Proceedings of the California HealthCare Foundation/Health Affairs Roundtable

“Retail Clinics: Disruptive Innovation in Primary Care?”
About Health Affairs

Health Affairs is a multidisciplinary, peer-reviewed journal dedicated to the exploration of domestic and global health policy issues of concern to both the private and public sectors. The journal incorporates diverse views and perspectives within the health sphere—from industry, labor, government, and academia—and particularly encourages contributions from decision makers who often generate creative ideas but who seldom advance them in a form for publication.

About the Foundation

The California HealthCare Foundation, based in Oakland, is an independent philanthropy committed to improving California’s health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care. For more information about CHCF, visit us online at www.chcf.org.
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Introduction

Retail, or Convenient Care, Clinics
Over the past several years, a new phenomenon known as retail clinics has appeared on the health care landscape. Also known as convenient care clinics, these are small facilities within high-traffic retail settings such as grocery, pharmacy, and department stores. They provide simple primary care health services on a walk-in, often pay-as-you-go basis; many of the clinics are open seven days a week, with extended hours. Some of the clinic companies are stand-alone entities, while others are part of larger, comprehensive health care delivery systems.

Retail clinics seek to provide accessible, non-emergency health care to consumers who otherwise would seek such care from a traditional primary care physician, or who might not seek care at all. The clinics are primarily staffed by nurse practitioners and other advanced practice nurses, as well as by physician assistants, with some participation by physicians. The clinics provide care for common acute or episodic ailments and injuries; they also offer immunizations, as well as some physical examinations and preventive health screenings.

Professional and organizational mechanisms for the delivery of primary care services are under ever-increasing strain. While many primary care physicians feel overworked and underpaid, and medical students increasingly favor specialist career paths, many patients find traditional primary care to be inaccessible and unaffordable. In response to this situation, there is a migration of some basic services away from primary care physicians to nurse-staffed “retail” clinics and other settings that emphasize convenience, low overhead, and out-of-pocket payment. While these clinics presently focus on acute care, some aspire to a broader role in providing care for consumers with chronic conditions who are poorly served by today’s mainstream delivery systems. These developments raise new questions concerning clinical functions and organizational structures for primary care physicians.

In November 2007, the California HealthCare Foundation partnered with the journal Health Affairs to sponsor a roundtable discussion regarding two related topics — the nature and future of retail clinics, and the future of primary care. The roundtable brought together 23 discussants [see Appendix for a list of participants] from a wide spectrum of the health care field, including primary care physicians, health policy academics, health insurance administrators, and representatives of the retail clinic industry. This report summarizes key aspects of the day’s proceedings.
Opening Remarks: Establishing the Framework

INTRODUCTORY REMARKS FRAMED THE RETAIL CLINICS roundtable as an attempt to weave together analysis of two related matters: the specific nature and development of retail clinics, and the future of primary care. The roundtable would also place discussion of retail clinics and primary care in the context of two broad issues with which the California HealthCare Foundation is deeply engaged: service to the underserved, and the design/redesign of the health care delivery system.

The day’s discussions were introduced by the question “Why does innovation in health care almost invariably result in higher costs?” Three answers were proffered:

- While some innovations reduce the unit cost of a delivered service, total costs rise because the innovation also permits or encourages greater utilization of the service.

- An innovation may be a supplement to, rather than an enhancement or improvement on, an existing service; whatever the new component’s unit cost, then, as a supplement it adds to total costs.

- Some innovations allow for treatment of previously untreatable or otherwise unreachable patients, while others add better detection; in either case they increase the number of patients receiving care and thus raise total costs.

These introductory remarks continued with an overview of the systemic barriers that impede the successful introduction of cost-lowering health care innovations:

- Health care is highly regulated, a phenomenon driven by and protective of the existing constellation of providers. Such regulation tends to suppress innovations that might shift care either to lower revenue-producing alternative services or to services provided by other, lower paid providers.

- The culture of health care does not usually welcome low-cost alternatives because of the reigning assumption that lower cost means lower quality of care.

- Health care’s long-standing set of self-identifications—professional, collegial, selfless—views the notion of
competition (from alternatives and innovations) as antithetical.

- The existence of either private or public insurance for most health care consumers makes them cost insensitive, and therefore not particularly supportive of cost-reducing innovation.

The standard retail model prevailing in the health care market, abetted by these above-described features, primarily responds to existing consumers, adding only supplemental (e.g., Lasik and cosmetic surgery) rather than alternative features. These continue to drive up costs and leave the underserved on the outside of the market. One important discussion topic was whether there are health care companies (retail clinics or others) who fit the “disruptive innovation paradigm,” i.e., they provide cost-lowering services that allow those who are currently not served, or are very poorly served, to participate in the market.

Whether retail clinics ultimately merit the term disruptive innovation may turn on the answers to a set of questions, which the roundtable discussants were challenged to address:

- Do retail clinics offer consumers a better “value” (that term having several more components than merely cost-per-service—e.g., convenience, time, transparency, predictability)?
- Will retail clinics expand their services (or will they continue to offer only a narrow range of relatively simple tasks)?
- Can they move “up market” — into chronic care or specialty care, for example?
- Will retail clinics be incorporated into the design of insurance products, thereby expanding their financial reach?

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**Disruptive, But to What Extent?**

Under the roundtable’s banner “disruptive innovation,” there was extensive discussion among participants about whether retail clinics were truly disruptive. But there was also a derivative question: Even if retail clinics are disruptive, will they remain in a limited niche on the low end of the spectrum or will they spread out and up through the system? As an example of the former, there is Lasik eye surgery—clearly disruptive but ultimately limited to a small, specialized niche. On the other, more pervasive end of the spectrum were the examples of generic drugs, the use of which some argued was one of the past decade’s most significant cost-reducing “innovations,” and ambulatory surgery centers which, driven by physicians, have shown a steady spread, moving up market to specialty hospitals and ultimately competing with traditional hospitals for large portions of the market’s high end.
**Session I. Retail Clinics in Primary Care: Challenge and Opportunity**

**Medicine’s Shift from “Art” to “Science”**

Another way of looking at the current landscape in which retail clinics are making their inroads is as part of medicine’s move from “art” to “science.” That is, the shift in medicine from intuitive, skill-, and personal experience-based care to rules-based, protocol-supported algorithmic decision-making. This shift has been supported by technological advances that allow lower-trained, lower-cost practitioners to provide more and more services. To what extent will technology make more of these changes possible? Indeed, to what extent will the foreseeable march of technology permit patients to diagnose and treat themselves (and, thereby, incidentally reduce retail clinics’ range of services)? The resulting reduction in low-end care costs might also free up both personnel and health care funds to better serve higher-end health care needs.

**The First Discussion Session Opened with a Review**

of the recent history of primary care. The primary care model was expanded in the 1980s to the point that the primary care physician was expected to be an “über doctor” responsible not only as a gatekeeper but also for nearly every substantive aspect of a patient’s care. Over time, certain tasks were winnowed away from this model: for example, the use of hospitalists reduced the load of hospital rounds and care of the very sick; hospice and end-of-life care removed a large realm of responsibility; and chronic care slowly moved away from the exclusive province of primary care doctors. Concerning this trend, the question was raised about the extent to which retail clinics will present a new challenge to what primary care physicians do.

**The Rise and Development of Retail Clinics**

Discussion returned to the rise in and recent development of retail clinics over the past several years. Can the basic innovation in delivery instituted by retail clinics be thought of as “disruptive”? Considering the changes in flows — of care, supplies, money, data collection, decisions/control — brought about by retail clinics, some discussants concluded that the clinic innovation was indeed disruptive. The primary question no longer seems to be “Will retail clinics work?” but “How will they evolve?” Participants saw the future of clinics as requiring continuing support from all five segments of the health care universe affecting and affected by the clinics: consumers, retailers, providers, regulators, and insurers.

There is now sufficient data to clearly indicate the demographic distribution of retail clinic consumers: Seventy-five percent are women ages 28 to 42 and their children. Some hypothesize that this consumer group thinks of its health care relationships differently than do people of the baby boomer generation and older. The younger cohort often has no “medical home,” while baby boomers and older people tend to view the primary care physician as the center of their medical care. Discussants concurred that what the data do not reveal, however, is whether the medical “homelessness” of this younger group and its high relative use of retail clinics reflect how these consumers want to receive their care or is instead merely their experience (or is a function of the fact
that they have fewer chronic conditions and thus need less care and care coordination).

There does not appear to be sufficient data to demonstrate whether total health care costs have been raised or lowered by the retail clinic innovation. Some participants pointed out that while the data support the conclusion that retail clinics are less costly per episode, it is not clear that they actually reduce total costs. That is because consumers may be seeking care at clinics when previously they might have taken a “wait and see” approach (often because their primary care physician, if they have one, could not schedule an appointment with them for several days).

Despite the lack of definitive data, discussants saw the demographics of retail clinic care, plus reports on the types of primary care being replaced by the clinics, as raising two potentially troubling issues for primary care practice.

- To the degree that patients go to retail clinics instead of primary care physicians, overall preventive care may be reduced because it is the primary care physician who traditionally advises about such screening/testing.
- To the extent that retail clinics siphon off simple, acute visits from primary care, primary care practices are left with a higher percentage of more difficult, time-consuming visits. That means fewer patients per day, a higher intensity environment for providers, and potentially lower reimbursement.

Concluding the first session, the group took up a challenge to consider a seemingly fundamental conflict with regard to the segment of the patient population seen by retail clinics. On one hand, many concurred that most of the minor acute conditions for which patients are seen at retail clinics need not—and perhaps should not—be treated. On the other hand, these very same conditions constitute 85 percent of all visits to traditional pediatric practices. Given this conflict, participants discussed the issue of the emotional as opposed to clinical “need” for these conditions to be attended to, particularly in the pediatric context of parents seeking care for their children.

Several Aspects to Retail Clinics’ Popularity
Feedback from clinic patients reveals a number of aspects of care that are particularly important or attractive to these consumers. Convenience is a major factor in clinic use; this includes geographic proximity, immediate access to care, hours of operation, and relative speed of treatment. Patients are also attracted by the clinics’ pricing—not only the cost but also its transparency. And many patients appreciate retail clinics’ cultural sensitivity, particularly the availability of staff members who can speak languages other than English.

The Effect of Retail Clinics on Primary Care Practice
The roundtable discussants were introduced to studies from HealthPartners regarding the types of care being “replaced” by retail clinic visits. In the early stages of HealthPartners’ venture into retail clinics (adding MinuteClinic to their network), most visits were replacing urgent care. Over time, however, clinic visits began increasingly to replace primary care and other physician office visits. In both cases, it has tended to be relatively healthy patients who have sought care at the clinics.
Session II. The Retail Clinic Landscape

Today

AtlantiCare

AtlantiCare uses the term “convenient care” to describe the retail clinics model it operates. AtlantiCare’s retail clinics are part of a hospital-based, full-service health care system. Of its convenient care patients, 70 percent carry AtlantiCare’s own insurance; the other 30 percent are uninsured, providing an additional income stream that might not otherwise flow into this system.

Because its retail clinics are part of an entire health care system, AtlantiCare is attempting to do more than provide the few basic services of most stand-alone retail clinics. By placing clinics in grocery stores, AtlantiCare is trying to establish those stores as “health venues” which can influence behavior early, rather than relying on the repair of health damage. AtlantiCare dubs this approach to behavior change “quantumentalism” (as opposed to “incrementalism”). In particular, AtlantiCare retail clinics partner with the Shop Rite grocery stores in which they are located to offer AtlantiCare-endorsed food products and to conduct “nutritional tours” through the stores.

AtlantiCare has also introduced a number of other innovations within the retail clinic setting. It is beginning to encourage patient use of self-examination technology before the patient goes to the clinic, with the clinic visit intended to confirm the results of the self-exam. AtlantiCare also offers medical equipment (e.g., scooters and walkers) at its clinics in grocery stores, with the consumer able to test out the equipment on the spot and take it away from the site. In the context of chronic care, AtlantiCare has established a “special care center” in conjunction with a large union, where patients are assessed and then referred to an appropriate clinic. AtlantiCare also has introduced a kind of health care warranty—clinic staff follows up with a patient within 48 hours of a visit; if the patient needs to return to the clinic for further care, there is no additional charge.

AtlantiCare is now exploring the possibility of adding risk-based care to its system. This would permit patients to save money (perhaps through a reduced or waived deductible) if they meet certain benchmarks (e.g., blood pressure) or participate in
sponsored programs intended to reduce high-risk conditions or behavior.

**MinuteClinic**

MinuteClinic is the nation's largest system of retail clinics; it has stand-alone sites in 19 states and currently serves about 50,000 patients a month. MinuteClinic's stated focus is not just to “repair” consumers but to make them healthier. One aspect of this health-improvement project is consumer education. MinuteClinic has begun pilot programs in educating consumers about access (e.g., Medicaid and other government-sponsored programs) and consumer self-care (prevention, chronic care monitoring, “risk stratification”). In this regard, MinuteClinic is exploring the possibility of offering “preventive check-ups.”

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**“Emotional Care” a Recognized Purpose**

In determining priorities for its clinics, the MinuteClinic system has sought feedback from consumers regarding their experiences with traditional primary care. Among the most consistent, significant responses were: Patients feel a lack of control over their care in primary care; they experience a lack of responsiveness from primary care physicians; and they feel constrained to ask questions about their care. This feedback has made clear to MinuteClinic that “confirmation” and emotional relief for a patient is a valuable part of primary/retail care, even if the patient requires no treatment.

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MinuteClinic aims ultimately to be seen as part of an “extended medical home.” To help accomplish this, MinuteClinic wants to insert “branding” into health care. An example would be the traveler who seeks medical care away from home, recognizes the MinuteClinic name and therefore feels comfortable visiting one of its clinics wherever he or she finds it.

MinuteClinic is a rapidly expanding system heading well past its current number of sites and its 50,000 patients per month. Aiding MinuteClinic's expansion is its recognition that having multiple sites “strips out” a significant percentage of administrative costs, which are normally about 20 percent of health care expenditures. Two phenomena were identified that may permit MinuteClinic to extend not only the number of sites but also its range of services: expanding technology that can perform more tasks, and expanding protocols as a way to leverage advances in technology.

**Sutter Express Care**

Sutter Express Care's clinics are intended to fit within the goals of the wider Sutter Medical Group system, the core of which is primary care. The express clinics address Sutter’s specific goals of transparency, ease of access, and expansion of service to the uninsured. The clinics offer an opportunity not only to provide the uninsured with particular, limited services but also for Sutter to “capture” the uninsured for future care within the Sutter system. This system-wide goal differentiates Sutter’s express clinic program from stand-alone retail clinics.

Sutter Express Care has identified three potential areas of difficulty regarding the expansion of the retail clinic innovation. First, the success of clinics will depend a great deal on word-of-mouth to change patients’ mind-set—to think “go to clinic” rather than “call doctor”—when they have a medical problem. Second, clinics need a volume of patients in order to succeed, but seeking greater volume by expanding services will eventually run up against competition and resistance from other providers. Finally, there is the problem of a decreasing number of primary care physicians and nurse practitioners; this will present a challenge to clinics to use their physician and nurse personnel more efficiently.

**Wal-Mart Stores, Inc.**

Wal-Mart’s in-store clinics operate on a different model and serve a somewhat different demographic than the other clinic systems discussed. Wal-Mart’s clinics respond to consumer demand across a wide spectrum of patients. From this consumer demand Wal-Mart has determined that convenience, low cost, and transparency are equally important.
Wal-Mart’s “co-branding” of the clinics adds consistency for the patient, though in-store clinics are operated and staffed not by Wal-Mart but by a local health care system (or retail clinic company) which rents space from the Wal-Mart store. The local health system gets the added benefit of seeing patients when they are relatively well, which increases the likelihood that they will remain in or return to this system when they need more extensive care. Wal-Mart’s in-store clinics make cooperation with health systems a priority, and emphasize the importance of non-fragmented information and systems. In this regard, they are endeavoring to get all store clinics across the country on a common IT platform.

**Session II—General Discussion**

Following the discussion of specific retail clinic systems, participants revisited the question of whether retail clinics in general could be viewed as a “disruptive innovation” in health care. Although there may not be enough data yet to confidently answer the question, it was asserted by some discussants that retail clinics will not create any significant disruption until there are changes in the financing mechanism by which retail clinics are reimbursed. Hospitalists were cited as an example of an innovation that was truly disruptive because it was supported financially by hospital systems.

Various reasons were offered for the contention that retail clinics in general were not yet truly disruptive innovations:

- The care now provided by retail clinics is not substantially different from that provided in a primary care office. That is, the same “mid-level” practitioners are performing the same protocol-based tasks, just in a different physical setting.

- Insurance is still paying for much of clinic care, so to this extent the clinics are not truly “retail.”

- The clinics have not been shown to significantly disrupt existing traditional primary care practices.

- Most patients’ “medical home” has not been changed, because for more serious illnesses and conditions they still go to primary care physicians.

- The claim that retail clinics can more than minimally reduce overall health care costs has not been demonstrated.

**Provider Experience within the Retail Clinic Setting**

Several discussants expressed concern about the experience of individual providers in retail clinics. It was proposed that the professional experience of doctors and nurses was quite different at retail clinics than in other settings. There were concerns about long-term satisfaction of clinic staff, analogized to the problems of assembly-line workers. Retail clinic staff, it was noted:

- Were isolated from other providers;
- Suffered boredom from the sameness of their limited, repeated daily tasks;
- Were without any buffer between themselves and the patients; and
- Lacked the satisfaction of a relationship with a patient over time.

The experience of the Sutter Express clinics showed some of these problems with certain but not all staff. Providers are generally satisfied with their work but do suffer some boredom and would like to see the types of services expanded. On the other hand, some providers prefer the less stressful work and schedule of the clinic. And clinic work offers mid-level workers a sense of “ownership” of the practice not usually available to them in a traditional primary care setting. In an integrated system it is easier to rotate staff, thereby reducing burn-out in primary and urgent care and addressing boredom in retail clinic care. In a non-integrated (stand-alone) clinic system, the issue of professional satisfaction is a larger problem.
Several participants then had a brief exchange on the issue of retail clinics and self-care. Questioning whether retail clinics were truly an innovation, some discussants argued that extension of algorithmic, protocol-based diagnosis and treatment of simple illnesses to patient self-care is feasible and would be the true innovation. One responding view was that retail clinics could be seen as an intermediate step along an innovative path to patient self-care. Others added that the retail clinic could be the site of further innovation if the development of algorithmic diagnosis/treatment permits such clinics to expand their services into chronic care. As retail clinics expand into more complex kinds of care, however, they will begin to resemble, and take on the current problems of, standard primary care practices.

One participant argued that if retail clinics were to become truly disruptive they would need to have a system-wide impact. In this regard, the retail clinic innovation was compared to the introduction of color television, which required a simultaneous systemic change in both production (broadcasting) and consumption (color TV sets) in order to achieve the disruption. Under this view, for retail clinics to become truly disruptive they need to become “integrated” (as Apple did in the computer world) in the health care system, and in particular to change from direct-pay consumers to mostly insurance payment.

Other discussants argued, however, that retail clinics should keep themselves within the cash-and-convenience model. Adding the insurance and regulatory systems would weigh down clinics, creating too much cost and complexity. Consumers seem attracted to clinics because of their low cost, convenience and transparency, all of which would be compromised by adding layers of insurance and attendant regulation.
Session III. Policy Issues and Future Trajectories for Primary Care

The day’s third session took up questions regarding retail clinics and the politics of health care. This was initiated in the form of a question: Where does the retail clinic movement fit within the political debate framed by the following two remarks?

One of the challenges I’ve made to doctors is, I said, “You’re either going to Canada or to Wal-Mart. You can either go to a nationally controlled bureaucratic structure or you can go to the marketplace. But you’re not going to stay in a guild status where you have all the knowledge and you share none of it.”

— NEWT GINGRICH, FORBES, FEB. 27, 1995

The American public cannot have it both ways. They must decide what is more important — money and time, or comprehensive, appropriate care.

— D. SCHELL, “MEDICINE IS NOT FAST FOOD” (LETTER) USA TODAY, AUG. 30, 2006

The overall question was reframed in terms of health care as either a brands model or a service model. In the 1990s, there was a movement by large insurance companies (Cigna, Aetna, et al.) to dominate the health care market through integrated, branded systems. This earlier branding effort failed, but discussants wondered whether retail clinics could be viewed as an effort to reinsert branding into the wider health care market.

The roundtable participants considered a series of issues regarding the future of retail clinics in the current health care landscape. First, what role might geography play? That is, why should centralized sites for the provision of health care succeed when most people in America do not reside in concentrated population centers? It was then noted that price predictability was a large plus for clinics but that other “customer service”-based changes must continue to be introduced. Retail clinics may redefine “basic primary care,” but in order to have a significant impact on wider primary care they will need to expand into chronic care. It was also proposed that retail clinics could be viewed as a “community engagement” exercise. In this regard, to what extent can clinic systems engage retailers and
local communities in political discussions about the provision of health care services?

The discussants then took up the future of retail clinics from the vantage point of the insurance sector. There are dangers for clinics, some contended, if their effort to expand the services they offer results in their becoming too complex. This would mean taking on many of the problems that now beset traditional primary care practice, and entering deeper into the problematic worlds of insurance and regulation. In California, for example, extensive regulation keeps retail clinic costs up and hinders their spread; expansion of clinics elsewhere into a wider set of services will bring the same problems. In determining whether they want to undertake this further complexity, retail clinic systems must decide whether they seek to be an add-on service (for the currently unserved) to primary care, or a significant substitute for emergency/urgent and primary care.

**Retail Clinics and the Patient-Centered Medical Home**

Discussion turned to the model Patient-Centered Medical Home. Its 1960s basic premise, originating within professional pediatrics associations, was that primary care should be the fulcrum of integrated care. In its current iteration as developed by the Patient-Centered Primary Care Collaborative (which includes private health plans, Medicare and Medicaid, and IBM, among others), the Patient-Centered Medical Home would include the following elements:

- **Personal physician.** A physician whose relationship to the patient answers the patient’s question: “Where would I go if I were sick?”

- **Physician-directed medical practice.** Comprehensive treatment at a practice that is physician-directed but depends on team responsibility and team care.

- **Care coordination and integration.** Use of information technology and an emphasis on follow-up medical care.

- **Quality and safety.** Evidence-based medicine, patient feedback reaching the physician, and a focus on the patient experience.

- **Enhanced access.** Mechanisms that provide advanced access and virtual contact.

- **Payment reform.** Primary care practices reimbursed through a combination of fee-for-service, performance-based payment, and a set monthly fee for “care management.”

Within the context of the problems identified by and goals embodied in this patient-centered practice model (though some discussants pointed out that “patient-centered” was really a misnomer, since the model was actually physician-centered), the question was asked what the retail clinic adds or solves. On the positive side, retail clinics are quick and basic, can solve simple problems, and can widen access. However, retail clinics do not help with coordination of care and may not have a significant effect on overall health care costs. Because of this limited balance sheet, there was no consensus among participants about how much positive impact the clinics will have on the health care system as a whole.

**Session III—General Discussion**

Setting the stage for a general discussion of the relationship between retail clinics and primary care was a description of current primary care practice as “broken” and impossible to continue in its current form. Several aspects of this untenable state were identified:

- Reimbursement is too poor to sustain the staff necessary for adequate care;

- Primary care practices as currently run are grossly inefficient; and

- The complexity of the practice is unsustainable (currently including acute, preventive, and chronic care; acute multiple morbidity care; care coordination; end-of-life care; and the subsets of mental health, women’s health, and substance abuse care).
There is also the notion of the primary care office as a “medical home.” Young, healthy adults may not need or care about having such a medical home, but older adults tend to need continuity of care and thus may well need and want a medical home.

In this context, some discussants contended that the success to date of retail clinics is indicative of the need and room for change within primary care. Several other possible aspects of such change are: primary care physicians reducing routine work; all physicians specializing to a greater or lesser degree; and community providers of various sorts—e.g., retail clinics, nurse call-in centers, hospitalists—filling the gaps vacated by primary care physicians. Some participants commented that another aspect of change should be greater management training for primary care physicians, to assist in the reallocation of tasks within primary care. Whatever the ultimate effects of retail clinics, however, it was noted that integrated system clinics and stand-alone clinic systems operate very differently and thus will alter primary care in different ways.
In summarizing the day’s discussions concerning the relationship between retail clinics and the future of primary care, the roundtable participants agreed that there are certain tasks, particularly those that fall clearly within rules-based care, that primary care physicians may no longer need to do. Ultimately, patients will be able to do much of these simple diagnostics and protocol-directed care themselves. For the time being, they can be effectively handled by “mid-levels,” and retail clinics are now part of this intermediate stage.

Discussants also agreed that pricing transparency and predictability were key components of the early success retail clinics have had with patients seeking help for relatively simple problems. However, it remains to be seen whether a broader payment model can be developed to facilitate retail clinics becoming a new form of “medical home” or the extension of a medical home.

Even the relatively limited reach and success to date of retail clinics suggests that patients—particularly newer generations—are not clinging to the traditional physician-patient relationship but instead are open to new forms. The response that retail clinics have seen from patients says something about the possibilities for change in the way primary care is delivered, regardless of the ultimate fate of retail clinics as businesses.

Finally, the roundtable participants were reminded of the significant differences, emerging during the day’s discussions, between stand-alone clinics and those that are part of a wider health care system. And for the future of each clinic form, significant questions remained:

- Will clinics begin to expand the types of services they offer, and if so, what types of services will they include?
- Will integrated or stand-alone clinic systems predominate and, if integrated, with whom?
- What effects will retail clinics have on the larger health care system, either by providing a new model or as new “players” in the market?
Appendix: List of Participants

Health Affairs Roundtable, November 9, 2007

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