



Forum Session Meeting Announcement

Friday, November 9, 2007
11:45am–12:15pm — Lunch
12:15–2:00pm — Session

Shampoo, Sunscreen, and Strep Tests: The Retail Approach to Primary Care

A Discussion Featuring:

Sandra Festa Ryan
Chief Nurse Practitioner Officer
Take Care Health Systems
(subsidiary of Walgreens)

Dean Lin
Chief Executive Officer
CareWorks Convenient Healthcare
(subsidiary of Geisinger Health System)

Bruce Auerbach, MD
Vice President
Chief of Emergency Services
Sturdy Memorial Hospital
Attleboro, Massachusetts

Location

**Reserve Officers Association
of the United States**
One Constitution Avenue, NE
Congressional Hall of Honor
Fifth Floor
(Across from the Dirksen Senate
Office Building)

Registration Required

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Shampoo, Sunscreen, and Strep Tests: The Retail Approach to Primary Care

OVERVIEW

Medical clinics housed in grocery stores, pharmacies, and other retail outlets are proliferating; there are about 500 now in operation and perhaps 200 more expected to join them by the end of 2007. Various known as retail clinics, convenient care clinics, and limited-service clinics, these facilities offer basic health care services on a walk-in basis. They are most commonly staffed by nurse practitioners, though some employ physicians. While surveys show that most consumers have yet to experience this type of health care, the reactions of those who have been served in such settings have been quite positive. Physician response to this new model has been mixed, with skepticism prevailing. Commercial insurers are gradually moving to covering a clinic visit as they would a visit to a doctor's office. This Forum session will explore the promise and the limitations of a model that seeks to make basic medical care more accessible and affordable. It will also consider how quality and continuity of care for patients may be helped or hindered by the entry of these new players.

For more information — See Mary Kate Scott, "Health Care in the Express Lane: Retail Clinics Go Mainstream," California Healthcare Foundation, September 2007.

SESSION

At 7:30 a.m. on Saturday, a woman wakes to find her eyelashes stuck together and her itchy eyes a gruesome red. Does she: a) resign herself to waiting until Monday to try to see her regular physician; b) head to an urgent care center; or c) stop by her local grocery store or drugstore? In a growing number of locations with retail clinics available, the choice might well be "c."

Of course, a number of factors play into such a decision. How much pain is this person in? Does she already have a primary care doctor? Is her doctor likely to be able to see her on Monday? Does she have health insurance? What if she had chest pain rather than probable pinkeye? And does she live where a grocery store or drugstore chain has gone into the clinic business?

DEVELOPMENT OF RETAIL CLINICS

Retail-based health clinics, whose proponents prefer the label "convenient care clinics," are a new player in primary care. From 60 or so locations at the beginning of 2006, their number has grown to 500; the Convenient Care Association (CCA) predicts 200 more by the end of 2007. MinuteClinic and Take Care Health, which began as independent businesses, have been acquired by CVS and Walgreens, respectively. The latter recently announced plans to open 100 new clinics in nine additional cities.

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Wal-Mart, Kroger, Target, and other major retailers have also entered the business. Their long-term commitment and that of other retailer partners naturally will depend on the financial return garnered and the extent to which clinic relationships with retailers become exclusive, as MinuteClinic's and Take Care Health's have become. To date, clinic operators have rarely competed head-to-head in the same market, though this is likely to change if expansion continues.

The retail clinic business model is fairly standard. As described by Mary Kate Scott in a report for the California Healthcare Foundation, the model is to "offer a limited set of services; minimize cost of care through lower-cost labor and small spaces; maintain quality with technology, physician oversight, and strict protocols; and encourage consumer use through convenience and low prices."¹

Clinic owners are quick to stress that they are not full-service health facilities. Staffed primarily by nurse practitioners, the clinics offer treatment for common ailments that can be diagnosed and treated quickly. Pinkeye is commonly on the list, as are headaches, seasonal allergies, sore throats, poison ivy, and the like. Lab tests and screenings are often available, along with vaccines. Some clinics perform routine physicals and offer prevention and wellness services.

Quick access and convenience are clinic hallmarks and selling points: no appointment necessary, most people in and out in 15 minutes, extended evening and weekend hours. Charges are in the range of \$40 to \$70, and prices are posted so that consumers know in advance what their bill will look like. For those without a physician they see regularly, or without insurance, a clinic offers another choice beyond emergency or urgent services—or foregoing care altogether.

Insurers are increasingly likely to cover retail clinic visits as they would a doctor's office visit. A Harris survey published in April 2007 found that 42 percent of clinic visits were covered by insurance (with co-pays of \$15 to \$35) and 36 percent were not; the remaining 22 percent of visits were made by people who had no health insurance. The 36 percent not paid for by insurance may have been less expensive to the patient with a doctor's office co-pay. For the uninsured, \$70 is cheaper than an emergency department visit. (On the other hand, in some communities an uninsured person also has access to community health centers that may offer a broader range of services as affordably.)

With respect to quality, clinic operators note that their employees are required to follow evidence-based guidelines for the conditions they are permitted to treat. The CCA has promulgated standards designed to ensure that patients receive "timely, accurate treatment from healthcare professionals"; adherence is mandatory for CCA members. Included among these standards are use of electronic records, agreement to monitor quality on an ongoing basis, and commitment to encouraging patients to establish a relationship with a primary care provider. Clinic operators emphasize their desire to integrate with other providers in the markets where they do business.

MIXED RESPONSE

The 2007 Harris survey found that, while only 5 percent of respondents reported visiting a retail clinic, 90 percent of those who did were satisfied with the care they received. Eighty percent expressed satisfaction with the cost. However, about two-thirds of all respondents (including those who had never visited a clinic) voiced some concern about quality of care provided by nonphysicians.²

Anecdotes have been offered about physicians who welcome the advent of retail clinics as a boon to the uninsured and those seeking care outside regular office hours. For the most part, however, the physician community's position has been guarded at best; many seem concerned that clinics have the potential to disrupt the physician-patient relationship. The American Academy of Family Physicians (AAFP) in June 2006 released its "desired attributes of retail clinics," which included a limited scope of services, use of evidence-based treatment guidelines and electronic health records, a team-based approach, and a referral system to community physicians for patients with conditions beyond the clinic's scope of practice.³ (Some analysts have commented that these might be deemed desirable attributes of physician practice as well.) The CCA standards referenced above were designed to be compatible with the AAFP's desired attributes.

The American Medical Association (AMA) adopted similar standards at its 2006 annual meeting, adding clauses about physician supervision, notifying patients of clinic practitioners' qualifications, and appropriate sanitation and hygiene guidelines.⁴ In 2007, the AMA's House of Delegates voted for further action, such as pushing for more state regulation of store-based clinics and also calling for an investigation of "inherent conflicts of interest" in joint ventures between retail clinics and pharmacy chains.⁵

The American Academy of Pediatrics (AAP) has been vocal in opposition to retail clinics as providers of service to infants, children, and adolescents on the grounds that children's health incorporates developmental expectations and milestones best addressed in the context of a "medical home." Community health center (CHC) leaders have voiced concern that clinics may lack the referring relationships with safety net providers that CHCs have worked to develop. However, they welcome expanded access to primary care, and they have expressed interest in collaborating with the new clinics.

Not all providers regard retail clinics as interlopers in the physician-patient relationship. Some large health systems have made the decision to establish their own clinics as a way of incorporating the new model into their own delivery continuum and forestalling competitors. For example, New Jersey-based AtlantiCare makes its HealthRite clinics available in ShopRite stores. Similarly, Geisinger Health System in central Pennsylvania has opened five clinics (so far) under an agreement with Weis Markets, a 167-store regional grocery chain. Geisinger leaders believe their clinics' ability to deliver high-quality care and make appropriate referrals to physicians is enhanced by their using the same electronic medical records and evidence-based guidelines employed throughout the health system.

REGULATION

All states regulate clinic personnel through licensure and scope of practice statutes (though some delegate the latter to state boards of nursing). For nurse practitioners, much hinges on state requirements for collaboration with a physician. The CCA reports that nurse practitioners currently practice independently or in remote collaboration with a physician in 43 states, while the remaining 7 states require direct physician supervision.⁶ Nurse practitioners have some level of independent authority to prescribe drugs and are eligible for direct Medicaid and Medicare Part B reimbursement in every state.

State regulation may also focus on the clinics as entities in themselves. For example, California's laws on corporate practice of medicine require clinics to be owned by local physicians who actually operate the facility and hire other staff. The Massachusetts Department of Public Health (DPH) held hearings in August 2007 focused on retail clinics after CVS sought permission to open up to 30 MinuteClinics in the Boston area. The DPH has proposed regulations that would apply to any operator of a limited-service clinic, which might include community health centers (in the form of satellite clinics) as well as corporations. Federal Trade Commission staff offered comments to DPH, commending regulatory flexibility as an approach that "might be especially helpful in an emerging market, as health care providers explore different ways to deliver basic care on a competitive basis."⁷

KEY QUESTIONS

- What is the demographic profile of clinic patients? For what conditions do they most frequently seek clinic services?
- How does the presence of clinics in a market change the profile of primary care practice overall? What effect do clinics have on utilization, especially of emergency services?
- How will the clinic business model evolve? What effect will increased competition have between physician practices and clinics and among clinics themselves?
- How can clinics demonstrate their quality of care and their cost-effectiveness to both consumers and payers?
- What efforts do clinics make to integrate their services with physicians and health centers in the community?
- Will clinics broaden their range of services, for example, to include chronic disease management?
- How is liability risk apportioned between clinic personnel, the parent company, and retail partners?
- What is the role of public programs such as Medicare and Medicaid in the further development of the clinic model?
- Are clinics an effective first step toward a medical home for all patients?

- Is greater use of independent nurse practitioners and other non-physician care providers a constructive way to prepare for what some analysts project as a looming physician shortage?
- Will physicians respond to clinics by competing on convenience, for example, expanding their own service hours, offering more same-day scheduling, or making greater use of nonphysician practitioners?

SPEAKERS

Sandra Festa Ryan is the chief nurse practitioner officer for Take Care Health Systems, now a subsidiary of Walgreens. She has 24 years' experience as a certified pediatric nurse practitioner, including 16 years as a nurse corps officer in the United States Air Force. Ms. Ryan is one of six founding officers of Take Care Health Systems. She also serves as co-chair of the quality committee of the Convenient Care Association.

Dean Lin is chief executive officer of CareWorks Convenient Healthcare, a subsidiary of Geisinger Health System in Pennsylvania. He formerly held management positions with Intermountain Health Care, most recently as regional operations officer for the system's four hospitals in Salt Lake City.

Bruce Auerbach, MD, is vice president and chief of emergency services at Sturdy Memorial Hospital in Attleboro, Massachusetts. He is president-elect of the Massachusetts Medical Society and holds teaching appointments in the medical schools at Harvard, Tufts, and the University of Massachusetts.

ENDNOTES

1. Mary Kate Scott, "Health Care in the Express Lane: Retail Clinics Go Mainstream," California Healthcare Foundation, September 2007, p. 6; available at www.chcf.org/documents/policy/HealthCareInTheExpressLaneRetailClinics2007.pdf.
2. "Most Adults Satisfied with Care at Retail-Based Health Clinics," Harris Interactive, April 11, 2007; available at www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=1201.
3. "Desired Attributes of Retail Health Clinics," American Academy of Family Physicians, June 2006; available at www.aafp.org/online/en/home/policy/policies/r/retailhealthclinics.html.
4. "Reports of Council on Medical Service," American Medical Association, June 2006; available at www.ama-assn.org/ama1/pub/upload/mm/38/a-06cms.pdf.
5. "Memorial Resolutions," American Medical Association, June 2007; available at www.ama-assn.org/ama1/pub/upload/mm/38/a07res.pdf.
6. Tine Hansen-Turton *et al.*, "Convenient Care Clinics: The Future of Accessible Health Care," Convenient Care Association; available at www.convenientcareassociation.org/whitepaperfordistribution.pdf.
7. Maureen K. Ohlhausen, Federal Trade Commission, letter to LouAnn Stanton, Massachusetts Department of Health, September 27, 2007, p. 2; available at www.ftc.gov/os/2007/10/v070015massclinic.pdf.



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