Retail Medicine

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Editor

The "convenient care" movement continues to make national headlines, from CVS's acquisition of MinuteClinic to Walgreen's recent acquisition of Take Care Health Systems. Developed in response to the need for accessible, affordable, quality healthcare, convenient care clinics (CCCs) based in retail stores and pharmacies seek to meet the basic health needs of patients with and without insurance.[1] The nurse practitioners (NPs) that primarily staff these clinics can treat common health problems (eg, strep throat and ear infections), triage patients to the appropriate level of care, advocate for a medical home for all patients, and reduce unnecessary visits to emergency rooms and urgent care clinics.[1]

Because physicians view themselves as the gatekeepers of healthcare, the convenient care movement has engendered controversy and led to a heterogeneous response from organized medicine. The American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American Medical Association (AMA) have all called for increased regulation of CCCs. AMA Board of Trustees member William A. Hazel Jr., MD, has stated that while "store-based health clinics can never replace the patient-physician relationship, with guidance from the AMA and AAFP they can offer patients a viable option for routine health care services."[2] However, in its policy statement concerning retail-based clinics, the AAP formally opposes CCCs as an appropriate source of medical care and discourages their use because of its commitment to the medical home model and because of concerns regarding fragmentation and quality of care. Nonetheless, the AAP recognizes that the economics of our current health care system will support the continued existence of CCCs and has therefore published principles to guide operations and the quality of care delivered.[3] On the other hand, with 400 CCCs in existence today and an estimated 1,500 operating by the end of next year,[4] some physicians have been trying to introduce legislation to hinder the industry's ability to grow. An Illinois State Medical Society-backed Illinois House bill would require CCCs to pay $2,500 for permits from the state health department, and the ability to obtain these permits includes stipulations such as having one physician supervisor for every two NPs.[4]

Unfortunately, these legislative efforts fail to acknowledge the excellent status of NPs in primary care. Numerous studies, as far back as the 1986 case study released by the Office of Technology Assessment,[5] have found the quality of care provided by NPs and physicians to be equivalent. Most recently, a descriptive evaluation was conducted at primary care nurse-managed health centers, where NPs practice independently within a nursing model of primary care, and population-based measures of quality and healthcare resource utilization were compared to those of like providers including community health clinics.6 With patients experiencing significantly fewer emergency room visits, hospital inpatient days, specialist visits, and having a lower risk of giving birth to low birth weight infants compared to patients in conventional healthcare,[6] the results indicate that nurse-managed health centers reduce healthcare costs through preventive care.[1]

Given the impending crisis in primary care, we therefore believe it is entirely appropriate to determine where CCCs fit into the future design of primary care delivery. Currently, the supply of physicians and nurses is diminishing while the demand for healthcare increases as baby boomers grow older and develop chronic conditions.[7] The CCC service model may efficiently provide services to a small portion of the population, giving primary care practitioners and emergency rooms more time for complex cases for which they are appropriately configured.[8] Such a model could even improve access to care and create spare capacity for primary care practices and emergency departments.[8]

In light of the CCC service model's ability to influence the design of future delivery systems, the Department of Health Policy has taken a keen interest in the growth of the convenient care industry. One of us (DBN) serves as chairman of the National Medical Advisory board of Philadelphia-based Take Care Health Systems, one of the largest retail clinic companies, and the Department of Health Policy has chaired two meetings of the advisory board to-date. We also recently produced a white paper appearing in the April 2007 issue of Disease Management whose purpose was to describe the entire history of the convenient care industry, explain the role of NPs in CCCs, describe the role of the new consumer-driven model of care, and to identify future directions for the convenient care industry.[1] This review of the field was co-authored by Tine Hansen-Turton, executive director of the newly-formed Convenient Care Association, a Philadelphia-based national organization representing CCCs that was founded by healthcare leaders in October 2006. To further understand this burgeoning industry, one of us (EJM) also attended the national Retail Health Clinic Summit in Philadelphia and the national Retail Based Health Clinic Summit in Chicago earlier this year.

As the industry grows and validates its business model for the delivery of healthcare, we are particularly interested in its future research and education agenda. With regard to future directions for research, a key issue to consider involves the collection of data on

adherence to applicable measures from the Ambulatory Quality Alliance, the National Committee for Quality Assurance, or the Centers for Medicare and Medicaid Services' Physician Quality Reporting Initiative. These outcomes may further certify CCCs' high quality of care due in part to their standardized protocols and guidelines grounded in evidence-based medicine. For example, emerging evidence suggests that usage of these protocols by NPs in CCCs to enhance the decision-making process has led to appropriate testing of, and antibiotic prescribing to, patients at risk for strep throat. Meanwhile, recent findings indicate that the major problem of primary care physicians in the testing and treatment of adults with sore throats is not which guideline to follow, but that they usually fail to follow any guideline.[9]

Moreover, formal collection of data on adherence to national quality measures leads to the question of whether CCCs should require an outside quality stamp in order to distinguish the various chains. Until this happens, CCC chains can differentiate themselves in the marketplace by publishing quality of care research in the peer-reviewed literature. Ideally, the entire industry would follow suit, leading to a commitment to transparency.

In addition to its future research agenda, the convenient care industry needs to consider its impact on the medical education system. CCCs will have to ensure continuity of care by building effective relationships with local primary care physicians.[8] It is therefore necessary to consider how this model of care delivery could become a component of the educational process. Questions then arise, including: should medical school curricula begin to include medical student training with NPs at these clinics?

While today's clinics focus primarily on providing episodic care, speculation about the future concerns whether they will become a "disruptive innovation," a service lacking features of incumbents that ultimately improves and captures the whole market.10 CCCs have clearly entered the market at the low end of medical complexity, and their current service model will almost certainly not interrupt the core business of primary care practitioners.8 However, as the industry develops over time, CCCs may in fact be poised to transmogrify into providers of chronic care management, with competency in areas such as core medical and pharmacy management and wellness management programs. The Department of Health Policy will continue to pay very close attention to these important issues.

As always, we are interested in your views. You can reach me at David.Nash@jefferson.edu.

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References

1. Hansen-Turton T, Ryan S, Miller K, Counts M, Nash DB. Convenient care clinics: The future of accessible health care. *Dis Manag*. 2007;10:61-73.
2. O'Reilly KB. Big retail clinics agree to AAFP operating guidelines. AMNews. March 5, 2007. Available at: http://www.ama-assn.org/amednews/2007/03/05/prsb0305.htm. Accessed June 6, 2007.
3. Retail-Based Clinical Policy Work Group. AAP principles concerning retail-based clinics. *Pediatrics*. 2006;118:2561-2562.
4. O'Reilly KB. Physicians pushing state lawmakers to regulate burgeoning retail clinics. *AMNews*. 2007;50(21):1-2.
5. Safriet BJ. Health care dollars and regulatory sense: the role of advanced practice nursing. Yale J Regul. 1992;9:417-488.
6. Hansen-Turton T, Line L, O'Connell M, Rothman N, Lauby J. Report to the Centers for Medicare and Medicaid Services: the nursing model of health care for the under served. Available at: http://www.nncc.us/research/CMSRevised-Section3(Body) Submitted 120604.doc. Accessed June 6, 2007.
7. Bodenheimer T. Primary care – will it survive? *N Engl J Med*. 2006;355:861-864.
8. Bohmer R. The rise of in-store clinics – threat or opportunity? *N Engl J Med*. 2007;356:765-768.
9. Linder JA, Chan JC, Bates DW. Evaluation and treatment of pharyngitis in primary care practice. *Arch Intern Med*. 2006;166:1374-1379.
10. Christensen CM, Baumann H, Ruggles R, Sadtler TM. Disruptive innovation for social change. *Harv Bus Rev*. 2006;84(12):94-101, 163.