Retail Healthcare: Growing Trend for Healthcare Service Delivery

Although more Americans than ever have private insurance or Medicaid coverage due to the Patient Protection & Affordable Care Act (PPACA), access to care continues to worsen as the number of primary care physicians has not kept pace with the clinical demands of an aging population and newly covered patients. The need for additional care settings, along with recent increases in patient out-of-pocket costs, has prompted the growth of non-traditional health care delivery settings such as retail clinics and urgent care centers.

Several major hospital and health systems have recognized this trend, and in addition to extending office hours and expanding urgent care offerings, are also partnering with national pharmacies and retailers to establish walk-in retail clinics. Texas Health Resources, one of the largest health care systems in North Texas, is emblematic of this trend having been in a retail pharmacy clinic partnership with CVS/Caremark two years and more recently, with Target.

Given his experience, A&M had a discussion with Barclay Berdan, Chief Executive Officer with Texas Health Resources, to better understand the emerging role of retail healthcare: "*The retail clinic was a relatively easy model for us to get into.* Our *relationship with CVS and Target offers a low cost option with convenient access for the public without having to take a half day off work to meet their minor medical needs."*

In this article, we examine this shift in care delivery site from emergency departments and physician offices to urgent care centers and retail clinics. We analyze how retail clinic strategies are being designed to promote positive patient experience and timelier access to care. We review how hospital and health care systems are recognizing that new health care delivery sites and channels are an increasingly important determinant of patient acquisition and retention, as well as a source of cost savings relative to over-utilized emergency room departments. And we evaluate how new care sites such as retail pharmacy clinics have the potential to extend health care provider brand equity and serve as a lower cost point of "capture" for new patients.

Growth of insured patients, increased demand for primary care and "urgent care" services and sensitivity to out-of-pocket costs is driving alternative service sites

Rising out-of-pocket health care costs, combined with increasing consumer demand for service excellence has created an opportunity shifting market share among sites providing care. Hospitals, with comparatively expensive emergency and outpatient departments are most vulnerable.

Since 2010, the number of uninsured Americans has declined from 50.7 million in 2010 (16.4% of the U.S. population) to 30.0 million in 2014 (12.9%).[1] The decline in the number of uninsured Americans has been driven in parts by: 1) an improving economy, 2) implementation of Affordable Care Act (ACA) coverage provisions, 3) state-by-state Medicaid expansion and 4) the availability of tax subsidies through health insurance exchanges.

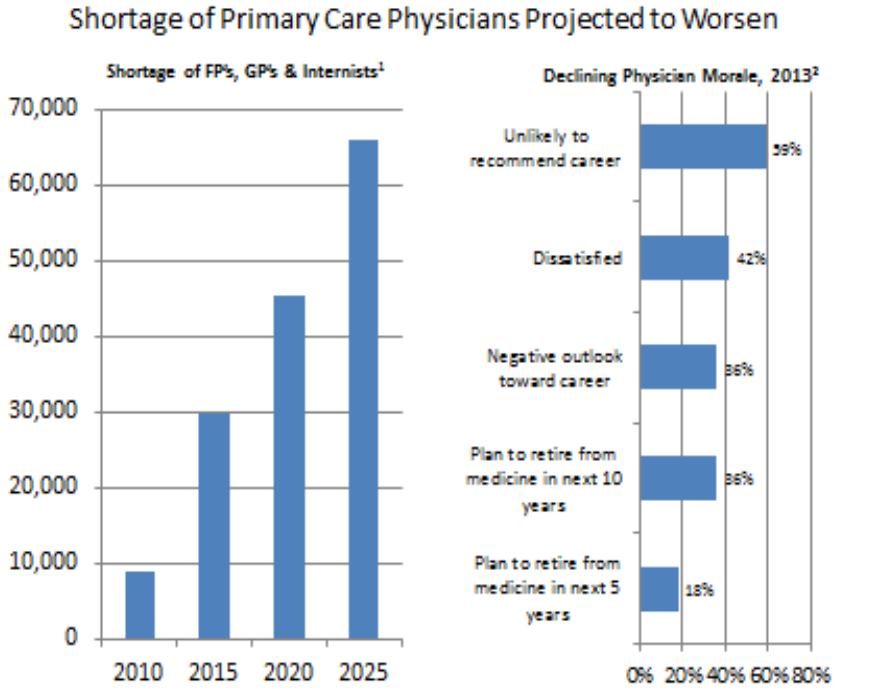
During this same period of health insurance expansion, however, Americans insured through employee plans or individual plans have seen a rapid rise in their out-of-pocket costs. Out-of-pocket costs are now approaching $5,000 per year for family coverage. Approximately 25-30% of employees are now enrolled in high deductible plans with minimum deductibles of $1,300 for self-only coverage and $2,600 for family coverage.[2] Higher out-of-pocket costs are affecting consumer

behavior, increasing consumer sensitivity to healthcare costs and encouraging them to look for lower cost care alternatives.

In 2009-10, there were 1.25 billion visits to primary care physician offices (45.7%), medical specialty offices (19.7%), surgical specialty offices (16.1%), hospital emergency departments (10.6%) and hospital outpatient departments (7.8%)[3] Non-specific diagnostic groups such as "supplementary classification of factors influencing health" and "symptoms, signs and ill-defined conditions" accounted for 25.3% of visits; injuries, mostly minor, accounted for an additional 6.4% of visits.

Although demand for health care services is expanding as the population grows and more Americans have access to health insurance or coverage, access to primary care does not appear to be keeping pace with service demand. The current number of primary care physicians (PCPs), approximately 270,000, is forecast to remain stagnant, if not slightly decline during the next decade. Due to an aging population and a reduction in the number of uninsured, the shortage, already at 30,000 PCPs in 2015 is forecast to reach 65,800 by 2025.

These primary care shortages could actually worsen with an increased likelihood of early physician retirements and the potential reduced productivity associated with acquisition of physician groups by health systems and hospitals. Access to timely care, especially for those with chronic, complex medical issues may become increasingly difficult. These trends will continue to drive the creation of new health delivery settings, such as retail clinics, staffed by nurse practitioners or physician assistants.



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More than 40 percent of Emergency Department visits are not for treatment of urgent conditions

In 2012, there were 134.4 million emergency department (ED) visits, a 12% increase from 120.0 million in 2006. Overall, 14% of patients seen in an ED are admitted for inpatient hospital care. Children, adolescents and adults under 44 years old are admitted at a far lower rate (4-8%) than the 45-64 (17%) and 65+ (37%) cohorts.[4,5] Semi-urgent patients, those seen within 1-2 hours and non-urgent patients, those seen within 2-24 hours, account for 35% and 8% of ED visits, respectively or 57.5 million visits[6].

Mild to moderate injuries caused by falls, motor vehicle accidents, being struck or cut, over-exertion and other activities account for nearly one-third of ED visits.[5] Other leading causes for ED visits include: respiratory conditions, including infections, asthma and COPD (12.7M), abdominal pain (6.4M), chest pain (5.4M), spinal disorders (4.0M) and a broad range of skin, genitourinary, musculoskeletal, nervous system and metabolic conditions.[7]

Medicaid recipients and the uninsured account for 45% of ED visits. Many of those visits are semi- or non-urgent in nature, likely due to the lack of a primary care physician. The number of ED visits per 1,000 persons in the Medicaid population is 2-5 times higher than those persons with private insurance.

Urgent Care Centers are a growing and lower cost alternative to Emergency Departments

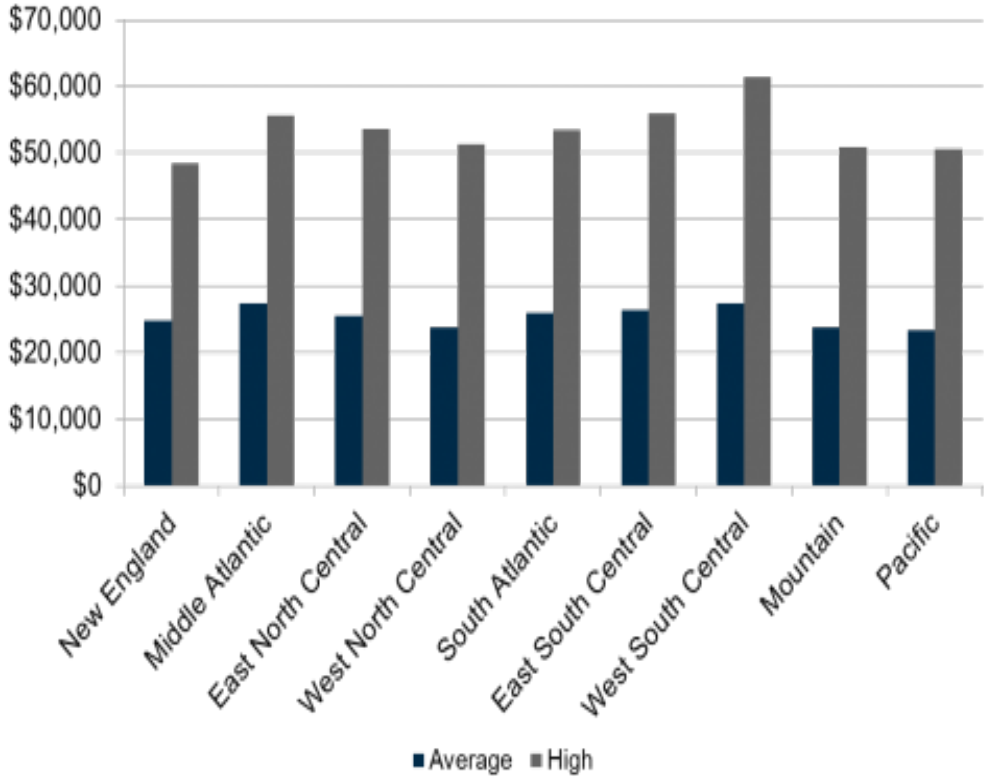
According to the Urgent Care Association of America (UCAOA), urgent care is defined as “healthcare provided on a walk-in, no-appointment basis for acute illness or injury that is not life or limb threatening, and is either beyond the scope or availability of the typical primary care practice or retail clinic”.[9] Urgent care centers are typically staffed by physicians, have x-ray and (stat) lab equipment, and can perform minor procedures such as suturing and bone casts. The range of services, as well as staffing levels may vary by location. Urgent Care centers represent an alternative to emergency departments as well as to physician offices, which have limited accessibility, especially on nights and weekends. Urgent Care centers are branded under multiple terms including: urgent care, immediate care, walk-in care and convenient care.

National estimates on the number of dedicated urgent care center settings are broad and range from 4000 to 9,000 Urgent Care centers. These same studies estimate between 70 and 160 million Urgent Care center visits per year, or the equivalent of 17,750 visits/center (48.6/day).[9] The UCAOA indicates that there are 6,400 Urgent Care centers in the United States.[10] Ownership of Urgent Care centers has been historically led by local physicians/physician groups (35%) and hospitals (25%), although in recent years small number of private for-profit entities have grown rapidly. These include the Urgent Care center leaders Concentra and U.S. Healthworks, followed by NextCare, MedExpress, Doctor’s Express and entities with several locations.[10]

Retail Clinic model continues to show growth

The growth in stand-alone “urgent care” centers has been accompanied by the growth of walk-in “retail clinics” in pharmacies, grocery stores and other retailers. Although the exact number of retail clinics is difficult to ascertain, according to a retail clinic trade association, the Convenient Care Association (CCA), there are nearly 2,000 retail clinic sites in 43 states and the District of Columbia. Sponsors or partners of retail clinics include among some of the largest national pharmacies and retailers including: CVS, Walgreens and RiteAid and WalMart, Target, Kroger and H-E-B.

After a short hiatus in growth between 2009-2011, possibly attributable to lower retail sales during the recession, growth in retail clinics resumed in the last three years.



The number of visits to retail clinics has increased from 1.5 million in 2007 to 10.0 million in 2012. Note, however, the number of patients per clinic declined from 5,813 patients/year (15.9 patients/day) in 2007 to 5,106 patients/year (14.0 patients/day) in 2009, before rebounding to 7,380 patients/year (20.2 patients/day) in 2012. In essence, the rate of initial clinic expansion exceeded volume growth. CVS, the market leader is forecast by The Continuing Care Association to reach 1,500 locations by 2017; other providers are also expected to grow, though at a lower rate.[12]

The vast majority of retail clinics are in metropolitan areas, with a concentration in just a few states including California, Florida, Illinois, Minnesota and Texas and to a lesser extent, New York. [13]

Minor medical conditions and preventive activities make up the vast majority of retail clinic visits such as: upper respiratory

tract infections (colds, flu, bronchitis, sinusitis), pharyngitis, immunizations, ear infections, urinary tract infections, and conjunctivitis (pinkeye). Minor rashes, sprains and injuries make up the smaller balance of retail clinic visits.[11] Ancillary offerings at retail clinics include throat swab (strep), urine and blood tests (e.g., cholesterol, glucose), and physical examinations inclusive of biometric screening for camp, sport activities and employment. Retail clinics are an attractive service component for national pharmacies and retailers as significant non-clinic revenues are generated to those businesses through prescription drugs, over the counter remedies and other products. Minute Clinics and other retail clinics have expanded their offerings to include chronic disease monitoring (e.g., hypertension, cholesterol, diabetes) and wellness services (e.g., weight loss, smoking cessation).

Retail clinics are typically staffed by nurse practitioners. Nurse practitioners are not primary care physicians and have less post-graduate clinical training than physicians, with state mandates varying from 500 to 1,000 hours. In comparison primary care physicians spend between 3 to 5 years in post-graduate residency. As a result, the scope of health care services that may be provided by a nurse practitioner may be limited unless primary care physicians become more engaged in the provision of care either directly, or though telemedicine.

Retail clinics are relatively inexpensive both to operate and on the basis of patient expense, with an average cost of a visit between $80 and $90. Laboratory testing represents an incremental charge. A study published in the Annals of Internal Medicine, based on 2005 - 2006 claims data, highlighted the differential in costs for three specific, *matched episodes of care* among retail clinics ($110/episode), physician offices ($166), urgent care centers ($156) and emergency departments ($570).[14] According to the published study, there was little difference found in quality and outcomes for the specified conditions.

Increasing health system provider involvement with retail clinics

In 2009, the CVS signed an agreement with the Mayo Clinic, inclusive of clinical consultation and electronic data exchange at nine sites in Northeastern Ohio. Inova Healthcare, a Northern Virginia based hospitals and health system entered into an agreement with CVS to co-brand and market service offerings, collaborate on patient education and disease management initiatives, and integrate electronic medical records. Inova physicians also serve as the medical directors for CVS' Northern Virginia locations (14), and are available to serve as a referral source and treat patients beyond the scope of CVS capabilities.[15] CVS currently has relationships with 32 providers.

In 2013, Walgreen (TakeCare Clinics) announced an expansion of their service offerings to include the "assessment, treatment and management for chronic conditions such as hypertension, diabetes, high cholesterol, asthma and others, as well as additional preventive health services." Clinical affiliations, such as that with the Community Health Network of Indianapolis are integral to ensure care coordination.[16]

Walmart also has relationships with health and hospital systems and medical groups including the Christus Medical Group (Texas), Aurora Health System (Wisconsin) and Cox Health (Missouri). In late-2014, Walmart changed its business model by directly contracting with Quadmed to staff and manage six in-store Care Clinics in Texas and South Carolina offering $40 visits to nurse practitioners ($4.00 for Walmart employees). The clinics are open seven days a week for nine hours per day for scheduled and unscheduled visits. A wide range of lab and point-of-care tests are being made available at comparatively low cost.[17]

Target recently opened four primary care clinics staffed by Kaiser Permanente certified family nurse practitioners, available to treat Kaiser and non-Kaiser patients. Services include pediatrics, adolescent medicine, OB/GYN and chronic care management. Telehealth technologies will be used for primary care physician consultation, as needed. Kaiser electronic medical record and lab services will be made available.[18]

Case study: Texas Health Resources experience with CVS/Caremark retail clinic partnership

In April, A&M visited with Barclay Berdan, the Chief Executive Officer of Dallas / Ft. Worth's Texas Health Resources (THR) to discuss his system's venture into retail clinics.

Texas Health is one of the largest nonprofit health systems in the United States and the largest in North Texas. The health system includes Texas Health Physicians Group (THPG) and hospitals under the banners of Texas Health Presbyterian, Texas Health Arlington Memorial, Texas Health Harris Methodist and Texas Health Huguley.

Texas Health has over 20,000 employees and operates 24 hospitals with more than 3,800 licensed beds including 16 acute care hospitals, 6 short stay hospitals, one transitional care hospital and one rehabilitation hospital. It also operates 68 outpatient facilities, including ambulatory surgical and imaging centers. Texas Health hospitals have over 5,500 medical staff members. Texas Health Physicians Group employs over 550 physicians and 270 nurse practitioners and physician assistants.

According to Berdan, partnering into the retail clinic space completely fit into the Texas Health vision as a unified healthcare

system.

"Our relationship with CVS/Caremark and Target include 49 locations currently. There are three areas we are focusing on at this time: First, what does our combined brand look like. Secondly, the ability to connect the information through a larger health information network and provide that information longitudinally on a patient; and third, after we have resolved the health information network connectivity, is to then focus on chronic disease management. The system will ultimately communicate both ways, with the ability to reach out directly to the patient to help manage their care, focusing primarily on the chronic disease management patients.

As we know, one of the leading challenges for patients is confusion about medication. Another area we are looking into is an untapped resource with the pharmacist that is sometimes under-utilized in these locations. The mid-level provider in these clinics will recognize when the patient has a need for explanation regarding their medications and can utilize the pharmacist resource to assist.

We certainly recognize we have a lot more to build on with this relationship in the future."

Like other healthcare executives, Berdan believes that cost and convenience are the two key driving factors behind the growth in retail clinics. He believes that access to care will continue to be a problem in many parts of the country even with insurance expansion under the ACA and a dwindling primary care physician base relative to the growing population.

Berdan says that entering into the partnership relationships with CVS/Caremark and Target was a low cost strategy to enter into a low-acuity service site where Texas Health did not yet have management experience. The partnerships with CVS/Caremark and Target permitted Texas Health to expand its access footprint without incurring new capital costs. All of the hard costs associated with the retail clinic (real estate, build out, maintenance, supplies) are borne by CVS/Caremark and Target.

As part of the partnership with CVS, Texas Health Resources provides an experienced primary care physician as the physician advisor and supervisor to the nurse practitioner staffing the retail clinics. Under the model, the nurse practitioners remain the employees of CVS/Caremark or Target, however, a THPG physician is available by phone for consultation and direction of patients to a higher level of care. The retail clinics are not yet linked to Texas Health's Epic electronic medical record (EMR). Berdan says that link may come in time.

The CVS/Caremark Minute Clinics are not yet branded with Texas Health, although in other settings CVS/Caremark or Target have co-branded the retail clinics with a local health care system. Berdan says that Texas Health is continuing to evaluate at what point co-branding makes sense. When he travels around the DFW area and he is near a CVS or Target where there is a retail clinic, Berdan says he will walk in to gauge the traffic and check out the look and presentation

Right now the decision on where to locate the retail clinics falls to CVS/Caremark and Target and most of the clinics are in the northern part of the DFW metroplex, which has seen the largest population gains in the last 20 years.

"There are all types of reasons that play into the demand function for this type service. In Texas we haven't expanded Medicaid, therefore we have about one million people that have insurance now through the federal exchange leaving about 1 in 5 of the people uninsured. All of our research indicates that as we move into an environment where consumers become more engaged on how they spend their dollars and how they access the system, there are two leading factors, with little varying indicators around age: it basically comes down to cost and convenience. The first dollar responsibility is growing with people who have insurance and for people who don't have insurance it is "all dollar" responsibility."

Bottom line

While hospital emergency departments continue to be a profitable (7.8% margin) part of most hospital system business and represent an important source of inpatient admissions, hospital systems need to adjust to a new reality of patients with less severe conditions going to urgent care centers or retail clinics.[19] Semi-urgent and non-urgent patients, account for 40-45% of patient ED visits and contribute to the leverage of high fixed costs. Although the decline in the number of uninsured through the Affordable Care Act is expected to reduce bad debt and uncompensated care and thereby increase ED profitability, hospitals in service areas with a proliferation of urgent care centers or retail clinics need to be attuned to the possibility of less semi-urgent and non-urgent patient traffic in the ED.

The "corporatization" of urgent care centers highlights an unmet need in the market; i.e., timelier access to lower cost treatment for acute, non-life threatening episodes of care. Hospital emergency departments are increasingly vulnerable to these marketing efforts. As with retail clinics, the business model for urgent care centers is evolving with increasing recognition of the importance of care continuity and electronic data interchange.

Retail clinics, as stated by Barclay Berdan, represents a low cost and convenient site of care for minor ailments. They also offer immunization and other health services. Provider co-branding activities highlight an intention to "capture" new

patients, especially the newly insured as well as those without a regular primary care physician. Telehealth opportunities exist (with the use of extenders) to remotely treat higher acuity patients with chronic illness; physicians no longer have to be with the patient for direct observation, listen to chest and heart sounds, and perform full physical examinations.

Convenience (site of service), availability (access), care extenders, telehealth and pharmacist adjuncts will increasingly be used to engage patients and their caregivers, better match clinician requirements with disease complexity and leverage the growing shortage of primary care physicians.

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