

Statement of the Rhode Island Medical Society Regarding retail-based health clinics March 2014

Small, limited-service health clinics situated within larger retail establishments (super markets, department stores, drug stores) have been a growing phenomenon in the United States over the past decade. For the consumer, these mini-clinics promise convenience and affordability. For the retailer, they promise increased consumer traffic and sales volume. These perceived advantages for consumers and retailers would seem to ensure that retail based clinics (RBCs) are here to stay as part of the American commercial landscape generally, and they appear likely to establish themselves soon in Rhode Island as well.

That being the case, state authorities have a unique and important opportunity to define at the outset what role RBCs may come to play in Rhode Island's evolving health care system. RBCs are organized to provide what may be called "convenience care," which may be understood as a variant of urgent care without the (apparent) medical urgency, yet with the potential drawbacks and dangers that are always inherent in self-triage. It is to be hoped that the public will understand that RBCs are not equipped to provide urgent care or emergency care. It may be less apparent to the public that RBCs are structurally unsuited as sites for the provision of primary care, preventive care or chronic disease management.

We urge state authorities to consider the following attributes and principles as requisite for the responsible integration of RBCs into the health care system that Rhode Island needs to evolve. (We have adapted these principles from official statements by the American Medical Association, the American Academy of Pediatrics, the American College of Physicians, the American Academy of Family Physicians, the American Academy of Physician Assistants, and from the deliberations of a special committee of the Rhode Island Medical Society):

- RBCs 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 RBCs 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 care should be provided in accordance with evidence-based guidelines and protocols.
- Any RBC licensed in Rhode Island should participate in CurrentCare (Rhode Island's Health Information Exchange) and act as an information source to CurrentCare, so that other health care professionals have access to patient information generated in the clinic.

- Consistent with the current standard of care required of emergency departments, the patient's primary care physician/medical home should automatically receive a report of a patient's RBC visit by fax or other means in a timely fashion. Ideally in some cases, it would be important for notice to go to a patient's appropriate subspecialist as well.
- Prescriptions should be sent electronically to the patient's choice of pharmacy. The patient's freedom of choice of pharmacy should be clearly conveyed through signage and oral instructions.
- Each RBC should have a referral base of primary care practices to provide for continuing care and for health issues that exceed the scope of practice of the clinic and its personnel. The clinic should have relationships with one or more ambulance services and hospital-based emergency departments to ensure appropriate 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, have appropriate liability insurance and be available to clinic personnel for consultation during the clinic's hours of operation.
- 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 or other available primary care practice.
- Patients should be advised that the clinics do not provide urgent care or 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 or urgent 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 retail 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 primary care and walk-in urgent medical care is adequate.

The following additional comments provide essential context and background for the above principles.

Any discussion of RBCs is inseparable from the concept of the Patient-Centered Medical Home (PCMH). Rhode Island is a national leader in the implementation of this proven concept of coordinated, comprehensive primary care for children, youth and adults. The PCMH is the foundation of Rhode Island's highly successful managed Medicaid program, known as RIteCare, which has been regarded a national model since its inception in 1994. Moreover, through Rhode Island's multi-payer Chronic Care Sustainability Initiative (CSI), which was launched in October 2008, as well as through complementary initiatives of Blue Cross & Blue Shield of Rhode Island and with the active support and engagement of various physician organizations, Rhode Island's statewide commitment to PCMH model continues to expand and deepen. Today ten percent of Rhode Island patients entrust their care to PCMHs. On April 5, 2013, CSI stakeholders announced plans to expand CSI to bring twenty percent of Rhode Islanders into PCMHs by the end of 2013 and fifty percent by the end of 2018. In the four and one-half years since its launch, CSI has achieved advances in quality and cost-savings. In addition, a CSI-Kids initiative is now underway.

Rhode Island's commitment to the PCMH movement is highly relevant to the prospect of RBCs entering our local market. Envisioning and planning how these entities can integrate themselves as constructive new players in the health care system here calls for careful consideration.

This is so because RBCs, in concept, are antithetical to the PCMH model. The PCMH regards patient care fundamentally as a relationship. The PCMH is therefore structured to promote integration, coordination, efficiency and continuity of comprehensive, personalized care. In contrast, health care services delivered in an RBC are necessarily 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, coordinated care, comprehensive care, full longitudinal record keeping and follow-up are systematically precluded by the RBC model. Superficially, services provided in RBCs may resemble those provided in a medical emergency, where caregivers and patients may of necessity have no previous acquaintance with each other. The public should be guided in the appropriate use of all components of the health care system, including the primary care setting, urgent care centers and emergency departments. The goal should always be to provide the right care at the right time in the right setting. RBCs have potential to work at cross-purposes with the PCMH and may tend to disrupt and confound community efforts to build a health care system that is anchored in the PCMH.

One brand of RBC, MinuteClinic, 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 education to appreciate the depth and significance of that distinction. RBCs do not and cannot provide primary care in the true sense.

This distinction is of particular and fundamental importance in the care of children and patients with chronic medical conditions. Parents should be advised that the American Academy of Pediatrics, in its February 24, 2014, updated policy statement concerning RBCs “continues to oppose RBCs as a source of primary care for pediatric patients.” Locally and nationally, pediatricians consider it inappropriate for a child under 6 years of age to be seen in a limited-service setting, even for seemingly “simple” conditions. Pediatricians emphasize that 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 up to date? Are physical development, social skills and language skills age-appropriate? Are there concerns about diet, sleep, weight or behavior? Is there reason for concern about autism or other developmental deficits that can impair a child’s social and educational progress? Primary care physicians caring for adult patients, too, routinely 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 PCMH as the universal foundation of a high-quality, high-efficiency health care system, RBCs tend to represent corporate, for-profit health care, which appears to be gaining ground in Rhode Island but remains a relatively unfamiliar phenomenon here. Moreover, to the extent RBCs are situated in retail spaces that also sell prescription and over-the-counter medications, the appearance of 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. We herewith renew our recent public commendations of Rhode Island-based CVS Caremark, owner of the aforementioned RBC known as MinuteClinic, for its national leadership in eliminating tobacco products from the shelves of its thousands of pharmacy stores throughout the U.S. by later this year.

Because of the important relevance of the PCMH model to consideration of the potential role of RBCs in Rhode Island, we append the “Joint Principles of the Patient-Centered Medical Home,” as approved by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association and published in 2007.

This statement has been updated from a document developed in 2007/8 and published in January 2008 by a Rhode Island Medical Society ad hoc Committee on Retail-based Clinics. The members of that Committee were as follows:

Fredric V. Christian, MD, Chair; Nitin S. Damle, MD; Jerald C. Fingerut, MD; Daniel H. 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

APPENDIX

Joint Principles of the Patient-Centered Medical Home

Published on Patient Centered Primary Care Collaborative -- February 2007

(<http://www.pcpcc.net>)

American Academy of Family Physicians (AAFP)

American Academy of Pediatrics (AAP)

American College of Physicians (ACP)

American Osteopathic Association (AOA)

Introduction

The Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PCMH.

Principles

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care, chronic care, preventive services, and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a

compassionate, robust partnership between physicians, patients, and the patient's family.

- Evidence-based medicine and clinical decision-support tools guide decision making.
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement.
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation.
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits.)
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Background of the Medical Home Concept

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these

operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the “medical home” (AAFP, 2004) or “advanced medical home” (ACP, 2006).

For More Information:

American Academy of Family Physicians
<http://www.aafp.org/online/en/home.html> [1]

American Academy of Pediatrics:
http://aappolicy.aappublications.org/policy_statement/index.dtl#M [2]

American College of Physicians:
<http://www.acponline.org/advocacy/?hp> [3]

American Osteopathic Association
<http://www.osteopathic.org> [4]

Source URL: <http://www.pcpcc.net/joint-principles>
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