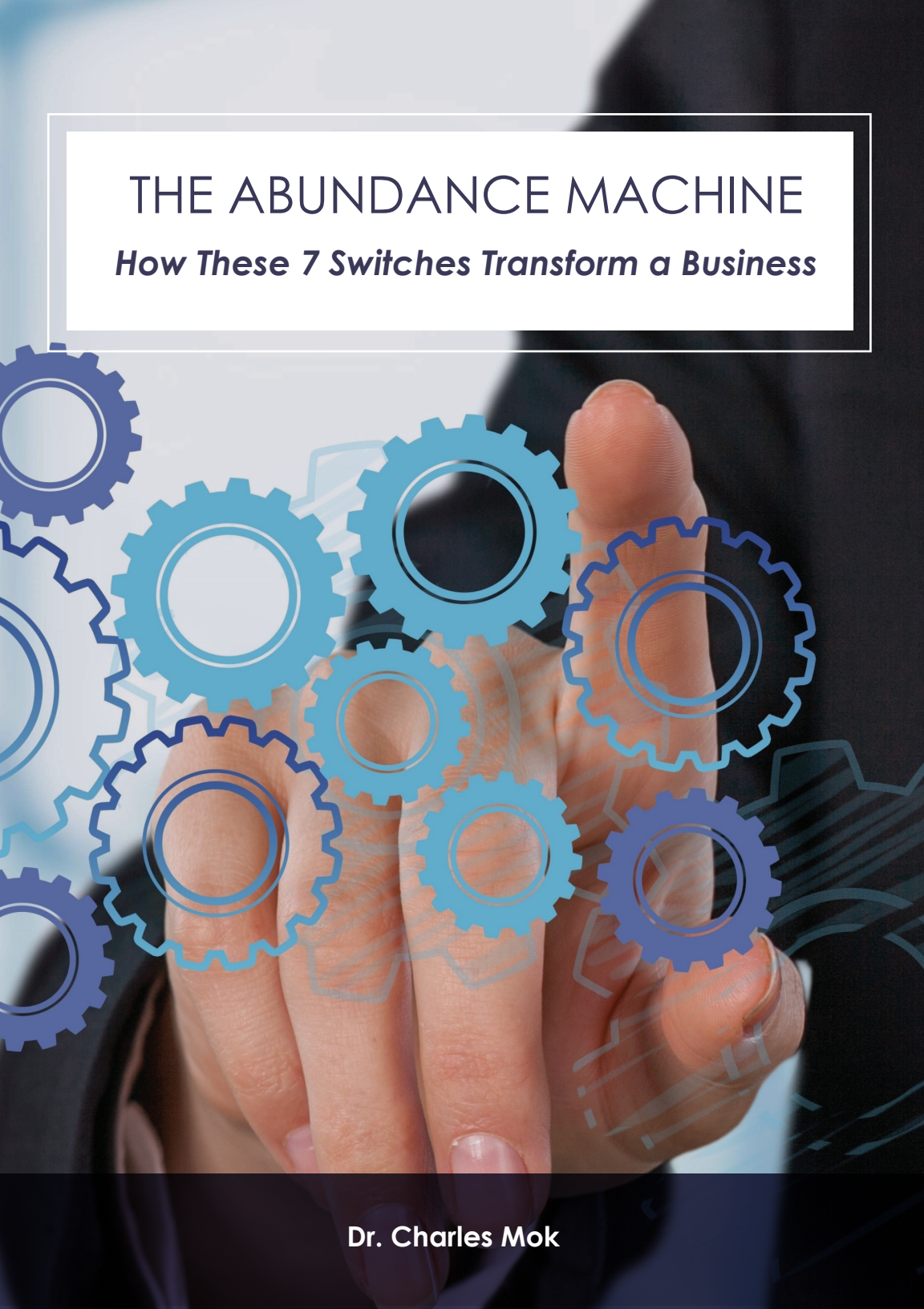
THE ABUNDANCE MACHINE

How These 7 Switches Transform a Business



Dr. Charles Mok

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CHAPTER 1

INTRODUCTION TO THE ALLURE OPERATING SYSTEM

Consider this book a tool to help you grow your business, prepare your business for sale, or just learn more about modern business practices.

The book is broken up into fifteen chapters; first, I'll review a little bit of our business history and how I discovered the Allure Operating System, and then I'll go into detail about what we call the "seven switches" of our business. Combined with our operating system, these seven switches have allowed us to grow at a robust pace, both organically—by opening additional locations—and also by acquiring existing medical practices. In the seven months preceding the writing of this book, we've doubled the number of our locations without taking on any debt, and we did it all through cash flow.

But it hasn't all been roses. Prior to founding this business in 2004, I worked in a hospital as an independent contractor and had zero employees. I had never run a significant business, nor did I have any business mentors. Most of what I've learned,

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I learned the hard way: through mistakes, some painful and expensive missteps and experimenting with business concepts that sometimes worked wildly well but also occasionally went horribly wrong.

What I'm offering in this book are steps you can take to transform a medical practice—not just a practice that looks like ours, but any medical practice—into a wildly profitable, uber-successful, job-creating healthcare business.

Because this book is about the business of medicine, I will not talk about medical necessities or best medical practices. Those are subjects for an entirely different book. In this book, I will explain how to ethically create enormous value in a medical business, how to deliver results to your customers, how to pay your staff more and be more profitable while simultaneously reducing healthcare costs by eliminating waste.

The Allure Operating System

We discovered the seven switches of our operating system when we experienced a failure following our initial success. And I don't just mean a failure, I mean a colossal failure that might have put us out of business if we hadn't addressed it immediately.

Our business was founded in 2004. It grew quickly, and by 2007—with just one physician and two physician assistants on staff—our sales (i.e., annual collections) were at $10 million. Certain fundamental founding principles led to this level of productivity. Those did not include hurrying, rushing, being dishonest or cheating, nor was our success due to a series of fortunate events.

We were successful because we focused on eliminating waste. We focused on giving the customer what they wanted and what they needed, and we focused on delivering our services in an efficient and expedient manner every time. This led to enormous sales and enormous profitability. It also led to high customer satisfaction, high employee retention, high employee wages and being the envy of our community.

But then something happened: we hit the ceiling of complexity. We continued to grow, but much more slowly. Our profit margin started going off a cliff. After a few years of wild profitability and success, we still had enormous production, but were no longer profitable. We were actually in danger of going out of business, to the point where I had to loan the company money to pay our bills.

I had hired a CFO and professional managers in the years leading up to these losses, but they did not understand the founding principles that led to our original, early and rapid success. We had unwittingly added professionals who did nothing but extract value from the company. They did not do what they were supposed to do, which was run the business better. They were basically bureaucrats.

We went into crisis mode—a short crisis mode that lasted a couple of years—I had to rethink how I was running the business, even as I was extremely busy from day to day. I ran the business on Sunday evenings because I worked Monday through Saturday.

There was something going on that I couldn't understand. I had started the business and made it very successful and very large, with very happy employees and very happy patients. Then, as

we grew, I had added more providers, I had added professional managers, and I had added staff, but still, our financial success was going off a cliff.

The amount we spent on wages relative to our income from sales was terrible. We were spending all kinds of money on marketing efforts and trying to bring in more business, but we weren't delivering good financial results. That said, we were certainly good at practicing medicine! We didn't have problems with patient satisfaction, we didn't have long wait times, and we had a very low complication rate. But I discovered that when most customers came in wanting our services, we simply didn't deliver those services. We were losing business without realizing it.

There Are Only Three Fundamental Ways to Grow a Business

Jay Abraham, a successful business coach, sums it up this way: to grow a business—no matter what kind of business it is—there are only three things to consider:

1. Increase the number of new customers.

2. Increase the size of your sales.

3. Increase repeat buying.

I was only focusing on the first one. At that time, we were not performing well at delivering services to customers or getting repeat buyers, but I had increased our marketing budget substantially, taking it from less than 2 percent of our gross sales up to about 10 percent. I was driving more customers into a broken system.

Then I started looking at the other two ways to grow a business. I discovered that, in the early years, when we were new and I didn't have a lot of money to spend on advertising, I had focused mostly on delivering results to customers, getting them to commit to treatment, and getting them to request repeat treatments or to go on to other service lines in our business.

As I hired other staff members, however, they didn't understand the founding mentality that had led us to success in the first place. They were coming to work and trying to do a great job, but they just didn't understand what it took to create a great business. (This dilemma is described well in *The Founder's Mentality*, by Chris Zook and James Allen.)

Predictable Success

We had wild success early on, creating happy customers, a happy owner, happy staff, and a happy community. But then we assumed that we could keep growing without putting in place a process for achieving success.

In his book *Predictable Success*, Les McKeown describes the stages we went through, arguing that success without a process is not repeatable. He explains that when businesses start out, they have some initial struggles. This is when most businesses fail. For those that persist, however, next comes a period that he calls the "fun" period, when there is significant profit. The founder has found something magical that has created success.

The next step that McKeown describes is what he calls "whitewater." That's when the early, "fun" success lacks a process; eventually, if there is growth, the business falls into turbulent times.

This is seen in loss of profitability—losing money even while making substantial sales—which is exactly where we ended up. This stage only happens to growth-oriented companies, as most businesses like to stay within the smaller, safer stage of "fun."

Around this time, too, I faced a health scare where I thought I might die. By then, the business had become very large, with about 150 employees. I was mentally checked out because I was working like crazy trying to produce enough money to cover the losses created by other business locations and divisions. I didn't have the time or energy to learn a new skill, namely, running a business.

But when the CFO asked me for a personal loan to cover our company losses during a year when our business had grown by $8 million in sales, I realized my job no longer included trying to run faster to cover up my own mistakes and shortcomings as a less-than-ideal business leader. And it turned out that the health scare, although serious, wasn't going to kill me. I could overcome that, too.

Next Steps

The next steps included years spent studying the best business practices of other companies, not necessarily just ones in our industry. I also started reading one to two business books every week and attending business seminars monthly. I hired business coaches and joined mastermind groups to understand how to run a business. I substantially reduced the time I spent in the operating room and practicing medicine and spent more time working on the business rather than in it.

The operating system we built was developed over a couple of years and we continue to develop it today. At the time of this writing, I've been focusing on the seven switches I'm about to describe, but I'm also looking at eighth and ninth switches, switches that I haven't quite figured out how to measure or maximize yet. But we will—so stay tuned.

The Seven Switches

Identifying the seven switches that make our business successful necessitated looking back at what founding principles had made us successful in the first place. After we defined those, we built a repeatable process to monitor, measure, and execute each crucial aspect of the business. Some people call the switches "KPIs," or key performance indicators. I call them "switches" because when we turn them on, things happen, and when they are left off, we are in the dark and things get stagnant.

"I call them "switches" because when we turn them on, things happen, and when they are left off, we are in the dark and things get stagnant."

We trained a team of people to keep the seven switches visible, and we also trained our entire staff on the importance of each of the seven switches and their processes. This has led to great success.

In his book *The Great Game of Business* (a great read!), Jack Stack talks about the importance of the entire staff knowing the critical numbers, or KPIs. Brad Hams explains it even better in his book,

Ownership Thinking: How to End Entitlement and Create a Culture of Accountability, Purpose, and Profit.

Our staff has an ownership thinking mindset. They understand the workings of our business and participate in its success strategically, practically, and by being more productive, which also increases their own income.

Success didn't happen overnight, but it happened quickly. As we implemented each of the seven switches, we went from losing money to a profit margin that more than doubles our industry's standard. And we're able to pay staff significantly more than our competitors can! The next goal we're working toward is to accomplish all of this (doubled profits, higher pay) while working fewer production hours.

CHAPTER 2

IS IT TIME TO GET VALUE OUT OF YOUR PRACTICE?

There are many reasons why physicians consider selling their practice. One reason is to get "the big check" to do something else, such as start a totally separate business, do a different type of investing, assure capital for retirement, or just safely extract value from what you've created to protect yourself from future unknowns.

It's Really a Good Time to Think About Selling

Right now is actually a good time for physicians to consider extracting value from their practice. There are many reasons for this, but most notably, there's a tremendous amount of available money looking for a home. Banks are loaning money at very low interest rates, hundreds of billions of dollars lie unspent in private equity funds, and the supply of money is very strong.

In our industry, we are seeing private equity firms purchasing medical practices.

As a side note: In most states, non-physicians cannot own a medical practice or employ doctors (with the exception of nonprofit hospitals in some states). I won't get into details, but because of this, private equity firms form something called a management services organization, or MSO. In this scenario, the medical practice itself is owned by physicians and medical

providers, and the business is owned by the non-physician MSO. Enough money is left in the medical practice to pay the salaries of the physicians and mid-level employees, and everything else flows into the MSO. This model allows businesses to comply with the corporate practice of medicine (CPOM) doctrines of most states. There are various regulations and legal considerations involved in this route, such as the Stark Laws, the CPOM doctrines, and other legal hurdles that I will not discuss here, as the subject is well outside of the scope of this book. If you are considering selling your medical practice, it is important that you have an attorney who is well-versed in these subjects.

Getting Back to the Money

As I write this book in 2018, there is over $850 billion of what is called "dry powder," which means $850 billion that has not yet been spent under the control of private equity firms. The managers of these private equity firms do not earn a commission until they spend that money. They are looking at healthcare because it's considered a stable business model and is expected to continue to grow, despite the challenges we currently face with respect to healthcare funding.

This has led to an unusual opportunity to extract maximum value out of the practice you've built. Because there's so much capital that needs to be invested and healthcare is an attractive business model—and because newly minted graduating residents are not interested in owning their own businesses nor in buying yours—physicians can get a substantial amount of money by selling their business now.

To be clear, our business is owned by a doctor—me—without any private equity influence.

I'm going to talk about something that you probably think about but are unable to implement because you're so busy taking care of patients and running your business.

Very likely, there's tremendous potential in your existing business that a private equity firm just can't see because they are only looking at the numbers.

You may have a strong sense of what your practice could become if the right tools were put in place or the right people could help you, but because you're working all the time—seeing patients and trying to deliver the best care possible—your efforts have been mostly patient-focused rather than business-focused. But let's look at the successful principles or "switches" that we have discovered and how we discovered them. We use these seven fundamental switches to run our business, and you can, too.

The Allure Operating System

The seven switches are KPIs, but they're more than just standard KPIs. The switches are data points, which—if you measure and focus on them—can leverage a business to a higher value.

A key component of each of the seven switches is that by

> "A key component of each of the seven switches is that by turning it on, not only can you save time and avoid wasted effort and wasted money, but it can allow you to earn more money and create more value. It also saves healthcare dollars."

turning it on, not only can you save time and avoid wasted effort and wasted money, but it can allow you to earn *more* money and create *more* value. It also saves healthcare dollars. When optimized, the seven switches can substantially increase the production of an existing business while saving the physician time. Saying that you can increase production while saving time sounds counterintuitive, I know, but it is possible.

To learn more about how to make more money while saving healthcare dollars, I refer you to my Abundant Economy book series. In the series, I discuss the details of how we, as physicians, can save healthcare dollars while ethically making a lot of money. In a nutshell, we can create more value and be reimbursed for it, rather than getting paid to do things that create very little value.

"The beauty of having multiple switches rather than just one or two is that the switches can be thought of in terms of compounding interest: the first switch leads to more opportunity for the second switch, which leads to more opportunity for the third switch, and so on."

The Seven Switches

The seven switches can be applied to your business. They are all about optimizing your efforts and eliminating waste. Though you may already be optimized in one or some of these areas, we have not found any other medical practices that have applied all seven switches effectively.

The beauty of having multiple switches rather than just one or two is that

the switches can be thought of in terms of compounding interest: the first switch leads to more opportunity for the second switch, which leads to more opportunity for the third switch and so on.

"We've applied the seven switches to our own business and have seen a 500 percent growth in production at struggling locations in just a few months."

If we increase each one of the switches' effectiveness by just 10 percent, we basically double the production of the practice. If we increase each of the seven switches by 25 percent, we increase the production of the practice by almost 500 percent. That is the beauty of compounding—each of the seven switches compounds into the next switch.

We've applied the seven switches to our own business and have seen a 500 percent growth in production at struggling locations in just a few months. We have also applied the same seven switches to other businesses and have seen similar growth.

A big question on your mind may be, "What is my practice worth?" Before we go on to the seven switches, we'll talk about how the value of your business is calculated.

CHAPTER 3

WHAT IS MY PRACTICE WORTH?

This can quite literally be the million-dollar question. The physician selling the practice wants to get maximum value from it and the company acquiring the business doesn't want to pay anything more than what they think the business is worth. So, an agreement must be reached.

There are a few types of acquisitions. There are also various reasons why a physician may want to sell their practice: It could because of imminent or future retirement. The physician owner may want to recapture the value that has accumulated in the practice, which may be the physician's largest asset. A physician who realizes that medicine is getting more and more complex with each passing year may want to be relieved of management

complexities while still practicing medicine.

In the first part of this chapter, I'll describe the standard types of practice acquisitions. Then I'll explain the hidden value in your practice, the value that you may have created that private equity companies comprised of people who are non-physicians and are inexperienced with the industry (e.g., Wall Street-type businesspeople) cannot see, even though that value is right in front of their eyes.

I'm not going to talk about hospitals purchasing medical practices, as this is outside my area of expertise. Hospitals are interested in businesses that increase utilization of costly and inefficient hospital services, a practice that is not aligned with the direction of our business.

Simple Acquisitions

One example of a simple acquisition would be a physician who is retiring and wants to sell their practice to another physician. In this case, the retiring physician may have been winding down the practice and probably has not been putting much money into the business in terms of giving raises and investing in upgraded facilities and technology. Still, another physician might buy out the retiring physician's practice and operate it as their primary location. Decades ago, this was quite common. It's not very common nowadays, though, as most newly minted physicians do not have the resources to buy a new practice and carry it along for months until they are paid by third-party payers. And that's not even considering the complexities of starting from scratch and dealing with healthcare and employment regulations.

Another example of a simple acquisition is when one physician retires and another physician buys their practice to add as a second location. This is more common, since physicians who are looking to expand in their own region generally have some financial resources and can carry the load of a second practice.

Simple acquisitions typically do not create a lot of value. They are common when a practice is generating just enough income to pay a reasonable salary, or if the retiring physician has a relationship with the purchasing physician.

In simple acquisitions, there is usually an asset purchase, meaning that the physicians will agree upon the value of the accounts received and that of the furniture, equipment, and other tangible (i.e., physical or quantifiable) assets.

Business Acquisitions

Business acquisitions may create more value. They occur when a physician wants to extract significant value from what they have built and when the acquiring company prefers to purchase an existing business with known variables, rather than starting from scratch in a new location.

In business acquisitions, there's a purchase of tangible assets as well as intangible assets. The latter includes goodwill, patient lists, the practice's name and brand, and other nonphysical items. Business acquisitions generally create more value than a simple acquisition does.

To calculate the value of a practice, take into consideration its profit, growth trajectory, reputation, and the overall financial

health of the practice.

How is the Profit Calculated?

The profit is generally considered to be the money left over after the cost of a reasonable salary for the physician owner.

Here is an example: A physician's practice generates total sales of $1 million. The expenses related to running the practice are $550,000. The physician takes home the difference of $450,000. Though he may consider this to be the practice's profit, it is not actually profit, as a big part of that sum would be typical compensation. If it would cost $300,000 to employ a physician within that specialty who operates in a similar fashion, then the profit left over is $150,000. That $150,000 would be the basis of negotiations.

EBITDA

A profit and loss (P&L) statement generally has two categories of expenses: direct costs (or cost of goods sold, COGS) and sales, general, and administrative costs (SG&A). But other expenses may also need to be considered, namely interest, taxes, depreciation, and amortization. EBITDA stands for earnings before interest, taxes, depreciation, and amortization.

For this discussion, we will use the words "profit" and "EBITDA" interchangeably, even though in the final negotiations, only "EBITDA" would be used in documentation and final valuation.

So…How Much is My Practice Worth?

Assuming the practice has a profit beyond the reasonable salary for a physician, several factors are considered.

- Is the practice growing or contracting?
- Is the practice running at optimum business efficiency?
- Is the practice in a desirable area based on the needs of the acquiring company?
- How big is the practice?
- What are the trends in the industry?
- What have other similar practices sold for?
- What are the plans for the practicing physician (e.g. staying on board for several years vs. exiting the business)?

Once all these things are considered, a multiple of the profit is generally considered to be the purchase valuation.

What do These Large, Well-Funded Businesses Typically Want?

To many companies, it's all about the multiple: they typically buy businesses at three to five times the value of the profit (EBITDA). Businesses with a profit of less than $5 million don't reach the radar of new startup private equity money, so medical practices that are owned by private equity companies generally acquire one large practice and then perform a "roll-up merger," putting together several smaller companies to create a larger conglomerate.

This roll-up strategy creates wealth for the private equity firm on a mathematical basis.

Private equity funds purchase several small practices at three to five times the multiple of profit, and when the collective profit of their own roll-up of practices exceeds $10 million, this new conglomerate becomes an attractive target for a larger private equity-backed firm.

At this point, they may have an evaluation of six to eight times the multiple of profit. They generate wealth, in this case, by being able to sell the combination of the practices to a bigger fish. So, after buying them at three to five times the multiple of profit, they sell them at six to eight times the multiple. The big-fish company that swallowed the midsize company at a rate of six to eight times the multiple combines it with other businesses it has bought and eventually puts the entire package up for sale at ten to fifteen times the multiple.

These larger companies also gain value by combining resources, such as billing, purchasing of supplies, and consolidation of managing services.

But the real value to the private equity companies (who generally want to hold the business for three to seven years) is to create short-term profits so they can capitalize on the multiple of the aggregate of profits (hence selling for up to fifteen times the profit and getting a windfall).

In a Market Watch story published the week I am writing this, the headline reads, "Medical Practices Have Become a Hot Investment—*Are Profits Being Put Ahead of Patients?*" In the article, the writer exposes the pressure that these profit-driven companies may put on doctors to choose short-term profit-

generating options, even though most state laws forbid businesses from doing so.

This is how businesspeople make money from medical practices. They make money without creating true value. I am not suggesting that you stay away from private equity-backed businesses, but you should be aware of their intent.

Is There a Better Way?

So, if private equity companies and Wall Street investors want to make money by combining a bunch of small businesses, can a physician gain value out of their own practice without being involved in this type of pyramid pricing?

It turns out there is, indeed, a way.
At Allure, we look for the hidden value in a medical practice. The fact of the matter is, you know what you know, you should know some of what you don't know and, quite frankly, you can't know some of the unknowns.

As previously mentioned, we have discovered seven basic "switches," or what many people call key performance indicators (KPIs), that can be measured and optimized within your existing business to make it substantially more valuable. I'll explain to you how we discovered the switches, how we applied them to our business when we were on the rocks, and how we created enormous success. We have also been able to apply the switches to businesses that we have acquired, which has created an abundance of value for both the buyer and the seller.

CHAPTER 4

HOW DO WE CALCULATE FUTURE PROFITS?

When we evaluate a practice's profit and loss (P&L) sheet, I separate out variable costs and fixed costs. Variable costs refer to expenses that may change based on relative production. If more procedures are done, for example, then the variable costs go up; if fewer procedures are done, the variable costs go down. We can also think of this as COGS, or cost of goods sold.

Fixed costs include expenses that you have to pay no matter what, regardless of how much business takes place. Obviously, you can adjust fixed costs by laying people off or decreasing marketing efforts or not paying bills. When making mathematical projections, though, we just calculate based on prior fixed costs. We assume things like wages and benefits are fixed (with the exception of bonuses, which are variable), marketing costs are fixed, your rent is fixed, and the cost of maintaining your computers and administrative tools is fixed.

There are other factors called "gross" and "net" profit, but these are geared more toward manufacturing or retail businesses, so I'm going to talk instead about the break-even point and contribution margin.

Break-Even Point

The break-even point is the point within a period of time—let's say a month—at which all the fixed costs are covered and the variable costs related to the production that's already occurred are covered. After the break-even point, the fixed costs are already paid for. They won't go up. After hitting the break-even point for that month, the variable expenses continue to rise, though, because as you treat more patients, you use more medical supplies or catheters or one-time use devices.

Contribution Margin

Contribution margin is the margin that occurs after the break-even point is achieved. It is basically variable costs subtracted from total sales. This margin is 75–90 percent in most medical practices that are similar to ours. The actual profit may be an average of 12 percent in large medical practices, but the contribution margin is much higher. Once the break-even point is reached, profit grows rapidly as all of the fixed costs have been paid for.

These break-even point and contribution margin tools are very useful when projecting future profitability.

In the book *Warren Buffett and the Interpretation of Financial Statements*, Mary Buffett and David Clark explain how Warren Buffett uses very simple financial fundamentals to predict winners in business. I'm not comparing our interpretation of company financials to what Warren Buffett undertakes, but the book explains some basic concepts can be used reliably when making predictions.

I have found that if I consider the contribution margin after the break-even point, I can accurately predict future profits. That said, there are many variables I need to consider beyond just these two metrics. But I would like to describe how I calculate these, because I use this information to help decide if a business is likely to be a financial winner and by how much.

In the following table, I use a fictitious medical practice with a known number of new patients annually and a known production. In this case, the practice generated $1.2 million in sales while only getting 30 percent of patients who came in for a consultation into

Call Center Effectiveness	$ -		0	Increased 25%	500
New Patients	400	New Patients	400	New Patients	500
Conversion Rate	30%	Conversion Rate	50%	Conversion Rate	50%
Ugly Leg Complete	$10,000	Ugly Leg Complet	$10,000	Ugly Leg Complet	$10,000
Expected Collections	$1,200,000.00	Expected Collecti	$ 2,000,000.00	Expected Collecti	$2,500,000.00
Collections	$1,200,000.00	Collections	$ 2,000,000.00	Collections	$2,500,000.00
Expenses		Expenses		Expenses	
Physician Wage	$ 350,000.00	Physician Wage	$ 350,000.00	Physician Wage	$ 350,000.00
Staff Wages	$ 280,000.00	Staff Wages	$ 340,000.00	Staff Wages	$ 400,000.00
Payroll costs	$ 55,000.00	Payroll costs	$ 55,000.00	Payroll costs	$ 55,000.00
Bank charge	$ 15,000.00	Bank charge	$ 15,000.00	Bank charge	$ 15,000.00
Equipment lease	$ 25,000.00	Equipment lease	$ 25,000.00	Equipment lease	$ 25,000.00
Insurance	$ 15,000.00	Insurance	$ 15,000.00	Insurance	$ 15,000.00
Legal	$ 15,000.00	Legal	$ 15,000.00	Legal	$ 15,000.00
Liscence	$ 1,500.00	Liscence	$ 1,500.00	Liscence	$ 1,500.00
Marketing	$ 35,000.00	Marketing	$ 35,000.00	Marketing	$ 35,000.00
Office Supplies	$ 16,000.00	Office Supplies	$ 16,000.00	Office Supplies	$ 16,000.00
Rent	$ 60,000.00	Rent	$ 60,000.00	Rent	$ 60,000.00
Repair and Maint	$ 12,000.00	Repair and Maint	$ 12,000.00	Repair and Maint	$ 12,000.00
Telephone	$ 8,000.00	Telephone	$ 8,000.00	Telephone	$ 8,000.00
Travel/CME	$ 15,000.00	Travel/CME	$ 15,000.00	Travel/CME	$ 15,000.00
Utility	$ 6,000.00	Utility	$ 6,000.00	Utility	$ 6,000.00
Medical Supplies	$ 240,000.00	Medical Supplies	$ 400,000.00	Medical Supplies	$ 500,000.00
Total Expenses	$1,148,500.00	Total Expenses	$ 1,368,500.00	Total Expenses	$1,528,500.00
Profit	$ 51,500.00	Profit	$ 631,500.00	Profit	$ 971,500.00
Break Even Point=					
Fixed Costs/(1-Variable Costs)	$1,135,625.00				
Contribution Margin=					
1-Variable Costs/Sales	80%				

production. While these numbers are made up, they are common numbers for a single-physician practice.

In the first column, I entered the actual profit and loss and highlighted the numbers I want you to look at more carefully, showing you what would happen if we applied the switches that lead to more patients getting into production (that is, getting treatment versus being turned away).

The table then shows what would happen if we increase the effectiveness of the call center by 25 percent. In the chapter regarding the switches to implement in a call center, a 25 percent improvement is very achievable—in fact, it's a very conservative figure.

That's a busy table. I did it in Excel and included less detail than I would if I were truly evaluating a business. The "ugly legs complete" is the anticipated revenue of a CEAP 4-6 individual with full treatment, both legs.

I set the variable costs at 20 percent, which assumes that for every dollar brought in, 20 percent goes to cover the cost of fibers, catheters, gloves, and other medical supplies. In your own practice, the variable cost may be higher or lower.

The first column shows that the fictitious practice has a $51,000 profit (which doesn't include the physician's wage of $350,000).

The subsequent column shows what would happen if they got more of their consults into production, and the third column shows what could potentially happen if they closed more leads on the

phone. In establishing this fictitious practice, I assumed that as the practice grew in sales, they would need more front-line staff, which of course means the fixed costs would rise.

The table also shows the power of adjusting these two switches: you can go from a profit of $51,000 to a profit of almost $1 million while spending twice as much on medical supplies and having the budget to afford more employees—all without increasing marketing expenses.

In the following chapters, not only will I show you the steps you can take to make this happen, I'll also show that this is just the beginning. We've taken this approach repeatedly with our business and have seen great success.

Even if you are already profitable, when you identify your break-even point and understand your contribution margin, making minor tweaks can make your business wildly profitable.

CHAPTER 5

BUILDING BLOCKS

The Building Blocks of a Business

When a business starts out, the founder of the business—whether a carpenter, a plumber, an accountant, a financial advisor, a cook-turned-restaurant-owner or, in this case, a doctor—is responsible for everything and has a basic understanding of what they want and where they expect the company to go. But mostly, at this point, the founder is producing business through their own production.

Things like the core values of the business, its culture, and its purpose are all in the founder's head. And even though the founder may not have written down these attributes or expressly shared them, the team inherently knows these aspects because they live in them. The strategy of the business, who the core customers are, what the business delivers—all of this is obvious to the founder and clear to the initial employees. As the business scales up, however, these aspects become murky and less clear.

Eventually, then, there is a need to clearly communicate these principles to the overall organization.

Core Values

We developed our five core values at a moderated, off-site meeting. Team members who had been with the company for a long time were able to identify the values that made our business tick. Our employees are required to know and demonstrate these

values in order to stay employed with the business; if we must, we are willing to lose money to protect these values.

Our core values are not a secret; we publish them online and proudly display them for all to see. They are part of our Vivid Vision that we invite you to read.

"We have a Vivid Vision, which is a three-year vision that we share with our staff and our vendors."

Scan this QR Code to view our Vivid Vision or visit allu.md/vision

Goals

Any business should think about having quarterly, annual, and even three- and five-year goals. Even if the business is not trying to scale or grow, goals should be identified so that external forces do not sneak up and cause the business to collapse.

Every month, our leadership team attends an off-site meeting where we put together and review quarterly goals. This meeting is moderated by a coach to help us stay on track. Every year, we have a two-day off-site meeting with the same team to make plans for the next year and to map out our three- and five-year goals.

(Note: For moderated meetings, I suggest you look at Verne Harnish's Gazelles or Gino Wickman's EOS. Both have independent contractors in your area whom you can hire to help you with this structure. We use Dale Meador of Petra Coach, who currently follows Gazelles. Before that, we used Mike Goldman with Performance Breakthrough. He was our first leadership coach, and he was amazing. It is common to outgrow your coach, so don't be afraid to change from time to time.)

Different businesses have different goals. Ours certainly include financial aspects, such as targeted revenue, profitability, number of patients, NPS score (both for our patients and our employees), number of locations, and other key metrics. We also have a BHAG, or—as coined by author Jim Collins—a Big Hairy Audacious Goal. A BHAG is a goal that is years away and has a reasonable chance of success but would seem impossible to most people. I'm not going to tell you what our BHAG is yet (because, after all, we don't know each other that well), but I will say that it has to do with how our company can participate in saving and sustaining healthcare.

Strategy

We used a process defined in *The Inside Advantage*, by Robert Bloom, to document our strategy. Basically, it is helpful to identify "who" your core customer is. It's not necessarily about age, economic status, demographic, or sex, but more about the type of customer you are serving. Another strategic step is answering the "what?": What is your uncommon offering that causes customers to seek out your business? The last part of the strategy is identifying the "how?": How do you deliver the "what" to the "who"?

Purpose

Every business has a purpose. Even if you don't know what it is, it's there. The purpose of some businesses is to make money. The purpose of other businesses may be to save a certain species of animal, or to create jobs in an impoverished area, or to deliver a unique customer experience. It takes a while, but spending time thinking about the purpose of your business can be helpful when it comes to making decisions regarding other opportunities.

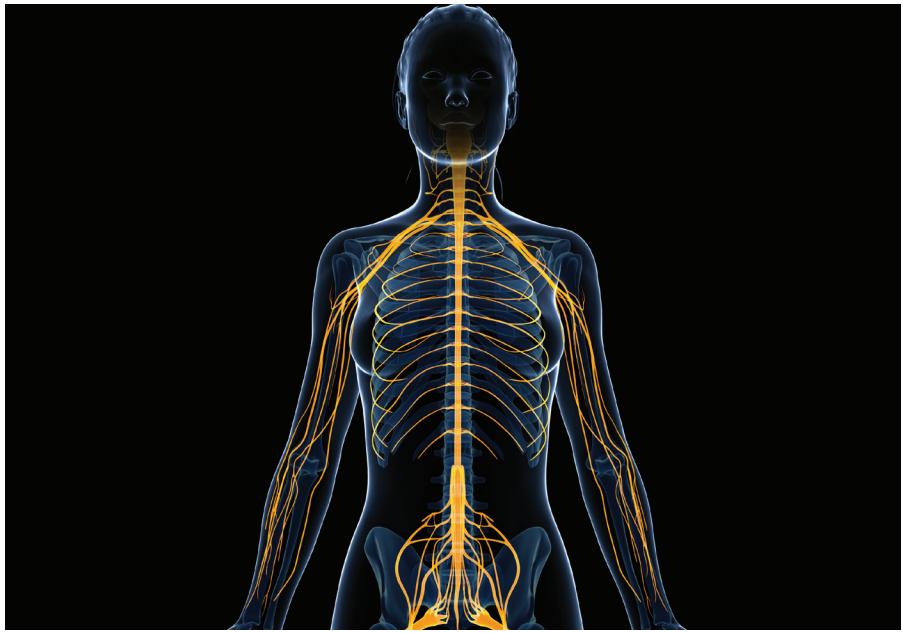
To me, the purpose of our business is very clear. Having identified the purpose, written it down, and shared it with our team makes it very easy for us to make decisions, as we can determine whether a given opportunity will have a positive or negative effect on our purpose. Some of the opportunities that come our way sound great, but if they don't serve the purpose of our business, we pass on them. Some opportunities may be very difficult to manage and may require considerable resources without guaranteed success, but if they can help us fulfill our purpose, we may choose to pursue them anyway.

CHAPTER 6

THE CONNECTED ORGANISM

When the organization grew, we developed multiple locations. We found that it's very difficult for the leadership team to communicate effectively to the front-line employees, and when we surveyed our staff, we found that this was their biggest area of discontent. They just didn't know what was going on, where the company was going, or what we expected of them.

That's when we started thinking of our business as an organism rather than an organization.



An organism has a neural network, a thinking part of the complex organism that is able to carry out complicated and intentional thoughts. It can create strategy, look for new opportunities, sense danger, and steer the organism in the right direction based on input from the rest of the neural network.

Then there are parts of the neural network that we call the limbic system. These allow you, as a human organism, to drive a car to work without consciously thinking about all the activities that are going on. When our limbic system is driving the car while our cortex is planning the day's activities, we often think, "Did I go through that light?". Our limbic system—that is, our habits and our programmed responses—are able to drive the car safely to work without a lot of direction from our cortex.

Then we have our primitive brain that controls our breathing, heart rate, and temperature. It doesn't require direction from our cortex—it just takes care of things. Our spinal reflexes allow us to jump back the second our finger touches a hot stove. Our cortex may tell us to turn the stove off and make sure nothing is burning, but the signal from the burnt finger that causes a corrective motion doesn't have to go that far up the neural network before the finger moves.

We realized that we needed a way for our entire organization to function in a way similar to how the neural network of the human organism functions. Our business is complex and has many things going on, from general operations to developing new business. Having a leadership team (i.e., the cortex) that didn't communicate to the rest of the neural network just wasn't working.

This led to the development of our meeting rhythms.

The Meeting Rhythm

We developed the meeting rhythm that Verne Harnish describes in his famous book Scaling Up: *Mastering the Rockefeller Habits 2.0* and which also appears in Gino Wickman's Traction.

The Morning Huddle

The morning huddle lasts about ten minutes and is done standing up, as we go over a few things. (At the Ritz Carlton, they famously call it the "morning lineup.") We briefly talk about wins from the day or week before. We discuss what is going on for the current day. We review what obstacles may be in our way and we talk about the numbers. The numbers vary from team to team. For the dermatology team, for example, it is the day's scheduled production. For the training team, it may be how many trainings will take place that day.

It's a standing meeting to ensure that it won't go on very long. At this meeting, we don't try to solve problems—we just address them, knowing that they can be taken off-line after the meeting. We start with the wins to put us in the right frame of mind.

It took us some time to make the morning huddle a routine. People thought that since they were working with each other all day, there was no reason to have a morning huddle because they could communicate goings-on throughout the day. But having a simple morning huddle ensured that everybody was on the same page, or "rowing in the same direction," for the rest of the day. Obstacles that were apparent to one person were likely not apparent to someone else, and that someone else just might be

able to solve the problem. With the morning huddle, issues could be addressed immediately and everybody was aware of what was going on.

The morning huddle is done by individual teams. Everybody is supposed to be in a huddle every day. Although we don't do it perfectly, most people have a huddle every day. The teams are anywhere from two people to about fifteen people.

The Weekly All-Staff Huddle

Every week, we do a video conference huddle. It's sitting, not standing, and it takes about twenty minutes. Any team can submit a request to discuss a topic during this huddle. The requester could be someone from billing, finance, general operations, training, human resources, leadership—you name it. This weekly huddle starts out with the Founder's Focus, which is a brief discussion of the founding principles of our business, clarifying those principles so that everybody understands what they are.

We then discuss various issues and try to wrap up the meeting at about the twenty-minute mark. I like to think of this brief weekly all-staff meeting as a "heads-up," since there is not a lot of opportunity for discussion. This leads to the next aspect of the neural network connection.

The Weekly Status Meeting

We follow a process described in *The 4 Disciplines of Execution*, by Sean Covey and others. We call ours a WIG (wildly important goal) meeting.

In this weekly meeting, we break up by department and each

group goes over their goal. The goal can be anything, but it must be wildly important, and it has to align with the wildly important goal of the organization.

Examples of wildly important goals might be, for the call center, maximizing the number of calls that turn into appointments, or for an office struggling with patient satisfaction, improving their NPS (net promoter score).

Along with the WIG meeting, we hold a short status meeting where the team can decide on issues that need to be discussed. They either solve them that week or assign accountability members to bring more information to the team during the following week's status meeting.

Weekly Leadership Meeting

In this meeting, various leaders get together and identify company wins, follow up on previous accountabilities, and identify issues that need to be discussed and resolved. We have a timekeeper and a meeting moderator to keep the meeting on pace. In his book *Meetings Suck*, business coach Cameron Herold discusses the importance of keeping meetings on a defined schedule, starting on time, and finishing early. Meetings also must have an agenda—otherwise, they suck. "No agenda, no attenda," says Herold.

Quarterly Off-Site All-Staff Meeting

The quarterly off-site all-staff meeting is very important to us. We obviously have to block out a day's production for it and because we have multiple offices in multiple states, people participate by video as well as in person. We may have a guest speaker

teaching us principles of business, or we may do some training. We try to clearly communicate the vision and the future of our business.

CHAPTER 7

THE SEVEN SWITCHES OF THE ALLURE OPERATING SYSTEM

The switches may be considered KPIs, but I think of them as switches, because they can be turned on or off. Each switch involves a process that, if followed, turns a switch on and grows the business or sheds light on a problem that can be fixed. If the process isn't followed, the switch turns off, leaving us in the dark, where things get stagnant and don't grow.

A switch in the "on" position leads to growth in business, increased production, profitability, customer satisfaction and deceased waste.

A switch in the "off" position leaves things at status quo, which may be successful or mediocre. In that sense, a switch that is turned off just represents lack of optimization—it's not really a negative, it's just not as good as it could be.

The switches can also be thought of as the lifecycle of a patient.

Each of the seven switches has the ability to compound. As discussed earlier, increasing each switch by 10 percent will double production. Increasing the effectiveness of each switch by 25 percent will increase production by 500 percent (or five times).

We identified the switches by looking at the success of our early years, writing down the things we did to create that success and then creating a process for each of the switches. In the early days, when the business was just me and a small team of employees, we didn't need a clearly stated process because I knew the process and communicated it. Everybody essentially understood it. But as we grew and the switches didn't yet formally exist, we no longer had the same success.

I was caught off-guard by the need to create formal processes that would allow us to be repeatedly successful and when I took the test that follows, I found out why: I have a processor score of 0, meaning that I don't really think in those terms. Fortunately, I work with people who have strong processor scores!

Find your success scores here.

Scan this QR Code to test yourself or visit allu.md/success

The first time we employed the switches was when we started to substantially expand the business. As we grew from two to five locations, we found that our performance in regard to each unit of measure was different.

For example, as we discussed earlier, one way to grow business is to increase the number of new patients or new customers. If new patients do not advance beyond the consultation, however, there is no production. If patients don't get put in production, there is no chance of repeat business and it's also very unlikely that they will refer anybody to you because they didn't get any farther than a consult.

To address this, we came up with a metric we called "revenue per new patient" or $/NP. In my book series *Abundant Economy*, I explain how for every dollar we make in non-cosmetic medicine, we save healthcare dollars. That means we can ethically and happily make $/NP and simultaneously participate in saving healthcare dollars. (For some of our service lines, for every $1 we earn, we save insurance companies $20.)

Case History

Though we had been successful with location number one, we were a little less successful with location number two, and even less successful with location number 3. Our fourth and fifth locations received very little attention from the founder, namely me, and they were not successful at all—in fact, they were hemorrhaging money.

Location number one remained wildly successful and wound up carrying all the other locations. But by the time we got to the fourth and fifth locations, the additional locations were losing so much money that the primary location could no longer support them. The business was in trouble!

So, I started looking at revenue per new patient at each of the locations. The first location had the highest revenue per new patient, and the last location—that is, the newest one—had the lowest revenue per new patient. And the rest of the locations fell along the same line: as we opened more places, each location had a lower per-patient revenue than the one before. The primary location was five times as effective at creating value as the fifth location.

I then realized how to create enormous value: what would happen if I took the newer locations and taught them how to perform as well as the first location? This is what we set out to do. Identifying the seven switches did not occur overnight; rather, we found one at a time. Some of them were things that we were already kind of working on, and some of them we didn't even know about until we started measuring them and investigating the weaknesses in our business.

Putting the Switches into Place

By the time we identified most of the seven switches, we were able to simultaneously put them into place at each of our offices. We developed a meeting rhythm (as described above) to do exactly that.

Within three months, all the locations had approximately the same revenue per new patient. Amazingly, in just a few months, the poorest-performing location's production quintupled and was equal to the mature, successful, long-standing location's production! Needless to say, this led to happy patients, happy staff and wild profitability.

Applying Seven Switches to Other Businesses in Other States

When we started acquiring other businesses, we used the same concepts: initiating meeting rhythms, identifying core values and purpose, and functioning like a human neural network when it came to communication.

The first business we acquired was by all measures successful: they had a good volume of new patients and we're very profitable (and are still doing a great job to this day). Our training team and business development team worked with the newly acquired practice and helped them apply the seven switches as well as implement our meeting rhythms and the entire company's core values.

After the acquisition, we retained all the employees and even had to add more. We were able to invest capital into the business to add new equipment, update the building, and enhance the supplies. We taught them how to be successful while working fewer hours and making more money.

By the third month after joining our team, the already-successful business had increased their sales by 500 percent.

It was astonishing that were able to do this just by applying the seven switches; we didn't add to the marketing or advertising budget or use any external factors to increase their production. By the third month, we were so busy that we had to start looking for a new location with more rooms.

All this growth occurred in a very short time, with the same core staff and the addition of a couple more team members. The practice's reputation grew too, which could be seen in the customer reviews and the net promoter score (NPS). We have repeated this method and have found that it is successful when we pick the right practice to work with.

We use a handful of measures to determine which practices will be a good fit. I won't discuss them in full since they change all the time, but briefly, the practice needs to be ethical, it needs to be adaptable and it needs to desire growth. The practice must have the desire to bring abundance to their community. If they are just trying to make more money, we are not interested. We're happy to make more money, sure—and to help them do the same—but we only want to do that if all the stakeholders benefit, including the patients and the healthcare system. So not every practice is going to be a good candidate for us.

CHAPTER 8

SWITCH 1
LEAD GENERATION

Lead generation involves causing potential patients to make a call, fill out an online form, or inquire about services. A common lead generator is word-of-mouth, either by way of another patient or a referring doctor. Lead generation can also result from direct marketing, which can include rented media, like advertising, or your own media, such as your website, publications, or newsletters.

Word-of-Mouth and Physician Referral Lead Acquisition

It is important to control the dialogue, because if you don't, the dialogue will control you. We carefully monitor our online

reputation and address it when there is an issue. Each team member is aware of our reviews every single week. We discuss them at our weekly all-staff huddle. If there's a negative review, we immediately address it and try to fix it. In some cases, the review winds up being modified by the individual; in other instances, we just did a bad job in customer service and will try not to repeat our mistake. The mistake could be making someone wait, messing up their fees, or confusing them when discussing treatment.

When I started looking at our online reputation, I didn't think it would blossom the way it has, but because we started controlling it early on, we have more than ten times the number of reviews of our nearest competitor in our market. And we have a thousand times more reviews than most of the practices in our city. This is because our employees conscientiously talk to our customers and ask for reviews. When an employee gets a good review that includes their name, we share the review with everybody and celebrate. This gives employees the motivation to ask for more reviews.

Physician Referrals

Some practices rely heavily on physician referrals, while other practices receive very few. If you google "How do I get more physician referrals?" you will see that the answer is, essentially, "Communicate with the physicians." So, we send letters not only to referring physicians, but to all our patients' physicians, even if the patient wasn't referred. The letters are somewhat automated and are generated by our electronic medical records. We also have physician liaisons who communicate with the physicians directly, and we do some seminars and training for physicians as well, which also helps us get referrals.

When a physician reports that a patient had a bad experience, we immediately do damage control and try to rectify the situation. Bad things happen, yes, and everybody understands that the patient may have been treated rudely by an employee or maybe had to wait too long, but issues like these can be resolved. People will forgive you if you address your mistakes. They will not forgive you if you ignore them.

Digital Effectiveness

You probably have a website. Maybe you do some pay-per-click advertising, or you contract a service that sends you leads. These are typically done by outside vendors and you may feel you have no control over them.

But there's a huge opportunity here! Because these communications are digital, they're essentially mathematical processes, which are relatively easy to measure.

Digital leads can be optimized through continuous testing and experimenting. For example, we created a way to measure our leads by getting patients to fill out digital forms and then we started doing "A and B" testing with various messages to discover what type of content led to patients filling out a form and what content didn't.

We found that making it easy for people to get information was much more effective than just piling all kinds of information onto them. We found that being very specific was much better than being general or vague. We found that having a focused message was much better than telling people everything they needed to know about X, Y and Z. We also figured out what types

of images worked and which did not, what kinds of text and fonts worked and which did not, and how many steps or tasks people would tolerate before we lost them.

It would be too much to try to explain all the steps that we went through or even all of the answers we got, but suffice to say that easy is better than hard. Our customers have a short attention span and want information to be real and relevant, rather than feeling like we're trying to sell to them.

By paying attention to all of these factors, we were able to double the effectiveness of our digital marketing while spending half the money. That meant a 400 percent improvement.

Advertising Effectiveness

Some practices advertise; some do not. In our business, advertising is not mandatory, but it sure helps. The services we offer were unknown to most physicians when we started because the medical problem we were addressing was relatively new and the disease was ignored. That's all improving now, but it's still an issue, so we do advertise directly to customers.

We started advertising on TV, radio, newspapers and magazines. Through all of that, we were able to learn which media worked the best. Note that what is "best" or most effective changes from time to time. You need to consider your budget, individual market, and core customer, yes, but the most important thing is the effectiveness of every dollar you spend. For example, we found that because of our early success, a lot of people were copying our marketing message, so as time went on, we had to change our strategy and our message.

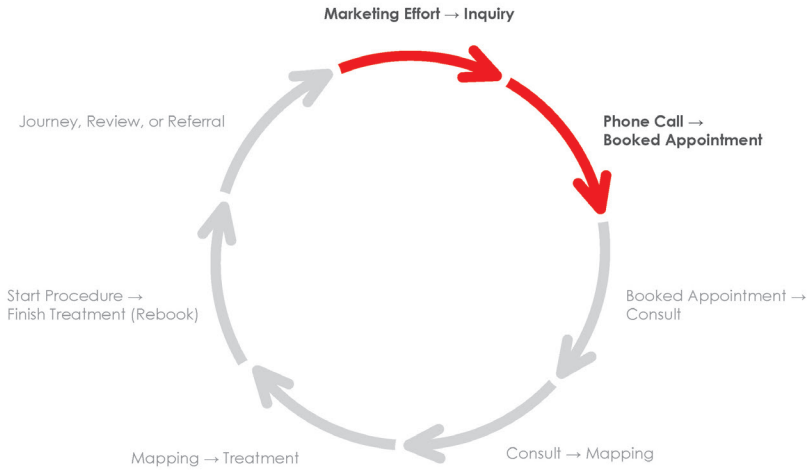
Just like digital leads, advertising effectiveness can be tested. Experiment with different spots on TV, for example. We run different types of messages at different times of the day on different days of the week and during different months of the year.

As author Salim Ismail describes in his book *Exponential Organizations*, companies that grow do a lot of experimentation, and they do it fast. We constantly experiment with advertising, and when we have a success, we try to tweak it even further. When we have a failure, we learn from it and move on.

Bottom line: the lead generation switch can be optimized through experimentation and by controlling the dialogue.

CHAPTER 9

SWITCH 2
CALL CENTER EFFECTIVENESS



We use the term "call center," but really, it's a communication center. We don't have any physical phones—everything is done through Voice over Internet Protocol (VoIP) with headsets. (We still call them phones, though.) We also get live chat inquiries via digital forms and we have an online appointment scheduler.

These can be effective or ineffective. When I first started scaling up our business and trying to fix the mistakes that had led to our lack of success, I started with the phones, because I thought they

were the first door into the practice. Really, this was the second switch, but I didn't know that at the time. By spending more money on advertising, I could keep the phones ringing.

Phones ring…and ring, and ring, and ring. Sometimes, a phone may ring and distract someone who is already working with a customer who just wants to get off the phone as quickly as possible. Or a phone can be answered by someone who talks too much, who tries to bring the customer in by selling a doctor or a service, but ultimately forgets to sell the appointment. Or the phone may be picked up by someone who is really an expert and who does the entire consult over the phone—and now the customer has no choice but to call another practice where they'll actually get an appointment to see a doctor.

Steps to a "Five-Star Call"

The first step is the greeting: the phone is answered in a consistent fashion, identifying the name of the practice as well as the call agent. The agent is trained to answer the phone with a physical smile on his or her face, because believe it or not, that smile is transmitted over the phone.

The second step is the inquiry: find out how they heard about us and what they are interested in.

The third step is gathering the caller's information: name, address, phone number and email.

The fourth step is the dual-stage close: instead of "When would you like to come in?", it is "Would you like a Tuesday or Thursday?". Then, instead of "What time works for you?", it is "Do you want a

morning or an afternoon appointment?". And so on.

The fifth step is the commitment: instead of closing the call with just a "Thank you," it's, "Thank you! My name is Nancy. I scheduled your appointment for X time, and if anything comes up and you can't make it, please be sure to call me so I can rearrange the schedule."

We've trained our agents to avoid attempting to answer questions that go beyond their areas of knowledge; instead, they redirect the customers, encouraging them to come into the office to meet the expert. (Right now, we're dabbling in telehealth consults. These have been very successful for patients who would otherwise need to travel some distance. More to come on this subject in the future.)

We record every call— we alert both parties that the calls are recorded, so we play a brief message about that before the phones are picked up—and we document the outcome of each new patient call. Was it booked? If not, why did we fail to make the appointment?

We avoid having significant delays before someone answers the phone: "For X, press 1; for Y, press 2…!" Ugh! I hate those voice menus, so I assume our customers do as well!

The leadership team does not evaluate the recordings—the recordings are for the employees who work in the communication center. They can listen to the calls and help each other out. They work as a team. They also track their individual outcomes, and the agents who are having the most trouble are assisted

by the ones who have more success. We don't do this to punish or reward anybody, but rather to identify the most successful communication agents and allow them to work with the individuals who are struggling.

By having our trained agents do mystery calls and measuring other practices, we find that fewer than 50 percent of calls lead to booked appointments in most practices we have evaluated. In comparison, by implementing our five-star system and constantly striving to improve, we are able to book appointments for more than 80 percent of incoming calls.

This step alone can increase production by over 50 percent. I think this is often ignored by physicians who don't understand the value of the phones.

We often see practices that feel they do not have the resources to assign somebody just to answer phones, so the person answering the phone often has many other things going on besides just booking an appointment and might be working on many other tasks when the phone interrupts them.

Nonetheless, handling calls is a hard job to outsource. In our business, all calls are answered by a central call system that we own and control. As we grow, we will need to have additional geographic areas with call centers, but for now, they're all done in one call center in Michigan because it has a proven success record.

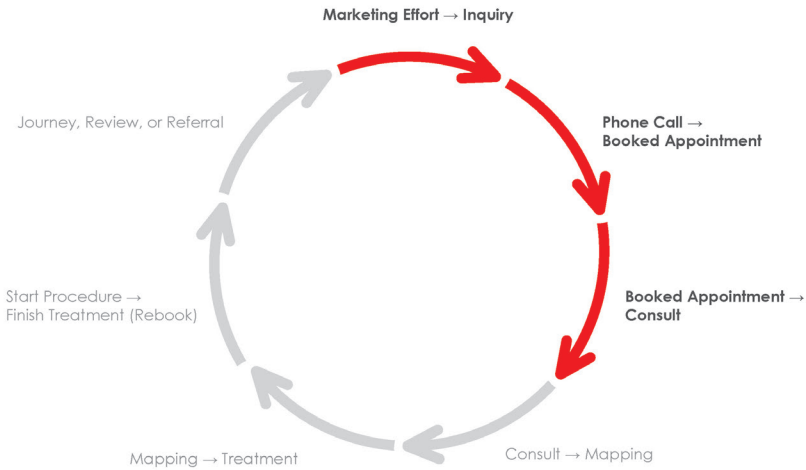
"This step alone can increase production by over 50 percent."

There are companies that do offer call centers that book appointments, but it is very difficult for an outsourced call center to have sufficient expertise to handle the minor questions that go along with the calls, plus they typically answer calls for multiple businesses. Unless you find a call center that is specific to your type of business and has a proven track record, your team will still need to answer the phones.

For your business, you may want to investigate phone center training programs. They're generally pretty good and quite valuable. I also recommend that you identify which times of day you receive the newest patient calls, and assign somebody to have totally interruptible work to do while they're waiting for the phone to ring. This beats having your front desk person or manager or medical assistant answer calls when they are doing work that cannot be interrupted, such as patient checkouts and collecting money. The latter scenario leads to lower success rates with calls.

CHAPTER 10

SWITCH 3
NEW PATIENT CONSULTATION "SHOW" RATE



Believe it or not, no-shows are hard to measure. Why? Because most practice management software erases an appointment once it's canceled, so they're relatively hard to track. When we've dug into the matter, we have found that most practices have a significant no-show rate.

(When we discuss this topic, we talk about the percentage of patients who do show up for their appointment—that is, the show rate, not the no-show rate.) Many factors can affect the show rate.

We have found that patients who were referred by their doctor or another customer are more likely to show up than those who call as a result of advertising. Then there are factors like the patient's proximity to the office, how convenient our hours are for them, how far ahead the appointment is booked, and how many times we remind them about their appointment.

We've addressed every one of these issues and have different methods for dealing with each circumstance.

In our practice, the communication center (or call center) is in charge of and accountable for the show rate. After all, they are the ones who book the calls and if they schedule a bunch of patients who are not likely to show up, it looks like they are doing a great job when maybe they aren't. So, the people in the communication center monitor the appointments in addition to booking them. By making the call center accountable for both booking the calls and ensuring patients show up, we've been able to experiment to see what works best.

We found that the factor that most affects the show rate is the proximity of the appointment to the date on which it's booked. If a patient calls today and can't get an appointment for a month, it's very likely they won't show up, unless the need is so substantial that they can't afford to miss the appointment. In our business, there's not an enormous sense of urgency, so we don't have the luxury of booking people months in advance—we must get them in right away.

Our call center agents have learned that offering the next available appointment is the best option, and they work with the

patient to try to accommodate them for that time and date. We find that getting the patients to the office within a week of their call is the most effective way to have a good show rate. If the appointment isn't going to be for another week, they are less likely to show up, and the odds of them showing up go down every week after that.

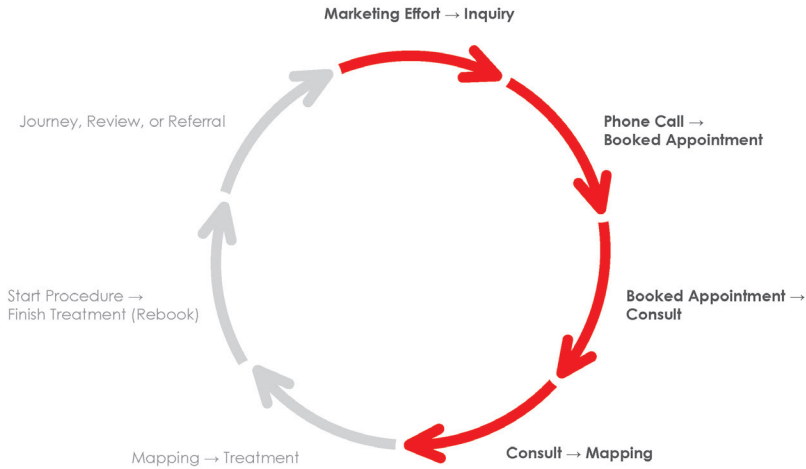
Other than the proximity-of-call-to-time-of-appointment factor, patient reminders are also very important. We have tried various avenues, such as text messaging, emails, and calls. We've also experimented with calling or texting at different times of day and even asking the customer how and when they want to be notified.

Since each individual practice has its own demographics, these factors are unique to each one, so we've tailored our methods to each location to optimize its show rate.

Since we first started measuring our show rate, we've increased the likelihood of a patient showing up by 30 percent. This factor alone has a huge impact on a practice's bottom line. It's a switch that we try to keep in the "on" position.

CHAPTER 11

SWITCH 4
CASE ACCEPTANCE RATE



In our case, this switch applies mostly to a specific service line, namely the journey from consultation to diagnostic ultrasound mapping. That said, this switch can be applied to any service line. If a dermatologist suspects a spot may be cancerous, for example, a biopsy is done right away to assure that it is done—because if the patient is scheduled to come back a month later for the biopsy, the patient may cancel and they may not wind up showing up again until the situation has become serious. As we are a multi-specialty practice, we consider this switch as it applies to all of our service lines.

For the new patient experience, we use what we call the Allure Way. In our business, our core service line (venous insufficiency) does not see a lot of repeat buys. We may need to repeat procedures for the same condition, but eventually, there comes an endpoint, and we're done seeing the patient, so we rely on seeing new patients and getting them into production. Because of that, we need to control the patient experience. It can be great (everything works well, we make it easy for them, and they get into production) or it may be subpar (maybe their questions were not answered or they didn't have a great experience). If the latter, they may decide to "think it over" before they move forward.

In sales, there are "tells" that a sale will be lost. Examples of an impending lost sale include customer statements like:

"I need to think it over."

"I'll talk to my husband/wife about it."

"That sounds too expensive."

"Let me go home and do some research."

"I need to talk to my doctor."

These are all "tells" that you did not adequately answer the patient's questions or do a good job of explaining what the solution is.

You might think that it is a good idea for a patient to go back to her doctor and ask for the doctor's thoughts, but we have

found that almost no physicians in our area have the level of expertise that we do when it comes to our specialty. That lack of knowledge means they have very little advice to offer. In fact, physicians refer these cases to us precisely because they do not have the means to treat it, nor are they familiar with the way the disease progresses. So, someone saying "I need to talk to my doctor" is a tell.

The same goes for the pricing—that's just something people say when you have not sold them on your services, something they know you don't have an answer for.

When you hear these "tells," realize that you've lost the sale and then learn from that experience. You can rarely overcome those statements, so accept that you've lost the sale, and next time, do a better job.

So, how do you get to a "yes"? Well, you start by controlling the situation.

We Control the First Impression

I've visited many medical businesses and I often see a clerk greeting the customer behind a glass partition. This makes it clear that patients are not invited to enter the practice. Why physicians choose to put a glass partition and a wall between them and their customers is beyond me, but many practices seem to do it.

When we acquire a business, we make sure to remove the divider between our staff and the customer. After all, we've essentially invited them into our house, so why make them stand behind a wall and sign something and then close the door on them?

We Control the Greeting

By implementing best practices from hospitality industries, we've learned that the best way to create a great first impression is to have a smiling person pleasantly greet patients with an open invitation to come in and stay. Ideally, we greet new customers by name. We spend time, energy and resources on training people in customer service. Anybody's capable of it, but, they have to be trained.

The lobby should be set up in an inviting and clean way: the magazines shouldn't be six months old, the coffee urn shouldn't be empty and the overall feel and style should convey cleanliness, pride and quality.

We Control the Experience

We have a new patient experience system in which the patient is brought into the space in a certain way: they are given an abbreviated tour of the office, we explain what we do and what the different rooms are used for, and we tell them about the various staff members they may encounter. Then, finally, they are shown to their room, where they are handed off to the person who will be taking care of them. For example, if the receptionist brings the patient to the room and hands them off to the medical assistant, the receptionist introduces the medical assistant and states their credentials.

When the medical assistant takes a history, he or she does it only after having gotten to know the new customer. We try to find out what kind of things they like, what's going on in their life, what's going on in their social environment, where they live, what kind of influence they have in their community, etc.

We use the six principles of influence that Dr. Robert Cialdini, an expert in ethical persuasion, outlines in his book *Influence: The Psychology of Persuasion*.

I won't go over the full concept—it takes an entire day of training and multiple hours of reinforcement—but it involves six principles: social proof, commitment, reciprocation, liking, authority, and scarcity. These principles are updated from time to time, but these are the basic ones, and we have a mechanism in place to invoke each of the principles of influence every time we encounter new patients.

The Four-Minute Rule

The four-minute rule is often violated—and it's the hardest one to measure—but it is very important. Although we don't do it well consistently, we do it okay most of the time. The idea is that when the provider enters the room, they spend a few minutes on things that do not relate to why the patient is there. It's an opportunity for the physician to get to know their patient as something other than only a medical concern.

The Close

One of the principles of influence is getting a commitment, and if we get a commitment from the patient to move forward with diagnostic testing but we make it hard for them or make them wait to get started, the probability of the patient continuing treatment drops significantly.

We attempt to do same-day treatments and/or diagnostics as often as possible. There are some situations where it can't be done, and that's understandable, but most of the time, it's a

matter of having adequate resources to accommodate the person who is a "now" buyer. If you do it today, there's a one hundred percent chance it will get done. If you schedule it into the future, there's a much lower probability that anything will ever happen.

Measuring the Fourth Switch

The fourth switch is not the most important switch, but it is one of the easiest to measure. When we evaluate businesses, most of them have a hard time measuring switches one, two, and even three because they may not have tools in place to assess those switches. The fourth switch, on the other hand, is simple: we just count the number of new patient visits and the number of diagnostic initial ultrasound mappings.

CHAPTER 12

SWITCH 5
OFFICE VISIT/DIAGNOSTIC IMAGING SCHEDULED INTO PRODUCTION

This is another big obstacle we see: you identify a patient who has a disease that should be treated and you know that not only will the condition not go away by itself, it will worsen over time. CEAP 4 disease, for example, will progress at a rate of approximately 4 percent per year and will become a CEAP 6 when treated with conservative management rather than modern vein care.

We find that in most practices, fewer than half of people with clinically significant venous disease ever get a venous ablation. This is because of all the hurdles that the practice—and, in some cases, the health insurance company—puts up to block successful treatment.

There are certain insurance company rules that require specific activities to occur before treatment and some people require preauthorization by their insurance companies before being eligible for treatment. Yet what we see is that the behavior of the practice itself is often what leads to people not getting into production.

I've seen this in my own practice and I've seen it in other practices I've evaluated. I think of it as linear thinking. Many practices decide to look at all the medical policies, find the most antiquated and backwards requirements, and then build one "super policy" that they know will be rock-solid against any audit or insurance rules.

In reality, patients with CEAP 4 and above have generally already done conservative management, or their insurance company may have excluded them from needing conservative management (which is ridiculously ineffective).

In a position paper from 2011, the American Society of Vascular Surgery advised physicians that people with clinically significant venous disease should not undergo additional conservative management if they were found to have reflux. Instead, they should be treated. So, we are advocates for patients, not for the insurance companies.

Many doctors, practices and billers get so hung up on overinterpreting the rules that they forget that their job is to be an advocate for the patient. Additional conservative management does absolutely nothing, so it is logical to take these patients on a case-by-case basis and figure out who really needs to wait and who you can go ahead and treat.

I'm not trying to give you specific advice on how to treat venous insufficiency, but I would recommend that you personally, as a physician, read the policies that are issued by your most common carriers. Find out if you've become an advocate for an outdated policy and if you've been overlooking an opportunity for your patients to get treatment immediately instead of having to wait for another three months.

We find that scheduling patients into production as soon as possible leads to a high likelihood of them being successfully treated. Scheduling them out for several months and then repeating the ultrasound, doing a pre-authorization and sending them a letter to come in for treatment leads to no production and continued patient deterioration. This type of linear thinking is doing patients a disservice.

Individuals with clinically significant venous disease typically will require more than one ablation per leg and they may also have bilateral disease. I recommend tallying the number of new patients you had last year and how many ablations you did last year. Then take a random sampling of ten patients who had an ultrasound mapping and calculate the average number of ablations per individual that you ordered.

Let's say you had five hundred new patients and three hundred ultrasound mappings. This means you did diagnostic imaging on 60 percent of new patients. Maybe you're doing a lot of spider veins, or maybe you're attracting people who are confused and think their leg pain is venous disease. This is an opportunity for you to focus on people with real disease and control the discussion. We accomplish this this by educating doctors on venous disease and by educating our patients.

We do not market to cosmetic vein patients because that is not part of our strategy. I'm not suggesting that there is no role for cosmetic vein patients, I'm just saying that you need to look at your percentage of ultrasounds relevant to the type of patients you are attracting.

Of the three hundred ultrasound mappings, how many ablations were actually performed during the same time period? I recommend you look at these figures over the course of just one year: new patients, diagnostic mappings and total number of ablations. They may not be directly related (some people may have had their ultrasound the year before) but looking at a full year of data evens out fluctuations.

If you think your average patient who gets treatment has three ablations because they have bilateral disease, how does that compare to the number of new patients you saw and the total number of ablations you did?

In the example above of five hundred new patients of which three hundred get mappings, if you did nine hundred ablations, you could guess that you're getting everybody into production. But if

you did three hundred ablations, you could guess that you only treated one-third of the candidates, meaning that you only did treatments on 20 percent of the new patients.

This leads to an opportunity on several fronts.
First, get the people with clinical disease into production by removing barriers. Get authorizations done as fast as possible. We always get them done within a week and we don't even wait for the authorization to come in to schedule a patient. Seek out patients who have already gone through conservative management by getting doctor-referred patients (as the doctor has likely already done conservative management). Aim all of your marketing efforts at people with "ugly legs," meaning people with discoloration or sores and other significant symptoms. These people have likely already tried many conservative management techniques.

In our practice, we only market to "ugly legs." We also market to physicians by using physician liaisons who do on-site doctor visits and we go after patients with wounds/venous stasis ulcers (which I talk about in a book in my *Abundant Economy* series).

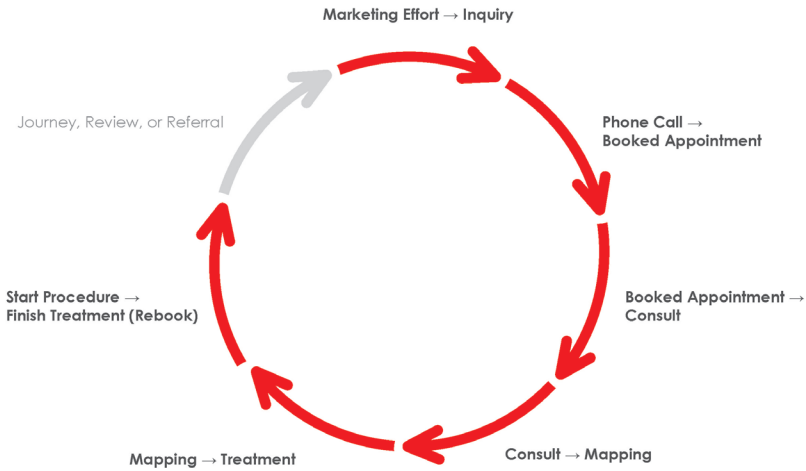
Scan this QR Code to learn more about
the *Abundant Economy* book series or visit http://allu.md/bookseries

These patients tend to have more disease and have usually had conservative management. Treating these patients leads to a bigger economic healthcare benefit, because if they are left untreated, they progress to wound care. Traditional wound care for venous stasis ulcers costs the United States $16 billion a year. Considering that these patients could have been treated with venous ablation at a much lower cost, this wound care is a tremendous waste of money.

Make it easy for patients to feel better and you will create abundance.

CHAPTER 13

SWITCH 6
COMPLETE TREATMENT PROTOCOL



You probably naturally assume that when you tell patients what to do, they do exactly that. And maybe you do have the unicorn practice where patients are perfectly compliant and you're so amazingly influential that this scenario occurs. For the rest of the medical community, however, there can be a disconnect between what you tell the patient to do and what they do.

There are several reasons why a patient may not complete the prescribed treatment.

1. They have billing questions that go unanswered. Maybe the patient has an unanswered question about their deductible or copay and when they called your office to ask it, they were put on hold or sent to voicemail, never to be reached again.

Whoever is doing your billing has a lot of work to do and they're probably on the phone a lot. If that's the case, when the customer calls in with a question, they're likely put on hold or into the voicemail system. This means the patient probably won't show up to their next appointment. We haven't entirely solved this issue yet, but we do assign somebody to answer billing questions every day, and we only allow them to do interruptible work so that they can answer calls with "warm answers." This allows us to avoid "cold answers," which means sending the calls to voicemail.

2. They have treatment questions that go unanswered. So, you've explained everything that's going to happen after the procedure. In our practice, we use videos and even give patients a quiz on which they must achieve a perfect score in order to move forward with treatment. We work hard to make sure they really understand the treatment. Still, though, questions may come up.

We have found that if we cannot provide a "warm" answer when they call to ask these questions, the patient may not complete their treatment. In other words, we lose the patient. Because of this, we've assigned a person who has only interruptible tasks to answer these questions. This person also has immediate access to a provider, an ultrasound tech, or a nurse if they cannot answer the question themselves.

3. Life gets in the way at times. This just happens. People are bombarded with all kinds of things they need to do. Something might come up, or, they might just forget to come in.

We've devised a system to remind patients about their appointments and give them an opportunity to tell us if there's a problem. We've also devised a system that notifies them within five minutes if they don't sign in for their appointment. When you've blocked out time for a patient and they don't show up, this is wasted time. We want to make sure they show up.

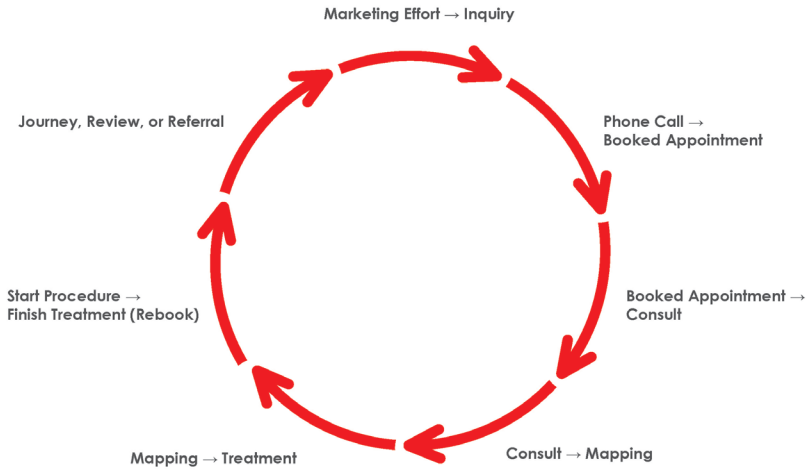
If someone calls and wants to cancel their appointment, we've built a system that can help the caller solve the problem so that they do show up, rebook them to a different day, or give them a warm answer from billing or medical.

4. They won't tell you why they're not coming back in. This certainly happens. It's generally because of one of the three reasons above, but you just don't know which one(s) it is. We find this happens most often after the first treatment. The way to avoid this is to call the patient and make sure we get ahold of them after that first treatment so we can answer any questions. In order to increase the probability of reaching them and decrease the odds of our staff wasting time calling, we ask patients, "When would you like us to call you to go over your treatment?" and more or less schedule a time to talk to them.

If you start treatment on a patient, they obviously have a disease. We know it's not going to go away on its own, so it's important for you devise a system that ensures that when people start treatment, they finish it.

CHAPTER 14

SWITCH 7
REFER OR REVIEW



The principle of this switch is that we want the patient to essentially replace themselves by leaving us a review or referral. In the above diagram, you can also see that we have what we call a "journey patient." This is because in our practice, we have multiple specialties, so a "journey patient" may be a senior citizen who has venous stasis disease but hasn't yet had an annual skin cancer screening check. In this instance, we may suggest that they see our dermatologist. Or they may have knee pain and we may assess them for arthritis.

Reviews

Early on in our practice, we discovered the value of patient reviews. Remember, if you do not control the dialogue, it will control you. One bad review alongside one or two good reviews can be damning, but if there's one bad review along with a hundred good reviews, the bad review looks like an anomaly.

We get dozens of reviews every week because we've trained our staff to ask for them. As I mentioned earlier in the chapter about marketing, everybody in our office knows the importance of high patient satisfaction and of asking our patients to quantify that satisfaction by leaving a review.

Patient Referrals

When we get referrals from patients, we send them a letter of thanks. By law, you're not allowed to give a patient anything of value in exchange for a referral, but you can certainly thank them. Because we cannot reward the patient directly, we also donate to charity every time we get a patient referral. We do not tie the donation to a particular existing customer or new customer, but we do add up all the referrals and then we make a charitable donation of substantial value based on the knowledge that new patients drive more business.

You have to be very careful about giving donations, because a donation can be construed as a kickback if the patient who was referred to you is somehow a beneficiary of the recipient charity. We created a very simple system that blinds us to knowing whether or not a patient could stand to benefit in this manner—that way, there's no possibility of a conflict of interest.

We also hold patient appreciation events. Again, these are not tied to any one referral patient, because you cannot give value to people for referrals. But you can be generous within your community and you can offer patient events. You just can't tie them to individual referrals.

Physician Referrals

We also work to drive physician referrals. Yes, there are rules regarding gifts of value to physicians, but they are not very strict. They are reasonable and are designed to prevent inappropriate referral patterns.

The real way to get physician referrals is to communicate with the physicians. Let them know what's going on with the patient so that they're not surprised when the patient comes back and has received treatment. Let them know what venous disease is because in general, the majority of physicians today have very little working knowledge of venous disease. They look at patients with "ugly legs" who may have been treated with creams or antibiotics or misdiagnosed with cellulitis. The physician may send these patients to a dermatologist to be evaluated for the chronic skin changes. Throughout this process, the physician may be missing the fact that there is a reversible cause of their patients' conditions, a cause that will continue to progress unless treated appropriately.

Once you've turned on the review and referral switch, then you've completed the circle, because the seventh switch starts a new patient on their journey, beginning the cycle all over again.

CHAPTER 15

WHAT'S NEXT?

After reading this book, I hope you'll take some action.

The purpose of this book is to lay out the aspects of our business that creates abundance in the medical practice. Part of the purpose of our practice is to work toward saving healthcare. A decade ago, we discovered the immense cost of untreated venous insufficiency and how it affects the US healthcare economy—when left untreated or given improper treatment (i.e., conventional management), patients go on to develop venous stasis ulcers. In 2016, these patients required $16 billion in treatment, a figure that is expected to rise to over $20 billion annually, according to Medical Economics. In 2017, the total cost of direct and indirect expenses resulting from venous stasis ulcers was eight times higher than the total cost of all endovenous ablation procedures done to treat venous insufficiency. In other words, we spend far more money managing the outcomes of venous insufficiency than we do in eliminating it.

"Part of the purpose of our practice is to work toward saving healthcare."

Part of our mission is to change this trend. Annually, venous stasis ulcer management costs almost three times as much as the management of diabetic foot ulcers in the United States. Venous

"Venous stasis ulcers cause half of all wound care expenditures in the United States. And this number is growing: in just a few more years, the cost is expected to hit over $23 billion annually. And this scenario is totally avoidable."

stasis ulcers cause half of all wound care expenditures in the United States. This number is growing: in just a few more years, the cost is expected to hit over $23 billion annually – and this scenario is totally avoidable.

To help remedy the issue, we are going around the country, identifying cities that are underserved in the management of venous disease. To identify these areas, we calculate a simple ratio of wound care visits to venous ablation claims. Cities with a high number of wound care treatments for venous stasis ulcers and a low number of venous ablations are highly desirable locations, where we would like to extend our influence.

There may be an opportunity for your existing practice to work with us. We hope to install vein practices in those regions that have essentially no dedicated vein practices. We are also looking for successful vein practices that would like to scale up and bring down the healthcare costs in their community.

If by reading this book, you can apply the seven switches as well as our operating system to your practice, we would love to support you in that effort. Feel free to visit our office or talk to our team members. We do not have a fee structure, nor do we

charge physicians to learn how to function the way we do—we give our knowledge away. This is because we intend to cut out billions of dollars in healthcare waste annually and we cannot do it alone.

You may also be in a situation where you really enjoy the practice of medicine, and you know you can apply the seven switches to your business—but you worry that if you do so, you'll have to stop doing what you love, which is practicing medicine and taking care of patients. Still, you may want to implement this kind of operating system in your own business. If that's the situation, you can talk to our project managers about whether we could work together with you as an acquisition practice, a situation that would involve us putting our operating system into place at your business.

"Feel free to visit our office or talk to our team members. We do not have a fee structure, nor do we charge physicians to learn how to function the way we do—we give our knowledge away. This is because we intend to cut out billions of dollars in healthcare waste annually, and we cannot do it alone."

FAQ

What happens to the employees when a practice is acquired?

We are a company that brings abundance, not scarcity. With the exception of employees who do not follow our core values (which are rare), everybody keeps their job after an acquisition, even employees whose jobs are redundant to a service that we already offer. There's plenty of work to go around, as we are growing at a very fast pace and we are always looking for talent.

Who will run my business after I'm acquired?

The leadership team and physician(s) at the current practice remain in place and have full autonomy over medical decision-making and basic operations.

We will provide all the support needed to install the seven switches as well as our Allure Operating System. In many cases, there are people within your organization who would love an opportunity to provide more leadership and give some relief to the doctor. We are experienced at showing front-line employees how to work in teams and manage themselves.

What about the equipment that I use and the way I like to do procedures?

We do have some expectations of best practices, but we do not dictate the practice of medicine. Of course, if any procedures being done could be considered unethical or fraudulent, we would never do business with you. Barring that, there may be things you can learn from us that would help you create a better

patient experience, and we will likely learn things from you that we can share across our organization as well.

Ultimately, the physician is the captain of the ship and is expected to practice good medicine. We leave you the autonomy to do exactly that. You also have access to numerous other specialists in our organization should questions arise or if you want to learn new techniques and procedures.

What about offering other services in my practice?

If you do research on Allure Medical in Michigan (www.alluremedical.com), you will see that we do many procedures and are a leader when it comes to many aspects of healthcare. As we scale up the business and team up with other practices, the new local practices may choose to add services to their business. It is up to the local business to determine which (if any) additional services they want to offer.

Does our business need to change its name?

This is a tough question without a set answer, and I don't know where we'll be heading in the future regarding this issue. Our business is very robust in the Metro Detroit market, and our SEO and page ranking on Google are extremely strong. While individual practices may remain separate, Allure functions more or less as a management company, and in some cases, it may be beneficial for the acquired practice to change its name to benefit from placement at the top of the page in Google search results. In other cases, the practice may be well-established in its community and there may be no reason for it to change its name. The jury is still out; we are currently considering this question on a case-by-case basis.

You talk about increasing business by 400 percent. How do we accommodate this?

This is a very common question and one that we've learned how to answer. First, we find that by dealing with new patient leads more efficiently and helping patients start and finish treatment more smoothly (I've referred to this as "production" throughout this book), we don't need to waste a lot of time seeing patients who never go into production. The biggest waste of time is to consult with patients who never get treated.

On the other hand, some physical buildings cannot handle a 400 percent increase in volume. For the most part, we've overcome this by eliminating waste and running more efficiently. We've found that once we do this, there actually is existing space and equipment capacity as well as existing human capital capacity.

The first thing we do is a full practice evaluation, considering patient throughput and wasted efforts. As these are optimized, we can generally achieve at least a 200 percent increase in business and up to a 300 percent increase without having to move to a new building. Once we get to a 300–400 percent increase, this will tax most practices' offices. Our plan is to expand capacity by either increasing the size of the local office, opening a second office, or getting a larger building.

We also have to consider employee capacity. Typically, we find that by optimizing work efficiency and minimizing wasteful work, people are capable of creating much more value than their previous baseline. We can generally increase production by 400 percent while increasing staffing by only 200 percent. This creates enormous abundance and allows us to pay higher wages than our competitors.

What about my electronic medical records and my billing system?

Our approach is "If it ain't broke, don't fix it." We will build bridges so that we can access your practice management software, but if your system already works well, we will continue to support it. You also have the option of looking at the vendor systems we use to see if you'd like to upgrade or change your system.

How do I share the financial rewards of increased production?

Currently, we have a bonus system where we calculate our profit weekly and distribute that profit to all employees regardless of their title. I'm not saying that this system will stay in place forever, but as of now, this is how we distribute profits. It is not the kind of profit-sharing that is seen in a retirement fund; rather, it is simply an adjustment to wages. It is based on each individual's wage, so somebody making more money will get a bigger bonus than somebody making less money.

We just split it up every week. Having a bonus based on profit is totally different than having a bonus based on the number of procedures. In fact, it's almost the opposite, because profit is created when there is minimal wasted effort. Every action should lead to value for the business, the patients, and the economy.

How will I know how my practice is doing financially?

We don't share our financial information, expenses, or profits with the general public. And we don't share wages or relative bonuses with anyone; those are confidential. However, if you want to know what your office's expenses are, how much is being spent on marketing at your location, how much profit the company

made in a month, what kind equipment we're buying, etc., we are completely transparent with our financials. You can have full access to this information.

Is there possibility of a partnership?

Right now, there is not. I have no short-term goals, only mid- and long-term goals and I fear that giving up control of our long-term purpose in the interest of short-term financial goals is not in our best interest. We will be working on a program in the future that will allow physicians to participate in the upside beyond sharing the profits every week, but as of now, we are not offering partnerships.

What is the next step if I want to know the value of my practice?

Accounting specialists can help you determine the value of your practice. Usually, they evaluate a business in the face of an event such as divorce or the breakup of a partnership. You can hire them to evaluate your business, too, but their assessment probably isn't a good indicator of what your practice is worth to a buyer in this economy—it's probably higher than what the accountant would tell you.

The value is really based on what the market is willing to pay. As discussed in the chapter on practice evaluation, different businesses will see the value of practices differently.

Here is what we assess at Allure to determine the value of a practice:

- Number of new patients annually

- Number of mappings annually
- Number of ablations annually
- Your digital presence and reputation
- Number of patients who are referred by physicians
- Profit and loss statement
- The geographic location of your practice and how it fits into our overall strategy

There are no good or bad answers to these questions—they simply help us determine whether your practice would be a good fit with ours in terms of the relative value of the business. When we put our seven switches and our operating system into place, we use custom algorithms to extrapolate future production.

Thank you for your attention. Even if we cannot do business together, I hope you got some value from reading this book.

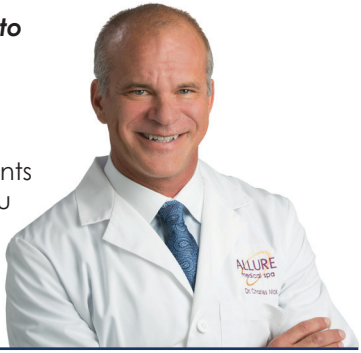
At your service,

Charles Mok, DO

In this book, ***I describe the steps you can take to transform your medical practice*** into a wildly profitable, abundant, job-creating healthcare business.

The kind of healthcare that benefits your patients and your community as much as it benefits you and your employees.

Dr. Charles Mok, Allure Medical



As my own practice has grown, my team and I have developed something we call the "seven switches." Combined with our unique operating system, these seven switches have allowed us to grow at a very robust pace. In the seven months preceding the writing of this book, we have doubled our number of locations without taking on any debt—we did it all through cash flow.

Some people would call the seven switches key performance indicators, but they're more than just standard KPIs.

The switches are data points, and when you measure them and focus on them, you can flip the switches on and bring greater value to your business.

Greater value also means providing modern medical care that results in healthier patients and saves healthcare dollars.

If you are interested in learning more about what we do, contact us—we would love to share our knowledge with you. ***We intend to cut out billions of dollars in healthcare waste annually, and we cannot do it alone.***

Have Questions? Call Us 586-992-8300