



## Health Care Continues Expansion Into Retail

### Thoughtful Integration of Medical Uses Can Improve Overall Health of Shopping Centers

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**Abstract:** This article examines the influx of health-care tenants into shopping centers in the last decade. It discusses which medical practice types work (or not) in these environments. Additionally, it considers the impact of parking demand, tenant improvement (TI) expenses, attracting medical tenants, understanding local health-care systems, and assessing risks associated with health-care tenants in a still-unsettled political environment.

The expansion of health-care practices into retail spaces and shopping centers has come a long way in the past decade. Landlords have shifted from arguing over why they should welcome health care into their centers to fielding calls asking how they can attract health-care tenants. Urgent care centers and dental practices led the most recent wave of retail health-care expansion (following the big optometry players, who have evolved from in-mall to freestanding or open-air center locations.)<sup>1</sup>

Initially, the premise was a tough sell: welcoming sick and injured people into a center. But the benefits of this move have become clear: Stable tenancy, length of lease term, significant capital that tenants put into their spaces, and in many cases, low parking use. The challenges are higher TI allowances and a learning curve for retail landlords on the peculiarities of the use, including medical waste, x-ray shielding, different operating hours, the need for reserved parking, etc.

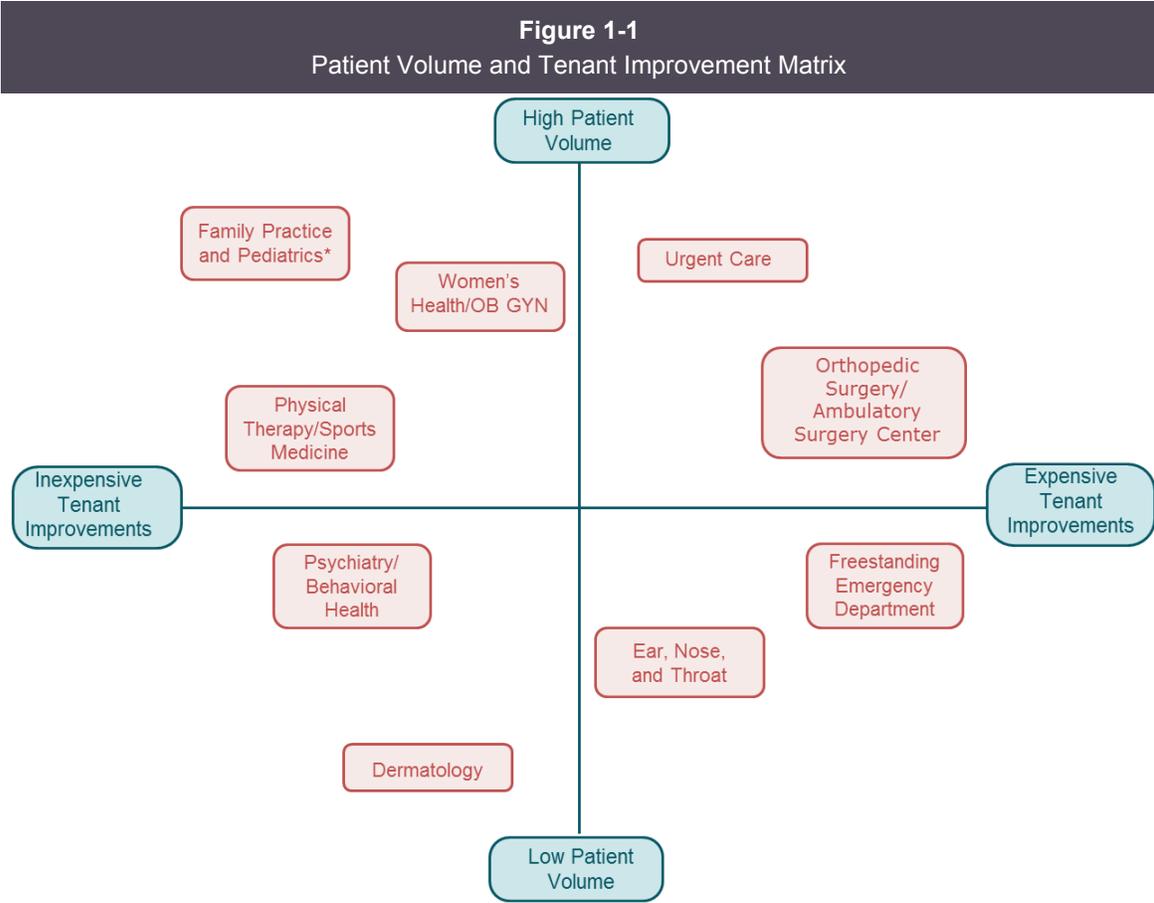
#### Lessons Learned

- Many medical practice types are drawn to shopping center space by such factors as access, convenience, visibility, and co-tenancy, as well as by gross occupancy costs that are often similar to Class A medical office space.
- The benefits of health-care practices moving into shopping centers include stable tenancy, length of lease term, capital that tenants can put into their spaces, and, in many cases, low parking use.
- Generally, medical tenants want five parking spaces per 1,000 square feet, a typical medical office building parking ratio in a suburban setting, but many do not need so much parking.
- Tenant improvement costs for medical tenants in shopping centers can range from more than \$100 per square foot (e.g., for urgent care facilities) to less than half that (for behavioral/psychiatric practices or physical therapy suites).
- Presentations to potential health-care tenant types should take into account such factors as visibility and ability to pay rent.
- The politics of local health-care markets differ significantly from retail and should be weighed appropriately when leasing.
- The key decision-makers at potential health-care tenants might not be directors of real estate, but instead hospital CEOs, directors of strategy, directors of outpatient facilities, etc.
- Even after correct decision-makers are reached, hospital systems will tend to move slowly, as they must balance dozens of concerns, including input from multiple internal constituencies.
- Retail landlords can best assess future risks of a specific health-care tenant by researching the workings of their reimbursement model and discovering the sources of their revenues.
- Health-care systems, private companies, and physician practices will continue to seek shopping center space as they look to thrive in an increasingly competitive market and to deliver convenient health care.

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<sup>1</sup> Allan Barker and Greg Stockbridge, "[Malls vs. Free-Standing Buildings: Before You Decide Where to reside—or Relocate—Your Practice, Consider These Critical Variables.](#)" *Optometric Management*, December 2010, retrieved May 5, 2017.



\*No imaging or lab

Sources: Patient volumes based on "[National Ambulatory Medical Care Survey: 2013 State and National Summary Tables](#)," U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; tenant improvement (TI) costs roughly based on experience of Equity LLC as a health-care developer.

**How Medical Practice Fits in Shopping Centers**

Just as a shopping center has a strategy of choosing an appropriate retailer, there is a logic to certain types of medical uses that could work equally well in the same center.

For example, a sports medicine practice draws a healthy (or potentially healthy) customer to its office. This type of use would be compatible with an organic-type grocery store, a health-club facility, a sporting goods store, or a nutrition and supplement retailer. Some of the larger health clubs have already integrated some type of physical therapy or massage therapy into their service offering or as a separate leased space within their walls, while allocating space for supplement retail. From a health-care developer's point of view, the inverse is sought: It is attractive to create a wellness campus that integrates retail uses that complement medical office space, surgery centers, etc.

Conversely, some practice types may not be a good fit for certain types of centers. For example, an oncology practice or dialysis clinic may not make sense for a high-end lifestyle center or power center. Therefore, a retail developer can look at medical as complementary to its overall center makeup and evaluate the co-tenancy as it would any other service provider beyond the more obvious walk-in clinic-type uses. Dental clinics and other health-

care operators have started to realize that "patient" is synonymous with "consumer."

The access, convenience, visibility, and co-tenancy offered by retail have become attractive to many practice types. Additionally, gross occupancy costs are often similar to Class A medical office space. If not dependent on direct medical co-tenancy, many multi-location health-care practices will opt for retail space if the costs are otherwise similar.

Besides urgent care centers, dental, and, in many states, freestanding emergency departments (FSED's), other practice types that are looking toward retail real estate include dermatology, physical therapy, primary care, pediatrics, orthopedic urgent care, sports medicine, ears, nose and throat specialists, allergists, as well as some cosmetic and alternative (chiropractic, acupuncture, massage therapy) medical uses.

**Medical Tenant Types and TI Costs**

While unscientific, Figure 1-1 should give retail landlords an idea of patient volume and TI costs for a sampling of common practice types. A significant part of the former is necessitated by parking demand, with particular medical tenant types having unique needs for this. Generally, medical tenants want five parking spaces per 1,000 square feet (sf), a typical medical office building

(MOB) parking ratio in a suburban setting, but many do not need so much parking. Additionally, some retail-focused health-care practices such as urgent care centers have quick patient visits of 30 to 60 minutes, so while they may see 60 to 100 patients per day, that is spread out over 12 hours of operation. This may necessitate only 5-7 parking spaces per hour on average in addition to a staff of two to four. As food and service uses continue to comprise much of small open-air center and outparcel space, such relatively low parking utilization may make a health-care practice one of the only viable options if the other tenants are fast-casual restaurants and coffee shops. The patient volume and average duration of patient visits both need to be understood if parking is tight.

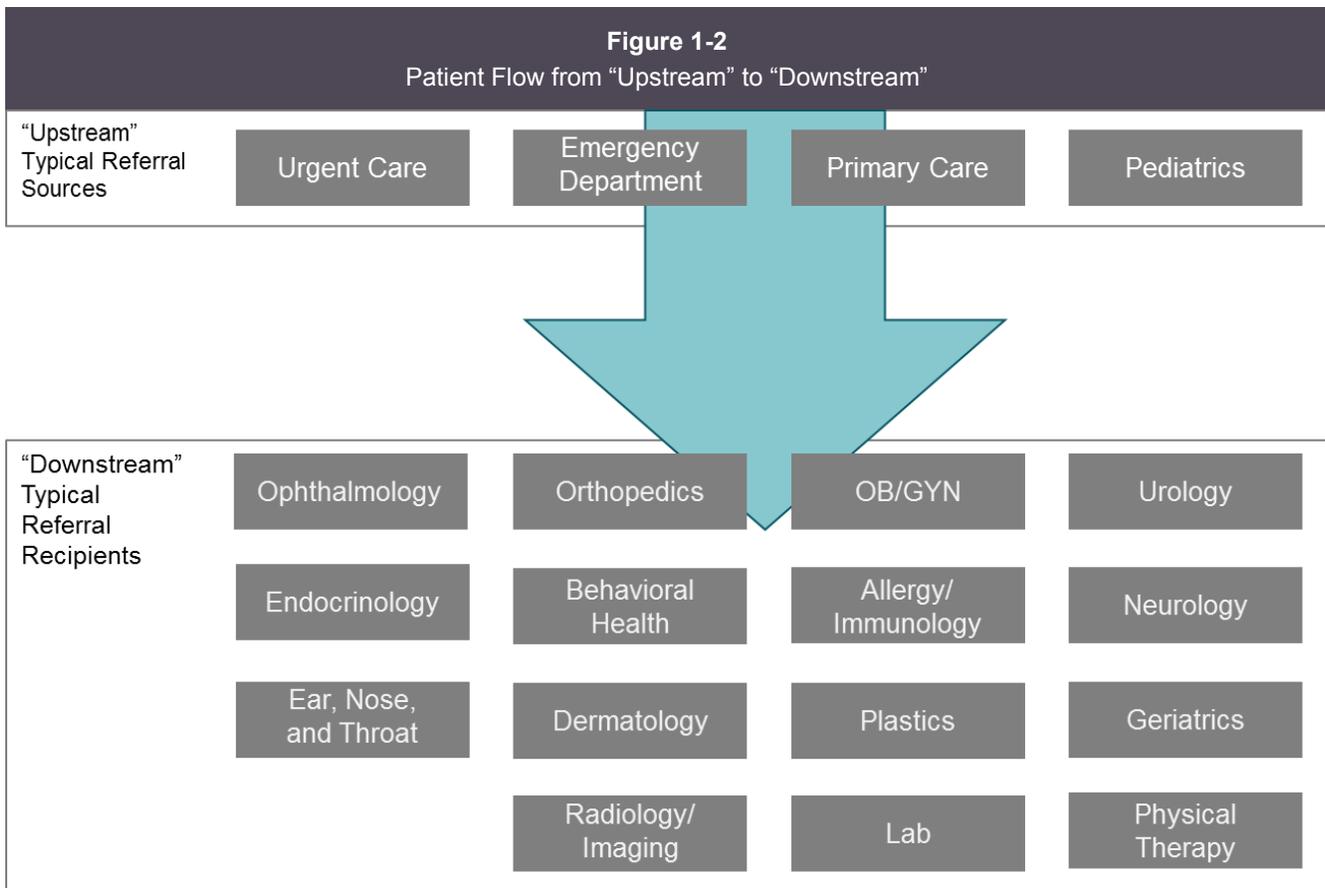
Those practices towards the right end of Figure 1-1 approach hundreds of dollars per square foot in TI. For an urgent care facility in most markets, TI costs above a warm shell will range from \$100 to \$120 per sf. That build-out is similar to a family practice, but imaging and lab adds cost. Typically, all of the practice types, starting with family practice and moving toward FSEDs, will have plumbing in every exam room, increased HVAC requirements (somewhere around 1 ton per 250 or 300 sf), and increased power requirements if they have imaging on site. On the low end, the behavioral and psychiatric practices will have a build-out that is closer to a traditional office suite and one could escape with total TI above white box costs at approximately \$40 per sf. Physical

therapy suites can cost even less due to the need for large open spaces.

Some growing practice types could be detrimental to retailers, such as behavioral or addiction therapy, due to a stigma attached to the patients or legal requirements for such practices to be located a certain radius from a daycare, school, or park. These should not be dismissed out of hand, however, as many of these service providers have high-end concepts with interior build-out that is almost spa-like and practice names that are innocuous.

### Attracting Health-Care Tenants

Image consciousness of health-care tenants ranges from FSED's, urgent care, dental (non-Medicaid) at the top, down to the sub-specialists at the bottom. For a presentation to a freestanding ED or urgent-care user, please do not send them a plan showing a part of the site that has no visibility and suggest that the property is ideal for them. Likewise, do not show family-practice users a \$40 per sf base rent outparcel space; they typically cannot pay that rent, and the visibility benefits their practice little. Generally, the more specialized the practice, the less visibility needed. In the health-care vernacular, it is "downstream" from the referral sources. (See Figure 1-2.) After securing a large family-practice tenant that is an "upstream" referral source for specialists, it would then make sense to pursue specialists for adjacent space. Urgent care, family practice, and pediatrics should be viewed as anchor tenants and specialists, as small shop or b-space users. A parcel



Source: Equity LLC

towards the rear of the site may work well for a multi-tenant MOB if desirable co-tenancies can be established.

### The Politics of Local Health-Care Markets

Another key part of attracting health-care tenancy is understanding the politics of local health-care markets, which differ significantly from retail. Local hospital systems are territorial and often highly competitive with each other. Centers that obtain an anchor tenant affiliated or sponsored by one local hospital system may not be able to secure practices that are owned or affiliated with other players in town. Within many hospital systems, the “directors of real estate” or similar positions are often order-takers who cannot establish new clinic locations until a decision has been made elsewhere in the organization. That may come from a hospital CEO, a director of strategy, a director of outpatient facilities, etc. Frequently, physician or outpatient practice companies are also set up under the hospital umbrella that have a separate hierarchy and decision-making process.

Once the right people and process for making a decision are reached, hospital systems will tend to move slowly and methodically, as they need to seek input from multiple internal constituencies, as well as understand staffing, demand for ancillary services, and impact on patient flow of existing facilities, among dozens of other concerns.

Consumers are likely to associate everything with “the hospital,” but the reality behind the scenes can be much more complicated. In most markets, there are also powerful local or regional multi-specialty physician groups. Within those groups, the hierarchy can sometimes be confusing, as individuals with limited decision-making power may function as administrators for physicians who own the practice: CEOs, COOs, CFOs, etc. In these cases, the decision-makers who really need to be addressed are the physician-partners.

### How Will “Repealing and Replacing” Obamacare Affect All of This?

The short answer is: Hard to say at this point. As of this writing, the Republican overhaul of Obamacare has passed in the House of Representatives and been sent to the Senate. Many of the more popular provisions of the Affordable Care Act (ACA) will likely continue, including enabling children to stay on parents’ plans until they reach 26 years of age. On the other hand, the individual mandate will almost certainly go away. Without vouchers, many of the less advantaged may lose coverage. Retail-based health care has expanded mostly in suburbs. Moreover, the highest-growth private companies and most hospitals have continued to focus on submarkets with the highest densities of private pay insurance. Those markets are going to be minimally impacted by changes to the ACA.

The best course for a retail landlord to assess the future risk of a specific health-care tenant is to dig into how their reimbursement model works and ask some simple questions around what percentage of their revenue comes from self-pay, private insurance, or government payors. This goes hand in hand with framing the tenant mix most compatible with the shopping center’s demographics.

### Conclusion

In the future, the merger of retail and health care will continue. As health-care systems, private companies, and physician practices look for ways to thrive in an increasingly competitive market, and as they seek to deliver convenient health care, they will seek retail. Landlords will continue to seek secure long-term tenancy that is not as susceptible to e-commerce risk (at least not yet; telemedicine is picking up steam, however). The key is how to do it intelligently and create win-win scenarios without disrupting or turning off the retailers that are still the bulk of tenancy. If done well, this continued integration will lead to healthier retail centers.



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