Chapter 6
Retail Clinics

ABSTRACT

This chapter addresses the poster-child of convenient care models, namely retail clinics. Retail clinics 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. The chapter discusses the evolution, operations, and stakeholders of retail clinics, and highlights the research related to their outcomes, such as cost, quality, continuity of care, and patient satisfaction. The author describes how some operators are expanding the scope of services to include management and treatment of chronic conditions and conclude that the future of retail clinics in terms of numbers and usage rates looks very bright.

An interesting thing happens when discussing retail medical clinics: individuals cease to be referred to as ‘patients,’ and begin to be referred to as ‘consumers.’ Retail clinics have placed patients in a role of medical consumer within the era of consumer-driven healthcare. —Schleiter, 2010

INTRODUCTION

Retail clinics represent a major revolution in healthcare in the last decade (Fottler & Malvey, 2010). Never before has a delivery option epitomized such a value proposition: convenient locations, walk-in care, short wait times and affordable prices. Scott was first to address this value proposition in a report to the California Healthcare Foundation in 2006: “Most efforts to address escalating healthcare costs attempt to innovate within the insurance system but don’t tackle the underlying structural costs of delivering healthcare. Labor overhead and technology expenses in the U.S. healthcare system are often assumed as givens,
even as health insurance benefits are cut to
the point that neither the scope of benefits nor
the expectations of what consumers will pay
provide a compelling value proposition. As the
trend in health insurance shifts more costs to
consumers, the public has indicated that they
are willing to approach at least their basic,
routine, and elective healthcare needs with
an eye towards price and value” (Scott, 2006,
p. 3). In one of the first major media stories
reporting on the topic, the Wall-Street Journal
exclaimed: “With catchy slogans like “You’re
Sick! We’re Quick!” retail health clinics are
spreading fast in supermarkets, drugstores
and big-box chains across the country, luring
patients with walk-in treatment for minor ailments like strep throat - at about half the cost
of a typical doctor visit” (Landro, 2006, p.
1). The concept was so foreign to healthcare
delivery that Bohmer likened it in 2007 to the
fast-food industry: “The originators based
their design on the McDonald’s hamburger
chain, in which customers select items from
a limited menu. The services listed are highly
standardized interventions and require no
physician evaluation. Diagnoses are made
by using a simple binary test (such as for a
streptococcal throat infection) or by applying
a rigid, protocol-based decision rule. In some
cases, no diagnosis is required (such as for a
hepatitis vaccination). In addition, the condi-
tions treated and therapies offered require no
or minimal follow-up (for instance, clinics offer
diabetes screening but not treatment), and
decisions can be guided by highly specified
protocols. More important, the conditions can
be diagnosed and treated quickly” (Bohmer,
Preston Gee commented in 2007: “There’s a
hassle factor. Filling out forms and sitting in
an office and feeling kind of intimidated by
the whole medical milieu -we don’t like that.
You can go to a [retail clinic] you’re comfort-
able with and buy a beach ball while you’re
waiting” (Callahan, 2007, p.1).

Physicians felt threatened and intrigued by
the new trend. Douglas Kamerow, former U.S. assistant surgeon general wrote in the
British Medical Journal in 2007: “These clinics
clearly work for people who have an acute, limited problem or need an immunization or other offered service, as long as they also have the means or insurance to pay for it. Perfect for the recurrent ear infection on Sunday for a child or an assessment of dysuria in the evening. Quick examination, diagnosis, treatment, and the prescription can be filled without moving your car. Or if you’re on vacation and develop conjunctivitis or a sinus infection, nothing could be more convenient. […] Certainly the retail health clinics are a threat. But they are providing a useful service, from which conventional practitioners could learn a thing or two. In that sense they provide additional impetus for medicine to reinvent itself to become more patient focused and responsive” (Kamerow, 2007, p. 21). Since these early days, retail clinics have been extensively studied with special attention to usage rates, quality, cost, and savings, but the most enthralling argument about them remains their value proposition. Fottler and Malvey (2010) described them as “a concept that is new to healthcare: no frills healthcare that is offered at bargain prices. The care is provided by a physician substitute such as a nurse practitioner at a much lower cost to the consumer. The clinics are located within retail stores, pharmacies, and supermarkets. Patients spend little time waiting to be seen, and prescriptions are filled before they leave the premise. This is a walk-in business, with
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