

Building a Culture of Health

# The Value Proposition of Retail Clinics



Deborah Bachrach  
Jonah Frohlich  
Allison Garcimonde  
Keith Nevitt



## Executive Summary

Retail clinics offer convenient, low-cost basic primary care treatment, screening and diagnostic services in a variety of settings. Increasingly, these clinics are an integral part of a U.S. health care system in the throes of massive change as payers and providers migrate toward Triple Aim goals of improved patient care, population health and reduced cost. Many retail clinics are adapting their offerings to provide basic chronic care management services and forming partnerships with area health systems in efforts to become better integrated with other community providers. Some retailers are leveraging other assets within their stores, including pharmacies and healthy foods, to create a package of enhanced services for customers and payers. A few retailers have gone a step beyond and are exploiting the enormous foot traffic they generate to offer additional services not traditionally found in their stores, including enrollment assistance and access to public nutrition programs.

As the role of retail clinics evolve they face a series of challenges and opportunities to integrate this business model into a health care system reconfiguring to advance Triple Aim goals and to contribute more broadly to a Culture of Health.

# The Retail Clinic Landscape

Retail clinics typically employ nurse practitioners (NPs) and physician assistants (PAs) to handle most patient interactions. Like many primary care providers, retail clinics are more prevalent in higher-income, urban and suburban areas, though they also can be found in rural and underserved communities. The majority of retail clinics accept commercial, Medicare and Medicaid coverage, and all accept cash payment regardless of insurance status.

The cost of providing care and treating patients has been found to be lower at retail clinics when compared to other settings. However, it remains unclear if retail clinics reduce the total cost of care by replacing other primary care encounters. And while some measures of performance indicate that the quality of care offered at retail clinics is comparable to other settings, there is less evidence of how clinics impact clinical outcomes.

To date, more than 100 partnerships between retail clinics and health systems have been formed, linking care between retail sites and primary care medical homes, expanding after-hours care options and enabling health systems to provide patients with alternatives to emergency departments (EDs). In fact, one study estimated that up to 27 percent of ED visits could be handled appropriately at retail clinics and urgent care centers, offering cost savings of \$4.4 billion per year. The full benefit of these partnerships can only be realized when care is coordinated, protocols are adopted, and information systems are effectively linked. The reach and effectiveness of retail clinics can be constrained by varying and restrictive state scope-of-practice rules that increase the administrative costs of retail clinic operators and limit their practitioners' scope of services. Health system partners have helped resolve some of these issues by providing physician oversight, though that can add to overhead and cost.

Increasingly, retailers are bundling clinic services with pharmacy, nutrition, lifestyle and obesity management programs to deliver more comprehensive offerings. The business case for providing those services can be compelling, especially when they are aligned with incentives from payers. Finally, the astonishing foot traffic that these retailers generate can serve as a platform for offering services not traditionally delivered in retail setting, such as enrollment assistance for public or private coverage, nutrition and housing support.

Retail clinics have demonstrated that their value proposition in a Culture of Health is convenient, low-cost, transparent and accessible routine primary care. To the extent they are able to coordinate care with health system partners, their value will be further enhanced. Additional research is warranted to examine the expanded role retail clinics can play in supporting public health initiatives, the benefits of tightly coupling and bundling services that better leverage retailer assets, and how stronger ties to a range of services not widely accessible through retailers that address underlying social determinants of health can be created and sustained.

## Recommendations for Optimizing Value and Advancing a Culture of Health

- **Integrating into the delivery system**, through better linkages between retail clinics and health system partners.
- **Measuring and reporting the quality of the care** using a more complete set of clinical outcome measures that assesses performance against other primary care providers.
- **Improving access in underserved communities**, through partnerships between municipalities and state governments to open new retail stores with clinics in disadvantaged areas.
- **Providing services to young children** by removing obstacles preventing the appropriate administration of vaccines and provision of routine primary care in retail clinics to children over 18 months.
- **Standardizing scope of practice** rules for NPs and PAs and removing restrictions that prevent NPs and PAs from practicing to the full extent of their license and training.
- Requiring Medicare and all other payers to reimburse retail clinics for **appropriate telehealth services**.
- Examine more expansive roles retail clinics can play in **supporting public health and emergency response efforts**.
- **Making the business case** to payers to broaden and bundle services.
- **Researching the business case for** a broader range of services including insurance enrollment assistance and access to nutrition, housing and other programs.

## ABOUT MANATT HEALTH

Manatt Health, the health care division of Manatt, Phelps & Phillips, is a fully integrated, multidisciplinary legal, regulatory, advocacy and strategic business advisory health care practice.

Manatt Health's extensive experience spans the major issues re-inventing health care, including Medicaid redesign and innovation; payment and delivery system transformation; health IT strategy; health reform implementation; health care mergers and acquisitions; regulatory compliance; privacy and security; corporate governance and restructuring; pharmaceutical market access, coverage and reimbursement; and game-changing litigation shaping emerging law.

With 80 professionals dedicated to health care—including attorneys, consultants, analysts and policy advisors—Manatt Health has offices on both coasts and projects in more than 20 states.

For more information:

[www.manatt.com/  
manatthealthsolutions.aspx](http://www.manatt.com/manatthealthsolutions.aspx)

## ABOUT THE AUTHORS

**Deborah Bachrach**, a partner with Manatt, Phelps, Phillips, LLP, has more than 25 years of experience in health policy and financing in both the public and private sectors and an extensive background in Medicaid policy and health care reform. She works with states, providers, plans and foundations in implementing federal health reform and Medicaid payment and delivery system reforms. Most recently, Ms. Bachrach was Medicaid director and deputy commissioner of health for the New York State Department of Health, Office of Health Insurance Programs. She has previously served as vice president for external affairs at St. Luke's-Roosevelt Hospital Center and as chief assistant attorney general and chief of the Civil Rights Bureau in the Office of the New York State Attorney General. Ms. Bachrach received her J.D. from New York University School of Law and a B.S. from the University of Pennsylvania, Wharton School.

**Jonah Frohlich**, a Managing Director with Manatt Health Solutions, provides business, policy and regulatory advice to a wide array of health care organizations, including health plans, hospitals, provider organizations, and state governments, with a particular focus on health care delivery transformation, population health, managed care and health information technology initiatives. He has led multi-stakeholder engagements on behalf of health systems and foundations, developed strategic and business plans for large delivery systems and accountable care organizations, led planning efforts for state health information technology initiatives, and published reports describing the impact of state and federal policy on public and private markets. Prior to joining Manatt, Mr. Frohlich was the deputy secretary of health information technology at the California Health & Human Services Agency. Previously, he was a senior program officer with the California Health Care Foundation and served as a manager at Brown & Toland Physicians. Mr. Frohlich received his M.P.H. from the University of California, Berkeley and a B.A. from McGill University.

**Allison Garcimonde**, a Manager with Manatt Health Solutions, provides policy expertise, strategic and regulatory advice, and project oversight to a wide range of clients on issues related to health care coverage, access and financing, as well as health information technology. Her most recent work has focused on advising states, foundations, safety net providers and other health care stakeholders on the implications and implementation of federal health reform. She has also helped to facilitate statewide, multi-stakeholder health information exchange planning efforts, providing project management and research expertise and assisting with governance, technology, privacy and security, and consumer engagement strategies and implementation. Ms. Garcimonde received her M.A. from The George Washington University and a B.A. from the University of Florida.

**Keith Nevitt**, a Senior Analyst with Manatt Health Solutions, provides policy analysis, project support and strategic business advice on a wide range of health care issues, including federal and state policy trends, Medicaid and other health insurance programs, delivery system and payment reform, and health information technology. His work includes tracking and analyzing state and federal legislation pertaining to the Affordable Care Act (ACA) implementation. Mr. Nevitt completed his master's project with Blue Shield of California, where he identified and evaluated policy options to advance shared decision making as a way to improve the quality of care. He also interned as a policy analyst at the California Association of Public Hospitals and Health Systems (CAPH) and began his career as a field representative and staff assistant to now Senator Tammy Baldwin in Madison, Wisconsin. Mr. Nevitt received his M.P.P. and M.P.H. from University of California, Berkeley and a B.A. from the University of Wisconsin.

# Building a Culture of Health

## The Value Proposition of Retail Clinics

Deborah Bachrach, Jonah Frohlich, Allison Garcimonde, Keith Nevitt

### Introduction

---

Since first emerging on the health care landscape more than 15 years ago, retail clinics are now a common feature, with 10.5 million visits occurring annually at more than 1,800 retail clinics.<sup>5,6</sup> The clinics typically serve as ambulatory care sites providing basic screening, diagnostic, and treatment services. Retail clinics are increasingly expanding their service offerings to include behavioral health screenings, more comprehensive primary care and chronic care management.<sup>7</sup> Retail clinics are filling gaps in our health care system for consumers who are uninsured or underinsured; for families with immediate care needs on weekends and evenings; and for employers, health systems and insurers looking for lower cost sites of care for low acuity conditions. As the nation's health care system enters a period of profound change, these clinics offer an important locus of patient access within large retail establishments.

The Affordable Care Act, enacted in 2010, has expanded coverage to millions of Americans and accelerated investments in accountable care models supported by value-based payments. The expansion of coverage is straining the nation's primary care capacity.<sup>8</sup> Retail clinics provide additional access points for basic primary and preventive care. While rates of uninsured adults have dropped significantly from more than 16 percent in

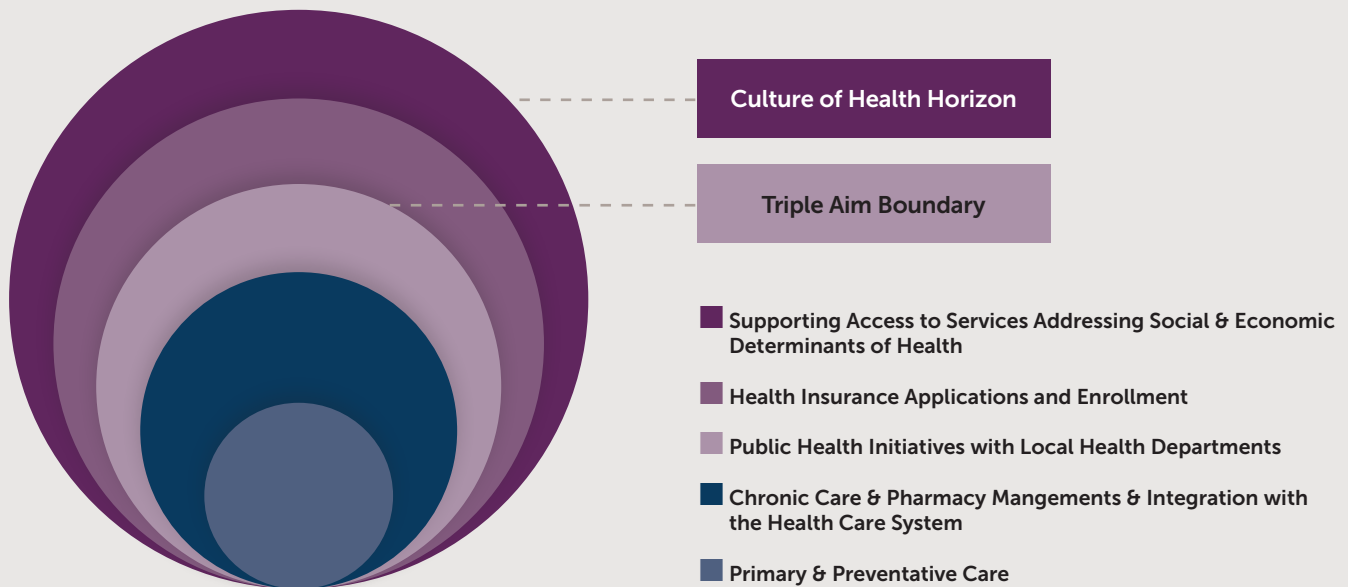
2009 to 12.9 percent in the fourth quarter of 2014, many remain uninsured and those who are insured often face high cost-sharing.<sup>9</sup> While retail clinics offer lower cost options for basic acute care, their largest challenge and opportunity is their relative ability to support new delivery and payment models that demand coordinated, high-value care and put a premium on improving health, rather than simply treating disease, for individual patients and communities.

Since the Institute for Healthcare Improvement first introduced the Triple Aim in 2008, its goals of better care for individuals, improved health for populations and lower per-capita cost have become the centerpiece of efforts to improve the efficiency and effectiveness of the nation's health care system.<sup>10</sup> The Robert Wood Johnson Foundation articulates an even more far-reaching goal: to build a Culture of Health in which living healthier lives is a fundamental societal priority.<sup>11</sup> At its core is a recognition that where we live, learn, work and play determine our health and influence our collective well-being. To achieve a Culture of Health requires a collaborative effort among multiple actors within the public and private sectors, extending well beyond the traditional medical community, perhaps reaching into the retail sector.

#### Insights from the Field

"[I]magine a culture that empowers everyone to live the healthiest lives that they can, even when they are dealing with chronic illness or other constraints. Imagine a health care system that couples treatment with care, and considers the life needs of patients, families, and caregivers, inside and outside the clinic."

**Risa Lavizzo-Mourey**  
Robert Wood Johnson Foundation



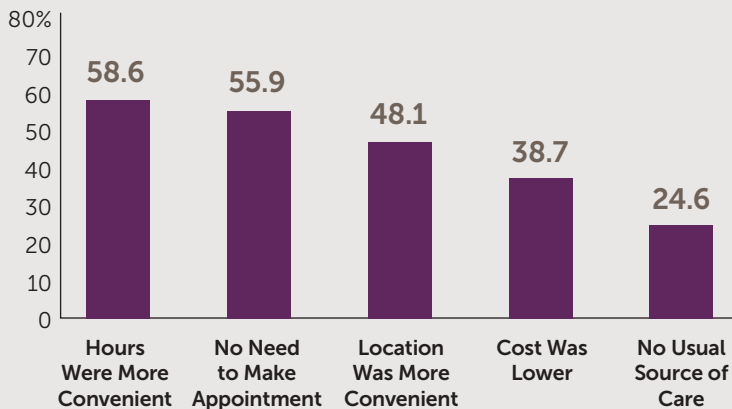
This paper examines the potential value proposition of retail clinics in building a Culture of Health in the United States. It was guided by an advisory committee, and informed by published research and interviews with 20 retail clinic experts and stakeholders. We review evidence of the impact retail clinics have had in expanding access to lower-cost, routine, primary care services and consider the quality of these services and whether they impede or facilitate a continuum of care. We describe how some retail clinics are establishing ties with other health system providers to enable coordinated care, and the challenges these clinics must confront to effectively support Triple Aim goals. We distinguish between three different loci of care and services within the retail setting: the retail clinic itself; the pharmacy, and the broader retail environment. We specifically consider opportunities to leverage the setting in which retail clinics operate to better support disease prevention and chronic care management. And we consider how the broader aspects of a Culture of Health can be realized by exploiting the considerable foot traffic within these retail environments to facilitate access to public, private and subsidized insurance, nutrition programs such as Women, Infants, and Children (WIC) and food stamps, public health and other programs that may fall outside of traditional health service horizons.

Finally, we propose a set of strategic recommendations for philanthropy, policy makers and regulators, providers, clinic owners, operators and other stakeholders to optimize the value of retail clinics in building both an effective and efficient health care system and a Culture of Health in the United States.

### The Robert Wood Johnson Foundation describes a nationwide Culture of Health in which:

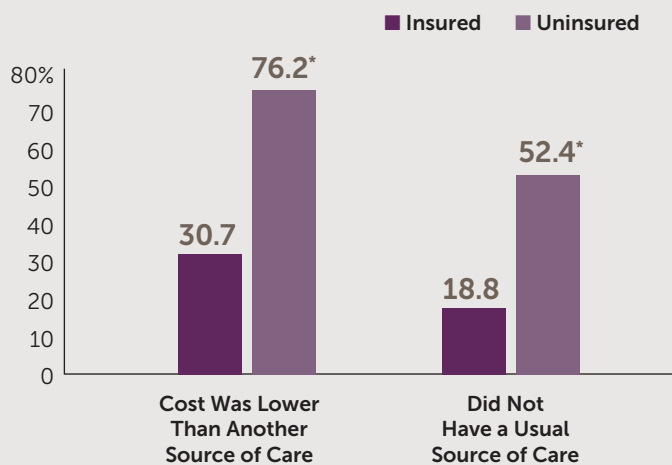
1. Good health flourishes across geographic, demographic and social sectors.
2. Attaining the best health possible is valued by our entire society.
3. Individuals and families have the means and the opportunity to make choices that lead to the healthiest lives possible.
4. Business, government, individuals, and organizations work together to foster healthy communities and lifestyles.
5. Everyone has access to affordable, quality health care because it is essential to maintain, or reclaim, health.
6. No one is excluded.
7. Health care is efficient and equitable.
8. The economy is less burdened by excessive and unwarranted health care spending.
9. The health of the population guides public and private decision-making.
10. Americans understand that we are all in this together.

### Among U.S. Families Using a Retail Clinic in Past 12 Months, Major Reason for Choosing a Retail Clinic, 2010



Note: Categories are not mutually exclusive; respondents could select multiple categories. Source: HSC 2010 Health Tracking Household Survey

### Retail Clinic Users Citing Reasons Other Than Convenience for Choosing a Retail Clinic, 2010



\*Difference between insured and uninsured is statistically significant at  $p < .01$ . Source: HSC 2010 Health Tracking Household Survey

## The Current Landscape

Retail clinics are ambulatory care sites typically located in and associated with brand-name retailers, including pharmacies, groceries and “big-box” stores. They primarily treat routine illnesses, provide preventative care and vaccinations, offer basic health screenings and low-level acute care services. Retail clinics emphasize convenience—walk-in availability, short or no wait times, and extended weekday and weekend hours of operation. Prices are typically fixed and transparent, generally posted on-site and online.<sup>12</sup> Nurse practitioners (NPs) and physician assistants (PAs) typically staff them with some physician oversight. Retail clinics are distinct from employer-based clinics, which tend to serve only corporate employees, and urgent care clinics and free-standing emergency departments (EDs), which can treat higher-acuity injuries. The latter are also required to have board-certified physicians on staff.

Retail clinics are low-margin businesses. They cost \$50,000 to \$250,000 to build out, are usually between 150 and 250 square feet, can generate revenues upwards of \$500,000 per year, and typically see 10 to 30 patients per day.<sup>13,14</sup> They offer low prices—typically ranging from \$40 to \$75 for a visit—by keeping down administrative overhead, operating in a small clinic footprint, aggressively managing their

supply chain, and by employing a workforce of NPs and PAs.<sup>15</sup> Given these attributes, retail clinics also tend to be limited in the services they can offer and equipment they can operate.<sup>16</sup>

### History, Growth and Patients Served

After the first retail clinics opened in 2000, the industry experienced a period of rapid growth through 2007, followed by more tempered expansion.<sup>17</sup> Still, the number of retail clinic sites increased almost 900 percent between 2006 and 2014, from 200 to 1,800, and the number of visits increased sevenfold from approximately 1.5 million to 10.5 million in 2012, representing upwards of 2 percent of primary care encounters in the United States.<sup>18,19</sup> Demand for convenient access to care for low-acuity, time-sensitive conditions or routine preventive services has been fueling clinic growth. The vast majority of clinic users reported that the primary purpose of their most recent clinic visit was the diagnosis and treatment of a new illness or symptom, followed by vaccinations and prescription renewals.<sup>20</sup>

In the early years, most retail clinics did not accept insurance; however, by 2008 almost all retail clinics accepted commercial insurance and Medicare, while 60

percent accepted Medicaid.<sup>21</sup> Regardless of insurance status, higher-income families earning more than 600 percent of the federal poverty level (FPL) are nearly twice as likely to use a retail clinic as families with incomes less than 200 percent of FPL. Families with children were also more likely to use a retail clinic than childless couples, single adults, and senior citizens.<sup>22,23</sup> This demographic is driven in part by the location of retail clinics, which tend to be in higher-income, urban and suburban settings, with higher concentrations of white and fewer black and Hispanic residents.<sup>24</sup> Regardless of the setting or income of the consumers, when compared to the general population, retail clinics patients are less likely to have insurance or a personal physician.<sup>25</sup>

Retail clinic consumers overwhelmingly cite convenient location, hours of operation and ability to receive care without an appointment as major reasons they choose to seek care at retail clinics over other care settings.<sup>26</sup> For uninsured and low-income consumers, lack of a usual source of care and lower costs factored heavily into their decisions to rely on retail clinics.<sup>27</sup> The longer hours of operation also give patients more flexibility to avoid time away from work.<sup>28</sup> For uninsured populations, retail clinics appear to function as a limited safety net, delivering more affordable and accessible, basic primary care services than they could receive in most other settings.

### Cost, Quality and Transparency

The cost of providing care for commercially insured patients has been found to be significantly lower when care was initiated at retail clinics (\$110) than when it was initiated in physician offices (\$166), urgent care centers (\$156), and EDs (\$570).<sup>29</sup> Studies have also found that for five common conditions treated at retail clinics (pharyngitis, otitis media, acute sinusitis, conjunctivitis, and urinary tract infections), costs savings of \$50 to \$55

per episode could be realized and that cost of care for consumers who visited a retail clinic on aggregate was \$262 less than those who did not.<sup>30,31</sup>

Other studies, however, suggest that retail clinics could add to costs by complementing physician care instead of replacing it, and generating new encounters that patients would not otherwise pursue.<sup>32</sup> While these visits may provide health benefits, the ability of retail clinics to impact overall health care spending remains unclear.<sup>33</sup> There may also be additional cost implications for the wide variation in pricing of generic drugs at large U.S. pharmacy chains, which can be as much as 18 times more expensive than wholesale chains such as Costco.<sup>34</sup> On the other hand, prescribing medication at retail clinics has been associated with better patient adherence with drug regimens; concerns raised by some parties that retail clinics might overprescribe antibiotics have not been supported by evidence.<sup>35</sup>

Retail clinics have also been found to provide as good or better care than physician offices, urgent care centers, and EDs on quality indicators for three common conditions (otitis media, pharyngitis, and urinary tract infections), and that the proportion of patients who sought preventative care within three months of a retail clinic visit was higher than those who sought such care at other sites.<sup>36</sup> In addition, as many as 90 percent of U.S. adults who used these clinics have also been found to be very or somewhat satisfied with the quality and cost of the care they received.<sup>37</sup>

The National Committee for Quality Assurance (NCQA) the National Quality Forum and others have developed a handful of outcomes measures—including Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis—that are applicable to both retail clinics and primary care providers.<sup>38</sup> The Minnesota non-profit MN Community Measurement reported performance of primary care

### Insights from the Field

“Clearly there’s a need because they’ve sprung up and they’re filling a gap. Our big concern is the lack of transparency regarding quality; they need to be accountable and they need to be scrutinized to the same extent as other providers. The data should prove that they can provide good quality, for good value, in a way that’s accessible to patients.”

**Doris Peter**

*Director, Health Ratings Center  
Consumer Reports*



providers, including retail clinics, in 2013 and found that MinuteClinic and Target Clinic were ranked amongst the highest performers in at least three measures.<sup>39</sup> More consistent application of quality outcome measurements to retail settings would allow an apples-to-apples comparison of quality relative to other types of providers, and would give consumers and purchasers better information to inform their choices.

### Ownership and Operating Models

The majority of retail clinics are owned by pharmacies and big box retailers,<sup>40</sup> although they operate under a variety of different models. On one end of the spectrum, retailers staff and control the clinic, retain all of its revenue and bear full financial risk for its operations. Retailers also affiliate with regional health systems. Under

these arrangements, sites may be co-branded, with the affiliate health system providing oversight for a medical director, while the retailer remains in control of and at financial risk for clinical operations, profits and losses. Together the affiliate and retailer may develop protocols to support clinical decision-making, and patients may be referred to the affiliate for additional primary and ongoing care. At the other end of the spectrum, the retail sponsor leases space in the store to a health system affiliate that staffs it, assumes control of clinic operations and is at full financial risk.

Retail clinic affiliations with health systems include relationships with a range of organizations from single specialty physician groups to large integrated delivery systems. The six largest retail clinics sponsors represent 93 percent of the total number of clinic sites nationwide.

Retail Clinic	Number of sites	Market Share	Health System Affiliations <sup>41</sup>
CVS MinuteClinic	901	50%	47
Walgreens Healthcare Clinic	437	24%	6
Kroger Little Clinic	140	8%	4
Walmart Retail Clinics	103	6%	46
Target Clinic	80	4%	2
RiteAid RediClinic	30	2%	3

### Insights from the Field

“If a patient has a medical home, and they have a relationship with the primary care setting, and they in turn have an agreement to use the retail setting for maintenance and routine evaluation, and that information will flow back in to the medical home, that creates a shared responsibility. The key is coordination and linkage back to the medical home, and the workforce’s ability to manage long-term health and wellness.”

**Shawn Martin**

*VP of Advocacy and Practice Advancement  
American Academy of Family Physicians*



## Spotlight:

### Heritage Provider Network

The **Heritage Provider Network** (HPN), a geographically diverse physician network in Southern California, is working with 30 Rite Aid pharmacies in a joint services program, supporting HPN's ACO contracts. RiteAid's clinics are offering a range of chronic care management services, including medication-adherence programs, comprehensive medication reviews and reconciliation, nutrition and weight management services, disease education, exercise coaching, and tobacco-cessation programs. Activities target patients with chronic conditions such as congestive heart failure, diabetes, COPD, hypertension, and high cholesterol.

RiteAid is staffing some of its clinic locations with specially trained care coaches to help meet wellness goals and to improve patient engagement and self-management skills. Collaboration is facilitated via an integrated EHR through which HPN physician orders are transmitted electronically to the care coach and pharmacist, and clinic-generated patient summaries are sent to the patient's HPN physician.

## Delivery System Integration: Challenges and Opportunities

For hospitals, providers and insurers, the Triple Aim's focus on patient outcomes, population health and the cost of care has brought into sharp focus the influence of non-clinical factors on patient and population health. While the impact of the social determinants of health—the social and economic factors such as housing, employment and education—and behavioral factors including diet and exercise have been well-documented for decades and shown to drive 80 percent of health outcomes, it is only recently that health care providers and payers have begun to consider their implications.<sup>42,43</sup> As a result, providers are incorporating interventions into clinical settings that address patients' social as well as clinical needs, recognizing that effective management of their patients care and costs requires them to do so,<sup>44</sup> all of which comes into play as we strive to build a Culture of Health. These emerging trends raise both challenges and opportunities for retail clinics.

### Improving Primary Care Access, Care Coordination and Chronic Disease Management

Health systems are responding to this constellation of pressures in a variety of ways, including forming affiliations with retail clinics; more than 100 partnerships between retail clinics and health systems have been established. For retailers, co-branding can bolster their

credential as a trusted health care provider and drive more individuals into their stores. For health systems, it can expand their networks and presence to regions where they have no physical sites, extending their primary care networks to new patient populations and increasing access to after-hours care for existing patients.<sup>45</sup> Retailers often engage health systems to help fulfill physician oversight requirements, which generates additional revenue for the systems. Some delivery systems seeking to improve primary care access and manage total cost of care are using retail clinics to reduce unnecessary ED visits. One study estimated that up to 27 percent of ED visits could be handled appropriately at retail clinics and urgent care centers, offering cost savings of \$4.4 billion per year.<sup>46</sup>

Payers have also begun to integrate retail clinics into networks in efforts to reduce cost. BlueCross BlueShield of Minnesota has created an "aligned incentive" ACO program that now accounts for 40 percent of its network spend. They have developed an ACO-like product with Allina Health Network (AHN) and have "wrapped" AHN's network with other providers, including retail clinics.<sup>47</sup> AHN is accountable for the total cost of care for members attributed to their network, including costs incurred at retail clinics.



## Spotlight:

### Walgreens

In early 2013, **Walgreens** announced it had formed accountable care organizations (ACOs) with three leading physician groups and would be participating in Medicare's Shared Savings Program (MSSP). The ACOs – Advocare Walgreens Well Network in Marlton, N.J.; the Diagnostic Clinic Walgreens Well Network in Largo, Fla.; and the Scott & White Healthcare Walgreens Well Network in Temple, Texas – were designed to deliver personalized pharmacy care and emphasize the physician-pharmacist collaboration.

Walgreens supported the ACOs by providing medication management, quality metrics, expertise and access points through its retail clinics. Medication management gave the ACO an opportunity to interact with the patient far more often than routine doctor appointments, and allowed for better insights into medication data via Medicare Part D claims. In some areas, Walgreens embedded pharmacists as members of an integrated care team to support hospital discharge planning and follow-up.

Walgreens is accountable for meeting the program's quality and cost control targets, with potential to share in any incurred savings that exceed Medicare's shared savings thresholds. In December 2014, Walgreens withdrew from two of its three MSSP ACOs that did not generate financial savings for Medicare.

Source: Atlantic Information Services,  
ACO Business News (ABN), Dec. 24, 2014.  
<http://aishealth.com/archive/nabn0115-03>

Payers and health systems intent on bending the cost curve also recognize that they must manage chronic disease, the treatment of which accounts for more than 75 percent of health care costs in the United States.<sup>48</sup> The increased focus on care coordination and disease management has not been lost on the retail clinic industry. Retailers are increasing their service offerings to include health screenings and chronic care programs:

1. CVS/MinuteClinic supports diabetes management including biometric screenings such as glucose, hemoglobin A1c, blood pressure, weight and foot exams, weight management counseling programs and asthma maintenance therapy education.
2. Walgreens Take Care Clinics include assessment, treatment and management for hypertension, diabetes, high cholesterol, and asthma. Take Care Clinic providers can evaluate, recommend and order preventive health services, such as screenings or lab tests, based on a patient's age, gender and family history.
3. QCare Clinic, a retail clinic operated by the Family Practice and Counseling Network within a

ShopRite grocery in an underserved community in Philadelphia partnered with the Thomas Scattergood Behavioral Health Foundation, the Philadelphia Department of Behavioral Health and Intellectual Disability Services (DBHIDS) and Screening for Mental Health, Inc. to develop a behavioral health screening kiosks placed in the retail clinic waiting area.<sup>49</sup> The kiosk, which was launched in 2014, asks users a series of questions to identify symptoms of common mental health conditions. Patients receive a print-out of results and a follow-up email with referrals to relevant services in the community.

The increased focus on chronic care has resulted in a rise in the percentage of visits for screening and management of chronic conditions at one retail clinic operator from 4 percent in 2007 to 17 percent in 2013.<sup>50</sup> While complex patients require more extensive testing and ongoing management than is available in retail clinic settings, screenings, assessments and ongoing monitoring by retail clinics using clinical protocols can be supportive of chronic care efforts for lower-acuity patients.<sup>51</sup> The use of evidence-based clinical practice

## Spotlight:

### Geisinger Health System

**Geisinger Health System**, based in Danville, Pa. launched Careworks Convenient Healthcare in 2006 inside Weis Markets, a regional chain of supermarkets. Careworks was established to provide low-cost routine primary care services and to act as an extension of Geisinger primary care medical home. Geisinger operates in a largely rural region of Pennsylvania, with large swaths lacking basic primary care access, resulting in congested EDs. Careworks provides seven-day-a-week and after-hours care and has been used to reduce ED visits and provide lower-cost care to less acute patients who could effectively be treated at a Careworks clinic. Geisinger and its Careworks clinics also share the same EHR and have integrated decision support tools to notify clinicians at all Geisinger retail clinic and primary care sites when a mammography, cholesterol screening or other interventions are indicated as needed to meet clinical guidelines and close care gaps. As a result, Geisinger has reduced the strain on their EDs, while establishing 3,000 new patient relationships per year with individuals who previously had no established relationship with a primary care physician.

guidelines embedded in electronic health records can help improve clinical outcomes for patients with chronic conditions, support more judicious use of tests and treatments—including use of generic medications—and help diminish costs and improve adherence to therapy.<sup>52</sup>

Emory Healthcare and MinuteClinic developed hypertension evaluation, treatment and management protocols to use at both Emory and MinuteClinic sites. The protocols include both guidelines to evaluate and treat patients newly diagnosed in the clinic, and guidance to support ongoing management of established patients previously diagnosed at Emory. Medical records and results are electronically exchanged between Emory and the clinic, and care is coordinated with Emory.

Sutter Health in Sacramento integrated Joint National Committee (JNC-8) guidelines for management of high blood pressure into their protocols, and extended them to the Express Care retail clinics they own and operate.<sup>53</sup> The protocols provide guidance on medication management and diet and exercise regimens to Express Care providers to help them adjust patient care according to guidelines, referring them back to the primary care physician when indicated.

### Sharing Information

These programs require close collaboration between the retail clinic and health system provider to adopt and adhere to clinical protocols. They also require robust data-sharing to ensure information is accurate, timely and complete to drive decision support tools. The programs at Sutter and Geisinger have been successfully implemented in part because the health systems operate the retail clinic and use the same EHR. In the Emory-MinuteClinic program, both institutions committed to closely linking their EHRs and adopting consistent protocols. Today, MinuteClinic has linked EHRs with a third of its 45 health systems partners. Some retail clinic-health system partnerships have overcome this obstacle by extending the health system's EHR to the retail clinic site, so that the organizations share the same system.

The challenges of coordinating care and sharing information are also faced by hospitals, physicians, post-acute care and other providers, who are impeded from sharing information by a lack of a robust national health information exchange infrastructure.<sup>54</sup> All members of the Convenient Care Association, a national trade association of retail-based health clinics, operate with EHR systems, compared with 78 percent of physician practices and 59 percent of acute care hospitals.<sup>55,56</sup> While information exchange is key in any coordinated care model, it is particularly important with respect to retail clinics, where care may be provided outside of a patient's primary care medical home.

## Telehealth

Telehealth has the potential to reduce cost and improve both access to care for rural and underserved communities and support treatment of patients with acute and chronic conditions<sup>57</sup> at retail clinics and beyond. Average telehealth costs are \$40 to \$50 compared to \$136 to \$176 for a related in-person visit, while the most common diagnoses made during telehealth visits are sinusitis, cold, flu, pertussis, and urinary tract infections<sup>58</sup>—conditions also frequently treated at retail clinics. Live telehealth consults can be used to extend the scope of consultative, diagnosis and treatment service options by connecting patients and practitioners at the retail clinic “originating site of care” with a remote primary care physician or specialist. This can be particularly useful when cases arrive at the retail clinic that may not be routine, but still can be effectively treated by practitioners with appropriate levels of training.<sup>59</sup>

Medicaid programs in 46 states provide some form of telehealth reimbursement, primarily for live video telehealth consults, though there are some limits.<sup>60</sup> Twenty-one states and the District of Columbia have laws governing telehealth reimbursement policies by commercial carriers.<sup>61</sup> Both Medicaid and private insurers provide coverage for telehealth in retail clinics; Medicare does not.<sup>62</sup> Efforts to expand reimbursement are underway and could extend Medicare payment for telehealth consults in rural communities, including at retail clinics.<sup>63</sup>

**In 2012, 18 states and the District of Columbia allowed nurse practitioners (NPs) to diagnose and treat patients and prescribe medications without a physician’s involvement, while 32 states required physician involvement to diagnose and treat or prescribe medications, or both.**

In Washington, for example, NPs can run practices independently of physicians, while in Alabama, a collaborating physician must be present at an NP’s practice site at least 10 percent of the NP’s scheduled hours, and must visit the site at least once per quarter. In addition to scope-of-practice restrictions, 17 states require multiple bodies (such as nursing and medicine boards) to regulate NPs. All physician assistants must practice under some physician supervision. Eleven states have no limit on the number of PAs a physician can supervise; the remaining have limits as restrictive as 2:1 in Mississippi (the same ratio applies to physician supervision of NPs), to as high as 7:1 in Texas.

### Insights from the Field

“When a patient is seen at MinuteClinic and identifies a UCLA primary care physician, that physician automatically obtains a copy of the patient’s encounter from MinuteClinic directly into the UCLA EHR. This is still a unidirectional flow; however, once we are able to have a bidirectional flow of information, we can start using MinuteClinic as a way of obtaining results and adjusting care by having patients obtain follow-up at MinuteClinic sites. So for our ACO and capitated populations, we would be able to offer MinuteClinic as an alternative to primary care, ED and urgent care visits where appropriate, which should reduce our need to expand other sites of service that may be more expensive.”

**Bernard Katz**

*Medical Director*

UCLA Primary Care and Specialty Care Network

## Workforce

As previously discussed, retail clinics typically employ a workforce of nurse practitioners and physician assistants. NPs' practice are licensed by all 50 states and the District of Columbia; they are trained to provide comprehensive physical examinations, diagnose and treat acute and chronic illnesses, provide immunizations, prescribe and manage medications and other therapies, order and interpret lab tests and x-rays, and provide patient education and supportive counseling. They must also pass a certification exam to be licensed. Physician

assistants are health professionals trained to provide diagnostic, therapeutic, and preventive care services under physician supervision and must pass a national certification exam to become licensed by the state where they practice.

In short, the expertise and training of NPs and PAs is well-suited for retail settings. However, states' varying regulatory and licensure schemes constrain the ability of retail clinics to make full use of these professionals in every state.

## Leveraging the Big Box: Expanding and Bundling Services in and Beyond the Clinic Walls

For consumers, a "big box" retailer offers convenient one-stop shopping for groceries, pharmaceuticals, medical supplies and other goods that could be packaged into a coordinated set of products and services to promote wellness and help manage chronic disease. In short, retail clinics need not be confined to a "doc in a little box," when retailers could leverage assets they have outside of the clinic but within the walls of their stores. Some assets and services that already exist within some retail stores could be bundled with retail clinic services to expand their potential.

### Pharmacy & Food

The pharmacy located in the retail store represents a significant opportunity to support better patient engagement and management. Pharmacists and nurses are among the most trusted professions, and studies have shown that incorporating pharmacists into chronic disease medication counseling programs significantly improves patient outcomes.<sup>64,65</sup> Integrating pharmacists into the retail care team presents opportunities to help manage complex poly-pharmacy regimens. When these regimens are left unmanaged, they have often been associated with an increased risk of taking inappropriate medications and unnecessary medical and hospitalization utilization and expenditures.<sup>66,67</sup> Payers can also use their access to medication history—with the appropriate patient consents—to support pharmacists, thereby enabling medication management at the pharmacy site.

CVS launched the Pharmacy Advisor program in 2011 to interested employers who contract with CVS/Caremark for pharmacy benefit management (PBM) services. The

program delivers messages to both mail-order and retail pharmacists about patients' medication adherence; pharmacists then pass that information along to both patients and their physicians. Pharmacists counsel patients about initiating recommended therapies, and offer to discuss regimens with their doctors. Patients receiving new medications are counseled at the time of their first fill, while pharmacists follow-up via phone with patients late in refilling a medication. One review found new medication therapy initiation rates for patients with diabetes increase by as much as 68 percent when retail pharmacists counsel patients in person, while medication adherence rates increase by 3.9 percent. Researchers estimated the total financial value to the employer in the study to be more than \$600,000 in cost avoidance, representing a tri-fold return on investment.<sup>68</sup> The program aligns CVS's PBM and pharmacy dispensing business, offering the above benefits to employers, while increasing appropriate medication use for patients and increasing dispensing fees and revenues from medication sales to the retail pharmacy.

Walgreens created WellTransitions, a pharmacotherapy management program to help reduce readmissions and medication-related complications. The program supports medication management for patients admitted to hospitals and includes bedside delivery of medications, patient consultation and discharge instructions. It also includes post-discharge pharmacist education and follow-up, clinical therapy review, analytics and outcomes reporting. Walgreens reported that WellTransition patients were 46 percent less likely to experience an unplanned readmission within 30 days

of discharge than a comparison group.<sup>69</sup> The program can benefit patients by reducing adverse medication and hospitalization events and potentially can reduce hospital readmission payment penalties.

RediClinic is leveraging the assets of the H-E-B grocery stores in which they are located through its “Weigh Forward” 10-week comprehensive medically supervised weight and lifestyle management program. The program includes physicals, nutrition programs tailored for diabetes and other restricted diets, pedometers and exercise routines. The clinic also provides patients with grocery lists, to direct them toward healthy food purchases within the store. Program results produced average weight loss of one to two pounds per week, while patients diagnosed as hypertensive decreased by 62 percent.<sup>70</sup>

The sponsors of Weigh Forward noted challenges in securing reimbursement from insurers without compelling evidence of clinical and economic returns. With the ACA requiring first-dollar coverage of obesity screening and counseling, the business case for employers and payers may ultimately materialize. In 2011, Medicare began reimbursing intensive behavioral therapy for obesity for Part A or B beneficiaries, using U.S. Preventive Services Task Force guidelines. However, Medicare will only reimburse for services provided by primary care practitioners in primary care settings.

These and other programs point to numerous potential opportunities to be explored and that could be more tightly coupled with retail clinic services. Retailers could package “kits” for patients with diabetes that include medical supplies found on their shelves, weight-loss, exercise and cookbooks and guided shopping to help make healthier and more informed choices. The success of building and delivering these programs may in large

part be determined by the willingness of payers and consumers to pay for them.

## Public Health

Approximately 50,000 adults die annually from vaccine-preventable diseases in the United States. With low rates of adult and adolescent vaccination, retail pharmacies and the on-site clinics can support education efforts, expand convenient access to vaccines, and reduce vaccine-preventable illness and death.<sup>71</sup>

Before the swine flu (H1N1) pandemic of 2009, few pharmacists administered flu vaccines.<sup>72</sup> By 2013, more than 200,000 pharmacists, or approximately 70 percent of the workforce, have been trained to administer vaccines, while all 50 states, District of Columbia, and Puerto Rico authorize pharmacists to administer vaccines at some level.<sup>73,74</sup> Nearly one in five adults now receive a vaccination in a pharmacy or retail store, second only to a doctor’s office, and 10 times the number of vaccines administered in public health departments.<sup>75</sup>

Retailers have leveraged their broad geographic footprint and workforce to support public health vaccination programs. Walgreens collaborated with the Alaska Department of Health and Human Services (DHHS) on a diphtheria, tetanus and pertussis (DTaP) vaccination voucher program in response to increased pertussis cases in the state. Vouchers were made available on the Alaska DHHS website for download and could be redeemed for any individual age 10 or older at specified store locations.<sup>76</sup> CVS and Direct Relief are providing \$1 million in flu shot vouchers, redeemable at any CVS/pharmacy or MinuteClinic location, to patients in underserved communities who lack health insurance.<sup>77</sup> Walmart is working with local health departments in Albany to administer flu clinics at its stores.<sup>78</sup>

## Insights from the Field

“As a payer, there’s always a worry when you agree to pay for something new that you will just pay for something the providers are already doing. Pharmacy dispensing fees should cover some level of counseling and education to the individual. Where does that line get drawn and cross over into moving above and beyond to spend time with someone to provide more robust medication management? Thus far, we haven’t seen anyone present us with a compelling, well defined approach.”

**Tony Keck**

*Former South Carolina Medicaid Director*

The Federal Emergency Management System's National Response Framework calls for the creation of distribution points for mass dispensation of vaccines and prophylactic medications in response to natural or man-made disaster events.<sup>79</sup> The broad distribution of retailers and retail pharmacies make them well-suited to support such emergency response initiatives. CVS/MinuteClinic

supported Moore, Okla. after a devastating tornado in 2013 and New York residents after Hurricane Sandy, providing examples of how public health and retailers can work together to support disaster relief.<sup>80</sup> It also suggests that a more intentioned and synchronized emergency response that includes retailers and clinics could further improve public safety.

## Leveraging the Big Box: Exploiting the Foot Traffic

Retail clinics offer an access point for basic primary and preventive care, and in partnership with health care systems and government agencies, may extend their reach to chronic care management and public health initiatives. In addition, opportunities may exist to leverage services and assets within many retail stores to further advance their value proposition. In this section, we examine how additional services may be added to retail stores with clinics that further support a Culture of Health that appeal and are directed towards the large volumes of shoppers retailers attract.

Retail pharmacies, grocery stores and big box retailers have astonishing volumes of foot traffic. Walmart alone serves more than 140 million customers in the United States each week.<sup>81</sup> Across the United States, the top 25 pharmacy chain stores represent about 28,000 pharmacy locations.<sup>82</sup> One of the nation's largest pharmacies, Walgreens reports that approximately 6.3 million customers visit its stores on a daily basis and that two-thirds of Americans live within three miles of a Walgreens pharmacy.<sup>83</sup> Given the volume and demographic composition of people served by big box retailers and their geographic distribution, these stores could be used to help target and enroll lower-income populations in a range of programs that address underlying social determinants.

### Improving Access to Public and Private Health Insurance

Lack of health insurance contributes to a person's state of health and has been shown to account for as much as one-fifth of population health outcomes.<sup>84,85</sup> Since passage of the ACA, more than 20 million individuals have gained access to public and private insurance. Millions more Americans are eligible but remain uninsured in large part because they are unaware of the opportunity.<sup>86</sup> One study in 2014 found that an astonishing nine out of 10 potentially eligible uninsured adults were unaware that

public marketplace enrollment opened in November, and more than half were unaware that the ACA offers financial incentives to help them purchase insurance.<sup>87</sup> Federal and state governments, along with consumer organizations, are going to great lengths to reach out, educate and offer personal enrollment assistance to individuals, targeting high-traffic settings, including athletic events, music venues and states fairs.<sup>88</sup> Big-box retail stores, especially those with embedded clinics, hold the potential to support these efforts.

CVS and Enroll America launched a partnership in conjunction with CVS's Project Health wellness program, bringing free in-store health screenings to communities with the goal of promoting wellness and disease prevention. In addition to free screenings conducted by medical professionals, body mass index measurements and glucose, blood pressure and cholesterol checks, Enroll America staff and volunteers informed consumers about new health coverage options and financial help available to pay for coverage. One hundred and thirty Project Health events in 10 markets were staffed around the country, reaching more than 11,000 consumers, 82 percent of whom said they were likely to enroll during the open enrollment period.<sup>89</sup> CVS continued to provide free screenings and one-on-one consultation with health care and insurance professionals at select stores in late 2014 during open enrollment.<sup>90</sup>

In 2014, Walmart launched Healthcare Begins Here to educate customers on health insurance options and provide them with enrollment assistance through a partnership with DirectHealth.com. Walmart created a set of simple tools in multiple languages to educate customers about Medicaid, Medicare and subsidized/private insurance options.

DirectHealth.com developed a retail exchange portal with health plan options, leased store space and placed agents in 2,700 stores to help answer customers'



questions and enroll them either online or by phone.<sup>91</sup> In addition, Walmart implemented its first national health fair in 2,000 stores and provided more than 109,000 blood pressure and glucose screenings and 26,000 immunizations in a single day.<sup>92</sup>

### Addressing Other Economic and Social Needs

The social determinants of health go well beyond having or not having health insurance and include factors such as economic well-being, food security and safe and affordable housing. Programs such as the federal Supplemental Nutrition Assistance Program (SNAP) and the Earned Income Tax Credit seek to address these needs but, like health insurance, many who are eligible and in need do not take advantage of them. Reaching target populations and enrolling them in public programs has historically proven to be a challenge; nearly 12 million people, or one of out every three individuals, who were eligible for and needed SNAP did not receive benefits, while one analysis estimated that at least \$65 billion in government services and support including SNAP remain unclaimed.<sup>93,94</sup> Again, the location of big box stores and their high volume of foot traffic suggest they may have a larger role to play in the health of their communities.

Some government agencies and non-profit organizations have begun to confront this challenge by streamlining application processes for public benefit programs, and setting up outreach stations in non-traditional venues, such as shopping malls and other locations with high-volume foot traffic. Evidence from these efforts shows promising results, with more families gaining and maintaining access to critical benefits.<sup>95</sup>

In San Antonio, the grocer H-E-B has collaborated with the Texas Health and Human Services Commission to create outreach stations, placing food bank workers in select stores to enroll eligible customers in SNAP. Food bank workers complete approximately 1,500 applications a month for people seeking various types of federal assistance, primarily SNAP.<sup>96</sup> H-E-B is also partnering with the American Diabetes Association to deliver in-store nutrition service programs. These programs employ registered dietitians and nutritionists to provide affordable nutrition education and care, private one-on-one consultations, grocery shopping tours, cooking demonstrations, group health classes, kids' cooking classes, "lunch and learn" sessions, and disease management classes. Customers eligible for SNAP and WIC will be offered a discount on some services within the program.<sup>97</sup> Walmart has also partnered with organizations, including Virginia Cooperative Extension, to provide nutrition information and assistance in determining eligibility for SNAP to Walmart customers.<sup>98</sup>

Collaborations between retailer clinics, non-profits and government agencies to deliver a broader range of services could yield additional benefit to retailers in the form of increased spending by customers, increased foot traffic, brand loyalty, and attainment of philanthropic goals. Interventions linking patients to local resources that can address their unmet social needs have been deployed in other health care settings with some success. The nonprofit Health Leads operates in community health centers, helping health care providers write prescriptions for their patients' basic needs such as food and heat.<sup>99</sup> Medical-legal partnerships connecting patients to resources to

### Insights from the Field

"Retail clinics should be thinking more broadly, beyond just health insurance, to contribute to the development of a single point of online registration for a full range of federal benefits. They could also provide wellness and nutrition counseling to ensure that additional dollars that are freed up through accessing additional public benefits are spent in ways that support health, and not in the potato chip aisle, so to speak. Retail clinics need that rung of chronic care management and educational services to ensure patients are supported in making healthy choices."

**Sarah Di Troia**  
Chief Operating Officer  
Health Leads

address legal issues linked to health status have been established across the country in a variety of health settings. One program targeting patients with moderate to severe asthma found a 91 percent decline in ED visits and hospital admissions among those receiving housing services.<sup>100</sup> And SingleStop, which operates in more than 90 sites in seven states and connects families with services and benefits including insurance food, financial, legal and tax preparation helped 156,821 families access more than \$470 million in such benefits in 2012.<sup>101</sup>

These examples suggest the potential of clinics to help connect millions of low-income families and individuals who shop at retail stores to federal, state and non-profit resources and benefits. It also helps put money in the pockets of consumers—money that can be spent on food, prescription medications and other necessities. The business rationale for the retailers may ultimately determine the extent to which relationships are established that make these benefits and services available in and around retail clinics.

## Optimizing the Value Proposition of Retail Clinics

---

The value of retail clinics rests both on the accessibility of the services offered by the clinic, as well as the range of services offered by the retail establishment beyond the clinic walls. There is little doubt that the retail clinics themselves are important low-cost access points for routine care. That value is enhanced when clinics establish relationships and coordinate care with area health systems and compounded further when clinic services are coupled with other retail services—offered by the in-store pharmacy or available in the food aisles. Finally, new services that could be added that exploit the store's foot traffic and contribute to the health of the community could expand the value equation to encompass social determinants of health.

Ultimately, retail clinics are health care businesses that make decisions based on factors including cost, revenue and profit. Retailers with clinics, on the other hand, are businesses whose core mission is broader and not limited to health care. They compete with each other on price, value, convenience and diversity of product choices. Some retailers with clinics respond to these pressures by supporting business practices that appear inconsistent with their role as providers—limiting employee health benefits, or selling tobacco products while offering smoking cessation programs in the same aisle. Though this is certainly true and maybe even a bit ironic, it does not change the overall value proposition of retail clinics. And in at least one case, a retailer has changed its model and in the process come up with a creative business rationale for ending tobacco sales.

In February 2014, CVS ended tobacco sales, estimating it will forego \$2 billion in annual tobacco revenue.<sup>102</sup> CVS simultaneously launched a new smoking cessation program, training pharmacists and MinuteClinic practitioners in nicotine-dependence assessments,

individualized smoking cessation plans, and over-the-counter and prescription nicotine-replacement recommendations.<sup>103</sup> CVS subsequently announced plans for Caremark, which manages pharmacy benefits for health plans, to require some of its customers to make additional co-payments for prescriptions filled at pharmacies selling tobacco products.<sup>104</sup> As a result, pharmacies that sell tobacco products will be at a competitive disadvantage, as patients electing to use them will experience increased out-of-pocket costs. The alignment of incentives has convinced at least one payer, the City of Philadelphia, to participate in the Preferred Health Network, a pharmacy network consisting of more than 100 independent pharmacies and three pharmacy chains that prohibit tobacco sales. The City will add \$500 in premium costs for some employees who use tobacco products and an additional \$15 copay for employees who fill prescriptions at pharmacies that sell tobacco.

### Recommendations

With big box retailers expanding into the health care market, it is an opportune time to consider the role they might play not only in addressing the basic clinical needs of their customers, but also the social needs which influence patient and population health. Open long hours, seven days a week, retail clinics provide a convenient source of basic primary and preventive care, with some opportunity for chronic care management and better coordination with regional health systems. The retail setting provides additional opportunities related to its on-site pharmacy, food and other assets it carries that can be bundled into more comprehensive health offerings. Further opportunities exist to leverage the foot traffic to add services—not yet widely available in these settings—that can meaningfully contribute to a culture of health.

At the same time, retail clinic reach is limited by scope-of-practice rules that constrain services in many states, sporadic connections to the larger health care system, and their prevalence in urban, affluent communities. In this regard, there may remain some tension between retailers' business case for locating clinics in stores in more affluent urban areas and the important role of retail clinics as access points for lower-income and uninsured and underinsured consumers. Likewise, the business model of the retail store may constrain its ability to or interest in offering more extensive social and economic outreach efforts.

**Below are a set of strategic, interdependent recommendations to optimize the value proposition of retail clinics in delivering health care to individuals and enabling the health of communities.**

- 1. Integrating into the Delivery System.** With the increasing emphasis on accountable whole person care built on a patient centered medical home, the question inevitably arises about the value of intermittent care offered at retail clinics. Do these clinics support or undermine the goal of integrated or coordinated care? Perhaps that is not even the right question. The evidence shows that retail clinics offering convenient and at times essential access points are popular with consumers. Thus, we would suggest that the challenge for these clinics and the health care system at large is to find ways to link up. The linkage can be achieved through formal partnerships supported by shared clinical protocols, integrated IT systems with decision support prompts. Integration is not just desirable but essential if retail clinics are to support consumers with chronic or behavioral health needs or to provide even routine care to children.
- 2. Providing and Measuring the Quality of the Care.** The proliferation of retail clinics and their potential integration into emerging health care delivery models inevitably raises the question of the quality of care they provide. Evidence suggests that retail clinics improve access to routine care for some populations and that the quality of that care, as measured by a series of nationally recognized process measures, is good.<sup>105</sup> However, the quality of care at retail clinics is neither routinely measured nor publicly reported.<sup>106</sup> Policymakers, philanthropic organizations and other stakeholders should stimulate the application and reporting of both process and clinical outcome

measures with respect to the care retail clinics provide. In addition, it would be important to use and develop standardized metrics specifically relevant to retail clinics, including care coordination measures that assess the handoff of information from and to referring providers and outcome and medication reconciliation measures, such as those required for eligible providers in the federal Meaningful Use program.<sup>107</sup> Whether retail clinics provide standalone or more integrated care, their increasing role in the nation's health care system warrants more systematic attention to the quality of the care they deliver.

- 3. Improving Access in Underserved Communities.** While retail clinics do operate in some underserved and rural communities—20 percent of MinuteClinics operate in rural areas—there remain large pockets of communities not served by retail clinics or other primary care providers. This recommendation is particularly challenging, as there is little doubt that the availability of retail clinics in medically underserved communities would be beneficial. But for the same reasons health care providers do not locate in these communities, retailers are likewise reluctant to open clinics there. Perhaps the nature of retail clinics—inside large retailers—suggests a solution. An initiative in Howard Park in Northwest Baltimore is worth examining. The Reimbursement Fund, a neighborhood revitalization financing organization, and City First Bank provided tax credit financing to open a 67,000-square-foot ShopRite grocery store. The new supermarket, the first in the area since 1999, will offer fresh food choices, participate in SNAP and WIC, and will also house a 1,000-square-foot health clinic and pharmacy in partnership with UpLift Solutions, a national non-profit.<sup>108</sup> To the extent retailers and retail clinics can contribute to economic development and help improve access to primary care, municipalities, state governments and others should explore public-private partnership opportunities and financing and tax credit options to open sites in underserved areas.
- 4. Providing Services to Young Children.** Some states pose limits on the provision of services retail clinics can provide to children. With respect to infants under 18-months of age, there is generally consensus that such restrictions are appropriate, though the American Academy of Pediatrics emphasizes that retail clinics are an inappropriate source of primary care for infants, children, and adolescents.<sup>109</sup> Evidence however suggests that most pediatric primary care



services can be safely and effectively provided by nurse practitioners.<sup>110</sup> Many states have taken a balanced approach and allow retail clinics to provide care to patients over 18-months of age. All states should consider permitting retail clinics to provide basic services to such children. In return, states should require retailers to coordinate care with other primary care and specialty providers and support vaccine reporting efforts to public registries. States must do their part and ensure their registries support federal Meaningful Use reporting standards.

- 5. Workforce.** The retail clinic workforce is both its strength and Achilles heel. While nurse practitioners and physician assistants have been shown to deliver safe and efficient routine primary care services,<sup>111</sup> variable state scope-of-practice rules for NPs and PAs pose a barrier for retail clinics, as well as a source of enormous debate for policy makers across the country. The value of retail clinics ultimately cannot be fully realized as long as states maintain restrictive rules that prevent NPs and PAs from practicing to the full extent of their license and training. The issue of state scope-of-practice laws with respect to NPs and PAs is a significant one and beyond the scope of this paper. However, it is important to reiterate that until this issue is resolved and— better yet— uniform standards developed that fully recognize the training and expertise of NPs and PAs, many state scope-of-practice laws will continue to impede the development of retail clinics and a greater realization of their potential.
- 6. Telehealth.** Expanding capacity, scope and training opportunities for retail clinics could be supported through the use of telehealth services. State laws, however, often limit both the types of providers allowed to use and be reimbursed for telehealth services, and the ability to use providers who are licensed to practice medicine in other states. Medicare meanwhile only covers reimbursement for telehealth in limited settings, and never in retail clinics. All payers should be encouraged to cover telehealth in retail settings consistent with the expertise and training of the clinicians practicing in those settings.
- 7. Supporting Public Health Initiatives.** In researching this paper, we were struck by the significant role retailers—through their clinics and pharmacies—have come to play in administering vaccines, serving nearly

one in five adults. Retailers, likewise, have a critical role to play in ensuring pharmaceutical and primary care access during natural disasters. Targeted opportunities to integrate retail clinics and pharmacies into public health efforts—whether routine vaccination efforts or emergency response initiatives—should be explored, considering available reimbursement streams for specified services, training, and linkages with more robust state vaccine reporting systems.

- 8. Broadening and Bundling Services.** Retail clinics are important access points for routine acute and preventative primary care. Retail assets, including the pharmacy and pharmacist, food and other health products, can be bundled with clinic services to further enhance the value of the retail clinic. The challenge is twofold: demonstrating the economic and clinical value of the bundled services and finding willing payers. Certain types of lifestyle and obesity management services may be reimbursable under Medicare or Medicaid. Notably, with ACA-mandated coverage for some preventive services such as obesity screening and counseling programs,<sup>112</sup> there may be additional opportunities for retailers. Studies of the efficacy of delivering more comprehensive bundled service programs in retail settings should be conducted and results published to clearly define the business case.
- 9. Giving New Meaning to One-Stop Shopping.** There are additional services that can be offered in retail settings that take advantage of the foot traffic they generate to expand access to coverage and other programs that contribute to health and address social determinants of health. These include health insurance, food security and housing among others. Remarkably, only 5 percent of low-income working families with children receive the full package of supports for which they qualify, including SNAP, child care and Medicaid.<sup>113</sup> Some of the consumers using these retail establishments would benefit from on-site assistance with accessing these supports. Some retailers have moved into this space in a limited way, most notably with respect to assistance with accessing health insurance coverage. This is a role that merits additional research to determine the business case for the retailer, the role that the clinic may play, the social value for the community and the retailer, and sustainability overall.



## Conclusion

---

Retail clinics are now a part of the health care landscape in every state and in many communities, offering convenient weekend and after-hours care for basic primary care, including immunizations. Retail clinics have demonstrated that their value proposition in a Culture of Health is convenient, low-cost, transparent and accessible primary care and retailers are seeking ways to further exploit the assets of the retail environment and the large volumes of customers they serve to expand access to other health-related services. Additional research is warranted in a number of areas to examine the expanded role they can play in supporting public health initiatives, the benefits of tightly coupling and bundling services that better leverage retailer assets, and how stronger ties to a range of services not widely accessible through retailers that address underlying social determinants of health can be created and sustained.

There are two key determinants of the long-term impact of retail clinics; their ability to integrate with the health care system at large, and economics. Retail clinics' ability to effectively coordinate care with other health system partners and engage payers to reimburse for a more expansive set of integrated services will largely determine the greater role retail clinics and their sponsoring retailers play in our health care system. Retail clinics are businesses operating on thin margins, and like any other low-margin business, they must pay close attention to reimbursement for the services they provide and the direct and indirect revenue they generate for the retailer. And while retailers, health systems and payers recognize the impact of social determinants on health outcomes, most have not yet embraced initiatives that help improve population access to in-store offerings and public programs that address their non-clinical needs. These are weighty challenges; if retail clinics overcome them, they have the potential to become a much more powerful enabler of a Culture of Health.

## Appendix A—Advisory Committee Members

---

**Thom Atkins**

*Medical Director*  
Sutter Express Care

**Ken Berndt**

*Former CEO*  
Geisinger Careworks

**Web Golinkin**

*CEO*  
RediClinic

**Bernard Katz**

*Medical Director*  
UCLA Primary Care and  
Specialty Care Network

**Tony Keck**

*Former Medicaid Director*  
South Carolina

**Scott Keefer**

**Vice President**  
Blue Cross Blue Shield of Minnesota

**Jennifer LaPerre**

*Senior Director*  
Walmart

**Doris Peter**

*Director*  
Consumers Union

**Andrew Sussman**

*President*  
MinuteClinic

## Appendix B—Interviewees

---

**Thom Atkins**

*Medical Director*  
Sutter Express Care

**Ken Berndt**

*Former CEO*  
Geisinger CareWorks

**Ethan Berke**

*Associate Professor*  
Dartmouth Institute

**Sarah DiTroia**

*COO*  
HealthLeads

**Denise Egan**

State of Massachusetts

**Web Golinkin**

*CEO*  
RediClinic

**Eric Hoag**

Blue Cross Blue Shield  
of Minnesota

**Bernard Katz**

*Medical Director*  
UCLA Primary Care and  
Specialty Care Network

**Tony Keck**

*Former Medicaid Director*  
South Carolina

**Scott Keefer**

*Vice President*  
Blue Cross Blue Shield  
of Minnesota

**Jennifer LaPerre**

*Senior Director*  
Walmart

**Nancy LeMond**

*Executive Vice President*  
AARP

**Shawn Martin**

*Vice President*  
American Academy of  
Family Physicians

**Rebecca Onie**

*CEO*  
Health Leads

**Doris Peter**

*Director*  
Consumers Union

**Mary Kate Scott**

*Founder*  
Scott & Company

**William Sage**

*James R. Dougherty*  
*Chair for Faculty Excellence*  
University of Texas at Austin

**Andrew Sussman**

*President*  
MinuteClinic

**Marcus Thygeson**

*Chief Health Officer*  
Blue Shield of California

# Endnotes

1. <http://www.rwjf.org/en/about-rwjf/annual-reports/presidents-message-2014.html>.
2. Thygeson M, Vorst KAV, Maciosek MV, Solberg L. Use And Costs Of Care In Retail Clinics Versus Traditional Care Sites. *Health Aff.* 2008 Sep 1;27(5):1283–92.
3. Retail Health Clinics & Urgent Care Centers Poised For Strong Growth—Market Worth \$10 billion]. PRWeb. [cited 2014 Dec 4]. Available from: <http://www.prweb.com/releases/2012/9/prweb9931728.htm>
4. Robin M. Weinick, Rachel M. Burns and Ateev Mehrotra, Many Emergency Department Visits Could Be Managed At Urgent Care Centers And Retail Clinics, *Health Affairs*, 29, no.9 (2010):1630-1636
5. Thygeson M, Vorst KAV, Maciosek MV, Solberg L. Use And Costs Of Care In Retail Clinics Versus Traditional Care Sites. *Health Aff.* 2008 Sep 1;27(5):1283–92.
6. Retail Health Clinics & Urgent Care Centers Poised For Strong Growth—Market Worth \$10 billion]. PRWeb. [cited 2014 Dec 4]. Available from: <http://www.prweb.com/releases/2012/9/prweb9931728.htm>
7. Retail Clinic Counts Will Double Between 2012 and 2015 and Save \$800 Million Dollars per Year. Accenture; 2014. <http://www.accenture.com/SiteCollectionDocuments/PDF/Accenture-Retail-Medical-Clinics-From-Foe-to-Friend.pdf>
8. Stephen Petterson et al., Projecting US Primary Care Physician Workforce Needs: 2010-2025, *Annals of Family Medicine*, Vol 10, No 6, November/December 2012.
9. Levy J. U.S. Uninsured Rate Sinks to 12.9%. Gallup. January 7, 2015. <http://www.gallup.com/poll/180425/uninsured-rate-sinks.aspx>
10. Berwick, Donald M., Thomas W. Nolan, and John Whittington. 2008. "The Triple Aim: Care, Health, And Cost." *Health Affairs* 27 (3): 759–69. doi:10.1377/hlthaff.27.3.759.
11. "Building a Culture of Health." 2014 President's Message Robert Wood Johnson Foundation.
12. Thygeson et. al. 2008
13. Retail Health Clinics & Urgent Care Centers Poised For Strong Growth—Market Worth \$10 billion. PRWeb. <http://www.prweb.com/releases/2012/9/prweb9931728.htm>
14. Deale S. Retail Clinics: Retailers Leveraging In-Store Services I InStore Trends. <http://www.instoretrends.com/index.php/2012/04/11/retail-clinics-retailers-leveraging-in-store-services>
15. Stine T. Convenient Care Clinics: An Innovative Business Model that Broadens Primary Care Accessibility. *Philadelphia Social Innovations Journal*. 2011 [http://www.philasocialinnovations.org/site/index.php?option=com\\_content&id=352%3Aconvenient-care-clinics-an-innovative-business-model-that-broadens-primary-care-accessibility-&Itemid=35&limitstart=2](http://www.philasocialinnovations.org/site/index.php?option=com_content&id=352%3Aconvenient-care-clinics-an-innovative-business-model-that-broadens-primary-care-accessibility-&Itemid=35&limitstart=2)
16. What's the Difference between Urgent Care and Retail Clinics? West Valley Urgent Care. <http://westvalleyurgentcare.com/whats-difference-urgent-care-retail-clinics>
17. Zamosky L. What retail clinic growth can teach physicians about patient demand. *Medical Economics*. 2014. <http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/cvs-caremark/what-retail-clinic-growth-can-teach-physicians-about-pat?page=full>
18. Monthly Newsletter: Walk-in Quick Stats. Merchant Medicine. <http://www.merchantmedicine.com/CMSModules/Newsletters/CMSPages/GetNewsletterIssue.aspx?issueGuid=9799be71-1cdf-4ca7-90a9-ac42284ca194>
19. FastStats - Physician office visits. CDC. <http://www.cdc.gov/nchs/fastats/physician-visits.htm>
20. Ha T. Tu and Elyn R. Boukus, Despite Rapid Growth, Retail Clinic Use Remains Modest, Center for Studying Health System Change, Research Brief, No 29, November 2013
21. Rudavsky, Rena, Craig Evan Pollack, and Ateev Mehrotra, "The Geographic Distribution, Ownership, Prices, and Scope of Practice at Retail Clinics," *Annals of Internal Medicine*, Vol. 151, No. 5 (Sept. 1, 2009). More recent publicly available information was not available at the time of publication.
22. Rena Rudavsky and Ateev Mehrotra, The SocioDemographic Characteristics of the Communities Served by Retail Clinics, *J Am Board Fam Med*. 2010 Jan–Feb; 23(1): 42–48.
23. <http://content.healthaffairs.org/content/31/9/2123.full>
24. Pollack, Craig E., and Katrina Armstrong, "The Geographic Accessibility of Retail Clinics for Underserved Populations," *Archives of Internal Medicine*, Vol. 169, No. 10 (May 25, 2009).
25. Health Care on Aisle 7: The Growing Phenomenon of Retail Clinics, 2010, [http://www.rand.org/content/dam/rand/pubs/research\\_briefs/2010/RAND\\_RB9491-1.pdf](http://www.rand.org/content/dam/rand/pubs/research_briefs/2010/RAND_RB9491-1.pdf)
26. Ha T. Tu and Genna R. Cohen, Checking Up in Retail-Based Health Clinics: Is the Boom Ending?, Center for Studying Health System Change, December 2008
27. Ha T. Tu and Elyn R. Boukus, Despite Rapid Growth, Retail Clinic Use Remains Modest, Center for Studying Health System Change, Research Brief, No 29, November 2013
28. William M. Sage, Out of the Box: The Future of Retail Medical Clinics, *Harvard Law and Policy Review* online, Vol 3., Feb 2, 2009
29. Ateev Mehrotra et al., The Costs and Quality of Care for Three Common Illnesses at Retail Clinics as Compared to Other Medical Settings, *Ann Intern Med*. 2009 September 1; 151(5): 321–328. Cost of care for patients diagnosed with one of three common conditions (otitis media, pharyngitis, and urinary tract infection)
30. Thygeson et. al. 2008
31. Andrew Sussman, MD, Lisette Dunham, MSPH, Kristen Snower, MBA, Min Hu, MPH, Olga S. Matlin, PhD, William H. Shrank, MD, Niteesh K. Choudhry, MD, PhD, and Troyen Brennan, MD. 2013. "Retail Clinic Utilization Associated With Lower Total Cost of Care I Page." *American Journal of Managed Care* 19 (4): e148–57
32. Ashwood JS, Gaynor M, Setodji CM, Reid RO, Weber EA, Mehrotra A. Estimating the impact of retail clinics on health care utilization and spending. Paper presented at: AcademyHealth Annual Research Meeting; June 25, 2012; Baltimore, MD.
33. Jason Hwang and Ateev Mehrotra, Why Retail Clinics Failed to Transform Health Care, *Harvard Business Review*, December 25, 2013
34. Consumer Reports. 2013. "Generic Drug Prices I How Drug Costs Compare - Consumer Reports," May. <http://www.consumerreports.org/cro/magazine/2013/05/same-generic-drug-many-prices/index.htm>
35. J.D. Woodburn, Smith K,L., and Nelson G.D., Quality of care in the retail health care setting using national clinical guidelines for acute pharyngitis, *Am J Med Qual*. 2007 Nov–Dec;22(6):457–62.
36. Mehrotra, Ateev, Hangsheng Liu, John Adams, Margaret C. Wang, Judith Lave, N. Marcus Thygeson, Leif I Solberg, and Elizabeth A. McGlynn. 2009. "The Costs and Quality of Care for Three Common Illnesses at Retail Clinics as Compared to Other Medical Settings." *Annals of Internal Medicine* 151 (5): 321–28.
37. Wall Street Journal/Harris Interactive Study, 2008: <http://www.harrisinteractive.com/NewsRoom/PressReleases/tabid/446/ctl/ReadCustom%20Default/mid/1506/ArticleId/333/Default.aspx>

38. The National Committee for Quality Assurance, accessed January 8, 2015: <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014.aspx>
39. MN Community Measurement, 2013 Health Care Quality Report
40. Kaissi, Amer and Tom Charland, The Evolution of Retail Clinics in the United States, 2006-2012, *Health Care Manager*. 32(4):336-342, October/December 2013.
41. Source: Manatt Analysis of Publicly Available Data including: (1) Walgreens.com; Accessed December 4: <http://www.walgreens.com/topic/healthcare-clinic/clinical-affiliations.jsp>. (2) The Little Clinic; Accessed December 4: <http://www.thelittleclinic.com/who-we-are/Pages/Affiliations.aspx>. (3) Walmart retail clinics include 16 primary care locations Walmart launch in 2014 [http://i.walmart.com/i/if/hmp/fusion/Clinic\\_Locations.pdf](http://i.walmart.com/i/if/hmp/fusion/Clinic_Locations.pdf). (4) RediClinic.com. Accessed December 4. <http://www.rediclinic.com/careers/faqs/>
42. County Health Rankings & Roadmaps, Building a Culture of Health, County by County, accessed February 12, 2015, <http://www.countyhealthrankings.org/our-approach>
43. Deborah Bachrach et al., *Addressing Patients Social Needs: An Emerging Business Case for Provider Investment*, Commonwealth Fund, May 2014.
44. Id.
45. Craig E. Pollack, Courtney Gidengil and Ateev Mehrotra, The Growth Of Retail Clinics And The Medical Home: Two Trends In Concert Or In Conflict?, *Health Affairs*, 29, no.5 (2010):998-1003
46. Robin M. Weinick, Rachel M. Burns and Ateev Mehrotra, Many Emergency Department Visits Could Be Managed At Urgent Care Centers And Retail Clinics, *Health Affairs*, 29, no.9 (2010):1630-1636
47. Heather Punke. 2012. "Allina Health, BCBS of Minnesota Launch ACO-Like Health Plan." *Becker's Hospital Review*. September 12. <http://www.beckershospitalreview.com/hospital-physician-relationships/allina-health-bcbs-of-minnesota-launch-aco-like-health-plan.html>
48. Chronic Disease - At A Glance. Accessed December 4, 2014. Centers for Disease Control: <http://www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm>
49. Sapatkin, Don. 2014. "Newest Supermarket Service: Mental Health Screenings." *Philly.com*. Accessed December 4. [http://articles.philly.com/2014-08-06/news/52476362\\_1\\_mental-health-issues-health-clinic-kiosk](http://articles.philly.com/2014-08-06/news/52476362_1_mental-health-issues-health-clinic-kiosk)
50. Walgreens press release, July 17, 2014, [http://news.walgreens.com/article\\_display.cfm?article\\_id=5882](http://news.walgreens.com/article_display.cfm?article_id=5882)
51. Robin M. Weinick et al., Policy Implications of the Use of Retail Clinics, RAND, 2010
52. Shrank WH, Hoang T, Ettner SL, et al. The implications of choice: prescribing generic or preferred pharmaceuticals improves medication adherence for chronic conditions. *Arch Intern Med*. 2006;166(3): 332-337
53. James PA, Oparil S, Carter BL, and et al. 2014. "2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report from the Panel Members Appointed to the Eighth Joint National Committee (jnc 8)." *JAMA* 311 (5): 507-20
54. A Robust Health Data Infrastructure, JASON report, Prepared for AHRQ, [http://healthit.gov/sites/default/files/ptp13-700hhs\\_white.pdf](http://healthit.gov/sites/default/files/ptp13-700hhs_white.pdf)
55. Lewis Jr., Morgan. "Payers warm up to retail clinics." *Managed Healthcare Executive*. October 2013.
56. 2013 National Ambulatory Medical Care Survey and 2013 American Hospital Association Survey, cited on <http://dashboard.healthit.gov/dashboards/dashboards.php>
57. Joseph Kvedar, Molly Joel Coye and Wendy Everett, Connected Health: A Review Of Technologies And Strategies To Improve Patient Care With Telemedicine And Telehealth *Health Affairs*, 33, no.2 (2014):194-199
58. Dean H. Yamamoto. 2014. Assessment of the Feasibility of Cost of Replacing In-Person Care with Acute Care Telehealth Services. Alliance for Connected Care. <http://www.connectwithcare.org/wp-content/uploads/2014/12/Medicare-Acute-Care-Telehealth-Feasibility.pdf>.
59. Innovative telehealth initiatives such as Project ECHO in New Mexico have successfully expanded practitioner capacity and provided best practice care for primary care and specialty providers in rural health clinics settings. Project ECHO has provided more than 10,000 patient consults for hepatitis C and other chronic conditions and delivered more than 20,000 hours of continuing medical and nursing education units.
60. State Telehealth Policies and Reimbursement Schedules: A Comprehensive Plan of the 50 States and District of Columbia. 2014. Center for Connected Health Policy. <http://cchpca.org/sites/default/files/uploader/50%20STATE%20MEDICAID%20REPORT%20SEPT%202014.pdf>.
- 61.
62. U.S. Department of Health & Human Services Telehealth Services Fact Sheet accessed December 5, 2014. <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfactsht.pdf>
63. July 2014 Medicare Telehealth Parity Act. <https://www.congress.gov/bill/113th-congress/house-bill/5380>, accessed January 12, 2015.
64. 2012 Honesty and Ethics Survey," Gallup, <http://www.gallup.com/poll/1654/honesty-ethics-professions.aspx>
65. Rothman, R., R. Malone, B. Bryant, C. Horlen, and M. Pingnone, "Pharmacist Led, Primary Care-Based Disease Management Improves Hemoglobin A1c in High-Risk Patients with Diabetes," *American Journal of Medical Quality*, Vol. 18, 2003, pp. 51-58.
66. Chisholm-Burns M, Kim Lee J, Spivey CA, Slack M, Herrier RN, Hall-Lipsy E, et al. US pharmacists' effect as team members on patient care. *Med Care*. 2010;48:923-33
67. Robert L. Maher, Jr, et al., Clinical Consequences of Polypharmacy in Elderly, *Expert Opin Drug Saf*. Jan 2014; 13(1): 10.1517/14740338.2013.827660.
68. Troyen A. Brennan, et al., An Integrated Pharmacy-Based Program Improved Medication Prescription And Adherence Rates In Diabetes Patients, *Health Affairs*, 31, no.1 (2012):120-129
69. Walgreens presentation at the American Pharmacists Association (APhA) Annual Meeting & Exposition, Orlando, FL, March 28-31, 2014. Research study conducted by Bobby Clark, PhD, MSPharm, MHA, MS, MA
70. Yale University data analysis of Weigh Forward program provided by RediClinic, 12/30/2014.
71. Goad JA et al., Vaccinations administered during off-clinic hours at a national community pharmacy: implications for increasing patient access and convenience, *Ann Fam Med*. 2013 Sep-Oct;11(5):429-36
72. Though pilots over a decade ago showed that pharmacist-managed vaccination programs were shown to increase influenza immunization rates in rural areas. Jenny Van Amburgh, Improved Influenza Vaccination Rates in a Rural Population as a Result of a Pharmacist-Managed Immunization Campaign, *Pharmacotherapy*. 2001;21(9)
73. National Pharmacist Association- <http://media.pharmacist.com/imz/ACIPresentationRothholzJune2013.pdf>
74. United States Bureau of Labor Statistics, <http://www.bls.gov/oes/current/oes291051.htm>
75. March 2012 National Immunization Survey, March 2012 National Flu Survey
76. Michael Johnsen. 2014. "Walgreens Announces Tdap Vaccination Voucher Program in Collaboration with Alaska Health Department."



- DrugStoreNews.com. August 28. <http://www.drugstorenews.com/article/walgreens-announces-tdap-vaccination-voucher-program-collaboration-alaska-health-department>
77. CVS Health and Direct Relief Partner to Donate \$1 Million in Flu Shot Vouchers to Uninsured Patients of Community Health Clinics." 2014. Direct Relief. October 23. <http://www.directrelief.org/2014/10/cvs-health-direct-relief-partner-donate-1-million-flu-shot-vouchers-uninsured-patients-community-health-clinics>
  78. Health Officials Partner with Retailer for Flu Shots." 2013. Wwww.albanyherald.com. September 24. <http://www.albanyherald.com/news/2013/sep/24/health-officials-partner-with-retailer-for-flu/>
  79. Federal Emergency Management System. The National Response Framework: emergency support function #8—public health and medical services annex. [www.fema.gov/pdf/emergency/nrf/nrf-esf-08.pdf](http://www.fema.gov/pdf/emergency/nrf/nrf-esf-08.pdf) (accessed 2011 Jan 29).
  80. "CVS Caremark Supporting Tornado Relief Efforts in Oklahoma and Texas." May 23, 2014. <http://www.cvshealth.com/newsroom/press-releases/cvs-caremark-supporting-tornado-relief-efforts-oklahoma-and-texas>
  81. Walmart corporate website: <http://corporate.walmart.com/microsites/global-responsibility-report-2013/walmartUSLocal.html>
  82. National Pharmacy Market Summary SK&A (March 2010) <http://www.skainfo.com/index.php>
  83. Walgreens corporate website: [http://news.walgreens.com/article\\_display.cfm?article\\_id=831](http://news.walgreens.com/article_display.cfm?article_id=831)
  84. Centers for Disease Control and Prevention Citing: Tarlov, A.R., Public Policy Frameworks for Improving Population Health. Annals of the New York Academy of Sciences, 1999
  85. Benjamin D. Sommers et al., Changes in Mortality After Massachusetts Health Care Reform: A Quasi-experimental Study, *Ann Intern Med.* 2014; 160(9):585-593
  86. David Blumenthal, and Sara R. Collins, Health Care Coverage under the Affordable Care Act — A Progress Report, *N Engl J Med* 2014; 371:275-28, July 17, 2014, and Census.gov figures accessed November 2014: <http://quickfacts.census.gov/qfd/states/00000.html>
  87. "Nine in Ten Uninsured Unaware That the Affordable Care Act's Second Open Enrollment Period Starts in November." 2014. The Henry J. Kaiser Family Foundation. October 21. <http://kff.org/health-reform/press-release/nine-in-ten-uninsured-unaware-that-the-affordable-care-acts-second-open-enrollment-period-starts-in-november/>
  88. What Worked and What's Next? Strategies in Four States Leading ACA Enrollment Efforts, The Henry J. Kaiser Family Foundation, July 2014 Issue Brief
  89. Enroll America. "Enroll America's Grassroots Campaign and Early Lessons Learned, November 2013- February 2014." April 2014. Available at: <https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2014/04/Grassroots-Campaign-and-Early-Lessons.pdf>
  90. CVS Project Health. <http://www.cvs.com/project-health>
  91. Robin L. Rose, MBA. 2014. "Attention Shoppers: There's a Special on Flu Shots and Corn Chips in Aisle Three." *Becker's Hospital Review.* November 12. <http://www.beckershospitalreview.com/hospital-management-administration/attention-shoppers-there-s-a-special-on-flu-shots-and-corn-chips-in-aisle-three.html>
  92. Walmart e-mail communication, January 12, 2014.
  93. McKinsey & Company. (2007, February). Single Stop Rollout Strategy Project—Final report.
  94. Making a Difference: Effective SNAP Strategies Tailored to Target Groups and Locations, Food Research and Action Center, October 2011.
  95. Improving Access to Public Benefits: Helping Eligible Individuals and Families Get the Income Supports they Need, the Annie E. Casey Foundation. April 2010
  96. Making a Difference: Effective SNAP Strategies Tailored to Target Groups and Locations, Food Research and Action Center, October 2011.
  97. Iris Dimmick. 2014. "H-E-B Adds Nutrition and Health Care Services at Select Stores." *The Rivard Report.* November 7. <http://www.therivardreport.com/h-e-b-stores-offering-nutrition-services/>
  98. Making a Difference: Effective SNAP Strategies Tailored to Target Groups and Locations, Food Research and Action Center, October 2011.
  99. Deborah Bachrach et al., *Addressing Patients Social Needs: An Emerging Business Case for Provider Investment*, Commonwealth Fund, May 2014.
  100. Ibid
  101. Single Stop USA - <http://www.singlestopusa.org/>
  102. New York Times, accessed on January 12, 2014, [http://www.nytimes.com/2014/02/06/business/cvs-plans-to-end-sales-of-tobacco-products-by-october.html?\\_r=0](http://www.nytimes.com/2014/02/06/business/cvs-plans-to-end-sales-of-tobacco-products-by-october.html?_r=0)
  103. Minute Clinic Smoking Cessation. Accessed December 4, 2014. <http://www.cvs.com/minuteclinic/resources/smoking-cessation>
  104. Wall Street Journal, accessed on January 12, 2014, <http://blogs.wsj.com/pharmalot/2014/10/20/smoke-this-caremark-to-charge-extra-co-pay-at-pharmacies-selling-cigarettes/>
  105. Mehrotra, Ateev, Hangsheng Liu, John Adams, Margaret C. Wang, Judith Lave, N. Marcus Thygeson, Leif I Solberg, and Elizabeth A. McGlynn. 2009. "The Costs and Quality of Care for Three Common Illnesses at Retail Clinics as Compared to Other Medical Settings." *Annals of Internal Medicine* 151 (5): 321–28.
  106. Robin M. Weinick et al., Policy Implications of the Use of Retail Clinics, RAND, 2010
  107. CMS, Stage 2 Meaningful Use Measure: <http://www.healthit.gov/providers-professionals/achieve-meaningful-use/core-measures-2/medication-reconciliation>
  108. ShopRite of Howard Park. <http://www.trfund.com/liberty-heights-shoprite-baltimore-md/>
  109. American Academy of Pediatrics, accessed January 30, 2014, <http://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/The-AAP-Advises-Parents-Against-Using-Retail-Based-Clinics.aspx>
  110. IOM (Institute of Medicine). 2011. *The Future of Nursing: Leading Change, Advancing Health.* Washington, DC: The National Academies Press.
  111. Julie Stanik-Hutt et al., The Quality and Effectiveness of Care Provided by Nurse Practitioners, *Journal for Nurse Practitioners.* 2013;9(8):492-500
  112. Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act." *Federal Register, Interim Rule.* 75 (19 July 2010): 41726-41760. <http://www.gpo.gov/fdsys/pkg/FR-2010-07-19/pdf/2010-17242.pdf>
  113. Zedlewski, S., Adams, G., Dubay, L., & Kenney, J. (2006). Is there a system supporting low-income working families? *The Urban Institute. Low-Income Working Families Paper 4.* Washington, DC: Urban Institute.