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IN THIS ISSUE

FEATURES

DEPARTMENTS

Assessment, Intervention, and Disposition of Patients with Psychiatric Symptoms

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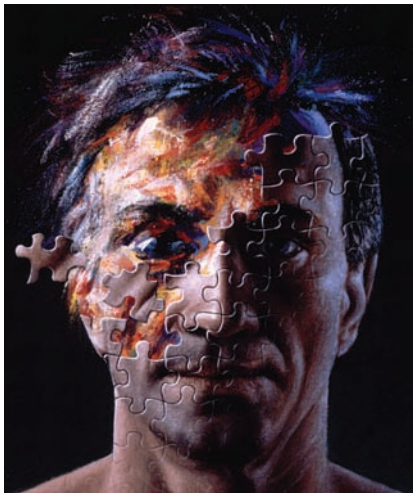

CLINICAL

PRACTICE MANAGEMENT

Community healthcare may be a competitive marketplace, but that doesn't mean perceived rivals for patient visits cannot be a rich resource for referrals. The first of two parts.

By Alan A. Ayers, MBA, MAcc

IN THE NEXT ISSUE OF *JUCM*

As winter and spring breaks approach, are you prepared to provide traveling patients with the proper vaccinations and to help them ward off water- and insect-borne disease?

WEB EXCLUSIVE

A Case Study of an Infected Thyroglossal Duct Cyst

A 3-year-old girl presents with a seemingly spontaneous one-day history of swelling in her neck, with associated erythema. Would you be prepared to diagnose it as secondary infection of a thyroglossal duct cyst and commence appropriate treatment? Available only at *www.jucm.com*.

By Marcia Taylor, MD, MSCR and Carlos Soto, MD

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Most urgent care clinicians are well versed in conducting a physical history and examination on a patient who complains of a lingering sore throat. Such patients are often communicative, specific, and fully able to participate in the work-up.

Suppose you had to suspect the veracity of everything a patient was telling you, though, or could not be sure whether her off-hand remark about being immortal was an attempt at humor or the mark of a distant relationship with reality? Is his racing pulse being caused by cardio distress, or a sign that he is having a panic attack?

Getting to the root of possible psychiatric problems can be difficult in any arena, but in a community setting where assessing mental health is probably not the clinician's forté, the challenges and possible consequences can be extreme.

In Assessment, Intervention, and Disposition of Patients with Psychiatric Symptoms (page 9), **Gregory P. Brown, MD**, provides an overview of assessing a few of the more common psychiatric conditions, shares his expertise on appropriate pharmacologic and non-pharmacologic treatment that can be administered on site, and offers advice on assessing the degree of risk a patient might pose to himself or others.

Dr. Brown came to our attention when he gave a compelling presentation on this very subject at the 2009 UCAOA Urgent Care Convention in Las Vegas last April. He is associate professor, chair, and residency program director of the Las Vegas Department of Psychiatry at the University of Nevada School of Medicine. His clinical interests include forensic psychiatry, transpersonal psychiatry, Jungian themes, and mind-body issues focusing on concepts of consciousness.

Obviously, patients with serious mental or emotional issues will need referral to a psychiatrist or other mental

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health professional. The referral gate swings both ways, though. Some urgent care operators are learning that it can be very beneficial for the patient and good for the business to establish referral relationships with other healthcare professionals such as pharmacists (or even the staff at a retail clinic).

In Building Urgent Care Referral Relationships: Pharmacies and Retail Host Clinics (page 29), **Alan A. Ayers, MBA, MAcc** walks us through the process of identifying and gaining the trust of viable referral candidates in the pharmacy and retail worlds.

Mr. Ayers is assistant vice president, product development for Concentra Urgent Care and content advisor for the Urgent Care Association of America.

Often, of course, no referral is necessary even if a patient presents with a less than run-of-the-mill problem. Take the case of a 3-year-old girl who presented with a one-day history of swelling in her neck that turned out to be caused by secondary infection of a thyroglossal duct cyst. In A Case Study of an Infected Thyroglossal Duct Cyst, available only at *www.jucm.com*, authors **Marcia Taylor, MD, MSCR** and **Carlos Soto, MD** recount the diagnostic process and how the patient was treated successfully.

Drs. Taylor and Soto are colleagues at Lexington (SC) Urgent Care; Dr. Taylor also practices at Lexington Medical Center.

Also in this issue:

Emory Petrack, MD, FAAP, FACEP examines how medical legal risk is affected by the age of the patient—and how to minimize your risk when treating children.

Nahum Kovalski, BSc, MDCM reviews new abstracts on community-acquired pneumonia, bronchiolitis in children, a possible link between antibiotics and birth defects, whether the serum D-dimer is used effectively, and a government accounting of the toll of the H1N1 virus to date.

John Shufeldt, MD, JD, MBA, FACEP borrows a page (or perhaps a tablet) from Moses and deconstructs the 10 commandments for staying litigation-free in 2010.

As the calendar turns from one year to another, **Frank Leone, MBA, MPH** discusses the virtue of embracing change in your tactics for marketing urgent care occupational medicine services.

David Stern, MD, CPC answers questions regarding reimbursement for time spent, and coding for time spent and care administered by midlevel providers.

JUCM is always looking for a few good authors. If you'd like to be one of them, share your idea for an article via e-mail to **Lee A. Resnick, MD**, *JUCM*'s editor-in-chief, at *editor@jucm.com*. ■

Building Urgent Care Referral Relationships: Pharmacies and Retail Host Clinics

Urgent message: Viewing other community healthcare providers (e.g., pharmacists) or even possible competitors (e.g., retail clinics) as referral sources can increase revenues and bolster the urgent care center's place in the healthcare system. The first of two parts.

Alan A. Ayers, MBA, MAcc

Urgent care has evolved to the point that it is a vital part of a community's healthcare infrastructure, offering access when primary care appointments are unavailable and relief when emergency rooms are at capacity.

As a first point of triage for many patients, urgent care also serves as a hub from which patients are directed to diagnostic facilities, medical specialists, and therapy services. The greater ties urgent care has to the tertiary healthcare system, the more effectively it works to assure affordable, accessible care in a community.

Before the benefits of urgent care can be realized, however, community providers must understand how urgent care complements their practices and adds value for their patients. This requires urgent care operators to educate the healthcare community on its delivery model and scope of services, identify mutually beneficial referral relationships, and develop processes to coordinate best patient care.

Urgent Care is Not a Threat

Before an urgent care center can build any referral relationship, it must overcome the perception that urgent care is a competitor. Some primary care physicians fear that urgent care's focus on episodic treatment leads patients to neglect preventive care and chronic disease management. Likewise, some emergency room administrators fear urgent care siphons away privately insured patients, increasing the financial burden of Medicare, Medicaid, and charity care on the ED.

Ideally, a well-organized healthcare delivery system matches a patient's needs to the most appropriate provider skill set and facility capabilities. For example,

Table 1: Urgent Care Referral Sources and Downstream Providers

Referral sources	Downstream providers
• Primary care physician offices • Medical specialist offices • Retail health clinics • Hospital emergency departments • Employer on-site medical clinics • Student health services • Ambulance/emergency medical services • Public health departments • Pharmacies	• Diagnostic imaging • Laboratory • Primary care offices – Family practice – Internal medicine – Pediatrics • Medical specialists: – OB/GYN – Dermatology – Podiatry – Physiatry • General and specialized surgery • Hospital emergency departments • Physical therapy/rehabilitation • Pharmacies • Durable medical equipment

emergency rooms are designed for trauma, resuscitation, and hospital admissions. Although an ED with excess capacity can profitably treat a patient with a minor sprain, urinary tract infection, or seasonal allergies, the ED's capabilities (and by extension, operating costs) are far beyond what's required for low-acuity cases. When an ED becomes congested due to staffing shortages, hospital patients boarding in ED beds, a surge in ambulance traffic, etc., shifting non-emergent cases to urgent care improves flow and reduces wait times in the ED. And because an urgent care visit costs approximately one-sixth of an ED visit, the availability of urgent care can reduce hospital write-offs, as many patients who cannot afford a $600 to $800 ED visit can easily pay $100 to $200 for urgent care.

Urgent care is not intended to replace established providers, but, rather, to support them in assuring patients get care in the most efficient and effective manner possible. Integrating urgent care starts with identifying what sources of care are available, understanding how patients access and navigate medical providers, and by creating win-win scenarios in which referral providers build up urgent care and in turn, urgent care builds up referral providers. **Table 1** lists common referral sources and downstream providers for urgent care patients.

Pharmacy Referrals

One of the most visible (yet often overlooked) referral sources is the retail pharmacy. According to the National Association of Chain Drug Stores (2009), there are more than 56,000 pharmacies in the United States, including 39,000 operated by food, drug, and mass-retail chains and 17,000 independents.

Most patients who visit a doctor will go to a pharmacy immediately after, making the pharmacist the first person to hear about the patient's experience. Pharmacists gain unique insight as to providers' reputations, practice methods, and patient base. And by managing all of a patient's prescriptions, a pharmacist can see a patient's entire health history. Pharmacists not only identify potential treatment interactions, but understand the complexities of chronic disease states like diabetes and hypertension.

Because pharmacists are tied in to patients and their providers, are trained in patient counseling, and are generally trusted advisors, consumers who have questions about their health will often ask their pharmacist what steps to take. Pharmacists routinely assist patients in selecting over-the-counter remedies, but when a more serious illness is suspected—such as a cough that could be pneumonia or swelling that could be a fracture—the pharmacist can recommend that the patient go to urgent care. Likewise, pharmacists may refer patients who need refills on expired prescriptions and do not have a local doctor.

Building a referral relationship starts with introducing the pharmacist to the urgent care center's range of services, operating hours, insurance participation, and pricing for cash pay patients. Providing the pharmacist with marketing collateral—magnets and maps to the center—will facilitate referrals when opportunities occur.

Pharmacy customers are healthcare consumers, so if the pharmacist is willing, display urgent care collateral at the pharmacy counter to raise awareness among all customers. Whenever collateral is placed, be sure to set a follow-up schedule to assess continued interest and replenish those materials.

Because the pharmacist is interested in building his own business, he may ask for your support in directing prescriptions to the pharmacy in return for promoting the urgent care center. Urgent care centers sometimes receive promotional benefits from pharmacies, such as free magazines for the waiting room placed in pharmacy-branded vinyl covers. Or, a pharmacy may pro-

vide coupons for the urgent care to display or give to patients at discharge. These perquisites add value to a patient's urgent care visit.

In addition, co-promotions such as health fairs or immunization clinics held at the pharmacy and staffed by urgent care personnel can also drive traffic into the pharmacy (while increasing awareness of urgent care), especially if the event is advertised.

There is nothing inherently wrong with an urgent care center recommending a particular pharmacy, provided the conditions in **Table 2** are met. Having data on hand—such as the number of patients seen at the urgent care or number of scripts written—can strengthen an urgent care center's presentation to the pharmacist.

Table 2: Conditions for Referring a Pharmacy

Generally, an urgent care center may recommend a particular pharmacy to patients when the:

- patient makes the ultimate decision whether to use the pharmacy
- recommendation is in compliance with all regulations and contractual agreements
- pharmacy is convenient to patients
- pharmacy accepts common insurance plans
- pharmacy is reputable, charges competitive prices, and provides good service.

Table 3: Conditions Subject to Referral From Retail Host Model Clinics to Urgent Care Centers:

- Automobile accidents and on-the-job injuries requiring a physician examination.
- Procedures requiring special lights, table and supplies such as:
  - incision and drainage
  - removing foreign objects
  - suturing cuts
  - casting fractures
- Conditions requiring an x-ray for diagnosis—from pneumonia to sprains/strains.
- Other conditions requiring equipment beyond the retail health clinic's capabilities—such as a pulmonary function test or nebulizer treatment for asthma.
- Other conditions beyond the scope of practice of the midlevel provider (often dictated by state laws).

Retail Health Clinics

An increasing number of pharmacies also operate in-store medical clinics. According to MerchantMedicine.com, as of November 2009 there were 1,165 retail host model clinics in 40 states, about three-quarters of which are operated by the two largest pharmacy chains—Walgreens' Take Care Health and CVS' MinuteClinic.

Retail health clinics range from 100 to 300 square feet and are staffed by solo nurse practitioners or physician assistants whose scope of practice is limited by state regulations and the off-site supervising physician. Retail health clinics lack much of the basic equipment of an urgent care center, such as x-ray, slit lamps, and gynecology stirrups (many don't even have an exam table or a restroom), which further limits the scope of services to conditions like sore throat, athlete's foot, and pink eye.

Recognizing the provider and facility limitations of retail clinics, American Academy of Family Practice (AAFP) guidelines state, "Retail health clinics must have a referral system to physician practices or to other entities appropriate to the patient's symptoms beyond the clinic's scope of work." **Table 3** outlines common conditions a retail health clinic might refer to urgent care.

Although the retail clinic's corporate owner may be interested in steering referrals to affiliated hospitals or supervising physicians, midlevel practitioners take pride in their autonomy and rely on their own experience when making referrals.

Building a referral relationship with a retail health clinic starts with introducing the midlevel provider to urgent care and positioning urgent care as the solution to the retail clinic's limited practice scope. Meet with the retail clinic's practitioners one-on-one to review the services and hours of the urgent care center, explain cash pricing and insurance plans accepted, provide maps and other marketing collateral, and offer assurance that referrals will be treated on a priority basis. Also consider inviting retail practitioners to visit the urgent care center to see firsthand the good experience his or her patients will encounter.

Like pharmacists, retail clinic operators are interested in expanding their businesses; where there are services provided by the retail clinic that urgent care does not offer, agree to promote those services in the urgent care center. For example, many retail health clinics utilize a national distribution network to carry a broad range of

"Reciprocal referral relationships strengthen the urgent care center's standing in the medical community and improve coordination of patient care."

vaccinations that an individual urgent care center may find unprofitable to stock due to short shelf life, high inventory costs, and/or low insurance reimbursement.

A well-positioned retail health clinic may also function as overflow for a busy urgent care center. After the initial meeting with the practitioner, set a follow-up meeting to review data on number of patients referred, replenish marketing collateral, and seek feedback on how to improve the referral process.

Strategic Value of Referrals

Referrals should be viewed as a strategic asset of an urgent care center—they tie the urgent care center into other healthcare providers and solidify urgent care's position in consumer minds as a "front door" to the healthcare system.

Every time a patient is referred to an urgent care center, the urgent care provider has the opportunity to capture that patient's repeat business and spur word of mouth among the patient's friends and family. Reciprocal referral relationships strengthen the urgent care center's standing in the medical community, improve coordination of patient care, and build urgent care revenue and volume—a win-win solution. ■

Note: This article is part 1 in a two-part series on building referral relationships for urgent care. Part 2 will detail referral relationships with primary care, emergency rooms, and specialists, as well as describe the processes necessary to facilitate referrals and coordinate patient care.