



CALIFORNIA
HEALTHCARE
FOUNDATION



Health Care in the Express Lane: Retail Clinics Go Mainstream

September 2007

Health Care in the Express Lane: Retail Clinics Go Mainstream

Prepared for:

CALIFORNIA HEALTHCARE FOUNDATION

Prepared by:

Mary Kate Scott, Scott & Company

About the Author

Mary Kate Scott is the principal of Scott & Company, a strategy consulting firm providing services to health care providers, payers, technology firms, and their investors. Ms. Scott is also an adjunct professor at the University of Southern California's Marshall School of Business, where she lectures on entrepreneurship in life sciences. She can be reached at mks@marykatescott.com.

About the Foundation

The **California HealthCare Foundation**, based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care. For more information about CHCF, visit us online at www.chcf.org.

Contents

2	I. Executive Summary	
4	II. Overview	
6	III. The Clinic Operators: Consolidation, Expansion, and Attrition	
14	IV. The Retailers: Still in the Testing Phase	Retailers' Strategies for Clinic Operation
17	V. The Payers: Moving Towards Coverage	Insurance Carriers Large Employers
19	VI. The Consumer: Attitudes and Adoption	
21	VII. The Health Care System: Concerns, Regulatory Factors, and Integration	Quality of Care Regulatory Forces and Changes Clinic Integration into the Wider Health Care System
25	VIII. California Update	
27	IX. Areas and Issues to Watch	
31	X. Conclusion	
32	Endnotes	

I. Executive Summary

RETAIL CLINICS—STILL A SMALL PLAYER IN THE HEALTH care industry—are stimulating a debate about the best way to meet consumer demand for convenient, timely, and affordable medical services. This report updates the findings of *Health Care in the Express Lane: The Emergence of Retail Clinics*. It explores the evolving retail clinic environment and describes the current status of clinic operators, retailer perspectives, emerging business models, consumer reactions, physician responses, and payer relationships. It also probes the legislative forces that are shaping the national supply of clinics, paying special attention to the opportunities and challenges that will determine California's ability to host retail clinics.

Since they came on the scene a few years ago, retail-based health clinics have attracted a great deal of attention from the media, the public, the medical establishment, and investors. The model is straightforward: retail clinics offer a limited menu of medical services on a walk-in basis. They are typically staffed with nurse practitioners (NPs), who provide diagnoses and prescriptions in about fifteen minutes, and are located inside retail stores, including drug and grocery stores, and mass merchandisers.

Retail clinics have proliferated rapidly—from 62 clinics in January, 2006, to more than 500 today. They have also evolved from an interesting experiment to what may become an alternative model for providing routine medical services. Consumers across all socioeconomic groups are increasing their use of clinics and reporting high levels of satisfaction. Retailers are expanding the space allotted to clinics, and insurance carriers are offering co-payments at many clinics. Demand is likely to keep growing as consumers accept the model and payers offer incentives to use clinics as a way to reduce costs. This trend may also be driven by large payers (particularly governments) that are seeking affordable ways to increase access to basic services.

Health care providers are taking notice, with some entering the market as clinic operators, a few others providing co-branding for clinic operators, and many watching from the sidelines to learn how they might deliver health care in new and more streamlined ways. Physician response has been mixed; while the American Academy of Family Physicians (AAFP) has created a working

partnership with retail clinic operators, other provider groups have voiced concerns about quality and the erosion of the “medical home” model of delivering primary care that emphasizes a stable patient-physician relationship.

Clinic services are likely to expand as new medical device technologies enable rapid, accurate, binary diagnoses. Communications technologies may also expand the use of clinics by making consumers’ clinic records available to their physicians, allowing for an extended medical home. While the physician community is probing clinics on quality of care issues, clinic operators are pushing the health care industry on other quality issues, including the adoption of electronic medical records, electronic chart review, and protocols grounded in evidence-based medicine.

Regulators will play a significant role in enabling or limiting clinics. Each state has a great deal of latitude in deciding how hospitable to be toward retail health clinics. There is health care legislation currently under debate in several states concerning the scope of practice for nurse practitioners, including potential changes to their prescribing authority and physician oversight requirements. Corporate-practice-of-medicine laws also control who can own and operate medical practices, and interpretations of such statutes can foster or inhibit the expansion of clinics in different states.

II. Overview

IN THE YEAR SINCE THE PUBLICATION OF *HEALTH CARE in the Express Lane: The Emergence of Retail Clinics*,¹ retail-based clinics have rapidly proliferated across the United States. In the health care sector, where change tends to be gradual and new ideas can take years to mature, retail clinics have quickly gained widespread acceptance in the marketplace. However, critics remain skeptical of the quality of care provided at retail clinics, and wary of their potential to undermine the primary care relationship between patient and physician. It seems clear that retail clinics could become a disruptive innovation in health care, capable of fundamentally challenging long-established models of care, and changing consumer expectations of the cost, quality, and delivery of care.

Retail clinics (sometimes referred to as convenient care clinics) are located within a larger retail operation. They offer basic medical diagnoses and treatments for common ailments (strep throat, urinary tract infections), and basic preventive care (such as flu shots and cholesterol checks) on a continual, year-round bases, rather than as a one-time or seasonal service. These clinics differ from urgent care clinics in several ways: a limited service offering (which increases the speed of care delivery), co-location with a pharmacy (which increases convenience for the consumer), and lower cost structure through the use of nurse practitioners and smaller leased space (which reduces the prices they charge).

In-store clinics are typically between 200 and 500 square feet, with a setup consisting of a reception desk and one or two exam rooms. Retailers often place them in a space that is generating less income per square foot than the clinics are anticipated to provide, so some clinics occupy former video game arcades, photo development booths, vending machine areas in grocery stores, or waiting areas near pharmacies. The retailer has a one-time cost of about \$20,000–\$100,000 to make the space “broom-ready,”² and the clinic companies typically pay for the physical retrofitting. The cost ranges from \$25,000 for a basic clinic with one room to \$145,000 for a multi-exam-room clinic offering broader services; the average setup cost is about \$50,000. The majority of clinics are staffed with nurse practitioners supervised by an off-site physician who is available by phone for consultation, although some clinics employ on-site full-time physicians.³

The clinics use proprietary software systems that they describe as delivering evidence-based treatment guidelines. These systems serve as diagnostic tools as well as a checklists to constrain the types of conditions that can be treated at the clinic. Clinics have referral relationships with local physicians or hospitals for customers with conditions that fall outside of their treatment scope and who need a regular source of care. Clinics are open during extended hours and weekends; most visits take about 15 minutes and don't require an appointment. Prices are clearly posted and typically range from \$40–\$70 per service. Some clinics accept insurance, while those that don't provide the documentation needed for consumers to file for reimbursement on their own.

III. The Clinic Operators: Consolidation, Expansion, and Attrition

THERE ARE NOW ABOUT 500 RETAIL CLINICS LOCATED in drug, grocery, and mass merchandise retailers in 36 states. In the first six years of operation approximately 60 retail clinics opened. The phenomenon took off in 2006; 220 new clinics opened that year, and 130 more opened before April 2007. While forecasts vary, there is general agreement that there will be approximately 700 clinics open by the end of 2007 and more than 1,500 by the end of 2008. Longer-range forecasts are more varied, with estimates ranging from 2,500 to 6,000 clinics in operation by the end of 2012.

There are two primary models of clinic operators today: independent clinic operators⁴ (MinuteClinic, Redi-Clinic, Take Care, The Little Clinic, QuickHealth, and others); and clinics that are affiliated with a larger network of conventional health care providers (Aurora, AtlantiCare, Sutter, Geisinger, Memorial South Bend Indiana). The independent operators comprise about 85 percent of the market and the affiliated operators about 15 percent. Clinics affiliated with health care providers have only been in operation for a few years, but have recently grown from 12 clinics one year ago to more than 40 as of June, 2007.

The business model for retail clinics remains fundamentally the same: offer a limited set of services; minimize cost of care through lower-cost labor and small spaces; maintain quality with technology, physician oversight, and strict protocols; and encourage consumer use through convenience and low prices. Clinics remain committed to a strategy of offering limited-scope and routine care rather than seeking to expand medical services. Clinics make strategic choices about their scope of service; some clinics provide adjacent services in preventive care and wellness (such as weight loss, screenings, physicals, and vaccinations) and others focus solely on acute episodic care. Whereas MinuteClinic emphasizes acute care and using clinics as a complement to primary care physicians, other operators such as RediClinic emphasize a full suite of acute and preventive care.

Some clinic operators can offer a wider range of services because they staff on-site physicians. Two examples are Quick Health and Solantic. Both follow essentially the same business model as more limited-scope retail clinics in that they do not require

Table 1. Clinic Operators

Clinic Operator	Headquarters	Locations and Expansion Plans	Retailers	The Consumer Pitch	Notes	Website/URL
AtlantiCare HealthRite	Egg Harbor Township, NJ	4 in NJ 6 additional locations planned	ShopRite	"Taking You Well into the Future"	Opened August 2006; associated with AtlantiCare.	atlanticare.org
Aurora QuickCare	Milwaukee, WI	20 QuickCare clinics in Aurora Pharmacy locations 2 additional locations planned	Aurora Pharmacy, Piggly Wiggly, Wal-Mart	"No appointment. No waiting. No hassle."	The only major clinic operator with a not-for-profit parent company. Opened March 2004. Associated with Aurora Health Care.	aurorahealthcare.org/services/quickcare/index.asp
Bellin Health Fast Care	WI	3 locations in WI	ShopKo	"Walk in without an appointment. Get help without a wait."	Opened June 2006. Associated with Bellin Healthcare.	bellinfastcare.com
Corner Care Clinic	IN, OH	14 locations in IL, IN, OH, NY, PA 100 additional locations planned	Medicine Shoppe, Medicap Pharmacy Stores	"Convenient, Compassionate, Cost-Effective" "Walk right in."	Opened November 2006.	cornercareclinic.com
Early Solutions Clinic	Taylor, MI	6 in MI	Meijer	"Where Early Treatment and Prevention are the Cure"	Opened January 2006. Working with National Kidney Foundation on early detection of hypertension. Clinics are 1,000 square feet in size.	earlysolutionsclinic.net
FastER Care	Sumpter, SC	5 locations in CA	Vallarta	"Emergency Care without the Wait."	Opening 2007.	fastercaresumter.com
Geisinger CareWorks Convenient Healthcare	Danville, PA	2 locations in PA 4 planned	Weis Markets	"Healthcare for People on the Go."	Opened April 2006. Associated with Geisinger Health System.	careworkshealth.com
Healthy Access	TX, MD	7 locations in TX, MD 12 additional locations planned	Wal-Mart	"Your Health...Your Clinic..."	Opened October 2006.	healthyaccess.net
Lindora Medical Clinics	Costa Mesa, CA	1 location in CA 2 additional locations planned	Rite Aid	"The Most Convenient Way to Look and Feel Better."	35 independent locations for supervised weight management only. Opened October 2006.	lindorahealthclinics.com
MedBasics	Irving, TX	2 in TX 15 additional locations planned in Kansas City, MO	Ball's Food Stores: Price Chopper and Hen House Markets	"Convenient, Affordable, Quality Healthcare"	First in-store clinic late summer 2007.	med-basics.com

Table 1. Clinic Operators (Continued)

Clinic Operator	Headquarters	Locations and Expansion Plans	Retailers	The Consumer Pitch	Notes	Website/URL
MediMin	Phoenix, AZ	3 locations in AZ 20 additional locations planned in the next 4 years	Bashas, Food City	"Convenient Medical Care."	Opened March 2006.	medimin.net
MedPoint Express	South Bend, IN	3 locations in IN 2 more Wal-Mart clinics planned	Wal-Mart	"Get Well Sooner."	Affiliate of Memorial Health System, Inc.	medpointexpress.com
MinuteClinic	Minneapolis, MN	168 locations in AZ, CT, FL, GA, IN, KS, MD, MI, MN, MO, NC, NJ, NV, NY, OH, TN, TX, WA 300 additional locations planned	QPC, CVS, Cub Foods, U of MN Campus, Shopping Centers/Office Space in MN, Eden Prairie Center & Southdale Shopping Center, Target	"You're Sick, We're Quick!"	Formerly known as QuickMedx. The first mover and current leader in national retail clinic market share. Backed by Bain Capital; CEO Michael Howe is former CEO of Arby's.	minuteclinic.com
Pronto Clinics	FL	At least 4 were promised in 2006—one each in Tampa, St. Petersburg, Bradenton and Sarasota 8–10 additional locations planned		"Check in. Check up. Check out."	Summer 2006	prontoclinic.com
Quick Quality Care [Now called CheckUps]	Tampa, FL	23 locations in FL, MS, AL, LA Plans to expand to 28 clinics.	Wal-Mart	"Your health is our priority." "Healthcare when you need it."	Clinics are set up for diagnostic imaging (including x-rays) but not yet offering these tests.	checkupsusa.com
QuickClinic	Akron, OH	6 locations in OH 9 additional locations planned	Acme Fresh Market, Ritzman's Pharmacy	"On the spot relief."	2005	quickclinic.com
QuickHealth	San Francisco, CA	8 locations in CA, 1 in Idaho operating under their license 18 additional locations planned 250 by 2010	Wal-Mart, Farmacia Remedios, Longs Drugs (pending)	"We make quality medical care affordable and convenient."	2004	quickhealth.com
RediClinic	Houston, TX	46 locations in AR, GA, OK, TX, VA Plans to open 70 more clinics in 2006. The majority will be in Wal-Mart stores.	HEB, Wal-Mart, Duane Reade	"Get well. Stay well ... Fast!"	Division of Interfit Health (Revolution Health Group); General Manager Sandra Kinsey was formerly head of marketing for Wal-Mart's pharmacies. Partnership with Memorial Hermann.	rediclinic.com

Table 1. Clinic Operators (Continued)

Clinic Operator	Headquarters	Locations and Expansion Plans	Retailers	The Consumer Pitch	Notes	Website/URL
SmartCare Family Centers	CO	15 locations in CO, 4 in GA, pending in AZ, NV, WA, NC, SC	Wal-Mart; Kerr Drug pending	"Convenient Healthcare for Everyday Needs."	2004	smartcarecenters.com
Solantic	Jacksonville, FL	13 locations in FL Plans to open 500 more clinics.	Wal-Mart and free-standing	"Great care. Fast and fair."	Opened 2002. The only major clinic operator that staffs with board-certified physicians in all locations.	solantic.com
Sutter Express Care	Sacramento, CA	6 in CA	Rite Aid	The Care You Need is Just Around the Corner	Opened January 2007. Associated with Sutter.	sutterexpresscare.com
Take Care Health Systems	Conshohocken, PA	50 locations in KS, MO, PA, IL Plans to open 200 clinics in next 12 mos., 1,400 clinics by the end of 2008. Contract in place with Brooks Eckerd Pharmacy. Walgreens is planning to open more than 20 this summer, and Osco (Albertson's Inc.) locations are expected to close and staff to move to the new facilities.	Walgreens, Eckerd	"Professional Care. Always There." "We're here to take care of you."	Just secured \$77 million in financing (led by Beeken Petty). Chairman of the Board Hal Rosenbluth was the founder of a large travel company that he sold to American Express.	takecarehealth.com
The Little Clinic	Louisville, KY	24 locations in SE FL, OH, IN, KY, GA	Publix, Krogers	"Convenient neighborhood medical care."	Opened 2003. Formerly known as Fast Care.	thelittleclinic.com
Trinity MedXPress	IA	1 location in IA	Hy-Vee		Opened December 2005.	trinityqc.com
Wellness Express	No longer in operation. All clinics closed November 16, 2006.					

appointments, have transparent menu-based pricing, occupy retail spaces, and offer common medical services, but they offer a wider range of treatments (suturing, mild trauma care) and more advanced diagnostics (such as pelvic exams with STD screening).

Thus far, clinic operators rarely choose to compete with one another in the same market, opting instead to position themselves as the best alternative to waiting a few hours in a doctor's office, urgent care clinic, or emergency room. As the market becomes more crowded and competition emerges between operators, clinics will likely differentiate themselves through the experience provided by the care provider, the level of convenience for consumers, the range of services offered, and the prices they charge.

From a strategic perspective, clinic operators differentiate themselves through the type of retail channel in which they are housed, local geography, and customer service. Some operators have a single-channel focus, such as Minute Clinic and Take Care, which are located only in drug stores, or The Little Clinic, which operates only within grocery stores. Others, including RediClinic and Quick Health, pursue a multi-channel strategy with clinics in drug, grocery, and mass-merchandise locations. When selecting locations, there is often a tradeoff among foot traffic, consumer interest in health services, and consumer convenience. Foot traffic—the number of shoppers who physically walk past the clinic each day—is a major determinant of a clinic's viability, and mass merchandisers attract a high volume of shoppers, many of whom visit frequently (for instance, Wal-Mart has 75,000 to 100,000 visitors per week, whereas a busy grocery store has 25,000–35,000 visitors per week and a typical large drugstore has 8,000–10,000 a week). Superstores have the highest volume of shoppers, which helps to generate awareness and usage of clinics, but they may also have less convenient access with larger, busier parking lots, and more consumers interested in categories other than health. Grocery stores generate a medium volume of foot traffic from a

similarly broad clientele, but offer the benefit of a higher frequency of visit rate, averaging 2.2 visits by shoppers each week, compared to less than one visit per week for mass merchandisers and drug stores. Drug stores attract the fewest customers but their consumers are likely the most interested in health services.

Clinic operators make strategic choices about geography and concentration to gain customer awareness and market share. One strategy is for a clinic operator to open clusters of between eight and twelve clinics in an area in which there are no rival operators. This density strategy is designed to build customer awareness quickly and allow for cost effective marketing across multiple clinic locations; also, if a city can reasonably sustain ten clinics and an operator has seven or more locations, it discourages a competitor from entering the market. Most clinic operators have begun to control a few regional markets in this manner. For instance, Take Care now has ten clinics in Kansas City, and no significant direct competition from other clinic operators. Similarly, Don Parker, president of AtlantiCare, says, “We were the first to open a retail clinic in New Jersey. Our intention was to get started and to create some barriers to entry [for competitors].” An alternative geographic strategy is to enter an established retail clinic market as a second mover, taking advantage of the customer awareness and education built by the first operator.

Clinic operators also choose locations based on the attractiveness of the customer base. Wal-Mart claims it works with operators to select locations in geographies where they believe there is greatest consumer need for access to routine, moderately priced care by taking into consideration physician shortages and higher uninsured populations. Following this strategy, clinic operators might place clinics in areas of high demand, including neighborhoods that have younger populations with children, a shortage of physicians, higher use of high-deductible health plans, or higher uninsured populations. One example of an attractive market

is the fast-growing Tampa/Orlando area of Florida, where there are now several different clinic operators operating in all three retail channels vying for business. Demographic strategies allow clinics to customize their services for a particular market and customer segment (by say, hiring bilingual staff for a clinic in a predominantly Hispanic neighborhood).

Clinic operators consider customer service a distinctive competitive advantage. Several clinics offer pagers so customers can shop while waiting to be seen. Other customer service innovations now being piloted by clinics include online check-in, online search for locations with the shortest wait time, and in-store touch screen kiosks for registration.⁵ Several clinics have discussed the potential for a magnetic card system that could streamline check-in, access to personal health records, and payment. First and foremost, though, retail clinics are a “high touch” business—each customer is seen by a nurse practitioner or physician. Consumer research indicates consumers judge the quality of the visit by their experience with the clinician.⁶ As a consequence, clinic operators understand that customer service revolves around the clinic staff, particularly nurse practitioners. Stuart Lowenthal, founder of The Little Clinic, says, “The right NP is critical. She provides the experience for the consumer and truly differentiates our clinics.” Retail clinic success will depend on the availability of qualified nurse practitioners to staff these operations, and their ability to provide a positive and consistent customer experience.

After a year of trial and error, the fundamental financial assumptions for all clinics remains the same: a clinic must see 17 to 23 customers per day to break even (the number varies depending on the cost of overhead and average revenue per visit). How long it takes to achieve that depends mainly on traffic from stores, so operators at high-traffic retailers such as Wal-Mart may break even more quickly than small pharmacies and other low-traffic stores. Clinic operators confirm that the break-even point (on a clinic basis) is usually reached within

18–24 months, though in some cases the process can take as little as 12 months or as long as three years.⁷

Financially, the clinics use a fixed cost model, with over 85 percent of expenses generated by labor, lease payments, and corporate overhead. Labor rates for nurse practitioners vary across the country, but the majority of clinic operators pay between \$65,000 and \$80,000, and some offer small bonuses tied to customer service. The leased spaces for clinics are getting smaller and less expensive. A year ago the average was 350 to 400 square feet, and now the average is around 220 square feet. (The notable exceptions are locations within mass merchandisers, where clinics still average 450–600 square feet at the front of the store). Most clinics are paying \$60–90 per square foot—fair market value—with substantial variation by geography.⁸

Overhead for many of the larger (independent) clinic operators ranges from \$2 million–\$5 million per year, depending on size and maturity of operation and the complexity of the consumer offer.⁹ Costs include infrastructure for medical records systems, technology support for NPs to provide evidence-based care, marketing for the brand, and high-caliber talent to manage these fledgling businesses. Many of the early clinic operators continue to amortize their investments in sophisticated IT systems to ensure quality care and support decision protocols. Human resources are a major expense; the clinic operators require 5–10 people to manage NPs, consumer marketing, retail leases, and payer contracts, and all employ a Chief Medical Officer who is responsible for maintaining protocols and quality of care. While individual clinics are beginning to break even at the store level, the corporate break-even point for independent operators is still far away, and hundreds of clinics may be required to generate a reasonable economic return. “We believe that 400-plus clinics will provide the right model for capital efficiency given the support cost needed,” says Michael Howe, CEO of Minute Clinic.

Strategies for Operators Affiliated with Conventional Providers and Networks

Clinic operators that are affiliated with hospitals or broad health care facilities have service models similar to those of the independent operators, but they are driven by different motives, economics, consumer propositions, and geographic strategies. These larger health care operations have revenues of \$500 million or more, so their primary reason for opening an affiliated clinic (which might generate only \$700,000–\$900,000 in revenues) is not purely financial. Rather, it is part of a strategy to provide a complete spectrum of options for delivering care to their patients and to retain them in their networks. Clinics raise the visibility of the health care provider's brand, since consumers visit retail outlets far more frequently than hospitals or primary care physicians.

Integrated health care systems that provide coverage *and* care are motivated by cost considerations as well as a desire to better serve their customers. One such provider is AtlantiCare, a nonprofit health care and insurance provider with more than 60 care locations in southeastern New Jersey. AtlantiCare is now operating several HealthRite clinics housed in ShopRite stores. Its president, Don Parker, has commented that he views retail clinics as an additional avenue for delivering care to patients, and part of a wider network of hospitals, primary care physicians, emergency departments, and urgent care clinics. He notes that retail clinics may support better overall health and wellness by connecting health care and lifestyle choices, from food decisions to vaccinations.

Affiliated operators have different business models, reflecting their ability to draw upon existing infrastructure (technology, protocols, electronic records) and assets. Several hospital-affiliated clinics believe that connecting their retail clinics to their medical records system is a strong differentiator—and enables them to offer greater continuity of care. These clinics can establish retail outlets very cost-efficiently; they can apply their existing brand, tap into their pool of medical professionals (including nurse practitioners), and obtain referrals from their

physicians. The geographic strategy for affiliated-clinic providers is different from that for national independent operators. Their expansion plans are strictly limited to their existing geographic footprint, and none has announced plans to extend beyond its own marketplace.

One unique challenge for affiliated providers has been to secure their own physicians' support, and several operators have acknowledged that their physicians were not in favor of the clinics before they opened. Clinic advocates have made two arguments to physicians: one, if the hospital didn't offer a clinic then a competitor would; and two, clinics are an opportunity to keep a patient in the hospital's care network. Several hospital systems discussed their efforts to inform their physicians, including their investment to educate them on the model, and the rationale for the clinics, only to encounter strong residual concern. However once the clinics were open, physicians were positive, and viewed the advent of clinics a worthwhile addition to the care network. Launching a clinic business has required a paradigm shift for hospital providers, who are eager to innovate and extend their knowledge of new delivery models, but who often know little about executing consumer-driven health care. "We're learning every day about consumers and the retail world," says Linda Khachadourian, vice president of strategy and business development at Sutter Express Care. "This is so consumer-centric, and we don't have retail experience... We hired a program director, specifically recruiting someone with a retail background. We've also had to learn to be lean and simplify. As a large organization, making these changes has required a mindset shift."

All retail clinic operators—independent and affiliated—rely on fundamental consumer marketing skills, including targeting the most promising consumers, creating awareness of the clinics, educating the consumer on how to use clinics, and keeping their services in the public mind through mass advertising, direct mail, and in-store marketing programs. Clinics have all experimented with consumer awareness campaigns (including flyers,

posters, coupons, in-store announcements, and media coverage), but, to date, most have relied more on retail foot traffic to build consumer awareness. A consumer marketing approach—understanding the customer base, building awareness, and creating a desire to buy—is familiar to the retail world, but is still largely foreign to health care providers.

Failed operators

While clinic operators have generally done well, there have been failures. Both Wellness Express in Sacramento, California, and Portland, Oregon; and Smarter Care in Los Angeles, California, closed their doors, largely due to a lack of capital to sustain the business until it could make a profit. According to May Liu, vice president of business development for Smarter Care in Los Angeles, “The business worked...within months, we saw six or seven patients every day, and I think we could have been successful in the longer term. We just didn’t have the capital to market and sustain our clinics for 18–24 months until we broke even.”

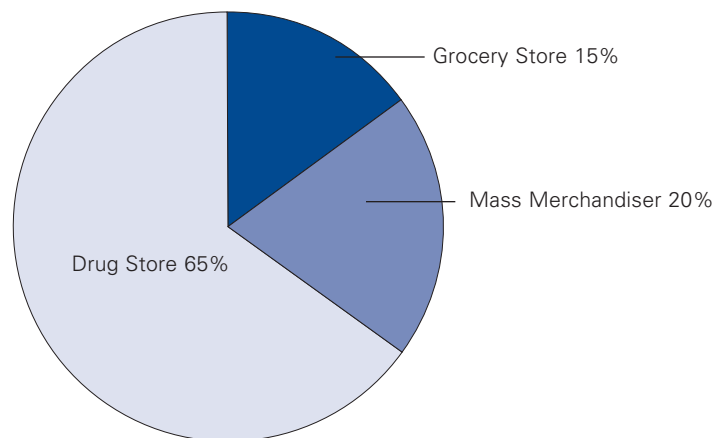
IV. The Retailers: Still in the Testing Phase

“This is a pilot. We are still learning.”

—Alicia Ledlie, Senior Director of Health Business Development, Wal-Mart

RETAILERS OF ALL FORMATS—DRUG, MASS MERCHANDISE and grocery—have significantly increased their participation in clinics over the past year, and several have made strong commitments to continue to develop clinics. Since the original CHCF report was released in 2006, CVS purchased Minute Clinic for an estimated \$170 million and increased its number of clinics from 83 to more than 200, with a view to opening an additional 300 in 2007 and 2,500 over the longer term.¹⁰ Walgreens acquired Take Care Clinics and plans to expand it to 250 clinics in 2007. In the past twelve months, Wal-Mart has opened 76 clinics across 12 states with 8 different operators, and announced plans for clinics in 55 percent of its stores by 2012. Target has increased its commitment to its own brand of clinics. Grocery retailer Publix contracted with The Little Clinic to open 13 clinics, and has announced that it will expand to 30 clinics by the end of 2008. Kroger and other national and regional grocery players continue to announce openings, with Wegmans as the latest entrant. To date there has been no participation in retail clinics by warehouse retailers.

Figure 1. Stores Hosting Retail Clinics, by Type



Despite the growing presence of clinics in stores, retail clinics are in only 1 to 3 percent of most retailers' stores, and retailers insist that they are still testing the concept. Alicia Ledlie, senior director of health business development at Wal-Mart, says, “This is a pilot. We are still learning.” Similarly, Chris Bodine, executive vice

president and president of CVS Health Services states, “this is still an emerging model.”

Retailers have indicated that they are creating space for clinic operators for three reasons: to assert their position in the market for a “health and wellness” consumer offer; to strengthen their pharmacy, prescription, and over-the-counter medication business; and to attract new customers. “We think the clinics will be a great opportunity for our business,” says Lee Scott, CEO, and president of Wal-Mart, Inc.

Each retailer is competing for the dollars that consumers are able and willing to spend on their health care. Given the extent of retail “category blurring” (marketing the same items in different stores and formats—cold medicine in a grocery store, or ice cream in a drugstore), clinics are a way to reinforce health and wellness and maintain relevance to a consumer. Retailers all agree that in-store clinics reinforce a consumer message of focus on wellness and health. “The clinics create a halo and a destination for health care.” says Chris Bodine of CVS. Retailers also acknowledge that their customers drove them to place clinics in stores. “Research from our consumers pointed us to these clinics...consumers requested them,” says Publix spokeswoman Maria Brous.

Retailers disagree about the extent to which an in-store clinic can increase sales elsewhere in the store, particularly sales of pharmacy goods. Alicia Ledlie of Wal-Mart says, “Driving pharmacy sales and foot traffic has never been the main focus for Wal-Mart in this pilot. Our primary goals are to offer one-stop shopping convenience; to improve Wal-Mart as a health and wellness destination; and to play a role in offering affordable health care. Clinics are about access and affordability—we’d like to play a big role in that.” Pharmacies see the clinics somewhat differently. While drug stores have similar aspirations to provide a full service health destination, prescriptions and over-the-counter medications are core to their economic model, and clinics provide both the service and the opportunity for increased product revenues and a way to attract new

customers. Grocery stores fall in between, with the dual desire to build pharmacy and over-the-counter revenues, and to expand their categories to deliver their goal of a “one-stop full-service shopping” approach to attract and retain customers.

Prescriptions are crucial for pharmacy retailers. As noted in the 2006 report, prescriptions offer higher margins than other items in drug, grocery, and mass merchandise stores, and prescription customers tend to purchase more items. Whether the clinic brings a new customer to the store or simply keeps an existing customer, clinics are expected to boost store pharmacies’ bottom line. Tom Ryan, chairman, president, and CEO of CVS, said his company acquired Minute Clinic for control of the brand, the service delivery, and the clinic expansion rate, as well as the opportunity to attract new customers. “About 25 percent of the people using Minute Clinic have never been in a CVS pharmacy,” he explained.

Prescription Drugs and Retail Clinics

Clinics undoubtedly have the potential to be a major driver of prescription drug sales. If half of the 2,500 clinics projected to be in operation by the end of the decade break even with 20 visits a day, and the other half see 40 patients a day, clinics could see 26 million patients a year. Should early estimates hold that about half of clinic patients receive a prescription, they would generate 13 million prescriptions by the end of 2010. If every clinic operated at full capacity, then in theory there could be 315 million visits in this time frame—and even if only 25 percent resulted in a prescription, 79 million annual prescriptions could pass through clinics within three years. Of course, many of these prescriptions may not be new, and may not be filled at the in-store pharmacy where the clinic is located.

Retailers' Strategies for Clinic Operation

Retailers are pursuing several different clinic strategies: owning their own clinics; working with a single operator; working with multiple clinic operators; and opening vendor-sponsored clinics.¹¹

In-house model. CVS, Target, and Walgreens have their own clinics (CVS and Walgreens through acquisition and Target through in-house development). Owning clinics is a higher-cost strategy, yet allows for the most control over the consumer experience, the brand, expansion plans, scope of services, and consistency of delivery. These retailers stated that clinics are a core element of delivering a health and wellness offer to consumers and that this investment was appropriate.

Exclusive-operator model. Some retailers have chosen to partner with a single operator, such as HEB with RediClinic and Publix with The Little Clinic. This single operator model is the easiest to manage. Operators are usually selected on the basis of meeting the needs of the retailer's specific customer segment. Maria Bours of Publix says, "[Selecting a clinic operator] was a strategic decision; we wanted to line up with someone who has the same great customer service skills and philosophy as us... customers still see The Little Clinic as representing the brand of Publix."

Multiple-operator model. Having multiple operators is managerially more complex, yet provides greater flexibility for a retailer to match up local market needs with an operator's skills and expand the number of clinics quickly. Wal-Mart has chosen to work with eight operators (whom they call tenants), selected based on how well they fit the specific local needs of the community. The company also maintains an arm's-length relationship with its tenants by keeping their brands clearly separate from Wal-Mart's. "In addition to giving Wal-Mart flexibility while testing different models and rapid expansion, this strategy essentially turns the clinic operators into competing vendors (a standard way of business for Wal-Mart)—presumably, the most

successful of these operators will set the bar for the others in terms of profitability, margins, and consumer satisfaction.

Snapshot of Wal-Mart's Clinic Rollout

Wal-Mart has about 15–18 percent of all the retail clinics, having opened 76 clinics in 12 states, using eight different clinic operators. The majority of the Wal-Mart clinics are staffed by NPs, with the exception of those operated by Quick Health and Solantic. The mix of people paying with insurance vs. out-of-pocket is about 50/50. Most of the clinics accept co-pays. Some operators are affiliated with a hospital network (Memorial Health and Aurora). Quick Health is Wal-Mart's operator in California. My Healthy Access is a newer operator with a focus on African American and Hispanic customers. Revenue from leasing the clinic space varies widely by location; the leases are at fair market value based on local conditions. The amount of clinic space is a crucial element of the equation—Wal-Mart imposes minimum requirements of 500 square feet, an ADA compliant toilet, four walls and a ceiling, and locates the clinics at the front of supercenters. Space availability—along with customer demographics—determines which Wal-Mart stores will host the clinics.

V. The Payers: Moving Towards Coverage

Insurance Carriers

Insurance carriers have made a big—and rapid—turnaround when it comes to covering care at retail clinics. At their inception, clinics were cash-only, and as recently as a year ago there was substantial uncertainty about how insurers would react to them. Today, all major national private insurers and many smaller regional insurance companies provide clinic coverage with co-payments, and most clinic operators actively work with insurance carriers to secure coverage. As a result, according to the Harris Survey published in April 2007, 42 percent of all retail clinic visits were covered by insurance companies, with co-pays ranging from \$15 to \$35. The Harris survey also showed that clinics are being used by both insured and uninsured households; 78 percent of people who visited a clinic had insurance, and of those, 54 percent indicated their insurance covered some or the entire cost of the visit.

Although payers have been willing to experiment with co-payment relationships with clinic operators, they continue to closely monitor quality of care and test for any potential increase in demand for services. Early on, there was concern that retail clinic operators could not easily or cost effectively conform to existing payment mechanisms, and that payers' systems would be too difficult, expensive, and time consuming to change. In fact, there were difficulties, including some initial confusion when payers erroneously applied urgent care or emergency care coding rates—which typically have consumer co-payments of \$50 or more—to retail clinic visits. Clinic operators now report a strong relationship with most payers, including relatively prompt payments and limited claims denial. Billing has not proven overly complicated, with few CPT (billing) codes required for the limited set of treatments. Nevertheless, all carriers require connectivity to their networks, and have lagging payments adding in new costs for clinic operators. Larger clinic operators have added up to five full time staff to negotiate insurance carrier agreements and manage billing departments.

To date, public insurance carriers (through the federal Centers for Medicare and Medicaid Services) have not included retail clinics in their coverage. However, recently Minute Clinic and RediClinic announced they are accepting Medicare and Medicaid patients.

Not all clinics pursue relationships with insurance providers. QuickHealth does not work with insurers to cover treatment, arguing that most of their customers don't have insurance anyway. QuickHealth CEO Dave Mandelkern explains, "We don't think that the few people who want to use their health insurance at our clinics should burden the majority of our customers who don't have health insurance. We think it's better to offer a reasonably priced service and charge the consumer 100 percent of the services payable in cash."

Large Employers

Employers can influence the adoption of new health services in many ways. They can put pressure on their insurance carriers, or they can create incentives for employees to use lower-cost services. There have been examples of both these approaches with regard to retail clinics. A few employers, including Black & Decker and Best Buy, offer lower co-pays for retail clinics than for visits to family physicians, urgent care clinics, or hospital emergency departments. However, such examples remain rare and can't be regarded as a trend. Given that both large private employers (which are often self-insured) and the public purchasers in city, state, and federal governments have a large stake in reducing health care costs, it is possible that they might someday participate more widely in retail clinic care. Smaller and mid-sized employers may also drive this trend as they seek to provide cost-effective health care coverage by combining consumer-driven health plans with retail clinic services.

VI. The Consumer: Attitudes and Adoption

RETAIL CLINICS HAVE NOW BEEN IN OPERATION long enough to generate real data on consumer satisfaction. MinuteClinic, RediClinic, TakeCare, and The Little Clinic all reported customer satisfaction scores of 95 percent or higher, with similar responses for how many would return for a second visit or recommend the clinic to friends or family.

In the early days of retail clinics, consumers fell into two categories based mainly on socioeconomic status: those who valued convenience at any price, and those who had no other way to obtain low-cost health care.¹² As recently as mid-2006, more than 90 percent of retail clinic patients paid the full fee (\$39-69) in cash, with few opportunities for a co-pay or reimbursement. For consumers accustomed to a co-pay of \$10-\$30 at their doctor's office, the clinic price represented a significant premium.

One year later, these lines have been blurred. Clinic consumers are coming from all layers of society, and only 22 percent of visits are from the uninsured, according to a Harris poll. Many clinics have secured payer coverage through almost all major health insurance plans, bringing down the out-of-pocket cost for consumers.

The Harris poll also found that only 5 percent of respondents had used a retail clinic. However, of this group, the vast majority indicated they are very or somewhat satisfied with the quality of care they received (90 percent), with having qualified staff to provide care (85 percent), with the cost (80 percent), and with the convenience the clinic offered (83 percent). Compared to two years ago, fewer respondents are concerned about the qualifications of the staff (71 percent in 2005 vs. 64 percent in 2007) or their ability to accurately diagnose serious medical problems (75 percent in 2005 vs. 68 percent in 2007). Usage of in-store health clinics was for routine simple care including: vaccination (44 percent), treatment for a common medical condition such as an ear infection, cold, strep throat, skin rash, or sinus infection (33 percent), and preventative screening tests (19 percent).

Trends in health insurance will continue to encourage consumers to seek out less expensive care. As of 2006, 4.5 million Americans now have high-deductible, high-premium (HDHP) insurance, up from 3 million in January, 2006, and 1 million in 2005.¹³ Formerly used primarily by low-income Americans in need of

affordable health coverage, high-deductible plans are now being purchased by all sorts of people, including high earners who participate in tax-advantaged spending accounts that make the economics of these plans favorable. In general, consumers with high deductibles are personally invested in managing their out-of-pocket costs and select providers using their own criteria (price, convenience, quality), rather than the mandates of an insurance company. Finally, for all insurance plans, co-pays are expected to rise, which may favor retail clinics in a competition with similarly priced services at a doctor's office.

For people with no health insurance, retail clinics offer substantial cost savings over other alternatives. For simple diagnoses such as strep throat or urinary tract infection, clinics represent a savings of \$240 or more over an emergency room visit.¹⁴

VII. The Health Care System: Concerns, Regulatory Factors, and Integration

Quality of Care

Critics of retail clinics have repeatedly raised concerns about quality of care. Clinics respond to these concerns by claiming that they consistently practice high-quality evidence-based medicine. According to a recent study conducted by RAND, Americans receive evidence-based care only 55 percent of the time at other kinds of health providers.¹⁵ By contrast, Minute Clinic's internal recent analysis of 58,000 sore throat cases seen at their clinic indicated that 99.15 percent of the time, the diagnosis and treatment conformed to evidence-based guidelines.¹⁶ MN Community Measurement, an independent agency, determined that Minute Clinic was the best-performing provider in the state in the treatment of strep throat, with a guideline compliance rate of 100 percent.¹⁷ In 2006, Take Care reported that its performance in delivering appropriate antibiotic treatment for adults with acute bronchitis is approximately 50 percent better than national standards.

Critics contend that the proliferation of retail clinics may lead to overprescribing, particularly when it comes to antibiotics. Some insurance companies have been able to track pharmacy claims that originate at in-store clinics. According to Ken Patric, M.D., chief medical officer at BlueCross BlueShield of Tennessee, which has contracted with MinuteClinic, "One might think, 'If these clinics are in a pharmacy, they might write more prescriptions,'" he says. "That actually isn't what we've seen. We've tended to see—it's only been six months so far—fewer prescriptions." Clinics explain the reduction of prescriptions by noting that they adhere to evidence-based guidelines.

To date there have been no independent studies of this issue of quality of care. The California HealthCare Foundation has commissioned RAND to collect information from retail clinics across the country on patient demographics and the reason for their visit. In addition they are interviewing patients at the California retail clinics of Quick Health, WellnessExpress (now defunct), and Sutter Express to provide a qualitative view of why patients chose the retail clinic as a site of care. Lastly, they are using claims data from a large health plan to compare the quality and costs of care at retail clinics versus primary care offices or urgent care centers.

Regulatory Forces and Changes

Clinics are regulated by the states, and each state has wide leeway through legislation and regulation to encourage or discourage the growth of retail health clinics.¹⁸ Licensure requirements for retail clinics and the clinicians who practice within them vary. In many states, clinics are licensed as physician practices, and are regulated by the state's Medical Board. In some states (for example, Arizona), each site must be licensed, and in others the clinic is licensed at the corporate level and the license covers multiple sites. Some states require an in-state supervising physician, while others permit out-of-state oversight through a corporate office. Clinics who accept Medicare or Medicaid patients also require a license from the federal or state government.

Regulations on the scope of services, non-physician licensing, nurse practitioner oversight, and physician-ownership requirements are major considerations for the future of retail clinics in any given state. Spurred by consumer demand, concern over the need to reduce health care costs and increase access to care, and a shortage of physicians, some states are writing legislation to encourage retail clinics by addressing regulatory barriers.¹⁹

To keep labor costs low, most clinics depend on employing nurse practitioners rather than physicians. According to the American College of Nurse Practitioners, 22 states and the District of Columbia allow NPs to treat patients without physician involvement, while 28 require documented physician involvement in the form of a doctor's presence some or all of the time, availability for consultations by phone, or written protocol agreements. States vary in whether they require supervising physicians to reside within the same state as the clinic they oversee.

The NP's scope of practice is under scrutiny in every state. Some, such as Pennsylvania and California, are trying to increase the use of these clinicians by expanding their scope of services and prescribing authority. Pennsylvania Governor Edward Rendell

has proposed a health plan that, among other things, calls for insurer reimbursement of Certified Registered Nurse Practitioner services for primary care, confirms their prescribing authority for medications and durable medical equipment, and enables them to "practice to the fullest extent of their education, skills, and training to provide care," says Barbara Holland, legal counsel to the Office of Health Care Reform in the Office of the Governor of Pennsylvania.²⁰ Texas is considering lowering its requirement for on-site physician oversight of nurse practitioners from 20 percent of the time to 10 percent, using a combination of remote and on-site supervision.

Other states have debated legislation to limit the use of NPs and other "mid-level" providers. Florida enacted a bill (Florida HB 669, June, 2006) that could restrict clinics' growth by limiting the number of clinic sites that a primary-care physician may supervise to four. Missouri debated but failed to pass a similar measure that would have restricted the number of physician assistants that a physician could supervise to three, and Georgia considered legislation that would have barred NPs from writing prescriptions at clinics located within retail establishments that house a pharmacy.²¹ In March, Illinois introduced a bill that would require retail health clinics to have more physician supervision (doctors could supervise no more than two advance practice nurses) and limit their ability to advertise.

Physician-ownership requirements—referred to as "the corporate practice of medicine"—regulate who can own health provider facilities. States vary in their requirements for physician versus non-physician ownership as well as in-state residency. Expanding or contracting ownership opportunities—as dictated by corporate practice regulations—will either enable or inhibit retail clinic openings within each state. Several clinic operators commented that the laws make it fundamentally untenable to do business, as they can't employ the NP directly and thus control their ability to provide consistent high-quality standardized care, and they can't own equity in

these operations—significant detractors given the investment required. Many operators observed that states without these ownership laws are much higher priorities for clinic expansion.

Clinic Integration into the Wider Health Care System

Retail clinics got their start by positioning themselves as separate and distinct from the traditional health care world, and by resisting partnerships with insurance carriers, hospitals, and local physicians. With their slick storefronts, catchy slogans, and cash-and-carry approach to health, the clinics seemed more like an extension of the retail world than like a part of the long-established order of doctors, pharmacists, and insurance companies. For its part, the wider health care community initially distanced itself from the clinics and their operators, raising concerns about quality of care rather than evaluating them either as potential partners, or as an alternative model that might offer valuable lessons about low-cost care delivery.

In the past twelve months, however, clinics have begun to find a place within the traditional health care delivery system. Clinic operators have invested in creating close relationships with all players in the health care community, including local physicians, hospitals, payers, and health advocacy groups. In turn, health care leaders have engaged with clinics, worked to create referral networks for clinic customers who don't have a family doctor, encouraged physicians to refer patients to retail clinics for after-hours service, and created co-branding relationships. For example, RediClinic's 50/50 partnership with Memorial Hermann Houston calls for the hospital to provide physician oversight, clinical quality initiatives, and co-marketing—one of several innovative arrangements that illustrates how this new relationship with traditional health care providers is evolving. In fact, Take Care claims that up to 20 percent of its Chicago-area patients have been referred to a primary care physician or specialist for follow-up care.²²

Clinics are adamant that they do not wish to play—nor can they perform—the role of the primary care physician. In 2006, the American Academy of Family Physicians (AAFP) published guidelines for retail clinics,²³ and in February, 2007, the three largest clinic operators signed an agreement in support of the Academy's list of desired attributes. The AAFP investigated the impact of clinics on their members and concluded that the longer the clinics were in a city and the more active their connections with local physicians, the more supportive members were likely to be. Rick Kellerman, M.D., president of the board of directors of the AAFP echoes the sentiments of many physicians, saying, "Clinics are one more attack on primary care physicians, but we do appreciate that they keep patients out of the ED—that is the worst place for primary care. We advocate that retail clinics accept our guidelines for clinics and we encourage our members—especially those who don't like the retail clinics—to look at the convenience they are providing and consider how they might incorporate (the lessons from retail clinics) into their own practices."

As noted in CHCF's 2006 report, the market will dictate the clinics' survival—the market being consumers, operators, insurers, retailers, and regulators. Some will thrive by reaping the benefits of appropriate capitalization, business models, locations, and management. Others will not. In some ways, retail clinics challenge consumers, clinicians, governments, employers, and carriers to address the shortcomings of the traditional health care system by investing in primary care and integrating the lessons they offer for providing better, faster, easier, and cheaper care.

Meanwhile, the clinic industry has formed the Convenient Care Association to create and disseminate policies and guidelines to ensure appropriate, high-quality health care through retail clinics. Their agenda appears focused on quality-of-care issues and legislative reform to enable the proliferation of retail clinics, with some debate among the members as to the role of the association in ensuring the supply of qualified nurse practitioners and consumer education efforts.

On a technological level, clinic operators have been working with the established players in the health care system to coordinate patient medical records. Clinics all use electronic medical records, and many operators envision a day when patients can automatically have their clinic visit record and results sent to their primary care physicians. Consumer surveys confirm that 78 percent of clinic customers would like a record of their clinic visit sent to their doctors.

VIII. California Update

AS THIS REPORT HAS NOTED, REGULATORY CONSTRAINTS continue to affect the proliferation of retail clinics in many states, including California. Regulatory hurdles are primarily about ownership of clinics and the scope of services provided by nurse practitioner. (Other regulations concern advertising and licensing arrangements.)

The corporate-practice-of-medicine laws in California require ownership by local physicians who operate the health care facility.²⁴ Out-of-state physicians, or non-physician retail clinic operators, cannot own clinics. Clinic operators confirm that the California Corporate Practice of Medicine laws make it challenging to establish retail clinics in the state. Notes Web Golinkin of RediClinic, “It’s very difficult to justify the investment in California when you can’t own equity in the clinics or employ nurse practitioners directly, particularly when there are 47 other states that don’t present these obstacles.”

In California, a nurse practitioner’s scope of practice is covered by the Nursing Practice Act in the Business and Professions Code. There are three aspects to this regulation: what services can be provided, what is the scope of prescribing authority, and what are the arrangement for supervision of the nurse practitioner. Broadly, standardized procedures must be developed and approved by the NP, the supervising MD, and the facility administrator before an NP can perform anything that might be considered “practice of medicine,” including diagnosis of mental or physical conditions, use of drugs, or severing or penetrating tissue.²⁵ Prescribing authority is set by the state and dictates the types of prescriptions that can be written. Oversight regulations include issues such as the amount of supervision, location of supervision (remote or on-site), the type of chart review conducted, and the number of NPs a physician can supervise.

As of now there are very few clinic operators or clinics in California. Quick Health, with its physician-based model, was an early pioneer, and recent entrants Sutter—a large hospital system in Northern California—and Faster Care Clinics (also a physician-based model in grocery stores) are the primary players. These clinic operators have been able to work around the regulatory issues because they have local physicians, already own health care

facilities, and have opened up a few clinics in the state. The largest national clinic operators have yet to establish a foothold in California despite its obvious appeal as a consumer market, but that may be changing. Minute Clinic has announced expansion plans for 50 new clinics in Southern California starting September, 2007, and confirmed they are creating a management-company relationship with a physician-owner in the state. Several clinics are now under construction.

Improving the health care system in California has emerged as one of state lawmakers' top priorities. In such an atmosphere, the focus on finding ways to reduce costs, expand access to care, and improve the health care safety net offer clinic advocates the chance to push for relaxing the requirements of ownership and physician oversight, and expanding the scope of service for nurse practitioners—all of which would make it possible for clinic operators to enter the potentially vast, relatively untapped California market.

Several health reform proposals introduced this year included some reference to making the California regulatory environment more welcoming to the clinics. The Assembly Republican proposal included a section entitled “Ensuring More Convenient Care at Neighborhood Health Clinics,” and advocated “eliminating the barriers in state law that prohibit establishing additional walk-in, neighborhood health clinics will enable California families to access more convenient health clinics at pharmacies, grocery stores, and shopping malls in their communities.” The Senate Republican proposal SB236 included the language, “Allow nurse practitioners to establish and run primary care clinics.” And the Governor’s Health Care Reform proposal looked to “remove statutory and regulatory barriers to expansion of lower-cost models of health care delivery such as retail-based medical clinics by making scope of practice changes for ‘physician extenders’ such as nurse practitioners and physician assistants.”

IX. Areas and Issues to Watch

THE YEAR SINCE THE RELEASE OF CHCF'S 2006 RETAIL clinics report has seen rapid growth in both the number of clinics in operation and media attention. Consumers across the country have become familiar with the concept and are curious about and largely receptive to using clinics for some conditions or ailments. Clinic proponents have projected continued rapid growth, and interest in additional regulation and oversight has increased, driven by concerns from medical organizations and associations. New players are getting into the business of operating clinics, and government payers, many of which are struggling to expand access to care, are beginning to explore the role that clinics might play. In short, the retail clinic has begun to enter the mainstream, and the convenience clinic model, with its positive attributes and its limitations, is drawing predictable attention and scrutiny from the medical and regulatory communities.

Many of the issues raised in *Health Care in the Express Lane: The Emergence of Retail Clinics* are now key focal points for the industry. Consumer experience, profitability, and the relationship of clinics to the rest of the health care system are fundamental to how the clinic landscape has taken shape. With more than 500 clinics now up and running, here are some areas to watch as the next phase unfolds:

Will the expansion of retail clinics proceed at the ambitious pace projected by their operators?

Clinic operators project that they will open more than 700 sites by the end of the year. An analysis of the pace of expansion, customer demand, density of available locations, and other market factors suggests that the total number of retail clinics will reach 6,000 by 2012. The influx of capital into the industry is continuing at a level sufficient to support rapid growth. But to hit their targets, clinic operators will need to aggressively recruit providers—primarily nurse practitioners and physicians' assistants. These provider groups are already in high demand in the broader health care system, so competition will likely be fierce, with potential ramifications for salaries. Operators will also need to meet extremely aggressive construction schedules. The influx of capital into the industry is continuing at a level sufficient to support rapid growth.

Other Resources

Convenient Care Association

www.convenientcareassociation.org

This group represents retail clinic operators and is involved in sharing resources, developing quality standards, and forging ties with the mainstream medical practitioners.

Merchant Medicine

www.merchantmedicine.com

This organization, which specializes in tracking trends in retail medicine, maintains a continuously updated database of retail clinics in the United States.

How will the business model evolve?

The original CHCF report asked how clinic operators would develop their businesses—which services, partners, and consumer segments they would target and how they would expand, contract, or consolidate their businesses. Fundamentally, the business model has not changed—clinics are still a fixed cost model that requires at least three years to reach the break even point and produce a reasonable return on investment. What is not known is whether investors (and most investors in clinics are not traditional health care investors) have the patience to remain in the game as stand-alone clinics, or if they will seek shorter-term lucrative alternatives such as merging with larger retail or health care entities. Clinics have not yet experienced real competition, and have not come close to finishing their expansion phase. Clinics have also not solved the challenge of finding an adequate supply of talented nurse practitioners.

How will organized medicine respond to clinics?

Several organizations representing physicians have come out with opinions on retail clinics. The American Academy of Family Physicians (AAFP) issued their “desired attributes of retail clinics” in June of 2006. After significant internal debate, the

American Medical Association (AMA) followed the AAFP, calling for retail health clinics to:

- Offer a well-defined and limited scope of practice;
- Follow protocols derived from evidence-based guidelines to ensure quality of care;
- Ensure supervision by a physician;
- Establish a formal connection with community physicians to ensure continuity of care and encourage use of medical homes;
- Use electronic health records that can gather and communicate a patient’s information with his or her medical home;
- Inform patients, in advance, of the qualifications of the practitioners providing care; and
- Establish appropriate sanitation and hygiene guidelines.

In June of 2007, the AMA membership voted to adopt the following directive:

- Ask the appropriate state and federal agencies to investigate ventures between retail clinics and pharmacy chains with an emphasis on inherent conflicts of interest in such relationships, patients’ welfare and risk, and professional liability concerns.
- Continue to work with interested state and specialty medical societies in developing guidelines for model legislation that regulates the operation of store-based health clinics.
- Oppose waiving any state or federal regulations for store-based health clinics that do not comply with existing standards of medical practice facilities.

The most vocal group on the topic of convenient care clinics has been the American Academy of Pediatrics (AAP). The organization states that it “opposes retail-based clinics (RBCs) as an appropriate source of medical care for infants, children, and adolescents and strongly discourages

their use, because the AAP is committed to the medical home model.” They further state that “The AAP acknowledges that the shifting economic and organizational dynamics of the current health care system will likely support the continued existence and expansion of RBCs. However, the aforementioned concerns and the overall effects these clinics will have on pediatric practice have led the AAP to respond with principles related to communication, the medical home model, evidence based medicine, contagious diseases, and financial incentives.”

How are state regulators responding to retail clinics?

As of this publication of this report, New York, New Jersey, Rhode Island, Massachusetts, Illinois, and California are all considering additional regulation of retail clinics. In New York the primary area of focus is the relationship between clinics and the pharmacies in which they operate. Other states are considering or have considered whether the space, facilities, and hygiene regulations for physician’s offices should apply to clinics and whether the licensure restrictions of a pharmacy should apply to a clinic operating within it. Some states are considering restrictions on advertising, limiting the number of visits consumers can use within a year, and requiring annual licensing including site specific, versus corporate licenses. To date, the response from retail clinic operators has indicated some concern about the impact of these discussions on the viability of the model for states where restrictions become cost prohibitive.

Will integrated health systems and others continue to develop convenient care options of their own?

Several health systems, including Sutter in California, have developed “express care” sites to extend the convenience of the retail clinic model to their customers under their own brands. Public systems and community clinics in California have expressed an interest in considering how opening their own express care options might help them more effectively meet patients needs while

encouraging preventive, primary, and basic acute care in settings other than the emergency department.

Only a few other systems across the country are currently taking this approach, but many predict that we will see additional system-branded convenient care or express clinics. Centene, a multi-line health plan based in St. Louis with a significant Medicaid population is slated to open its first two convenient care pilot clinics with Federally Qualified Health Center partners by 2008.

What role will technology play?

Affordable, compact, rapid diagnostic devices and evidence based clinical software are keys to the viability of retail clinics. Medical device manufacturers continue to develop devices with CLIA waivers²⁶ that expand the potential services and productivity of retail clinics. For example, new optical devices could deliver faster, less-invasive testing of blood pressure and glucose with data feeds directly into electronic records. Digital otoscopes, audiology testing devices and other digital equipment that capture and transmit data have similar potential. Swabs with nanosensors are being developed to provide rapid detection of influenza A (H5N1) and E. coli. Imaging devices may one day be small, quick, cost effective, and simple enough to use in retail clinics.

The addition of digital devices and high-speed data transmission may also enable retail clinics to become part of the telemedicine delivery network to better manage chronic conditions. The retail clinic might create a digital data stream of critical vital signs to a patient’s primary care physician. While retail clinics are not structured to manage chronic disease, there may be an option to use clinics as one of several monitors of patient health. Primary care physicians will continue to provide a holistic health care management perspective for a person which may also include aggregating the patient’s information, using additional data points, trend analysis, and pattern recognition to provide more comprehensive health care. Retail clinics may be used as an extension of the primary doctor to provide more capacity into the health care system. A key to this scenario is the

clinics' capacity (and reimbursement) for receiving, integrating, and interpreting data. This would require a standard electronic medical record system and the ability for multiple integrated data feeds. The clinics may then become one of many points of data in a robust, detailed, multi-component picture of a patient's health using several health care providers linked through telemedicine.

Will clinics working with insurers be able to keep administrative costs down?

Many of the clinic companies are now accepting insurance from multiple carriers, and insurers have responded quite favorably to the clinics. To provide this service, the clinic corporations have incurred additional overhead in the form of staff to process claims. Though they indicate that they are able to simplify the claims process with insurers, it remains to be seen how much additional cost this will add to the model. Several clinic operators report positive experiences with insurers who are testing new systems and procedures to streamline the payment process with clinic operators.

Will retail-based clinics move into chronic disease management, diagnostic testing, wellness, and other consumer health services, and how will this affect other providers?

While some clinic companies—notably Minute Clinic—have indicated that they intend to keep a narrow, tightly focused array of services, others have begun to introduce or have plans for broader service menus, including disease management and “wellness” services. In the “disruptive innovation” paradigm, innovators often move upstream, taking on more functions and capabilities from established players. The growth of the clinic sector and the moves of some players into activities beyond the initial narrow scope of services pioneered by Minute Clinic has begun to spark a debate about the role clinics should play—or should not play—in delivering

primary care. Several clinics are expanding their wellness offers including school physicals, diabetes screening programs, nutrition counseling, hearing tests, and asthma medication therapy programs. New technologies that allow for rapid screening of chronic conditions are being tested by clinic operators. And new therapies, such as an osteoporosis drug administered annually through a 15-minute infusion, are being considered by several clinic chains.

X. Conclusion

THE 2006 *HEALTH CARE IN THE EXPRESS LANE* POSED several questions about how consumers, providers, payers, and policymakers would respond to the emergence of retail clinics. The last year has seen a rapid response from each of these groups, and the pace of expansion is such that a forecast of 6,000 clinics by 2012 seems a reasonable projection. If retailers' plans prove out, within five years it will be the norm to have a local retail clinic in the neighborhood drug, grocery, or mass merchandise store. Furthermore, if 6,000 clinics were to operate at 50 percent of their capacity, they would draw 10,000 patient visits per clinic per year—or 60 million visits in total.

Given the volume of patients that may go through the doors of these clinics, it will be vital to monitor quality of care, prescribing habits, and consumer use in order to understand the overall health impact of clinics as consumers receive care from multiple providers and multiple points of care. Will electronic medical records be rapidly diffused to ensure a coordinated medical home? Will the wider health care system integrate with these clinics? Will the clinics extend their services to become a data collection point for the primary care physician? Will clinics be a driving force for greater cost transparency to the consumer and put further pressure on primary care physicians?

It seems clear that clinics have an opportunity to change the game for each of the stakeholders. They are likely to provide consumers with greater convenience and lower prices, challenge primary care physicians to reinvent their practices for more complex care, enable payers to reduce the cost of routine care, and allow retailers to enhance their positions as health and wellness destinations.

Endnotes

1. Scott, Mary Kate. *Health Care in the Express Lane: The Emergence of Retail Clinics*. Oakland, CA: 2006 (www.chcf.org/topics/view.cfm?itemID=123218).
2. “Broom-ready” refers to clearing and cleaning the space and potentially installing HVAC, electrical, and plumbing upgrades, depending on the clinic concept and the contract between retailer and clinic company.
3. Solantic is a major provider in Florida, with clinics in two Super Wal-Marts and ten other locations. All Solantic clinics are staffed with on-site physicians. QuickHealth of California is a physician-based model in Farmacia Remedios (drug stores) and Wal-Mart.
4. Independent from the traditional health care providers, including hospital systems, but not necessarily retailers.
5. For example, Take Care uses touch screen technology, and about 90 percent of their patients rate the sign-in process as either very good or excellent
6. Scott & Company, 2006
7. Interviews conducted by Scott & Co.
8. According to Alicia Ledlie of Wal-Mart, “we lease our space at fair market value as determined by local independent appraisers.”
9. For example, including a broad range of insurance carriers, offering a wider scope of services, or utilizing complex technology to support electronic records or consumer convenience.
10. CVS Conference Call Transcript Q4 2006 Feb 1, 2007.
11. Over-the-counter, pharmaceutical, and device companies like Johnson and Johnson have long supported the in-store clinic model, and are eager to find a way to connect their brands with clinic services. For the most part, sponsorship has been limited to special events (flu shot clinics) or single-product promotions (giveaways in conjunction with healthy heart screenings), but we may see growth in this phenomenon.
12. Waiting for medical attention during working hours is particularly expensive for lower income consumers, who may not have paid time off.
13. AHIP Annual Report; see www.ahipresearch.org.
14. HealthPartners, 2005.
15. McGlynn, E.A., S.M. Asch, J. Adams, and others. “The quality of health care delivered to adults in the United States.” *New England Journal of Medicine* 2003;348:2635-45.
16. Minute Clinic submitted this study to the American Journal of Medical Quality for peer review; publication has been confirmed for Fall 2007.
17. www.MNhealthcare.org.
18. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation is not required; we note Minute Clinic pursued and was granted this accreditation; much debate exists among clinic operators as to the appropriateness of this accreditation for clinics and other ambulatory services.
19. Some experts believe the retail clinic expansion is a response to the shortage of family physicians. Within the next 15 to 20 years, the deficit is expected to reach as many as 200,000 physicians—20 percent of the needed workforce, according to Dr. Richard Cooper, a professor of medicine at the University of Pennsylvania.
20. www.rxforpa.com.
21. Burton, Rachel. “Rapid Expansion of In-Store Clinics Has Lawmakers Watching.” *State News of National Conference of State Legislatures*. (August 7, 2006).
22. Doug Trapp. “Illinois bill proposes stricter requirements for retail clinics” *AMNews*. (March 26, 2007).
23. See *Health Care in the Express Lane: The Emergence of Retail Clinics*, 26.
24. Medical Board of California, *Corporate Practice of Medicine Guidelines*, www.medbd.ca.gov/corporate_practice.htm.
25. See *Health Care in the Express Lane: The Emergence of Retail Clinics*, 13.
26. Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988 to establish quality standards for laboratory testing, and in 1992 published guidelines for waived tests: simple laboratory examinations and procedures that are cleared by the FDA for home use; employ technologies that are simple and accurate and render the likelihood of erroneous results negligible, or pose no reasonable risk of harm to the patient if the test is performed incorrectly.