REPORT OF THE
DEPARTMENT OF HEALTH AND THE
DEPARTMENT OF HEALTH PROFESSIONS ON

Commerical Walk-In Medical Clinics in the Commonwealth

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 45

COMMONWEALTH OF VIRGINIA
RICHMOND
1990

COMMONWEALTH of VIRGINIA

Department of Health Professions

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January 10, 1990

To: The Honorable Gerald L. Baliles
Governor of the Commonwealth of Virginia

The Members of the General Assembly of Virginia

It is our privilege to present the accompanying report which constitutes the response of the Department of Health and the Department of Health Professions to the request contained in House Joint Resolution Number 303 of the 1989 Session of the General Assembly of Virginia.

The two departments empaneled an interagency Task Force to conduct the study of walk-in medical centers and develop appropriate recommendations. This report is a result of the work of the Task Force.

The Task Force concluded that although State regulation of walk-in medical centers is unwarranted at this time, the Commonwealth should institute procedures to monitor continued safe practices within these centers. The two departments endorse the conclusions and recommendations of the Task Force.

C.M.G. Buttery, M.D., M.P.H.
State Health Commissioner

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VIRGINIA DEPARTMENT OF HEALTH

and

VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

REVIEW OF THE NEED TO REGULATE COMMERCIAL WALK-IN MEDICAL CLINICS

In Response To

House Joint Resolution Number 303

of the

1989 Session of the General Assembly of Virginia

January, 1990
Richmond, Virginia

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HOUSE JOINT RESOLUTION NO. 303

Requesting the Department of Health Professions and the Department of Health to study commercial walk-in medical clinics.

Agreed to by the House of Delegates, February 24, 1989
Agreed to by the Senate, February 23, 1989

WHEREAS, commercial walk-in medical clinics have proliferated in the Commonwealth in recent years; and

WHEREAS, these clinics increasingly provide convenient medical treatment to many Virginians, but there are no standardized definitions provided to the consumer regarding the levels of available emergency care and other medical services; and

WHEREAS, patients have no guarantee of availability of prescriptions and other medical records if such clinics go out of business; and

WHEREAS, physicians and nurses who work in these facilities are licensed by the Commonwealth, but there is no licensing required for such facilities; and

WHEREAS, responsibility for these facilities presently is divided between the State Department of Health pursuant to its authority to regulate health facilities, and the Department of Health Professions pursuant to its authority to license and regulate certain health care professionals, creating the necessity for a legislative review of the problem; and

WHEREAS, the lack of a coordinated system for the regulation of commercial walk-in medical clinics may jeopardize the health and safety of the citizens of the Commonwealth; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Health Professions and the Department of Health are requested to study commercial walk-in medical clinics. The Departments shall determine the types and levels of medical care provided by such facilities and the qualifications of the staff to render general and specialty medical care, review the relevant state laws concerning the licensing and construction of such facilities, the licensing of medical and health care professionals, and state and federal law, if any, concerning reimbursement for health care services, particularly by public health assistance programs. The Departments shall recommend whether licensing of commercial walk-in medical clinics should be required and whether regulation of such facilities is necessary.

The Departments shall complete their work in time to submit their findings and recommendations to the Governor and the 1990 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

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SPECIAL ACKNOWLEDGEMENT

The Task Force on Walk-in Medical Centers acknowledges the contributions to this study made by many individuals and organizational principals who responded to requests for comments on issues related to walk-in medical centers.

We are especially appreciative of the efforts of Donald H. Bridges, Jr., a graduate student in health administration, School of Allied Health Professions, Medical College of Virginia Campus, Virginia Commonwealth University. In consultation with faculty members and the co-directors of this study, Mr. Bridges conducted a comprehensive review of the policy literature related to the growth of outpatient health care facilities and services over the decade just concluded. The scope and the excellence of his review contributed substantially to the study.

Mr. Bridges is a remarkable young man. As a result of a sports injury a few years ago, he is respirator-dependent and quadriplegic, but far from "disabled." In addition to his full-time graduate study, Don is an active advocate for programs to use to the fullest the talents and competencies of other disabled members of the community. His intelligence, humor, insight, and professional demeanor were sources of inspiration. We thank him for his generosity in sharing his talents with us.

The Task Force on Walk-in Medical Centers

I EXECUTIVE SUMMARY

The lifting of regulatory restraints and the unleashing of market forces in the early 1980s created unprecedented growth and diversification in the provision of outpatient health care services in Virginia and throughout the nation. A significant part of this growth is the proliferation of walk-in medical centers (WIMCs) that provide primary health care services to an increasingly broad segment of the population. These consumers require and demand services organized and delivered to appeal to their special needs for convenient, essentially episodic care.

While the growth of WIMCs throughout the decade has been dramatic, there is current evidence of market saturation and decreased rates of growth. Nonetheless, freestanding, walk-in medical centers comprise a significant and permanent part of the health care delivery system. Many services can be provided cost effectively in these centers, and both patients and third party insurers are increasingly willing to pay a premium for convenience.

During the past decade, policymakers have identified legitimate public protection concerns related to the operation of WIMCs. These concerns focused especially on centers owned or operated by corporate or commercial interests, often located far from the point of service delivery and from local or state oversight. The diversity of organizational arrangements in the current market, however, frustrates any effort to pinpoint centers that are "commercial" in character.

Industry studies document a changing profile of ownership and operation of walk-in centers. While most WIMCs were originally owned and operated by physicians, there is a pronounced trend toward ownership by hospitals and for-profit corporations.

At one end of a continuum of ownership and service provision are the primary or specialty care practices of physicians or groups of physicians on an extended schedule of hours, often on a "no appointment required" basis. At the other end of the organizational continuum are hospital-owned or corporate-affiliated centers that provide true emergency services, or specialty services such as imaging, ambulatory surgery, dialysis or cardiac catheterization on an outpatient basis.

Many variations of ownership and operation exist between these points. The literature documents that WIMCs may be owned by individual physicians or groups of physicians, laymen or groups of laymen, corporate franchisers or franchisors, secular or sectarian hospitals or chains of hospitals, public or private

corporations, venture capitalists, and governmental, scientific, charitable and other public, quasi-public, and private concerns.

Physicians, nurses, pharmacists and other licensed health professions in the Commonwealth are regulated by boards within the Department of Health Professions, regardless of practice setting. Some centers that function as hospital satellites are regulated by the Department of Health, but there is no coordinated regulatory program that extends to all WIMCs. As a consequence of public protection concerns and the lack of a coordinated regulatory program, House Joint Resolution 303 of the 1989 Session of the Virginia General Assembly requested the Department of Health and the Department of Health Professions to study the need to regulate commercial walk-in medical centers as an approach to ensuring greater consumer protection.

The most prevalent concerns related to WIMCs include:

- misleading advertising of facilities and services as "emergency" or "urgent care," and the potential for harm that may result from public misunderstanding of the true nature of services available in WIMCs;

- the quality of episodic care, generally, including specific concerns for patient record keeping and transfer, adequacy of staffing and equipment, and the coordination and integration of WIMC services with attending physicians, specialists, and community emergency services;

- access to WIMC services for the medically indigent, recipients of publicly funded health services, and others with limited ability to pay; and,

- the potential for WIMCs to: (a) shelter health practitioners with histories indicative of incompetent or unscrupulous practice; and, (b) inadvertently contribute to prescription drug addiction or abuse problems.

- difficulty in determining accountability due to ownership characteristics and the mobility of employed physicians, nurses, and other professional staff.

In response to HJR 303, an interagency task force studied these issues with the assistance of expert individuals and organizations and the general community of health care providers and consumers in Virginia. The objectives of the review were to determine:

- the degree to which these concerns are valid and unique to specific segments of the health care enterprise;

- the adequacy of voluntary efforts within the health care industry to address these concerns; and,

- the need for state regulation as a means to address unresolved concerns.

The task force was governed in its review by statutory and administrative policies that restrain the use of the regulatory authority of the Commonwealth, unless it can be clearly demonstrated that regulation is required for public protection.

While the task force found a potential for public harm to exist in some WIMC operations, it also determined that this potential extends beyond WIMCs to the larger general arena of outpatient health care. It is not possible to relate the potential for harm to specific characteristics of WIMC ownership or operation that are amenable to effective state regulation.

It was also clear to the task force that problems identified early in the decade of the 80s have been addressed by voluntary, private sector quality assurance initiatives. These initiatives are prompted by existing and emerging standards for third party reimbursement, by the forces of competition, by increasingly influential accreditation and peer review programs, and by the possibility of governmental intervention should voluntary efforts fail.

Regulation invariably increases the cost of services and may hinder innovation in the marketplace. Only a small number of states have proposed or implemented regulatory approaches to the resolution of concerns related to WIMCs, and several of these have abandoned or withdrawn their initiatives. The task force found no evidence that those few regulatory programs that have been implemented have been sufficiently effective in protecting the public to warrant regulatory costs. Indeed, there is no evidence available to demonstrate that state regulation offers greater public protection than voluntary compliance with industry, accreditation, or reimbursement standards.

Notwithstanding these observations, participation in voluntary standard-setting programs is not universal. While competition may eventually eliminate risky or exploitative practices in the health care marketplace, the Commonwealth has a legitimate concern in monitoring WIMCs to assure continued safe practice. To this end, the task force has prepared recommendations to address concerns identified in its study.

Identifying and Classifying Walk-in Medical Centers

It is in the interest of the Commonwealth that an inventory and classification system for walk-in medical centers be established.

The Task Force recommends that the Department of Health initiate a voluntary registration program for walk-in medical centers in the Commonwealth. A voluntary registration program can contribute to sound health planning and policy through a systematic inventory and classification

of primary and other health care resources in Virginia communities.

Assuring Quality and Continuity of Health Care

Virginia citizens are entitled to quality health care services that are appropriately marketed and coordinated with other community resources.

The Task Force recommends that the Department of Health distribute this report to all known walk-in medical centers in the Commonwealth to encourage their participation in private sector quality assurance programs, including those programs that set standards for staffing and equipment, marketing, and coordination with community resources appropriate to the level of service actually provided within these centers.

Access to and Payment for Services

Walk-in medical centers represent a unique point of access to the larger health care delivery system and make important contributions to the provision of primary health care in Virginia communities. Increasingly, services provided in these centers are reimbursed by public and private third party reimbursement plans. Standards established by insurers are important elements in assuring access, quality and coordination of services provided by walk-in centers.

The Task Force recommends that the State Health Planning Board, the Virginia Department of Health, and the Department of Medical Assistance Services receive this report and consider walk-in medical centers in their approaches to the more general problems of geographic access to primary health care and to health care for the uninsured, underinsured, and medically indigent.

Licensed Practitioners and Controlled Substances

Special efforts are required to ensure that walk-in medical centers do not inadvertently shelter problem practitioners or contribute to prescription drug diversion or abuse.

The Task Force recommends that the Department of Health Professions request the U. S. Department of Health and Human Services to include walk-in health centers explicitly in the requirement for participation in the National Practitioner Data Bank.

The Task Force also recommends that the Department provide all known walk-in health centers with statutes and regulations governing controlled substances and the practice of physicians, nurses, pharmacists, and other licensed health care providers. The Department should also encourage centers to make readily available to patients the procedures for complaints involving licensed professional practice.

Ensuring for continued safe practice

While the task force concludes that the regulation of walk-in medical centers is not currently warranted, a method to monitor continued safe practice within these centers is necessary.

The Task Force recommends that the Department of Health survey all known walk-in medical centers in the Commonwealth by 1992 and periodically thereafter to assess the degree of compliance with private sector standards for safe and appropriate care.

The Task Force also recommends that all agencies of the Commonwealth that receive and adjudicate health care complaints remain vigilant in the detection of problems related to walk-in medical centers.

II. INTRODUCTION

House Joint Resolution Number 303 of the 1989 Legislative Session of the Virginia General Assembly requested the Department of Health Professions (DHP) and the Department of Health (VDH) to determine the need to regulate commercial walk-in medical centers (WIMCs) in the Commonwealth.

The Resolution was based on the following concerns:

- **commercial walk-in medical centers have proliferated in the Commonwealth;**
- **these centers increasingly provide convenient medical treatment, but there are no standardized definitions regarding the levels of medical services available;**
- **patients using these centers have no guarantee of availability of prescriptions and other medical records if centers go out of business;**
- **physicians and nurses who work in these facilities are licensed by the Commonwealth, but there is no licensing required for the centers;**
- **authority for regulation of these facilities is divided between the Department of Health (for any facility regulation), and the Department of Health Professions (for the regulation of health care personnel), creating a need for an interdepartmental review of all problems; and,**
- **the lack of a coordinated system for the regulation of commercial walk-in medical centers may jeopardize the health and safety of the citizens of the Commonwealth.**

The State Health Commissioner and the Director of the Department of Health Professions appointed the Director, Division of Resources Development of the Department of Health, and the Executive Director of the Board of Health Professions to design and co-direct the study. The Commissioner and the Director of DHP endorsed a multi-tiered study approach to assure that all concerns expressed in the Resolution were addressed, and that the views of a representative cross-section of interested organizations and individuals were reflected in any findings and recommendations,.

Consistent with this approach, the agency heads appointed an interagency Task Force to provide guidance and assistance to the study co-directors. A network of expert organizations and individuals with an interest in WIMCs was also invited to consult with the interagency Task Force. Major professional associations, the insurance industry, local and regional health directors, regional health agencies, and other individuals and

agencies were included in the network. A complete listing appears in Appendix B.

The study also included the conduct of a widely publicized public hearing to permit the general community of health care providers and consumers to comment on any concerns related to WIMCs in the Commonwealth. The hearing format encouraged discussion of problems related to WIMCs and of approaches to ensure that these centers remain responsive to the needs of Virginia citizens and communities. It was especially helpful to hear the concerns of Delegate Marian Van Landingham, a principal sponsor of HJR 303 at the public hearing.

The Board of Health Professions within DHP is required by statute to evaluate the need for regulation of health care professions and occupations not currently regulated in the Commonwealth. For this reason, the Task Force determined that this Board should be involved in the study through its standing Regulatory Evaluation and Research Committee. Members of this committee assisted the Task Force in presiding at the public hearing and in identifying and discussing concerns related to the regulation of health care professionals who practice in WIMC settings. Regulatory boards within DHP license physicians, nurses, pharmacists, and more than 30 other health occupations. With few exceptions -- none of which affect WIMCs -- these professions are regulated wherever the professional service is provided. Pharmacies -- including those conducted within WIMCs -- are also regulated and included in the Department's facility inspection and complaint investigation programs.

The Task Force was also guided by regulatory principles established in Virginia statutes and expressed in policies of the Governor. The statutory principle governing the regulation of occupations and professions is established in Code of Virginia Sec. 54.1-100: the right of every person to engage in any lawful profession, trade or occupation is protected, except when it is found clearly necessary to abridge this right for the preservation of the public health, safety and welfare. In addition, Executive Order Number Twenty-Six (86) of Governor Gerald L. Baliles establishes that "it is the policy of the Commonwealth of Virginia to conduct required regulatory activities in a manner that intrudes to the least possible extent into the legitimate functions of private enterprise and individual citizens, and to strive to draft, adopt and enforce regulations that do not unnecessarily burden the activities of private businesses or citizens."

This report places the study of Virginia WIMCs in the context of the evolution of outpatient health services in the 1980's by comparing concerns documented in health care policy literature with those identified in testimony and written comments of the network of consulting organizations and individuals, and the community of health care providers and consumers in the Commonwealth. Based on that comparison, it is clear that the growth and diversification of outpatient services in the Commonwealth mirrors the experience in other states and jurisdictions. Because all concerns about WIMCs are expected to

extend into the foreseeable future, a concerted effort has been made to present relevant baseline information in this report.

The workplan initially adopted by the Task Force (see Appendix C) included as a goal the classification and inventory of commercial walk-in health care centers in the Commonwealth. As the study progressed, evidence drawn from public comments, the public hearing, and a review of the evolution of WIMCs led the Task Force to revise this plan. Instead, this report documents that distinctions among WIMCs and between WIMCs and other outpatient services have become increasingly blurred. As a result, any attempt to impose a predetermined classification system on existing and developing WIMCs would fail to depict accurately the complex patterns of ownership and operational styles that characterize the current marketplace.

A number of problems related to WIMC operations are documented in this report, but it is difficult to conclude that these problems are unique to walk-in health care centers. The study discloses that as the outpatient health care market stabilizes, competitive forces are stimulating private sector initiatives to address problems related to the cost, quality, accessibility, safety, and marketing of WIMC services. Under these conditions, Task Force recommendations encourage the continuous and systematic monitoring of the development and adequacy of private sector quality assurance programs affecting WIMCs rather than the imposition of restrictive regulatory programs at this time.

III. THE EVOLUTION OF WALK-IN HEALTH CARE CENTERS

Walk-in medical centers (WIMCs) constitute a significant segment of a proliferating ambulatory health care industry. It is important that the findings and recommendations in this report be framed in the context of a more general evolution of outpatient health care services. This evolution reflects still larger changes in public expectations for accessible, cost-effective health care services. It includes the movement away from highly regulatory approaches to the control of the quantity, quality and distribution of health services to greater reliance on competition and market forces as principal mechanisms of control.

The following discussion is based on a review of the health care policy literature. The dimensions addressed include:

- o growth and diversification of outpatient services;
- o ownership and operational characteristics of ambulatory health care centers;
- o conditions typically treated in WIMCs;
- o payment and reimbursement for services;
- o problems identified in the policy literature, and private quality assurance mechanisms that address these problems; and,
- o state regulatory initiatives.

Growth and Diversification of Outpatient Care Services

The decade of the 1980s witnessed a pronounced shift in the provision of health care services from inpatient to outpatient settings. The causes of this shift are complex and include:

- o changing practice patterns;
- o technological advances;
- o increased competition among health care providers;
- o growing costs, especially capitalization costs;
- o increased pressures for cost containment; and,
- o third party reimbursement requirements.

The ambulatory health care sector is highly diversified. It serves a variety of patient needs in a complex array of settings that complement or replace traditional physicians' offices and hospital emergency rooms. Among the settings are:

- o primary or "urgent" care walk-in centers (the focus of this study);
- o large physician group practices;
- o health maintenance organizations (HMOs) and other managed health care systems;
- o federally funded community health centers;
- o ambulatory surgery centers;
- o imaging centers;
- o dialysis facilities; and,
- o cardiac catheterization centers.

While the growth of freestanding ambulatory care centers in the current decade has been dramatic, there is evidence of market saturation and declining rates of growth. Nonetheless, this segment of the health care delivery system constitutes an important and frequently less costly alternative to traditional delivery mechanisms (i.e., access to medical care through "personal" physicians or hospital emergency rooms).

Industry studies conducted in 1982 estimated that there were 500 freestanding centers in the nation in that year. About 100 of these were hospital-affiliated, and the balance were owned and operated primarily by corporate interests, physicians and other owners or sponsors. The studies projected growth to about 2,900 centers by 1986, followed by a leveling in the rate of growth to reach a total of 4,500 centers nationally in 1990.

The 1982 studies also projected industry-wide averages of 18,000 patient visits per year per center (after an initial start-up period of five years), and an annual growth of about four percent beyond this level. The total number of patient visits was reported to be 9.4 million in 1983, and projected to rise to 26 million in 1986 and to 61 million in 1990. Gross revenues were predicted to exceed $1 billion in 1986 and more than $2.5 billion in 1990.

The volatility of the market is evidenced by revised estimates published by the same industry group only two years later. Studies reported in 1984 estimated that 5,500 centers would be in place by 1990 -- 1,000 more than projected in 1982 studies. These centers were expected to attract 73.1 million patient visits by the end of 1987, and 111.7 million in 1990. Despite these upward revisions, the studies concur in predicting a sharp decline in rates of growth, and a leveling of growth in patient visits from 1985 to 1990.

Industry studies do not report specifically the proportion of all freestanding ambulatory care facilities that fit the profile of commercial, primary care centers operated on a walk-in basis, or estimate patient visits or revenues specific to WIMCs.

This is largely due to the difficulty in sharply differentiating WIMCs from other segments of the outpatient health care market.

The studies document a changing profile of ownership and operation of freestanding ambulatory care facilities. These changes make it difficult to isolate WIMCs from other segments of the ambulatory care market based on characteristics of ownership or operational characteristics. Moreover, the changes alter a number of traditional assumptions about the organization and delivery of health care.

Ownership and Operational Characteristics

The changing profile of ownership and the operation of WIMCs is central to this study since HJR 303 refers specifically to those "commercial" centers, operated on a "walk-in" basis that are not currently regulated in the Commonwealth. A perplexing issue in assessing the need for state regulation of WIMC facilities and services is determining precisely which sectors of the industry are currently regulated, and, among unregulated sectors, the relationship of identified problems and specific characteristics of ownership and operation that might be effectively addressed by state regulation.

The policy literature suggests that the WIMC sector may be divided among three classes with different recommended requirements for levels of treatment capability, staffing and equipment.

- **Physicians Offices with Extended Hours**. Because these services are like other physician's offices, no minimum requirements for hours of operation, staffing, or emergency equipment are viewed as necessary, nor is mention made of any requirement for integration of these offices with area emergency services.

- **Freestanding Ambulatory Care Centers.** These centers offer primary care services, and it is suggested that use of the term "emergency," or its derivatives be prohibited. It is recommended that facilities be open at least ten hours a day, seven days a week, and be capable of stabilizing patients with life- or limb-threatening conditions. .

- **Freestanding Emergency Care Centers**. These centers are the equivalent of hospital emergency departments, and would be required only to indicate the "freestanding" nature of the facility in marketing activities to differentiate the centers from hospital emergency rooms. Recommended requirements are those that apply to any accredited or licensed hospital emergency department.

The literature also suggests classifying ambulatory care facilities as "hospital-associated" -- divided further into "hospital-sponsored" and "hospital-affiliated" centers -- and "independent" centers, operated with no hospital sponsorship or affiliation. This division implies that hospital associated

centers are governed by licensure and accreditation standards, while independent centers operate outside the jurisdiction of these quality assurance programs.

The Task Force initially accepted these classifications and determined to eliminate physicians' offices with extended hours and hospital-associated centers from the purview of the study. In the first instance, the decision was supported by the belief that physicians offices are not "commercial" enterprises, and, in the second by the assumption that hospital-associated WIMCs are sufficiently controlled by accreditation and licensure standards. It was also decided initially to exclude health maintenance organizations (HMOs) and other managed health care systems since the services of clinics and centers operated by these systems are not typically available to the general public.

As the study progressed, however, the Task Force found reason to question the categorizations suggested in the literature as well as the beliefs and assumptions supporting the exclusion of certain kinds of centers from the purview of the study. The problem with the taxonomies -- as well as with the initial beliefs and assumptions of the Task Force -- is that they do not reflect current market realities.

According to the policy literature, freestanding ambulatory care centers were originally owned and operated primarily by physicians. More recently, there is a trend toward ownership by hospitals and for-profit corporations. Industry groups attribute this trend to high start-up costs and to economies of scale created within networks or chains. The trend applies both to new facilities and to changes in ownership of existing facilities. Many corporations that own centers are negotiating to acquire existing facilities to expand their service networks.

Increasing numbers of centers are also associating with HMOs and Preferred Provider Organizations (PPOs). These arrangements provide convenient and economical care for subscribers (when compared to emergency room costs), and center operators gain from better control of patient flow and referrals, as well as increased revenues and better cash flow from capitation payments.

Other important developments among hospital-associated WIMCs illustrate further the difficulty in applying traditional assumptions or classifications to this market segment.

A substantial number of WIMCs are governed, managed and financed directly by hospitals. These centers are owned or leased by the hospital, constructed on hospital land, and operated as hospital cost centers with a portion of hospital overhead allocated to the satellite. Accordingly, they charge a facility fee separate from charges for professional services. This may result in overall patient charges per visit that are higher than those of independently owned facilities. Both components may be reimbursed by third party payers, generally at the 100 percent level applicable to hospital emergency room or outpatient visits.

In an effort to establish rates more competitive with independently owned centers, some hospitals have developed innovative financial arrangements to divorce legal ownership of the freestanding center from the hospital. By transferring ownership and management functions to a physician group, the hospital may avoid the allocation of overhead to the satellite and eliminate the need for licensure, accreditation, and Certificate of Need (CON) review. Costs may be reduced further by contractual provisions under which the satellite shares hospital administrative services and participates in joint purchasing programs.

In summary, the policy literature documents that walk-in health care centers may be owned by individual physicians or groups of physicians, laymen or groups of laymen, corporate franchisers and franchisors, secular or sectarian hospitals or chains of hospitals, public or private corporations, venture capitalists, and governmental, scientific, charitable, and other public, quasi-public, and private agencies. Moreover, intense competition has led many physician practices to provide extended hours of service and to serve patients on a "walk-in" basis, either independently or through contractual arrangement with hospitals or other corporate sponsors, owners or managers.

Given the diversity and the dynamics of the health care convenience market, it is increasingly difficult to differentiate services by reference to "commercial" or "walk-in" criteria, or to determine the degree to which specific segments of the industry are regulated or governed by private quality assurance mechanisms.

The fluid nature of the market -- coupled with a lack of any evidence that Virginia differs from other jurisdictions in its experience with WIMCs -- led the Task Force to revise its initial plan to classify and inventory walk-in health care centers. It was determined that a more productive exercise would lie in the presentation of the following information that may be used to measure change in any future studies:

- a description of services commonly provided by WIMCs;
- payment and reimbursement for WIMC services;
- problems affecting public safety, health and welfare identified in the WIMC policy literature;
- the adequacy of private sector approaches to address these problems; and,
- a review of the experience of other states in addressing problems associated with WIMCs.

In considering these factors, however, the Task Force continued its attempt to discern any systematic relationship between identified problems and characteristics of ownership or operation of WIMCs that might be addressed appropriately by state regulation.

Conditions Typically Treated in WIMCs

Industry studies conducted in 1982 conclude that nationally less than 1.4 percent of all patient visits to WIMCs were classified as "life- or limb-threatening," and that most of these encounters occurred in hospital satellites. The four medical conditions most frequently treated (each ranging from 15 to 23 percent of patient volume) were: upper and lower respiratory tract infections; fractures and sprains; lacerations; and ear, nose and throat complaints. A large majority of patients (nearly 95 percent) were reportedly treated by the facility and released. Fewer than one-half of the most common causes for seeking treatment were described by survey respondents as "urgent" in nature.

A resurvey in 1984 found the same four types of conditions to account for the vast majority of patient encounters. Because the reports do not include sufficient detail to assess validity and reliability, caution must be exercised in evaluating these industry reports. It is notable, however, that no evidence was presented to the Task Force that the experience in Virginia differs in any significant way from these findings.

Payment and Reimbursement for Services

Although WIMCs traditionally required cash payment (or a credit card) at the time of treatment, insurance plans increasingly pay for services provided in WIMCs, and centers are conforming accordingly to billing and documentation requirements.

Historically, private insurance plans paid for emergency services only when these services were provided in a hospital-based emergency room. These restrictions have eroded more recently in light of inappropriate uses of emergency room facilities and lower costs for many services that may be provided safely and appropriately in WIMCs and physicians' offices.

Increasingly, both reimbursement and the amount of copayment required for services provided in WIMCs are tied to compliance with licensure or voluntary quality assurance mechanisms. Some insurers now require specific standards of access, equipment, and staffing of WIMCs services for reimbursement. In addition, the industry is devising strategies to control the costs of outpatient services. Among the proposals under consideration are standards for appropriate and effective treatment of common complaints or conditions. This strategy is modelled on prospective payment systems based on diagnostically related groups (DRGs) used by Medicare and other third party payers.

WIMCs as a whole have avoided involvement with Medicaid patients and the medically indigent, although fees for professional services rendered to Medicaid clients in Virginia are paid to physicians and others eligible for reimbursement regardless of the setting in which the service is delivered. Because payment is not tied to the practice setting, information about the actual amounts of Virginia Medicaid payment for services in WIMCs is not available.

In general, the Task Force concluded that just as the outpatient care industry is in flux, so too are the reimbursement policies of public and private providers of third party payment. Under these conditions, the information or search cost to patients seeking care that is reimbursable may be high, but there is no evidence that this factor interferes with insured patients' ability to obtain health care in a timely fashion.

Problems and Issues Identified in the Policy Literature.

Two public interest concerns are prevalent in the literature: (1) marketing strategies emphasizing "emergency" or "urgent" care that may create misunderstanding of the levels of care actually available, and (2) the limitations of episodic care, generally, including specific concerns with continuity and documentation of care. Other less frequently expressed concerns focus on the refusal of some WIMCs to treat patients unable to pay, on inadequately staffed and equipped facilities, and on the lack of integration of WIMCs with area speciality and emergency services.

Misleading advertising and marketing. Concerns were expressed in the early 1980's about the potential harm that could result from misleading advertising of emergency services that are not actually available in primary care WIMCs. There is mounting evidence that voluntary efforts have led to more restrained marketing activity that fosters accurate public expectations of WIMC services.

Reflecting an initiative within the industry to prevent misleading representation of WIMC services, the major industry trade association -- established as the National Association of Freestanding Emergency Centers, or NAFEC -- was renamed the National Association for Ambulatory Care, or NAFAC, in 1984. The association's code of ethics requires that, unless appropriately modified, the term "emergency" should be limited to facilities that provide 24 hour care and are equipped to evaluate and treat life- or limb-threatening conditions. NAFAC claims that nearly 100 percent of its members have dropped the term "emergency" from their corporate names, advertising and marketing materials.

Leading standard-setting organizations in health care have also addressed the need for guidelines that differentiate primary care centers and emergency centers. The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), imposes more stringent accreditation standards for freestanding emergency care facilities than for primary care centers. Although JCAHO accreditation of walk-in primary care centers has not been widespread, the recent change of name of this organization from the Joint Commission on the Accreditation of Hospitals (JCAH) signals an intent to extend accreditation beyond the Commission's traditional focus on hospitals. Separate standards for emergency centers and "immediate/urgent" care centers are also used by the Accreditation Association for Ambulatory Health Care (AAAHC).

Despite these initiatives, some centers continue to use "emergency," "urgent," "emergi-," "urgi-," and other terms in

their names or marketing materials. It was anticipated that examples of public harm related to misunderstandings of the level of services available in WIMCs might be documented during this study. However, representatives of Virginia WIMCs that use variations of these terms claim either to have met appropriate standards, or that no misunderstandings of available services have occurred. Although the opportunity for public comment was widely advertised, the Task Force was presented with no documentation of public harm caused by inaccurate advertising during the course of this review.

Continuity of care, patient records, and service coordination. Episodic care provided by a succession of physicians is alleged to constitute poor medical care. However, the degree to which the care of patients treated in WIMCs differs from more traditional care according to any valid measures of quality or outcome has not been documented. In addition, the "commercial" or "walk-in" characteristics of WIMCs may not be sufficient to isolate this sector from other health care segments in which more-or-less frequent turnover of medical staff occurs. Even when the traditional patient/provider relationship exists, there is evidence that patients often seek care of an essentially episodic nature.

With respect to the documentation of care and the quality, availability and transfer of patient records, no body of evidence examined showed that these problems are more pronounced among WIMCs than in other ambulatory health care sectors. WIMC representatives testified that greater care is now taken in documenting, maintaining and transferring patient records than during the early stages of development. Insurance requirements, among other factors, have stimulated record keeping improvements throughout the health care industry.

The Task Force was also unable to conclude that unique problems existed among WIMCs with respect to continuity of care, coordination of care with patients' attending physicians, integration of WIMCs with area emergency services, or mechanisms for referral of patients who require the care of specialists. Private sector accreditation and quality control programs include standards for coordination and integration of WIMC care with other community services. Even for WIMCs that do not elect to participate in these voluntary programs, economic viability is linked to acceptance by both consumers and the professional community.

Other quality assurance developments. The primary voluntary quality assurance mechanisms affecting WIMCs are the JCAHO and AAAHC programs discussed above. A number of other standard-setting programs and mandates for quality review have arisen. These affect WIMCs only insofar as relevant services are provided. The following are examples.

- The National Committee on Quality Assurance (NCQA), cosponsored by the American Medical Peer Review Association, American Medical Care and Review Association, and Group Health Association of America

conducts voluntary quality assessments of HMOs and other managed care systems.

- The American College of Radiology, the College of American Pathologists, and the American Association for the Accreditation of Ambulatory Plastic Surgery Facilities each accredit specialty practice within a variety of settings, including freestanding ambulatory centers.

- Federal mandates now require review of care provided to Medicare beneficiaries through HMOs and other managed care systems.

- General Motors/United Auto Workers have contracted for evaluation of quality of care in HMOs contracting with GM.

While none of the existing voluntary programs currently accredits significant numbers of WIMCs, there are indications that voluntary subscription will grow as insurance requirements and other mandates increasingly include participation in licensure or voluntary quality assurance programs as a condition for reimbursement.

As earlier noted, some associations of private insurance providers have set specific standards WIMCs must meet to qualify for reimbursement. These include: minimum numbers of hours and days of WIMC operation (e.g., 16 hours per day, seven days per week); staffing, equipment and record keeping requirements; requirements for periodic facility review by insurers; and policies affecting referral or transfer of patients who develop complications or require co-insurance.

More than any other single factor, standards established by the insurance industry -- including Medicare and Medicaid -- have the potential to ensure acceptable quality and cost effectiveness of services provided in WIMCs.

A significant problem in evaluating and assuring quality of health care in any setting in the past has been the concentration by accrediting agencies on structural and functional measures of service instead of more direct indicators of quality or outcome of care. It is notable in this regard that JCAHO has reoriented it focus to encompass not only the wider diversity of health care organizations in the marketplace, but to include continuing evaluation of clinical processes and outcome measures. While currently in development only for hospitals, the standards will be adapted and used for the full spectrum of health care organizations in the future.

Finally, the American Medical Association supports voluntary, physician-directed peer review of services provided in all health care settings <u>except</u> care provided in physicians' offices. Because of the difficulty of differentiating "physicians' offices" and other outpatient care settings, it seems predictable that any general requirement for accreditation

or licensure of WIMCs would be resisted by the medical profession.

The AMA also encourages states to consider prohibitions on the "corporate practice of medicine," but in the view of the Task Force the use of the state's regulatory authority to restrict physicians from affiliating with commercial corporations may invite federal scrutiny under antitrust provisions of the Sherman and Federal Trade Commission Acts. In Virginia, statutes prohibiting physician practice in connection with commercial or mercantile establishments were repealed in 1986. (Acts of Assembly 1986, c.87)

State regulation of WIMCs

Despite widespread concern in the early and mid-80s, only a small number of states are reported to have used licensure or Certificate of Need regulation as the basis for controlling the growth or assuring the quality of WIMC services. Even fewer have enforced regulatory requirements in the face of legal opposition.

- In 1981 Rhode Island adopted regulations governing facilities that use terms such as "emergency room," "urgent treatment center," "accident room," "critical care facility," and similar phrases in titles, advertising or marketing materials. According to available sources, these regulations have not yet been enforced.

- In Georgia, proposed regulations were withdrawn before their effective date following challenge by physicians affiliated with a multi-hospital organization that claimed the regulations violated the First and Fourteenth Amendments of the U.S. Constitution.

- A suit filed by the State of New York to challenge the legality of the operation of freestanding centers that had not obtained Certificate of Need approval was met by a countersuit filed by the centers, which claimed denial of due process and equal protection.

- The State of Tennessee has drafted minimal regulations which specify the required hours of operation, staffing, integration into local emergency services systems, and maintenance patient records.

- Other states are reported to have studied WIMC issues (Arizona, California, Connecticut, Florida, Indiana, Massachusetts, Ohio, South Carolina), but none are known to have enacted laws or regulations as a result of these reviews.

Although limited in number, scope and rigor, these state efforts have stimulated compliance with emerging industry, reimbursement and accrediting standards. The Task Force concluded that changes within the industry in response to market forces and competition have blunted the force of arguments for state regulation that appeared in the early and mid-1980's.

IV. A REVIEW OF WIMC PROBLEMS IN THE COMMONWEALTH

The Task Force attempted to provide every reasonable opportunity for the community of health care providers and consumers to identify concerns and problems related to walk-in medical centers in the Commonwealth.

Personal invitations to comment were extended to more than 100 expert individuals and organizations by the State Health Commissioner and the Director of the Department of Health Professions. In addition, more than 200 facilities throughout Virginia were identified by field inspectors of the Department of Health Professions and notified of the study and the opportunity to comment. A public hearing was convened on September 15, 1989, announced in the Virginia Register of Regulations and in regional newspapers and by direct mail to all known and relevant individuals and organizations. Members of the Task Force and the Board of Health Professions presided at the hearing which was organized to provide a forum for discussion of concerns as well as to receive testimony.

A synopsis of the concerns expressed and of Task Force responses follows.

Access to and payment for WIMC services. Several commenters expressed concern about the ability of uninsured, underinsured and the medically indigent to secure services from WIMCs. Because Medicare, Medicaid and medically indigent patients may not have access to WIMC services, hospitals and other community facilities may incur an inequitable burden in caring for these patients.

The problem of access to health care by Medicaid clients and by the medically indigent is pervasive and cannot be ascribed solely or primarily to the WIMC sector. The Task Force was informed that Medicaid payments are reimbursable on the basis of the physician(s) providing services, regardless of the setting or facility in which the service is provided.

There is documentation in the policy literature that Medicare patients are as welcome as WIMC outpatients as in other ambulatory service settings. Operators of WIMCs testified that every effort is made to accommodate patients with limited resources.

WIMCs represent a unique point of access to the larger health care system. In light of the increasing number of patient visits to these center, WIMCs may contribute significantly to resolution of more general problems related to the provision of primary health care services in

communities that are underserved. This report presents recommendations for exploring public policy options to realize this largely untapped potential.

Advertising, trade names, and public perceptions. This concern -- related to possible public misperceptions of services available in WIMCs using terms such as "emergency," "urgent," etc. in trade names or promotional materials -- was expressed by a substantial number of those submitting comments.

One WIMC operator testified that his chain of facilities changed its name to eliminate any possible misperception based on recommendations of the industry trade association. Another testified that a variant of "urgent" was retained in his trade name despite these recommendations. All WIMC representatives stressed that the dominant segment of the population served by WIMCs (educated and employed, insured or self-sufficient) understands the nature of services provided and seeks only appropriate services. In rare instances, true emergency services are required, and these were reported to be handled expeditiously by referral or transport to appropriate facilities and specialty services.

No evidence was presented that inappropriate marketing of WIMC services or misperceptions of services actually offered contributed to public harm. Nonetheless, the Task Force acknowledges a potential for harm. Recommended actions to address this potential are presented in the Executive Summary.

Quality and continuity of care and patient record issues. Concerns were expressed by a number of respondents related to:

- **the quality and continuity of patient care in WIMCs and the need for peer review of patient treatment;**
- **minimum standards that should be imposed relative to equipment, staffing and training**
- **linkage and coordination with other community care resources, especially for emergency and specialized medical care;**
- **the availability of follow-up care on a 24 hours per day basis; and,**
- **standards for record keeping and patient record transfer.**

While recognizing that these factors have potential for harm, this same potential exists in virtually every sector in which outpatient health care is provided. No evidence was presented that documented a systematic relationship between WIMC operations and negative effects on public health, safety and welfare.

The literature and public comments document that appropriate voluntary standards have been developed throughout the outpatient care sector. These private initiatives converge in addressing concerns related to quality and continuity of care, appropriate staffing, training and equipment standards, patient record guidelines and coordination with other community services. Because of the virtual impossibility of isolating any one sub-classification of WIMCs that cause unique concern, the Task Force has concluded that it would be both impractical and inequitable to impose restrictive regulatory standards on any segment of the market that would not be applied to all outpatient care.

Based on the limited evidence available, the Task Force believes that most WIMCs are committed to quality care through voluntary compliance with industry standards. Because this commitment may not be universal, however, the Task Force has presented recommendations for continued and systematic monitoring of WIMCs in the Commonwealth.

Problems related to licensed practitioners in WIMCs
Representatives of the Board of Medicine and Board of Nursing were concerned that the pre-employment screening practices of some WIMCs may not be be sufficient to identify practitioners who have been subject to disciplinary or other actions indicating incompetent or unscrupulous practice.

While it was apparent from limited testimony that WIMC employers ensure that practitioners required to be licensed are in fact licensed in Virginia, checks on disciplinary actions taken in other states may not be made.

This problem pervades other sectors of the health care marketplace and resulted in a new federal initiative, the National Practitioner Data Bank. Final regulations to govern this new program were recently been published in the Federal Register. The program requirements will apply initially only to physicians and dentists.

The regulations require licensure boards, insurers, professional associations, and hospitals and "other health care entities" to report adverse actions -- including malpractice settlements and judgments -- to a national data base. Hospitals and "other health care entities" are required to query the data base prior to the employment or extension of staff privilege to licensed practitioners, and periodically (at least every two years) thereafter.

It is not clear whether WIMCs are included in the regulations defining "other health care entities." Since it is anticipated that revisions to final regulations -- including extension of the provisions to practitioners other than physicians and dentists -- will be made in the near future, the Task Force has presented recommendations to encourage the explicit inclusion of WIMCs as "health care entities" subject to the requirements of the National Practitioner Data Bank program.

Board of Nursing representatives cited complaints and inquiries that indicate that nurses and other licensed practitioners may be requested by WIMC employers to perform acts outside their legal scope of practice.

Upon examination, the number of these complaints proved to be small and manageable within the existing enforcement program operated by the Department of Health Professions.

Concerns related to controlled substances. Two kinds of concerns were evidenced in this review: (1) the need for adequate control of drugs sold by physicians, dispensed by physicians or pharmacists, or administered by professional personnel in WIMCs; (2) the potential for WIMCs to become "dupes" of drug addicts or other drug dependent persons seeking inappropriate prescriptions of controlled substances.

The possibility for overprescription as a means for enhancing revenue, and the potential for addicts and drug dependent patients to "doctor shop" in WIMCs are real, but DHP pharmacy audits and other current drug enforcement activities are sufficient to detect, investigate and adjudicate violations.

With respect to the prescription, dispensing and administration of controlled substances, and the conduct of pharmacy operations, existing regulatory programs apply regardless of setting. New regulations of the Board of Pharmacy establish standards for physicians who elect to sell drugs as a convenience to patients, and for the safe handling and storage of drug supplies in physician offices. These standards will apply without regard to practice setting.

WIMC representatives argued that physicians, nurses and pharmacists are aware that addicts and others may attempt to exploit the special characteristics of episodic care wherever that care is provided. Because of the potential for abuse, WIMCs have procedures in place that limit the quantity of controlled substances prescribed and identify abusers within community networks of providers. No documentation was submitted that isolated WIMCs for special attention relative to real or potential abuse.

Notwithstanding these regulatory and voluntary controls, the Task Force has presented recommendations for special efforts to notify all outpatient centers of the provisions of federal and Virginia law and regulation that govern controlled substances.

The conclusions and recommendations of the Task Force regarding the issues it has examined in response to House Joint Resolution Number 303 of the 1989 Session of the General Assembly appear as the Executive Summary of this report.

APPENDIX A

Announcement of Public Hearing

Special Invitation to Comment to Expert Agencies and Individuals

COMMONWEALTH of VIRGINIA

Department of Health Professions

Board of Health Professions

Bernard L. Henderson, Jr.
Director

Richard D. Morrison, Ph.D.
Executive Director

1601 Rolling Hills Drive, Suite 200
Richmond, Virginia 23229-5005
(804) 662-9904
FAX (804) 662-9943

ANNOUNCEMENT OF PUBLIC HEARING

Review of the Need to Regulate Walk-In Medical Clinics

Friday, September 15, 1989, 1:00 p.m.
Virginia General Assembly Building
House Room D
910 Capitol Street
Richmond, Virginia

In response to House Joint Resolution 303 (see reverse) of the 1989 General Assembly, the Virginia Department of Health and Department of Health Professions -- in cooperation with other public and private agencies -- are reviewing problems associated with the operation of commercial walk-in health care facilities in the Commonwealth.

The objective of the review is to determine whether licensing or other regulation of these facilities is necessary for the protection of the public health, safety and welfare.

The scope of the review will include identification of the types and levels of health care provided by these facilities; assessment of relevant state laws and private, voluntary standards governing their operation; review of requirements for reimbursement for health care services provided in the facilities (particularly by public health assistance programs); and, identification of problems affecting the health, safety and welfare of the public.

Agencies and individuals wishing to comment may testify at the public hearing or submit written statements which must be received by September 29, 1989. Please address written comments, and requests for additional information or for reservations to speak to:

Richard D. Morrison or Marilyn West, Staff Coordinators
Review of Walk-in Health Care Centers
Department of Health Professions
1601 Rolling Hills Drive -- Suite 200
Richmond, Virginia 23229-5005
(804) 662-9904

LETTER TRANSMITTED TO CONSULTING ORGANIZATIONS INVITING COMMENT ON WALK-IN MEDICAL CLINICS

August 18, 1989

Dear :

In response to House Joint Resolution 303 of the 1989 Session of the Virginia legislature (see enclosures), the Department of Health and Department of Health Professions--in cooperation with other public and private agencies--are reviewing problems associated with the operation of commercial walk-in health care facilities in the Commonwealth. As requested by the legislature, the review will include:

- types and levels of health care provided by these facilities, and the qualifications of staff to render the levels of care provided;
- relevant state laws concerning the licensing and construction of these facilities, and the regulation of health care professionals practicing in the facilities;
- private, voluntary programs for quality assurance which affect health care provided by the facilities;
- state and federal law concerning reimbursement for health care services, particularly by public health assistance programs;
- problems affecting the health, safety or welfare of the public, either referenced in HJR 303, or brought to the attention of study principals during the review.

The objective of the review is to determine whether licensing or other regulation of these facilities is necessary for the protection of the public health, safety and welfare. The enclosed overview has been prepared by a task force of state agency officials to govern the study.

While the review will include a widely announced public hearing on September 15, it is vital to the credibility of the effort that expert organizations and individuals be especially invited and encouraged to submit comments for careful review by the task force. This letter constitutes our invitation for this comment.

To provide for careful review of any comments you submit within the established time frame, we ask that your written statement be filed by September 15, 1989, the date of the public hearing. You may also wish to summarize your comments at the public hearing to inform the general public of your views.

Your written comments should be addressed to Marilyn H. West, Director, Division of Resources Development, Virginia Department of Health at the address on this letterhead. Should you wish to discuss this activity or desire additional information, please contact Ms. West at (804) 786-7463 or Richard D. Morrison, Policy Analyst, Department of Health Professions, (804) 662-9904.

We invite you also to attend meetings of the task force to discuss your views and to stay abreast of developments related to this study. The next meeting is scheduled on August 31 at 1:00 p.m. at the Department of Health Professions, 1601 Rolling Hills Drive, Richmond, 23229-5005, and a final meeting will be held on November 15 at a location to be announced. For additional information about meetings of the task force, please contact either Ms. West or Dr. Morrison at the phone numbers listed above.

Thank you for your consideration of this invitation to comment on issues related to House Joint Resolution 303. We look forward to receiving your comments.

Sincerely,

State Health Commissioner
Department of Health

Director
Department of Health Professions

Enclosures

APPENDIX B

Network of Consulting Organizations

Respondents to Invitation to Comment

NETWORK OF CONSULTING ORGANIZATIONS
RESPONDENTS TO INVITATION TO COMMENT

Alliance for Black Social Welfare

Alliance of Nurse Organizations

American Association of Retired Persons

American College of Emergency Physicians

American Health Planning Association

American Medical Association*

Better Business Bureau of Central Virginia, Inc.

Blue Cross/Blue Shield of the National Capital Area*

Blue Cross/Blue Shield of Virginia

Community Hospital of Roanoke Valley***

Council on Indians

Council on the Status of Women

Department for Children

Department for the Aging*

Department for the Deaf and Hard of Hearing

Department for the Rights of the Disabled

Department for the Visually Handicapped

Department of Agriculture and Consumer Affairs*

Department of Health**

Department of Health Professions**

Department of Medical Assistance Services**

Department of Mental Health, Mental Retardation, and Substance Abuse Services**

Department of Rehabilitative Services*

Department of Social Services

Department of Volunteerism

Division of Emergency Medical Services, Department of Health

Elizabeth Nichols*

Emergency Nurses' Association

Equicor Health Plan

Family Care*

Health Insurance Association of America

Health Services Cost Review Council

Mary Immaculate Med-Care***

Maryview Medical Center***

Maryview Med-Care***

Medical Society of Virginia

Medical Society of Virginia, General Counsel's Office***

Medical Society of Virginia Review Association

National Association for Ambulatory Care

Old Dominion Dental Society

Old Dominion Medical Society

Old Dominion Pharmaceutical Association

Patient First**

PHP Health Care*

Regional Health Planning Agencies
Health Systems Agency of Northern Virginia*

Regional & Local Health Districts
Fairfax Health District**
Fredericksburg/Winchester Health Department*
Hanover Health District Director*
Mecklenburg County Health Department*
Northwestern Regional Medical Director*
Portsmouth Health District*
Prince William Health District**
Rappahannock/Rapidan Health District*

Regulatory Evaluation and Research Committee, Board of Health Professions, Department of Health Professions**

Richmond Area Business Group on Health, Inc.

Richmond Academy of Medicine***

State Corporation Commission

The Honorable Marian Van Landingham***

The Retreat Hospital

Virginia Academy of Clinical Psychologists

Virginia Academy of Physician Assistants

Virginia Association of Allied Health Professions*

Virginia Association of Chain Drug Stores*

Virginia Association of Counties

Virginia Association of Dental Hygienists

Virginia Association of Non-profit Homes for the Aging

Virginia Association of Nurse Anesthetists

Virginia Association of Volunteer Rescue Squads

Virginia Chamber of Commerce

Virginia Chapter, National Association of Social Workers

Virginia Chiropractic Association

Virginia Citizens Consumer Council*

Virginia Clinical Counselors Association

Virginia Counselors' Association

Virginia Dental Association

Virginia Farm Bureau Association*

Virginia Health Care Association

Virginia Health Council

Virginia Hospital Association**

Virginia Licensed Practical Nurses Association

Virginia Municipal League

Virginia Nurses Association*

Virginia Optometric Association

Virginia Osteopathic Medical Association

Virginia Pharmaceutical Association

Virginia Physical Therapy Association

Virginia Podiatric Medical Association

Virginia Poverty Law Center**

Virginia Primary Care Association

Virginia Psychological Association

Virginia Society for Clinical Social Workers

Virginia Society of Hospital Pharmacists

Virginia Society of Ophthalmology

Virginia Society of Respiratory Therapy

Virginia Speech, Language and Hearing Association

Virginia State Bar, Health Law Section

Williamson Institute of Health Studies, Medical College of Virginia

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* Organizations and Individuals submitting written comments on Walk-In Medical Clinics (WIMCs).

** Organizations and Individuals submitting written comments and participating at or attending the Public Hearing on WIMCs.

*** Organizations and Individuals participating at or attending only Public Hearing on WIMCs.

APPENDIX C

Overview and Design

Study of Walk-in Medical Centers (WIMCs)

OVERVIEW AND DESIGN FOR STUDY OF COMMERCIAL WALK-IN CLINICS

STATUTORY BASIS FOR STUDY

HOUSE JOINT RESOLUTION NO. 303
1989 SESSION OF THE VIRGINIA GENERAL ASSEMBLY (attached)

PURPOSES AND OBJECTIVES OF THE STUDY

1. To define, classify and inventory commercial walk-in medical centers (WIMCs) in the Commonwealth;

2. To identify and document problems in the WIMC industry in the Commonwealth that negatively affect the health, safety and welfare of consumers;

3. To describe the current regulation of WIMCs and health care personnel operating in WIMCs and to assess the adequacy of this regulation to protect the public;

4. To recommend any changes in the State regulation of WIMCs that may be necessary to address identified problems;

5. To prepare a report of findings and recommendations for consideration by the Governor and the 1990 Session of the General Assembly.

METHODS OF STUDY

The study plan establishes a three-stage process to accomplish the objectives identified above:

1. A small Task Force will be formed to oversee the implementation of the study; monitor progress and suggest changes, when appropriate, to accomplish study objectives; establish appropriate communication and consultation with expert agencies and individuals; convene public hearing(s); and prepare a report of findings and recommendations.

Task Force membership will include representatives from the Department of Health Professions (Policy Analyst, Boards of Medicine, Nursing and Pharmacy), Department of Health (Offices of Planning and Regulatory Services and Community Health Services), Department of Medical Assistance Services, and Office of the Attorney General.

2. A network of expert organizations and individuals will be consulted to assist the Task Force. This network will include, but not be limited to, representatives of the WIMC

industry, professional associations in medicine, nursing and pharmacy, provider organizations, peer review organizations, insurers and third-party payors, consumer organizations, and educational and policy research institutions.

3. The larger community of health service providers and consumers will be invited to comment in one or more public hearings convened during the study period.

SPECIFIC COMPONENTS OF THE STUDY

1. A literature review and an inventory will be conducted to: (a) identify means of defining and classifying WIMCs; (b) establish base line information on the history and current status of WIMC development in the Commonwealth; and, (c) compile an inventory of:

i. type and range of services offered;
ii. staffing patterns;
iii. regulations that affect development and operation of WIMCs;
iv. methods of financing and reimbursement for services rendered, especially by public health assistance programs;
v. organizational structure;
vi. factors that affect utilization, and;
vii. other dimensions identified by the Task Force.

2. Existing regulations of the Commonwealth, the federal government, and privately controlled quality assurance programs will be reviewed and assessed for their adequacy in protecting the public.

3. The views of a wide audience of providers and consumers relative to the adequacy of WIMC operations, regulations that affect WIMCs, the effects of WIMCs on other types of health care delivery, and other topics will be solicited using public hearing formats. Invitations to comment will be extended to identified owners/operators of WIMCs, organizations representing health care providers, practitioners and consumers, third party payors, relevant agencies of the Commonwealth, and the general public.

4. Complaints related to the operation of walk-in medical centers filed with agencies of the Commonwealth and with private agencies will be analyzed to detect deficiencies, misrepresentations and other problems that adversely affect the health, safety and welfare of the public.

5. A written report of the Task Force will be prepared as a result of this study and submitted to the Governor and 1990 General Assembly following approval by the Directors of the Department of Health Professions, Department of Health, Department of Medical Assistance Services, and the Secretary of Health and Human Resources.

TIME FRAME FOR COMPLETION OF STUDY

The duration of the study will be four months (July 1 - November 30, 1989).

AGENCIES OF THE COMMONWEALTH RESPONSIBLE FOR CONDUCT OF THE STUDY

Virginia Department of Health Professions
Virginia Department of Health

STUDY CO-DIRECTORS

Richard D. Morrison, Ph.D., Policy Analyst, Department of Health Professions

Marilyn H. West, Director, Division of Resources Development, Department of Health

SCHEDULE OF SIGNIFICANT EVENTS

7/21/89	Obtain Comments from State Health Commissioner, Director of Department of Health Professions, and Secretary of Health and Human Resources
7/25/89	Finalize Preliminary Work Plan
8/10/89	Convene first meeting of Task Force
8/15/89	Complete literature review
8/22/89	Determine additional information required to develop inventory on WIMCs
9/1/89	Convene second meeting of Task Force to consider findings from tasks completed to date and identify any additional research required.
9/15/89	Convene Public Hearing(s) on WIMCs
9/30/89	Deadline for public comments
9/30/89	Complete inventory of WIMCs in the Commonwealth
10/10/89	Convene third meeting of Task Force to consider findings and review preliminary drafts on completed work
10/31/89	Complete preliminary draft of report including suggested recommendations
11/15/89	Convene final meeting of Task Force, review and approve draft report.
11/30/89	File final report with Secretary of Health and Human Resources for forwarding to the Governor and General Assembly.