membership only as a hook to fill in slow times and drive revenue into the business during slow seasons. So to present my concept, I decided to use the airline industry as an example. Here it is: think of the seating arrangement in a passenger jet. The airline has a great deal invested in safety, equipment, personnel, training, fuel, licenses, computers, software programs, insurance policies, and so on. The airline's plane has an excellent first-class cabin with all the desired amenities; they have also developed a business-class cabin for the flyer who desires additional services but can't or won't pay for first-class accommodation. After the airline's first-class and business-class passengers get settled in, the owners look out over the seating of the airplane and realize that over 85 percent of the seats are empty. Now, they still have to pay their pilots, mechanics, flight crew, safety inspectors, fuel costs, and countless other daily expenses, but they just can't sell enough tickets in the first-class and business-class cabins. Although the airline may have started off wanting to cater solely to first-class and business-class passengers they now see the need for another seating classification, so they decided to incorporate a coach class. Coach customers enter their cabin through the same door of the plane, they share the aisle and the air-conditioning with first-class and business-class, and they arrive safely at their destination at the same time as first-class and business-class customers. But it is certainly not

the same travel experience, nor did they pay the same fee. Less than 5 percent of the plane is occupied by first-class passengers; now add an ambitious 10 percent for business-class, which means the plane comprises 85 percent coach-class passengers and only 15 percent upper class. But keep in mind that it is the coach-class customers who make the trip affordable for first-class and business-class travelers as well as profitable for the owners and stockholders. If the entire plane were first-class seating, travelers would pay ten times the amount they pay today, and most airlines would be out of business—there are nowhere near enough travelers with that kind of disposable income to sustain several businesses catering to the same market. This holds true for primary care providers as well.

Just like golf courses and health clubs, too many practices miss the boat and price the membership fees too high in an effort to be all-inclusive. They try to include all the inexpensive things like lab results and prescriptions and pretty soon, they've priced themselves right into the high end of Concierge Care. This is just like public courses price themselves into competing with country clubs and health clubs price themselves into competing with full service, upscale athletic clubs.

What are some of these profit centers in primary care? How can doctors supplement their $19.00 to $99.00/month membership fees? Let's look at the numbers. If a practice has two thousand patients, paying

an average $45 a month, that's $90,000 a month or $1,080,000 a year—just in membership fees. To put that in perspective, that's equivalent to what most Concierge Care practices can make providing specialized care if they are successful.

Once you have your basic membership plans in place, then we start looking at the extra products and services (profit centers) not covered.

One of the easiest ways to supplement income is through prescriptions, X-rays, and other basic services. For example, Patrick Rohal, MD, runs a DPC practice in Pennsylvania. In an article he wrote about the benefits of DPC, he spoke of a friend of his who cut his leg jumping over a guardrail while jogging. Since his friend had a traditional insurance plan, he went to the ER for stitches. While the doctor did a great job stitching his leg, he was promptly given a bill for $1,800. With Dr. Rohal's DPC practice, in contrast, that same process would have cost $50—$70 to come into the office after hours and another $20 to do the stitches. Millions of people need stitches every single year for small cuts and lacerations. If you have twenty-five to fifty people a month come into your practice requiring stitches and you charge $20 each, that's an additional $6,000 to $12,000 a year.

The same is true for X-rays. It's estimated that in the United States alone, some two billion X-rays are performed. X-rays performed in standard practices, hospitals, or other insurance-backed medical

endeavors can cost anywhere from $100 to well over $1,000, depending on a person's insurance and the body part being scanned. In contrast, many DPC practices charge a flat rate per body part, usually in the $30–$100 range. If you perform fifty X-rays a month at $50 per X-ray, that adds another $30,000 to your practice's income.

Prescription medications are another area where both the doctor and the patient can win. With today's insurance plans, many patients struggle to pay for their medications. Recent studies have shown that as many as 51 percent of patients have insurance plans with a deductible as high as $1,000. That means that those patients often have to pay for their medications out of their own pockets. With DPC plans, many doctors are able to provide their patients with near-wholesale prices, adding on a 10–20 percent handling fee. While that may not seem like much, take a moment to think about how many times you write a prescription throughout your day. Each time you do, that's a 10–20 percent markup that can represent thousands of dollars to your practice a year.

Below is a partial list of the medications a DPC practice can charge for:

Amaryl, Augmentin, Bactrim, Celexa, Cipro, Cymbalta, Effexor ER, Flomax, Glucotrol XL, Imitrex, Keflex, Kenalog, Levaquin, Lexapro, Lipitor, Lotrel, Microzide, Naprosyn, Neurontin, Norvask, Plavix,

Prednisone, Prilosec, Singulair, Wellbutrin, Zantac, Zofran, Zocor, and Zoloft.

Again, think of how many times during the day or week you prescribe the above medications. Even with a modest 10–20 percent handling fee, prescription meds represent thousands of dollars of additional income per year, and all the while you are providing them to patients at a fraction of the cost they would otherwise pay.

Immunizations represent yet another area where doctors can charge additional fees. For example, the following is a list of common immunizations that doctors perform on a daily basis:

Prevnar 13, Pneumovax, Flu for Patients under 65 (Influenza Low Dose), Flu for Patients over 65 (Influenza High Dose), Tuberculosis Screening (PPD), Shingles (Zostavax), Meningitis (Menactra), Tetanus with Pertussis (TDaP), Tetanus without Pertussis (Td), and Varicella.

In addition to X-rays, sutures, and prescription medications, there's a litany of tests, lab panels, and injections that can be profit centers. Just like the casual golfers I talked about in Chapter Two, don't expect their membership to be all-inclusive; patients understand that their monthly membership fee doesn't include extra lab work, tests, and injections. Again, with a minimal up-charge, a medical practice can add thousands to their bottom line and still deliver significant value to their patients.

Here's a small list of the many different items that can be valuable profit centers:

Antinuclear Antibody, Basic Metabolic Profile, C-Peptide, C-Reactive Protein, CBC w/ Diff and Pit, CBC w/out Diff, CK, Total Comprehensive Metabolic Panel, Cytomegalovirus (CMV) Titers, Epstein-Barr Virus Antibodies, Estradiol, Ferritin, Folate, Serum, Follicle Stimulating Hormone, Hemoglobin A1c, Hepatic Function Panel, Hepatitis B, Hepatitis C, Hepatitis Panel (Acute), Hepatitis Panel (Chronic), HIV, HSV (Herpes Simplex) Iron, Total Lipid Panel, Liver Function Panel, Lyme Disease, Pap Smear Cytology (High Risk), Pap Smear Cytology (Low Risk), Microalbuminuria/cre Ratio, PSA (Prostate-Specific Antigen), PT/INR, Rheumatoid Factor, T-SHIRT, Testosterone, Uric Acid, Urine Culture, Vitamin B12, and Vitamin D.

Switching to DPC

It's easy to see the advantages of a switch to DPC. With all these advantages, why aren't more doctors doing it? Why aren't doctors switching at a faster rate?

Unfortunately, switching to DPC can be like starting all over again. A doctor's new practice will be membership-based and won't need or accept insurance. As most people aren't fans of change, a DPC startup can expect to lose 90 percent of their patient list. Imagine any other business making a decision that will strip away 90 percent of their business for

the sole reason of wanting to provide better services to their customers. DPC providers take back control of their businesses and practice medicine the way they've always wanted to, but often with a substantial short-term loss.

The good thing is that individual doctors and multi-provider practices don't have to make this leap alone. With so many practices surviving the initial leap and building up their patient bases, there are now member organizations to help you learn the steps needed for a DPC practice conversion. There are even organizations nationwide for doctors to join and get help with the legal, financial, and logistical details involved with converting to a DPC practice. But there is still one missing link that no one is getting right. The single biggest need that providers changing to a DPC practice report is a need for cash! In school, they studied medicine. Over a provider's years in practice, they learn how to run a health care business. They just haven't had the time to become marketing experts too.

That's where MMC® comes in. Our years of experience in identifying, engaging, and acquiring members make us ideally suited to help. Partnering with a company with decades of experience in raising immediate cash, operational revenue, and acquiring hundreds if not thousands of new members mostly from the casual and non-user segments for clients makes taking the plunge a whole lot easier. We are the membership marketing experts! In addition to acquiring hundreds

of new patients, MMC®'s program will help most practices retain upwards of 60 to 90 percent of their current patient panel when making the transition.

Our company is performance-based (we are paid solely on a success basis), data-driven (our targeted members are qualified through a consumer profile), worry-free, and turnkey (we design and manage the entire campaign from conception to closeout). MMC® is a member (frequent, infrequent, casual and non-users) acquisition company specializing in campaigns specifically designed to acquire new patients/members from untapped segments through no-risk/self-funding health care marketing (there are no upfront fees or out-of-pocket expenses, and we get paid solely on the success of the campaign).

If our country one day has free health care for all—Medicare becomes the universal health care voted in by the new socialist movement—DPC will become the most popular way for most individuals, as well as doctors, to provide and receive health care. In this proposal, they are basing the cost of health care being over 32 trillion dollars over the next ten years, and this number relies heavily on doctors being willing to take a 40 percent cut in their professional fees.

Even though this scenario seems farfetched today, it could very well be a reality in the future. I often tell my clients, it's not the inventers of a fad that get rich, it's the business people who get out ahead of the fad. Smart people plan for the best but

are prepared for the worst. Waiting until you must change your model is the worst time to change. DPC is the future of primary care, and *now* is the time to make the move.

DPC is absolutely the model most primary care physicians should be in. If you take out the financial incentives for doctors, there will be far fewer doctors at a time when we're already looking at a shortage of hundred thousand doctors by 2030.

Patients are looking for new alternatives to conventional insurance plans and are learning they can abandon the previous antiquated system of relying on insurance companies and government programs for regulated care to a more forward-thinking, practical, and affordable model, which consists of a membership-based primary care and preventive care program, backed up with a catastrophic (or similar) insurance policy.

A catastrophe insurance plan is a plan in case of a major illness or accident, which could result in a long-term hospital stay or care. These programs usually have a higher deductible but they have a much lower premium (monthly fee). So, with the other program, it can take care of the daily needs—the preventive health of any of the common simple things for health care, but the catastrophe insurance program provides a safety net in case of a catastrophe that could bankrupt and in a lot of cases does bankrupt probably 500,000 Americans every year.

Health care (primary care, elective care, preventive care, and so on) providers are looking for a safe way to stay profitable, provide unparalleled care/service, and minimize their patient load. Health care and elective care providers are stepping out of the mainstream business model and looking for new solutions. Concierge and DPC providers are just two of the latest examples of health care providers successfully transitioning into the membership model.

Doctors, hospitals, and clinics are learning that they can abandon the previous model of relying on insurance companies and government subsidies for payment and regulated care to a more forward-thinking business model based on "membership." With the membership/patient model, you can lighten your patient load, earn more revenue, and provide unparalleled care, which you can customize for your patients/members.

By becoming a member of their primary and preventive care provider's patient list, patients are able to "insure" themselves for minor medical care (covered under their low-cost monthly membership) and have insurance (low monthly payments) in case of a more serious (expensive) medical scenario.

The most challenging and scariest aspect of this move for physicians is not knowing how they will acquire the necessary patients to sustain their business/practice under this model.

Our promise:

DPC's business model is in need of an overhaul. But overhauling the entire model is not necessary: The focus should only be on overhauling the packaging, marketing, sales system, and targeted customer/patient/member so it presents health care as more affordable for the masses while ensuring the physicians/health care providers do not sacrifice their income and instead maximize their earning potential. The biggest fear (false evidence appearing real) of all is always, "What if . . . it doesn't work?"—which is a completely natural fear.

In fact, other industries like fitness and golf experience the same fears when presented with a similar business model. But once businesses from those industries partnered with MMC®, they experienced an increase in revenue with an average of $250,000 in immediate cash within the first ninety days and increases in annual revenue by as much as 120 percent. The most difficult hurdle of this health care business model is getting beyond the fear between your ears.

Membership will be the "affordable health care" model of the future.

MMC® has directly brought affordable golf and affordable health and fitness to over one million consumers and indirectly to millions more by penetrating the hard-to-reach market for our partnering clients since 1991. There is no company better qualified to grow the health care industry and your practice—including

bringing in new patients you wouldn't otherwise reach—under this health care business model than MMC®.

MMC® is guerrilla health care marketing on steroids.

The proof

MMC® has been providing affordable golf (www.golfmarketingmmc.com) and affordable health and fitness (www.healthclubmarketingmmc.com) to the elusive market since 1991. MMC® has thrived while all other companies and concepts have failed miserably in their attempts to acquire the members/customers health clubs and golf courses are so desperately trying to target, for example, couch potatoes and the deconditioned as well as the casual and non-golfer—in other words, the uncommitted market with expendable income. MMC® is the only logical choice to be the "go-to" marketing company for growing this new health care business model and acquiring the ideal demographic (young adults up to age thirty-three and adults ages thirty-four to forty-four) to offset the impending cost of caring for the baby boomers (elderly), all the while providing the health care professionals with a more than respectable income.

The concept of "affordable health care"—targeting young adults up to forty-four years old, who rarely need health care services, to offset the cost of caring for patients sixty-five years-old and up who represent a minimal profit margin—is a very logical concept and a plausible model that works.

Question: How can we be so sure the customers/patients will join/enroll in membership-based health care programs?

MMC®'s Answer: Because we know the target audience's profile, their emotional and psychological core needs and triggers, buying patterns and spending habits, how to structure the membership program/offer to where they know they must act now, and how to lock them up in long-term relationships.

For example, a major mistake the Obamacare marketers made was assuming that just because millennials are digitally connected, it does not mean e-marketing is the best platform to engage them about something as unimportant (to them, in their lives, at that moment) as health care. You will never capture the millennial market by telling them (the ACA approach) that the only reason they need health care is to help offset the cost of caring for the elderly (even though this is the objective). A large portion of millennials thinks baby boomers ruined the country by being self-centered and selfish. Why on earth would they sign up to help them pay for their health care cost?

A simple search about millennials will provide you with elementary data that will show you that millennials are distrustful of people, organizations, institutions, political parties, and so on. They marry later in life and they are drowning in debt. This generation has been shell-shocked by the economic climate they grew

up in. Not knowing and understanding your prospects is an elementary mistake in marketing.

The process

Just like in the golf and health club industries, as well as what Obamacare tried to achieve, the desired outcome in this new health care business model is achieved by offsetting the costs of frequent users by bringing in non-frequent users.

MMC® achieved our desired outcome in the golf industry by offsetting the frequent play of core and avid golfers with memberships targeting the casual and non-golfers. Hence, we brought affordable golf to all while at the same time improving the financial health of the course. The millennials and generation Z will offset the cost of caring for the baby boomers but the difference is, the membership will never be presented in that light. We will attract new customers by appealing to their needs, wants and desires—not the needs of the elderly.

The premise is basically the same in the health club business, where we profiled and targeted the deconditioned and couch-potato markets (who never worked out and rarely thought of it) to offset the cost of membership for the health and fitness conscious (who worked out four to six times a week). A health club as small as 5,000 sq. ft. could literally sell five thousand memberships and never be overcrowded due to the ratio of nine to one—nine deconditioned members

who came maybe ten times per year, and one being the health and fitness conscious who was in the health club four to six times per week.

Warning! This health care business model too will only work if it is presented to the consumer/patient/member correctly. A lot of physicians love the idea of this health care business model but are struggling financially because they lack the tools necessary to acquire enough members/patients (and members/patients in the appropriate ratios), to make this model work for both parties.

You can have the greatest product in the world, but if you lack the skills to bring it to the market, it will fall by the wayside.

No matter what happens with health care—whether we stay with Obamacare, or move toward Universal health care, or some new version of a way to pay for health care—DPC is the only path to independence and financial freedom for physicians, and quality care for consumers. The foundation of DPC is solid and the concept is spot on. The only challenges that must be addressed are the packaging and marketing. DPC is a win-win for all parties.

According to a survey conducted by the AAFP in the spring of 2018, involving both DPC practices and non-DPC practices, "The average DPC panel size is 345 patients. The average target panel size is 596 patients." With MMC®'s member/patient acquisition marketing campaign, all partnering DPC physicians

can achieve and surpass the optimal panel size in ninety days or less.

The standard FFS practice model would maintain between two thousand and two thousand five hundred patients per doctor. Under DPC, with MMC®'s guidance, that number would be very similar. However, the number of active patients would shrink to between six hundred and eight hundred active patients per provider. The most notable point to be made here is that it would be completely up to the doctor as to how many patients that number would be.

The current DPC model needs help because most physicians who have subscribed to this model are falling far short of the desired panel, which creates fear for those physicians wanting to migrate over. DPC needs to offer a solution to eliminate the physician's fear of making the move to the business model by providing converts with a proven system that will help them with cash flow, building a new patient list, and long-term financial security. MMC® is the only obvious partner.

In the next and final chapter, I will outline in detail how MMC® will walk physicians down the path to independence and financial freedom with our no-risk, self-funding patient/member acquisition marketing campaign. In fact, we are so confident that we invest our own money, and if we do not grow your practice you won't owe us a dime.

4

INDEPENDENCE AND FINANCIAL FREEDOM FOR ALL PHYSICIANS

A recent study by Health is Primary showed that 86 percent of Americans agree that having primary care leads "to healthier patients, higher quality health care and lowers costs." This means that the overwhelming majority of Americans recognize that they need to have a primary care physician. Yet the cost of insurance, the ACA preventing people from going to the doctor they want, and an ever-increasing shortage of doctors keep many people from using the services of a primary care physician.

Of course, once a person does go to the doctor, they get to spend an average of eight minutes talking to their doctor, getting their questions answered, and receiving the care they need. As mentioned in Chapter One, neither patient nor physician is happy with this state of affairs—and neither believes the patient is getting the attention or care they deserve.

This is no secret; industry experts freely admit these problems exist. Writing for *Forbes*, Russ Alan Prince quotes Daniel Carlin, MD, CEO of WorldClinic and author of *The World of Concierge Medicine*:

"The general consensus is that overall the traditional health care system in the United States is broken. For example, a significant failing of the U.S. health care system is that hospital-based care is centered on complex diagnostics and procedures, not simple, yet consistent, prevention. Also, the rise of hospital-based care has fostered the age of '7-minute medicine,' or rather doctors, who only have time to capture a problem, not get to know the patient's context. Understanding the patient's context—and the patients themselves—often reveals the root of the issue. Consequently, doctors who practice '7-minute medicine' may not provide true primary care. The net result is a missed opportunity to prevent or effectively treat health care problems before they worsen into crises."

In another article for *Forbes*, Prince quotes Jeffrey Friedman MD, Director of Medicine at Community Health Associates and a member of Medical Doctor Value in Prevention (MDVIP), regarding the problems doctors face and the solutions before them:

"Although there are many really good doctors out there, they're not able to practice medicine the way they want to. Critical to high-quality medical care is having a primary care physician who understands you, has the time to spend with you, and who is sincerely

concerned about your wellbeing. If patients want to assure themselves of getting access to top-of-the-line medical care when they need it as well as concerted follow up including a physician acting as a health advocate with specialists and hospitals, concierge medicine is probably the answer for many of them."

While Friedman specifically mentions concierge medicine, his statement applies equally to DPC. Even more importantly, Friedman is not the only one who recognizes that DPC and concierge medicine represent the future of the industry.

In a white paper entitled "Direct Primary Care: Restoring the Doctor-Patient Relationship," Katherine Restrepo, Health and Human Services Policy Analyst at the John Locke Foundation writes the following:

"DPC restores the traditional doctor-patient relationship. Imagine physician practices that do not have to spend over 40 percent of practice revenue on overhead costs and personnel responsible for filing insurance claims. Opting out of insurance contracts allows smaller practices to break even on as little as four patients per day, rather than an average of 32 in today's typical practice setting.

"According to an article published in Health Affairs, DPC doctors can treat roughly one-third the number of patients normally seen in a medical office that accepts insurance and still bring in comparable practice revenues. More importantly, DPC heightens providers' professional satisfaction because they can escape

the corporate environment of the ever-consolidating health care industry. Calling their own shots under this business model allows for them to actually practice the art of medicine and hold fast to their autonomy."

Unfortunately, when trying to move to DPC, everyone in the health care industry is focusing on the wrong thing and trying to attract the wrong type of patient. Let's go back to our comparison to the golf industry for a moment.

In 2016, it was estimated that roughly eighty million Americans buy golf-related merchandise, such as magazines, clothing, products, and more. Some thirty-five million Americans were interested in taking up the game. This is compared to just thirty million core and avid golfers. Which group do you think the vast majority of golf courses and golf marketers focus on? That's right, they focus almost exclusively on the core and avid golfers, completely ignoring the potential golfers who are already interested in the game and just need some incentive to take the leap.

The same is true for the health care industry today. The vast majority of individuals and entities trying to fix health care are focusing on attracting and serving the part of the population that needs it most. This is completely understandable. After all, if your primary way of making money is by charging directly for services performed, you need sick people to make your practice profitable. The more you have, the more money you make.

Unfortunately, this does nothing to address the issues the medical community, in general, is facing. This approach only exacerbates the issue of limited face-time with patients, not to mention the issue of overworked doctors. Just like the golf industry, and the health club industry before it, medical practices need large numbers of non-users to help subsidize the cost of servicing the heaviest users, all the while freeing up time for the doctor to be able to give quality care to each and every patient. The ACA had half of the equation with an emphasis on enrolling young, healthy individuals in an effort to offset the cost for the heaviest users. As we pointed out above, however, the ACA gets the marketing all wrong, not to mention it creates a host of additional problems.

Unfortunately, when many doctors try to make the jump to DPC or Concierge Care, they take the same approach with the new model. Writing for *Datica*, Travis Good, MD, makes this case beautifully:

"Cash-pay medicine has seen a tremendous growth in popularity and will continue to grow as the traditional commercial insurance model of health care continues to get worse. Survey data consistently shows that a high number of providers are interested in switching to concierge medicine. Sadly, the poster children for building networks and scaling cash-pay medicine have not fared well—QLiance and Turntable Health have struggled and had to shut down. One Medical has grown more slowly than expected and has had to raise

almost $250M in the process. Some, like MedLion, are trying to sell subscription medicine, mainly virtual care, through employers.

"The lessons from these companies is not that cash-pay medicine doesn't work (here's data showing saving from cash pay), it's that scaling a network of cash-pay medical practices is very hard in today's health care environment. Cash-pay practices that hold on and remain outside the system will be smaller, more independent practices. That's the biggest obstacle to cash-pay medicine—converting small practices is hard and perceived as very risky. But, those smaller, independent cash-pay practices are starting to share their stories and insights through online forums. These online forums, like Facebook groups, are reducing the barriers for providers to convert practices to cash pay. I personally know multiple physicians who are planning to convert to cash-pay practices in 2018 and their main source of information is Facebook."

"At the same time, consumers/patients are more open to cash-pay practices. As health care delivery and traditional, claims-based payment have become more convoluted, consumers have become more willing to pay directly for higher-level access to their providers. I don't think a large portion of the public is ready to spend $150–$200/mo. for concierge medicine but I do think a decent proportion is willing to pay $40–70/mo."

A white paper published by the Health Policy Programs Group, University of Wisconsin Population

Health Institute School of Medicine and Public Health, also highlighted QLiance's failure:

"The QLiance Medical Group has received perhaps the most attention in the literature. Founded in 2007 in Seattle, QLiance established itself as the nation's largest DPC health care consortia. Supported by Washington State's permissive DPC law, QLiance served individuals, employers, and Medicaid members. In 2014, the company became the nation's first DPC provider to join the ACA health insurance exchange. By 2015, QLiance groups served 35,000 patients in the Seattle area, half of whom Medicaid covered.

QLiance had early success with market expansion, but faltered financially and, by 2017, had closed all clinic operations. The QLiance Medical Group filed for Chapter 7 bankruptcy on May 7, 2018. The payment levels apparently proved insufficient to cover the DPC costs. Others have voiced this concern: one 2015 review of existing DPC practices reported that DPCs charged patients an average of $77.38 per month, while another reported monthly rates between $42 and $125.32. Such rates fall substantially short of the average of $182.76 per month charged by 'concierge' or 'boutique' medical practices, which also usually bill insurers for their services.

Practices that approach DPC, focusing only on the demographic who needs help the most, are destined to experience the same struggles as the above-mentioned QLiance and Turntable Health. The key is to sustain

the practice with those who don't need health care very often, but are willing to pay for it to have the security and peace of mind it provides.

According to the *CIA World Factbook*, the US population breaks down as under:

0–14 years: 18.62% (male 31,329,121 /female 29,984,705)

15–24 years: 13.12% (male 22,119,340 /female 21,082,599)

25–54 years: 39.29% (male 64,858,646 /female 64,496,889)

55–64 years: 12.94% (male 20,578,432 /female 22,040,267)

65 years and over: 16.03% (male 23,489,515 /female 29,276,951) (2018 est.)

As highlighted in Chapter Three, a successful DPC practice could charge according to the following tiers (*these are not set in stone; they are just sample ideas of possible rates for reference):

- Young adult, 18–33 years old, $19/month
- Adults 34–44 years old, $29/month
- Middle age 45–60 years old, $59/month
- Seniors 61+ years old, $99/month.

Nineteen dollars a month may not seem like a lot of money for the first category of patients, but with roughly thousand five hundred to two thousand five hundred patients/members, $19 adds up fast. What's

more, these patients are usually relatively healthy, aside from the occasional cold, flu, and vaccination, which doctors can charge extra for. The same is true for the next category of patients, adults aged thirty-four to forty-four. These patients are in the prime of their lives and often require less care than children.

As a result, the key to successfully building a DPC practice is to focus on the first two categories of patients. These patients will rarely need to see a doctor, yet they—or their parents, in the case of children—will happily pay $19 and $29 a month for the peace of mind DPC provides.

To successfully build a practice around these two groups, DPC practices must market to them via the mediums they are most comfortable and familiar with. That's where MMC® comes in with our campaigns. We understand how to market to the specific audience you need to target in order to make your practice grow.

How the Cash Campaign works?

The first step is a soft internal launch, via electronic marketing. During this phase, we help you to reach out to all your existing patients and inform them of the change. This has tremendous opportunity to grow your patient base and generate immediate monthly income. This important phase will help your practice convert existing patients to the new model. By marketing to existing patients, practices take advantage of an age-old principle: It is six to eight times cheaper

to retain, convert, and up-sell an existing patient than it is to acquire a new one. For example, you may have been treating a single member of a four-person family. If there are two parents in the thirty-four to forty-four range, and two children, the entire family can get medical care for $96 a month. Suddenly, for the price of a single, non-covered medical visit, the entire family can visit the doctor as much as needed during the month.

During this first phase, we use electronic marketing to reach out to your new and existing patients. This is where our expertise in working with social media platforms comes into play. Too many businesses believe it's as simple as creating a Facebook, Twitter, or Instagram account and making posts.

In reality, different demographics use different social media platforms more. Even within the same demographic, people use different social media, chat, and messaging platforms for different reasons. For example, a while back, I was speaking with one of my sons (Chaz), who was totally immersed in his devices and gadgets. I asked him why he was using his computer and iPad at the same time. He replied, "Dad, one is for streaming video, and the other is for gaming." He then informed me that his sister (Azha) uses three devices at a single time, not only for gaming and streaming but also for chatting. Millennials and Generation Z are the new generations of consumers. If you can get to just a few millennials, and your message resonates

with them, you may get lucky and have your message go viral. But you would be foolish to assume this will happen. You must be well versed in all media and platforms so that you're not just hoping for a successful campaign but also planting the seeds to ensure a successful campaign.

It's important to save some of the money earned during the first phase to help fund the second phase, which is newspaper, radio, and conventional media marketing. While these outlets are dying out when compared with social media marketing and other solutions, they still have avid followers, especially in the top two patient brackets. Since our campaigns are based on guerrilla marketing, it's important to leave no stone unturned, let alone one that is critically important to two entire categories of patients.

The third phase is the heart of the campaign and is especially important for doctors and their practices: direct mail will be deployed through four consecutive mail drops to profiled targets selected on a criteria-based formula. The first two phases were building to this point.

When working with golf courses, MMC® has had courses stop the Cash Campaign after bringing in five hundred golfers or so, only to regret their decision of not going deeper into the campaign within just a few short months. Ending the campaign early is a devastating mistake, as it completely destroys the momentum you have built up to this point.

This is also the most important phase, as it further helps your practice convert existing patients to the new model. By marketing to existing customers, practices take advantage of an age-old principle: It is six to eight times cheaper to retain, convert, and up-sell an existing customer than it is to acquire a new one.

The fourth and final phase of the Cash Campaign is the closeout. During this phase, all media, platforms, and resources are enlisted. No stone is left unturned. During this phase, if the closeout is managed properly, your practice could easily raise 20 percent of the total gross of the campaign in the final two weeks. It's important to remember that the campaign is set up with built-in adjusters to accommodate individual circumstances. If your practice reaches its goals before closeout, we can wind down the campaign with a soft, quiet closeout. Alternately, if your goals are not met, we can push the closeout as hard as necessary to deliver the desired results.

Either way, the closeout is extremely important because it helps you clinch any individuals who may have been thinking about signing on but have yet to make a move. The closeout also adds urgency by informing your prospective and existing patients that this is a once-in-a-lifetime opportunity that is about to expire and will not be offered again.

To help you make the most of our Cash Campaign, we offer twenty-four to thirty-six months of free support that is included as a bonus for doing business with us. During this time, you will be receiving videos,

downloads, mini in-house promotions, and other materials that have been designed specifically to help you cultivate these new relationships.

Why commit to MMC®?

A campaign of this magnitude consumes hours upon hours of our staff's time, which, in my experience, most doctors and medical staff don't have. Most doctors, as well as their staff, are already wearing too many hats, yet some doctors want to saddle their staff or themselves with this enormous responsibility of growing the practice. A successful campaign demands hours and hours of personnel to monitor social media, gather data, conduct surveys, run competitive overviews, correspond with vendors, coordinate schedules, adhere to deadlines, and so on. Any given campaign launched by MMC® has a minimum of thirty people's fingerprints on the project.

There is an old saying in the legal world: "A man who is his own lawyer has a fool for a client and an idiot for an attorney." Forget for a minute that I am the one saying this, and think logically for a second. If you own a medical practice and want to transition to DPC, you get one shot at running (ruining) a campaign of this magnitude; if you, your employee, or whoever you hire makes only one mistake (out of a thousand possible mistakes), you could easily, bankrupt the business.

In contrast, we bring decades of experience in managing campaigns to the table. We know the

pitfalls, mistakes, and deal-breaking issues as a result of that experience. We know what works and what doesn't.

We offer a no-risk, self-funding solution to execute market-dominating campaigns to grow your practice. Our program requires no cash outlay on your part. MMC® is paid only on performance. Meanwhile, you will handle and deposit all funds raised through this campaign into your bank, not ours. Each week, you will simply pay MMC® a success fee from the previous week's revenue raised through the campaign and *only* on the revenue derived directly from the campaign. The program is truly no-risk and self-funding and, therefore, self-propelling. Each phase of the campaign, from the start and moving forward, is propelled and funded by the previous phase. If for any reason the revenue to advance the campaign has not been generated by the campaign, the owner may cancel our agreement at any time without any further financial obligation to MMC®.

Best of all, we have a proven track record of success. The examples I highlighted above, in terms of what we have achieved for our customers, is by no means unique. In our work with golf courses, since 2006, over 95 percent of our customers have raised more than $100,000 in immediate cash, with many of those properties raising as much as $500,000, all in ninety days or less with our no-risk, self-funding Cash Campaign.

MMC®'s Cash Campaign's supremacy over any campaign ever designed for the golf and the health club industries to this day still goes unchallenged. That's why I'm excited to apply this program to the medical field. Most medical practices—and marketing companies—would never be able to afford the resources or personnel to launch campaigns as massive or successful as this. We make it possible because our campaigns pay for themselves: they are 100 percent self-sustaining. Even better, 99 percent of the work is done behind the scenes by our team, saving your practice valuable time and energy. That's why I have said for years that MMC®'s programs are marketing on steroids. Your practice can transition to DPC and grow stronger than ever in a matter of months.

It's important to remember that the Cash Campaign was never meant to be a business model; it is simply meant to be a marketing campaign that helps a traditional practice transition to DPC and grow its patient base to support that transition in both the short and long term. Once you have established your rates and your perceived value within your community, we will design mini-campaigns to sustain the growth you've already achieved.

Always guard against the downside. The only possible downside to MMC®'s Cash Campaign would be inexperience, incompetence, or laziness. The campaign can't fail; only the human components can, as outlined in the examples above. These innovative marketing campaigns require a team of marketing professionals who

are up to par with relevant data and have experience in growing businesses. There can be a bright future for the health care industry, but it is not a future that can be left to legislators, presidents, or bureaucracies.

Moving forward

Touching people's lives in a positive way has been extremely rewarding for me over the years. Exercise, proper eating habits, and plenty of uninterrupted sleep is the triad to a long, happy, healthy life. Unfortunately, no matter how long, healthy, and happy a person's life is, eventually they will need medical care. In the United States and much of the world, however, the medical industry is broken—dominated by insurance companies on one side and a bureaucratic nightmare of legislative red tape on the other. Doctors are miserable, patients feel cheated, and the worst days are still ahead—at least for traditional health care practices.

In contrast, as this handbook has made the case, DPC is the future. It offers patients the care they need and want while offering doctors a way to take back their practice and control their own destiny.

I know firsthand how frustrating it can be to deal with the limitations of our current medical and insurance systems. That's why I've taken my decades of experience helping the health club and golf industries and applied it to the medical community. I know that with my program, you can make the switch to DPC and get back to focusing on what you love—helping people!

Partner today with MMC® and lower your patient load, have complete autonomy, complete control of your practice, lower your overhead, spend more time with your patients and less time on paperwork, and spend more time doing what you spent your life studying for—which is to provide excellent care for your patients.

Wishing you good health and prosperity,
Chuck Thompson

PS: Please take a few minutes to write a review for my book, and post it on as many websites and platforms as possible with a direct link to where your friends and followers can buy *A Physician's Guide to Financial Freedom, Autonomy, and Complete Control of Their Practice.* Also, be sure to register with my company and personal websites—www.mmctoday.com, www.healthcaremarketingmmc.com www.hotelmarketingmmc.com, and www.chuckthompson.guru (not dot com)—for freebies and updates. If you wish to contact us at MMC®, you may call 904-217-3762, call toll free 877-620-8135, or email me at chuck@mmctoday.com. For comments or any other correspondence, please use my personal email address at chuck@chuckthompson.guru.

Mulligan:
A mulligan is when a golfer or business gets a second chance to take another shot, whether it's a shot at a pin to improve the golfer's score or a golf course

getting another shot at growing its business with no penalty—a do-over. (Chuck Thompson)

MMC® has a mulligan for growing your business today.

Mulligan Marketing Concepts® Since 1991

America has the greatest health care in the world, yet everyone (physicians and patients alike) hates it because of the regulated care dictated by insurance companies. Health care is bankrupting Americans (physicians and patients alike) every day.

Primary care providers as well as physicians, in general, feel as though they have no choice, no options, and no way out. Exiting the current model is just too scary to even fathom. Thankfully, there is a better way. If you want to grow your practice, lower your patient load, and be free to offer the care you choose, read this handbook, because I am going to show you a better model.

Physicians need an expert in raising cash and operational revenue, giving them the security to take chances and make the necessary changes that will enrich their lives as well as their patients'.

My name is Chuck Thompson and for the past thirty years I have been penetrating untapped markets, identifying, engaging, and locking up long-term relationships with casual users and non-users to offset the inadequate revenue paid by the frequent and heavy users for my company's clients. I have engineered a no-risk system (there are no up-front fees for my team's services; we are paid solely on performance) that raises immediate cash flow—daily receivables as well as monthly receivables—that solidifies our clients' long-term growth and overall success. We have worked with over nine hundred clients as of January 2020, acquired more than one million customers, and raised over half a billion dollars in up-front cash and backend revenue for those clients.

ISBN 979-8-6422-6845-2