POLICY STATEMENT

AAP Principles Concerning Retail-Based Clinics

abstract
The American Academy of Pediatrics views retail-based clinics (RBCs) as an inappropriate source of primary care for pediatric patients, as they fragment medical care and are detrimental to the medical home concept of longitudinal and coordinated care. This statement updates the original 2006 American Academy of Pediatrics statement on RBCs, which flatly opposed these sites as appropriate for pediatric care, discussing the shift in RBC focus and comparing attributes of RBCs with those of the pediatric medical home. Pediatrics 2014;133:e794–e797

INTRODUCTION
In 2006, the American Academy of Pediatrics (AAP) published its original policy statement opposing retail-based clinics (RBCs) as an appropriate source of medical care for infants, children, and adolescents and strongly discouraged their use.1 This stance was based on the AAP commitment to the medical home model and its attributes of accessible, comprehensive, continuous, coordinated, compassionate, and culturally effective care for which the pediatrician and family share responsibility.2 The structure and function of the RBC is not driven by the medical home model. The concerns expressed were based on the following attributes that influence the health care received by infants, children, and adolescents in RBCs:

- Fragmentation of care
- Possible decreased quality of care
- Provision of episodic care to children who have special needs and chronic diseases, who may not be readily identified
- Lack of access to and maintenance of a complete, accessible, central health record that contains all pertinent patient information
- Use of tests for the purpose of diagnosis without proper follow-up
- Possible public health issues that could occur when patients who have infectious diseases are in a commercial, retail environment with little or no isolation (eg, fevers, rashes, mumps, measles, strep throat)
- Seeing children who have “minor conditions,” as will often be the case in an RBC, is misleading and problematic. Many pediatricians use the opportunity of seeing the child for something minor to address other issues in the family, discuss any problems with obesity or mental health, catch up on immunizations, identify
undetected illness, and continue strengthening the relationship with the child and family. Visits for acute illnesses are important and provide an opportunity to work with patients and families to deal with a variety of other issues.

In expressing its opposition to RBCs in 2006, the AAP recognized that shifting economic and organizational dynamics of the health care system would likely support the continued existence and expansion of RBCs. It outlined principles to which RBCs should be subject because of concern regarding the medical care received by pediatric patients in these settings. These principles included supporting the medical home model by referring patients back to their primary care physician or facilitating establishment of timely communication to the patient’s pediatrician, using evidenced-based or evidence-informed medicine with requirements for oversight related to quality improvement, maintaining accepted protocols to manage infectious diseases, and opposing payment that offers financial incentives for use of RBCs by pediatric patients for the stated reason that the medical home is the optimal standard of care. This policy does not cover freestanding urgent care clinics, which are addressed in a separate AAP policy statement.

GROWTH, ACCEPTANCE, AND DIRECTION OF RBCs

Since the original RBC opened in 2000 in the St Paul/Minneapolis area, it is estimated that the number of RBCs has grown to more than 6000 as of 2012. Polls indicated that 15% of children were likely to use an RBC in the future, although the majority of patients seen in RBCs are adults. These clinics generally follow a model of staffing by adult medicine or family practice-trained physician assistants or nurse practitioners with off-site supervision by physician medical directors. Protocols are followed that dictate conditions and patients who can be seen as well as suggested treatment regimens to be followed. RBC protocols often restrict pediatric ages and conditions that will be seen by the providers. National organizations for member RBCs provide guidelines for accrediting and patient care.

Patients cite convenience as the most important reason for using RBCs. No appointment time is needed, and wait time is often minimal. Charges for minor illnesses treated are often less than a physician office and much less than an emergency department.

Many RBCs are located in retail stores, such as grocery stores, drug stores, or “big box” stores. Average driving time for patients is less than 5 minutes, and average income and education for communities with RBCs are above average nationwide. More than 70% of patients report having a primary care physician. Demographic data to date do not indicate that expansion of RBCs has improved access to care in areas shown to have a shortage of primary care physicians.

Most RBCs are owned by for-profit companies, many with a national presence. Most RBCs are not profitable as standalone entities and rely on location within a retail store for financial support. Some large companies have indicated plans to aggressively add RBCs to their stores and possibly expand their scope of services. Hospital and health care systems are increasingly partnering with or establishing their own RBCs to capture or increase market share and provide other avenues of accessibility for their patients because of increasing shortages of primary care physicians in their networks and service areas.

Many RBCs have protocols in place to refer patients who do not have primary care physicians or medical homes to a physician and provide correspondence of the patient’s visit to those who have identified a primary care physician.

PEDIATRIC MEDICAL HOME VERSUS RBCs

A commentary published in Pediatrics in 2007 stressed that the emergence of RBCs has created a conflict between relative priorities of continuity of care and those of convenience and cost. Continuity of care embraces 3 primary dimensions: time, accessibility, and setting. Fostering a setting in which a pediatrician cares for a patient over many years (time) with knowledge of not only the medical but developmental and emotional needs of a patient and family significantly affect care and outcomes in a positive manner. Accessibility refers to ensuring care by a pediatrician and team with 24/7 availability for prompt and expert care in an appropriate medical setting. The setting is the pediatric medical home, which involves effective coordination of care throughout various medical settings, including office, hospital, home, school, and specialty referrals. The AAP, American Academy of Family Physicians, American College of Physicians, and American Osteopathic Association in 2007 issued a statement, “Joint Principles of the Patient-Centered Medical Home.” Summarized, the principles state:
pay or live in underserved areas. As toward caring for children who cannot patient/family questions or complica-
ting equivalent to pediatricians and do clinical providers lack pediatric train-
episodic, and not coordinated. RBCs caring for children challenge this
more serious unrecognized
care. As pediatric patients and their health
issues become more complex, the concern exists that even a child pre-
with a simple complaint may have a more serious unrecognized
condition. In addition, there has been scope of care “creep” within the
setting, as these clinics now provide services such as childhood im-
munizations and “school and sports physicals.” These offerings impinge on
core preventive care services of the pediatric medical home and are mis-
perceived by patients and families as an appropriate substitute for regular
preventive care within the medical home.

In an era of stagnant or decreasing physician payment rates by govern-
ment and private payer sources, one of the primary challenges for the pri-
mary care pediatrician is to continue to adhere to the central tenets of the
medical home model by providing high-quality coordinated care in ap-
propriate settings that optimize access, outcomes, and value. However,
health care consumers, including those seeking pediatric health care services,
also value convenience, a concept that, although similar, is not identical to
access. Opportunities to improve convenience can include but are not limited to
extended hours, open scheduling, and same-day appointments for even “mi-
nor” acute illness. Pediatricians will then have the opportunity to not only
improve patient satisfaction but also increase office revenue and make the
RBC setting less attractive for the care of children. At the same time, for many
smaller pediatric practices, convenience can be a difficult or impossible
metric with which to directly compete with RBCs without significant financial
or work/life balance costs. Depending on the situation, the pediatric medical
home may deem it prudent for access to incidental acute care to actively en-
gage with RBCs within the local community as a means of expanding access
without compromising the viability of the medical home and still provide an
organizational plan for comprehensive care.

RECOMMENDATIONS REGARDING
RBCs

1. RBCs Are an Inappropriate
Source of Primary Care for
Pediatric Patients
The AAP continues to oppose RBCs as a source of primary care for pe-
diatric patients, because they risk increasing care that is fragmented and
detrimental to the medical home concept of longitudinal and coordinated
care.

2. Financial Payment
The AAP is opposed to payers offering lower copays or financial incentives for
patients to receive care at RBCs in lieu of their pediatrician or primary care
physician. Furthermore, the AAP strongly believes that the medical home is the
optimal standard of care and that RBCs do not satisfy that definition. Payment
for care received within the medical home must be continually evaluated to
ensure that pediatricians and other primary care physicians receive ade-
quate compensation for the continuous, coordinated, and comprehensive
health care that they provide.

3. Support the Pediatric Medical
Home
If pediatricians and the pediatric medical home wish to or need to use
the services of an RBC within their community as a means to expand
access for acute care outside of the medical home, both the medical home
and the RBC should develop a formal collaborative relationship, which should
include, but not be limited to:

- use of evidenced-based pediatric protocols and standards;
- pediatric quality review;
- prompt communication with the pediatric medical home of pertinent
  information for all visits of patients to RBCs;
- referral of all patients back to their pediatric medical home or
  arrangements to establish one for those who do not have one; and
- formal arrangements for after-hours coverage or emergency situations
  that may occur during a patient visit to an RBC.

CONCLUSIONS
The AAP continues to oppose RBCs as a source of primary care for pediatric
patients. As the RBC model continues
to evolve, traditional RBCs, health systems, and insurance companies alike must recognize the critical role of the medical home in providing optimal health care for children. The AAP, its members, and the pediatric medical home should be the required partner for all RBCs that provide treatment of pediatric patients, with the pediatric medical home as the model of pediatric care.

LEAD AUTHOR
James J. Laughlin, MD, FAAP

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