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The Growth of Retail Clinics and the Medical Home: Two Trends in Conflict?

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Abstract

There has been growing interest in the patient-centered medical home as a way to provide coordinated, high quality primary care. At the same time the number of retail clinics has increased dramatically. Many are concerned that retail clinics undermine the medical home by fragmenting care. In this piece we explore the juxtaposition of these trends, highlighting shared characteristics and sources of tension. We describe three types of relationships between retail clinics and primary care providers. With some relationships we argue that there is no conflict, while we describe areas of potential concern for other relationships.

Introduction

The patient-centered medical home has garnered increasing support as a mechanism to better coordinate care, improve quality, decrease costs, and revitalize primary care(1-3). During the same period that the medical home concept has gained prominence, there has been tremendous growth in the number of retail clinics which offer convenient care for simple acute illnesses.

At first glance these two trends are in opposition: the medical home emphasizes coordination of care, while retail clinics focus on single visit, acute care. Retail clinics might lead to increased fragmentation(4-6); as a visit to a retail clinic may represent one less visit to a medical home. This could undermine a patient's connection to their medical home and prevent the medical home from providing coordinated and continuous care.

However, on closer examination it becomes clear that the medical home and retail clinics share a number of core principles. In this piece we examine these shared principles and identify where retail clinics might be in conflict with the medical home. We first describe the medical home and retail clinics and then define three different types of relationships that currently exist between retail clinics and primary care physicians. For each relationship we highlight how care coordination and financial considerations may promote and/or impede collaboration between the two care settings.

Increasing interest in the patient-centered medical home

The medical home has received growing attention as a way to reinvigorate primary care by providing "continuous and coordinated care throughout a patient's lifetime to maximize health outcomes(7)." In this issue of Health Affairs, Bruce Landon and colleagues describe the many ongoing medical home pilot programs.

There is no single definition of the medical home. Several physician organizations have published descriptions of the core principles of the medical home while the National Committee for Quality Assurance has outlined the capabilities necessary for a practice to be a medical home(8-9). The medical home concept emphasizes improved access through open scheduling and enhanced hours. The medical home is staffed by a team of providers, which may include nurses and other health professionals, led by a personal physician, and there is a focus on coordination of the patient's care among providers. An integral component is an electronic medical record (EMR) that directly incorporates evidence-based medicine and decision support tools. Finally, proponents have emphasized the need for changes in the payment system to support the creation of medical homes.

The number of retail clinics is growing amidst criticism

Retail clinics are medical clinics typically located within retail stores such as grocery stores or pharmacies that are usually staffed by nurse practitioners. Their focus is on patient convenience and they are open on evenings and weekends on a walk-in basis. Retail clinics generally have a limited scope of care that includes minor infections such as sore throat and cough, immunizations, and routine preventive screening. For conditions that fall outside their scope of care, retail clinics refer patients to other providers in the community. Almost universally, retail clinics use EMRs that directly incorporate evidence-based guidelines.

Compared to an emergency department or physician's office, care at retail clinics is less costly(10). Retail clinics may even avert costly non-emergent emergency department visits, though there is not yet any evidence to support this possibility. The evidence to date suggests that retail clinics provide high quality care compared to other settings(10) and have high adherence to evidence-based guidelines(11).

Nearly all clinics accept some form of private insurance and many accept public insurance options(12). To encourage enrollees to visit retail clinics, some health plans have reduced or waived copayments for retail clinic visits(13). For patients that pay out of pocket for care, prices are clearly posted so that patients know the costs of care prior to the visit.

There are an estimated 1,177 clinics as of December 2009(14) and over a third of the urban US population (35.8%) lives within a 10-minute drive of a clinic(12). While some retail clinics are located in underserved communities, as a whole, they are more likely to be located in wealthier neighborhoods(15-16). Estimates for retail clinic utilization have varied widely in surveys from 2.3% of the population to 13% of families(17-19). Compared to the general population, retail clinics users are more likely to be uninsured and lack a usual source of care(17).

Retail clinics have faced criticism on a number of fronts. Perhaps most prominently, physicians and policy makers have worried that retail clinics will lead to further fragmentation and undermine the medical home(4-6). Visiting a retail clinic for acute conditions rather than one's medical home may, over time, erode the patient-PCP relationship. In situations where a patient does not have an established relationship with a PCP, the opportunity to receive acute care at a retail clinic may lessen the patient's impetus to establish one. Increased fragmentation may further present 'missed opportunities' for patients to receive appropriate preventive care and chronic conditions. For example, a child who presents to their PCP with an earache, could also receive a needed immunization, and an adult who sees their PCP because of a cough could also have their diabetes medication adjusted. These ancillary but important services may be missed if a patient presents to a retail clinic. Though the data were limited to one health plan in Minnesota, the only study to examine this issue did not find any negative impact of retail clinics on the delivery of preventive services(10).

Another important criticism of retail clinics stems from the fact that many are for-profit entities. For example, Take Care Health Systems is a wholly-owned subsidiary of Walgreens which is a for-profit company. Given their location within retailers that sell medications and other health-related items, the concern has been raised that retail clinics may be motivated to inappropriately increase the sale of pharmaceutical products(20). So far, initial studies do not show inappropriate prescribing(10-11). An additional concern is that the short and long-term business objectives of parent companies may not always overlap with important public health goals(21).

There has been criticism that retail clinics will undermine the financial viability of the medical home. Common reasons for retail clinic visits comprise approximately 13% of adult PCP visits and the loss of visits may represent a financial blow to PCPs(22-23). Further, physicians may be less able to spend saved time from simple acute visits on more complicated and time-intensive patient visits for which time spent is often inadequately reimbursed. Alternatively, off-loading simpler visits could provide physicians with more time to schedule and bill for more complicated patient encounters. Lastly, there is concern that despite the lower costs per episode of care at retail clinics(10), induced demand could increase health care spending overall.

In response to these concerns, many medical societies have issued statements and guidelines on retail clinics. The American Academy of Pediatrics has formally opposed retail clinics for children(4). Other medical societies have neither opposed nor endorsed retail clinics(24-26), but they have emphasized that retail clinics should have a limited scope of practice, provide adequate oversight of the providers, and ensure care coordination with local providers.

Shared principles and key conflicts

In light of the criticism of retail clinics, it is perhaps surprising that the medical home model and retail clinics share many key principles. These include a focus on improved access to care; the incorporation of electronic medical records and evidence-based guidelines; and the use of non-physicians for services that do not require physician-level training. Moreover, both medical homes and retail clinics are 'patient-centered', though they rely on a different conception of the term. In the medical home, patient-centeredness focuses on shared decision-making and addressing the multi-faceted needs of patients. For retail clinics, patient-centeredness relies on convenience where care is provided in consumer-friendly locations, with extended hours, and no appointment.

However, there are some differences in the two models. The medical home emphasizes comprehensive care while retail clinics provide only episodic care for acute conditions or preventive care services. In practice the medical home is typically a single geographic location where care is provided. In contrast, retail clinics provide care at multiple different sites that may be considered largely interchangeable within chains given the shared EMR and highly standardized menu of options.

The key difference – and important source of potential conflict – centers on care coordination. Care coordination, as typically envisioned, addresses the integration of care across all providers for patients with complex chronic illnesses. Care coordination has a different interpretation in the context of the simple acute conditions managed by retail clinics. Ideally providers in both settings have access to shared medical records at the point of service. This would improve patient safety (e.g. prescribing a medication to which the patient is allergic). In addition, providers could identify larger trends outside of the acute illness (e.g. recurrent episodes of sinusitis might represent a more serious

immunodeficiency) and ensure optimal preventive or chronic disease care (e.g. administer influenza vaccine to patients with asthma).

Three different types of relationships that currently exist between retail clinics and primary care

The relative importance of the differences described above varies considerably and depends on the relationship between the medical home and retail clinics. We describe three commonly encountered models: the fully integrated model, the hybrid model, and the independent model. Under each we assess the impact on coordination of care and discuss the potential financial impact of retail clinics on primary care providers.

Integrated model

In the integrated model, retail clinics are owned and operated by existing health care providers. In 2008, over 20 physician groups or hospital chains operated retail clinics, including MayoClinic and Geisinger Health System(12). For example, the Heritage Valley Health System in Pennsylvania operates three retail clinics in nearby Walmart stores. The nurse practitioners who staff the retail clinics are employees of Heritage Valley. Each retail clinic is linked to a primary care practice and the larger health system through a shared EMR, which allows the retail clinic provider access to the patient's medical history. The nurse practitioners at the retail clinic collaborate with physicians in the linked practice and their notes are co-signed by physicians in the practice. Nurse practitioners may work at both the retail clinics and the linked primary care practices. Lastly, visits to the retail clinic accrue to the larger physician group, mitigating any negative impact of retail clinics on aggregate primary care physician revenue(27).

In this type of integrated model, retail clinics can be reasonably seen as simply an extension of the medical home. Except for the physical location where they take place, visits to the nurse practitioner in the retail clinic are identical to those with the same nurse practitioner in the primary care practice. Though the medical home might be interpreted as a single geographic location, there is no reason that the medical home could not encompass multiple sites. Through this type of relationship, the medical home may choose to rely on the retail clinics to off-load simpler conditions as well as extend hours and convenience. It is also possible in this model to leverage retail clinic visits to encourage patients to receive chronic care management or preventive services(28), though it is currently unknown to what extent this is occurring in practice.

It is also important to recognize that this model is not integrated for all patients, as integrated retail clinics provide care for many from outside the health care system. EMRs for these patients will not necessarily be linked, and the retail clinic would then operate similarly to the independent model we describe below.

Hybrid model

The second model of care is a hybrid model in which there is a formal collaboration between retail clinics and medical practices and the clinics are "co-branded." However, the retail clinics and medical practices remain separate financial entities. An example of this scenario is the partnership between Cleveland Clinic and MinuteClinic(29). Supervision of the retail clinic provider will be performed by a Cleveland Clinic physician and, though it has yet to be fully implemented, the two organizations are moving towards a shared EMR.

Under a shared EMR retail clinic providers would have access to the patient's history including medications and allergies. Physicians in the medical home could review the

patient's retail clinic records, allowing them to see trends in patient visits that could signify the need for expanded care. Such a shared electronic medical record eliminates several potential problems with lack of care coordination. Further, oversight of the care provided at retail clinics by a physician in the same health care system—though not necessarily the patient's medical home—may help mitigate some concerns over care coordination.

While a shared EMR is important, there are residual concerns. It is unclear whether retail clinics would encourage patients to receive preventive care and chronic care as there may be less incentive to do so for services not offered by the retail clinic. Further, the use of retail clinics in this scenario may still present lost opportunities for patients to strengthen their relationship with the medical home.

Under a hybrid model the medical home may lose revenue from acute care visits. However, it is conceivable that retail clinics could generate revenue for partnered medical practices through (1) fees paid by retail clinics for branding, (2) payments to physicians for oversight of retail clinic providers, (3) increased referrals and (4) further advertising for the health system.

Independent model

The final model is the independent model. In this setting, clinics are owned and operated by private companies such as MinuteClinic (for most sites), Target, and TakeCare. There is no shared EMR and communication to primary care providers is performed via faxes/printouts. There is no financial linkage between the sites.

The key difference between this model and the hybrid model is the lack of a shared EMR. While there is communication back to the PCP, it is solely in one direction (from retail clinics to the PCP). This may present safety issues and create missed opportunities for patients at retail clinics. Safety issues may arise, for example, when the retail clinic provider does not have a list of a patient's current medications or allergies. Missed opportunities may stem from patients not being 'flagged' to receive preventive care or chronic disease management. Further, oversight of the retail clinic providers is not performed by a physician in the patients' medical home or in the same health care system. Given retail clinics' current scope of care, the relevance of these concerns over care coordination are uncertain. For simple acute problems, the patient's own physician may not need to supervise care given the high quality of care provided by nurse practitioners(10). Most patients who visit a retail clinic are generally healthy and therefore are more likely to accurately report their history and medications(30).

From a financial perspective, retail clinics in this model could represent a loss of revenue for medical homes. Medical homes may also elect to receive referrals from retail clinics which may help offset any potential financial loss.

VI. Conclusions and future directions

In examining the juxtaposition of retail clinics and the medical home, we have described the potential conflicts that exist between retail clinics and the medical home under three main types of relationships. Under the first type, the integrated model, we argue that retail clinics are an extension of the medical home without conflict. Retail clinics may expand access to and the convenience of the medical home. In the other two types of relationships we have highlighted the potential concerns about care coordination and financial issues for the medical home. These are legitimate concerns and merit further empirical research to assess their significance.

Retail clinics are a relatively new industry and their relationship with medical homes are likely to change over time and within specific communities. The impact of retail clinics on the medical homes could change if retail clinics expand their scope of practice to include more chronic disease management. For example, some retail clinics are offering injections for osteoporosis(31). At other retail clinic chains, there has been discussion about provision of follow-up visits to assess peak flows for asthmatics and blood sugar control for diabetics(5). In this scenario, retail clinics would ideally work closely with medical homes to assist in any medication adjustment and patient management. Such collaborations between retail clinics and medical homes have the potential to lessen concerns over ‘missed opportunities’ and achieve better chronic disease management through increased access and convenience for patients. The financial implications for the medical home are, at this point, uncertain. This arrangement would likely require significant time for care coordination, raising issues of reimbursement and potential lost revenue from both the time spent on coordination and from lost follow-up appointments.

Another factor that may influence the ability for medical homes and retail clinics to coordinate care is evolving health information technology. The use of personally portable and accessible medical records or the development of robust community-wide electronic health records may increase communication between retail clinics and PCPs and allay many concerns about care coordination. An accurate and interoperable electronic vaccine registry, for example, may promote opportunities for patients to receive appropriate vaccines while ensuring that the medical home is aware of what has been administered.

The health care reform under consideration in Congress could increase the number of insured and thereby boost demand for primary care. Recent health reform in Massachusetts increased the number of insured, leading to long wait lists for new appointments with primary care physicians(5, 31). Though retail clinics are relatively new in Massachusetts, anecdotally they have been particularly popular in the state which may be a sign for future directions nationally(32).

Even without an influx of newly insured individuals, many patients currently do not have a medical home. Given the projected future shortage of primary care physicians(33) some primary care will likely need to be provided by non-physicians. Indeed, there is strong evidence to suggest that nurse-practitioners can provide high-quality primary care(34) with many states allowing for nurse practitioners to practice primary care independently(35). This trend may increase the acceptance of retail clinics. Alternatively, if medical homes take root, providing increased access and convenience for all patients, this may undermine the potential demand for retail clinics.

V. Summary

Retail clinics have different formal and informal relationships with health care systems. In models where retail clinics and medical homes are integrated in the same health care system, retail clinics appear to support the functions of the medical home. In less integrated relationships, conflicts may arise over care coordination and the potentially negative financial impact of retail clinics on medical homes. The possible expansion of retail clinic’s scope of care, changes in health information technology, and projected shortage of primary care may lead to new conflicts and opportunities for cooperation.

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