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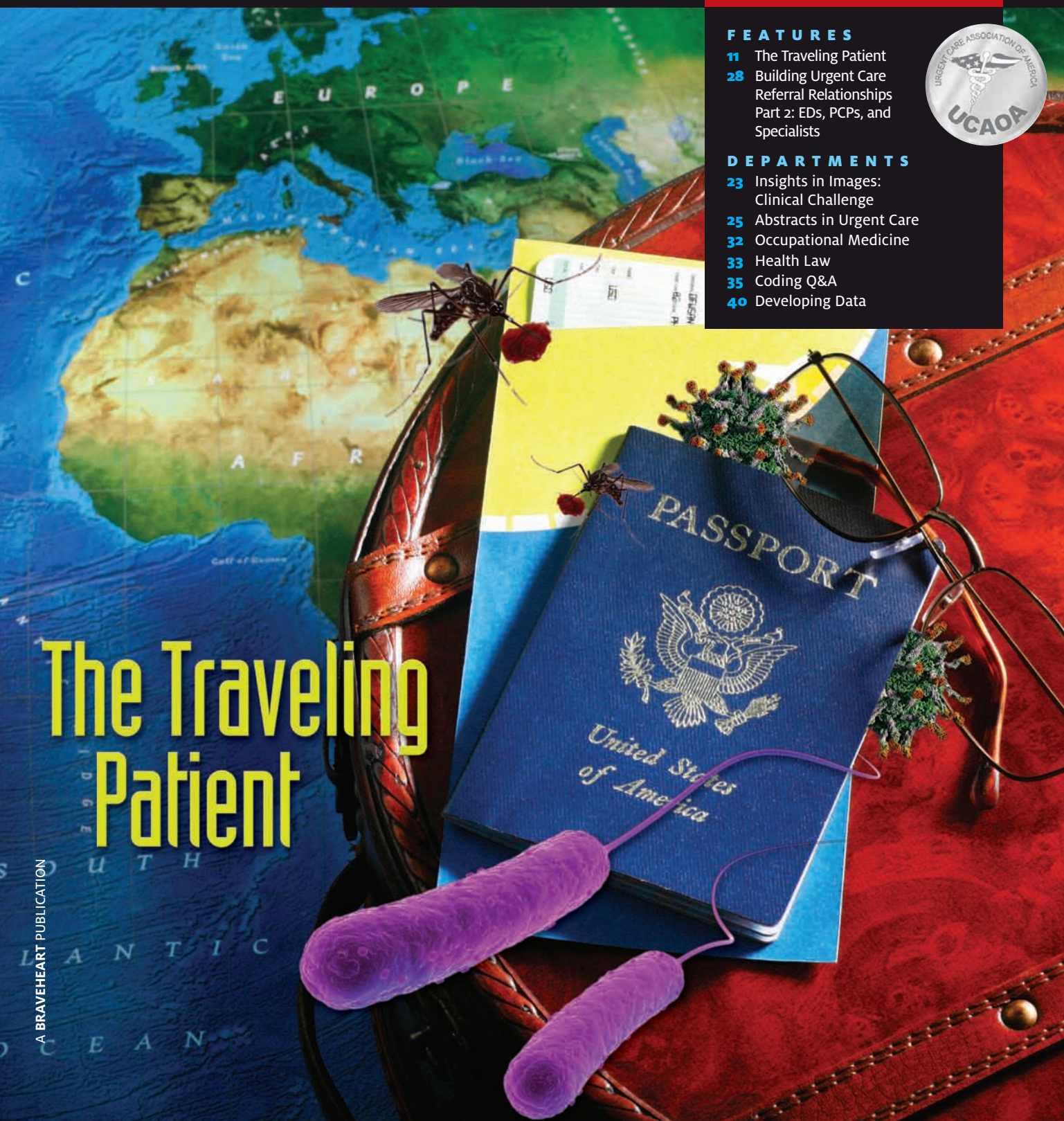
IN THIS ISSUE



The Traveling Patient

A **BRAVEHEART** PUBLICATION

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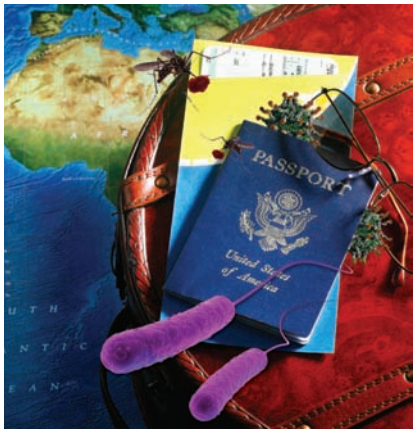

CLINICAL

11 The Traveling Patient

Last-minute preparation for overseas travel may lead many a patient to the urgent care center. Are you also prepared for the patient who presents with particular symptoms after returning from a trip?

By Francine Olmstead, MD, FACP

PRACTICE MANAGEMENT

28 Building Urgent Care Referral Relationships Part 2: EDs, PCPs, and Specialists

Forging solid relationships with other clinicians in emergency, primary care, or specialty settings is good business that also benefits the patient. The second of two parts.

By Alan A. Ayers, MBA, MAcc

IN THE NEXT ISSUE OF *JUCM*

Effective treatment of wounds promotes, rather than inhibits, the skin's natural ability to heal itself. An urgent care-specific review of principles in wound management and pitfalls to avoid.

WEB EXCLUSIVE

Case Report: Gout vs. Cellulitis

A 45-year-old Caucasian male presents with pain in his right thumb, accompanied by redness and swelling. Is it gout or cellulitis? Does he need antibiotics? A new case report available only at *www.jucm.com*.

By Paul Nanda, MD and Ramana Reddy Kankanala, MD.

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Mark Twain implored us to "Sail away from the safe harbor. Catch the trade winds in your sails." For travelers who catch more than "trade winds" while they're away from home, however, foreign lands can lose their appeal at best and, at worst, offer threats to life and limb.

Urgent care clinicians are in a great position to offer preventive care for travelers who plan ahead and treatment for those who, to their own detriment, did not. That's assuming, of course, those clinicians are up to speed on various infectious diseases and pathogens indigenous to the far reaches of the globe.

In The Traveling Patient (page 11), **Francine Olmstead, MD, FACP** offers a comprehensive overview of common—and not so common—health risks faced by those who take Twain's advice, including an introduction to a variety of resources for tracking a host of perils overseas.

A point to consider: travel medicine is more than knowing which vaccinations a patient needs before visiting a country. Would you be prepared to treat a patient with a particular galaxy of symptoms that arise after he returned from a mission trip to Ghana?

Dr. Olmstead is medical director of NM Travel Health, a division of Olmstead Health Care Services. She holds the Certificate in Travel Health from the International Society of Travel Medicine and is board certified in internal medicine. Dr. Olmstead came to our attention when she delivered a well-attended lecture on travel medicine at the UCAOA National Convention in Las Vegas in April 2009. She may be contacted at *francine.olmstead@nmtravelhealth.com*.

Building a reputation as someone well-versed in travel medicine can help your business, too, of course—especially if you've established a referral network with busy primary care physicians. Developing such a network requires initiative and strategic thinking, of course. In Building Ur-

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gent Care Referral Relationships Part 2: EDs, PCPs, and Specialists (page 28), **Alan A. Ayers, MBA, MAcc** offers advice on how to get started. Part 1 was published in the January 2010 issue of *JUCM* and is available on our website (*www.jucm.com*).

Mr. Ayers is vice president of strategy and execution at Concentra, as well as content advisor to the Urgent Care Association of America.

The hope, of course, is that you will need to refer as few patients as possible. Take a patient who presents with pain, redness, and swelling in his right thumb. Gout springs to mind. So does cellulitis. But which is it; will he need antibiotics? Most importantly, do you know the appropriate steps to reach the right answers? This challenge is covered thoroughly in a new case report by **Paul Nanda, MD** and **Ramana Reddy Kankanala, MD**, available exclusively at *www.jucm.com*.

Also in this issue:

Nahum Kovalski, BSc, MDCM reviews new abstracts on forearm fractures in adults, urethritis in young men, IV drugs and out-of-hospital cardiac arrest, and group A ß-hemolytic *Streptococcus*.

John Shufeldt, MD, JD, MBA, FACEP explores the difference between an apology and an admission of guilt in the context of "I'm sorry statutes" being enacted in states across the country.

Frank Leone, MBA, MPH makes a pitch for making "connectivity" an essential part of an urgent care occupational medicine marketing initiative.

David Stern, MD, CPC responds to queries about coding for new patients who visit twice in the same day and for services typically provided in a primary care setting, as well as billing on the UB-04.

Do you have an idea for an article? An interesting x-ray case to share? Describe it in an e-mail to **Lee A. Resnick, MD**, *JUCM*'s editor-in-chief, at *editor@jucm.com*. New contributors are always welcome.

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Building Urgent Care Referral Relationships Part 2: EDs, PCPs, and Specialists

Urgent message: Forging solid relationships with other clinicians in emergency, primary care, or specialty settings can help facilitate two-way referrals and prove beneficial to all parties involved—including patients. The second of two parts.

Alan A. Ayers, MBA, MAcc

Overbooked primary care offices and time-consuming (not to mention costly) trips to the emergency room leave many patients frustrated and feeling they have no place left to turn when a medical condition requires immediate attention but is not an emergency.

With its record of improving medical outcomes, reducing costs, and saving time for patients, urgent care is ideally suited to be the solution of choice for these patients—assuming they know to go there.

Establishing referral relationships with emergency departments, primary care, and medical specialists is an important tactic in building urgent care volume and establishing urgent care as an access point to the tertiary healthcare system.

Reasons for Increased Utilization of Emergency Rooms

Hospital emergency departments are designed for trauma and resuscitation. They are also an entryway for hospital admissions; due to Emergency Medical Treatment and Active Labor Act (EMTALA)[1] requirements that EDs evaluate all patients, they provide a healthcare "safety net" for society.*

Emergency rooms in the United States are overwhelmed, however. Over the past 10 years, per capita utilization of EDs has increased 18%, and median wait times there have increased 50%, while the percentage of ED patients suffer-

*EMTALA applies primarily to hospital emergency rooms but may also apply to an urgent care center on a hospital campus under limited circumstances. EMTALA requires emergency rooms to provide a screening examination to determine whether an emergency condition exists and (a) if an emergency condition exists, the facility must treat it to the best of its capabilities, or (b) if an emergency condition does not exist, the facility has no further obligation to treat the patient under EMTALA.

ing "true" medical emergencies has fallen by 32%.[2] Today, only 18% of ED visits are classified as "medical emergencies."[2]

While casual observers correlate this increase in utilization for non-emergent conditions with rising numbers of uninsured, studies show that decreased access to primary care for all patients is to blame. In fact, only 14% of ED visits involve patients without health insurance.[3] Considering that 59% of ED patients regularly receive care from a physician's office,[3] it's apparent that many insured consumers use the ED when they cannot get an appointment with a traditional office-based physician.

"Even when a patient sees a doctor regularly, only 29% of primary care physicians have made arrangements for after-hours care."

The reality is that the ED appeals to consumers because of its walk-in convenience, 24-hour/365-day operating hours, and perceptions that hospitals have more advanced capabilities than doctors' offices.

Do Emergency Rooms Want Low-acuity Patients?

Despite operational challenges, many hospitals advertise that they treat low-acuity patients in their emergency departments—sometimes with wait time or service guarantees.

According to the American College of Emergency Physicians, crowding is not due to non-emergent patients seeking care in the ED. Rather, the practice of "boarding"—holding patients who have been admitted to the hospital in ED beds—is responsible for delays in care, ambulance diversion, medical errors, negligence claims, and financial losses to ED physicians.[4]

So even if non-emergent patients have to wait, they can be profitable to a hospital if there is facility capacity and staff available because the cost of treating one additional patient in the ED is relatively low. Cash and insurance payments subsidize emergency department write-offs to Medicaid and charity care. And emergency room visits frequently result in downstream revenue for a hospital's affiliated specialists.

Hospitals, however, take exception to low-acuity patients when the emergency department is operating at or over capacity, when patients utilize the ED frequently for non-emergent conditions, and when patients cannot or will not pay their bills.

Urgent Care as a Solution to ED Woes

Studies indicate that 80% to 85% of emergency department patients could be treated in a lower acuity setting,[5] and urgent care centers offering x-ray and performing minor procedures like casting and suturing are capable of seeing moderately complex ER cases. Shifting the working uninsured to urgent care can also help an ED reduce its financial write-offs; while many uninsured patients cannot afford $600 or more incurred with an ED visit,[6] they can come up with $100 for urgent care.[7]

A good start is to raise awareness among emergency room nurses and registration staff that the urgent care is available. Although EMTALA requires a medical evaluation, which limits pre-triage referrals to urgent care, it's not uncommon for overworked ED staff to tell patients, "You know, a lot of people are going to the urgent care located at such and such address…," giving the patient the opportunity to act likewise.

Other emergency rooms place urgent care literature at their front desk or in their waiting room. And triage staff who determine a patient is non-emergent—and thus exempt from continued treatment under EMTALA—may refer patients to urgent care as a more affordable option. Direct referrals to the urgent care center also come from emergency physicians for follow-up care.

Because urgent care is not occupied with medical emergencies, it's often better positioned to tend to the details of work-related injuries. For example, many employer accident protocols require a drug screening at the first report of an injury. Not only does an ED's high overhead make drug screening unprofitable, but the paperwork is impractical for ED nurses juggling trauma and resuscitation. Urgent care can offer more focused attention and lower costs to employers in occupational medicine.

Table 1 describes urgent care referral occasions and next steps for developing a referral relationship with a hospital emergency department. Demonstrating the benefits urgent care brings to the hospital in terms of relieving excess volume, reducing write-offs, and generating downstream referrals to hospital management is key to making a convincing case.

Primary Care Shortages Anticipated

"Primary care" refers to healthcare providers—family practice, internal medicine, and pediatricians—who act as a first point of consultation and provide longitudinal

Table 1: Urgent Care Referral Occasions and Next Steps for Emergency Departments

Urgent care supports hospital EDs by:	To develop a referral relationship with a hospital ED:
• reducing non-emergent caseload to alleviate wait times and demands on staff. • providing a more affordable alternative to patients without health insurance, reducing uncollectible receivables. • providing follow-up care for initial emergency room visits. • handling overflow during seasonal or epidemic volume surges. • providing services involving detailed protocols or distinct payors such as workers compensation programs. • referring medical emergencies, automobile accidents, and reportable cases to the hospital's emergency room. • referring urgent care patients to the hospital's affiliated specialists and diagnostic facilities.	• identify hospitals within a 10-minute drive of the center and evaluate each ED's positioning in terms of reputation, wait times, advertising, clinical capabilities, and physical facility. • schedule a face-to-face meeting with the hospital's emergency director or chief operating officer to introduce the urgent care center and its capabilities. • assess challenges facing the ED that urgent care can resolve; focus on immediate needs like seasonal flu surge, as well as systemic problems like overcrowding and financial write-offs. • promote the benefits of urgent care to the hospital, such as the downstream referrals urgent care provides to diagnostic, specialist, and rehabilitation services. • secure commitment that the hospital will refer low-acuity insured and/or cash pay patients to urgent care, communicate the availability of urgent care to front-line clinical and operations staff, and place urgent care marketing materials at the ED registration desk, literature stand, and triage area. • set a schedule for follow-up to assess the relationship, improve processes and communication, and replenish marketing materials.

care for patients with chronic illnesses like diabetes, hypertension, and chronic obstructive pulmonary disease (COPD).

Like emergency rooms, many primary care offices are overwhelmed. Not only is primary care coping with falling reimbursement, but patients are aging with increased incidence of lifestyle-induced illness, and the United States is facing a labor shortage of primary care providers.

As a result, it can take weeks or months for a patient to get an appointment, and many practices are not accepting any new patients at all.

According to the American Academy of Family Physicians, by 2020, the U.S. will face a shortfall of 39,000 family physicians.[8] Considering that <2% of medical school students express an interest in generalist fields; the number of nurse practitioner graduates is falling by 4.5% per year; and there will be 25% fewer physician assistant graduates in 2020 than today, access to primary care will become increasingly constrained.[8] Even when a patient sees a doctor regularly, only 29% of primary care physicians have made arrangements for after-hours care.[9]

Such lack of convenient access to primary care is causing greater numbers of patients to seek treatment from hospital emergency rooms.[3]

Urgent care can provide continuity of care when patients are unable to get an appointment with their regular doctor, however. Differentiating "episodic" from "longitudinal" care, the urgent care center can augment the primary care office by accepting capacity overflow and after-hours referrals. For example, if a pediatrician's office closes during Spring Break, it may leave a message on its answering machine and a sign on its door directing patients to the urgent care center.

Likewise, a family practice may find it impractical to maintain a certified laboratory and refer patients to urgent care for collections and testing. Urgent care can also support primary care with imaging and surgical procedures that may be too expensive to perform in a doctor's office. Primary care patients who present at the urgent care center—and sign a release form—will have their medical chart forwarded to the primary care office for inclusion in their permanent record.

The key is for the urgent care operator to gain the trust of the primary care provider by clearly explaining services offered, communicating patient visits and progress (with patient consent), and helping the primary care provider build a high-quality panel of patients by referring urgent care patients with longitudinal needs. **Table 2** describes the value and next steps in developing reciprocal primary care referral relationships.

Medical Specialists as an Urgent Care Resource

Urgent care centers encounter many patients requiring additional care beyond the center's capabilities. Common specialist referrals include general and specialized surgery, dermatology, gynecology, podiatry, and orthopedics. Being connected to a network of medical special-

Table 2: Urgent Care Referral Occasions and Next Steps for Primary Care

Urgent care supports primary care practices by:	To develop a referral relationship with a primary care practice:
• accepting "overflow" volume when the primary care office is at capacity. • providing coverage during evenings, weekends, vacations, and holidays when the primary care office is closed. • providing services not routinely offered in a doctor's office, including x-ray, lab testing, and medical procedures such as suturing and casting. • providing services involving detailed protocols or complex payors such as workers compensation. • referring patients with chronic illness—such as diabetes or hypertension—who require longitudinal care in a "medical home" to the primary care office.	• identify independent and group primary care offices within a 10-minute drive of the center, compare insurance plans, and assess whether new patients are accepted, the availability of non-scheduled appointments, and number of days to get an appointment. • become acquainted with the primary care physician(s) personally in an informal setting, such as a breakfast gathering. • explain the scope of services and operating model of the urgent care center, including capabilities for lab, x-ray, and medical procedures. • assess the services offered by the primary care practice related to specific chronic conditions, including specialist relationships and hospital admitting privileges. • agree upon a process for communicating patient progress and follow-up, such as forwarding a copy of the patient's chart (with consent) or scheduling recheck appointments. • provide maps and other marketing collateral to facilitate primary care referrals to the urgent care center. • set a schedule for follow-up to assess the relationship, improve processes and communication, and replenish marketing materials.

ists increases the urgent care center's relevance as a point of triage; when patients do not know where to go, they know they can rely on urgent care to get them to the appropriate provider.

In order for urgent care to effectively function as "front door" to the healthcare system, however, processes and systems to facilitate referrals must be in place. The ability to schedule a patient's appointment with a medical specialist before they leave the urgent care center is much more effective than leaving the patient to find his/her own specialist. This requires the urgent care provider to maintain a listing of specialists who are accepting new patients, to understand insurance network affiliations and limitations, and to have ready access to the specialist's schedule.

Urgent care may also benefit from referrals from specialists. For example, some urgent care centers provide pre-surgical physical examinations or post-surgical rehabilitation. An obstetrics practice may refer pregnant women to the urgent care for conditions not involving the fetus, while an orthopedist may display the urgent care center's marketing material in his or her waiting room to raise awareness in the community.

Summary

Urgent care is a vital part of a community's healthcare system, but in order to function fully, urgent care must be connected to other healthcare providers and facilities. Establishing mutually beneficial referral relationships can help an urgent care center increase its own visits, alleviate capacity issues in primary and emergency care, and brand urgent care as an access point for medical specialists. ■

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Note: This article is part 2 of a two-part series on building referral relationships for urgent care. Part one described urgent care referral sources and downstream providers, including pharmacies and retail health clinics. It is available in the Past Issues Archive section of the JUCM *homepage,* www.jucm.com.