Nodera Health

WHITE PAPER · PROGRAM DESIGN

The real cost of building a consumer-centric cash-pay program.

An honest accounting of the time and staffing required to develop, deploy, and manage outsourced cash-pay programs.

$85K – $171K

YEAR 1, SINGLE PROGRAM (FULLY-LOADED)

$180K – $380K

THREE CONCURRENT PROGRAMS

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Executive Summary

Cash-pay medicine is the fastest-growing profit lane in independent practice. Weight loss, sleep, hormone, longevity, and metabolic programs routinely produce $2,000–$15,000 in per-patient revenue at 40–70% gross margin — numbers no insurance line can match.

But the sticker price of the equipment or vendors is not what breaks these programs. What breaks them is **the invisible operating cost of running one well**: the sourcing meetings, the vendor onboarding calls, the workflow rewrites after the first ten patients, the marketing that has to keep the funnel warm every single week, and the staff hours consumed by the seams between all of the above.

We built this paper because we watch clinics discover this the hard way — six months in, with a program that "technically works," a P&L that looks fine on paper, and a founder or ops lead who quietly admits the whole thing is costing them 15–20 hours a week they didn't budget for.

This paper is not a pitch to build in-house. **We assume you are already outsourcing the clinical, diagnostic, and product components to vendors** — as any modern operator should. The point is to make the *time cost* of running a vendor-orchestrated program visible so you can price it, staff it, or automate it deliberately.

Headline numbers (fully-loaded, single program, Year 1):

COST CENTER	HOURS	COST @ $95/HR BLENDED
Program design & offer construction	60–120	$5,700 – $11,400
Vendor sourcing & vetting	40–80	$3,800 – $7,600
Workflow design & documentation	40–80	$3,800 – $7,600
Vendor onboarding & integration	30–60	$2,850 – $5,700
Ongoing vendor management (annualized)	100–200	$9,500 – $19,000
Consumer marketing (planning + weekly ops)	200–400	$19,000 – $38,000
Patient concierge / coordination (annualized)	400–800	$38,000 – $76,000
Compliance, SOPs, audit trail	30–60	$2,850 – $5,700
Year 1 total (one program)	**900–1,800**	**$85,500 – $171,000**

Three concurrent programs — the point at which clinics typically start seeing meaningful cash-pay revenue diversification — push the annualized labor cost to **$180,000–$380,000**, most of which is not visible on the P&L because it's absorbed inside existing salaries.

The rest of this paper walks each line item — what the work actually is, why it takes the hours it takes, and where the real leverage points sit.

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1. Framing: What "Consumer-Centric" Actually Means

A consumer-centric cash-pay program has four operational qualities that a traditional insurance line does not:

1. **The patient is the buyer.** They compare you to a website, an at-home kit, and a competitor across town. Anything friction-y — a hard-to-schedule intake, a confusing invoice, a vendor result that arrives late — is a churn event, not just a service failure.
2. **Vendors are a delivery layer, not a referral.** Diagnostics, lab draws, wearables, coaching, pharmacy, and compounding pharmacies are all part of *your* branded experience. The patient does not care that their sleep study is Itamar, or their metabolic panel is Quest, or their compounded GLP-1 comes from a 503A pharmacy. They care that *you* delivered a smooth outcome.
3. **The margin is unforgiving.** Cash-pay margins look large until you subtract the labor cost of coordination. A $2,400 sleep program that consumes 6 staff hours across intake, ordering, vendor follow-up, results delivery, and 30-day follow-up has already spent $400–$600 on labor before you consider marketing.
4. **Marketing is a permanent operating cost.** Unlike insurance-driven volume that flows through referrals, cash-pay volume decays the instant you stop feeding it. Every program needs a weekly content + funnel motion.

Miss any one of these four and the program either doesn't scale or scales into a labor sinkhole.

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2. Program Design — 60 to 120 hours

The number people underestimate most, because it *feels* like a one-time upfront task.

What the work actually is:

- **Market and competitive research.** Understanding what similar cash-pay programs charge in your metro, what the digital-native competitors (Ro, Hims, Function Health, Lifeforce, etc.) include and exclude, and where your differentiation sits. Not a Google session — a real 15–25 hour research cycle for one category.
- **Consumer segmentation and positioning.** Who is this program *for*? A cash-pay weight-loss program that targets the 45-year-old peri-menopausal executive is a fundamentally different product than one that targets the 32-year-old post-partum patient — different intake questions, different vendors, different price points, different marketing angles.
- **Offer construction.** What is included at what price tier? One-shot? Recurring? Bundled? Are labs included in the base price or upsold? Is coaching monthly, weekly, on-demand? Every decision cascades into vendor cost, workflow complexity, and margin.
- **Pricing and margin modeling.** Backing into a defensible consumer price by starting from vendor cost stacks, staff labor, marketing CAC, and target gross margin. This is spreadsheet work but it's *judgment-heavy* spreadsheet work; most first drafts leave 15–25% margin on the table.
- **Clinical protocol design.** What are the branching decisions in the patient journey? Which inclusion/exclusion criteria disqualify a patient at intake vs. at labs vs. mid-program? Who signs what? What does the follow-up cadence look like at 30/60/90 days?
- **Legal and scope-of-practice review.** State-by-state constraints on telehealth, prescribing, compounding pharmacy relationships, informed-consent language.

Why it takes what it takes:

You can't shortcut program design by copying a competitor because the constraints (your state, your license, your vendor availability, your patient panel demographics) are yours alone. And the offer/pricing decisions made here will bind every downstream vendor and workflow decision.

Common failure mode: designing the program in isolation from the vendors who will fulfill it, then discovering three weeks into vendor sourcing that the price point doesn't work, the intake criteria the clinical lead insisted on aren't compatible with the diagnostic vendor's operating model, or the marketing team cannot articulate the value prop cleanly to a consumer.

Hours: 60 for a well-scoped single-vertical program, 120+ for a multi-tier program with premium/base bundles.

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3. Vendor Sourcing — 40 to 80 hours

The cash-pay economy is enabled by an ecosystem of specialized vendors — but the sourcing work sits entirely on the clinic.

What the work actually is:

- **Identifying candidate vendors** for each service layer (labs, diagnostics, compounding, coaching, monitoring, wearables). The public directory of "vendors who serve cash-pay clinics" barely exists — most sourcing happens through peer networks, industry conferences, and cold outreach.
- **RFI/RFP process.** For each vendor, understanding their pricing model, minimum commitments, turnaround times, data handoff format, geographic coverage, and account-management model. A short RFI is a 45-minute discovery call plus 2–3 follow-up email cycles.
- **Compliance and credentialing verification.** BAA execution for anyone touching PHI. State registration and licensure verification. For compounding pharmacies, 503A vs 503B distinction, USP <795>/<797> compliance posture, DEA registration. This is not optional and it is not fast.
- **Reference checks.** Talking to two or three clinics already using the vendor. Real conversations, not testimonials — five to seven questions each.
- **Contract negotiation.** Price schedules, service level agreements, termination clauses, data ownership, cross-referral restrictions. Most first-round vendor contracts contain 3–5 terms that are indefensible on a re-read; you have to catch them.

Why it takes what it takes:

Every vendor category has different failure modes. A lab vendor with a great UI can still have a 6-day median turnaround that will collapse the patient experience. A coaching vendor with cheap per-seat pricing can require a 12-month commitment that outlives your first cohort. A compounding pharmacy that's willing to onboard fast may not be able to ship into all your states. You only learn this by asking the right questions of the right people — which is time.

Common failure mode: signing with the first vendor that returns a proposal. The second and third vendor conversations always change the negotiation.

Hours: 40 for a single-vertical program with 2–3 vendors, 80+ for a multi-vendor stack (labs + wearables + coaching + pharmacy).

4. Vendor Onboarding & Integration — 30 to 60 hours

Between "signed contract" and "patient can flow through the vendor cleanly" is a valley most clinics underestimate.

What the work actually is:

- **Account setup, SSO, permissions.** Every vendor portal has its own auth, its own permission model, its own account hierarchy. Getting the right staff members into the right vendor accounts with the right permissions takes 2–4 hours per vendor.
- **Data handoff design.** How does the intake form data get to the lab? How do lab results get back into your record system? Is there an actual integration or is somebody manually re-typing? Is the manual re-typing HIPAA-safe? Almost every vendor claims "we integrate with your EHR" and almost every integration turns out to be a shared Google Drive folder in practice.
- **Test patients / dry runs.** Running 2–3 fake patients through the entire flow before a real patient sees it, and finding the seams — the missing consent form, the vendor account that wasn't provisioned, the notification email that goes to the wrong inbox.
- **Standard operating procedures.** Writing down, for each vendor, exactly how a request gets submitted, what the expected turnaround is, what the escalation path is when it doesn't turn around, and who owns each of those steps.
- **Staff training.** Whoever is going to run this program needs to be able to operate the vendor tools. That's a training block, not a "we'll figure it out on the fly."

Common failure mode: treating onboarding as a checklist rather than a rehearsal. Every program has failure modes that only surface when a real patient hits them; test patients let you find them cheap.

Hours: 30 for a well-documented vendor, 60+ for a stack where you're the first clinic asking the vendor to integrate with a specific EHR or scheduling system.

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5. Workflow Design & Documentation — 40 to 80 hours

Workflow is the connective tissue. It is what turns "we have vendors" into "we have a program."

What the work actually is:

- **Patient journey mapping.** For each program, the full sequence: discovery → intake → screening → payment → diagnostic order → vendor fulfillment → result review → protocol delivery → follow-up → renewal. Every state, every branch, every "what if" (what if the lab is abnormal, what if the patient no-shows the intake, what if the vendor is delayed, what if the patient wants to cancel).
- **Event and trigger design.** Which events cause the workflow to advance? Patient submits intake form → advance. Lab result received → advance. Provider reviews and signs → advance. Payment succeeds → advance. Which events trigger notifications, which trigger tasks, which trigger escalations.
- **Assignment and ownership.** Every step has an owner. If the owner is "whoever notices first," the step is broken. Assignment rules — by role, by patient panel, by day of the week — are unglamorous but this is where quality lives.
- **SLA and drift monitoring.** What's the expected turnaround at each step? At day 3 past expected turnaround, who gets alerted? At day 7? How do you notice — in aggregate — when a vendor's median turnaround has silently drifted from 3 days to 5?
- **Exception paths.** What happens when the vendor doesn't respond? When the patient goes silent? When labs come back abnormal in a way the protocol didn't anticipate? These need to exist *before* the first patient triggers them, not after.
- **Documentation.** Everything above, written down, in a place staff will actually look — not a Google Doc from 8 months ago.

Common failure mode: treating workflow as a project you finish. Real programs' workflows require 2–4 iterations in the first 90 days as reality collides with the theoretical map. Budget for the rewrites.

Hours: 40 for a straightforward linear program, 80+ for a program with multi-vendor branching (e.g., a metabolic program that routes to different follow-up tracks based on labs).

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6. Ongoing Vendor Management — 100 to 200 hours per year

This is the line item that surprises people the most. Vendor relationships are not "set and forget."

What the work actually is:

- **Weekly or bi-weekly touchpoints** with your top 2–3 vendors — 30 minutes each, 25 weeks/year at minimum. Escalations, upcoming volume forecasts, product changes on their side, product changes on yours.

- **Quarterly business reviews (QBRs).** A serious QBR — with volume, quality, turnaround, complaint, and financial data — takes 4–6 hours of prep and 2 hours of meeting. Four per year, per top vendor.
- **Complaint investigation.** When a patient complains — "the lab kit didn't arrive," "the compounded medication came damaged," "the vendor rescheduled my telehealth twice" — someone has to investigate, escalate, follow up, and document. 15–30 minutes per incident, and the incident rate is not zero even with great vendors.
- **Contract renewals and re-negotiation.** Every 12–24 months, every vendor contract. Real preparation (comparing usage vs. commitment, benchmarking pricing, negotiating new terms) is 6–12 hours per contract.
- **Vendor swap-outs.** When a vendor genuinely underperforms and needs replacing — a 40–80 hour project that involves finding a replacement, running a parallel pilot, migrating patients, decommissioning the old integration.
- **Vendor drift monitoring.** Vendors change. Personnel turn over, integration endpoints get deprecated, service catalogs shift. Someone has to be watching, or you'll discover it via a broken patient experience.

Common failure mode: delegating vendor management to whoever answered the last email. Vendor relationships benefit enormously from a single accountable owner on the clinic side.

Hours: 100 for a small stack (2–3 vendors, no swap-outs), 200+ for a larger stack across multiple programs.

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7. Consumer Marketing — 200 to 400 hours per year

For most clinics, marketing is where the "real cost" lives — and it's the hardest to reduce.

What the work actually is:

- **Positioning and messaging development.** Landing page copy, program description, differentiation language. This is a real writing task — not "we'll paste in the vendor's blurb." 20–40 hours upfront per program.
- **Content production.** Blog posts, videos, testimonials, case studies. Even a modest cadence (2 posts/month) is 8–12 hours/month of production time.
- **Paid acquisition.** Facebook/Instagram ads, Google search ads, or influencer partnerships. Even an outsourced agency requires 2–4 hours/week of client-side management (creative approval, budget adjustments, campaign strategy).

- **Funnel design and optimization.** Landing page → screener → intake → consultation → conversion. Every drop-off point is a diagnostic problem. 4–8 hours/month of analytics + iteration.
- **CRM / nurture sequences.** Email flows for people who screen in but don't convert, people who converted but haven't completed intake, people mid-program who need retention. Real email sequences, not "we'll email them when we remember." Setup is 20–30 hours; ongoing management is 4–6 hours/month.
- **Patient reviews and reputation.** Actively soliciting and managing Google, Yelp, and specialty-directory reviews. This is not optional in a cash-pay economy.

Common failure mode: letting the marketing motion decay. Cash-pay volume dies within 60 days of any pause in top-of-funnel activity. Programs that succeed treat marketing as a permanent weekly ops cadence, not a launch campaign.

Hours: 200 for a lean in-house motion with an outsourced ad partner, 400+ for a program run entirely in-house or across multiple programs.

Note on outsourcing: you can absolutely outsource most of this to an agency, but agency fees ($3,000–$10,000/month per program) plus the client-side management hours (still 2–4 hours/week) usually exceed the in-house cost — just moves the dollars from labor to vendor spend.

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8. Patient Concierge & Coordination — 400 to 800 hours per year

The unglamorous middle of every program. Even with great vendors and great workflow, patients need a human at critical moments.

What the work actually is:

- **Intake completion nudging.** Patients who start but don't finish the intake need reminders — the fewer, the better, but zero is a mistake.
- **Scheduling assistance.** Multi-vendor programs require multi-vendor scheduling. Automated is best; when it fails, human catches.
- **Result delivery and Q&A.** A patient who receives lab results without human context churns. Someone needs to be reachable.
- **Escalation triage.** Which patient complaints are the vendor's problem, which are the workflow's problem, which are the clinician's problem. Someone has to route each one.

- **Renewal and retention outreach.** For recurring programs (memberships, quarterly labs), the retention motion is patient-by-patient, and it's staffed.

Typical staffing model: one FTE patient coordinator per 200–400 active patients, or one part-time coordinator per active program in year one.

Hours: 400 for a small-volume program (30–50 patients/year), 800+ for a program at 200+ patients/year.

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9. Compliance, SOPs, and Audit Trail — 30 to 60 hours

Not a large line item, but a non-negotiable one.

What the work actually is:

- **Standard operating procedures** for every intake, vendor handoff, and follow-up. Written, versioned, dated, reviewed.
- **HIPAA-adjacent operational safeguards.** Access logs, minimum-necessary reviews, BAA registry, incident response plan.
- **Consent management.** Program-specific informed-consent forms, telehealth consent (state-by-state), consent to share data with each vendor.
- **Financial audit trail.** Cash-pay creates its own audit surface — receipts, refund records, chargebacks, credit-card reconciliation. Not clinical audit, but operational audit.

Common failure mode: treating compliance as an event ("we passed the audit") rather than a maintenance cadence. State telehealth rules change. Vendor BAAs need renewal. Consent forms need to reflect current protocol.

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10. Bringing It Together: The 3-Program Reality

Most clinics we work with don't run one cash-pay program. They run three — a sleep program, a metabolic/weight program, and a longevity/optimization program. The Year 1 totals compound, but not linearly:

	1 PROGRAM	3 PROGRAMS (CONCURRENT)
Program design	$8,500	$22,000
Vendor sourcing	$5,700	$14,000
Workflow design	$5,700	$14,000
Vendor onboarding	$4,300	$11,000
Ongoing vendor mgmt	$14,000	$32,000
Consumer marketing	$28,000	$75,000
Patient coordination	$57,000	$145,000
Compliance & SOPs	$4,300	$9,500
Total (Year 1)	**$127,500**	**$322,500**

Notice: patient coordination and marketing dominate the total. Program design and vendor sourcing — the parts that *feel* like the "big projects" — are less than 20% of the annual cost.

What this means for your P&L: if you're planning a program on the assumption that vendor cost + a clinician's time = your cost stack, you're understating true cost by 3–5x.

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11. Where the Leverage Points Actually Sit

The temptation is to reduce these costs by cutting corners — running a program without the vendor QBR cadence, skipping the workflow rewrites, letting the marketing decay. That works for exactly one to two quarters before the program's quality (and margin) collapses.

The leverage points that actually work:

1. Turnkey program templates instead of blank-page design. If someone has already done the market research, offer construction, pricing modeling, and clinical protocol for a comparable program, and it's a defensible starting point, you save 40–80 hours of program design and dramatically reduce the "we designed it wrong" iteration risk. This is one of the two highest-leverage moves.

2. Pre-vetted vendor networks instead of solo vendor sourcing. If your operating partner has already vetted, credentialed, and negotiated with a stack of vendors that fits your program, and you can inherit the diligence rather than repeat it, you save 40–80 hours of sourcing and — more importantly — you inherit the risk assessment.

3. Workflow-as-a-product instead of workflow-as-a-doc. Written SOPs decay. Real workflow orchestration — where events actually advance patients, alerts actually fire, drift is actually detected — is a piece of software, not a document. Building it yourself is a 200–400-hour project. Inheriting it as a product is a configuration exercise.

4. Marketing playbooks and positioning that transfer. The marketing angles that work for a metabolic program in Ohio are 80% transferable to a metabolic program in Nevada. Access to that library — plus the templates, funnels, and nurture sequences — compresses the marketing setup from 40 hours to 8.

5. Consolidated vendor management. A single operating partner managing the vendor stack across multiple programs reduces per-program vendor-management hours by 40–60%, and — critically — makes drift detection a byproduct of normal operations rather than an extra project.

None of these leverage points are exotic. They exist because someone has already done the work at scale.

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12. How Nodera Health Compresses Each Line Item

We are the operating layer for consumer-centric cash-pay programs. We do not replace your clinicians, your license, your relationships, or your patient panel. We compress the operating cost of running programs well.

Here's what that looks like against the line items in this paper:

LINE ITEM	TYPICAL YEAR 1 (IN-HOUSE)	WITH NODERA
Program design	60–120 hours	4–8 hours (activation from template)
Vendor sourcing	40–80 hours	0 (pre-vetted network, per program)
Vendor onboarding	30–60 hours	2–4 hours (SSO + branding)
Workflow design	40–80 hours	0 (turnkey, versioned)
Workflow management	60–120 hours/yr	Managed by the platform
Vendor management	100–200 hours/yr	20–40 hours/yr (escalations only)
Consumer marketing	200–400 hours/yr	60–100 hours/yr (playbooks + templates)
Compliance & SOPs	30–60 hours	Inherited (BAA registry, SOP library)

For a clinic running three concurrent programs, this typically maps to **$180K–$260K of avoided Year 1 operating cost**, plus the option value of moving faster on new programs when the market shifts.

Patient coordination is the one line item that stays with you — because it's your patients, your brand voice, your clinical relationship. But the *volume* of coordination work drops by 40–60% when the workflow and vendor management around it are already handled.

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13. Closing: The Honest Trade

Building cash-pay programs in-house is defensible if you're a large group willing to fund a dedicated operations team, or if your program is so specific to your practice that no external template applies. In those cases, use this paper as a budget guide.

For everyone else — the 90% of independent practices for whom cash-pay is a growth engine but not an operating identity — the mathematics of hours-to-revenue argue for a different posture: **outsource the operating layer, not the medicine**.

Program design, vendor sourcing, workflow orchestration, and vendor management are commoditizable in a way that clinical care and patient relationships are not. If somebody else can compress those line items by 60–80% without compromising quality, the honest question is not *can*

I do this myself? — it's *should I spend Q3 running vendor RFPs, or should I spend Q3 seeing patients?*

We built Nodera because we think that answer is obvious.

Appendix A: Rate Assumptions Used

All labor costs modeled at a **blended $95/hour** fully-loaded (salary + benefits + overhead). This reflects: - Founder/MD time: $200–$400/hour (fewer hours, higher rate) - Practice manager / RN: $80–$120/hour - Patient coordinator / MA: $45–$65/hour - Marketing coordinator: $60–$85/hour

Substitute your own rates for a bespoke model. Directional conclusions hold across a wide rate range.

Appendix B: What This Paper Does Not Cover

- Capital equipment (assumed outsourced to vendors).
- Physical space / facility costs.
- EHR / practice-management software (assumed already in place).
- One-time state licensure or credentialing for the practice itself.
- Founder / owner opportunity cost of being the on-call operator during the first year.

The last one — founder opportunity cost — is the largest unmodeled expense in this entire paper. Every hour a clinic owner spends managing vendors is an hour not spent on clinical work, business development, or life. That's the real ceiling on how many programs an in-house model can support.

Nodera Health builds the operating infrastructure for cash-pay medicine. If you're evaluating how much of the above you actually need to build yourself, talk to us.