HEALTH POLICY REPORT

Mary Beth Hamel, M.D., M.P.H., *Editor*

Convenient Ambulatory Care — Promise, Pitfalls, and Policy

Ji Eun Chang, M.S., Suzanne C. Brundage, S.M., and Dave A. Chokshi, M.D.

Every year, 1.2 billion visits are made in ambulatory care settings, accounting for approximately one third of health care spending in the United States.[1,2] Although the vast majority of these visits take place in office-based clinics and emergency departments, an increasing number of patients are seeking care in nontraditional sites such as retail clinics and urgent care centers. Retail clinics are walk-in health clinics, typically located in pharmacies or supermarkets, that provide immediate care for a narrowly defined scope of services, such as the diagnosis and treatment of minor acute illnesses, as well as some preventive care and care for chronic conditions. Urgent care centers are also walk-in health centers, but they treat a wider range of acute conditions requiring immediate but not emergency care (Table 1).

Both retail clinics and urgent care centers are part of the rapidly growing "convenient care" industry, which encompasses a broad spectrum of consumer-oriented innovations providing swift, easily accessible, and more affordable care.[3,4] Some new convenient care approaches, such as electronic visits and telemedicine, allow patients to determine the locus of care. Retail clinics and urgent care centers represent convenient ambulatory care. Unlike traditional ambulatory care, retail clinics and urgent care centers operate almost exclusively on a walk-in basis and are often conveniently located in areas of high foot traffic within communities. Many also provide transparent pricing, with the menu and price of services often listed online, on site, or both.

A confluence of factors — including expanded health coverage, lengthy wait times for primary care appointments, crowded emergency departments, and increasing health care costs — have stimulated considerable interest and investment in convenient ambulatory care in recent years.[5-7] However, physician organizations such as the American Academy of Pediatrics and the American Academy of Family Physicians have expressed concerns about the potential for convenient ambulatory care to fragment care and provide lower-quality care.[8,9] These debates have ensued with greater frequency in recent years as several states consider legislation around the practice of convenient ambulatory care.

This article aims to further characterize retail clinics and urgent care centers; to examine the evidence of their effect on cost, quality, ac-

Table 1. Similarities and Differences between Retail Clinics and Urgent Care Centers.

Variable	Retail Clinics	Urgent Care Centers
Definition	Walk-in health clinics typically located in pharmacies or supermarkets	Walk-in health care centers that treat episodic conditions that need immediate but not emergency care
No. of clinics in United States	1900	6400
Primary scope of services	Low-acuity episodic care, immunizations, and some preventive care and care for chronic conditions	Episodic care for a range of acuity levels
Staffing model	Generally nurse practitioners or physician assistants	Generally emergency medicine and family medicine physicians
Hours of operation	Extended hours — open nights and at least one weekend day — but not 24/7	Extended hours — open nights and at least one weekend day — but not 24/7
Industry	Concentrated	Fragmented

cess, patient navigation, and continuity of care; to discuss existing standards and regulatory approaches; and finally to lay out the key policy considerations in balancing support for these new care models while ensuring essential protections for patients.

CHARACTERIZING CONVENIENT AMBULATORY CARE

RETAIL CLINICS

Retail clinics first emerged in the early 2000s, and today there are more than 1900 such clinics. Further growth is expected as current and new operators rapidly carve out clinics in preexisting retail spaces. For example, CVS, the largest retail-clinic operator (currently with 980 MinuteClinic locations), announced plans to expand to 1500 clinics by 2017.[10] The industry is highly centralized; four operators — CVS, Walgreens, Kroger, and Target — account for more than 85% of the market. These four operators currently have clinics in only 8% of their 20,000 stores, leaving ample room for potential expansion (Fig. 1).

Retail clinics are often staffed by a single nurse practitioner or physician assistant who delivers a standard set of basic screening, diagnostic, and treatment services for low-acuity episodic needs with clear clinical protocols. More than 90% of retail-clinic visits are for 10 simple medical conditions, such as sinusitis or urinary tract infection.[11] However, in recent years, some retail clinics have expanded their services to include behavioral health screenings as well as chronic disease management.[12] For example, the new primary care clinics operated by Walmart diagnose, treat, and manage a wide range of chronic illnesses, including hypertension, dyslipidemia, chronic obstructive pulmonary disease, asthma, and diabetes.

URGENT CARE CENTERS

Urgent care centers emerged in the United States during the late 1970s as after-hours extensions of physician practices. Because there is no systematic registration process for urgent care, estimates of the number of urgent care centers vary widely. However, according to the Urgent Care Association of America (UCAOA), there are now approximately 6400 urgent care centers, with an annual growth rate of approximately 300 to 600 new centers per year.[13] Unlike the retail-clinic industry, the urgent care industry is highly fragmented, with the five largest operators accounting for less than 13% of the market.[14]

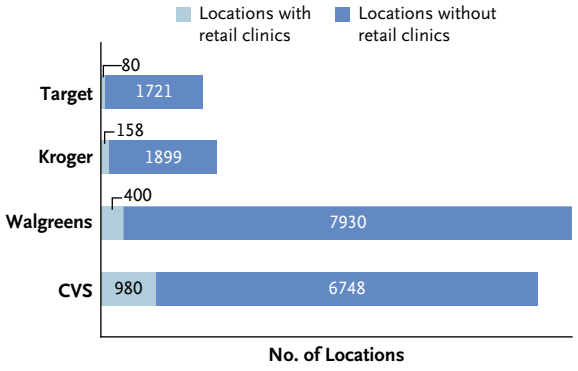

Figure 1. Number of Provider Locations with Retail Clinics and without Retail Clinics.

Data are based on telephone and e-mail interviews conducted in May 2015 with representatives from each retail-clinic operator. Note that there is room within each clinic chain for expansion of services.

With no consensus definition of "urgent care," there is relatively little standardization; sites vary in scope of practice and staffing levels. It is common for urgent care centers to diagnose and treat fevers, sprains and strains, lacerations, and acute low back pain, and some locations also provide ongoing primary care.[15] Although most facilities have basic radiology and laboratory capacities, urgent care centers are usually not equipped to deal with trauma, resuscitation, or other life-threatening conditions.[16] Most urgent care centers are staffed by physicians, generally with backgrounds in family or emergency medicine, although some centers operate on a nurse practitioner–based model.[17]

OPPORTUNITIES AND CHALLENGES IN CONVENIENT AMBULATORY CARE

COST

A key argument in favor of convenient ambulatory care has been the potential to reduce health care costs. Convenient care options rely on less expensive staffing models and often incur lower fixed costs than those borne by traditional care sites, such as emergency departments. Indeed, care delivered at retail clinics and urgent care centers has been shown to cost less per episode

than care delivered at primary care physicians' offices and the emergency department, at least for some minor acute conditions.[18,19] According to one estimate, 13 to 27% of all emergency department visits could be shifted to an urgent care center or retail clinic, amounting to a potential annual cost savings of $4.4 billion.[20] Despite these visit-based savings, patients' total cost of care could increase if retail clinics and urgent care centers stimulated increased utilization of services — for instance, if patients were to use duplicative follow-up care at a traditional site. Although research on total costs is sparse, one retrospective analysis of CVS Caremark employees showed a significantly lower total cost of care in the year after a first visit to a retail clinic than that incurred by matched persons who received care in other settings.[21]

QUALITY

Little is known about the quality of care at urgent care centers. However, a growing body of evidence suggests that retail clinics provide a quality of care that is equal to or higher than that of other ambulatory care sites — at least for minor acute conditions. For example, two studies showed that the quality of care for otitis media, pharyngitis, and urinary tract infection was higher in retail clinics than in emergency departments or other ambulatory care facilities.[18,22] Retail clinics also achieved a ranking above the 90th percentile for some quality measures in the Healthcare Effectiveness Data and Information Set.[23] Furthermore, the vast majority of retail-clinic users (90%) report being satisfied with their care.[24] Positive results have been observed with the pediatric population as well: in one study, children treated for otitis media at a retail clinic had a lower rate of return visits within 2 weeks than their counterparts who visited standard office clinics.[25]

ACCESS

Another potential benefit of retail clinics and urgent care centers is increased access to ambulatory care. In addition to expanding geographic access points, convenient ambulatory care can supplement traditional sites temporally by providing care on evenings and weekends. Indeed, studies have shown that nearly half of retail-clinic visits occur after hours.[26,27] A limitation to this expanded access is that retail clinics and urgent care centers tend to locate in affluent areas, catering to patients with private health insurance, rather than in underserved areas.[28-30] Nonetheless, the convenience of immediate walk-in care may be particularly valuable to those without a regular source of care or those with simple episodic care needs. For example, approximately 61% of retail-clinic visits and 37% of urgent care visits involve patients without a primary care provider — roughly triple and double the national rate, respectively.[11,15] Most adults (72%) who lack a usual source of care do so as a matter of preference.[31] For those persons, convenient care centers may act as a substitute for primary care. For others, such as those who present with an acute symptom of a chronic illness, convenient ambulatory care may serve as a gateway to the larger health care system.

PATIENT NAVIGATION

The appropriate use of convenient ambulatory care hinges on the ability of patients to self-triage their symptoms and navigate to the appropriate setting. One study exploring this topic in the context of retail clinics showed that patients did properly self-triage, with more than 88% of retail-clinic episodes resolved in one visit.[32] Another study showed that 2.3% of retail-clinic patients were triaged to an emergency department or physician's office.[11] Comparable peer-reviewed studies were not found for visits to urgent care centers. However, according to an internal benchmarking survey administered by the UCAOA, 4% of visitors to urgent care centers are either directed or transferred to an emergency department.[16]

CONTINUITY OF CARE

Relational continuity of care is defined as "an ongoing therapeutic relationship between a patient and one or more providers."[33] Expanded access to episodic care may therefore result in a decline in relational continuity. Indeed, patients who visited retail clinics were shown to make fewer future visits to their primary care physician and to have less continuity of care.[34] Reductions in relational continuity are particularly detrimental for patients with chronic conditions and those with complex or long-term care needs.[35]

Nonetheless, advances in informational continuity of care may mitigate deleterious effects on relational continuity. Informational continuity

Table 2. Integration between Retail Clinics and Health Systems.*

Clinic Operator	Clinic Name	No. of Clinics	EHR System	No. of Partnerships	Information Sharing and Referrals to PCPs†
CVS	MinuteClinic	980	EpicCare	55	Yes
Walgreens	Healthcare Clinic	400	Proprietary system	21	Yes
Kroger	The Little Clinic	158	eClinicalWorks	9	Yes
Target‡	Target Clinic	80	Athenahealth	1§	Yes

* Data are based on telephone and e-mail interviews conducted in May 2015 with representatives from each retail-clinic operator. EHR denotes electronic health records, and PCP primary care physician.
† For patients without a PCP, clinics provide a list of PCPs who are accepting new patients; for patients with a PCP, clinics share post-visit information electronically, by mail, or through hand delivery by the patient.
‡ On June 15, 2015, CVS agreed to acquire Target pharmacies and clinic businesses; under the agreement, Target Clinics will be rebranded as MinuteClinic locations.[36]
§ The sole partnership is with Kaiser Permanente.

is defined as "the use of information on past events and personal circumstances to make current care appropriate for each individual."[33] There is near-universal adoption of electronic medical records by retail clinics, and retail clinics partake in a growing number of health system partnerships (Table 2). For example, Kaiser Permanente–staffed Target Clinics in California offer pediatric care and women's wellness services in addition to the typical retail-clinic offerings and are connected electronically to the Kaiser Permanente network. Other integrated health systems such as Mayo Clinic and Geisinger Health System operate their own retail clinics. Furthermore, numerous academic medical centers, including the Cleveland Clinic and UCLA Medical Center, have invested in interoperability with retail clinics, in part to generate referral relationships for retail-clinic patients without a usual source of care.

Health systems have also engaged in a flurry of activity in partnering with, purchasing, or building their own urgent care clinics. For example, in 2014, North Shore–LIJ Health System on Long Island in New York State partnered with a private-equity–backed urgent care operator to open the first of 80 planned urgent care centers under the brand GoHealth.[37] Urgent care providers are increasingly viewed as vital partners in the population health management strategies of accountable care organizations, such as Lahey Health in Massachusetts.[38] These efforts may allay concerns about continuity and care coordination by ensuring integration with more traditional elements of the health care system.[39]

BALANCING OPPORTUNITIES AND CHALLENGES

Balancing these opportunities and challenges may depend on substitution and referral among convenient ambulatory care and more traditional sites. Cost savings could accrue if patients use convenient ambulatory care as a substitute for emergency rooms or (more judiciously) for segments of primary care — and continuity and access could increase if convenient care operators shared information with and referred patients back to primary care. However, substituting traditional care with convenient care also increases the potential for fragmentation. Maximizing the benefits of convenient care thus depends on patients' safely navigating these settings — and strong informational and referral relationships across sites of care.

EXISTING STANDARDS AND REGULATORY APPROACHES

Numerous efforts have been undertaken to develop norms for retail clinics and urgent care centers. These efforts have centered on three approaches: industry-led professional standards, voluntary accreditation by external bodies, and state-based legislation and associated regulations.

Trade organizations offer standards of practice and accreditation programs specific to the convenient ambulatory care industry. For example, the UCAOA accreditation process involves "comprehensive site tours administered by an independent third party" that assesses the scope of services, hours of operation, and licensure of providers.[40] Urgent care centers and retail clinics

can also seek accreditation through national health care evaluation and certification agencies. For example, some urgent care centers and retail clinics are accredited under the Joint Commission Ambulatory Care Accreditation program, which evaluates operators' adherence to safety and quality standards as well as compliance with clinical practice guidelines.[41] Meanwhile, the newly minted Patient-Centered Connected Care program of the National Committee for Quality Assurance recognizes nontraditional outpatient sites for communicating effectively with a patient's other providers.[42]

Although such accreditation programs establish standards for the industry, participation is voluntary and hence standards are not adopted universally. Instead, state legislation and regulations set the minimum requirements for convenient ambulatory care in a given jurisdiction. In most states, retail clinics and urgent care centers are treated as private physician practices, subject to professional regulation by state medical boards. However, a growing number of states are considering legislation and licensing requirements for urgent care and retail clinics.

To date, at least 10 states have adopted some legislation or regulation specific to urgent care (see Table S1 in the Supplementary Appendix, available with the full text of this article at NEJM.org). For example, Arizona, Florida, Maryland, Minnesota, New Hampshire, and Utah provide specific definitions of "urgent care" as distinguished from primary care or emergency care. Illinois restricts the terms "emergent" or "emergi-" to hospital emergency rooms or freestanding emergency centers licensed under the Emergency Medical Services Systems Act. New Hampshire requires licensure for nonemergency walk-in care centers, which includes both urgent care centers and retail clinics. Arizona remains the only state to have adopted a dedicated licensure program specific to urgent care centers.

According to the National Conference of State Legislatures, at least 16 states have considered legislation specific to retail clinics (Table S2 in the Supplementary Appendix).[14] Some of the proposed bills, such as those in Kentucky and Illinois, were opposed by the Federal Trade Commission on the grounds that they discouraged competition by imposing undue costs and restrictions not borne by the rest of the ambulatory care sector.[43,44] At least 3 states have adopted legislation specific to retail-clinic practice. Kentucky establishes scope of operations and services, minimum staffing requirements, and physician oversight requirements. Vermont requires nonemergency walk-in centers, including retail clinics, to not discriminate against any patient on the basis of insurance status or type of health coverage. In Massachusetts, retail clinics are regulated as a separate category of health care entity known as "limited service clinics." Massachusetts law does not solely impose restrictions on the practice of retail clinics but instead also requires the Department of Public Health to promote the use of these clinics within the full scope of practice of a nurse practitioner.[45] Some other states, such as Arizona, Florida, New Hampshire, and Rhode Island, license retail clinics as outpatient treatment centers or ambulatory care facilities.[46,47]

KEY POLICY CONSIDERATIONS

Convenient ambulatory care poses a double-edged sword for policymakers. On one hand, assisting their growth could help address the imperative to reduce cost while increasing access to care. On the other hand, concerns about quality, the potential to mislead patients in need of higher levels of care, and fragmentation of care call for regulatory safeguards for patients.

In addition to industry-specific regulations, retail-clinic operations are affected by scope-of-practice laws governing the activity and independence of nurse practitioners and physician assistants.[48] In some states, nurse practitioners are able to work independently without physician oversight, though a certain level of supervision is required in most states. Because the retail-clinic model is built around these mid-level practitioners, scope-of-practice regulations affect the cost structure of retail clinics and influence where they locate.

Convenient ambulatory care is also influenced by laws regarding the corporate practice of medicine, which generally prohibit the employment of physicians by corporations in order to ensure that corporate entities do not influence treatment decisions made by physicians.[49,50] Because most retail clinics and one third of urgent care centers are owned by corporations, these guidelines influence operating costs as well as decisions around expansion. For example, the

strong prohibition in New York against the corporate practice of medicine allows corporations to pay physicians to work for them as private contractors but not as hired employees. This restriction has made the retail-clinic model more costly to implement and deterred their growth in the state.[30]

Three considerations predominate in formulating sound policy in this complex milieu. First, patients face increasing challenges in navigating to the right care setting, owing in part to wide variations in services and staffing levels across the ambulatory care sector. States can aid patients in making informed choices by developing common definitions and naming standards for retail clinics and urgent care centers. Individual states may also consider enforcing licensure and accreditation requirements on the basis of common definitions to ensure minimum service standards. Second, adoption of electronic tools and partnerships with health systems make it easier for providers of convenient ambulatory care to support continuity of care. Policymakers can further encourage continuity of care by mandating or incentivizing connectivity to health information exchanges and supporting referral of patients back to more permanent sources of care. Third, there is a need to ensure that routine efforts to collect quality or safety data from convenient ambulatory care sites are integrated into existing quality frameworks. For example, the National Quality Forum could drive consensus on the quality and safety measures that are most germane to convenient ambulatory care.

Retail clinics and urgent care centers are promising innovations with intertwined opportunities and challenges. Balancing the societal benefits of convenient ambulatory care with basic consumer and patient protections will probably remain a task for state-level policy efforts. The growing body of evidence around convenient ambulatory care and current voluntary and professional standards can inform policymakers as they deliberate on potential regulations.

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From the Wagner School of Public Service, New York University (J.E.C.), New York City Health and Hospitals Corporation (J.E.C., D.A.C.), United Hospital Fund (S.C.B.), and New York University Langone Medical Center (D.A.C.) — all in New York.

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