Preface

The idea for writing this book came to me two years ago when my then 5-year-old son started complaining from an earache and mild fever on a Saturday morning. Since he has had a history of fighting ear infections, my wife and I knew immediately what it was and what needed to be done: a quick diagnosis and an immediate dose of antibiotics, with some fever and pain medication. The problem, though, was that our pediatrician’s office was closed all weekend long. We would have to wait until Monday morning to call and schedule an appointment for Monday afternoon, at best. That meant that he would have to miss a day of school and, most importantly, one of us would have to take a day off work and stay with him at home and take him to the pediatrician. The visit would cost us about $80 out of pocket (we have a high-deductible health plan provided by my employer). It would last anywhere between one and two hours, and then we will have to drive to the nearest retail pharmacy to get the prescription filled. He would probably get his first dose of antibiotics by Monday evening, not nearly enough to fight the infection on time for Tuesday morning. Another lost day of productivity for child and parent!

Up to about eight years ago, this would have been our only option, unless we wanted to waste half a day waiting in the hospital Emergency Room and pay $500 to treat an ear infection. However, on that Saturday morning in 2012, we had at least two other options, both allowing us to get faster and more convenient care than the pediatrician’s office. First off, we could take him to one of the many walk-in pediatric or adult urgent care centers that have mushroomed all over our area in the last few years. The wait time would be anywhere from 15 minutes to two hours, depending on our luck, but at least we would get to see a physician that same day and have the precious antibiotics in his system before the end of the day. The visit would cost about $110, again all out of pocket. The second option was to take him to RedicClinic, a nearby retail clinic that had opened at our local H-E-B grocery store. He would be seen by a nurse practitioner within 15 minutes, and we could fill the prescription at the store pharmacy. The visit would cost about $75.

As we discussed our options, I remembered a new service that Aetna, my employer-provided health plan, had recently made available. It was called WhiteGlove Health, a sort of house-call service. I ran the idea by my wife, but she did not warm up to it: a nurse practitioner would come to treat him here at home? She preferred the more traditional urgent care center, and to a lesser extent, the retail clinic that we had used once before. So I used the “I work in the healthcare field and know about this stuff” card and convinced her to give WhiteGlove a try. In truth, I was mainly adding the dollar signs in my head: the usual cost of membership for that service is $400 per year, but my employer had generously offered that service for free. The fee is $35 per visit, but WhiteGlove was offering a special discount that month for $10! I called WhiteGlove, scheduled the visit, and paid the fee by credit card over the phone. Two hours later, the nurse practitioner showed up on our doorstep with two large bags. She was professional, kind,
and very efficient. She started with a series of questions about my son’s medical history and symptoms, proceeded with a quick ear check, and confirmed our suspicions of ear infections in both ears. Then, to our surprise, she prepared the antibiotics solution right there in our living room and gave him his first dose. She then produced a free “well-kit” that contained chicken noodle soup, Jell-O, ginger ale, Motrin, and Mucinex. Before leaving, she asked us to take a quick 10-question patient satisfaction survey on her iPad. Not surprisingly, my wife checked “strongly satisfied” for all questions. With four more doses of antibiotics in, my son was feeling better by Sunday evening. We woke up on Monday morning to a regular beginning of another week. No school days missed, no days off from work needed. Crisis averted.

This book is not one that tackles the fundamental problems that ail our healthcare system and offers radical solutions to address them. Rather, it discusses some relatively new basic healthcare services that many American families and individuals find themselves pondering and exploring on evenings and weekends, when family physician or pediatrician offices have already called it a day. The title, *Flipping Healthcare through Retail Clinics and Convenient Care Models*, is inspired by the concept of “flipping the classroom” in academia. The flipped classroom is a pedagogical model where roles are reversed: students are expected to learn class materials on their own through pre-recorded lectures before coming to class, and to use class time to test their knowledge, inquire about in-depth issues, and interact with the professor and their classmates. In that sense, students are transformed from passive recipients to active learners. Similarly, convenient care trends have such as WhiteGlove “flipped” healthcare roles by turning passive patients into active consumers who need and demand more convenient, faster, and cheaper primary care, and who are starting to get that care with a quick trip to the strip mall or grocery store, or thorough a phone call or a mouse click.

The methodological framework of the book relies heavily on thorough and systematic reviews of the academic literature (peer-reviewed articles published in scientific journals), the grey literature (reports published by various organizations, associations, and individuals), the popular literature (articles in newspapers, magazines, online sites, blogs, etc.), and the general Internet. Moreover, I conducted in-depth interviews with 12 key informants who are well-recognized experts in the various areas of convenient care. I also used previous and current academic research on retail clinics that I am involved in, and recalled dozens of presentations attended at various conferences and numerous conversations that I have had with a large number of people over the years. The intended audience of the book includes healthcare practitioners, managers, policymakers, researchers, students in healthcare administration and policy programs, as well as members the general public who have specific interests in healthcare-related issues.

In Chapter 1, I discuss how the American healthcare system lags behind systems of other developed countries on the important measures of cost, quality, access, and convenience. These problems have resulted in an unsustainable, inefficient, oversized, fragmented, and provider-centric system that rewards treatment over prevention and quantity over quality. While cost of care per capita and as a percentage of the Gross Domestic Product is much higher than in other countries, quality of care measured in terms of life expectancy at birth, infant mortality rates, and preventable mortality rates is questionable. Moreover, the U.S. is the only developed country that does not provide coverage to 99.9% of its citizens. A large number of uninsured patients are expected to receive coverage under various provisions of the Patient Protection and Affordable Care (PPACA), but many others will remain uninsured or underinsured. The system has been built and designed around the convenience and preference of the providers of care, not the patients and consumers seeking it, as evidenced by many physician offices closing on weekday evenings and weeknights, and long waiting lines and times. Because of these various inadequacies, hospital emergency rooms have been acting as the safety net of the healthcare system, but evidence suggests
that this net has been gradually breaking: overcrowding, long wait times, ambulance diversions, patient boarding, and patients leaving without being seen by a provider are common occurrences. These problems will only be exacerbated by the expected shortage of physicians and other primary care providers.

In Chapter 2, shortages of physicians in general and primary care physicians in specific are addressed. Primary care is the backbone of healthcare systems. There is strong empirical evidence linking primary care to improved quality and reduced costs. However, the primary care system in the United States is stricken with chronic systematic problems that are likely to aggravate in the near and long-term future. A large proportion of Americans have difficulty accessing a physician due to cost issues. Moreover, there is a substantial current and expected shortage of primary care physicians and other providers. The Patient Protection and Affordable Care Act (PPACA) will expand insurance coverage to an additional 32 million Americans by the year 2019, which will increase demand for primary care services and exacerbate those shortages. Recent legislation, including the PPACA, has attempted to address the shortages by increasing the supply of providers, but with limited success. Solutions to increase access have taken the form of Community Health Centers (CHCs), as well as the restructuring of care models to foster teamwork, the use of information technology, the provision of after-hours care, as well as the use of non-physician providers such as nurse practitioners and physician assistants.

In Chapter 3, I highlight the importance of the role played by non-physician providers. The imminent primary care physician shortage, as well as other cost-related and access-related hurdles, have created a pressing need to prepare and train non-physician providers who can provide adequate primary care services. Nurse Practitioners (NPs) and Physician Assistants (PAs) have delivered services in a variety of healthcare settings for a long time, but there is a recent urgency about the importance of the role that they can play in the healthcare system. While there is strong evidence that care provided by these providers is of high quality and leads to improved patient satisfaction, some questions remain about potential cost savings. Despite a boom in the numbers of providers, their supply will likely be insufficient to meet the healthcare demands. Barriers such as restrictive scope of practice and unjust payment policies have stifled progress, and physician opposition is still a major factor in some states. Opportunities exist in some federal and state legislation to expand the scope of practice and revamp payment policies, while the recently enacted Patient Protection and Affordable Care Act (PPACA) can provide some relief towards improving the pipeline of NPs and PAs. Moreover, the use of other providers such as pharmacists and grand-aides can help fill the gap.

Chapter 4 describes the convenient care trends that are the main focus of the book. With the availability of non-physician providers to treat limited-scope conditions, several alternatives to traditional care provided in the physician office during regular business hours have started to surface in the last decade. While the settings where the care is delivered are different, the common characteristics among these alternatives are to have non-physician providers deliver care that is more convenient and less costly than that delivered in regular physician offices. These convenient care alternatives include urgent care centers, retail clinics, worksite clinics, house call services, and online services, among others. These services could be described as “disruptive innovations,” or powerful changes in which a larger population of less-skilled providers can provide care in more convenient, less expensive settings that historically was only provided by expensive specialists in centralized, inconvenient locations. Given the myriad of problems faced by the American healthcare systems, these innovations are well positioned to change the way healthcare is delivered for generations to come.

In Chapter 5, the first of the convenient care trends, urgent care centers, are highlighted. Urgent care centers represent a unique innovation that has been in the making for the last 30 years. As such, they are
considered more “mainstream” than other recent innovations. Urgent care centers provide unscheduled or walk-in care, are open for extended hours on weeknights and weekends, and provide services that go beyond what primary care physicians provide, such as occupational medicine, laboratory tests, and fracture care such as splinting and casting, with some providing intravenous fluids, routine immunizations, and primary care services. Half of all urgent care centers are located in freestanding clinic buildings and the other half are in retail shopping centers, and all are convenient and easy to find and access. Most centers are staffed by full-time physicians with at least one physician present at the center all the time, but care is typically delivered by non-physician providers. They tend to be located in high-density urban areas and states with larger populations. Consumers appreciate the convenience of walk-in, extended hours, while physicians and other providers see them as an opportunity to practice medicine in a more controlled environment. The owners of urgent care centers are large organizations, health systems, and individual physicians operating in a highly fragmented industry. Urgent care centers seem to provide care that is of higher quality and lower cost than hospital emergency rooms, although the empirical evidence is scarce. Given the expanding industry, strong growth in company numbers, greater employment opportunities, and rising per-capita usage of urgent care centers, the urgent care industry is in the growth phase of its life cycle.

Retail Clinics, a major trend in convenient care today, are addressed in great depth in Chapter 6. They are walk-in clinics located in grocery stores, drugstores, and general merchandise retailers such as Wal-Mart, Target, CVS, Walgreens, etc. They offer a limited scope of diagnostic and treatment services for common medical conditions, as well as preventative and wellness services. Most retail clinic visits are for simple conditions and services such as upper respiratory infections, urinary tract infections, immunizations, and tests. Care is delivered by a nurse practitioner or physician assistant, and many clinics have up-front menu-style pricing, a feature that is unparalleled in the American healthcare system. The clinics operate on a walk-in basis with no appointments needed and very short wait times, and are open on evenings and weekends when most physician offices are closed. They charge an average of $70 per visit and accept all types of insurance plans. Retail clinics first appeared on the healthcare scene in 2000. Since then, there have been periods of slow growth, exponential growth, relative stagnation, and more measured growth. Many quality assurance programs are in place at the clinics and are enforced internally as well as by external bodies and agencies, such as the Convenient Care Association and the Joint Commission. When retail clinics first emerged, the main operators were investor-owned and venture-backed companies that were independent from the retailers. However, in recent years, drug store-owned clinics (such as CVS-owned MinuteClinics and Walgreen-owned Take Care) and hospital-owned clinics have become more prevalent. Empirical evidence suggests that retail clinics provide higher or equal quality, lower cost, and more convenient services than alternative care sites. However, the evidence around the effect of retail clinics on coordination and continuity of care is mixed, and some experts have warned that retail clinics may lead to new utilization and higher overall costs. The future of retail clinics in terms of numbers and usage rates looks very bright, with some operators expanding the scope of services to include management and treatment of chronic conditions.

In Chapter 7, I expound on the development of worksite clinics. Prior to the 1980s, many large employers operated onsite company clinics to treat work-related injuries. However, many of these clinics closed in the 1980s and 1990s because of the decline in heavy industry and manufacturing sectors and the reduction in workplace hazards. Recently, there has been a significant resurgence of worksite clinics. The new generation of clinics is markedly different in that their main focus is on primary care, health promotion, and wellness rather than occupational injuries. Worksite clinics are typically located on em-
ployers’ campuses and serve on-campus employees, employees’ dependents, and retirees. Most are staffed by non-physician providers that can address occupational health and safety issues, administer travel and influenza vaccinations, conduct new employee drug screenings, provide health and wellness education, and refer employees to in-network physicians. Clinics associated with larger employers employ physicians on a full-time or part-time basis. Worksite clinics provide care at lower costs than alternative care sites, and employers enjoy the increased productivity and decreased absenteeism of employees. However, the evidence on Return on Investment (ROI) is mixed. Some worksite clinics are operated by the employers themselves while others are operated by local health systems or physicians groups, but many choose to outsource clinic operations to external vendors. Worksite clinics seem to be well positioned to thrive in a post-reform healthcare environment.

In Chapter 8, other convenient care trends such as online services, house call services, and additional emerging models are discussed. Under the umbrella of telehealth, there are three key modes of delivery: First, real time (synchronous) delivery requires a live telecommunication connection and uses phones, video conferencing, and chat sessions. Second, “store & forward” (asynchronous) delivery captures digital media and transmits to it to providers via images, video, audio, x-rays, etc. Third, remote monitoring (synchronous or not) is a combination of real-time and store and forward, and it uses connected devices. Patient demand for telehealth services seems to be on the rise, and several companies, such as Hello Health, virtuwell, Zipnosis, and American Well, among others, are meeting this demand. However, significant legal and reimbursement hurdles still need to be overcome. Despite the scarce research evidence, care delivered in online clinics and through e-visits seems to follow clinical guidelines, and costs are significantly lower than other settings of care. However, some concerns related to overprescribing of antibiotics are raised. House call services by nurse practitioners are on the rise again. One such service, WhiteGlove, offers access to nurse practitioner care at home or at the office from 8:00 am to 8:00 pm all days of the week. It is available on a membership basis for individuals and for employees of certain companies with specific health plans.

In Chapter 9, I address the role that hospital systems have played in convenient care models and discuss the implications of healthcare reform. Convenient care models have mostly originated from outside the traditional healthcare organization circles. Large hospital systems are not known for being nimble and innovative, as many are inhibited by fixed budgets and low tolerance for risk. However, recently, hospital systems have joined the trends and developed their own retail clinics, urgent care centers, and online clinics. In fact, several hospital systems now have a “convenient care strategy” to reduce demand on their overwhelmed emergency rooms and better serve their patients. These strategies also help the systems better position themselves to deal with provisions of the Patient Protection and Affordable Care Act (PPACA), such as value-based purchasing and bundled payments. More specifically, PPACA will require hospitals to take on substantial financial risks for population health management, with specific implications such as increasing access, focusing on primary care and post-acute providers along the continuum of care; dedicating resources and expertise to reduce cost and increase value; better coordinating services and reducing readmissions; investing in health information systems and robust analytics programs to track large amounts of data on care quality and costs and assess risk and price services. Convenient care models that are appropriately aligned and integrated with the new arrangements will embody excellent opportunities for hospital systems to provide easy-access entry-points for new patients to substitute expensive traditional care settings with less costly alternatives and to deliver high-quality and expedient care that will keep patients in their network.
In Chapter 10, I evaluate the convenient care models discussed in previous chapters and attempt to predict what the future will hold for them. The convenient care models receive high scores on convenience, costs, and quality when compared to hospital emergency rooms and primary care physician offices, despite issues related to possible fragmentation of care. However, improving access to care, especially among uninsured and underserved populations, is not an advantage currently offered by convenient care. Given that the majority of the uninsured population will be receiving coverage under the Patient Protection and Affordable Care Act (PPACA), this might be less of an issue in the near future. The American healthcare system appears to be at a tipping point. Consumerism is rising, demands for price and quality transparency are increasing, and regulatory forces are forcing providers to focus on value over quantity. In this new healthcare reality, traditional healthcare providers such as hospitals and physicians will have to rethink their roles and business models, and new convenient care models will continue to emerge. Healthcare consumers in the United States should feel optimistic about the prospects of healthcare delivery. Newer, more convenient, cheaper, and better performing care models will continue to emerge and spread. The race between hospitals and health systems under legislative pressures and giant retailers spotting strategic opportunities will accelerate innovations and enable convenient care models to move from the margins to become the mainstream way of providing preventative services, treating minor conditions and managing some chronic conditions.

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