Sue Bornstein, MD, FACP, Executive Director, Texas Medical Home Initiative; Governor, American College of Physicians Texas Northern Region.

Inside Medical Liability: As Walmart and other retail giants expand the number and scope of their retail clinics, what are the main concerns of the Texas Medical Association?

Bornstein: Far and away, the two biggest concerns we have are safety and continuity of care for patients. We know from research that when people are seen by the same physician (and team) consistently they have better outcomes. There is better coordination of care and less duplication (as far as medications, testing, laboratory, etc.). With the proliferation of chronic illnesses such as diabetes, hypertension, obesity, and heart disease the best care is delivered in a longitudinal manner. Episodic care is not sufficient for management of these conditions and in turn, prevention of long-term complications.

IML: Are there consequences, for both quality and safety of care, in a one-time visit to a retail clinic? One observer has said that this is treating healthcare much like a 20-minute oil change.

Bornstein: There are consequences both in terms of quality and safety. Comprehensive primary care consists of acute care, preventive care, chronic care, and end-of-life care. While retail clinics can provide acute care, this care is best delivered in a setting in which the other aspects of care can be addressed. Example: if I go to my physician’s office for a sore throat, the clinic staff/physician should still remind me that I am due for my mammogram in a month. So acute care without the context of a longitudinal relationship with the patient and an understanding of their history is suboptimal. We are working hard toward moving away from only episodic (transactional) care toward more longitudinal care.

Gary Floyd, MD, Member, Texas Medical Association Board of Trustees

IML: What concerns do you have about retail clinics?

Floyd: The retail clinics are staffed by mid-level practitioners: nurse practitioners, physician assistants. The ones that I am familiar with operate with only a limited group of protocols and they carry out those protocols pretty well. But if the patient has something that doesn’t fit those protocols, then the tendency is just to refer on to an emergency room. And that, again, drives up the cost of healthcare.

I’m a pediatric ER doc, and a lot of patients come in that don’t need to be seen in the ER. I think that’s going to happen with these retail clinics as well. If patients come in, and they don’t fit with one of the protocols, then chances are they will send them to the ER, or take a stab at handling something they don’t really feel comfortable handling.
“Far and away, the two biggest concerns we have are safety and continuity of care for patients.”

IML: Who supervises the mid-level providers at the clinics?

Floyd: The idea is that each of these mid-level practitioners has a supervising physician who has reviewed the protocols and who is available. I personally have met with representatives of the groups that have started up these clinics, and suggested that they let the county medical societies help them find practitioners in the area of the clinics.

That could work well both ways; they could offer expanded hours for those doctors, and it would give that clinic a local referral source. If a patient’s condition did not fit the protocol, they could send them over to the office.

But most of the clinics have not gone in that direction. They have gone with contracts with large medical centers that may be within the state—but at a significant distance away. That kind of defeats the purpose of having a good place to refer a patient if the clinic can’t handle it.

But that hasn’t happened. Most of the clinics have gone with large groups, or large medical centers that may or may not be anywhere near. I understand their vantage point. It’s easy to get a large group to cover 15 clinics in a metro-plex area, as opposed to going to individuals for each of those clinics. But I think it would be a lot better patient care coordination—a lot less fragmentation—if they would take the time to find local physicians in that market.

IML: What do you think it would take to make that happen?

Floyd: Probably, legislation. Otherwise, I don’t see that happening in our current system. When I visited with them—it was several years ago, when they were just coming into the market—they had their model. Their protocols were nationwide, and they were just looking for a group to follow the protocols.

So there wasn’t a lot of give-and-take there. It is what it is.

It fascinates me, if you look at where they’ll open, most of these retail health clinics, urgent care centers, standalone ERs, they’re all opening up where there are a lot of rooftops which they are guessing are insured people. Seldom do you see those come up in underserved areas.

So clearly, this is a matter of generating more revenue. It’s not a matter of serving the public.

IML: How do prescriptions fit into the picture?

Floyd: They are also counting on their clinics to generate more prescriptions. So, it’s convenient: you can have your prescription filled here; they can sell more medications.

If you ask physicians who have patients that went to these, and ask about it, they’ll say something like, “Yes and they were put on an antibiotic. I would probably not have prescribed an antibiotic. It was a viral—it wasn’t bacteria.”

So is their over-prescribing? Yes. But there are physicians who over-prescribe, too. Being in the pediatric ER, I’ve seen over-prescribing. And we in the ER tend to over-prescribe at times, depending on what will happen to the patient next.

IML: What about parents taking their children to these retail clinics?

Floyd: Most of these clinics will not see children younger than 5 to 7 years old. Most of them are not trained in pediatric medicine. They are trained more for the adult world. I would hope parents would be attuned to the fact that these are not pediatric providers. They should seek out an urgent care center that is just for children, staffed with pediatric trained people.

IML: I used to think that this was the solution for making medicine more accessible. But it doesn’t seem like that’s what’s really happening here. It seems like more of a marketing tool.

Floyd: Yes, that was the big push for this at one point. And I think Walmart, if I remember correctly, I read a statement from them to the effect that they wanted to be the international leaders of primary care.

To do that without many physicians in their system, it makes you scratch your head and say—what?

For patients who go to a Walmart, there is no follow-up, they may need to go to an ER when they get sicker, and guess what—the condition was something that clearly didn’t fit within the protocol, and the provider in the retail clinic didn’t realize that there was something else going on.

I think that retail clinics are just not a wise way to save money.