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Retail Clinics: Gold Mines or Flops?

RECENT TRENDS AND CURRENT STATUS OF RETAIL HEALTH CLINICS IN THE UNITED STATES

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The Wall Street Journal recently reported a net drop in the number of retail health clinics nationwide. Doctors and especially primary care physicians would like to believe that these numbers reflect the public's dissatisfaction with the business model of the retail health clinic.

Our guest today will explain why is this and other beliefs held by doctors regarding the business of retail health clinics may in fact be incorrect.

You are listening to ReachMD XM157, The Channel for Medical Professionals. Welcome to The Clinician's Roundtable.

I am Dr. Larry Kaskel your host, joining me today is Mr. Tom Charland, CEO of Merchant Medicine, and a consultant that specializes in retail health clinics and he is going to help explain the recent trends and the current status of retail health clinics in the United States.

DR. KASKEL:

Tom, welcome to the show.

MR. CHARLAND:

Thanks for having me.

DR. KASKEL:

What is the current status? I read in the paper that some clinics are opening, some clinics are closing. It seems like there is a lot of flux.

What's going on?

MR. CHARLAND:

Well, we did have our first net decline in retail clinics between the months of May and June, but that was really the first and only time we saw that. We're back to growth, although we may not see the kind of crazy growth that we were seeing this time last year, but still just between the months of August and September, I think we saw an addition of maybe 27 or 28 new clinics as a net increase, so slowing growth maybe, but certainly not declining.

DR. KASKEL:

Who and what is fueling the current growth?

MR. CHARLAND:

There are three different types of players in the market and I think the fueling is coming from mostly those that are owned by retailers and kind of retailers we are talking about are retail pharmacies, mass merchants, but retail pharmacies, the two big players are CVS Pharmacy, which own Minute Clinic and Take Care, which is owned by Walgreens and I would say this year we're going to see the most growth out of Take Care.

DR. KASKEL:

So, it appears that this business model is not a fad?

MR. CHARLAND:

I would say no, definitely not a fad, it's here to stay.

DR. KASKEL:

What are some of the misconceptions that you deal with daily in terms of what physicians believe? What's the number one thing that we kind of got wrong?

MR. CHARLAND:

Well I think the statement that this is poor quality and it's driven primarily to push prescriptions is not real accurate and it concerns me that physicians believe that because it means that they are unprepared when they do sort of get into this debate.

DR. KASKEL:

What is the position of the retail clinic? Why do they exist? Is there mission to serve the population or is it to make a profit and get extra scripts written?

MR. CHARLAND:

Well they exist because there was an opportunity to better serve customers. Keep in mind that this was not started by retail pharmacies. It was started by a couple of entrepreneurs in Minnesota, who, you know, had kids and they went to the doctor and after a few times of sitting there for an hour for something that shouldn't be rocket science to get, you know, a strep throat test, they teamed up with their family physician and finally got a grocery store with a pharmacy here in Minneapolis to partner with them. They opened the clinic and the rest is history. That was in May of 2000. So, I think eventually a few years later the retail pharmacies really got interested in this, but the primary driver for this were patients, who were looking for more convenient care, and frankly employers, who were looking for more economic care and getting people back to work faster.

DR. KASKEL:

Let's talk about one of the other myths that is that the care given at these health clinics is not as good as the care given from a private practice, and I guess I believe that because most of the care is given by extenders and not physicians that may miss some diagnoses and just think everything as a sore throat.

MR. CHARLAND:

Well, you've to keep in mind that these clinicians probably in this area have the same kind of training, and I am talking about the amount of hours that are devoted to upper respiratory issues, and in fact, these clinicians are probably seeing more upper respiratory cases than many physicians out there. So they are getting pretty good at it. The second thing is that many of the physicians, who would make this claim are using extenders, only the extenders are down the hall instead of down the street and so to make the claim they would also have to make the claim that they see everyone of those patients, in my mind, and if they are not seeing those patients before they leave then that extender has just as much chance of missing the diagnosis as the one down the street.

DR. KASKEL:

Touché, well put. Another myth is that these clinics are really, what I talked about earlier, just lost leaders that they want to get the patients in. They may not make a profit on the actual medical care, but they will make their profit on the prescriptions, and as we've been asking the question, I am thinking well how do you make a profit on a 4-dollar prescription these days?

MR. CHARLAND:

Right.

DR. KASKEL:

So, where is the profit coming from?

MR. CHARLAND:

The profit is coming from a new prescription customer. That's really the motivation behind the retailers getting into this is that there is some value to a new prescription customer.

DR. KASKEL:

So, have they done the math to see what a new prescription customer is worth over 10 years?

MR. CHARLAND:

Well, I haven't actually seen their math, but I can tell you anecdotally that there are gift cards or reward cards that there being given to a new prescription customer worth 10 dollars in cash. So I know it's worth at least that much, and you know, you got to figure that if someone has a good experience at a Walgreens or a CVS Pharmacy, people with healthcare tend to go where they feel most comfortable. So if they do a good job, then that's a new prescription customer. That isn't just a one-time incident, hopefully it's more than that, but I think where I get concerned about physicians saying this is a lost leader is that these clinics do a pretty good job of keeping track of statistics and if you look at their prescribing trends, which they can give you by practitioner on any given day, their rules are pretty tough to get a prescription. In order for a practitioner to write a prescription, they have to follow guidelines, and in following those guidelines, they have to come to a diagnosis that means yes I have a positive strep test and they have to back that up with either, you know, a Quidel Rapid Strep Test and if the RST says it's positive, then they prescribe. If it's negative, they may go to a culture and they can't prescribe until they get a positive culture. I know a lot of physicians who don't go through that whole process and just prescribe.

DR. KASKEL:

Correct.

MR. CHARLAND:

And so I would argue that I see guidelines being followed more rigidly in these clinics than I do in a lot of the physician offices that I consult with.

DR. KASKEL:

If you've just tuned in, you're listening to The Clinician's Roundtable on ReachMD XM 157, The Channel for Medical Professionals. I am Dr. Larry Kaskel and I am talking with Mr. Tom Charland, CEO of the Merchant Medicine, a consulting firm specializing in retail and on-site health clinics. We are talking about some of the common misconceptions that are held by many primary care physicians concerning retail health clinics.

DR. KASKEL:

Tom, you mentioned that they are pretty good at keeping statistics and monitoring trends, is that really because they've all embraced the electronic health record?

MR. CHARLAND:

Well, certainly they wouldn't be able to keep those statistics without the electronic health record. I think it's a combination of the fact that they all employ an electronic health record and the fact that 80% of what they see are the five or six conditions that are these episodic typically upper respiratory conditions that are binary. In other words, at the end of the visit there is yes or no answer in terms of whether or not they have it or they don't, and when things are binary, it's a lot easier to keep track of statistics. So let's take the example of someone who has a sore throat. Typically that's someone who has self-diagnosed and they want to come in, have you verify their diagnosis and write him a prescription. That's kind of a way the patient thinks and I think everyone listening probably would agree with that. So they come in and these clinics are monitoring everything from the beginning to end, and I know clinics, who can tell you the incidents of positive rapid strep test per practitioner for a given day as of midnight, the end of that day, and by doing so they can track statistically one standard deviation beyond the norm anybody who is outside of that one standard deviation on rapid positive strep test, they will take them aside and figure out what's going on because something is going on, and if in these meetings with physicians and these retail clinics where those physicians are very emotional, that these guys role out their quality matrix and it's impressive and then they turn and they ask the physicians to show us their matrix and they don’t have them.

DR. KASKEL:

Well, I am of the mindset that this is fine if this is all they do is deal with sore throats and upper respiratory infections, but is there a business model out there that is looking towards expanding the current scope of what they provide at these clinics?

MR. CHARLAND:

Well, there is and that's where I think we get beyond rhetoric into some legitimate concern. I would argue that these clinics should not be doing physicals if they don't have an exam table. I just don't see how you can do a complete physical without it and there are clinics out there doing that. You know, and then there is the argument of whether or not you should be taking away those well checks, which is an opportunity particularly in pediatrics to check in with these patients and see that they are up-to-date. So to me there are some legitimate arguments there and then, you know, back to the sort of physician extender to the extent that the physicians overseer or collaborative physician is someone, who's kind of on-contract to cover an entire state, you know, that physician should be available, particularly during these well checks or physicals or consultation by phone, you know, they are running their own practice and have their own patients, they are not going to be available during the 15-minute intervention that these extenders are having. So, I think that there are some legitimate issues around quality where these retail clinics could be short of or where the scope should be limited.

DR. KASKEL:

Tom, tell me a little bit about how private practices are adapting or evolving to deal with the onslaught of all of these clinics?

MR. CHARLAND:

I think the biggest way is that they are paying more attention to customer service. In my mind, what has happened is that up till now primary care physicians haven't paid a lot of attention to the patients as customers and legitimately I don't think they went into practice in order to become business people. If they went into practice to become business people and make a lot of money, they probably wouldn't have gone into primary care is my feeling, but now you've got these retail clinics, who are forcing them to pay attention to these things and, you know, frankly that's kind of what we try to do as a consulting firm is to help them with that, and you know what it boils down to is they are having to learn to be merchants and good merchant, all of us experience this, is someone when you walk in the door makes you feel like you are their best customer, and in my mind when a physician's office has someone walking the door and they hand him a clipboard with a blank form and say fill this out, when you've been there 5 times before, they are communicating to you have no idea, who you are, I don't know what your name is, and let's start from scratch, and to me that's a very poor way to treat your patients.

DR. KASKEL:

Are there any other misconceptions that I have not asked you about that you think are important to get out to primary care physicians?

MR. CHARLAND:

Well, I think another one is the assumption about who the typical patients are. I often hear people sort of relate this to the uninsured to the indigent to inner cities, and that's a clear misconception. If you look at where Walgreens and CVS are opening these clinics, it's in the outer ring suburbs and that's because the slam-dunk demographics for these retail clinics is dual-income, upper income parents with kids. They are well educated, they are the ones, who are very comfortable self-diagnosing. They have seen it before. They want a practitioner to confirm what they think it is and give them a prescription. Everything outside of that core demographic, I think in a market is an evolution. It's a movement toward the mass market, but when these open in a new market, the core demographic, the first one to use it are these dual-income, upper income parents.

DR. KASKEL:

Tom Charland, thanks for talking with me today.

MR. CHARLAND:

You're welcome. Thanks for having me.

Tom Charland is the CEO of the Merchant Medicine, which is a consulting firm that specializes in retail and on-site health clinics and we were discussing some of the common misconceptions held by primary care physicians concerning retail health clinics. I am Dr. Larry Kaskel and you've been listening to the Clinician's Roundtable on ReachMD XM 157, The Channel for Medical Professionals.

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