

# Virtual Mentor

American Medical Association Journal of Ethics  
November 2013, Volume 15, Number 11: 937-942.

## ETHICS CASE

### Primary Care Practice Response to Retail Clinics

Commentary by Rachel O. Reid, MD, MS, and Ateev Mehrotra, MD, MPH

You are chief of pediatrics at a New York City community health center. Your center has a particularly high census and is fully booked for appointments for the next 3 weeks.

One day, Dr. Colbert, a recent addition to the staff, walks into your office looking concerned. “Chief, what are we going to do about all of these CareNow patients?”

Confused, you ask for clarification. Dr. Colbert explains that because the clinic has been fully booked and has had unusually long wait times for urgent appointments, several patients on the panel have been getting checkups and care at the local CareNow, a retail clinic located in a pharmacy that is staffed by nurse practitioners. The CareNow providers are able to see patients sooner than the community health center can and write prescriptions to treat common illnesses such as strep throat and ear, eye, sinus, bladder, and bronchial infections. Minor wounds, abrasions, and joint sprains are treated, and vaccinations for common viral infections such as influenza, tetanus, pneumonia, and hepatitis A and B are also available.

“I just had a patient come in with a severe case of strep throat who had been prescribed a course of antibiotics, and I never even knew about it,” Dr. Colbert says. “What if he’d been allergic to the medication, or what if the nurse didn’t fully examine him? I had to spend an extra 20 minutes just getting the details of a medical problem I didn’t even know about, and I’m the kid’s pediatrician! What’s our policy for patients going to these clinics?”

As a seasoned physician, you are sympathetic to Dr. Colbert’s concerns about the quality of care at retail clinics. Furthermore, you realize that, since your practice’s electronic medical records are not synced with those of CareNow, there is no way to know what treatments patients actually receive. Most importantly, you want your clinic to be your patients’ “medical home,” and that means keeping tabs on all of your patients’ health interventions. At the same time, you realize that the CareNow clinic can usually treat patients faster than they can be seen in a doctor’s office, and some problems just don’t need to be dealt with by a physician. You struggle to come up with formal policy concerning the CareNow clinics.

## Commentary

This scenario asks us to consider how a busy pediatric clinic should respond to their patients visiting CareNow, a retail clinic, a type of clinic physically located within a

pharmacy or big box store. Before considering the scenario, it is useful to understand that retail clinics differ in significant ways from traditional primary care physician (PCP) offices. Retail clinics offer walk-in visits with a nurse practitioner or physician assistant for a limited range of simple acute conditions and, increasingly, some chronic and preventive services. Retail clinics are also distinct from but related to urgent care centers. Both offer walk-in care for acute medical conditions; however, urgent care centers are generally freestanding, are staffed by a mix of physicians, physician assistants, and nurse practitioners, and typically have a broader scope of practice than retail clinics and PCP offices, inasmuch as they can provide intravenous medications and laboratory and radiology services. Although they have only existed since 2000, there are more than 1,400 retail clinics nationwide, which record 6 million visits per year [1, 2].

Dr. Colbert's concerns about his patients' use of retail clinics are representative of those of many practicing physicians. Indeed, the American Academy of Pediatrics, American College of Physicians, American Academy of Family Practitioners, and the American Medical Association all have formal positions on retail clinics [3-6]. There are three general concerns of the clinic chief and professional societies: (1) unease regarding quality and safety of care, (2) apprehension regarding potential impact on coordination and continuity of care, and (3) anxiety regarding scope, oversight, and interaction with traditional PCPs.

Some research has already addressed these concerns. Retail clinics have been shown to deliver care that is comparable in quality and lower in cost than primary care offices [7, 8]. Among pediatric patients, visiting a retail clinic in lieu of a PCP is associated with less continuity of care in the following year, less likelihood of having a routine physical in the following year, and less likelihood of seeing a PCP at all in the following year [9]. There has been little empirical research on the interaction with PCPs. However, just under half of all pediatric patients who visit retail clinics report having no PCP [10]. Therefore, many children or adolescents are not making a choice to visit a retail clinic in lieu of their own PCPs.

Given this background and physician concerns, it might be tempting to create a policy banning patients from visiting a retail clinic. It is important to recognize that this is unrealistic. For the health center in the scenario, a 3-week wait for an acute care appointment is not acceptable or fair from a patient's perspective. For a given patient, retail clinics are also only one of many alternatives to visiting his or her own PCP. Patients visit other physicians or nurse practitioners within the same practice, emergency departments, and urgent care centers as well. Currently, for patients of all ages, only 42 percent of acute care visits are to a patient's personal physician [11]. Other alternatives to traditional visits with PCPs such as phone visits and telemedicine are emerging and will also attract new patients [12]. The goal of any policy towards retail clinics (or other such alternatives), therefore, is to balance patients' need for access to care with physicians' desire to serve as their patients' medical homes to achieve the shared goal of high-quality primary care.

In light of this, one prudent component of a health center's response to retail clinics would be to encourage efficient exchange of information between PCPs and retail clinics and other providers in the community. This exchange may not entirely replace the relationship continuity one has with a PCP [13], but the health center could attempt to improve informational continuity by reaching out to the retail clinics and other providers frequented by their patient population and establish a procedure for exchanging summaries after a visit. Retail clinics currently employ a variety of follow-up responses, from transmitting information between different electronic medical records (EMRs) to faxing visit summaries directly to physicians to providing hard copies of these summaries to patients [14]. The health center in the scenario could work with retail clinics in the area to formalize the most convenient or effective method for their workflow. This would only represent a one-way flow of information, however, and may not address the safety concerns raised by Dr. Colbert in the scenario. We are not told much about the health system that this health center might be a part of or about their electronic health records. However, bidirectional information flow might be achieved by providing patients access to their own health records, improving electronic health record interoperability or exchange capacity, or, lastly, by establishing a more formal partnership with local retail clinics, as UCLA and the Cleveland Clinic, among others have done [15, 16]. Such relationships may also make it easier for retail clinics to refer a patient lacking an established primary care relationship to a PCP. Indeed, the same strategies that enable informational continuity between PCPs and retail clinics may facilitate achieving the patient-centered medical home principle of coordination and integration of care [17].

Another component of any response to retail clinics requires PCPs to explicitly acknowledge what patients' behavior already makes clear: primary care is often not provided exclusively in the context of a one-on-one relationship, but rather by a broader team that sometimes includes retail clinics. This especially true for acute care, in which the time-sensitive nature of an illness often precludes a visit with a patient's own PCP due to scheduling constraints. While many retail clinics have procedures in place to send visit summaries to PCPs, many patients do not give retail clinics their PCPs' names, worried that their doctors will be upset about or uninterested in the retail clinic visit [14]. Indeed, some PCPs have reportedly adopted a policy of not seeing patients in follow-up after a retail clinic visit, not wanting to "clean up their messes" [14].

We question such policies that actively project animosity and prohibition towards retail clinics; they are detrimental to both patient safety and access to care and do not reflect a patient-centered approach to coordination of care. We also feel that it is inappropriate to single out retail clinics in this regard; visits to urgent care clinics, emergency departments, and specialists without referrals all can substitute for visits to PCPs and may warrant primary care follow-up afterwards. Moreover, many retail clinics have codified phone follow-up procedures (i.e., calling patients to check for improvement or additional problems after their visit) [14], and patients do not appear more likely to seek early follow-up care after retail clinic visit than a physician office visit [18-20]. If patient safety and continuity are paramount, then PCPs should

consider: (1) openly acknowledging their understanding that patients do sometimes need to see other providers, (2) ensuring that patients understand the importance of information being shared between providers in these instances, and (3) empowering their patients to facilitate this sharing when possible.

A final component of a potential response to retail clinics could be to use this time of deliberate evaluation of the health center's relationship with retail clinics as an opportunity to consciously consider differences between the two care delivery models. Adopting some of the attributes that attract patients to retail clinics—i.e., walk-in availability and extended hours—would be well aligned with creating the patient-centered medical home principle of enhanced access [17, 21]. It may be possible to work towards open-access scheduling, to create evening or weekend appointment slots, or to build non-visit-based mechanisms for communication (e.g., e-visits, e-mail communication with clinicians, electronic or telephonic management of chronic conditions). By making it more convenient to seek care at the health center, these strategies may increase continuity.

We are not told about the staffing or empanelment practices at this health center, but it is reasonable to assume that visits are primarily staffed by physicians. The health center chief acknowledges that “some problems just don't need to be dealt with by a physician.” Patients' implicit recognition of this fact is evidenced in their choosing to visit retail clinics at all. Perhaps strategies to staff walk-in appointments with nurse practitioners or to move toward physician-led teams including advanced practice nurses and other clinical staff for panels of patients with needs of varying complexity could be pursued to allow enhanced access while still maintaining physician-led continuity. Such strategies could free physicians to attend the complicated cases. Indeed, some have argued that retail clinics themselves serve this function, to free primary care physicians to be providers of complex care [15].

For the physicians in the scenario, development of a policy towards retail clinics and efforts to serve as a medical home could call upon many common strategies. Both require recognition of the role the PCP can play as a coordinator of the larger medical neighborhood and that a key part of that role is maintaining informational continuity. Both necessitate acknowledgement that the very nature of acute conditions requires timely and convenient access to care. The extended hours, walk-in or same-day appointment availability, and short wait times offered by retail clinics and many medical home practices better accommodate the schedule and timing constraints many patients face when seeking care for an unforeseen acute illness. Understanding why patients seek simple acute care at retail clinics and creating a medical home to provide enhanced access to comprehensive primary care services also both require physicians to recognize patients' agency in seeking health care and to more fully appreciate patients' needs and preferences regarding care delivery. An effective policy towards retail clinics and acute care in a primary care practice should address patients' need for timely and convenient acute care; enhance PCPs' role in facilitating communication and continuity between their clinics, retail clinics, and the

larger medical neighborhood; and build capacity for enhanced access to acute care within the primary care clinic itself.

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