RE: Expanding the Retail Care Clinic's Reach

Executive Summary

The retail care clinic (RCC) is a potentially powerful player in the healthcare industry. It promises greater coverage of people's needs for preventive care, while also offering convenience and lower costs. However, RCCs are not meeting projected growth indicators and are failing to reach levels of expected usage. It seems that physician disapproval, as well as state legislature, have effectively reduced the development of RCCs through several methods. At a time when the nation's healthcare system is undergoing tremendous change, it is important to reconsider the role of the RCC and its possibility to alleviate an already overburdened system.

Background

Also known as convenience care or walk-in clinics, the retail care clinic's various names suggest the same images: health centers that efficiently provide basic medical services, where a patient may receive care at their leisure without an appointment. RCCs are often located in retail pharmacies or businesses such as large-scale grocery stores or mass-market retailers; these businesses frame the medical clinic as an uncomplicated way to multitask and have one's basic medical needs met while buying groceries or household items.

RCCs cannot treat emergencies and are not targeted towards people with chronic illness: about 60% of RCC visits are for treatment of respiratory infections; immunizations and preventive services account for about 20% of visits; minor conditions such as rashes or insect bites 10%; and urinary tract infections make up around 4% of visits.[i]

The business model for retail clinics is fundamentally the same: clinics offer limited services, and encourage consumers through ease of appointment, and price transparency.[ii] Cost of care is minimized through the employment of nurse practitioners and physician assistants, and the clinics themselves are small and minimal, with most housed within a retail space, although some are freestanding.[iii] Early retail care clinics operated on an out-of-pocket model, but today many insurers, including Medicare and Medicaid, often pay for these services.[iv]

In 2006, the retail care clinic experienced a boom, and RCCs created the Convenient Care Association, allowing clinics to establish national standards of operation, as well as foster professional relationships with the medical community.[v] All indications pointed to a steady rise in usage of RCCs.[vi] However, in 2008 many RCCs began closing, and some retailers began opening their clinics only seasonally for flu shots or other periodic services.[vii] Generally speaking, growth has been disappointing, although RCCs have experienced sudden new development with the introduction of the ACA's individual mandate.[viii]

Evidence

The evidence for this report was compiled by conducting an informal literature review, researching articles on "retail clinics" and its various titles on PubMed, Google Scholar, and the online version of *Health Affairs*.

Problem

With all the benefits of easy access, convenience, and lower costs, why has the retail care clinic model not achieved greater utilization? Some have suggested that the operation of clinics has remained restricted because they are primarily run by nurse practitioners instead of physicians.[ix] However, studies show that RCCs have higher levels of satisfaction than physician offices, primarily due to the levels of personal interaction customers receive at the retail clinics.[x] Concerns about the quality of care and disruption of the medical "home" pervade the discussion of RCCs, and not surprisingly the American Medical Association, American Academy of Family Physicians, and the American Academy of Pediatrics have all been outspoken in their disapproval of the RCC model.[xi]

Fundamentally, there is a mismatch of values, comparisons, and categories concerning retail care clinics. The tacitly acknowledged issue is that RCCs are encountering obstacles to expansion and greater use because of objections raised by the physician community. From an economic perspective, physicians may be exhibiting rent-seeking behavior; that is, protecting their turf from encroaching nurses who are now becoming autonomous caregivers. This widening of NP roles may eventually lead to less demand for physician services and consequently a decrease in reimbursements. The various physician associations are resistant to change and want to keep the categories that have served them well. The relationship, or as they argue, non-relationship, that retail clinics foster with their patients goes against physician ideals of valuable doctor-patient interactions, the medical home, and continuity of care. More importantly for the consumer, physicians argue that the quality of care found at RCCs lacks in comparison to the care they can provide.[xii]

Although there is a lack of evidence that retail clinics deliver lower quality of care, the influence of various medical associations has guided state legislature, and regulations regarding RCCs have greatly hindered the ability for the clinics to grow or sometimes even operate. The FTC has already halted passage of legislation that would have prohibited clinics from freely marketing their services, but there are many other laws already in place. State corporate practice of medicine laws prohibit businesses from employing physicians or owning the organization providing physician services.[xiii] Different permits are required per state guideline, and in some states every individual clinic must be licensed, while other states allow one license to cover multiple sites.[xiv] In many states, clinics cannot employ NPs directly, and cannot own equity in these operations; studies have shown that states without ownership laws have higher clinic expansion rates.[xv]

More and more hospitals are trying to work with retail clinics to provide better service for their patients, but federal Stark Laws prevent physicians from referring patients to medical services in which they have financial interests, prohibiting an official relationship between RCCs and individual physicians. RCC proponents envision a situation where physicians are willing to collaborate with clinics, creating medical "neighborhoods" where RCCs would refer patients to physicians for long-term monitoring, and physicians refer patients to clinics to help them meet basic needs. It is difficult to seriously consider the claim that RCCs are attempting to replace physicians; most clinics have protocols to forward patient data to their primary physicians, as well as recommend patients to hospitals for further treatment.[xvi]

Additionally, there are wide variations in legislation prohibiting retail clinics from opening in certain areas and hindering the nurse practitioner's scope of work. NP practice regulations vary widely state-by-state, and requirements for physician oversight range from none required to constant on-site supervision.[xvii] In the cases of direct physician management, the increased costs associated with physician income would make it more difficult to offer lower-cost services. 22 states allow NPs to treat patients without physician supervision, while 28 require that a physician's approval needs to be documented at some point in the treatment process.[xviii] Additionally, many states have such strict legislation concerning the NP's scope of work that retail clinics find them too prohibitive and cannot expand in these states. A narrow scope of service can be a strategy in reducing costs, but it also serves

to hinder future growth. In order to expand services to preventive care and screenings, regulatory structures will need to allow NPs to work in an extended capacity.

Another problem is that retail clinics face a great deal of economic uncertainty, so most are attached to "big box" businesses in locations that need them the least; clinics often compete in large urban areas, where there are many choices for primary care. Rural areas with a greater percentage of uninsured or poorly insured still remain underserved. Marketing may also be an issue; it has been a struggle for many clinics to effectively advertise a business that has a strictly limited offering to new clients.[xix]

As the ACA expands insurance coverage to the previously uninsured, it is projected that 10 to 30 million people will be introduced into the healthcare system.[xx] Multiple studies have shown that the number of primary care physicians is at an all-time low, and the higher demand for care combined with this shortage of physicians will only worsen the delivery of primary care; retail clinics may be the key to lessening this burden.[xxi] Essential preventive services can be efficiently provided through RCCs and should not be overlooked; evidence suggests that the rapid control of H1N1 in 2009 was partially due to the accessibility of vaccinations through RCCs.[xxii] A recent study argues that RCCs are an untapped resource for HIV screening, especially in light of new CDC recommendations for individuals aged 13 to 64 to get tested at least once for HIV.[xxiii] Additionally, retail clinics have the potential to reduce emergency room costs. According to a recent RAND paper, up to 7.9% of ER visits are for non-acute conditions easily treatable at an RCC; $4.4 billion could potentially be saved annually by diverting this group.[xxiv] However, while RCCs may alleviate the overburdening of the acute care system as well as improve accessibility to basic care, there are significant regulatory barriers hindering the growth of RCCs.

Options

I suggest the following options:

1. A national licensing program for nurse practitioners solely to work in retail care clinics.
2. A communication campaign mounted by the Convenient Care Association, encouraged by the government, to increase awareness of retail clinics and nurse practitioner abilities.
3. Encouraging the expansion of clinics in underserved areas by offering incentives, such as federal corporate tax credits.

Recommendation

I believe Option 2, increasing public awareness of NP abilities and retail clinics, will be the most practical and effective choice at this time.

National retail clinic licensing for nurse practitioners would streamline the development of new clinics and widen the NP's role only in the capacity of retail clinics, controlling for physician backlash and possible unforeseen effects of NP autonomy. However, it is likely that all medical associations would present strong opposition, and state governments would not be accommodating. Considering the ACA has just begun rollout of the individual mandate and the healthcare market is uncertain, it is not the right time to push for a licensing program. This should be a long-term goal, but the issue is currently too contentious to come to a conclusion.

Expanding clinics in rural areas will help alleviate utilization issues that clinics are facing, which may slowly increase popularity and strength of RCCs. However, incentivizing retail clinics to open in these areas is essentially a patch solution that circumvents the main issue: a majority of the medical community disapproves of RCCs. While opening RCCs in unpopular areas would be a good way to compromise with physicians anxious over territories, a federal incentive would threaten the rights of state governments and may be a disservice to the growth of clinics in the long run.

Public education is essential in increasing clinic utilization, as studies have shown that consumer awareness of retail clinics remains relatively low, partly due to the misunderstanding of the nurse practitioner's scope of work and abilities.[xxv] Most marketing strategies have been counterintuitive; rather than promoting RCCs in lower income areas, advertisements have been directed towards higher income communities.[xxvi] A national campaign will strengthen public confidence in the NP's ability to provide treatment for straightforward issues, and also provide clarity on RCC services, ultimately increasing clinic use. The individual mandate will bring in a significant population to access RCCs, and as demand grows for services outside the retail clinic's domain, it is the public's influence that will drive medical associations and state legislature to reconsider RCC effectiveness. Eventually, promoting RCCs and bringing in a larger clientele will help soften the medical community's stance against retail clinics. Encouragement from the government is important because physicians easily dominate the debate, and the asymmetric information being circulated is incompletely informing the public's decision making.

Studies must be conducted to better estimate the amount of potential healthcare lost by existing legislation. While there is no current evidence that RCCs are detrimental for isolated health issues, there are indications that RCCs may lead to fragmented care, although the consequences of this care are unknown. It currently seems outside the FTC's purview to launch an investigation on market implications of long-term retail clinic practice; without enough evidence to show that RCCs do not harm the overall health of patients, the FTC will find it difficult to challenge legislative barriers already in place.

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