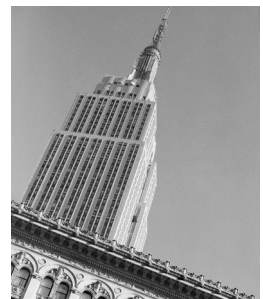
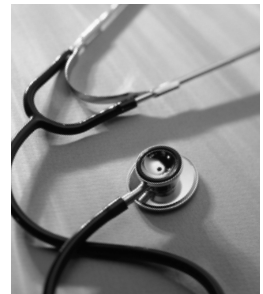
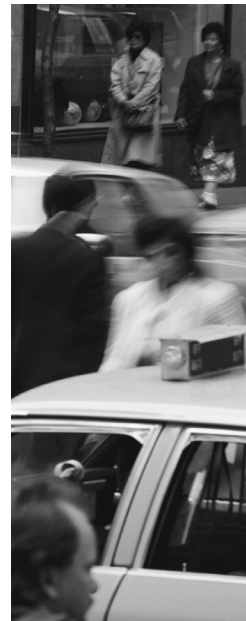
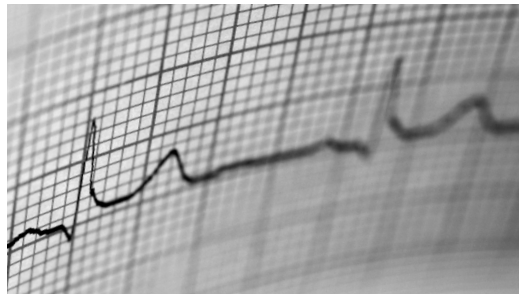


Convenient Care: Retail Clinics and Urgent Care Centers in New York State



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Convenient Care: Retail Clinics and Urgent Care Centers in New York

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Foreword

Driven by both consumer demand and the prospect of new business and professional opportunities, “convenient care”—the collective term for urgent care centers and retail clinics—is a major development in the delivery of ambulatory care. The report that follows, produced by staff of the Fund’s Innovation Strategies Initiative and colleagues at the NYU Langone Medical Center, recognizes that the impact of these new types of providers goes well beyond the consumers they serve, to the wider health care system.

This project is an outgrowth of the significant investment the Fund has made in documenting and analyzing the continuing evolution of primary care. A large part of that work has focused on the goal of integrated care, as embodied in the patient-centered medical home.

Urgent care centers and retail clinics insert an interesting twist in that emerging story. They represent, potentially, a step back from the ideal of a team of providers working together to coordinate care, focus on wellness and prevention, and better manage quality, continuity, and costs. As such, it is vital that we understand their implications, and consider how New York’s policymakers, payers, and other providers might best respond.

In looking to the literature on convenient care nationally, and assessing its status in New York, we sought to connect the dots between this recent development and the restructuring, throughout the health care system, of how care is delivered, paid for, and coordinated. We found not only possible points of conflict but, as important, ways that convenient care might support primary care. We hope you will find this report of value, and welcome your comments on it.

JAMES R. TALLON, JR.
President
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The views expressed here are those of the authors and not necessarily those of New York University or the New York City Health and Hospitals Corporation.

Executive Summary

Over the last few years New Yorkers have seen the emergence of two relatively new models of ambulatory care—retail clinics and urgent care centers, collectively known as “convenient care.” This growth has been driven by consumer demand for more convenient, accessible, and affordable care, and entrepreneurial providers willing and able to respond to this market force.

The growing role of convenient care in New York poses important questions on who these providers are, how they interact with the rest of the health care system, what their potential is for enhancing access, how they may disrupt traditional relationships, and how their quality performance compares to traditional sites of care. This paper will help policymakers tackle the challenge of how to balance support for the potential positive contributions of convenient care with the essential protections that patients require.

Convenient Care: The National Picture

Definitions and Distinctions

Both retail clinics and urgent care centers offer walk-in services with extended evening and weekend hours, but important distinctions exist between the two models:

Retail clinics generally offer limited services for specific minor acute conditions with clear clinical guidelines; some are expanding their scope to include management of chronic illness. Nationally, there are some 1,800 retail clinics, receiving more than 6 million visits annually. Most (70 percent) are owned by pharmacies or big-box retailers, and rely on lower-cost providers—nurse practitioners and physician assistants. Their client base is primarily young adults (ages 18-44) and people without a usual source of care (61 percent, versus the national average of 20 percent).

Urgent care centers treat patients with higher-acuity conditions, similar to those treated in primary care but with an emphasis on episodic illness and minor trauma; nearly all provide simple lab tests, and most offer basic x-ray services. Nationally, an estimated 9,000 urgent care centers receive some 160 million visits annually. Ownership is divided among physicians/physician groups (35 percent), corporations (30 percent), hospitals (25 percent), and non-physician individuals or franchisers (7 percent). Nearly all centers have at least one physician on staff, about three-quarters of them board-certified, most often in family medicine.

Potential Benefit and Risk

Lower costs. A number of studies have found lower costs per episode of care at both retail clinics and urgent care centers, compared with physicians’ offices and emergency departments, despite concerns about stimulating increased utilization or unnecessary or duplicative follow-up care elsewhere.

Increased access—for some. Sited in more affluent areas, with high concentrations of residents with employer-sponsored coverage, convenient care providers increase access for higher-income consumers by providing after-hours care, but are not yet addressing the access issues of residents of low-income, medically underserved areas.

Quality—comparable, with some cautions. The limited number of studies, to date, indicate that quality is at least as good as that provided in more traditional settings—at least for certain acute conditions. But study limitations, in part, have led several physician associations to raise concerns.

Continuity of care versus fragmentation. Evidence supports concerns that convenient care may reduce opportunities to build long-term primary care relationships. Several studies found that patients using retail clinics had less continuity of care in the following year; the uninsured and other vulnerable patients are at particular risk of “care disjuncture.”

Convenient Care in New York

A systematic analysis of convenient care databases allowed us to determine the number of retail clinic and urgent care sites in New York and their distribution in relation to population density, median household income, and medically underserved areas.

Number

Of 366 urgent care centers in New York State, 103 are in New York City. An additional 105 centers are slated to open throughout the state in the next three years. Among the state’s 18 retail clinics, 12 are in New York City—one of the lowest penetration rates, per capita, nationally.

Geography Limits Access for the Underserved

Convenient care providers tend to locate in areas of relatively high population density or high income. Few of either model—33 of 366 urgent care centers, and 6 of 18 retail clinics—are located in Medically Underserved Areas or convenient to Medically Underserved Populations, limiting the potential benefit for the Medicaid population.

Assessing the Field: The Conversation in New York

Retail clinics and urgent care centers play an important role in satisfying consumer demand and in potentially shifting care to lower-cost settings, but have the potential to disrupt longitudinal doctor-patient relationships and undermine the medical home model of primary care. How these providers might help or hinder New York’s goals of providing high-quality, affordable, accessible health care for all—and whether policymakers should adopt a stronger regulatory stance, assist the growth of convenient

care, or take a laissez faire approach until more is known about performance—is at the heart of growing discussion.

Intragroup Variation

Among urgent care centers, differences in ownership and operating models lead to significant variations in clinic hours, services provided, staff training, and on-site equipment and capacities. Retail clinics differ most markedly in their scope of services—whether they manage or treat chronic diseases as well as minor acute conditions.

Potential Benefits

The growth of convenient care offers a number of potential benefits, including reducing unnecessary emergency department utilization, expanding access to preventive services such as immunizations, supplementing primary care through extended evening and weekend hours, and connecting patients who lack primary care physicians with permanent sources of care.

Significant Challenges

Convenient care also presents a set of intertwined challenges, including the potential for fragmenting and disrupting existing care relationships, particularly for the chronically ill; destabilizing the economic viability of primary care providers through “cream skimming” of high-volume commercial insurance business; and making it more difficult for patients to navigate the range of available health care resources safely and appropriately. Quality of care, particularly in urgent care centers, is also a concern.

Vulnerable Populations

While most of the concerns about convenient care apply to all New Yorkers, two populations—Medicaid beneficiaries and pediatric patients—warrant particular scrutiny.

Medicaid beneficiaries. A number of circumstances have thus far limited the value of convenient care, particularly urgent care centers, for the Medicaid population. These include the paucity of convenient care providers in low-income neighborhoods, contracting issues related to payment classification codes, and concerns about interfering with primary care relationships. Access-improvement strategies that have been proposed include “public” urgent care centers and insurer/health system partnerships to establish urgent care centers in neighborhoods with high emergency department use.

Pediatric patients. Concerns about the appropriateness of convenient care for children focus on two major issues: disruption of existing, important primary care relationships, and ensuring that staff have sufficient pediatric experience and will follow pediatric clinical guidelines.

Policy Options

In weighing regulatory options, policymakers must balance the significant consumer demand for convenient care, and the potential for these providers to reduce emergency department overuse and costs, against the potential for harm from poor quality or inappropriate use of this care. Too little is currently known about how those concerns stack up against the benefits empirically. As our understanding evolves, however, the State could consider several policy options to establish basic consumer and public health protections.

Define urgent care centers and retail clinics. Defer to standards established by existing accrediting organizations or develop naming conventions and standards specifying required services. Alternatively, require posting of consumer information on services and consider mandating signage indicating pediatric expertise.

Encourage convenient care providers to proactively connect patients who lack primary care providers to a permanent source of care, and support their doing so. Options include formally recognizing “gold standard” referral practices; making tools and information, such as lists of nearby primary care providers, available to convenient care providers; and mandating referral to permanent care sources.

Promote connection with regional health information exchanges and the SHIN-NY health information system when it is operational. Integrating convenient care into the broader health ecosystem requires the flow of high-quality information between urgent care centers/retail clinics and primary care providers. The State should ensure that convenient care providers are incorporated into regional and statewide strategic plans for health information exchange.

Develop consensus on quality and safety measures and their reporting. As measurement of outpatient quality evolves, policymakers should begin systematically tracking the performance of retail clinics and urgent care centers—ideally using a subset of existing metrics for other ambulatory care settings. The State could consider beginning with metrics from two common ambulatory care data sets: the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS).

Encourage greater access for underserved areas and populations, without jeopardizing current special designations. With proper assurances of quality and continuity of care, opportunities for incentivizing the growth of convenient care in underserved areas could be explored through Medicaid reimbursement; within the State’s tax, fee, and subsidy structures; and via municipal zoning regulations. The State must guard against unintended consequences of such efforts, notably loss of designations as medically underserved areas or primary care shortage areas, which could destabilize full-service primary care practices already located there.

Introduction

New York State's health care market is rapidly changing, with partnerships and consolidation increasing among existing providers, and a proliferation of new types of providers with the avowed mission of making care quicker, better, easier, and more affordable. Chief among these new entrants are two emerging models of ambulatory care: retail clinics and urgent care centers, collectively known as "convenient care." The growing role of these providers in New York's health care poses important questions for policymakers—such as how to balance support for the potential positive contributions of convenient care with the essential protections that patients require. This paper is an initial attempt to give policymakers, and other stakeholders, the overview they need to tackle that challenge.

The seemingly sudden growth in New York of urgent care centers and, to a lesser extent, retail clinics has been attributed to a number of forces, including a general shift to care being increasingly delivered in ambulatory settings. But a central force behind this growth is consumer demand. Consumers increasingly expect health care services to be as responsive and accessible as other service industries, such as banking. With enrollment in high-deductible health plans now common, consumers are also facing a higher share of health care costs, leading them to seek lower-cost care when possible.

Compared to traditional sites of ambulatory care, retail clinics and urgent care centers place a greater emphasis on providing on-demand care. Both operate mainly on a walk-in basis and typically offer extended evening and weekend hours, compared with primary care offices. Yet there are important distinctions between these newer models. Retail clinics generally offer limited services for specific minor acute conditions, while urgent care centers are often equipped to care for patients with higher-acuity conditions. Their overlapping domains of practice—and their relationship to more traditional sites of care—are outlined in Table 1.

To explore what is known about these models, both nationally and in New York, and to identify key issues that they raise for New York State, we undertook three primary activities for this report: a literature review; a census of urgent care centers and retail clinics across New York State, overlaying locations on maps of income, population density, and medically underserved areas; and semi-structured qualitative interviews with experts and other representatives from the convenient care sector, health systems, and health insurance plans, as well as policymakers. We did not explore other convenient care options, such as virtual care, "telehealth," and mobile health platforms, which we considered beyond this project's scope.

Table I. Typology of Convenient Ambulatory Care

	Retail Clinic	Primary Care Office (regular practice and walk-in service)	Urgent Care Center	Freestanding Emergency Department	Emergency Department (fast-track and full-service)
Level of acuity of condition	<div><div>Low</div><div>High</div></div>				
Services provided	Walk-in care for specific acute conditions with clear clinical guidelines. Some retail clinics are expanding their scope to include chronic illness management.	Health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses.	Acute care services similar to those provided by primary care, but primarily on walk-in basis. Emphasis on episodic care; not intended for long-term management of chronic conditions.	Walk-in care for acute conditions, but without the capacity of a hospital-based ED to handle the full scope of trauma and life-threatening conditions (e.g., requiring surgery or inpatient care).	<i>Fast-Track:</i> Various approaches and services but typically treating lower-acuity conditions. <i>Full-Service:</i> Extensive and highly specialized care for all levels of acuity.

The resulting report focuses on four broad questions:

- What does the academic and popular literature indicate about the organization, growth, and performance of retail clinics and urgent care centers across the United States?
- How many convenient care providers exist in New York State, where are they located, and whom do they serve?
- What are the major opportunities and challenges posed, for the health care system as a whole and for subsets of patients, including the uninsured and underinsured?
- What options should New York’s policymakers consider to help guide the growth of retail clinics and urgent care centers, improve their performance, widen accessibility, and integrate them into the state’s evolving health care system?

Convenient Care: The National Picture

Despite a relatively limited body of literature, particularly peer-reviewed studies, recent academic and popular press analyses provide a valuable overview of the proliferation and performance of retail clinics and urgent care centers across the U.S. Our full literature review methodology, including search terms and results, appears in Appendix A.

Proliferation and Scope of Care

Urgent Care Centers

Definition: While no single nationally accepted definition exists, urgent care centers are generally considered to be health care facilities providing walk-in medical care for a wide range of acute conditions that are non-emergent but require prompt attention. New York State’s Public Health and Health Planning Council (PHHPC) recommended that urgent care be statutorily defined as the “treatment of acute episodic illness or minor traumas...not for emergency intervention for major trauma, life-threatening or potentially disabling conditions, or for monitoring and treatment over prolonged periods. Urgent care is not intended to be a patient-centered medical home or a source of continuing care” (PHHPC 2014). That definition was not enacted, however, as discussed below in “Assessing the Field” (page 14).

With a focus on convenience, essentially all urgent care centers offer immediate walk-in care—no appointment required—with extended hours on weekday evenings and service on at least one weekend day (Urgent Care Association 2011; Weinick and Betancourt 2007).

Growth and Ownership. Urgent care centers began appearing in the U.S. during the 1970s but the industry did not begin growing steadily until the mid-1990s, a trend that continues. Because federal registration is not required, estimates of the number of urgent care centers vary. The most frequently cited figure, however, based on a database maintained by the Urgent Care Association of America (UCAOA), is 9,000 centers (Urgent Care Association 2014). Of these, 35 percent are owned by physicians or physician groups, 30 percent by corporations, 25 percent by hospitals, and 7 percent by non-physician individuals or franchisers (Urgent Care Association 2013). Nationally, urgent care centers receive some 160 million visits annually, UCAOA estimates.

Services. The scope of services offered by urgent care centers varies widely but typically falls between those of a primary care office and an emergency department (Weinick and Betancourt 2007). The most comprehensive national survey of urgent care centers found that the vast majority offered some form of occupational medical services¹ (92.6 percent), fracture care and other orthopedic services (80.7 percent), and sports and school physicals (79.3 percent). Nearly two-thirds (63.5 percent) offered routine immunizations, and—although ongoing care isn’t within their avowed scope of

¹ Occupational medical services include employment physicals, employment-related drug testing, treatment of workplace injury or illness, and case management and evaluation.

practice—more than half (54.4 percent) offered treatments and services that they considered to be primary care (Weinick, Bristol, and DesRoches 2009b).²

Nearly all the surveyed centers (93.3 percent) provided some onsite laboratory tests, primarily those considered to be simple and with low risk of error; only about a fifth offered complex tests requiring full laboratory certification. While the vast majority could perform x-ray exams, only 18.6 percent offered ultrasound and 14 percent CT scans (Weinick, Bristol, and DesRoches 2009b).

Staffing. The vast majority of urgent care centers follow a physician-staffing model, with 96 percent of surveyed centers reporting at least one physician on staff, about three-quarters of them board certified (Weinick, Bristol, and DesRoches 2009a, 2009b). Family medicine is the most common specialty; about 75 percent of all centers had one or more family physicians on staff, with an average of 3.3 per site. Emergency medicine physicians were on staff in 47 percent of the clinics, and internists in 39 percent.

Retail Clinics

Definition. Like urgent care centers, retail clinics offer convenient walk-in care, with extended evening and weekend hours. Located in retail stores, supermarkets, or pharmacies, however, their emphasis is on treating a limited number of low-complexity acute conditions, as well as providing select preventive health care services, such as vaccinations.

Growth and Ownership. Nationally, the number of retail clinics has grown steadily since their inception in 2001. After several years of relatively slow growth, the industry experienced a rapid expansion between 2006 and 2008, with a net addition of 999 clinics (Kaissi and Charland 2013). Visits to retail clinics also quadrupled between 2007 and 2009, to an estimated 6 million (Mehrotra and Lave 2012). Growth slowed in the following two years but picked up again in 2011 and has continued to accelerate since. As of November 2014, there were approximately 1,805 retail clinics throughout the country (Terhune 2014), a number projected to reach upward of 2,800 by 2015 (Accenture 2013). Despite this rapid growth, retail clinics remain a relatively small presence in the health care scene. Results from the nationally representative 2010 Health Tracking Household Survey found that only 2.9 percent of U.S. families reported using retail clinics in the previous year (Tu and Boukus 2013). About 70 percent of retail clinics nationwide are owned by pharmacies or big-box retailers; the remainder belong to hospital systems (18 percent) or private owners (12 percent) (Kaissi and Charland 2013).

Services and Staffing. In general, retail clinics offer a limited scope of services based on clear clinical protocols (Mehrotra et al. 2010). Ten clinical situations, including sinusitis and requests for immunizations, account for more than 90 percent of retail clinic visits³ (Mehrotra et al. 2008). This limited scope of service reflects a staffing

² The survey did not define primary care, however. As noted above, several commonly accepted components of such care—including immunizations and physicals for sports and school—were defined separately.

³ The ten conditions are: upper respiratory infections, sinusitis, bronchitis, pharyngitis, immunizations, otitis media, otitis externa, conjunctivitis, urinary tract infections, and screening lab test or blood pressure check (Mehrotra et al. 2008).

model that is heavily reliant on lower-cost providers such as nurse practitioners and physician assistants (Mehrotra 2013). Some large retail clinic chains, including Walmart and Walgreens, have recently started to broaden their array of services to include chronic disease management and primary care (Abrams 2014).

Client Base. Retail clinics tend to attract young adults, as well as people without a usual source of care. A study of 1.3 million visits to retail clinics between 2000 and 2007 found that 43 percent of patients were between the ages of 18 and 44—a group that accounts for only 23 percent of patients seeing primary care physicians. The same study also found that only 39 percent of retail clinic patients reported having a personal doctor. In contrast, 80 percent of patients nationally report a usual source of care (Mehrotra et al. 2008).

Opportunities and Risks

Cost: Lower than Other Settings, Initial Findings Show

One of the “value propositions” most commonly cited for these convenient care options is their potential to deliver health services at lower cost than traditional ambulatory care sites, largely due to lower overhead for staffing and facilities (Mehrotra 2013; Weinick, Burns, and Mehrotra 2010). A number of studies support this view, finding lowest costs per episode of care for a number of simple acute conditions at retail clinics and urgent care centers, as noted in Table 2. The first of these was based on claims data from a large health plan in Minnesota, calculating cost as the sum of health plan reimbursements and any patient co-payments (Mehrotra et al. 2009). Similar results were found by another study calculating cost as the sum of both medical and pharmacy costs paid by the insurer and patient (Thygeson et al. 2008).

Table 2. Costs per Episode of Care Based on Ambulatory Care Site

Total Costs	Retail Clinic	Urgent Care Center	Physician Office	Emergency Department
Mehrotra 2009*	\$110	\$156	\$166	\$570
Thygeson 2008**	\$104	\$154	\$159	\$383

Source: Adapted from Weinick RM, CE Pollack, MP Fisher, EM Gillen, and A Mehrotra. 2010. Policy Implications of the Use of Retail Clinics. http://www.rand.org/content/dam/rand/pubs/technical_reports/2010/RAND_TR810.pdf. Accessed January 14, 2015.

* Included costs for treatment of otitis media, pharyngitis, and urinary tract infection.

**Included costs for treatment of conjunctivitis; otitis media without surgery; tonsillitis, adenoiditis, or pharyngitis without surgery; acute sinusitis; and infection of the lower genitourinary system.

This lower per-episode cost has the potential to reduce the total cost of care if convenient care is used instead of a more expensive site, notably the emergency department. According to one estimate, 13-27 percent of all emergency department visits could be handled at an urgent care center or retail clinic—a potential annual cost savings for the health care system of \$4.4 billion (Weinick, Burns, and Mehrotra 2010).

Conversely, total costs of care could increase if retail clinics and urgent care centers stimulated increased utilization—in part due to the greater access they provide—or if patients use unnecessary or duplicative follow-up care at a traditional site. Few studies have addressed this issue but we did find some that suggest that—at least for retail clinics—cost savings generated by the substitution effect outweigh the negative impact of induced demand or additional follow-up care.

One study addressed the potential for further downstream costs by analyzing patients' total medical costs for six months following an index visit to a retail clinic or to a same-day acute care clinic. Although based on a small sample from a single group practice in Minnesota, the study found that patients who visited retail clinics had lower total costs than matched patients who visited the acute care clinic (Rohrer, Angstman, and Bartel 2009). A more recent study of adult primary care patients, also in Minnesota, found that the odds of return visits for treatment of sinusitis were the same whether patients received care at a retail clinic or in a regular office visit (Rohrer, Angstman, and Garrison 2012).

Perhaps more telling, a larger study of spending patterns of CVS Caremark employees found a significantly lower total cost of care in the year following a first visit to a retail clinic compared to costs incurred by propensity score-matched individuals who received care in other settings. In total, retail clinic users spent \$262 less than their counterparts, with savings stemming primarily from lower medical expenses at physicians' offices (\$77 savings) and reduced spending for hospital inpatient care (\$121 savings). Retail clinic users also had 12 percent fewer emergency department visits than their counterparts (Sussman et al. 2013).

We saw nothing analogous on the impact of urgent care centers on total costs, but one study found that initial use of an urgent care center significantly reduced emergency department visits without increasing patient hospitalizations (Merritt, Naamon, and Morris 2000). Those results should be cautiously interpreted, however, given the study's design limitations.

Access: A Boon for More Affluent Patients

Another potential benefit of convenient care is the increased access to care that it may afford, particularly for underserved and uninsured populations that lack a regular source of primary care (Cassell 2012; Urgent Care Association 2011; Convenient Care Association Fact Sheet). Yet studies have found that both urgent care centers and retail clinics tend to be located in more affluent areas, with higher concentrations of patients with employer-sponsored health coverage, rather than in underserved or low-income areas. For example, Rudavsky and Mehrotra (2010) found that only 12.5 percent of retail clinics are located in a designated health professional shortage area, although 21 percent of the U.S. population resides in one; Pollack and Armstrong (2009) also found that retail clinics were less likely located in medically underserved areas. And Tu and Boukus (2013) found higher-income families nearly twice as likely as lower-income families to have used a retail clinic. Meanwhile, a study of urgent care centers in six cities found that they tend to locate in more populous and higher-income areas (Yee, Lechner, and Boukus 2013).

Nevertheless, while not poised to address the access issues facing the underserved, retail clinics and urgent care centers may make receiving care simpler for more affluent patients by filling gaps left by traditional sites of ambulatory care. In one study, for example, nearly 60 percent of individuals with a usual source of primary care reported that their doctor's practice did not have extended hours; one in five patients who attempted to reach their primary care provider after hours found it "very difficult" or "somewhat difficult" to make contact with a clinician (O'Malley 2013). In contrast, two separate studies found that nearly half of all visits to retail clinics occurred on weekends or in the evening, when primary care offices are usually closed (Patwardhan et al. 2012; Mehrotra and Lave 2012).

Quality: Comparable Results, with Caveats Noted

While research is still relatively sparse, the few studies addressing the quality of care in urgent care centers and retail clinics indicate that it is at least as good as that received in more traditional ambulatory care settings, such as the primary care office—at least for certain acute conditions.

Using claims data from one large health plan, Mehrotra, Liu, and colleagues (2009) found that aggregate quality on 14 measures—calculated by dividing the number of instances in which recommended care was delivered by the number of opportunities for providing recommended care—was similar in urgent care centers (62.6 percent), retail clinics (63.6 percent), and physicians' offices (61.1 percent), while significantly lower in emergency departments (55.1 percent). The same study found that a significantly lower percent of patients first seen in an emergency department received any preventive care as part of their visit and in the three months following the first visit, compared to patients who first visited a retail clinic, physician office, or urgent care center for the same condition. This study examined an insured population in Minnesota, matched for cases of otitis media, pharyngitis, or UTI, so it is difficult to generalize to a larger population or wider range of conditions.

Addressing the small scope of that study, Shrank and colleagues (2014) replicated it with a larger, nationally representative sample, using Aetna medical and prescription claims from 25 states. They examined the treatment of otitis media, pharyngitis, and UTI, matching episodes initiated at CVS Minute Clinics with those from ambulatory care facilities and emergency departments, and found that the quality of care, based on measures of evidence-based practice including appropriate diagnosis, was higher at retail clinics than at both ambulatory care facilities and emergency departments. As with the earlier study, however, their retrospective matching to establish comparison groups may not have captured systematic differences that may bias the results (e.g., those with more severe illness seeking care at an ED).

Despite these findings, and perhaps in part due to the study limitations described above, several leading physician associations, including the American Academy of Family Physicians and the American Academy of Pediatrics, have raised concerns about the quality of care provided in these settings (AAFP 2014; AAP 2014).

Continuity of Care—and Fragmentation: Findings Validate Concerns

Another major concern is that these new ambulatory care models may disrupt care continuity and erode the relationship between patients and their primary care provider or medical home. Both the American Academy of Family Physicians and the American Academy of Pediatrics have released public statements of concern about the potential for retail clinics to fragment care and reduce opportunities to build a primary care relationship (AAFP 2014; AAP 2014).

Some empirical evidence exists to support that concern. Reid and colleagues (2013), for example, found that patients who visited a retail clinic to treat a simple condition experienced lower continuity of care in the following year than matched patients with similar conditions who visited their PCPs. Additionally, those who visited a retail clinic were also significantly less likely to go to their PCP when they developed a new condition. Similar results were found in an observational study of adult primary care patients in a large group practice in Minnesota (Rohrer et al. 2013). Vulnerable patients, including those who are uninsured or underinsured, are particularly subject to care disjuncture when moving between health systems, plans, or communities (Ladapo and Chokshi 2014). The proliferation of convenient care options has the potential to increase overall access to care for low-income populations, but could also widen the divide between those with continuous sources of care and those without.

Convenient vs. Traditional Care: Key Comparisons

Taken together, the findings from this literature review and our other research help crystallize the similarities and differences between convenient care and more traditional ambulatory care settings, as outlined in Table 3.

Table 3: Ambulatory Care Site Comparisons

	Retail Clinic	Primary Care Office	Urgent Care Center	Emergency Department
Highest acuity of conditions treated	Low	Moderate	Moderate	High
Staffing and equipment levels	Low	Moderate	Moderate	High
Costs per episode*	Low	Moderate	Moderate	High
Evening and weekend access	High	Low	High	High
Emphasis on care continuity	Low	High	Low	Low

*For those episodes commonly treated at all four sites of care.

Convenient Care in New York: Mapping the Sites

To determine the number of convenient care sites in New York State and the characteristics of *where* they are located we called on a variety of resources. We identified urgent care center locations primarily through the membership directories of three organizations, the American Academy of Urgent Care Medicine (AAUCM), Merchant Medicine, and the Urgent Care Association of America (UCAOA). For our census of New York retail clinics, we conducted an independent search of each of the websites of the 17 largest retail clinic operators in the country. We also used the Merchant Medicine retail clinic database, obtained in October 2014, and, finally, information gained during our interviews with experts and stakeholders.

For the mapping segment of this study we geocoded the addresses of New York's urgent care centers and retail clinics and then overlaid them on maps of population density, median household income, and medically underserved areas of New York State and New York City.

Details on our data sources and methodology appear in Appendix B.

Number of Sites

Our census found 366 open urgent care centers in New York State, 103 of which are located in New York City. We also found 55 urgent care centers slated to open in the near future, 50 of which belonged to three urgent care chains: CityMD, Cure Urgent Care, and ProHealth. In October 2014, North Shore-LIJ Health System announced plans to open 50 Go Health urgent care centers over the next three years.

The search process for retail clinics identified 18 sites, 12 of them in New York City. The clinics belong to three operators: Duane Reade (10 locations), CVS Minute Clinic (6 locations), and Quick Care (2 locations).

Table 4. Census of Convenient Care Options in New York State

	New York City	Rest of State	Total
Urgent Care Centers	103	263	366
Retail Clinics	12	6	18

Determinants of Location: Population Density and Income

Consistent with findings from our literature review, New York’s urgent care centers and retail clinics are disproportionately located in areas with either relatively high population density or high income (Yee, Lechner, and Boukus 2013; Rudavsky and Mehrotra 2010), as seen in Figures 1 and 2. This relationship is observed at both at the state and city level. In New York City, in particular, clusters of convenient care in areas of lower population density tend to be in areas of high household income (Figures 3 and 4).

Access for the Underserved

To explore the hypothesis that urgent care centers and retail clinics have the potential to be a new source of care for the underserved, we plotted the locations of New York’s convenient care options over the state’s Medically Underserved Areas/Populations (MUAs/Ps), as designated by the Health Resources and Services Administration. These MUAs/Ps are defined by insufficient access to health care resources, as determined by both the supply and demand for primary care.⁴ MUA/P designations can be based on geographic boundaries or on the proportion of specific medically underserved populations within broader geographic areas.⁵

In New York State, only 33 of the 366 urgent care centers (9 percent) currently operating are located in an area considered to be medically underserved. The figure for retail clinics was higher, with 6 of the 18 located in an MUA/P (Figure 5).⁶

In New York City, 18 of 103 urgent care centers, and 3 of 12 retail clinics, were located in designated MUAs/Ps (Figure 6).

While location is not the only factor determining whether urgent care centers and retail clinics will serve as new access points for the underserved, physical proximity to underserved neighborhoods is a prerequisite for providing care to high-need populations. Other important considerations, such as whether these providers accept Medicaid reimbursement, are discussed in the “Vulnerable Populations” section below (page 25).

⁴ Supply of primary care is assessed by measuring the number of primary care physicians relative to the population served; demand is measured relative to need-related variables, including rates of infant mortality, poverty, and advanced age.

⁵ Additional population groups that do not meet the standard threshold but face documented “unusual local conditions [that] are a barrier to access to or the availability of personal health services” can also be recommended, by the governor and local health officials, for inclusion as MUPs.

⁶ This figure was determined using the “select by location” function of ArcGIS, counting retail clinics and urgent care centers that “intersect” with an MUA/P.

Figure 1. Convenient Care Locations by Population Density, New York State

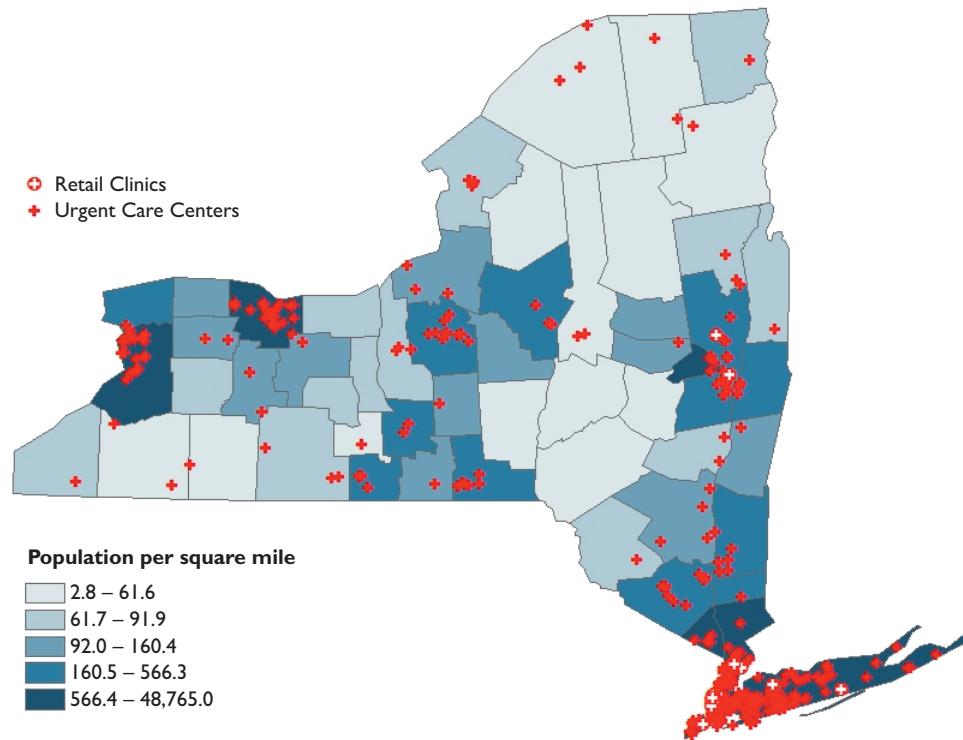
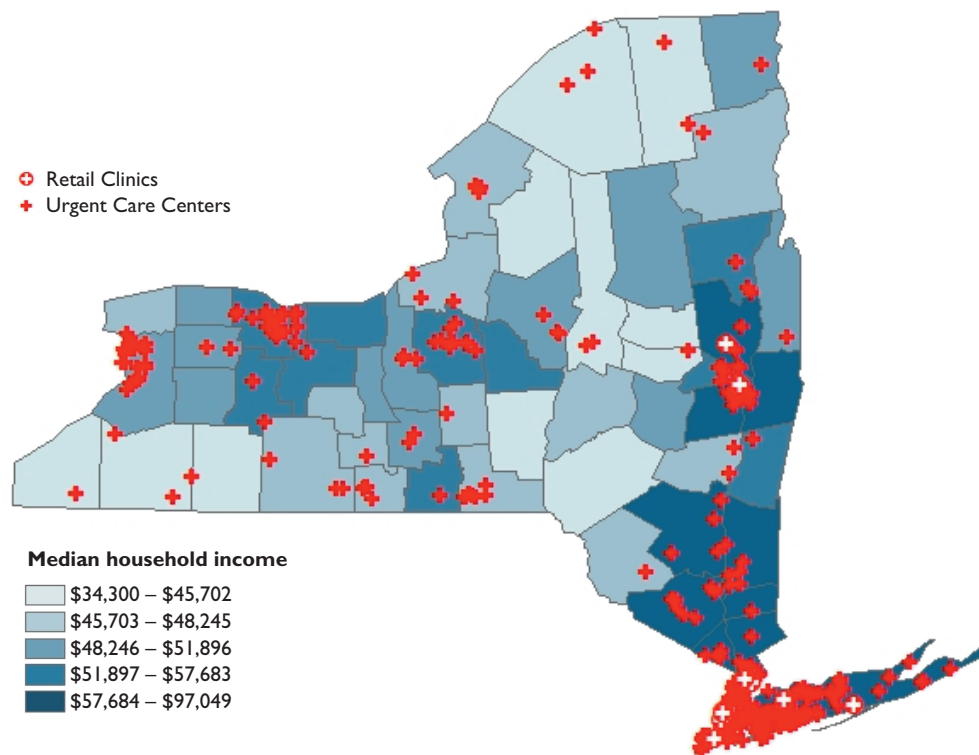


Figure 2. Convenient Care Locations by Household Income, New York State



Note: Income based on quintiles because range of income across counties was deemed too narrow to use poverty level.

Figure 3. Convenient Care Locations by Population Density, New York City

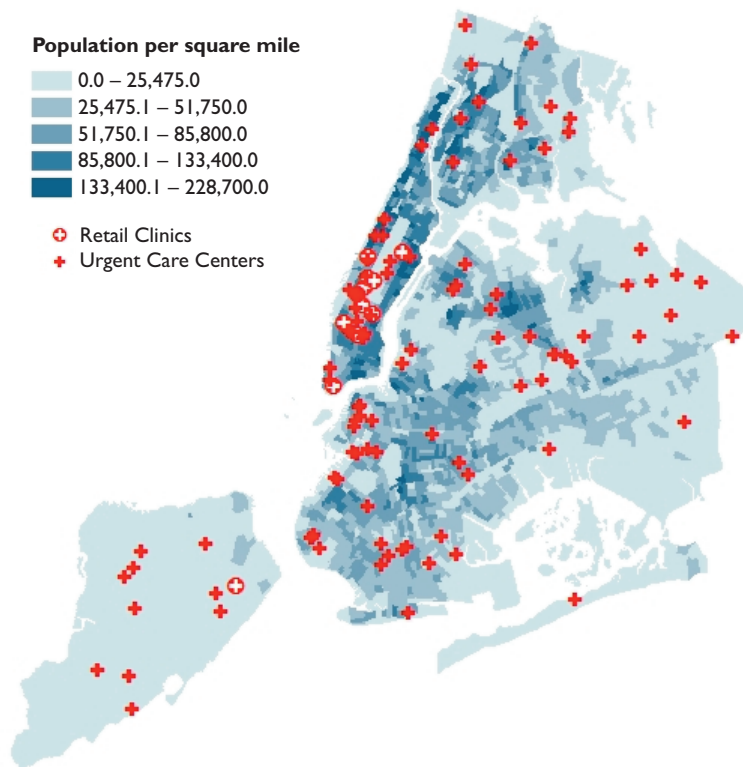
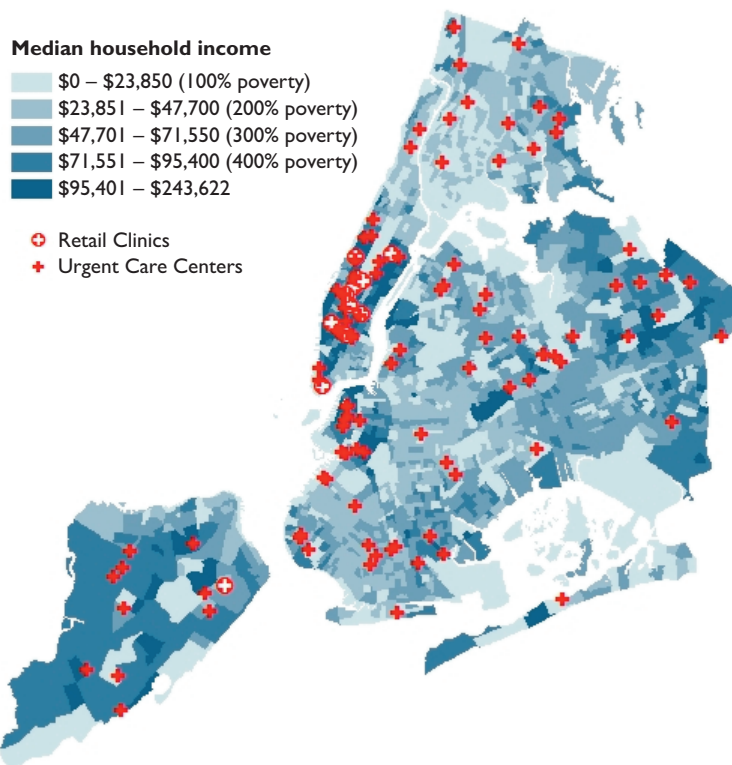
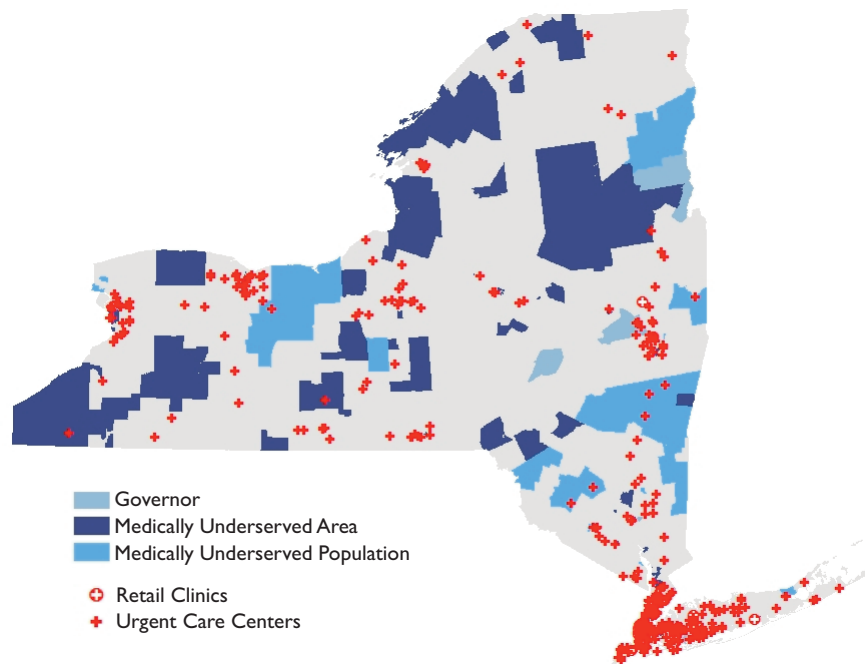


Figure 4. Convenient Care Locations by Household Income, New York City



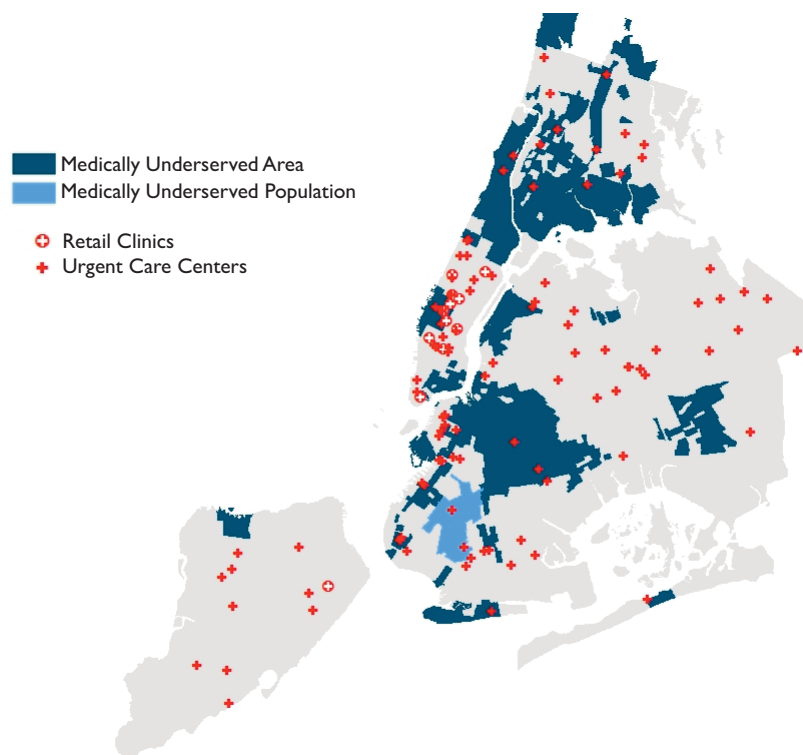
Note: Income based on federal poverty level for a household of four—for 2014, \$23,850.

**Figure 5. Convenient Care Locations by Medically Underserved Areas/
Populations, New York State**



Note: Medically underserved areas (MUAs) or populations (MUPs) are designated per Health Resources and Services Administration criteria or, for specific populations that do not meet HRSA criteria, by State designation (Governor).

**Figure 6. Convenient Care Locations by Medically Underserved Areas/
Populations, New York City**



Note: Medically underserved areas (MUAs) or populations (MUPs) are designated per Health Resources and Services Administration criteria.

Assessing the Field: The Conversation in New York

Growing awareness of retail clinics and urgent care centers in New York has prompted statewide discussion of the role these providers play in the broader health system—and how they might help or hinder the State’s goals of providing high-quality, affordable, accessible health care for all. Much of this discussion focuses on whether New York’s policymakers should take a stronger regulatory stance, assist the growth of convenient care, or take a *laissez faire* approach until more is known about the performance of convenient care (PHHPC 2014).

In 2013, New York’s Public Health and Health Planning Council (PHHPC) took up the issue of ambulatory care regulation, including a focus on convenient care. Its recommendations to the state legislature included clarifying reporting requirements for new entities like retail clinics; establishing connections with regional and state health information technology hubs; and helping consumers understand their rights and responsibilities vis-à-vis convenient care through uniform definitions of services. Although the legislature did not enact those recommendations they may revisit them in its 2015 session.

Given the active dialogue about convenient care, we sought to capture the current conversation to better inform future policy debate. We did that by conducting semi-structured interviews with a range of stakeholders—22 individuals from 20 organizations, including urgent care center and retail clinic operators, professional associations, health system representatives, payers, and state and local policymakers.⁷ The full interview protocol appears in Appendix C.

Our interviews led us to conclude that any black-or-white judgment about convenient care would be premature. There is a powerful consumer desire for the increased accessibility and availability of health services that comes with the growth of convenient care. Certain New Yorkers, particularly relatively healthy individuals without a permanent primary care doctor, stand to benefit from an expansion in these services. Yet there are potential drawbacks as well.

Growth

Urgent care centers have become an increasingly prominent, and recognized, feature in New York’s health care landscape. Virtually all of the payers we interviewed include urgent care centers as in-network providers, and some actively promote their use as an alternative to the emergency department.

Because of their structure, retail clinics have grown far more slowly and have yet to penetrate most parts of the state. Interviewees suggested a number of reasons for this slow growth, among them New York’s strong prohibition of the corporate practice of medicine. This law requires a clear delineation between management services, which corporations may provide, and the actual provision of medical care, which remains the domain of physicians. In keeping with this distinction, retail clinics contract with private

⁷ This study, #14-01720, was approved by the New York University Medical School Institutional Review Board.

physicians to provide all professional services, including overseeing nurse practitioners, instead of directly employing providers themselves.

Retail clinic operators also cited New York City's high rents, which make it more challenging to lease clinic space to outside physician groups, and higher clinical management fees than in other parts of the country. In central and western New York, interviewees pointed out, low population density may preclude the increased foot traffic that retail stores need to help offset clinic costs. Several retail clinic startups, including one sponsored by Rochester-based Wegmans Food Markets, moved out of the retail clinic business after struggling to make a profit.

Nevertheless, interviewees anticipated rapid growth of retail clinics in the near future. CVS, for example, has reportedly built out space for Minute Clinics in all its New York stores, to open in 2015.

Regulation

How New York's urgent care centers are regulated depends on how the State categorizes them. New York's regulatory structure consists of two categories: private physician practices, which are primarily regulated by physician licensing, and Article 28 facilities, such as hospital extension centers, which are under more significant State oversight. As explained by the PHHPC, many urgent care providers operate as private physician practices, which means they are "governed solely through radiological imaging and professional licensing requirements" (New York State Department of Health 2013). Other urgent care centers are licensed by the State as Diagnostic and Treatment Centers or hospital extension clinics because they were formed by a pre-existing Article 28-licensed facility. These urgent care centers are subject to higher regulatory scrutiny, including Certificate of Need review and licensure standards for physical facilities.

For retail clinics, two regulatory phenomena have shaped their development in New York State. First is the dichotomy described above, in which private physician practices receive less oversight than "centers" or "clinics." That can have a major impact on staffing. When Duane Reade first opened its doors to retail ambulatory care, the practices were staffed by physicians and considered private practices by the State. When Walgreens acquired Duane Reade, it did not change this core model, although nurse practitioners have been added to the mix of available providers.

The second regulation affecting retail clinics, as discussed above ("Growth," page 14) is New York's ban on the corporate practice of medicine. Retail stores are essentially landlords, leasing clinic space and infrastructure to a physician group or physician, who in turn either directly staffs the clinic or oversees nurse practitioners who do. Although the ban on the corporate practice of medicine also applies to urgent care centers, it is less of a regulatory barrier for them than for retail clinics. Effectively, urgent care centers must be either physician-owned and -operated, physician-owned but non-physician-operated, or licensed as a Diagnostic and Treatment Center.

Role

In general, interviewees felt that retail clinics and urgent care centers—with their convenient locations and extended hours—play an important role in satisfying consumer need and demand, and provide a significant benefit in their ability to shift care to lower-cost settings. Some were uneasy, however, about the potential for disruption of longitudinal patient-doctor relationships and undermining of the medical home model of primary care.

Most of those interviewed, however, noted the value of convenient care for New Yorkers without primary care doctors—some 40 to 50 percent of all adult patients it served, noted one urgent care provider. Many convenient care operators, offering such patients referrals to local primary care providers, thus act as a “portal of entry” to the health system, *increasing* access and continuity of care.

Overall, most interviewees pointed to the positive value of convenient care in providing a narrow set of services for a particular segment of the market. Those services and the relationships established with consumers, they noted, differ between urgent care centers and retail clinics, as outlined in Table 5.

Table 5. Convenient Care Providers: Distinctive Roles

	Retail Clinics	Urgent Care Centers
Mild to moderate episodic illness (e.g., bronchitis, asthma, flu, GI)	X	X
Mild to moderate trauma (e.g., simple fractures, lacerations requiring sutures)		May substitute for ED
Prevention and wellness (e.g., immunizations, wellness services)	X	
Chronic disease management (potential)	X	
Patient-provider relationship	Potentially ongoing, especially with patients using pharmacy	Episodic

Convenient care’s value is not necessarily uniform, however, as interviewees pointed out. Among urgent care centers, for example, there are some key differences in role, capacities, and approach to coordinating and integrating care, depending upon ownership: a large medical group or health system, a chain specializing in urgent care, or independent—individual or small group operators (see Table 6). Anecdotal evidence

suggests that much of the convenient care growth in New York is accounted for by group practice and system-owned and -operated urgent care centers. Urgent care offers strategic advantages for health systems by serving existing patients and attracting more patients into the system.

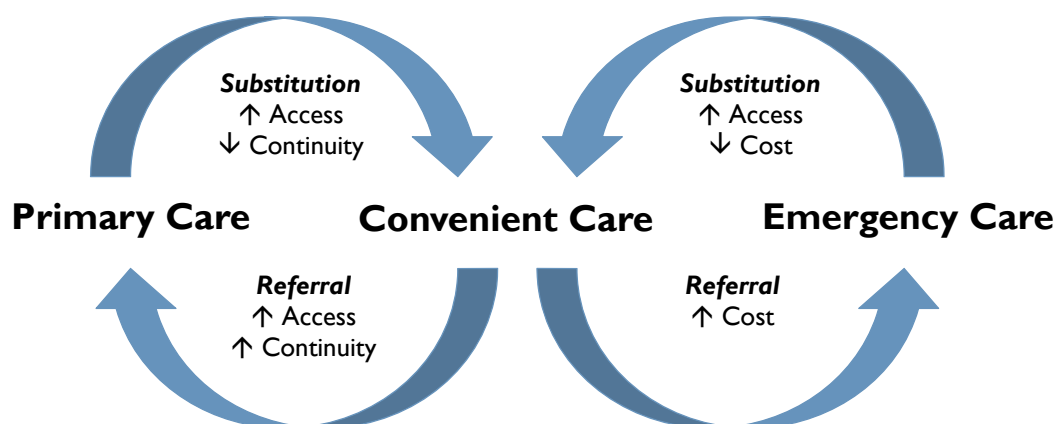
Table 6. Urgent Care Ownership Influences Role

	Health System	Urgent Care Chain	Independent
Description	Owned and operated by group practices or large health systems	Part of a chain of centers specializing in urgent care	Individual center associated with neither a health system nor a chain of urgent care centers; typically owned by physicians
Example	Hudson Headwaters Health Centers	CityMD	Atlantic Urgent Care
Coordination and integration	Potential for high integration within health system but concerns exist re coordination with out-of-network providers	Often acts as a “Switzerland” vis-à-vis health care systems; possesses the scale to develop platforms that help coordinate with other providers	Potential difficulties coordinating care with outside providers; may not possess scale to maintain and update lists and contact information for referrals
Key functions	Supporting group or system primary care practices by offering after-hours care “in-system,” which protects against leakage into other systems; branding; acquiring new patients	Development of niche product that can provide missing set of services at high quality; neutral to health care system; can treat “invisible” populations	May fill gaps in urgent care service needs in particular geographic areas

New Opportunities

Both retail clinics and urgent care centers have the potential to contribute to health policy goals in New York, interviewees agreed, but their net benefit may depend on whether consumers use them as a substitute for emergency services or for primary care, and whether convenient care operators refer patients back to primary care or emergency departments for follow up. The theoretical effects of substitution and referrals are summarized in Figure 7.

Figure 7. Substitution and Referral among Primary, Convenient, and Emergency Care Sites



Redirecting Care from Emergency Departments

The potential for convenient care to help reduce unnecessary emergency department utilization, by shifting appropriate trauma cases and illnesses to urgent care settings, was the “value proposition” that interviewees cited most frequently. Treating these conditions in a lower-cost, more convenient setting could help ensure that patients receive “the right care, in the right place, at the right time.”

When used appropriately, urgent care as a substitute for emergency care has a number of advantages for patients: urgent care centers are often closer to patients’ homes; wait times are reportedly less than in the ED⁸; and, under some insurance plans, the patient’s co-payment can be as little as a tenth of the co-payment for an ED visit.

The chain-based urgent care providers with whom we spoke also suggested that—in focusing on their niche role and offering a narrower set of services—these centers have the advantage of specialization, allowing them to devote greater resources and attention to improving quality and tailoring services to meet their specific client population’s needs, resulting in a better patient experience.

While payers were largely optimistic about urgent care’s potential to reduce ED utilization and produce cost savings, they also offered some caveats. One payer doubted that an urgent care center owned by a hospital system could truly drive down the unit cost of care, because fixed costs of the emergency department (and the rest of the hospital) would mitigate any savings an urgent care center could generate. Another payer, however, discussed the difficulty of diverting frequent emergency department users to an urgent care center *unless* it were situated directly adjacent to the ED. There are other considerations as well: some consumers may have greater trust in the quality

⁸ Data provided by the urgent care chain CityMD shows an average lobby wait time of four minutes in its suburban locations and five minutes in its Manhattan locations.

of services in an ED, and others may only be able to access care by calling an ambulance, precluding use of an urgent care facility.

Promoting and Marketing Prevention

On the other end of the acuity spectrum, retail clinics, in particular, present an opportunity to greatly expand access to preventive services such as immunizations. While retail pharmacists have been allowed to offer flu shots in New York since 2009, nurse practitioners working in retail clinics are licensed to provide a wider set of vaccines. Both Duane Reade and CVS offer eleven immunizations—including the single-dose pneumococcal polysaccharide vaccine and the measles, mumps, and rubella (MMR) series—although there is some variation between the chains in which are offered. Other provided services include smoking cessation programs, depot contraception (Depo-Provera or other injectable progestin contraceptive), and weight loss coaching.

Many interviewees anticipated a larger push into prevention and screening. The experience of Walgreens, for example, is illustrative. The chain has increased its primary prevention services over the last five years and expects to further expand those offerings, especially in early disease detection. Walgreens has now partnered with Theranos, a company offering inexpensive, complete blood analysis based on a tiny sample drawn from a finger stick, and plans to integrate the real-time laboratory capacity that partnership can provide with the health care services already available in its retail clinics (Parloff 2014). With the addition of lifestyle coaching, such as nutritional counseling for pre-diabetics, such partnerships could offer a convenient, comprehensive preventive medicine package.

Similarly, retail clinics may play a role in public health campaigns, some interviewees noted, by making important services accessible in the context of daily routines like grocery shopping. Promoting HIV testing in retail clinics, for example, could improve screening rates in high-risk communities.

Yet several interviewees cautioned that, with a focus on quick single-concern visits, retail clinics and urgent care centers are not well suited to offer the personalized “anticipatory guidance” that primary care doctors often provide, using sick visits as opportunities to counsel on wellness and to build relationships.

Supplementing Primary Care through Extended Hours

New York State continues to make progress on its goal of primary care for all by expanding the patient-centered medical home model—one tenet of which is improved access to care through, for example, evening hours. Yet in many practices, such expanded access remains more aspiration than reality. Urgent care centers and retail clinics, many interviewees suggested, are helping fill this void.

The demand for extended hours is partially substantiated by data from CityMD that we reviewed. Although there were more visits on weekdays, there was still a substantial number of patients flowing into CityMD’s offices during the weekend. Evening hours

were also significant, with approximately a quarter of weekday visits occurring after 6 pm.

The benefits of after-hours care, one interviewee noted, go beyond time saved for individual patients. In the absence of such services consumers often opt to forego care rather than wait to be seen in an emergency department, which can worsen health over time. And for individuals who seek care for themselves or a child but must take time off from work to do so, there is often significant financial cost—for employees themselves, particularly hourly wage workers, and for their employers, in lost productivity.

Connecting Patients to Primary Care

One of the most promising features of both urgent care centers and retail clinics is their ability to provide immediate care for individuals currently unconnected to the health care system, and then link them to primary care providers. The retail clinic and urgent care providers we interviewed estimated that at least 40 percent of their adult patients do not have an established relationship with a primary care doctor. Many of these unconnected users may be young, relatively healthy adults without a pressing need for longitudinal primary care. But some may have serious undiagnosed or unmanaged illness, either chronic or unrelated to their current acute complaint, and their convenient care visits are opportunities to connect them with longer-term care.

The providers we spoke with used a number of ways to do that. CityMD, for example, has built its own customer relationship management software to flag patients who do not have, but need, a primary care doctor or specialist. The company uses a homegrown database of 27,000 doctors, coded by insurance, zip code, and quality data, to refer patients to permanent sources of care. Each patient's risk level is graded as green, yellow, or red depending on the gravity of the medical condition, and a central call center follows up, with appropriate intensity, with a referral. CityMD built this software system, it says, because it feels responsible for a patient's health, especially one who is chronically ill, until that patient has been handed off to a primary care doctor or specialist. The software is also used to share the patient's medical history and laboratory results with the receiving physician once a referral has been made.

Referrals to physicians within a health system network were cited as a primary driver of many partnerships between convenient care and health systems. Walgreens, for example, maintains a referral list of local primary care providers working in health systems, such as Mount Sinai, that have formed relationships with the chain. Such partnerships benefit health systems by attracting new patients and ensuring that existing ones are not redirected by convenient care providers to other health systems for follow-up care. Both CVS and Walgreens emphasize patient autonomy in this process, asking them to identify a preferred provider, if they have one, before a referral is made.

Seizing this opportunity to link patients who may otherwise be “invisible” to the health care system requires both commitment and capacity. Our interviews revealed that when both exist, convenient care providers can help patients connect to a regular source of care.

Significant Challenges

The rapid proliferation of convenient care brings with it a set of intertwined challenges, our research found.

Continuity of Care

Continuity of care has been described as a “Triple Aim home run,” helping bring about better health, improved health care quality, and lower costs (Gupta and Bodenheimer 2013). Many patients place high value on continuity of care, particularly those who are older or have multiple chronic conditions—i.e., those most vulnerable to serious illness, whose care incurs the highest costs. For these people especially, it is a continuing relationship with a caring professional that provides the needed context for shared decision-making and responsibility for maintaining and improving health. Convenient care, with its episodic nature, poses the risk of fragmenting and disrupting such relationships.

While retail clinics and urgent care centers may offer expanded access, the care delivered in those settings must be coordinated with that of the other providers caring for a patient. Through our interviews we heard of several approaches to ensuring continuity of care, particularly with respect to information sharing. On one end of the spectrum, some clinics provide patients with a print-out of their visit history and rely on them to share that information with a primary care doctor. On the other end, convenient care providers more tightly integrated with health systems are building portals for bi-directional, near-instantaneous exchange of health information directly between providers. There are several challenges, however, to such information sharing.

First, convenient care providers often see patients from a wide range of health systems and providers with a plethora of communication modalities. That diversity makes it difficult to adopt a single approach to transmitting patient information. One of our interviewees described a “must connect” mantra, using all means available—phone, fax, or electronic—to convey health information to primary care offices. Yet this approach can be resource intensive: one urgent care provider told of placing 2.1 million phone calls to patients and their providers annually. And several of our interviewees voiced doubts that small, independent urgent care centers have the scale to maintain and update lists and contact information for referrals.

Second, as one interviewee involved in network building for a major hospital in New York City noted, many urgent care centers, particularly independents owned by individual physicians, use urgent care-specific electronic health records. These records are not compatible with the electronic health records of most primary care providers. In contrast, CVS is adopting the Epic electronic health record, citing its broad penetration among health systems.

Third, even if convenient care providers have the commitment and capacity to coordinate with the rest of the health system, the primary care doctors and specialists to whom they are reaching out must be responsive. Several interviewees were uncertain

whether the physicians receiving convenient care information ever looked at that patient data, or whether the data would be incorporated into the patient's electronic medical record. One urgent care provider described calling the primary care doctor of a patient whose injury required transfer to a hospital, and the primary care doctor refusing to see the patient because she had opted to visit urgent care instead.

Finally, several physicians and payers we interviewed expressed misgivings about clinical assessments done in convenient care without the benefit of the patient's full medical history—particularly because patients often make recall mistakes. Other interviewees, however, pointed out that this happens routinely across the health care system—new patients often arrive at a practice without a medical record.

Economic Destabilization of Primary Care

Low-cost but narrowly focused providers have the potential to destabilize the economic viability of primary care providers offering a wider range of essential services. Some physicians described the net effect of patients seeking care in retail clinics and urgent care centers as “cream skimming” of high-volume commercial insurance business. Similar concerns were voiced about the potential destabilization of hospitals through reduced emergency department visits.

Compared to specialty services, the margins on primary care services are generally low and, in a fee-for-service payment model, often require physicians to rely on high volume to stay economically viable. Minor conditions like ear infections often represent relatively easy revenue for primary care. These acute issues present in large numbers and can be quickly squeezed in between the day-to-day work of primary care: preventive and chronic care visits.

Chronic Care

Nationally, although some retail clinics are owned by hospital systems or private operators, the vast majority are owned and located in big-box retailers or pharmacies (Kaissi and Charland 2013). These corporately owned clinics all provide acute care for minor illnesses and a range of wellness services, but they vary in the extent to which they treat chronic disease and provide ongoing primary care services, as described in Table 7.

Table 7: Scope of Retail Clinic Chronic Care

	Limited Services Clinic	Mixed Services Clinic	Primary Care Clinic
Example	CVS Minute Clinic	Walgreens Healthcare Clinics	Walmart Care Clinic*
Range of services for chronic diseases	Chronic care limited to lab tests and education for patients with diabetes, high cholesterol, or high blood pressure	Provides treatment and management for a range of ongoing health conditions including asthma, chronic bronchitis, diabetes, osteoarthritis, high cholesterol, and high blood pressure	Diagnoses, treats, and manages a wide range of chronic illnesses including hypertension, dyslipidemia, asthma, COPD, hypothyroidism, uncomplicated CAD, and diabetes; also addresses depression and anxiety

*Refers only to clinics owned and operated by Walmart.

New York-based retail clinics portrayed themselves as more on the “limited services” end of the spectrum,⁹ generally helping manage single, simple chronic conditions. This model relies upon both on-the-ground clinical staff and centralized outreach functions (such as call center capacities) to support patients’ personal physicians in monitoring and counseling the chronically ill. Services include in-person disease and medication counseling as well as routine monitoring of blood pressure and other vital signs and basic laboratory data, such as hemoglobin A1c (blood sugar) levels in patients with diabetes. Some interviewees described this retail extender role as appealing to health systems, which are increasingly being held accountable for ensuring positive outcomes for their patients with chronic diseases. Partnering with retail clinics helps buttress health systems’ existing resources with lower-cost face-to-face and “light touch” check-ins with patients.

Others were more skeptical. One payer representative stated, “People with chronic conditions don’t do well because the system is so fragmented and they’re bouncing around to different specialties. A retail model isn’t going to solve that.” At minimum, expanding into chronic disease management would require an augmented ability to meaningfully connect and coordinate with a patient’s primary and specialty health care providers. With so few New Yorkers accessing care in retail clinics, it remains to be seen how well those clinics can be integrated into a chronic disease management care team.

⁹ The near-term absence of Walmart clinics in New York State means providers will most likely find retail clinics looking to partner in chronic care management, rather than directly compete in this area.

Patient Navigation

The creation of new types of walk-in care puts more of an onus on patients to know which setting is most appropriate for their medical problems. Yet, as one physician noted, symptoms do not neatly sort themselves into diagnoses, nor do they always convey the right level of acuity. Chest pain can result from a benign muscle bruise—or from an acute coronary syndrome.

This challenge is exacerbated in the urgent care setting in New York, where there is tremendous variation in services provided, training of physicians, and even hours of operation. Some urgent care centers, particularly independent ones owned by one or two physicians, are essentially primary care offices with extended hours. Others are 24-hour urgent care centers staffed by board-certified emergency medicine physicians and with on-site laboratory and radiology capabilities.

While some urgent care centers publicly list the types of conditions they treat and the ancillary equipment available on-site, others don't communicate to potential patients what they can and cannot do. Patients must navigate this rapidly changing world of ambulatory care services with limited information, at a time when symptoms and concerns about their health are already creating stress.

Quality Concerns

While some interviewees voiced concerns about quality in both types of convenient care, most thought that urgent care centers warranted greater scrutiny, particularly because they deal with a higher level of acuity and tend to offer more advanced technology, like radiology. Unlike emergency departments and hospitals, which undergo multiple accreditation reviews by organizations like the Joint Commission, urgent care centers are the target of little quality oversight. Our interviews revealed some developing internal quality assurance practices among urgent care centers—but also some cause for concern.

On the positive side, some urgent care center chains provide intensive training for new clinicians and mandatory in-house exams on treatment protocols. One chain, PM Pediatrics, runs its own fellowship program, to increase the number of pediatricians working in urgent care considered high-quality providers. Other interviewees, however, described urgent care centers without adequate radiology technician support or protocols for radiologist interpretation of complex diagnostic imaging.

Yet many interviewees were quick to note that significant quality variation exists throughout the broader ambulatory care sector, including among primary care practitioners—and that quality assurance programs like those some urgent care centers have developed are not often seen elsewhere in the ambulatory care sector. Any regulation of convenient care to ensure quality, they argued, should be part of a wider effort to improve the quality of ambulatory care overall.

Vulnerable Populations

In general, the opportunities and challenges of convenient care—in essence a need to expand access while assuring quality and continuity of care—are relevant to all New Yorkers. But for two populations—Medicaid beneficiaries and children—an enhanced focus on coordination with primary care and on unique health needs might be required, our interviews found.

Medicaid Beneficiaries

Urgent care centers, in their current form, are of only modest value to the Medicaid population, interviewees agreed. As our maps revealed, few are located in low-income neighborhoods, where many Medicaid beneficiaries reside. And even when a beneficiary is able to access convenient care, particularly an urgent care center, it is often unclear whether Medicaid will pay for the visit.

Contracting with urgent care centers is often problematic for fee-for-service Medicaid because these centers do not generally use the Medicaid-specific ambulatory payment classification (APC) codes that are the main basis for provider payments. Medicaid managed care organizations (MCOs) have greater flexibility in contracting with urgent care centers, but it is unclear how many do so. One major New York City Medicaid MCO has very few urgent care center contracts, our interviewee told us, and limits those contracts solely to centers that are part of systems or provider groups with which it currently contracts. That's because the MCO makes an enormous effort to connect beneficiaries with primary care doctors—and views urgent care centers, particularly chain-based and individual providers, as undermining that cause.

As in our interviews with commercial payers, Medicaid representatives felt that urgent care centers would bring value to New York's health system if they succeeded in reducing unnecessary emergency department visits. In 2011, there were 2.1 million potentially preventable emergency department visits among the state's Medicaid beneficiaries, a rate of 36.08 visits per 100 Medicaid lives (New York State Department of Health 2014). Given the low penetration of urgent care centers in low-income and medically underserved areas, however, most interviewees doubted these providers will reduce Medicaid beneficiaries' emergency department use in the near future.

That might change under the Medicaid Delivery System Reform Incentive Program (DSRIP), which seeks a 25 percent reduction in avoidable hospitalizations among beneficiaries, including emergency department visits, over the next five years. One of the 44 projects to be developed under DSRIP calls for the co-location of primary care in emergency department settings, essentially establishing urgent care or an "ED fast track" for lower-acuity and ambulatory care-sensitive conditions. However, only one Performing Provider System (PPS), the new type of collaboration developed to carry out DSRIP projects, elected this option in its final application to the State. The low adoption rate might be because many hospitals already offer an emergency department fast track option, making urgent care a redundant service. Regardless of the reason, it seems unlikely that DSRIP will lead to an expansion of urgent care center access for Medicaid beneficiaries.

Several interviewees discussed creative access-improvement strategies for Medicaid beneficiaries, including county health departments sponsoring “public” urgent care centers, and partnerships between insurance companies and health systems to establish urgent care centers in neighborhoods with high ED use. CityMD/Premier Care, a chain of 34 urgent care centers throughout the downstate region, recently opened a separately branded “HEAL” clinic in Jackson Heights, Queens, a culturally and economically diverse neighborhood with a large uninsured and Medicaid population. In addition to providing standard urgent care services, the clinic has an intensive focus on obesity and diabetes screening, both of which are significant health burdens for Medicaid patients. Efforts are made to link at-risk patients to primary care doctors as well as community services such as the local YMCA. The HEAL clinic is a test case for CityMD, which hopes to expand its Medicaid-oriented services if the Jackson Heights center ends up being viable. As of November 2014, however, two months after opening its doors, the HEAL clinic did not have contracts with major Medicaid managed care organizations.

From our interviews, it was clear that Medicaid leaders will only support contracting with urgent care providers if they avoid becoming a cottage industry disconnected from the larger health care system. Medicaid leaders are also concerned that non-credentialed, unmonitored providers will take advantage of beneficiaries by providing poor quality care while driving up costs, à la the Medicaid mills of the 1980s. Finally, our interviewees hoped that urgent care centers serving Medicaid beneficiaries would provide culturally, socially, and epidemiologically relevant care. That would include sufficient emergency mental health services, including evening psychiatric support, as a requirement for providers serving predominantly Medicaid beneficiaries.

Far fewer concerns were raised about retail clinics, which are viewed as less likely to disrupt the patient-primary care relationship, and as having the unique potential to incorporate a pharmacist’s knowledge into patient care. As a result, visits to retail clinics are a covered benefit, our interviewee from a major Medicaid MCO noted.

Pediatric Patients

Most urgent care centers and retail clinics provide services designed primarily for relatively healthy adults. This care model raises important questions about the suitability of extending those services to the chronically ill and to children and adolescents.

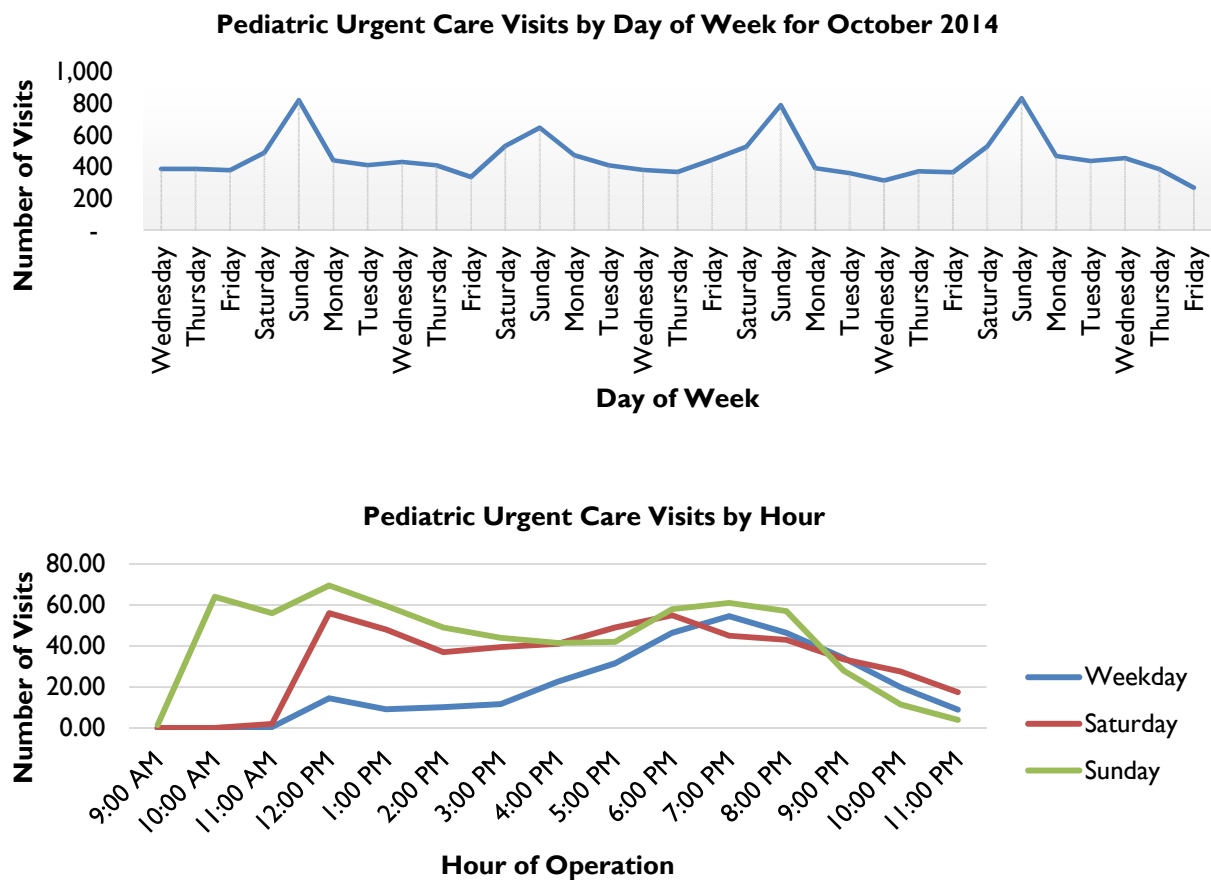
While timely and accessible care is particularly important for children, some interviewees expressed concern about how to make the convenient care model work for pediatric patients. Unlike adults, essentially all children presenting for care at an urgent care center or retail clinic have a primary care relationship with a pediatrician. This medical home relationship has particular value for young children. Visits to a pediatrician during the first two years of life provide key opportunities for the pediatrician to assess early childhood development and offer guidance to parents on how to raise healthy, well-balanced kids. The pediatrician may use this time to address critical, but potentially sensitive, concerns about a parent’s health or home environment that might have a devastating impact on the child’s development, such as postpartum depression or intimate partner abuse.

Many of our interviewees felt that these important functions can only be done in the context of a longitudinal trusting relationship between a pediatrician and a family, and noted several examples of protections for this doctor-family relationship in New York. Some payers, for example, do not reimburse for immunizations that could have been received in a primary care pediatrician's office. In the same vein, Walgreens has set a policy of not seeing children under the age of two.

While there was general agreement that infants should not be cared for in retail clinics, interviewees were more accepting of older children being seen in retail clinics and children of all ages being seen in urgent care centers—although there was no consensus about which cohorts of children can safely be seen and under what circumstances. A central concern is that pediatric clinical guidelines, such as for appropriate antibiotic use or—in extreme cases—pediatric advanced life support, may not be followed. An interviewee from a pediatric medical society, for example, noted that adult internists, unlike emergency medicine doctors, do not have significant experience treating children but may routinely encounter them in an urgent care setting. One interviewee suggested enabling more informed consumer decisions by developing signage or alternative messaging to denote urgent care centers with pediatric expertise.

In response to these concerns a number of pediatric-specific urgent care centers have been developed to serve the special needs of children. PM Pediatrics—an urgent care chain with 14 downstate sites staffed by board-certified pediatric emergency medicine physicians—emphasizes information-sharing with the child's medical home, and has designed its facilities to provide a calming environment for kids under stress. Laboratory testing and radiologic exams can also be performed onsite. Utilization data provided by PM Pediatrics supports the notion that there is significant consumer demand for pediatric care outside of normal work and school hours. Visits to 11 pediatric urgent care facilities in the greater New York City area peak on Saturdays and Sundays, and on weekdays between 7pm and 8pm—when parents are home from work but many pediatricians' offices are closed, as shown in Figure 8. On average, 30 percent of visits are for trauma-related events (see Table 8).

Figure 8. Pediatric Urgent Care Visits by Hour and Day



Source: PM Pediatrics, October 2014.

Table 8. Pediatric Urgent Care Visits by Type

Type	Percent of all visits*
Medical	71%
Asthma	9%
Dehydration	7%
Trauma**	29%
Fracture	7%
Laceration	8%
Other	14%
Other procedures	5%

Source: PM Pediatrics, 2014.

* Less than 1% of patients seen require transfer to a higher level of care.

**16% of patients treated for trauma require x-ray imaging, which is provided on-site.

Shaping the Future: Policy Options

In January 2013, the New York State Public Health and Health Planning Council (PHHPC) was charged with redesigning the regulatory framework for ambulatory care services in New York. PHHPC formally adopted a set of policy recommendations in January 2014; some of the recommendations required authorizing legislation, while others required only regulatory authorization (Chokshi, Rugge, and Shah 2014). PHHPC's policy recommendations flowed from five main premises (PHHPC 2014):

- Regulation should strive to create conditions for fair competition in the ambulatory care market, particularly between institutional providers and independent professional practices. However, in cases of market failure, particularly in underserved areas, other regulatory considerations may predominate in order to develop highly integrated “utility-style” models of care.
- The public's awareness of novel ambulatory care services is a paramount consideration. Standard nomenclature for services and public signage should serve to reduce consumer confusion.
- Patient safety and quality standards for new models of care should equal or exceed existing clinical standards.
- Continuity of care, particularly with patients' primary care practices, should be preserved and promoted.
- A robust data infrastructure, implemented via interoperable health information technology systems, should support providers' reporting requirements as well as patients' continuity of care. Over time, the availability of this data should enable further refinement of the State's own regulatory system.

PHHPC's recommendations, as well as other states' approaches, are catalogued in Appendices D and E along seven dimensions: consumer disclosure, such as naming conventions; scope of services; licensure, accreditation, and Certificate of Need; patient safety and quality; continuity of care; health information technology; and Medicaid and safety net considerations.

To date, none of PHHPC's recommendations have been put into effect. However, the 2015-2016 New York State Executive Budget includes legislative proposals related to convenient care, including authorizing Article 28 providers to establish—without Certificate of Need review—retail clinics under the title of “limited services clinics”; standardizing the use of the term “urgent care”; and requiring PHHPC and the Commissioner of Health to adopt rules and regulations relating to the establishment, marketing, and operation of limited services clinics and urgent care centers.

In weighing all of the regulatory options, it is essential that policymakers acknowledge the significant consumer demand for convenient care that exists. By increasing the accessibility and availability of health services, urgent care centers and retail clinics are highly appealing—and of particular value to those New Yorkers who don't have a primary care doctor and to those who cannot be seen by their primary care doctor in a timely or convenient manner. These innovative services may also prove an alternative to

the overuse of EDs for non-emergent care, with the potential to reduce ED use and costs. Increased regulation could diminish the availability of these popular care options.

Still, urgent care and retail clinic providers presently operate in the less-regulated space of the private practice of medicine. By attracting large numbers of patients seeking immediate care for acute illnesses or injuries, the potential for harm from poor quality is concerning. In addition, widespread marketing of urgent care services could mislead patients needing higher levels of care. Too little is known about how these potential drawbacks, and others, like the potential to fragment care, stack up against the benefits in reality. As our understanding evolves, however, the State could consider several policy options to establish basic consumer and public health protections.

Define urgent care centers and retail clinics. Given the broad variation in service and staffing models among convenient care providers the State can—as an initial step—help consumers safely navigate this new provider landscape by developing and enforcing common definitions. For retail clinics, PHHPC recommended a definition as “limited services clinics” to reflect a discrete scope of services they would be allowed (see Appendix E). For urgent care centers, two options are available:

- **Defer to established standards** of a recognized accrediting body, such as the Urgent Care Association of America (UCAOA). The UCAOA accreditation process includes a provider application, often—but not always—followed by an on-site visit. The accreditation process assesses governance, human resources, patient care processes, physical environment, quality improvement, record management, and patient privacy/rights/responsibilities based on UCAOA standards. Many urgent care centers in New York have already sought this accreditation, so it may be only minimally burdensome to promote universal adoption of these standards.
- **Develop State standards** for what qualifies as “urgent care.” PHHPC proposed a naming convention in 2013, calling for urgent care centers to be capable of:
 - Accepting unscheduled, walk-in visits, typically with extended hours on weekdays and weekends;
 - X-ray and EKG services;
 - Phlebotomy and lab services (CLIA-waived tests);
 - Administration of oral (PO), sublingual (SL), subcutaneous (SC), intramuscular (IM), intravenous (IV), and respiratory medications, as well as IV fluids;
 - Repair of uncomplicated lacerations;
 - Maintenance and use of crash cart supplies and medications;
 - Advanced Cardiovascular Life Support and Pediatric Advanced Life Support protocols, as evidenced by current staff certification.

Alternatively, the State could forego any naming conventions but require convenient care providers to publicly post, online and on site, basic information about their operations. Relevant information for consumers would include services offered, hours of operation, and clinician credentials. The State might also consider mandating signage or a universal symbol to denote urgent care facilities with significant clinical pediatric

experience, particularly those with emergency medicine, pediatric, or family physicians on site.

Encourage convenient care providers to proactively connect patients who lack primary care providers to a permanent source of care, and support their doing so. While much concern has been voiced about the potential of convenient care providers to disrupt continuity of care, it must be noted that convenient care providers also have an important opportunity to connect patients to permanent sources of primary care for the first time. The State should recognize that this is a valuable activity. A wide range of options to encourage this practice is available, including offering formal recognition to innovative providers with “gold standard” referral practices; making tools and information, such as lists of nearby primary care providers, available to convenient care providers; and mandating referral to permanent care sources.

Promote connection with regional health information exchanges and the SHIN-NY health information system when it is operational. Integrating urgent care centers and retail clinics into the broader health ecosystem rests on the flow of high-quality information between convenient care and primary care providers. The State should ensure that convenient care providers are incorporated into regional and statewide strategic plans for health information exchanges. As the rest of the health care system links together through regional health information organizations and, in the longer term, the SHIN-NY, it will be critical that urgent care centers and retail clinics join with them.

Develop consensus across policymakers, providers, and payers on the quality and safety measures that are most germane to convenient care, and incorporate reporting of those measures alongside other ambulatory care measures. As measurement of outpatient quality evolves, policymakers should begin systematically tracking the performance of retail clinics and urgent care centers—ideally using a subset of existing metrics for other ambulatory care settings. The State could consider beginning with metrics from two common ambulatory care data sets: the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS). Relevant sample measures and domains from these sets include: appropriate testing for children with pharyngitis; appropriate treatment for children with upper respiratory tract infection; avoidance of antibiotic treatment in adults with acute bronchitis; pharmacotherapy management of COPD exacerbation; use of appropriate medications for people with asthma; use of imaging studies for low back pain; use of high-risk medications in the elderly; timeliness of care; how well providers communicate with patients; attitude of office staff (helpfulness, courtesy, respectfulness, etc.); and the patient’s rating of the provider.

Encourage greater access for underserved areas and populations, without jeopardizing current special designations. Neighborhood-based, convenient health care is particularly important for low-income New Yorkers who often do not have the option of missing work to seek care during the day. With proper assurances of quality and continuity of care, the State could use existing policy tools to promote the growth of

urgent care centers and retail clinics in low-income neighborhoods. Opportunities for incentivizing growth in underserved areas could be explored through Medicaid reimbursement; within the State's tax, fee, and subsidy structures; and via municipal zoning regulations. The State must guard against unintended consequences of such efforts. In particular, an increase in convenient care providers in federally designated medically underserved areas or primary care shortage areas could result in removal of those designations, possibly destabilizing the few full-service primary care practices already located there.

Conclusion

Urgent care centers and retail clinics have emerged as new providers in New York's health care system and are poised to grow rapidly in the next few years. While differing in their structures and core competencies, retail clinics and urgent care centers pose similar opportunities and challenges. They both fulfill consumer demand for expanded access to care. But because services and staffing vary so widely, consumers may have trouble selecting the most appropriate site of care; the episodic nature of convenient care may also further fragment a system that already is often lacking in adequate coordination. The key question for all players in New York is how to promote accessible, continuous, high-quality care within this new paradigm.

References

All URLs cited in the references were accessed on January 22, 2015.

Abrams R. 2014. In Ambitious Bid, Walmart Seeks Foothold in Primary Care Services. *New York Times* August 8: B1. http://www.nytimes.com/2014/08/08/business/in-ambitious-bid-walmart-seeks-foothold-in-primary-care-services.html?_r=0.

Accenture. 2013. Retail Clinic Counts Will Double Between 2012 and 2015 and Save \$800 Million per Year. <http://www.accenture.com/SiteCollectionDocuments/PDF/Accenture-Retail-Medical-Clinics-From-Foe-to-Friend.pdf>.

American Academy of Family Physicians. 2014. Retail Clinics Policy. <http://www.aafp.org/about/policies/all/retail-clinics.html>.

American Academy of Pediatrics. 2014. AAP Principles Concerning Retail-Based Clinics. <http://pediatrics.aappublications.org/content/133/3/e794>.

California HealthCare Foundation. 2009. Retail Clinics: Six State Approaches to Regulation and Licensing. <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/R/PDF%20RetailClinicsSixStateApproaches.pdf>.

Cassell CK. 2012. Retail Clinics and Drugstore Medicine. *Journal of the American Medical Association* 307(20): 2151-2152. <http://jama.jamanetwork.com/article.aspx?articleid=1167325>.

Chokshi DA, J Rugge, and NR Shah. 2014. Redesigning the Regulatory Framework for Ambulatory Care Services in New York. *Milbank Quarterly* 92(4): 776-795. <http://www.ncbi.nlm.nih.gov/pubmed/?term=Chokshi%2C+Rugge%2C+Shah>.

Convenient Care Association. CCA Fact Sheet: Increasing Access. http://ccaclinics.org/images/stories/downloads/factsheets/ccafactsheet_increasing_access.pdf.

Gupta R and T Bodenheimer. 2013. How Primary Care Practices Can Improve Continuity of Care. *JAMA Internal Medicine* 173(20): 1885-1886.

Kaissi A and T Charland. 2013. The Evolution of Retail Clinics in the United States, 2006-2012. *The Health Care Manager* 32(4): 336-342.

Ladapo J and D Chokshi. 2014. Continuity of Care for Chronic Conditions: Threats, Opportunities, and Policy. *Health Affairs Blog*. <http://healthaffairs.org/blog/2014/11/18/continuity-of-care-for-chronic-conditions-threats-opportunities-and-policy-3/>.

- Mehrotra A. 2013. The Convenience Revolution for Treatment of Low-Acuity Conditions. *JAMA* 310(1): 35-36.
<http://jama.jamanetwork.com/article.aspx?articleid=1707731>.
- Mehrotra A, JL Adams, K Armstrong, et al. 2010. Health Care on Aisle 7: The Growing Phenomenon of Retail Clinics. RAND Research Highlights.
http://www.rand.org/pubs/research_briefs/RB9491-1/index1.html.
- Mehrotra A and JR Lave. 2012. Visits to Retail Clinics Grew Fourfold from 2007 to 2009, Although Their Share of Overall Outpatient Visits Remains Low. *Health Affairs (Millwood)* 31(9): 2123-2129.
- Mehrotra A, H Liu, JL Adams, et al. 2009. Comparing Costs and Quality of Care at Retail Clinics with that of Other Medical Settings for 3 Common Illnesses. *Annals of Internal Medicine* 151(5): 321-328.
- Mehrotra A, MC Wang, JR Lave, JL Adams, and EA McGlynn. 2008. Retail Clinics, Primary Care Physicians, and Emergency Departments: A Comparison of Patients' Visits. *Health Affairs (Millwood)* 27(5): 1272-1282.
- Merritt B, E Naamon, and SA Morris. 2000. The Influence of an Urgent Care Center on the Frequency of ED Visits in an Urban Hospital Setting. *American Journal of Emergency Medicine* 18(2): 123-125.
- New York State Department of Health. 2013. Ambulatory Services: Urgent Care Policy Options.
https://www.health.ny.gov/facilities/public_health_and_health_planning_council/meetings/2013-10-04/docs/ambulatory_services_uc_policy_options.pdf.
- 2014. Medicaid Potentially Preventable Emergency Visit (PPV) Rates by Patient County: Beginning 2011. <https://health.data.ny.gov/Health/Medicaid-Potentially-Preventable-Emergency-Visit-P/cr7a-34ka>.
- New York State Health Foundation. December 2014. The New York State Health Care Provider Database: A Framework for Action.
<http://nyshealthfoundation.org/uploads/resources/new-york-state-health-care-provider-database-report-dec-2014.pdf>.
- O'Malley AS, D Samuel, AM Bond, and E Carrier. November 2012. After-Hours Care and Its Coordination with Primary Care in the U.S. *Journal of General Internal Medicine* 27(11): 1406-1415. <http://www.ncbi.nlm.nih.gov/pubmed/22653379>.
- O'Malley AS. January 2013. After-Hours Access to Primary Care Practices Linked with Lower Emergency Department Use and Less Unmet Medical Need. *Health Affairs (Millwood)* 32(1): 175-183.

Parloff R. June 2014. This CEO Is Out for Blood. *Fortune*.
<http://fortune.com/2014/06/12/theranos-blood-holmes/>.

Patwardhan A, J Davis, P Murphy, and SF Ryan. October 2012. After-Hours Access of Convenient Care Clinics and Cost Savings Associated with Avoidance of Higher-Cost Sites of Care. *Journal of Primary Care and Community Health* 3(4): 243-245.

Pollack CE and K Armstrong. 2009. The Geographic Accessibility of Retail Clinics for Underserved Populations. *Archives of Internal Medicine* 169(10): 945-949.
<http://archinte.jamanetwork.com/article.aspx?articleid=414985>.

PHHPC (Public Health and Health Planning Council). 2014. NYS Public Health and Health Planning Council: Oversight of Ambulatory Care Services.
http://www.health.ny.gov/facilities/public_health_and_health_planning_council/meetings/2014-01-07/docs/ambulatory_care_services_recommendations.pdf.

Reid RO, JS Ashwood, MW Friedberg, ES Weber, CM Setodji, and A Mehrotra. April 2013. Retail Clinic Visits and Receipt of Primary Care. *Journal of General Internal Medicine* 28(4): 504-512.

Rohrer JE, KB Angstman, and GA Bartel. December 2009. Impact of Retail Medicine on Standard Costs in Primary Care: A Semiparametric Analysis. *Population Health Management* 12(6): 333-335.

Rohrer JE, KB Angstman, and G Garrison. August 2012. Early Return Visits by Primary Care Patients: A Retail Nurse Practitioner Clinic versus Standard Medical Office Care. *Population Health Management* 15(4): 216-219.

Rohrer JE, KB Angstman, GM Garrison, JA Maxson, and JW Furst. April 2013. Family Medicine Patients Who Use Retail Clinics Have Lower Continuity of Care. *Journal of Primary Care and Community Health* 4(2): 150-153.

Rudavsky R and A Mehrotra. January-February 2010. Sociodemographic Characteristics of Communities Served by Retail Clinics. *Journal of the American Board of Family Medicine* 23(1): 42-48.

Shrank WH, AA Krumme, AY Tong, et al. October 2014. Quality of Care at Retail Clinics for 3 Common Conditions. *American Journal of Managed Care* 20(10): 794-801.

Sussman A, L Dunham, K Snower, et al. April 2013. Retail Clinic Utilization Associated with Lower Total Cost of Care. *American Journal of Managed Care* 19(4): e148-157.

Terhune C. November 17, 2014. Kaiser Permanente Joins Forces with Target Corp. on In-Store Clinics. *Los Angeles Times*. <http://www.latimes.com/business/la-fi-kaiser-target-clinics-20141118-story.html>.

Thygeson M, K Van Vorst, M Maciosek, and L Solberg. September-October 2008. Use and Costs of Care in Retail Clinics versus Traditional Care Sites. *Health Affairs (Millwood)* 27(5): 1283-1292.

Tu HT and ER Boukus. November 2013. Despite Rapid Growth, Retail Clinic Use Remains Modest. Center for Studying Health System Change Research Brief #29. <http://hschange.org/CONTENT/1392/1392.pdf>.

Urgent Care Association of America. September 2011. The Case for Urgent Care. <http://c.ymcdn.com/sites/www.ucaoa.org/resource/resmgr/Files/WhitePaperTheCaseforUrgentCa.pdf>.

— 2013. Urgent Care Industry Information Kit. http://c.ymcdn.com/sites/www.ucaoa.org/resource/resmgr/Files/UrgentCareMediaKit_2013.pdf.

— Industry FAQs. <https://ucaoa.site-ym.com/?IndustryFAQs>.

Weinick RM and RM Betancourt. September 2007. No Appointment Needed: The Resurgence of Urgent Care Centers in the United States. California HealthCare Foundation. <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/N/PDF%20NoAppointmentNecessaryUrgentCareCenters.pdf>.

Weinick RM, SJ Bristol, and CM DesRoches. 2009a. The Quality of Care at Urgent Care Centers. *Journal of Urgent Care Medicine* 27-32. http://jucm.com/pdf/The_Quality_of_Care_at_Urgent_Care_Centers.pdf

— 2009b. Urgent Care Centers in the U.S.: Findings from a National Survey. *BMC Health Services Research* 9:79. <http://www.biomedcentral.com/1472-6963/9/79>.

Weinick RM, RM Burns, and A Mehrotra. September 2010. Many Emergency Department Visits Could Be Managed at Urgent Care Centers and Retail Clinics. *Health Affairs (Millwood)* 29(9): 1630-1636.

Yee T, AE Lechner, and ER Boukus. July 2013. The Surge in Urgent Care Centers: Emergency Department Alternative or Costly Convenience? Center for Studying Health System Change, Research Brief 26.

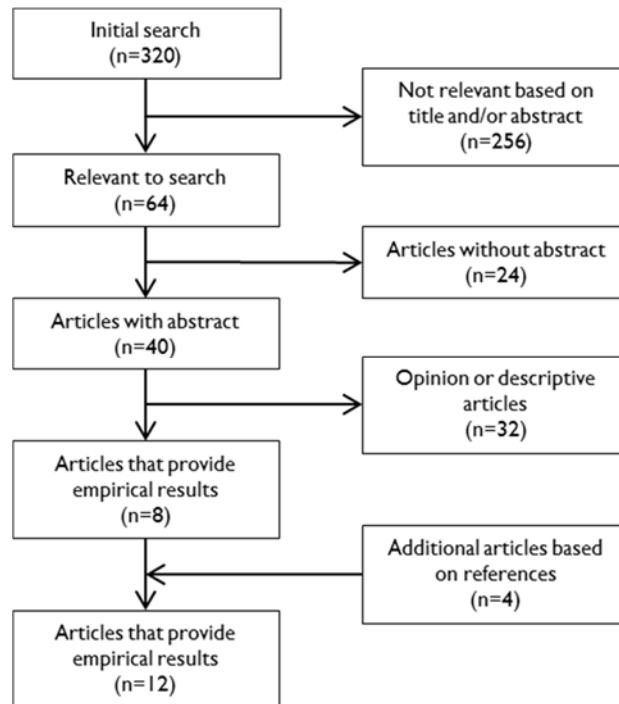
Appendix A. Literature Review Methodology

Multiple sources, including peer-reviewed articles, the grey (non-peer-reviewed) literature, and popular media, were consulted in our search for literature on urgent care centers and retail clinics. The primary source for peer-reviewed articles was PubMed, the National Institutes of Health resource of more than 24 million medical and health care journal citations and abstracts. Because retail clinics and urgent care centers are both known by various names, we used multiple search terms to identify articles related to these providers.

Following the selection process employed by Weinick, Pollack, et al. (2010) we excluded articles outside the scope of this report based on title or abstract, as well as articles without abstracts; we also excluded opinion pieces, keeping only articles with empirical data and results. This process yielded eight articles related to urgent care centers and 21 related to retail clinics. We also included articles meeting the criteria from a search of references in the initially selected articles, for a total of 25 articles related to retail clinics and 12 related to urgent care centers. (Charts outlining this selection process appear on the following page.)

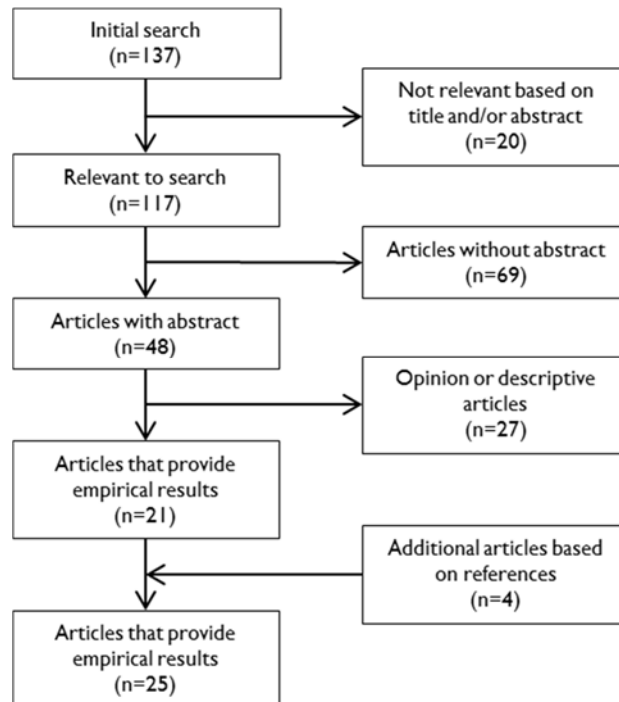
Because of the relative dearth of peer-reviewed articles, we supplemented the search with industry reports, policy papers, foundation reports, and presentations from the grey literature. We identified these by consulting the bibliographies of peer-reviewed papers and the websites of industry organizations (e.g., the Urgent Care Association of America), research-based think tanks (e.g., RAND), and foundations (e.g., New York State Health Foundation). Finally, we included information from select news articles published in the three months prior to this report's publication.

Figure A1: Urgent Care Centers Literature Search



SEARCH TERMS: "Urgent Care Clinic" [all] OR "Urgent Care clinics" [all] OR "Urgicenter" [all] OR "urgent care center" [all] OR "urgent care centers" [all] OR "urgent clinic" [all] OR "urgent care practice" [all]

Figure A2: Retail Clinics Literature Search



SEARCH TERMS: "Retail Health Clinic" [all] OR "Retail-based Clinic" [all] OR "Retail Clinic" [all] OR "Retail Health Clinics" [all] OR "Retail-based Clinics" [all] OR "Retail Clinics" [all] OR "Retail medicine" [all] OR "Retail medical clinic" [all] OR "Retail medical clinics" [all] OR "Convenient care clinic" [all] OR "Convenient care clinics" [all] OR "Retail store clinics" [all] OR (retail AND ambulatory care facilities[mesh])

Appendix B. Census and Mapping Methodology

Table B1. Census Methodology

Type	Data Sources and Process
Urgent Care Centers	<p>Sources. The American Academy of Urgent Care Medicine (AAUCM), a national organization representing providers who practice urgent care medicine, provided a New York State clinic directory containing the names and addresses of 322 urgent care practices. Merchant Medicine, a consulting and research firm in the field of walk-in medicine, provided a directory of 282 urgent care centers in New York, including those that have not yet opened. The Urgent Care Association of America, a membership organization representing professionals working in urgent care centers around the world, has a directory of 363 urgent care centers in New York, accessible through its website.</p> <p>Methodology. Significant overlap existed across the three directories, and we removed all duplicates from our initial list. We then identified additional clinics based on information obtained from the websites of urgent care practice chains or groups. Inclusion in the census was based on two criteria: (1) the center must be currently open or operating and (2) it must fit the definition of an urgent care center. Both of these were verified by obtaining information from the company's website or, for those without a web presence, contacting the urgent care center via phone.</p> <p>For the first criterion, we excluded those organizations that did not have any web presence or a working phone number. For the second, we drew on our typology of ambulatory care (Table 1) to exclude sites identified primarily as a primary care office or multi-specialty practice (including those that allowed walk-in care) or an emergency department (including free-standing, full-service, and fast-track). Consistent with the definition of an urgent care center as providing convenient care, we excluded those that did not offer extended evening or weekend hours.</p>
Retail Clinics	<p>Sources. We searched each of the websites of the 17 largest retail clinic operators in the country.* We also utilized the Merchant Medicine retail clinic database, obtained in October 2014. And we used additional information gained during the interviews.</p> <p>Methodology. As we did for urgent care centers, we removed all duplicate listings from the three sources. The search process resulted in a list of 18 clinics, 12 of them located in New York City. The clinics are owned by three operators: Duane Reade (10 locations), Minute Clinic (6 locations), and Quick Care (2 locations).</p>

* The 17 largest retail clinic operators, identified by Becker's Hospital Review, are: Minute Clinic, Walgreens Healthcare Clinic (formerly Take Care Clinic), The Little Clinic, Target Clinic, Fast Care, Redi-Clinic, Baptist Express Care, DR Walk-in Medical Clinics, Cigna Care Today, Aurora Quick Care, Lindora Health Clinics, Alegant Quick Care, Avanti Medical Group, Cox Health, Geisinger CareWorks, Heritage Valley Health, and Southwest Medical.
<http://www.beckershospitalreview.com/lists/17-largest-retail-clinic-operators-in-the-united-states.html>

Table B2. Mapping Data Sources

Item	Source	Description
Street address database	ESRI Streetmaps Premium for ArcGIS	The Environmental Systems Research Institute (ESRI) is an international supplier for ArcGIS geographic information system software. ESRI's Streetmaps for ArcGIS provides an enriched street dataset that works with ESRI's ArcGIS software to provide cartographic displays for geocoding, routing, and turn-by-turn directions for North America, Europe, Australia, and New Zealand.
Population Density	U.S. Census (2010)	Population information was obtained from the 2010 U.S. Census. Population density is calculated as the number of people per square mile.
Median Household Income	American Community Survey (2012)	The American Community Survey is an ongoing statistical survey that provides broad social, economic, housing, and demographic information annually. Median Household Income includes income for the previous 12 months of the householder and all other people 15 years or older in the household, whether or not related to the householder.
Medically Underserved Areas/Populations	HRSA Medically Underserved Areas and Populations (http://www.hrsa.gov/shortage/)	Medically underserved areas/populations (MUAs/MUPs) are areas or populations designated by the Health Resources and Services Administration as having too few primary care providers, high infant mortality, high poverty, and/or a high percentage of elderly.

Appendix C. Interview Protocol

Central Questions

1. How would you characterize the current status and trajectory of retail clinics and urgent care centers? (*probe for*)
 - a) Nationally?
 - b) In New York State?
 - c) In New York City?
2. Who are the most influential players in the New York State retail clinic and urgent care centers market? (*probe for*)
 - a) Among urgent care center/retail clinic “parents” (i.e., general retail, pharmacies)
 - b) Among affiliated providers/groups?
 - c) Who is financing them?
3. What benefits do retail clinics and urgent care centers bring to patients and the health system?
 - a) What impact do retail clinics and urgent care centers have on cost savings and increased access?
 - b) What level of care should be provided at retail clinics and urgent care centers and what types of patients should be served?
4. What are the major issues posed by retail clinics and urgent care centers? Specifically, what potential do you think retail clinics and urgent care centers have for increasing the fragmentation of care, inducing demand, and “cream skimming” from other providers?
5. What are some of the emerging trends for retail clinic and urgent care center operations?
 - a) Specifically, what trends exist re expanding the scope of care, forming new partnerships, and extending to new markets and locations?
 - b) Do you know of urgent care centers and/or retail clinics that plan on growing into primary care practices?
6. What is the relationship between retail clinics and urgent care centers and other providers (i.e., PCMHs, EDs, PCPs)
 - a) What specific emerging partnerships are forming and what health systems are at the leading edge of integrating with urgent care centers and retail clinics?
 - b) What are the minimum requirements required for collaboration and partnerships with other providers?
 - c) What are the ramifications for continuity of care, particularly for chronic conditions?
7. What existing federal and State policies or laws are likely to affect retail clinics and urgent care centers and those who use them? (*probe for*)
 - a) Specific areas where additional policies should be developed going forward?
 - b) Policies re licensing, network adequacy, physician extended scope of practice, CON?

(continued on next page)

8. How are payers responding to the rise of urgent care centers and retail clinics?
 - a) Are there specific examples of targeted responses by payers either encouraging or discouraging use of retail clinics and urgent care centers?
 - b) Are there differences in the responses between individual market and public payers?
9. How important are urgent care centers and retail clinics in the context of expanding coverage under high-deductible, “it’s my money” health plans?

Optional Questions Related to Medicaid and Underserved Populations

1. How does the presence of retail clinics and urgent care centers impact the Medicaid and underserved population?
 - a) What are the benefits of retail clinics and urgent care centers in relation to access to care, cost of care, and the quality of care?
 - b) What are the concerns related to retail clinics and urgent care centers?
 - c) (For providers) Are you a Medicaid participating provider and do you see many Medicaid patients?
2. What is the relationship between retail clinics and urgent care centers and other providers that focus on underserved populations (i.e., community health centers, HHC, other health system clinics and urgent care centers)?
3. How are Medicaid managed care plans responding to the rise of urgent care centers and retail clinics?
 - a) Are some Medicaid managed care plans more likely than others to have retail clinics and urgent care centers in their networks?
 - b) For those plans with retail clinics and urgent care centers in-network, how are they letting beneficiaries know of this option?
4. What regulations and policies impact retail clinic and urgent care center participation in providing for Medicaid and underserved populations? (*probe for*)
 - a) Specific areas where additional policies should be developed going forward?
 - b) Policies related to licensing, network adequacy, physician extended scope of practice, CON?
 - c) Lack of language in MCO contracts with the state and with providers regarding this type of urgent care infrastructure and payment?

Appendix D. Policies and Regulations: Urgent Care Centers

Topic	Goal	PHHPC Recommendations	Other State Approaches
Naming conventions and consumer disclosures	Clarify, for consumers, the role of urgent care providers versus other facilities	<ul style="list-style-type: none"> Require use of the term “urgent care” in the name and signage of provider sites and their materials. Prohibit use of the word “emergency” or its equivalent in urgent care providers’ names. Require consumer disclosures, including signage clarifying services that are and are not offered, pricing information, guidelines for when it is appropriate to visit an urgent care provider instead of an ED or PCP, and the lack of any requirement that prescription and over-the-counter medications be purchased on site. 	<ul style="list-style-type: none"> Illinois: Only permits use of the terms “emergency,” “urgent,” or any derivatives thereof if the facility is actually an emergency room. Delaware: Prohibits use of the term “emergency” or “urgent” by a facility that is not able to provide care for life-threatening situations.
Scope of services	Create a functional definition of urgent care, including scope of practice	<ul style="list-style-type: none"> Define urgent care as treating acute episodic illness or minor trauma: it is not for emergency intervention for major trauma, life-threatening or potentially disabling conditions, or monitoring and treatment over prolonged periods, and is not intended to be a patient-centered medical home or source of continuing care. Require providers, at a minimum, to: <ul style="list-style-type: none"> Accept walk-in visits, typically with extended hours; Offer x-ray and EKG exams; Offer phlebotomy and lab services (CLIA-waived); Be able to administer oral, sublingual, subcutaneous, intramuscular, intravenous, and respiratory medications, as well as IV fluids; Be able to repair uncomplicated lacerations; Maintain and be able to use crash cart supplies and medications. 	<ul style="list-style-type: none"> Arizona, Florida, Maryland, Minnesota, New Hampshire, and Utah: Have defined urgent care centers and urgent care center-equivalent facilities.

Topic	Goal	PHHPC Recommendations	Other State Approaches
Licensure, accreditation, and Certificate of Need (CON)	Create policies for restricting the use of the term “urgent care”	<ul style="list-style-type: none"> Require private physician offices and Article 28 providers to apply to the Department of Health for permission to use the term “Urgent Care,” and allow only approved providers to use the term. Require accreditation by a national organization approved by the Department of Health, and provision of defined minimum services. Maintain existing CON processes based on provider type (i.e., non-Article 28, existing Article 28, new Article 28). 	<ul style="list-style-type: none"> Arizona: Has legislation that defines freestanding urgent care clinics and outlines the licensure process, including the relationship between health care service organizations and UCCs, and established posting requirements. Urgent care centers require credentialing every two years. Accrediting bodies include: Joint Commission; Accreditation Association for Ambulatory Health Care; National Association for Ambulatory Care
Patient safety and quality	Regulate quality standards, including referral relationships and minimum standards for accreditation	<ul style="list-style-type: none"> Require policies and procedures for referring patients to emergency departments and/or primary care providers. Require timely reporting by both the accrediting body and provider if provider accreditation is lost. Require office-based surgery accreditation consistent with current private-practice requirements for providers who want to offer urgent care services needing more than minimal sedation or local anesthesia. 	
Continuity of care	Require processes to promote medical homes and longitudinal continuity of care	<ul style="list-style-type: none"> Require providers to offer patients without a primary care provider a roster of PCPs (including preferred providers recognized as PCMHs or federally qualified health centers) accepting new patients. Develop policies and procedures to identify and limit the number of repeat encounters with patients. 	
Health information technology	Develop requirements for sharing personal health information with patients, their PCPs, and specialists as needed	<ul style="list-style-type: none"> Require the use of electronic health records to ensure connections to the larger health care delivery system. Ensure that patients receive copies of their medical records. Require documentation, execution, and management of a discharge plan of care for every patient. 	

Topic	Goal	PHHPC Recommendations	Other State Approaches
Medicaid and the safety net	Establish an updated Medicaid reimbursement model for urgent care facilities (i.e., billing by facility rather than by physician)	(None addressed)	

Source: Public Health and Health Planning Council. October 2013. *Ambulatory Services: Urgent Care Policy Options*. https://www.health.ny.gov/facilities/public_health_and_health_planning_council/meetings/2013-10-04/docs/ambulatory_services_uc_policy_options.pdf. Accessed January 8, 2015.

Appendix E: Policies and Regulations: Retail Clinics

Topic	Goal	PHHPC Recommendations	Other State Approaches
Naming conventions and consumer disclosure	Develop naming conventions that convey the scope of services provided, and regulate signage, marketing, and advertising to protect consumers	<ul style="list-style-type: none"> Require retail clinics to be known as and use the term “limited services clinic” in their name at all sites and in all materials, to aid consumer recognition of this model of care. Require consumer disclosures, including signage clarifying services that are and are not offered, and the lack of any requirement that prescription and over-the-counter medications be purchased on site. 	<ul style="list-style-type: none"> Massachusetts: The only state to regulate retail clinics, it refers to them as “limited service clinics.” Kentucky: Proposing licensure for retail clinics as “minor care health clinics.”
Scope of services	Define the scope of services that retail clinics can provide (episodic, focused care), the populations they can serve, and business hours	<ul style="list-style-type: none"> Limit services to basic episodic care related to minor ailments, as well as immunizations. Prohibit: <ul style="list-style-type: none"> Surgical, dental, physical rehabilitation, mental health, substance abuse, and birth center services Dispensing of controlled substances, and lab work other than CLIA-waived tests Services to patients 24 months or younger Immunizations for patients under 18, except for flu and HPV vaccine. Offer unscheduled visits and extended business hours. 	<ul style="list-style-type: none"> Massachusetts: Prohibits provision of services to children less than 24 months of age, and prohibits childhood immunizations. Kentucky: Proposing licensure regulations to limit services to “minor health care” and prohibit treatment of patients younger than 18 months.
Licensure, accreditation, and Certificate of Need (CON)	<p>Create a separate licensure category for retail clinics</p> <p>Require a CON to ensure public need and financial feasibility, appropriate licensure, training, and experience of providers, and compliance with architectural and engineering requirements</p>	<ul style="list-style-type: none"> Amend section 2801-a of the Public Health Law to add “limited services clinics” in the category of Article 28 diagnostic or treatment centers, to allow corporations to provide professional services that are currently prohibited. (Private physician offices are not precluded from providing professional services in retail settings.) Require an architectural review to assure that health and safety requirements are met. Secure third-party accreditation by a national accreditation organization approved by the department. 	<ul style="list-style-type: none"> Massachusetts: “Limited service clinic” licensure regulations address physical space and fragmentation of medical care. Arizona: Retail clinics are licensed by the Department of Health under “outpatient treatment centers.” Kentucky: Proposing licensing retail clinics as “minor care health clinics.” New Hampshire: Plans to license retail clinics under the category of “outpatient clinics, laboratories, and collection centers.” Florida: Only requires licensure for corporately owned clinics and not for those owned by licensed clinicians, including nurse practitioners.

Topic	Goal	PHHPC Recommendations	Other State Approaches
Patient safety and quality	Regulate quality standards, including the use of clinical guidelines, third-party accreditation, and patient safety and quality data reporting	<ul style="list-style-type: none"> Require a corporate medical director who is licensed and registered to practice medicine in New York State. Require policies and procedures for referring patients whose needs exceed services provided, and to ensure continuity of care. Prohibit offering or providing any incentive, inducement, or payment to clinical staff for referring or recommending to patients items or services provided at the site or by the host provider. 	<ul style="list-style-type: none"> Massachusetts: Retail clinics must provide a toll-free number to enable patients to speak with a live practitioner after hours.
Continuity of care	Require processes to promote medical homes and longitudinal continuity of care	<ul style="list-style-type: none"> Require providers to offer patients without a primary care provider a roster of PCPs (including preferred providers recognized as PCMHs or federally qualified health centers) accepting new patients. Develop policies and procedures to identify and limit the number of repeat encounters with patients. 	<ul style="list-style-type: none"> Massachusetts: Ensure referral arrangements with PCPs, maintenance of rosters of PCPs who are accepting new patients, processes to identify and limit repeat encounters, and provision of patients' PCPs with records of their visits.
Health information technology	Develop requirements for sharing of personal health information with patients, their PCPs, and specialists as needed	<ul style="list-style-type: none"> Require use of electronic health records to ensure connections to the larger health care delivery system. Ensure that patients receive copies of their medical records. Require documentation, execution, and management of a discharge plan of care for every patient. 	
Medicaid and the safety net	Encourage retail clinics to accept Medicaid and establish sites in underserved areas, and encourage community health centers to become providers in retail settings Encourage Medicaid managed care plans to certify retail clinics and providers and to contract with retail clinics in their networks	(None addressed)	<ul style="list-style-type: none"> Massachusetts: The commissioner of health has encouraged community health centers to open limited service clinics but none have done so. Idaho and Illinois: Use primary care case management programs to manage Medicaid beneficiaries and allow use of retail clinics with prior authorization. Retail clinic operators say prior authorization is a significant hurdle for retail clinic use. Arizona: Managed care plans will pay for visits for emergent or urgent services.

Source: New York State Department of Health. 2013. Retail Clinics: Options for New York State. https://www.health.ny.gov/facilities/public_health_and_health_planning_council/meetings/2013-09-13/docs/rc_options_pros_cons.pdf. Accessed January 6, 2015.



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