EDITORIAL AND COMMENT

Retail Clinics Shine a Harsh Light on the Failure of Primary Care Access

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Retail clinics, which are usually located inside retail pharmacies, provide walk-in care mainly for low-acuity problems. Retail clinics have transparent pricing and are staffed by nurse practitioners or physician assistants. Since first opening in the United States in 2000, retail clinic use has grown rapidly but remains small: the proportion of families that reported using a retail clinic in the prior year increased from 1 % in 2007 to 3 % in 2010.¹ Retail clinics have obvious appeal as low-cost, accessible sites of care.

Much has been written about the potential promises and perils of retail clinics.^{2–4} For privately insured, healthy, wealthy, young patients, retail clinics likely provide similar quality and lower cost compared to primary care offices for otitis media, pharyngitis, and urinary tract infections without detracting from short-term preventive care.⁵ Antibiotic prescribing is more guideline-concordant at retail clinics than in primary care offices or emergency departments.^{6,7} Retail clinics may be associated with reduced costs.⁸ On the other hand, retail clinics have been found to impair continuity and to reduce seeking care with a primary care practice when a new problem arises.⁹ Little is known regarding retail clinic performance for underserved, older, sicker patient populations.

Retail clinics strive to provide fast access for patients, and are themselves experimenting with new models of care to improve their service. In this issue of the *Journal of General Internal Medicine*, Polinski and colleagues from CVS MinuteClinic describe a cross-sectional quality improvement assessment of retail clinic-based telehealth.¹⁰ Patients with specific symptoms, mostly acute respiratory infections, who might have to wait for an in-person practitioner for more than 20 minutes, were given the option to have their care provided by a remote practitioner assisted by an onsite nurse.

The authors estimated that 40 to 54 % of telehealth patients completed a post-visit survey ($n=1734$). Respondents were mostly insured (80 %), female (70 %), and had a primary care provider (59 %). For half, it was their first visit to a MinuteClinic. Thirty-two percent of respondents expressed a preference for receiving care via telehealth versus a

“traditional in-person visit.” The vast majority of users were highly satisfied with nearly all attributes of their experience. Respondents who lacked health insurance were significantly more likely to prefer telehealth visits. Women, those who believed they had a good understanding of telehealth, and those who were satisfied with the convenience of telehealth all had higher odds of liking telehealth. Over 70 % of respondents would use telehealth again and would recommend telehealth to someone else.

Polinski and colleagues should be congratulated for studying an innovative approach to improving low-acuity care delivery. A virtual network of clinicians who need only the assistance of a nurse assistant and specialized internet-connected tools could represent an improvement on an expanding model of care.

Yet this study highlights a concern about retail clinics: they create demand for unnecessary services. Telehealth facilitated visits for sinusitis, upper respiratory infections, bronchitis, allergic rhinitis, influenza, and conjunctivitis. These visits may be unnecessary and have the potential to stimulate unnecessary follow-up care.³ Retail clinics currently have no incentive to discourage unnecessary care. In fact, retail clinics may view these visits as easy, quick, and desirable and might fear that patients would leave if kept waiting for too long. Good continuity of care and effective pre-visit triage could have prevented many of these visits.

In a perfect world, all patients would have a usual source of care; be able to easily connect with their own primary care practice; receive triage advice; and practices would provide prompt, efficient advice and service. Comprehensive primary care is associated with lower cost, improved health outcomes, greater efficiency, and reduced disparities. All else being equal, patients would choose to get care from a primary care practice that knows them, is easily accessed, and will follow them over time.

Clearly, we do not live in that world. Primary care is not optimally structured or incentivized to provide accessible care. According to the Commonwealth Fund, 73 % of Americans responded that it was difficult to make timely doctors' appointments, get phone advice, or receive after-hours care without having to visit the emergency room. Retail clinics, urgent care centers, and commercial online care are all understandable responses to primary care that is inefficient, costly, and inaccessible. These new models of care reflect the failure of primary care to provide access.

Those of us in primary care should take note. CVS MinuteClinic feels that 20 minutes is too long to wait. They are innovating to increase access. Can primary care practices stand the harsh light shone by this delivery innovation? Can primary care practices learn, innovate, and radically improve access?

Radical improvement in access must be accompanied by radically improved efficiency. If a transaction presently takes place on paper or over the phone, we need to automate it when possible, switch it to the web, and optimize it for mobile. We need to move most communication to secure, usable web portals that are aggressively promoted and monitored. We need to provide chronic disease management through a combination of registry analytics, group visits, community health workers, synchronous and asynchronous e-visits, and traditional in-person visits. For our high-utilizer and homebound patients, we need to make house calls, a practice we gave up only due to now-archaic financial and technological constraints. A single urgent care episode should be able to seamlessly and promptly be transformed, as needed, from an asynchronous e-visit to a synchronous e-visit to an in-person visit with the primary care practice or involvement of an emergency department. Illness does not end for patients when they hang up the phone or walk out of the office; care should not stop when clinicians sign their notes. Practices should provide extended and weekend hours. Improved access and efficiency should improve the patient experience. Visits in which either the patient thought it was a “waste of time” or clinicians felt “the patient didn’t really need to come in for that” should be viewed as triage failures.

Primary care physicians’ days should look radically different. Although there is simplicity and comfort in seeing patients in-person, one-after-another, it is inefficient for the physician, the practice, and the patient. We can connect with many more of our patients if we are spending more of our time *not* seeing our patients in person. There will be more structured e-visits to review, video calls to make, teams to facilitate, and panels to manage with proactive outreach and follow-up.

There has been progress and new resources are available. Many health systems schedule phone visits and “desktop time.” The American Medical Association’s *stepsforward.org* and UCSF’s Center for Excellence in Primary Care both have turn-key approaches to optimizing the busy primary care practice. They describe pre-visit laboratory testing, synchronized prescription renewal, team documentation, and panel management techniques. Despite these and others, additional innovation is sorely needed.

How will we pay for these changes? Health systems’ incentives to support these innovations are becoming aligned with the passage of the Affordable Care Act and the expansion of Accountable Care Organizations. Medicare has already moved this direction with the Chronic Care Management Program. Many private insurers, recognizing value and patient demand, are moving to cover innovative care.

There will be plenty of practice innovations to implement, research to be done, and questions to ask. Can we deliver care that is equally effective over the internet as in-person? What is the optimal telehealth configuration? What is the ideal level of continuity that balances efficiency with outcomes and patient experience? Are there subgroups of patients who benefit most from telehealth treatment? Are there subgroups of patients who might potentially be left behind such as the underserved, elderly, and sickest? We need to demonstrate that new, proactive methods of delivering care can benefit our most vulnerable patients.

Primary care practices and clinicians should view visits to emergency departments, retail clinics, or urgent care centers as sentinel events. What was it about our own practice that made seeking care away from primary care necessary? Viewed from a more global, financial perspective—and to paraphrase Rushika Fernandopulle of Iora Health—primary care accounts for 4 % of healthcare spending in the United States; how much of the remaining 96 % represents a failure of primary care? What would primary care look like if it received 10 % of spending?

Ultimately, we look forward to the implementation of models with radically improved efficiency and access that could realize the benefits of comprehensive primary care. We do not begrudge the existence of retail clinics, urgent care clinics, or online care companies. They shine a harsh light on primary care’s failings. We should look where that light shines brightest and innovate toward doing better for patients.

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