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TECHNICAL
REPORT

Policy Implications of the Use of Retail Clinics

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RAND HEALTH

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Summary

Background: The Emergence of Retail Clinics

Retail health clinics are a recent and growing phenomenon in the United States. They treat a limited number of acute conditions and offer preventive services. They emphasize convenience: Located inside large retail stores, they are open evenings and weekends, require no appointment, and feature fixed, posted prices for all services. Care is typically provided by a nurse practitioner. Since the first retail clinic opened in the United States in 2000, the number of clinics has grown to an estimated 1,200 in 2010.

Empirical understanding of retail clinics and their place in the broader health care system is only beginning to emerge. Researchers have begun to examine the geographic distribution of retail clinics, the cost of services compared with those in other health care settings, the nature and quality of services, and the characteristics of users. Yet, a great deal remains unknown, and debate persists about the role that retail clinics will ultimately play in the health care system.

At the same time, there has been little federal policy action regarding retail clinics, and little evidence exists about the potential costs and benefits of integrating retail clinics into federal programs and initiatives. Federal policymakers who oversee Medicare, Medicaid, and CHIP need information in order to help inform policies regarding retail clinics, including those related to coverage and reimbursement.

Study Purpose and Approach

To shed light on these issues, RAND was asked by the Office of the Assistant Secretary of Planning and Evaluation at the Department of Health and Human Services to assemble a picture of what is currently known about retail clinics, identify unanswered questions, and flag key issues for federal policy. The ultimate goal of this work is to improve understanding of retail clinics and clarify their potential role in the U.S. health care system.

Our approach to this work consisted of three tasks:

- an environmental scan, consisting of a review of the peer-reviewed literature and the gray literature
- semistructured qualitative interviews with representatives from the retail clinic industry, physician and nurse practitioner organizations, consumer organizations, the health insurance industry, urgent care centers, public health departments, and federal agencies. We also

interviewed experts on health care topics, including quality of care, medical homes, and health care for the underserved.
- an expert panel meeting to which nine experts were invited and which was open to federal audiences and the public.

Key Findings: Current Knowledge and Understanding of Retail Clinics

We have synthesized the results from these three tasks and organized them into seven topic areas: (1) utilization, (2) the relationship of retail clinics to other parts of the health care system, (3) access to care for the medically underserved, (4) the business models under which retail clinics operate, (5) cost and insurance coverage, (6) quality of care, and (7) emerging trends. The following subsections summarize the results in each of these areas.

Utilization

- **Where are retail clinics located?** As of August 2008, retail clinics were located in 33 states. Nearly half of all clinics were located in five states: California, Florida, Illinois, Minnesota, and Texas.
- **What types of care do clinics provide?** Retail clinics currently offer a limited range of services. As of August 2008, all retail clinic chains offered treatment for minor infections (such as sore throats), minor skin conditions, and allergies. They also offered immunizations and routine preventive screening.
- **How many people use retail clinics?** Reports of the number of retail clinic users vary. A nationally representative survey in 2007 found that 1.2 percent of American families had visited a retail clinic in the prior 12 months. Other estimates have found higher percentages (up to 16 percent), but evidence suggests that the lower range of estimates is more reliable.
- **What are the characteristics of retail clinic users?** Retail clinic use is heaviest among younger adults, minority families, and families with children. Clinic users are typically younger than the patients seen in primary care or emergency departments. Patients who visit clinics are less likely to have an established relationship with a primary care provider: Only 39 percent report having such a relationship, compared with 80 percent of the general population. An estimated 16–27 percent of retail clinic users are uninsured.
- **Why do patients seek care at retail clinics rather than elsewhere?** The reason most widely cited by users is convenience (including weekend or evening hours and no need for appointments). Other reasons for visiting retail clinics include low-cost services, convenient locations, short wait times, transparent pricing, and dissatisfaction with primary care.

Relationship of Retail Clinics to Other Parts of the Health Care System

We encountered contrasting views of the relationship between retail clinics and primary care providers. Conditions for which patients typically visit retail clinics also constitute a significant proportion of reasons for patient visits to primary care providers. Retail clinics may pose a threat to the financial viability of primary care practices by treating the latter's most profitable patients. A contrasting view is that retail clinics may increase primary care revenue by generating referrals to practices and by allowing physicians to focus on sicker patients with more-complex needs, whose

care provides higher reimbursement. In some cases, primary care practices and retail clinics have built mutually beneficial working relationships, with the latter generating referrals to local physicians. Experts also emphasized that other providers could incorporate some of the methods used by retail clinics to improve access to care, since levels of satisfaction with their services are high.

Retail clinics' relationships to other parts of the health care system are still being shaped and defined, and they have not been studied in depth. In particular, we still know little about the extent to which people who visited retail clinics would, in the absence of such clinics, otherwise have visited emergency departments or urgent care centers. With respect to the public health system, retail clinics have had some interaction with public health agencies regarding vaccination and efforts to boost immunization rates. Experts have highlighted the role that retail clinics could potentially play in public health surveillance and in mass dispensing of countermeasures during a public health crisis.

Access to Care for the Medically Underserved

Some champions have argued that retail clinics may improve access to care for populations in underserved areas. However, retail clinics are not evenly distributed across neighborhoods, and they are more likely to be located in higher-income areas. Specifically, compared with the national average, census tracts containing retail clinics are more likely to have higher concentrations of white residents, fewer black and Hispanic residents, and fewer residents living in poverty. However, retail clinic use is more likely among minority families, and one study found that retail clinic users were disproportionately likely to live in poorer neighborhoods. The number of retail clinics that target underserved populations is limited. We are aware of only one community health center that has opened a retail clinic to treat a medically underserved population. The viability of retail clinics in underserved areas is uncertain and remains largely unexplored as a model for improving access to care in such areas.

Business Model for Retail Clinics

Retail clinics typically follow one of three business models. In the first, the clinic is owned and operated by the parent store that houses it. In the second, the clinic is owned by an independent company that partners with a retail store to house the clinic. In the third, the clinic is owned by a hospital, a physician group, or another health care provider. Nearly three-quarters of clinics follow the first model.

Profitability of retail clinics is a concern for operators, regardless of which model is used. The tenfold growth in the number of retail clinics between 2006 and 2008 has since slowed considerably. Some clinic chains and individual clinics have closed, and recent market projections forecast a slowdown in the growth of retail markets between 2010 and 2015. However, at least one retail clinic operator has announced plans for significant expansion.

Costs and Insurance Coverage

Several studies have examined the cost of retail clinic services and compared them with costs in other health care settings. The results show that retail clinics typically offer lower per-episode costs than urgent care centers, emergency departments, and primary care providers. Retail clinics therefore may reduce overall health system spending if patients substitute care at retail clinics for care at more-expensive sites. However, potential per-episode savings must be weighed against the fact that retail clinics could increase overall utilization by attracting patients who might not have otherwise sought care; an increase in utilization from this group would increase overall health care spending. Studies

that have modeled the likely impact of retail clinic growth on system spending have found that, in the best-case scenario, there would be modest savings of less than 1 percent of national spending.

Most retail clinics accept insurance coverage, including Medicare. Medicaid enrollees face barriers to retail clinic use. Reimbursement rates for conditions treated by retail clinics are low, and Medicaid managed care users—71 percent of all Medicaid beneficiaries—may need to pay out of pocket for care at retail clinics.

Quality of Care

Quality of care at retail clinics has been the focus of several studies. Here, we summarize findings in seven dimensions:

- **Patient satisfaction.** Patients have generally reported high levels of satisfaction with care received at retail clinics.
- **Processes of care.** Initial evidence shows that retail clinics deliver recommended care at rates that are comparable to those in other settings, although these studies have focused on only a small number of conditions. Three studies have shown that repeat visits for the same condition, which can be a measure of poor quality, were not more common at retail clinics than in other settings.
- **Appropriateness.** Representatives from several organizations voiced concerns that retail clinics may not always deliver appropriate care for certain kinds of patients, such as those with chronic conditions or taking multiple medications. A related concern is the potential conflict of interest created when pharmacy chains own retail clinics; in such situations, there may be an incentive to overprescribe medications. One study found comparable rates of antibiotic prescribing between physician offices and retail clinics.
- **Missed opportunities for preventive care.** Relatedly, there is concern that retail clinics may miss opportunities for delivering preventive care that a primary care physician would not overlook. The only study that has examined this issue found no significant difference in rates of utilization of preventive services between retail clinics and other sites; however, the study focused on a small insured population in only one state.
- **Coordination and continuity of care.** Many interviewees expressed concern that retail clinics will lead to less coordination, greater fragmentation of care, and the erosion of patient-physician relationships. However, some interviewees felt that retail clinics could complement the services offered by primary care providers.
- **Electronic health records and interoperability.** Electronic health records are widely used in retail clinics. However, they are not necessarily interoperable across different health care providers, which presents challenges to care coordination.
- **Quality measurement and oversight.** Although retail clinic operators typically conduct internal quality reviews, health plans and other organizations engage in relatively little collection of or public reporting on retail clinic quality. State laws dictate practices for physician oversight of nurse practitioners, and considerable variation exists both across states and among retail clinic operators.

Emerging Trends

The most commonly cited emerging trend is the management of chronic disease at retail clinics. For example, some retail clinics are expanding their scope of care to include the screening and treatment of hypertension and the management of asthma. This development has caused considerable debate. Experts in our panel discussion stressed the need to distinguish among screening, monitoring, and managing chronic disease, and they expressed greater comfort with the idea of retail clinics focusing on screening or routine monitoring of chronic diseases rather than conducting ongoing management. Emerging trends also include the expansion of services into other areas of care, such as treating acne, allergies, osteoporosis, and minor cuts that do not require sutures; providing travel immunization and weight loss services; and developing new sites of care, such as workplace clinics.

Unanswered Questions About Retail Clinics

Although research has begun to examine retail clinics and to understand utilization, costs, quality, and other aspects of their operations, many questions remain unanswered or have not been addressed in adequate depth. Key questions for further research include a better understanding of the following:

- How many people visit retail clinics?
- What is the impact of retail clinics on health service utilization and costs?
- What impact do retail clinics have on preventive care and chronic disease management?
- What is the quality of care at retail clinics?
- What is the impact of retail clinics on the fragmentation of care?
- How do retail clinics affect primary care practices?

Federal Policy Considerations

Medicare and Medicaid

The Centers for Medicare & Medicaid Services (CMS) recently developed a code to uniquely identify retail clinics as care sites under Medicare, creating the opportunity to analyze retail clinic expenditures for Medicare beneficiaries. The impact of Medicare reimbursement decisions on retail clinics, however, will likely be limited because only a small fraction of patients currently seen at retail clinics are Medicare beneficiaries. Increases in reimbursement rates for nurse practitioners, whose services are typically reimbursed at 85 percent of the Medicare fee schedule for physicians, may encourage the growth of retail clinics.

Quality and Care Coordination

There is growing interest in efforts by CMS to assess and report on the quality of care in many health care settings. To date, retail clinics have not been included in quality reporting initiatives sponsored by either the federal government or private insurers. Although many existing quality measures do not apply to retail clinics because of the clinics' limited scope of care, some measures—such as those related to appropriate antibiotic use—are relevant and could be used. The National Quality Forum is currently developing measures related to care coordination, and, if the final measures apply to care provided at retail clinics, policymakers may wish to consider including retail clinics in new initiatives.

Electronic Health Records

New initiatives funded under The American Recovery and Reinvestment Act of 2009 dedicate significant resources to promoting the adoption and use of health information technology. The Office of the National Coordinator for Health Information Technology has issued standards for the meaningful use of electronic health records, and CMS will provide incentive payments to eligible professionals who achieve such use. These incentives, which apply only to physicians, exclude nurse practitioners and physician assistants and therefore will likely have little impact on retail clinics. Because the use of electronic health records is an intrinsic part of the business model for nearly all retail clinics, extending such incentives so that they affect retail clinics may have little impact on the adoption of electronic health records. However, it may influence the ways in which electronic health records are used.

The Supply of Nurse Practitioners

The United States is facing an overall primary care shortage, and several factors may increase demand for nurse practitioners. First, if the number of retail clinics grows, the number of nurse practitioners required to staff these clinics will also rise. Second, nurse practitioners are increasingly used in other care settings. Finally, the expansion of insurance coverage under health reform may increase the demand for primary care and further strain the supply of nurse practitioners.

The Patient Protection and Affordable Care Act (P.L. 111-148) includes initiatives to increase the number of nurses and retain them in clinical practice; it also provides for demonstration grants for nurse practitioner training programs. In creating increased capacity for nurse practitioner training, policymakers may wish to consider trade-offs between expanding the supply of nurse practitioners working in retail clinics, where they would provide walk-in access to care, and having them work in primary care practices, where they would increase the availability of a broader range of primary care services.

Care for Underserved Communities

The Department of Health and Human Services, through the Health Resources and Services Administration (HRSA), plays a critical role in providing access to care in underserved communities by supporting Federally Qualified Health Centers. Currently, Federally Qualified Health Centers can operate their own retail clinics; in the future, policies could be expanded to allow such centers to partner with independent retail clinic operators. In addition, HRSA designates both Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs), and these designations may have an indirect effect on retail clinics. For example, Texas allows a higher number of nurse practitioners per supervising physician in HPSAs than in other areas. Such policies could reduce retail clinic operating costs in shortage areas and encourage them to locate there.

Demonstration Projects

A variety of federal demonstration projects that do not explicitly target retail clinics could nonetheless affect those clinics if they result in widespread changes to the health care system after the initial demonstration period. Their impact will likely depend on whether retail clinics are included on a care team. For example, medical home demonstrations are typically accompanied by payment changes, such as providing the medical home with a supplemental per-member, per-month payment. If retail clinics are included in the medical home, other providers on the team may divert patients to retail clinics because such care is less expensive than that provided in other settings. However, if

retail clinics are considered to be outside the medical home, other providers on the team would have an incentive to discourage patient utilization of services from providers outside their system.

The Patient Protection and Affordable Care Act

The impact of insurance expansions on retail clinics and on the broader health care delivery system remains unclear. There will be an influx of newly insured individuals, so primary care providers will likely experience increased demand for their services. At the same time, the nation will continue to face a growing shortage of these providers. This could lead to greater demand for retail clinic services. Further, if many newly insured individuals enroll in high-deductible insurance plans, these individuals may be more sensitive to the price of health care services, which may lead to increased retail clinic use.

Implications

The results of our work have three main implications for federal policymakers to consider.

Design Policies to Encourage Coordination and Decrease Fragmentation

Policies and programs to improve coordination and reduce fragmentation—such as patient-centered medical home demonstration projects, accountable care organizations, and increasing use of health information technology—can be designed to include retail clinics. Federal policies can encourage this integration by changing reimbursement structures and incentivizing care coordination and the transfer of information between providers.

Identify Key Lessons Learned from Retail Clinic Operations and How These Lessons Can Be Applied in Other Health Care Settings

Retail clinics have established a niche in the health care system based on their convenience and customer service. Growth in the industry to date appears to have been driven largely by high levels of patient satisfaction. The federal government can draw lessons from this experience to identify approaches to improve access and quality in other settings and can design policies to expand effective approaches.

Ensure That Retail Clinics Are Treated in the Same Manner as Other Health Care Providers

When developing or amending policies, federal policymakers can take steps to ensure that retail clinics are treated in the same way as other providers. These may include applying the same standards with regard to accreditation, measuring the quality of care and patient experiences with care, provider credentialing, and reimbursement; incorporating retail clinics into demonstration projects, such as those focused on telemedicine, the interoperability of electronic health records, and medical homes; considering the role that retail clinics could play in underserved areas; and examining the role of retail clinics in public health surveillance and the distribution of countermeasures during mass casualty events.

Concluding Observation

At the end of their first decade of existence, retail clinics have established themselves in the U.S. health care system. Yet, evidence about their functioning and their role in the health care system is still thin, and a good deal of additional research is needed. At the same time, retail clinics' role in the system may be evolving in the face of insurance expansions under the Patient Protection and Affordable Care Act, the growing shortage of primary care physicians, and the increased use of health information technology. Over time, these changes will create new opportunities for health policies at the federal and state levels to influence both how retail clinics function and the ways in which their care is integrated with that of other providers.