

The Expansion of Retail Clinics — Corporate Titans vs. Organized Medicine

John K. Iglehart

In a tumultuous era of change propelled by public health policies and private entrepreneurial activity, the spread of retail clinics offering basic primary care, walk-in visits, extended hours, and lower prices than a doctor's office or emergency department is unsettling the medical profession, especially family physicians and pediatricians. Most U.S. retail clinics are owned and operated by vast corporate enterprises and staffed by advanced practice nurses and physician assistants. Although relatively few assessments have been conducted of the quality of care in such clinics, some peer-reviewed studies indicate that they deliver their circumscribed set of services at least as well as physicians' offices do. Nevertheless, primary care physician groups have raised concerns about both the care at these clinics and their potential for disrupting patients' continuity of care.

The first retail clinics, called QuickMedx, were launched in 2000 within Cub Foods stores in the Minneapolis–St. Paul metropolitan area. They focused on common acute conditions including strep throat and influenza and common procedures such as pregnancy testing. Patients paid cash at posted prices that were lower than the cost of similar services in emergency departments or physicians' offices. The CVS drugstore chain purchased these centers in 2006 after their name was changed to MinuteClinic. Now, almost a decade later, corporate titans dominate the retail-clinic space. MinuteClinic (CVS),

Healthcare Clinic (Walgreens), the Little Clinic (Kroger Foods), Target Clinic (Target), and Redi-Clinic (Rite Aid) operate more than 1700 clinics in stores through wholly owned subsidiaries. Overall, there are some 1900 retail clinics in the United States, with the heaviest concentrations in Florida (154), Georgia (105), Arizona (76), California (76), Colorado (33), and Connecticut (28). Almost all accept private insurance and Medicare as forms of payment, and growing numbers accept Medicaid thanks to the program's expansion under the Affordable Care Act (ACA).

(Urgent care centers, an ambulatory care alternative launched during the 1970s, are more costly than retail clinics, but they offer more complex services, including occupational medicine, care for fractures and other orthopedic services, on-site laboratory tests, and x-rays. Typically, these centers are directed by a physician, but they also employ nurse practitioners who provide services, sometimes without a doctor present.)

Within the past year, the corporate giant Walmart announced a new health clinic strategy. Until recently, Walmart had leased space in its superstores to a clinic operator (usually a health system), but it is letting many of these leases expire. In those clinics, nurse practitioners have delivered primary care, and Walmart has contracted with a separate company (QuadMed) to arrange for community-based physicians to provide clinic oversight con-

sistent with state regulations. But recognizing a rapidly evolving health care landscape, Walmart has announced a new model, the "Walmart Care Clinic," which it will own but will contract with QuadMed to operate, according to Daniel Stein, Walmart's director of medical and clinical services.

Stein said the company will apply its "Every Day Low Price" approach in pursuing its goal of being recognized as "America's destination for health and wellness." For employees who participate in Walmart's health plan, clinic office visits cost \$4; store customers pay \$40 for similar visits. Recognizing that access to basic primary care can be a major challenge for many people, Stein said Walmart expanded the scope of its new clinics "to offer services expected from a primary care provider, with referrals to specialists as needed. Services include wellness and preventive care such as check-ups and physicals and treatment of common conditions like high blood pressure and high cholesterol, along with basic acute care." As of January, Walmart had opened its new-model clinics at 17 locations in Texas, South Carolina, and Georgia. The company has not announced its expansion plans for the new model, but Stein said it is "very encouraged with the pilot and remain[s] committed to innovating to make health care more affordable and accessible." Walmart operates about 4500 stores, with pharmacies in virtually all of them.

In almost every dimension of the drugstore business, CVS (7600

stores) and Walgreens (8200 stores) compete neck and neck, but here CVS has raced ahead, operating twice as many retail clinics as its primary competitor and touting its formal affiliations with 55 health systems. (On June 15, CVS announced it would pay \$1.9 billion to purchase 1600 pharmacies in 47 states and some 80 medical clinics, all of which are located in Target stores, and rebrand them as CVS facilities.) Walgreens has disclosed only three such affiliations with physician-run groups in Indianapolis, Las Vegas, and New Orleans. Nevertheless, both chains have opened clinics in only a tiny fraction of their stores and have plenty of room to expand.

Like all retail-clinic operators, CVS and Walgreens have faced criticism from the American Medical Association, the American Academy of Family Physicians (AAFP), and the American Academy of Pediatrics (AAP). These groups have questioned the clinics' quality of care and their possible disruption of physician-patient relationships, but according to Harvard's Ateev Mehrotra, who studies clinic performance, "research has not found that retail clinics deliver poor quality care, overprescribe antibiotics, or adversely impact delivery of preventive care."

Some physician leaders acknowledge that traditional medical centers must reckon with this development, given that the clinics are meeting patients' demands for greater convenience, their quality is withstanding peer-reviewed scrutiny, and their numbers are growing. AAFP President Robert Wergin has cautiously expressed this sentiment, saying, "The AAFP recognizes the growing presence of retail clinics in the health care

marketplace. . . . We recognize that many patients currently lack a primary care physician and we are optimistic that retail clinics can play an important role in connecting such patients with a primary care physician in their community." Similarly, Steven Weinberger, chief executive officer of the American College of Physicians, has said, "The ACP recognizes there is a role for retail health clinics but stresses that such care — minor and self-limited — should complement and not replace the longitudinal relationship with a physician." The AAP remains the most strident physician group, asserting in a 2014 policy statement that these facilities are an "inappropriate source of primary care for children because they fragment children's health care and do not support the medical home."

In general, states have not paid close attention to the rise of retail clinics, but Nebraska and Maryland recently took action to enable nurse practitioners to provide care within the scope of their training without close monitoring by a physician. There are now 20 states that extend the reach of nurse practitioners in this fashion, and the American Association of Nurse Practitioners says that 8 more are considering such legislation.² New York City and New York State, for their part, have a different concern: that urgent care centers and retail clinics are disproportionately located in areas with relatively high population density, high income, or both. In New York State, only 33 of 366 urgent care centers and 6 of 18 retail clinics are located in medically underserved areas; in New York City, the figures are 18 of 103 urgent care centers and 3 of 12 retail clinics.³ Research ex-

amining this question nationwide also found that most such facilities are in prosperous locales.⁴

Between 2007 and 2010, the Federal Trade Commission (FTC) advised policymakers in Illinois, Kentucky, and Massachusetts on proposals addressing retail clinics. In Illinois, a bill proposed to prohibit advertising that compared the costs of retail-clinic services with those of other care sites. In Kentucky, a regulation was proposed to limit retail clinics' scope of care. And a Massachusetts regulation would have required retail clinics to submit advertising material to the Department of Health for approval. In letters to state legislators and executives, the FTC emphasized the potential consumer benefits of retail clinics, arguing that they should not be held to higher standards than other clinics, which would put them "at a competitive disadvantage without offering countervailing consumer benefits." Although those opinions were not binding, the proposals were not adopted.

Assessing retail clinics' status in 2013, Mehrotra and Hwang noted that despite their rapid growth, they've failed to "transform health care," and pointed to regulatory and reimbursement barriers.⁵ Primary care physicians were not expected to protest a loss of visits to such clinics, but the current reimbursement system renders simple acute health problems high-margin work that can offset losses from treating more complex problems. In addition, regulatory limitations on nurse practitioners' scope of practice have increased the costs of running retail clinics and impeded their growth. Changes in policy under the ACA, a loosening of state restrictions on nurse practitioners' practice, and the

movement toward value-based care won't erase all the obstacles facing retail health clinics, but the train has definitely left the station.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

Mr. Iglehart is a national correspondent for the *Journal*.

1. Bachrach D, Frohlich J, Garcimonde A, Nevitt K. Building a culture of health: the value proposition of retail clinics. Princeton, NJ: Manatt Health Solutions, 2015.
2. Tavernise S. Doctoring, without the doctor. *New York Times*, May 25, 2015:D1.
3. Chang JE, Brundage SC, Burke GC, Chokshi DA. Convenient care: retail clinics and urgent care centers in New York State. *New York: United Hospital Fund*, 2015 (<https://www.uhfnyc.org/publications/881033>).

4. Pollack CE, Armstrong K. The geographic accessibility of retail clinics for underserved populations. *Arch Intern Med* 2009;169:945-9.
5. Hwang J, Mehrotra A. Why retail clinics failed to transform health care. *Harvard Business Review*. December 25, 2013 (<https://hbr.org/2013/12/why-retail-clinics-failed-to-transform-health-care>).

DOI: 10.1056/NEJMp1506864

Copyright © 2015 Massachusetts Medical Society.

Transplanting Hepatitis C–Positive Kidneys

Peter P. Reese, M.D., M.S.C.E., Peter L. Abt, M.D., Emily A. Blumberg, M.D., and David S. Goldberg, M.D., M.S.C.E.

The scarcity of kidneys for transplantation and high mortality among patients on the waiting list have led some patients to accept kidney transplants that carry elevated risks of transmitting infections or cancer. In certain cases, such as the transmission of cytomegalovirus, physicians can anticipate these events and institute preventive measures. But transplant teams often discard kidneys from donors with hepatitis C virus (HCV) infection because of the many complications and historical barriers to successful treatment of HCV. We believe, however, that new antiviral therapies with cure rates exceeding 95%¹ should prompt transplant leaders to view HCV-positive organs as a valuable opportunity for transplant candidates with or without preexisting HCV infection.

Of course, intentional HCV infection through transplantation will require rigorous programs that address the complexity of HCV treatment options, bolster informed consent, and overcome cost concerns. But the resulting expansion of the donor pool could save hundreds of lives each year.

Kidney transplantation extends life and saves money as compared

with long-term dialysis,² but it's available to an ever-smaller percentage of patients. In many regions of the United States, average waiting times for a kidney transplant exceed 5 years, especially for patients with blood type O or B, for whom there's a large imbalance between organ supply and demand. Average mortality among wait-listed patients is 4% per year, and rates are much higher among diabetic and elderly transplant candidates. The kidney-transplant waiting list exceeds 100,000 candidates, and thousands of other patients receiving dialysis who might benefit from transplantation are never even referred. These grim realities have prompted aggressive efforts to procure kidneys that would previously have been considered unacceptable, including kidneys from donors older than 70 years of age, kidneys that have sustained acute injury, and kidneys with diverse infections.

Using national registry data, we identified 3273 HCV-antibody-positive deceased donors from 2005 through 2014 (the positive predictive value of the antibody test for chronic HCV infection is 80 to 90%) for whom organ donation was authorized. Of these

6546 kidneys, only 2402 (37%) were transplanted; 91% of the recipients had documented HCV infection. The other kidneys were discarded, although most were of good quality (according to the Kidney Donor Profile Index, a widely used transplant metric). These discarded kidneys could have benefited more than 4000 patients during that period and provided more than 12,000 years of graft life by 5 years after transplantation (see table). In addition, an unknown number of kidneys were never procured because of legitimate concerns that no transplant center would accept them.

This reluctance to use HCV-positive organs reflects past experiences with post-transplantation HCV complications, both hepatic (e.g., cirrhosis) and extrahepatic (e.g., glomerulonephritis that can injure the transplant). It also stems from the problem that interferon, the historical mainstay of HCV treatment, causes transplant rejection. In the United States, the overwhelming majority of HCV infections are caused by genotype 1, which has historically been difficult to treat. For these reasons, HCV-positive kidneys are rarely transplanted into