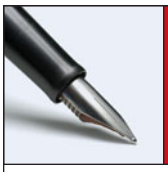

An Ominous Trend For Urgent Care

JOHN KOEHLER MD, ABPM(OM)

To My Colleagues:

I am writing to alert you to an ominous and pernicious trend in our industry that we must collectively address or we will face marginalization or even extinction in the years ahead. This may sound alarmist, but please hear me out.

I opened my first clinic in 1987 when "urgent care" was barely a recognized term. I was there when the Urgent Care Association (at that time known as the Urgent Care Association of America) was formed by a small group of my dear friends who had a vision to create a place where we could share ideas and help each other be successful. And that has continued to this day. For this I am truly grateful and hold you and this industry dear to my heart.

This is why I am particularly motivated to call out this disastrous trend I've seen emerging over recent years.

Alan Ayers, president of Experity Networks and *JUCM's* own senior editor, practice management, has called the phenomenon "acuity degradation;" I use the term "glorified triage." In the eyes of both patients and payers alike, we are increasingly being viewed as "triage centers." Carriers have actually used that term while negotiating with at least three groups I know of in the last week alone, all while proposing to keep reimbursements flat. In fact, one large carrier in Florida decided to simply stop contracting with urgent cares altogether, favoring other (cheaper) methods of "triage." (I suspect telephonic nurse triage.)

This is not good.

What happened? Simply put, we refer too many patients out from our UC centers. We do not "do" enough within our four walls for our patients.

The most glaring example is injury care. We excessively refer injuries to orthopedics (or other specialties) instead of treating them ourselves. As a result, orthopedic urgent cares have surged in popularity. A local UC group recently informed me that a large orthopedics group has actually followed their last three clinics by establishing an orthopedic-specific UC a few doors down and subsequently directly asked them for referrals! In the Chicago area, for example, there are at least 47 orthopedic UCs; each of them also advertises worker's comp care.

We are filling surgeons' schedules with minor fractures, sprains, tendinitis, injections, etc. (ie, non-surgical cases).

How difficult is it to put a boot on a nondisplaced metatarsal fracture or provide a subacromial injection? Even cases of "suspected fractures" are being referred. Why not order an outpatient CT and make the diagnosis yourself? As a result, surgeons are hiring their own advanced practice providers to ease their burden of nonsurgical cases, and who will ultimately provide a very similar level of care that we had the opportunity to provide definitively.

Sadly, we earned this. If we do not act now, we may lose orthopedics completely. And with that goes considerable revenue (x-ray, durable medical equipment, procedures, E&M code, global fee).

Impossible? Think again. How many unnecessary referrals like this does it take to train your community not to come to your UC for injuries anymore? And it should not be lost on us that the orthopedics groups are simultaneously marketing their orthopedics UCs to any patient you refer to them.

This also applies to workers' comp. Orthopedics UCs are selling themselves as "one-stop shops" for work comp injuries; they even go so far as to suggest that it's a waste of time to see us first. And it is our high referral rate that is driving this. We are doing this to ourselves.

It is not just simple fractures. We refer basic eye injuries, long lacerations, minor head injuries, burns, fingertip injures, etc.—in short, anything that makes us "uncomfortable" or "takes too long to treat." As a result, we have carriers and communities wondering, *What exactly is it that you do treat?*

John Koehler, MD, ABPM(OM) was a founding board member of the Urgent Care Association of America (now known as the Urgent Care Association) and is editor-in-chief, OccDocOne. He can be contacted at jkoehlermd@OccDocOne.com.

On the medical side, any emergency doc will tell you about the "dumps" from urgent care. To be fair, they have been saying that for a long time, but it is clearly getting worse. Our referral threshold keeps falling as we commoditize and narrow the range of services we provide. A large multispecialty group near Chicago even goes so far as to place signage at the bottom of their UC paperwork saying, "urgent care does not make the diagnosis...[the specialist does]."

Carriers know this because they have the data. They can see the codes and they can see where the patients are sent. Emboldened, they are using our own data against us. How can we blame them? The first volley in this struggle came with the introduction of the "case rate." If we don't act soon, we will be reduced to accepting a "triage rate" and then "no rate." Already in Florida, a large insurance carrier has gone with "no rate" for UC visits.

What happened? Well, it goes back to provider training and experience. The less training and experience UC providers have, the more likely they are to be uncomfortable with managing relatively common conditions. And it is this clinical discomfort which understandably results in unacceptably high rates of referrals.

We can fix this, but it will require effort. UCA will be convening a working group to discuss this issue, make recommendations, and possibly create training programs.

Please consider these suggestions for ways to dampen this trend within your UC organization:

- Study your referral data by code
- Start a robust onboarding and mentorship program for any new grad APPs
- Start fracture care, dislocation reduction, injections, and DME training
- Focus a segment of regular chart reviews on referred cases
- Set referral standards for injuries/fractures
- Require clearance from senior providers prior to referral
- Create a system for senior providers availability for case consultation
- Provide clinical guidelines/occ med guidelines with easy access
- Incentivize providers financially for performing procedures (yes, this is legal)
- Use your data to show you do "real" urgent care
- Avoid signing any case-rate contracts

Our destiny is in our own hands. I want to wish you the very best as you consider how this may apply to your group. ■