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IN THIS ISSUE

Managing Foot Fractures in Urgent Care

Second in a Two-part Series

A **BRAVEHEART** PUBLICATION

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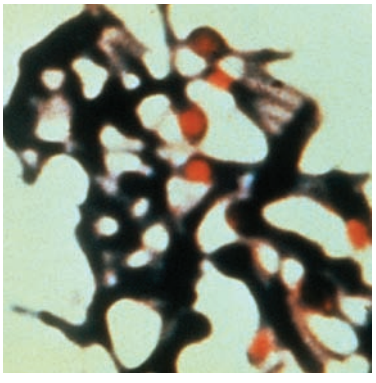
CLINICAL

CASE REPORT



JUCM CONTRIBUTORS

When a patient stubs his toe, he knows it. It may be a day or two before he seeks medical attention, but it's unlikely the acute pain and swelling of a fractured hallux will go ignored for long.

But what if the patient didn't experience that kind of sharp, blinding pain and thus wasn't compelled to seek medical attention for weeks (or longer)? Would delay in treatment compound the risk of a poor outcome?

Such are the dangers of certain injuries that occur beyond the forefoot, the pain of which may be mild at first but grows progressively worse (as does the chance of a positive outcome for the patient)—just one of the principles discussed in part 2 of Managing Foot Fractures in Urgent Care (page 13) by **Phillip H. Disraeli, MD, FAAFP**.

Where part 1 (*JUCM*, December 2008) discussed the role of the urgent care clinician in evaluating and treating or referring patients with various fractures of the great toe, metatarsals, and the forefoot in general, part 2 addresses the same concerns as they apply to fractures of the cuboid, cuneiforms, navicular, talus, and calcaneus.

Dr. Disraeli is a partner in Metro Urgent Care in Frisco, TX, and director of clinical programs for the Urgent Care Association of America.

Of course, before a patient can seek treatment in an urgent care center, he or she has to find it—a feat more challenging than one might assume, according to new research commissioned by UCAOA. The Search for the Urgent Care Center (page 38) by **Robin M. Weinick, PhD**, **Steffanie J. Bristol, BS**, **Jessica E. Marder**, and **Catherine M. DesRoches, DrPH** seeks first to articulate what distinguishes urgent care from other settings, and then to determine how many such centers exist in the U.S., using methods that are probably similar to those a patient might use on a random Tuesday evening.

The team's findings provide excellent rationale for ensuring you're easy to locate.

Especially hard to identify were urgent care centers affiliated with hospitals, even though this practice model is becoming more and more attractive across the country. In Making a Case for Hospital Urgent Care (page 34), **Alan A. Ayers, MBA, MAcc** explains why that's the case, and how hospital urgent care might be a partial solution to overcrowded emergency rooms while also helping the hospital capture new revenue.

Finally, we're pleased to present a case report on a presentation rarely seen in most settings these days—though, as they authors explain, urgent care clinicians may be more likely see patients with symptoms of tetanus than their colleagues in family or emergency medicine.

A 25-Year-Old Male Presenting with Tetanus, by **Curtis G. Kommer, MD**, **Latha Shankar, MD**, and **Mario Kapetsonis, MD** starts on page 22.

Dr. Kommer has been a board-certified family practitioner for over 20 years. He is a staff physician at Walk-In Medical Care in Flagstaff, AZ. Before relocating there recently, he worked at Columbia–St. Mary's Cathedral Square Urgent Care Center in Milwaukee, where Drs. Shankar and Kapetsonis remain as colleagues. Dr. Shankar has co-authored/published various medical research articles in other journals. In addition to urgent care, Dr. Kapetsonis is interested in medical acupuncture, integrative medicine, and preventative medicine.

Also in this issue:

Nahum Kovalski, BSc, **MDCM** reviews abstracts of new articles on establishing criteria for running blood cultures, advising parents on how to prevent scald burns to their children, the benefits of pre-hospital notification when transferring or transporting stroke patients, and other topics of high interest to the urgent care clinician.

John Shufeldt, MD, JD, MBA, FACEP discusses the urgent care center's obligations under the Emergency Medical Treatment and Active Labor Act (EMTALA) and offers sage advice on how to communicate with physicians on the receiving end of emergent referrals.

David Stern, MD, CPC tackles the thorny issue of how to determine who's a new patient and who is an "established" patient in the eyes of the American Medical Association and the Centers for Medicare & Medicaid Services.

Frank Leone, MBA, MPH offers rationale on the judicious use of "freebies" when promoting an urgent care center's occupational medicine business. Looking beyond pens and refrigerator magnets may work to your advantage without adding to your marketing budget.

What are your thoughts on these topics, or other press-

ing issues in urgent care? We invite you to take part in the dialogue by sending an e-mail to our editor-in-chief, **Lee A. Resnick, MD**, at *editor@jucm.com*. We'll share your perspective in an upcoming issue.

The same goes for cases for which you have good graphic support in the way of x-rays (or other imaging), photos, or electrocardiograms. Send us some basic information on the presentation—the patient's age and gender, the primary complaint, history, and any remarkable findings from the examination—along with the corresponding image or images and we will feature the case in an upcoming issue in our Insights in Images department.

Submissions for Insights in Images can also be sent to *editor@jucm.com*.

To Submit an Article to *JUCM*

JUCM, *The Journal of Urgent Care Medicine* encourages you to submit articles in support of our goal to provide practical, up-to-date clinical and practice management information to our readers—the nation's urgent care clinicians. Articles submitted for publication in ***JUCM*** should provide practical advice, dealing with clinical and practice management problems commonly encountered in day-to-day practice.

Manuscripts on clinical or practice management topics should be 2,600–3,200 words in length, plus tables, figures, pictures, and references. Articles that are longer than this will, in most cases, need to be cut during editing.

We prefer submissions by e-mail, sent as Word file attachments (with tables created in Word, in multicolumn format) to *editor@jucm.com*. The first page should include the title of the article, author names in the order they are to appear, and the name, address, and contact information (mailing address, phone, fax, e-mail) for each author.

Before submitting, we recommend reading "Instructions for Authors," available at *www.jucm.com*.

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To Find Urgent Care Job Listings

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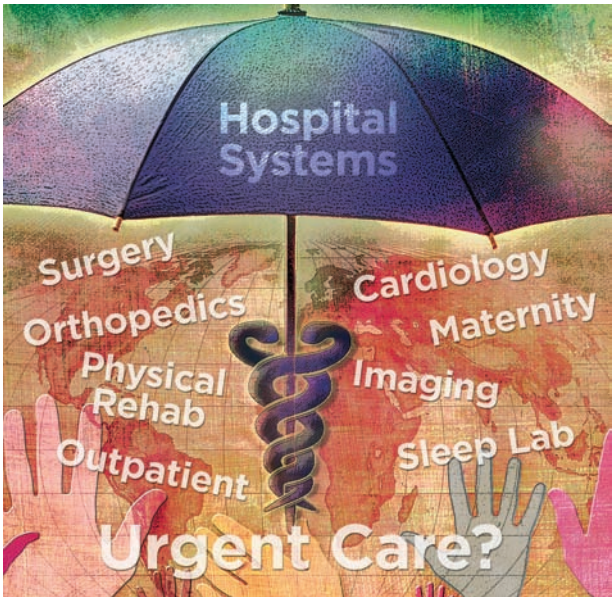
Making a Case for Hospital Urgent Care

Urgent message: Availability of hospital-affiliated urgent care can not only lower the burden on overcrowded EDs, but also help capture new business and keep existing patients within the health system.

Alan A. Ayers, MBA, MAcc

Hospitals have operated urgent care centers for over 25 years; today, estimates of how many centers are affiliated with hospitals range from 15% to 20%. In recent years, hospitals grappling with overcrowded emergency rooms and increased competition for outpatient visits have rediscovered urgent care as a way to shift low-acuity cases out of the ED while increasing revenue for affiliated providers and ancillary services.



The Cause of Long Emergency Room Waits

Over the past 10 years, private and government payors have focused on reducing inpatient hospital stays as a way to curb rising healthcare costs. In response, hospitals have invested in new clinical technologies and elegant outpatient facilities. These neighborhood facilities—often anchored by an ambulatory surgery center—host a myriad of integrated services, including diagnostic imaging, physical rehabilitation, women's health, occupational medicine, and sleep services.

Despite an aging population and deteriorating personal health, the combined efforts of hospitals and payors have been successful in reducing inpatient days per 1,000 approximately 7% between 1999 and 2006, according to the Kaiser Family Health Foundation.

Progress, indeed—but with an unintended consequence.

Up to 40% of hospital emergency departments are overcrowded, the Institute of Medicine reported in 2006. Average wait times in hospital EDs have increased each of the past 10 years; in some cities, the time to be treated and discharged by an emergency physician is now eight hours or longer, according to the U.S. Centers for Disease Control and Prevention.

The leading cause of emergency room overcrowding is the declining number of inpatient beds due to falling reimbursement and the shift to outpatient facilities, concludes the American College of Emergency Physicians. Without enough inpatient beds, hospitals "board" more patients in their emergency departments—which occupies beds there and increases wait times for new patients.

A Solution for Crowded Emergency Rooms

Of all the reasons hospitals are interested in urgent care (**Table 1**), it seems the most common is to decompress an overcrowded ED. Besides long wait times, emergency room crowding makes it difficult to hire and retain good emergency physicians and nurses, increases the potential for medical errors, prolongs pain and suffering, and diminishes patient satisfaction.

In addition, ambulance diversion to other facilities can cause life-threatening treatment delays and preclude a hospital's ability to handle any type of volume "surge"—an essential defense against terrorist attack or natural disaster.

Up to 70% of emergency room visits could have been treated in a lower-acuity setting or avoided altogether if early treatment had occurred before the condition progressed into an emergency, states a 2005 New York University study.

Between 1996 and 2006, visits to hospital emergency rooms rose from 90 million to 119 million—a 32% increase, according the CDC. And in 2007, the Advisory Board Company, which conducts best practices research and analysis, projected that annual ED visits will continue to increase to roughly 124 million by 2015.

If low-acuity patients could be treated in settings other than hospital emergency departments, capacity would be freed to focus on trauma care and hospital admissions.

ED Resistance to Urgent Care

When a more convenient, lower-cost alternative to the ED is made available, it's logical that consumers will use it. The challenge for some hospital and emergency department administrators is that while emergency room charges can be four to six times higher than urgent care, the incremental cost of treating a low-acuity patient in the ED can be very low, provided all resources are already in place. And when low-acuity patients have good insurance, their visits often subsidize losses on charity care and public assistance programs.

High margins from low-acuity, privately insured patients incentivize many hospital emergency departments to advertise "fast tracks," "service guarantees," and "zero wait" policies.

The legitimate fear among administrators is that losing privately insured and self-pay patients to urgent care will adversely affect ED margins. Because even when urgent care is available, there is a base of lower-margin patients—including Medicaid, indi-

Table 1. Common Value Propositions for Hospital Urgent Care

Branding
Urgent care is an inexpensive way to bring a hospital's brand and resources to the consumers where they live, work, and play. Not only does urgent care increase accessibility to a hospital's array of services, but a "halo" effect occurs as consumers associate a hospital-affiliated urgent care with higher quality and deeper capabilities. Urgent care can be integrated with a hospital's advertising and grassroots marketing efforts and serve as a venue for community events and screenings that promote the entire health system.

Flanking/catchment
Urban hospitals often use suburban urgent care centers to "capture" consumers into their system and "push" them back to the primary campus through referrals. If not for this neighborhood access point, consumers may prefer to utilize more convenient suburban hospitals. As a defensive measure, some hospitals "flank" competing hospitals with a ring of urgent care centers to capture patients from the competitor's catchment area. Urgent care can also be a solution when building a full-service hospital facility is cost-prohibitive or certificate of need requirements cannot be met.

Referrals/downstream revenue
Urgent care generates direct revenue for hospital services, including diagnostic imaging, laboratory, clinical specialists, and physical therapy. The availability of urgent care may also increase early detection of cancer, heart disease, and other chronic conditions. Downstream revenue generated to a hospital system through referrals and ancillary service utilization is often a multiple of the profitability of the urgent care as a freestanding entity.

Offset emergency department volume
Hospitals with emergency room crowding see urgent care as a way to shift low-acuity cases out of the ED into a lower-cost treatment setting, as well as a way to prevent acutely rising conditions from turning into medical emergencies.

Overflow and after-hours coverage for primary care
With coordinated medical records, an urgent care center can serve a primary care provider's patients when the office is closed or the schedule is booked. In exchange, urgent care provides primary care referrals for follow-up and management of chronic conditions. Functions like x-ray and lab collection can also be consolidated at the urgent care center.

Practice opportunities and equity participation for physicians
Hospitals often try to attract and retain high-quality providers by offering equity ownership. Many hospital-affiliated urgent care centers are joint ventures with physicians or management companies. Urgent care may also serve as a training ground for residents, a venue for midlevel providers to meet state practice requirements, or as supplemental income for various practice groups.

gent, mentally ill, and non-working uninsured populations—who are unlikely to change their behavior of using the ED as a stop-gap or access point for primary care.

Urgent Care as an Alternative to the Emergency Room

Despite concerns that urgent care will "cherry pick" the most profitable ER cases, studies show the percentage of indigent or charity care patients presenting to the ER with low-acuity conditions is relatively low. A 2005 report in the *Annals of Emergency Medicine* indicates that as many as 85% of emergency room patients have health insurance and 70% have incomes above the federal poverty level. Many patients use the ED not because they have to—but because they want to.

Affluent and fully insured patients expect convenience and demand quality—hospital emergency rooms are available 24 hours a day, seven days a week and consumers perceive that hospital affiliation and staffing by emergency physicians results in broader capabilities and a higher standard of care.

In order to woo premium patients away from the emergency room, urgent care must offer a superior experience—one that is closer to home, has shorter wait times, incurs less hassle with billing, and is delivered in a warm and friendly atmosphere. Lower copays built into an increasing number of insurance plans also help direct patients to urgent care, as do high-deductible health plans that make consumers responsible for the cost of their visit.

If hospitals don't embrace urgent care, emergency room capacity problems will only get worse and insured patients will be targeted by entrepreneurial urgent care centers, retail health clinics, walk-in family practices, and other delivery models. Each of these emerging players promotes itself as an "alternative to the emergency room," and while they may help the hospital achieve its goal of offsetting ED volume, in many cases they will not contribute anything back to the hospital in return for the revenue lost.

Table 2. Considerations Unique to Hospital Urgent Care

Ownership and management structure
A hospital may offer urgent care as an extension of the emergency department, as fully controlled ancillary service, as an equity joint venture, or as a landlord/tenant relationship. Partners may include physicians, physician groups, private developers, or urgent care management companies. Management—including billing, marketing, staffing, and operations oversight—may be by the hospital, joint venture investors, or a management company. The ownership and management model selected—including branding, financing, and controlling interests—must support the goals and objectives of all investors in the urgent care initiative.

Facility fee
Unlike a hospital emergency room that provides separate bills for the facility, medical provider, radiology, lab, and other services, a typical advantage of urgent care is one consolidated, easy-to-understand bill.

A hospital may charge a facility fee for urgent care under the following conditions:

- If the urgent care center is located physically in the hospital building or on the hospital campus; it must have the same licensure as the hospital, integrated clinical services, billing, and financial administration with the hospital, and be recognized by the public as being part of the hospital.
- If the urgent care center is located away from the hospital campus, either in a freestanding building or hospital ambulatory facility, it must have common ownership, control, administration, and supervision with the hospital and be located in the "immediate vicinity" of the hospital.
- If the urgent care center is a hospital joint venture, it must be partially owned by the hospital, located on the main campus of the hospital that is an owner, and designated by the Centers for Medicare & Medicaid Services as a "provider-based facility."

Emergency Medical Treatment and Active Labor Act (EMTALA)
A hospital-affiliated urgent care center may be required to provide—without regard to a patient's ability to pay—a medical screening and transfer for emergency conditions if the urgent care is located on a hospital campus, is within 250 yards of the hospital emergency department, or the urgent care center bills under the hospital's provider number.

Downstream Referrals Generated by Urgent Care

Hospital-affiliated urgent care allows hospitals to offset ED volume but still build their revenue base. When urgent care is integrated with affiliated practice groups and ancillary services, it becomes an entry point to the health system. Pediatrics, internal medicine, orthopedics, physical medicine, general surgery, and podiatry are just a few of the specialties that benefit from urgent care referrals.

Moreover, urgent care provides direct revenue to hospital ancillary services like diagnostic imaging, laboratory, and physical rehabilitation, which are also utilized by referral providers.

The degree to which urgent care is integrated with affiliated providers and ancillary services—including location in the same facility, shared electronic medical records, and consolidated billing—influences how effective the health system will be in capturing referrals and retaining downstream revenue.

In addition to supporting existing services, a professionally staffed and well-equipped urgent care provides visibility and access to consumer and business markets—allowing a hospital to enter new lines of business such as occupational or travel medicine. These new business lines generate additional referrals and further utilization of ancillary services. Hospitals may also use the urgent care center to make services otherwise provided in the hospital—such as laboratory collections—more convenient for consumers.

'Front Door' to the Health System

The result of fewer inpatient admissions and continued hospital investment in outpatient capabilities is increased competition among hospitals in many communities—with hospitals trying to establish themselves as having the most locations, greatest patient satisfaction, highest quality rankings, and widest range of capabilities to attract new patients and retain providers.

The very essence of urgent care is that it is a consumer-centric healthcare delivery model—a convenient, extended hours, walk-in facility. Urgent care can establish a hospital's brand in a community and provide a "front door" by which consumers can access all of the hospital's services.

While hospital urgent care does face some unique operational challenges (**Table 2**) not common to independent, freestanding urgent care centers, hospital-branded urgent care centers benefit from the halo effect described previously.

Although the case for hospital urgent care is appealing on the surface, in practice it isn't so cut-and-dried. Hospitals are large, complex organizations filled with a spectrum of financial, social, and clinical interests which need to be continually reconciled. Therefore, the business case for urgent care needs to be carefully constructed to meet the expectations of all interested parties in an integrated health system. ■