American Academy of Pediatrics
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POLICY STATEMENT

AAP Principles Concerning Retail-Based Clinics

abstract

FREE

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

COMMITTEE ON PRACTICE AND AMBULATORY MEDICINE

KEY WORDS
retail-based clinic, medical home, coordinated care

ABBREVIATIONS
AAP—American Academy of Pediatrics
RBC—retail-based clinic

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

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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.[1] 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.[2,3] 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.[2] 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.[4–6] Protocols are followed that dictate conditions and patients who can be seen as well as suggested treatment regimens to be followed.[7] 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.[4,6]

Patients cite convenience as the most important reason for using RBCs.[8–10] 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.[11,12] Many RBCs bill insurance carriers, and some are able to bill Medicaid.[8] Data on outcomes specifically looking at pediatric patients are limited, but minor illnesses, such as acute pharyngitis, demonstrate no significant issues with early return visits to primary care physicians.[7,12,13]

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.[5,14] 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.[15]

Most RBCs are owned by for-profit companies, many with a national presence.[14] 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.[14,16] Insurance companies have also started expanding into opening their own full primary care centers with referral arrangements to specialists for identified problems.[17]

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.[18] 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[18]:

1. The patient should have an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care;
2. The personal physician should lead a team of professionals who collectively take responsibility for the ongoing care of the patient;
3. The personal physician should be responsible for all aspects of the patient's care;
4. Care should be coordinated and integrated across all elements of the complex health care system; and
5. Care should be facilitated through registries, information technology, and health information exchange.

RBCs caring for children challenge this medical home concept by offering care that is arguably more convenient and less expensive but also fragmented, episodic, and not coordinated. RBC clinical providers lack pediatric training equivalent to pediatricians and do not provide after-hours coverage for patient/family questions or complications. RBCs do not typically contribute toward caring for children who cannot pay or live in underserved areas.[15] As pediatric patients and their health issues become more complex, the concern exists that even a child presenting with a simple complaint may have a more serious unrecognized condition.[19] In addition, there has been scope of care "creep" within the RBC setting, as these clinics now provide services such as childhood immunizations and "school and sports physicals." These offerings impinge on core preventive care services of the pediatric medical home and are misperceived 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 government and private payer sources, one of the primary challenges for the primary care pediatrician is to continue to adhere to the central tenets of the medical home model by providing high-quality coordinated care in appropriate 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 "minor" 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 engage 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 pediatric 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 adequate 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.

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