Author's response to reviews

Title: Urgent care centers in the U.S.: Findings from a national survey

Authors:

Robin M. Weinick (rweinick@partners.org)
Steffanie J. Bristol (sbristol@partners.org)
Catherine M. DesRoches (cdesroches@partners.org)

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Response to reviewers

We thank the reviewers for their extremely helpful comments, and believe that our resubmission represents a significantly stronger manuscript that has benefited from them. Our detailed responses are listed below.

Ellie Grossman

Major Compulsory Revisions

1 a-c: As Dr. Grossman points out, this segment of the health care system has not been previously explored in the literature. In the course of our literature review, in fact, we were unable to find any articles that conducted empirical research into the nature of urgent care centers, and none have previously defined their scope other than papers written by the authors of the current manuscript. As a result, we partnered with the Urgent Care Association of America, a non-profit trade organization, to define what did and did not constitute an urgent care center. We have published a paper in their journal, the Journal of Urgent Care Medicine, that provides details on our definition of an urgent care center and describes the process we used to construct our sampling frame in greater detail than in the current manuscript. That paper is now cited, and we have added additional information regarding the screening of clinics, the number of clinics we found in constructing the sampling frame, and the number sampled for the survey. We selected at random within the 4 census regions because we know very little about how clinics are distributed nationwide (since we have not screened the entire sampling frame), and therefore wanted to use the broadest geographic level we could while ensuring that we had a sample that was distributed across the country.

1d. We have included more information in the text to clarify our response rate calculations. We calculated this response rate using the American Association of Public Opinion research standard response rate 3, which applies and eligibility rate to the number of sampled respondents for whom we were unable to establish eligibility. The eligibility rate represents the estimated proportion of cases of unknown eligibility that are actually eligible for the survey, using the rate of eligibility found among respondents (e = total number of completed surveys/(total number of completed surveys + total number of ineligibles)). Applying the eligibility estimate to our data resulted in a response rate of 50.2% [18]. The specific response rate calculation is as follows:

\[
RR = \frac{\text{Total number of completes}}{(\text{total number of completes}) + (\text{refusals and non-contacts}) + e(\text{unknown eligibility})}
\]

\[
RR = \frac{436}{436} + 257 + .422(415)
\]

\[
RR = 50.2%
\]
There is no particular reason to think that responders and non-responders were differentially likely to actually be urgent care centers.

1e. Per the terms of our IRB for this particular project, no information was retained that would allow for a responder vs. non-responder analysis.

2. The envelope and cover letters that accompanied the survey were addressed to a physician at the organization, by name if one was available or to “Medical Director” if one was not. Approximately one-half of the surveys were answered by physicians, one-third by office managers, and the remainder by other clinical or non-clinical office staff. The surveys were mailed with telephone follow-up according to standard protocols. This information has been added to the manuscript.

3. We have published some information on center ownership in the Journal of Urgent Care Medicine (published since our submission to BioMed Central), which we have added to the current manuscript with a citation. Nearly all urgent care centers, other than those owned by hospitals, are likely to operate as for-profit organizations, as they often operate as standard physicians’ offices; more than half of such centers are physician owned. We had originally considered a geographic analysis of our sampling frame, but given the significant number of organizations that turned out not to actually be urgent care centers, we decided that this was not feasible unless we first screened the entire sampling frame.

4. We do not have any empirical information on how patients are charged, but believe that there is likely to be considerable variation within the field. Anecdotally, we know that some centers have contracts with insurance companies, others take cash payments, and some do have a sliding scale available – but there is not adequate evidence of this. We hope to partner with the Urgent Care Association of America on future surveys, and this is one of the topics we would like to explore at that time.

Minor Essential Revisions

1. Table 2 has been revised to include the percent of centers employing at least one person in each category, the mean number on staff if at least one, and the mean number on staff full time if at least one. We found this to be a particularly helpful suggestion from the reviewer, and thank her for the feedback.

2. In centers with at least one physician on staff (95.8%), there are 1.8 physicians on staff full time. We do not have data from this survey on numbers of FTE physicians.

3. Tests that are waived under CLIA are simple laboratory tests with a low risk of error, such as urinalysis by dipstick to check glucose levels, as determined by the Food and Drug Administration. Tests designated as moderate are those with greater complexity and level of error than waived tests, but are not so complex as to require full laboratory certification. This information, as well as more detailed information on pain management, has been added to the manuscript.
1. We have clarified the definition of urgent care centers in addressing the question of how we screened the organizations.

2 and 3. As this is a first study in this area, we believe it is important to provide comparison data to other types of clinical practice areas, which is available only in the published literature. Presenting these data in a separate section would result in a great deal of repetition in the manuscript. For the sake of brevity, we have retained the citations in the results section. However, we have restructured the discussion and conclusion to be consistent with the journal’s style.

4. We have added Table 3, which includes the distribution of number of patients per week, and thank the reviewer for this particularly helpful suggestion.