

# TRENDS & CURRENTS:

## The Mixed-use Clinic

Occupational Medicine + Urgent Care

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Both healthcare and the practice of occupational medicine continue to evolve in this country. As revenue and visits decline in occupational health clinics, there has been a rise in the mingling of occupational medicine and urgent care practices that provides benefits to both.

### History

Occupational medicine delivered on-site by large corporations has existed for decades. Often these clinics also provided episodic care to their employees for illnesses such as colds, sprains, and some preventive medicine — exactly the types of service that urgent care clinics provide.

In the early 1980s, hospitals entered the occupational health field. At first many tried to provide the service within their emergency rooms but soon discovered that it wasn't customer friendly. Subsequently, hospital-based clinics sprang up, both stand-alone and networked. Many programs later added corporate on-site clinics to their service line. For-profit programs emerged as well and quickly developed large networks, many that were multi-state enterprises.

The market for occupational health services began to shrink in the 1990s as the occupational injury rate dropped. Occupational health programs added services such as rehab and wellness. Adding rehab programs made sense because the type of rehab needed for these cases was work related. In fact, the injured worker often was referred to as an "industrial athlete." With rehab as an occupational health service, the clinics had control over early access to needed services, thus assisting the worker back to full duty quickly and safely.

All occupational health programs, whether they were hospital based or for profit, needed to provide for after-hours care. That care was often provided in a hospital emergency room, which was both time-consuming and expensive, and had a different focus than occupational health. After-hours providers needed to assign work-related restrictions based on physical abilities rather than take injured workers out of work. They also needed to communicate with the employer and occupational

medicine provider — not easy tasks in a busy emergency room environment. Therefore, as urgent care clinics became more accessible, more after-hours care for work-related injuries was shifted to that setting.

### The Need for Urgent Care Centers

Studies have shown that 70–80% of patients seen in hospital emergency departments could have been safely treated at a less costly center. Patients, employers, and managed care organizations want convenience and affordability when seeking care for minor illnesses or injuries. This led to the development of urgent care centers as well as fast-track departments within hospital emergency departments. By 1986 there were 2000 urgent care centers in the United States. Most centers are open 365 days a year, 12 hours a day, and many are located in the suburbs near residential areas. Location is key to the success of these clinics. A busy street location with prominent signage is considered ideal. The scope of services usually includes examination and treatment of minor illnesses and injuries. The facilities include examination rooms, radiology, and labs; some offer rehab services. Urgent care centers are consumer-driven and see patients of all ages. Urgent care is one of the fastest growing segments in healthcare today, with over 100 million walk-in visits per year and trending upward. Compare this to occupational medicine visits, which total about 30 million visits a year and are trending downward.

### The Rise of Mixed-use Clinics

The mixed-used clinic is evolving in this country as work-related injuries and occupational medicine revenue decline. The increase in revenue as well as improved utilization of clinic capacity is a strong motivator for this transition. Improved access for patients and decreased cost have been major drivers for both the industrial and consumer customers.

However, this transition does not come without serious challenges. Since urgent care clinics have provided some occupational medicine care for many years, the more difficult challenge lies in the conversion of an oc-

occupational medicine clinic to a mixed-use clinic. There was considerable interest in this topic at a recent RYAN Conference held in Nashville, Tennessee, in October 2007. Experienced leaders in the field provided guidance to both those practicing and those considering practicing this model.

### Transitioning to a Mixed-use Clinic

Changing an occupational medicine clinic to mixed use involves careful planning and consideration of a new practice model. Consider offering services in an area or areas where you can have 50% market penetration. Visit other sites already providing care under this model. Target an initial goal of ten new patient visits a day and expect some time to elapse before reaching that goal. If you are transitioning multiple clinics, plan to roll out these changes incrementally to adequately monitor and address issues as they arise.

After arriving at internal consensus, discuss plans with corporate customers and re-think marketing strategies. Urgent care is typically marketed directly to the consumer. Be prepared to address cultural changes internally and expect some staff resistance. Internal sales training is needed to promote a new scope of care. Allow time for new payer contracting, which can take as long as three to six months. Also allow time for staff education, including medical staff, particularly if they have been focusing solely on occupational medicine for more than four years. Policies and procedures need to be reviewed and updated, too.

### Scope of Care

In order to determine scope of care you must determine the age of patients to be treated. Pediatric patients typically comprise one-third of the visits to urgent care practices. However if your clinic is located in an industrial part of town, it is not likely that adults will travel home, then return to bring a sick child to your clinic. Such issues can be assessed by early focus group meetings with clients. In any case you need to review your providers' comfort level and expertise in treating pediatric patients.

Review the potential adult illnesses to be treated at your mixed-use clinic and the necessary training treatment requires. The adult patients will likely arrive with coughs, throat symptoms, back symptoms, stomach pains, headaches, chest pains, skin rashes, and musculoskeletal problems. Consider the equipment necessary to treat those illnesses. Providers should be

comfortable reading EKGs, X-ray films, evaluating lab results, suturing, splinting, and assessing and treating unknown patients in a limited setting. There will be a wider range of procedures required, as well as a change in the age of the patient. This expansion of procedures makes it advisable to also expand your clinic's X-ray overreading arrangement to have all X-ray films checked by a radiologist within a specified time period (usually 24 hours). Patients are given an initial reading by your clinic and informed that a consulting radiologist will provide confirmation. The patient is contacted if there is a discrepancy.

### Hours of Operation/Staffing

Urgent care clinics are generally open 365 days a year for 12 hours per day, far more than the typical occupational medicine clinic. Additionally, a mixed-use clinic books appointments as well as handles a large number of walk-ins, and the patient flow must be carefully managed with adequate examining rooms and providers. Train your employees to balance these two types of visits. For example, identify the busiest time for walk-ins and book appointments at less busy times whenever possible.

The staffs of a mixed-use clinic will likely include physicians, physician extenders, nurses, medical assistants, technicians, and clerks/receptionists. They can be cross trained so that nurses, technicians, and medical assistants can draw blood and run approved testing. Keep in mind the required training for BAT (Breath Alcohol Technician) and urine drug specimen collection. Also, your clerical staff needs to be trained on new pay arrangements, including co-pays and insurance verification. Emphasize that both types of patients are important and that competent, friendly service is key to success.

### On-site Laboratory Services

As an occupational clinic you likely have a CLIA (Clinical Laboratory Improvement Amendments) waiver in place. The CLIA regulations defined three categories of testing: waived, moderate complexity, and high complexity. As a mixed-use clinic, you may wish to expand laboratory services to the moderate-complexity level in order to treat the new mix of patients seen at your clinic. Examples of testing include:

- microscopic analysis of urinary sediment;
- direct antigen test for group A streptococci;
- gram stains hematology; and
- chemistry conducted on fully-automated instruments.

CLIA regulations require that a moderate-complexity lab have a lab director, clinical consultant, technical consultant, and testing personnel. The lab director can be a doctor with at least one year of experience supervising a lab or training equivalent to 20 CME hours in laboratory medicine. Web-based education is available for these CMEs. The lab director can also be a healthcare professional who has a BS degree and two years laboratory training/experience plus two years supervisory experience in a non-waived laboratory. The lab director is not required to be on site at all times of testing. In a small operation, the lab director could possibly qualify for all lab positions.

Establishing an on-site lab involves numerous details, and we encourage you to visit the website <http://wwwn.cdc.gov/clia/moderate.aspx> for a complete review of the regulations for moderate-complexity testing. In addition to the application, your plan must include equipment purchase, education, and the completion of a procedure manual.

### On-site Pharmacy

Some occupational health clinics already dispense prescription medications and know that patients appreciate this service. If you wish to continue (or initiate) this service in the mixed-use clinic setting, then develop a list of commonly-prescribed medications that you must have available. Establish relationships with vendors and set up quality- and inventory-control measures. Be certain you and your personnel understand the state and federal regulations concerning pharmaceuticals.

### Medical Records/Software

Evaluate software needs and use of an EMR (Electronic Medical Record) system, since data collection needs differ for a mixed-use clinic. For example, confidentiality of patient information differs between patients with workers' compensation injuries and those receiving non-workers' compensation care. Also, review your discharge process and develop instructions that can accommodate urgent care patients. Personnel will need to be trained on recording different types of visits in the software.

### Emergency/Patient Transfer

Emergency procedures are already in place in an occupational health clinic and should be reviewed in light of the urgent care patient. There is an increased likelihood of needing emergency procedures in the mixed-use

clinic. Establish procedures and train your staff in the use of the EMS system to transfer an acutely-ill patient to the nearest emergency room with proper communication and transfer of medical records. A recent study reported that of 706 calls to 911 emergency facilities, 310 came from family-practice offices and 396 from urgent-care practices. These emergencies occurred in patients of all age groups. However, older patients are more likely to require EMS services and are primarily of a cardiopulmonary origin. Younger patients tend toward respiratory complaints. Also consider expanding your network of referral specialists to satisfy follow-up care and referral needs.

### Conclusion

David E. Stern, MD, CPC of Urgent Care Association of America offered the following final advice. "Urgent Care is a rapidly expanding market segment. Both existing urgent care centers and existing occupational medicine centers can synergize revenue generation and clinic efficiencies by transitioning to the mixed-use clinic model." †

### REFERENCES

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