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Retail Services are Changing the Face of Traditional Primary Care

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After several decades of modest growth in retail clinic sites across the country, the movement toward on-demand, low-acuity health care options has now begun to accelerate and is increasingly being embraced by integrated delivery systems [1]. These non-traditional channels of access to primary care services include telehealth evaluations, asynchronous web-based clinical evaluations, as well as pharmacy-based and stand-alone retail clinics ("urgent care" or "immediate care"). Consumers are predictably drawn to the availability of online scheduling, convenient locations with easy parking, and reliably on-time and available appointments-qualities that define the customer experience in retail health care services. As Americans in almost every consumer-facing industry embrace express lanes, Fast Passes, priority seating, and the like, it should be no surprise that our patients have voted with their feet (and Health Savings Accounts) and put the medical community on notice that waiting days or weeks to see a primary care provider for simple and urgent conditions is no longer acceptable.

As retail clinical venues are increasingly connected to hospital systems, specialty networks and traditional primary care services of integrated delivery systems, there is an opportunity to seamlessly integrate and triage more complex and higher-acuity conditions into care settings with additional clinical expertise and greater diagnostic capabilities. As a component of larger delivery systems, retail clinics have access to an integrated EMR, which allows for population health management activities and care plan continuity to be extended into previously independent settings. Retail can provide a lower-overhead health care venue that can help drive down high costs of health care for delivery systems that are organized into accountable care organizations and trying to manage the total cost of care for a cohort of the population.

The repercussions of this growth and alignment should not be underestimated. Not since the hospitalist movement of the late 90s has a trend in American health care been poised to effect such a profound change in the daily lives of primary care internists. In a single decade, the hospitalist movement removed the burden of hospital rounds as well as night and weekend hospital call from the routine of most internal medicine practices located in urban geographies. That division of labor spurred increased focus and expertise for prevention and disease management in the ambulatory environment and new attention to high-acuity hospital diagnoses cared for by hospitalist providers. It also ushered in problems of care transitions, handoffs, and loss of familiarity with hospital services and specialty providers that continue to challenge today's medical community.

The retail movement will produce no less momentous shifts in the work and focus of primary care in the decade to come. That change in focus may benefit those we serve but will usher in patient care risks if not done correctly. To be sure, the changes facing primary care specialties today are not solely the consequence of an empowered consumer looking favorably upon on-demand clinic venues as a place to receive health care. The growing acknowledgement that the primary care medical home is the best foundation to improve the health outcomes of a population and lower the total cost of care is the second driving force that is redefining the daily routine of primary care. Payment reform initiatives in the Affordable Care Act (PPACA) and alternative payment methodologies in the Medicare Access and CHIP Reauthorization Act (MACRA) incent primary care practices to lower utilization, manage chronic illness, and better coordinate care to reduce unnecessary and low-value care. This is challenging work that can be professionally rewarding but requires dedicated time, new team members and clinic infrastructure, and analytics tools. To achieve success, something must come off the plate of our primary care work force; the shift in low-acuity, urgent care work to retail settings is poised to serve as just such a pressure valve. Although this combination of new work directed at primary care and old work removed from primary care is more serendipity than design, nonetheless these two movements are now paired to effect the most noticeable change in the daily work of primary care providers since the word hospitalist was coined by Dr. Robert Watcher in 1996 [2].

As low-acuity care moves to new care settings and as primary care is increasingly regarded as the solution to affordability challenges, the central function of primary care as the backbone of a population health machine begins to emerge. This differentiation of primary care will require an evolved mindset to be successful. The population health machine must be equally concerned with the patient who is *not* scheduled to be seen that day in the office, as it is with the patient who *is*. The primary care provider will function as the quarterback of a team of professionals that includes behavioral health providers, clinical pharmacists, nurses, licensed clinical social workers and community outreach workers. This new team will be empowered by predictive analytics and real-time claims data and connected to hospital and specialty providers by a health information exchange. In addition to the traditional office-based, problem-oriented clinic visit, the primary care team will engage in promoting healthy behaviors, wellness strategies, prevention activities, and illness screening for an assigned population. Optimal evidence-based disease management that ensures compliance to care plans and treatment regimens for patients with chronic diagnoses will need to be hardwired by responsible staff and electronic registries. Although directed by the primary care provider, much of this population-based management will be accomplished in a virtual or non-face-to-face setting. Fewer clinical encounters will be of greater complexity and significance, and when paired with the direction of a disease management infrastructure, a newly differentiated, narrower scope of primary care will emerge that is only vaguely familiar to those of us who have practiced medicine since the 80s.

One may lament change and wish for the primary care practice of yesteryear, but the forces of consumerism and the political dynamics

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at play are too strong to reverse this trend. Unwinding this change is no more likely than undoing the hospitalist movement of two decades ago. Intentional decisions in organizational design now will ensure that this evolution in primary care is embraced by clinicians and patients alike and brings value rather than disruption to the patients we serve. The potential for retail care to reduce the total cost of care by a lower overhead structure and lower staffing costs will depend upon patient guidance through education and real-time triage that ensures retail settings are reserved for conditions not easily managed by self-care, phone visits, or telemedicine. Overutilization of retail offerings could conceivably drive up total health care expenditures rather than reduce it without that guidance and appropriate use [3].

Retail health care can be an isolating environment with minimal opportunity for collegial interaction. Organizational design that creates provider rotations through the primary care medical home and higher-acuity, emergency-level services will ensure a sense of team and foster awareness of capabilities and functions of other components of the integrated delivery system. This cross-venue collegial interaction will also add variability necessary to prevent provider burnout and heighten career satisfaction for retail providers.

Likewise, design features of the primary care medical home can promote job satisfaction and sustainability for its providers. These changes will include a shift away from wRVU-based compensation models, protected time for case conferences and multidisciplinary care planning, and dedicated support (individuals and analytics) to manage a population proactively to reduce overall health care utilization. Moving toward compensation parity between primary care and specialty providers will likely be necessary to recruit and retain this critical workforce, which otherwise might look to careers in medicine subspecialties or hospitalist roles.

Probably the largest risk, as it was for hospital medicine, is a loss of continuity in care plans. An integrated EMR-which makes the problem list, medication list, allergies, care plans, POLST forms, and narcotic contracts easily available during retail visits-is a minimum specification of integration. Likewise, post-retail forwarding of visit assessments and plans to the medical home and triaging chronic disease patients into primary care will be critical features of a successful model.

The face of primary care is again changing. Traditional primary care continues to evolve into a more focused population health machine. That mechanized term may aptly describe the need for reliable processes that can predictably manage the health status of a population without any gaps, leaving no patient behind. Its ultimate success will depend upon these newly evolved providers to also deliver the physician-patient relationship and compassionate interactions that remain the hallmark of excellence in primary care.

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