

patient may be less likely to adhere to the treatment plan. HIT can enable effective patient-centered care, integrating patient choice into the primary care encounter.

Funding Source(s): AstraZeneca

Poster Number: 517

Hospital-Affiliated and Hospital-Owned Retail Clinics: Strategic Opportunities and Operational Challenges

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Research Objective: Retail clinics (also called Convenient Care Clinics) have experienced an exponential growth in the last few years. While the majority of retail clinics are free-standing, venture-backed companies affiliated with retail hosts, an increasing number of hospital systems have decided to develop their own retail clinics or partner with existing national companies in the last few years. The objective of this research is to assess the strategic considerations behind these decisions and the operational challenges associated with them.

Study Design: We conducted eight in-depth interviews with administrative and clinical leaders in seven hospital systems across the country that have or had a relationship with retail clinics in the last three years. The interviews were done by phone between July and September of 2009, using structured open-ended questions developed by the author.

Population Studied: The seven health systems represented a good mixture of owned/affiliated clinics (a total of 17 owned and 31 affiliated clinics). They operated in five states (Texas, California, Minnesota, Virginia and Pennsylvania). Given that there are only 25 health systems in the county that own/are affiliated with retail clinics, we believe that our sample is fairly representative.

Principal Findings: Our findings show that the hospital systems' association with retail clinics involves two main models: an affiliation with retail chains that operate the clinics, or ownership of the clinics with an arms-length relationship with the retail chain. Hospital systems are engaging in these relationships for several strategic reasons: to increase market share through enhanced referrals to physician offices and hospitals, to become closer to consumers, and to experiment with non-traditional ways of delivering health care. Operational challenges included physician resistance and skepticism, poor financial performance, people's perception of retail clinics, staffing issues, and the business model being new. Six out of eight respondents thought that hospital affiliation with/ownership of retail clinics is a trend

that is here to stay, although many provided caveats and stipulations.

Conclusions: Our interviews provide a selective profile of hospital systems that have affiliated with or developed their own retail clinics. We found several strategic reasons for these decisions, and identified important operational challenges that need to be overcome for this trend to continue. Further research is highly needed to provide more evidence about this emerging way of healthcare delivery.

Implications for Policy, Delivery or Practice: Several implications for research emerged. It is very important to compare the performance of hospital-affiliated and hospital-owned retail clinics, in terms of profitability, market share, costs and quality outcomes. There is reason to believe that health systems that jump on the retail clinic bandwagon without a good understanding of the model are more likely to end up with financially struggling clinics. Therefore, future research should examine the strategic planning process that health systems use to make affiliation or ownership decisions, and assess whether the length of time of the process and its thoroughness make any difference in terms of the future viability and success of the clinics. Another important unanswered question from the hospital systems' perspective relates to whether retail clinics actually increase referrals to Primary Care Physician offices and hospitals.

Poster Number: 518

English Language Proficiency and Lifetime Mental Health Service Utilization in a National Representative Sample of Asian Americans in the United States

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Research Objective: U.S. Department of Health and Human Services reported that the lack of English language proficiency and the shortage of providers who possessed appropriate language skills were identified as major barriers to mental health service use for approximately half of the population of Asians and Pacific Islanders. The aim of this study was to examine the predictors of lifetime mental health service use in relation to English language proficiency among Asian Americans.

Study Design: This is a secondary data analysis with data from 2,095 Asian participants from the

National Latino and Asian American Study (NLAAS) were analyzed using logistic regression.

Population Studied: NLAAS Data were collected between 2001 and 2003 during face-to-face interviews. The sample of 2,095 included 520 Vietnamese, 508 Filipino, 600 Chinese, and 467 Other Asian.

Principal Findings: The respondents who speak, write, and read English were more likely to use at least one mental health service once in their lifetime in the US (Odds ratio [O.R.] = 1.15, 95% confidence interval [CI]= 1.03, 1.28, $p = 0.011$). The age at immigration to the US was a significant predictor. Compared to respondents who were born in the US, those who immigrated to the US between the ages of 18 and 34 or 35 years old or older were less likely to use mental health services. Compared to the respondents who rated their physical health as excellent, the odds for respondents (who rated their physical health as poor) to use mental health service were 3.42 times as high as the odds. Compared to the respondents who rated their mental health as excellent, the odds for respondents 1) who rated their mental health as poor to use mental health service available were 8.43 times as high; 2) who rated their mental health as fair to use at least one service are 3.10 times as high; and 3) who rated their mental health as good were 2.47 times as high. Compared to respondents who had no mental health problems based on a DSM-IV diagnosis in their lifetime, the odds for those who had any mental health problem to use at least one service in their lifetime were 6.27 times as high.

Conclusions: Respondents with better English language proficiency and with mental health diagnosis were more inclined to use mental health services. Participants who were born in the US, who were widowed, separated or divorced, who sought comfort from religion, who reported worse physical health and who reported worse mental health self ratings, were more likely to use mental health services. The lack of health insurance coverage was not a significant predictor of mental health use.

Implications for Policy, Delivery or Practice: The public health implications for behavioral health include the need to educate health care providers working with Asian Americans regarding the benefits derived from seeking services and making interpreter services available in a culturally sensitive environment.

Funding Source(s): ESIN and NIA

Poster Number: 519

Impact of Onset to Admission in Inpatient Rehabilitation Facilities on Discharge Destination Settings in Patients with Stroke

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Research Objective: The objective of this study was to identify the association between days of onset of stroke to Inpatient Rehabilitation Facilities (IRF) admission and discharge settings (community, long term care, and institutions) in patients with stroke.

Study Design: The study was a secondary analysis of records obtained from the Uniform Data System for Medical Rehabilitation (UDSMR) for patients with stroke. The UDSMR is the largest non-governmental registry comprised of data for medical rehabilitation from across the U.S. We used multinomial logistic regression to determine impact of onset to admission on discharge settings (community, long term care [LTC], and institutions), after controlling for demographics, health-related, environmental, functional status, and availability of resources factors.

Population Studied: Patients with stroke discharged from IRF in the year 2006-2007 were included in the study. We included patients aged 30 and above, with complete information related to stroke type, and those admitted from acute setting to IRF. Excluded were patients with onset to admission duration of more than 20 days. Finally, data for patients with mortality as an outcome in the course of rehabilitation were excluded. The final sample comprised of 219,046 patients with a primary diagnosis of stroke.

Principal Findings: After adjusting for demographics (age, gender, race), health-related (stroke type, comorbidities), environmental (living at home prior to admission to acute care, and type of IRF), resources availability (type of health insurance), and functional status at admission (motor and cognitive Functional Independence Measure), days to admission to IRF was associated with discharge destination settings. For those under the age 65, higher onset to admission days were associated with higher odds for admission to long term care versus discharge to community settings (OR=1.008, CI=1.001-1.016). This association was higher for discharge to institutions as compared to community settings (OR=1.032, CI=1.026-1.037). Thus, for an increase of 5 days to admission to IRF after stroke onset, the odds of discharge to institutions are 17% higher compared to discharge to community settings. For patients 65 and above, the association between onset to admission and discharge to LTC was significant (OR=1.007, CI=1.003-1.011). This association was higher for admission to institutions as compared to community settings (OR=1.035, CI=1.031-1.038). Thus, for an increase of 5 days to admission to IRF after stroke onset, the odds of discharge to institutions are 18% higher compared to discharge to community settings.