

## BOARD OF DIRECTORS REPORT Q TO THE 2006 CONGRESS OF DELEGATES

### RETAIL HEALTH CLINICS

- (1) Resolution No. 212 adopted by the 2005 Congress of Delegates contained the following clauses:

“RESOLVED, That the American Academy of Family Physicians Board of Directors investigate the growing phenomena of retail health clinics via *AAFP News Now* and *Family Practice Management* regarding, but not limited to, patient access, ethical issues, third party payer reimbursement, legislative impact, midlevel provider relationships and statutes, and continuity and quality of care, and be it further

“RESOLVED, That the American Academy of Family Physicians identify the essential elements of a retail health clinic model that will assure quality, continuity of care with a medical home, and further help achieve the goals of the Future of Family Medicine, and be it further

“RESOLVED, That the AAFP provide leadership for the adoption and implementation of practice models consistent with the Future of Family Medicine, thus allowing family physicians to proactively meet community health care needs.”

- (2) To meet this charge, Board Chair Dr. Mary Frank appointed a workgroup on retail medicine to investigate these issues and to make regular reports and, as appropriate, recommendations to the Board. The Workgroup is chaired by the President-elect and includes several senior Academy staff. In March the Board chair added Julie Wood, M.D., to the Workgroup to bring additional member perspective. The Workgroup has met frequently over the past the year, often weekly, since this area is developing rapidly.

### The Environment

- (3) The Board of Directors first discussed the issue of retail health clinics at its meeting in December 2004, as part of its annual environmental scan. At that time only a handful of companies were providing limited health care services in retail settings, primarily in grocery stores and other retail outlets. Only one company, MinuteClinic Inc. of Minneapolis, was known to be developing a potential national model with clinics staffed by nurse practitioners and located in pharmacies in Minnesota and in Maryland. The Future of Family Medicine Report had identified that health care in the future will become more patient centered, and the Board decided that this was a potential “disruptive innovation” that could have a substantial impact on members and patients and therefore required close watching.

- (4) By the time of the December 2005 environmental scan, more than a dozen companies had entered the retail clinic field. Three in particular possessed the capital and business experience to emerge as dominant players. They are:

**MinuteClinic, Inc.** Based in Minneapolis, MinuteClinic was founded by a family physician but is now managed by professionals from the retail sector, led by Michael Howe, formerly CEO of Arby’s. In June 2006 MinuteClinic announced that it had been acquired by CVS Pharmacies for a reported \$170 million. This acquisition will give MinuteClinic a solid base of operations, although their clinics will not be located solely in CVS stores. The infusion of capital will allow MinuteClinic to accelerate expansion, and they expect to have 1,000 clinics in operation by the end of 2007;

**Take Care Health Systems, Inc.** Headquartered in Pennsylvania, Take Care is owned by Hal Rosenbluth, whose Rosenbluth Travel helped to revolutionize the travel industry through the use of technology and was subsequently sold to American Express. Mr. Rosenbluth has built a team of professionals from the pharmaceutical industry and other sectors and has strong support from the venture capital market. Take Care has clinics in Missouri, Kansas, and Oregon and is expanding to Illinois, Texas and several other states within the next 6 to 12 months.

**Redi-Clinic, Inc.** A division of Houston-based Interfit, Inc., Redi-Clinic is owned by Revolution Health Group, part of the Revolution organization being built by Steve Case, former CEO of America Online. Redi-Clinic was the first organization to pilot the retail clinic model with Wal-Mart.

(5) While there are new entrants into the retail clinic business practically every week – including some that are owned by family physicians or that employ family physicians as clinic staff – at this writing the other companies generally own one or two clinics and are not yet national in scope. The Retail Medicine Workgroup of the Board decided to focus its efforts on the three larger and better financed companies above.

(6) The members of the Workgroup have had numerous discussions with the senior management of all three organizations and have met with the leadership in person as well. The management of these companies has been willing to listen to the Academy and to address issues and concerns raised by members. It is important to note that these are for-profit business entities, and while they are willing to accommodate AAFP's views in many cases, the Academy has no real leverage to control their business model. The Academy has been able to influence their model substantially, however, due to its early and proactive engagement with them.

### **Desired Attributes of Retail Clinics**

(7) In response to the second "Resolved" in Resolution No. 212, the Workgroup developed a list of desired attributes that would address issues of quality and continuity of care in Appendix A. These Attributes have appeared in AAFP publications<sup>1,2</sup> and in the "Positions and Policies" area of *www.aafp.org*. They have also been part of AAFP's communications outreach to chapters and to members as retail clinics are introduced into their geographic areas. By creating, approving and promoting these Desired Attributes, the Academy has properly focused the discussion of retail clinics on issues of quality of care, continuity with a physician-based personal medical home, and limited scope of practice for midlevel professionals under physician supervision, consistent with other AAFP policies.

### **AMA Action**

(8) At the June 2006 meeting of the American Medical Association House of Delegates, the AMA considered Report 7 of the Council of Medical Service, "Store-Based Health Clinics."<sup>3</sup> The conclusions of that report and the recommendation that was subsequently approved by the House were very similar to the AAFP's Desired Attributes. The report specifically praised AAFP for its "proactive and pluralistic approach" and its leadership on this issue.

### **Agreement in Support of Desired Attributes**

(9) At the July meeting of the AAFP Board of Directors, the Board approved an "Agreement in Support of Desired Attributes." This agreement is a means by which retail clinic companies can formally acknowledge their support of the Academy's Desired Attributes and their intention to abide by them. The

agreement also requires a signing company to support publicly the AAFP's long-standing policy on non-physician providers. Other terms include an explicit statement that the agreement does not represent any endorsement of the companies or the retail clinic model by the AAFP, nor may the AAFP name or seal be used to promote the clinics. The Academy reserves the right to review any materials, including press releases, which make reference to AAFP. Either party may cancel the agreement with 30 days' notice. A benefit of such an agreement is that a clinic is binding itself to a limited scope of services and operation in accordance with AAFP policies. The provision requiring AAFP approval of clinic press releases about the agreement will help assure that a clinic does not imply AAFP endorsement solely because the clinic supports the Desired Attributes.

### **Member Reaction to Retail Clinics**

(10) Reference committee testimony at the 2005 AAFP Congress of Delegates represented a range of opinion and experience. For family physicians in states such as Minnesota, where retail clinics have been in business for several years, these businesses were not viewed as a financial threat, and physician practices had already adjusted to them by offering more flexible scheduling and hours of operation. Several physicians stated that retail clinics, and the wider phenomenon of consumerism in health care, are a fact of life, which would compel them to adapt and change the way they practice. Others saw the clinics as a potential threat to their practices that would siphon off the "quick and easy" office visits that are part of the typical family medicine practice.

(11) This same distribution of opinion was observed at a town hall meeting at the Annual Leadership Forum/National Conference of Special Constituencies in Kansas City in May. In this forum the views tended to be more negative, perhaps reflecting increased member awareness that this phenomenon is moving rapidly and will have an impact on family medicine practices that is not completely predictable.

(12) The AAFP also conducted member focus groups in various regions of the country. Once again, opinion on the issue seemed to be split, depending on the extent to which members had been exposed to and were familiar with the retail clinic concept.

(13) The Academy had a chance to observe firsthand the reaction of members, when Take Care opened eight retail clinics in Osco Drug Stores in the Kansas City area, the "backyard" of AAFP's headquarters. Take Care acknowledges that it made a significant mistake by allowing the news of the clinics to be announced in the local press prior to informing and educating the local physician community. The reaction of many members was negative, based in part on a misunderstanding of the business relationship between the clinics and the pharmacy chain, potential economic/competitive threat and philosophic concerns about fragmentation of care. Most family physicians in the area declined to participate with the clinics despite the company's repeated solicitations for supervising physicians and for listing in the clinics' local referral network. Take Care subsequently contracted with a network of emergency physicians in order to meet Missouri state requirements.

(14) To avoid this kind of situation in the future, the Academy has expressed its willingness to put the three leading clinic chains directly in touch with the respective state chapters before they enter a new geographic area and to ensure that the chapters have the most current information and policies to provide to their members. Family physicians may then decide for themselves how they will react to the retail clinics, whether to collaborate as a supervising physician or to find ways to compete.

### **Payers' Reaction to Retail Clinics**

(15) The reaction of the insurance industry to retail clinics has also been mixed. Originally these clinics were intended to be a cash business, with a flat fee for service and no insurance accepted.

However, many of the clinics have subsequently begun to accept and process insurance payments. Some insurers, such as CIGNA, view retail clinics as a “buy-up” for employers; in other words, retail clinics would increase the costs of care. Others, such as Blue Cross/Blue Shield of Minnesota, waive the co-pay for insureds who use retail clinics, which puts physician practices at a competitive disadvantage. The AAFP makes it a point to discuss the co-pay issue with payers routinely as part of its private sector advocacy activities and articulates AAFP’s view that payment policies should not unfairly disadvantage physician practices.

### **The Wal-Mart Effect**

(16) Recent dramatic news on the retail medicine front is that Wal-Mart, the nation’s largest retailer, is working with eight retail clinic companies to test the in-store clinic concept with the intention of rolling it out to all 3,400 outlets over the next two years. Clinics have already been established in Arkansas, Florida and Oklahoma. Wal-Mart’s interest is twofold: to draw customer traffic to Wal-Mart and keep customers in the store, and to have these services available for its own employees, nearly 1.3 million total, many of whom are uninsured or underinsured.

(17) Wal-Mart has the size and the resources to establish retail clinics rapidly and on a vast national scale, and this would have a profound impact on health care delivery in the U.S. Wal-Marts are located in communities of varying sizes and ethnic and economic composition. In July, President Larry Fields represented the AAFP at a “health summit” Wal-Mart conducted for its eight retail clinic “tenants,” along with representatives of the AMA, the American Academy of Pediatrics and the American Academy of Nurse Practitioners. It is likely that the AAFP will engage in discussions with Wal-Mart as the Academy seeks to communicate the value of a personal medical home to large employers.

### **The Future of Retail Clinics**

(18) Over the last two years, the Academy has approached the issue of retail health clinics with some basic assumptions: First, these clinics are likely to become a part of the health care system and cannot be ignored. A recent report from the California HealthCare Foundation stated, “The clinics are an attempt to respond to consumer needs for which the existing health care system doesn’t provide attractive options.”<sup>4</sup> The demand created by patients’ desire for quick, convenient care for common illnesses such as sore throat and ear aches is a powerful driver. The financial and business interests that are investing in these clinics are powerful as well. While on an individual level the first reaction of physicians may be to wish that the clinics would go away, this is not likely to happen. Ultimately, the marketplace will decide whether retail clinics, and which specific companies, will succeed or fail. Family physicians need to prepare themselves and their practices to respond to this shift in health care delivery. Family medicine practices must position themselves to adapt in order to be more competitive, by offering more attractive hours, more flexible scheduling, and by a team-based approach to medical care. The National Demonstration Project now under way by TransforMED, the new AAFP division, is intended to help develop the model for this new approach to practice for family physicians.

(19) Some family physicians may find it advantageous to work directly with the clinics, either in a supervisory capacity or as part of the referral network, in order to ensure that patients being seen in the clinics have access to a family physician who can manage their care and deal with more complex illnesses. All the leading clinics acknowledge that their services are not intended to serve as a medical home. The three major retail clinic companies have stated an intention to complement the continuous relationship that patients can only find as part of a personal medical home. They indicate that retail clinics could be used as an adjunct or extension of the physician practice, with the latter providing the full scope of services.

(20) One interesting development is emerging from the early experience with retail clinics: The clinics have shared some of their proprietary data with AAFP, which suggest that in many locations up to 50% of the patients being seen do not have a relationship with a primary care physician, nor do they have health insurance. In the words of one senior executive, “These are nobody’s patients.” These uninsured or underinsured individuals might typically go to the emergency room. Leaders in the health care sector, including the AAFP, would be wise to keep an eye on this phenomenon as it evolves.

## References

1. Sullivan D: Retail clinics are rolling your way. *Family Practice Management* 2006;13:65-72.
2. AAFP defines ideal retail health clinics. *AAFP News Now*, [www.aafp.org/online/en/home/publications/news/news-now/archive/retailhealth.html](http://www.aafp.org/online/en/home/publications/news/news-now/archive/retailhealth.html)
3. Report 7 of the Council on Medical Service (A-06), Store-Based Health Clinics, Reference Committee G, American Medical Association annual meeting, June 2006.
4. Health Care in the Express Lane: The Emergence of Retail Clinics. Prepared for the California HealthCare Foundation by Mary Kate Scott, Scott & Company. California HealthCare Foundation, 2006.

### AAFP Desired Attributes of Retail Health Clinics

The AAFP has identified the following attributes that are important to the patient care offered by retail health clinics. It is the individual physician's choice whether or not to work cooperatively with a retail clinic operation, using the following attributes as a guide in decision-making.

1. Scope of Service -- Retail clinics must have a well-defined and limited scope of clinical services.
2. Evidence-based Medicine -- Clinical services and treatment must be evidence based and quality improvement-oriented.
3. Team-based Approach -- The clinic should have a formal connection with physician practices in the local community, preferably with family physicians, to provide continuity of care. Other health professionals, such as nurse practitioners, should only operate in accordance with state and local regulations, as part of a "team-based" approach to health care and under responsible supervision of a practicing, licensed physician.
4. Referrals -- The clinic must have a referral system to physician practices or to other entities appropriate to the patient's symptoms beyond the clinic's scope of work. The clinic should encourage all patients to have a "medical home."
5. Electronic Health Records -- The clinic should include an EHR system sufficient to gather and communicate the patient's information with the family physician's office, preferably one that is compatible with the Continuity of Care Record supported by AAFP and others.

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