Statement of the Rhode Island Medical Society
Regarding retail-based health clinics

January 28, 2008

Small, limited-service health clinics situated within larger retail establishments (super markets, department stores, drug stores) are a new and growing phenomenon in the United States. For the consumer, these mini-clinics promise convenience and affordability. For the retailer, they promise increased consumer traffic and sales volume. These combined incentives would seem to assure that retail based clinics (RBCs) are destined to become a commonplace feature of the American commercial landscape.

That being so, it is important that consumers who would consider entrusting some of their own health care or the care of their children to these clinics be aware of the strengths and weaknesses that are inherent in the RBC model. RBCs provide a variant of urgent care that might best be termed "convenience care." Convenience care may be understood as urgent care without the (apparent) medical urgency, but with the potential drawbacks and dangers inherent in self-triage. RBCs are structurally unsuited to provide primary care, preventive care, chronic disease management or emergency care. The public must clearly understand these limitations and their ramifications.

It is also important that regulators and legislators be alert to opportunities they may have to shape the early evolution of these clinics in the best interest of the public.

Since RBCs have not yet entered the Rhode Island market, we have an opportunity to consider the attributes and principles that could enable them to integrate themselves with minimal disruption as responsible new health care partners here. Such principles include the following (adapted in part from principles articulated by the American Medical Association, the American College of Pediatrics, the American College of Physicians, American Academy of Family Physicians and a special committee of the Rhode Island Medical Society):

- The clinic must meet appropriate standards for a health care facility, as set forth in law and regulation. Standards should not be waived or weakened to facilitate the establishment and operation of RBCs.
- The professionals providing care in the clinic must act within the scope of their training and qualifications, as set forth in law and regulation. Standards of professional licensure and conduct should not be waived or weakened in order to facilitate the establishment and operation of RBCs.
- Patient co-payments required by third-party payers for visits to RBCs should be consistent with the levels of co-payment charged for other types of walk-in clinics and urgent care centers. Insurers' lowest co-pays should be reserved for settings that foster and strengthen the medical home model; copays should be waived in medical emergencies.
- Patient care should be provided in accordance with evidence-based guidelines and protocols. Other health care professionals should have access to health information generated in the clinic, as may be necessary for follow-up care. If

a patient's condition worsens, a plan should be in place for further evaluation and treatment by an appropriate health care professional or facility.

- Documentation should be in electronic form with interoperable capabilities, to allow transfer of clinical information to the patient's primary care physician/medical home. It should also be available after hours to facilitate emergency care.
- Prescriptions should be in electronic form and sent to the patient's choice of pharmacy.
- Each clinic should have a referral base of potential primary care medical homes to provide for continuing care and health issues that go beyond the scope of practice of the clinic and its personnel. The clinic should also have a relationship with one or more ambulance services and hospital-based emergency departments to facilitate care of acutely ill or unstable patients.
- The supervising physician's name should be clearly posted in patient areas, with clear instructions on filing complaints with the facility and with appropriate regulatory agencies.
- The medical director of the clinic or other supervising physician should have an unrestricted license to practice medicine in Rhode Island and be available to clinic personnel for consultation during the clinic's hours of operation.
- During hours when the RBC is closed, patients who have visited the clinic should be afforded telephone access to a physician employed by the clinic and licensed in Rhode Island who has access to the patient's clinic records and is able to coordinate emergency or other continuing care as indicated.
- Patients should be advised that the clinics do not provide preventive care, primary care or chronic disease management, nor do they provide care for patients younger than 6 years old. For such services, the clinic shall refer patients to a full-service medical home.
- Patients should be advised that the clinics do not provide emergency care, and the clinic shall properly refer and arrange transport for patients with potential emergency medical conditions to an appropriate emergency department. Advertising and signage for the clinic should be precluded from stating or implying that the clinic provides emergency care.
- Each clinic should have a quality assurance program to monitor adherence to clinical guidelines and protocols, respond to adverse events, document follow-up care, handle patient complaints, and assure that care delivered is within the scope of practice of the clinic and its personnel.
- Each clinic's quality assurance program should systematically collect and evaluate data on clinical outcomes, utilization and patient satisfaction.
- Each clinic's quality assurance program should include a publicly available conflict-of-interest policy that strictly separates and shields patient care from any commercial interest of the larger retail facility with which the clinic is associated.
- Clinics should not be located in or associated with facilities where tobacco products are sold.
- In determining the location of clinics, both owners and regulators should take community need into consideration and give preference to sites located in

medically underserved neighborhoods over areas where access to urgent medical care is already adequate.

The following further comments are intended to provide essential context and background for the above principles.

Any discussion of RBCs is inseparable from the concept of the patient-centered medical home. The proven concept of the primary care medical home has been the foundation of Rhode Island's highly successful national model Medicaid program known as RIteCare since 1994. Since then, a great deal of discussion and research, led nationally by the American College of Physicians, the American Academy of Family Physicians and the American Academy of Pediatrics, has been devoted to refining and developing the medical home as a concept and as a reality.

The medical home is a well developed, comprehensive model that systematically integrates relationship building with evidence-based medicine and information technology to provide the most efficient and effective management of patients' preventive care, acute care and chronic diseases. Today it is universally recognized that the medical home must be the cornerstone of the health care system of the future. It is the key to improving quality while containing cost, and it provides patients the best quality care in the most cost-effective manner and setting.

Accordingly, private foundations, government agencies, professional associations and third-party payers across the nation today are working together to reshape the American health care system with the medical home at the center. Rhode Island has an especially strong commitment to the medical home concept and is a clear national leader in efforts to reorganize health care progressively around the medical home model.

RBCs are antithetical to the medical home and incompatible with the medical home movement. The medical home regards patient care fundamentally as a relationship; as such, it promotes integration, coordination, efficiency and continuity of comprehensive, personalized care.

In contrast, health care services delivered in an RBC are isolated, commercial transactions between strangers. By design, the RBC provides narrowly focused, disarticulated, fragmentary care on a strictly protocol-driven, episodic and impersonal basis. Longer-term relationship building, comprehensive care, full record keeping and follow-up are systematically precluded by the RBC model.

It goes without saying, by the way, that some of these attributes are also generally precluded in a true medical emergency, where episodic care provided by strangers is likely to be absolutely necessary and desirable. Emergency care, however, should be reserved for emergencies. The public should be educated and guided in the appropriate use of all components of the health care system, including urgent care centers and emergency departments.

RBCs work at cross-purposes with the medical home and tend to confound community efforts to make the necessary transition to a health care system that is anchored in the medical home model.

One brand of RBC, MinuteClinic, which is based in Minnesota, has characterized itself as “an adjunct to primary care” and “not a substitute” for a relationship with a full-service, primary care medical practice. The general public will require significant education to appreciate the depth and significance of that distinction. The fact is, RBCs do not provide primary care in the true sense.

The distinction is of particular and fundamental importance in the care of children and patients with chronic medical conditions. Parents should be advised that pediatricians nationally consider it inappropriate for a child under 6 years of age to be seen in a limited-service setting, even for seemingly “simple” conditions. There is no such thing as a “simple” sore throat , earache or other sickness in a young child.

Moreover, every visit to a medical practice where the full spectrum of primary care services is available to pediatric patients will include quick and efficient checks on a child’s development and health status, often with far-reaching implications for the child’s long-term well-being. Are age-appropriate immunizations are up to date? Are physical development, social skills and language skills age-appropriate? Are there concerns about diet, sleep or behavior? Is there reason for concern about autism or other developmental deficits that can impair a child’s social and educational progress? Physicians of adult patients, too, review the patient’s medical chart at each medical encounter, assessing vaccination status and addressing the patient’s chronic medical conditions. The opportunities for such evaluation are likely to be attenuated or lost in an RBC.

Other attributes of RBCs raise concerns as well. In addition to their potential to retard Rhode Island’s efforts to further develop and promote the medical home as the universal foundation of a high-quality, high-efficiency health care system, RBCs represent something that is unprecedented and has historically been unwelcome in Rhode Island: corporate, for-profit health care. Moreover, to the extent RBCs are situated in retail spaces that also sell prescription and over-the-counter medications, the appearance and potential for conflict of interest is strong. Finally, it goes without saying that the sale of tobacco products is incongruous in conjunction with the delivery of health care in any setting.

Members of RIMS’ ad hoc Committee on Retail-based Clinics
Fredric V. Christian, MD, Chair; Nitin S. Damle, MD; Jerald C. Fingerut, MD; DanielH.Halpren-Ruder, MD, PhD; Elizabeth B.Lange, MD; Michael E. Migliori, MD; Albert J .Puerini, Jr, MD; Margaret A. Sun, MD; Kenneth A. Williams, MD