Urgent Care

A Brief Overview of Urgent Care and Opportunities in an Era of Health Care Reform

Presented at NCSL, August 2014
What Is Urgent Care?

Health care provided on a walk-in, no-appointment basis for acute illness or injury that is not life or limb threatening, and is either beyond the scope or availability/access of the typical primary care practice.

Emergency Room

Primary Care

ENTRY POINTS FOR CARE...

“The future ain’t what it used to be.” ~ Yogi Bera
UCAOA Defined Categories

<table>
<thead>
<tr>
<th>Service / Scope</th>
<th>Qualified UC</th>
<th>Pediatric UC</th>
<th>Other Specialty UC</th>
<th>Walk-in Care Center</th>
<th>Retail Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Min. of Episodic Care administered using Primary Care Medical Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Broad Spectrum of Injury/Illness/Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walk-in for the above during all posted hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open for walk-in care (all centers) 2000 hours/year or more</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 day a week care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray onsite during all posted hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EKG onsite during all posted hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimum of CLIA waived lab testing capability during all posted hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serving adults and children during all posted hours (not limited to practice patients only)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All categories are overseen by allopathic or osteopathic physicians

UCAOA Certified Urgent Care (CUC)

- Define & answer what is a “qualified” urgent care center
- Urgent care facilities meet nationally standardized criteria
- Scope of practice is consistent with a set of UCAOA criteria defining easy access and services that allow for care of a broad spectrum of illness, injury or disease
- Since 2009—750 certified centers nationwide
- An increasing number of payers are now accepting the CUC designation in lieu of their own credentialing process or on-site facility surveys
UCAOA Accreditation Program

- The highest level of distinction
- UCAOA Accreditation is the only program of its kind to showcase those urgent care centers that meet both certification criteria for scope of services and accreditation standards of quality and safety
- Excellence in Governance; Human Resources; Patient Care Processes; Physical Environment; Quality Improvement; Health Record Management; Patient Privacy/Rights/Responsibilities; and Scope of Care

Traditional Urgent Care Services

- UTIs
- Childhood illnesses
- Cold or flu symptoms
- Sore throats
- Viral illnesses
- Cuts, bruises and burns
- Dehydration (IV treatments)
- Ear and eye infections
- Foreign body eye
- Sports physicals
- Occupational medicine
- Immunizations (non-pediatric)

- Headaches and migraines
- Strains
- Respiratory infections
- Rashes
- Minor fractures
- Sprains
- Lacerations
- I & D abscesses

ON-SITE SERVICES

- Digital X-rays ✓
- Laboratory ✓
- Dispensing/Pharmacy ✓
- AED/Stabilize & Transport ✓
Market Trends: Growth

What Drives The Success of Urgent Care?

- Access to same-day care for illness or injury, including weekends, holidays, evenings or when traveling/away from the medical home
- Value to the consumer
- Patient Experience
- Quality
- Payer acknowledgement: savings vs. the E.D.
Access to Care - PCP
Current Physician Access vs. Patient Demand

- By 2020: 60,000 too few PCPs (American Association of Medical Colleges, 2010)
- PPACA to extend coverage to estimated 32 million previously uninsured individuals
- Expansion of PCP role with PCMH/ disease management responsibilities/ UCC’s supporting them by attending to episodic care
- Network adequacy is more than physician rosters but must also address timely access
- For Americans who do have a regular physician:
  - 63% report difficulty getting access to care on nights, weekends or holidays (Urgent Care Association of America, 2010)
  - 20% of adults waited 6 days or more to see a doctor when they were sick (Health Policy Survey, The Commonwealth Fund, 2010)

Wait time to see a Family Practitioner by Metropolitan Area

**FAMILY PRACTICE**

<table>
<thead>
<tr>
<th>City</th>
<th>Wait Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston</td>
<td>66</td>
</tr>
<tr>
<td>New York</td>
<td>26</td>
</tr>
<tr>
<td>Atlanta</td>
<td>24</td>
</tr>
<tr>
<td>Seattle</td>
<td>23</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>21</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>20</td>
</tr>
<tr>
<td>Houston</td>
<td>19</td>
</tr>
<tr>
<td>Denver</td>
<td>16</td>
</tr>
<tr>
<td>Detroit</td>
<td>16</td>
</tr>
<tr>
<td>Washington</td>
<td>14</td>
</tr>
<tr>
<td>Portland, Ore.</td>
<td>13</td>
</tr>
<tr>
<td>Miami</td>
<td>12</td>
</tr>
<tr>
<td>Minneapolis*</td>
<td>10</td>
</tr>
<tr>
<td>San Diego</td>
<td>7</td>
</tr>
<tr>
<td>Dallas-Ft. Worth</td>
<td>5</td>
</tr>
</tbody>
</table>

* Minneapolis only/ excludes St. Paul

Dark Blue: Wait time increased since 2009
Light Blue: Wait time was unchanged or decreased since 2009

*The Health Care Waiting Game, Elizbeth Rosenthal/ New York Times, July 6, 2014*
Access to Care - ER
Current Emergency Department Realities

- The majority of EDs are operating “at or over capacity.”
  (American College of Emergency Physicians, 2011)

- ED visit rates increased at twice the rate of US population growth from 1997-2007
  (Emergency Department Pulse Report, Press Ganey)

- Average ED visit wait time over 4 hours
  (Kaiser Health News, 2011)

- A documented contributor to ED overcrowding is non-emergency care
  (American College of Emergency Physicians, 2010)
Cost Differentiation

Average Urgent Care Cost:

- Significantly lower than Emergent Care costs
- Average UC visit ($102) vs. Average ER visit ($560)  
  (Agency for Healthcare Research and Quality)
- Similar Cases (UC vs. ER) $279-$460 less  
  (Health Affairs, 2008)

“AT A MINIMUM, $4.4 BILLION ANNUAL SAVINGS ARE POSSIBLE”  
  (Health Affairs, 2010)
ED Diversion Programs

1. Right Level of Care Education (PCP, Urgent Care, ER)

   **Single most important message**
   While it is always suggested you visit your PCP, there are times when he/she is not available and you need prompt care. Retail clinics and urgent care centers are a great option for illnesses and minor injuries. Call 911 or visit your local Emergency Room for any life-threatening needs.

2. Consumer Engagement Approach

   Digital, mobile, PR/Media/Advertising, Doctors Office, In home, Health Partnerships

3. Collaborate

   Share data between regions; review with providers, with members, with high ER utilization

4. Member Tools

   Nurse lines, Notify PCPs, update physician finders to include UCCs, Retail Centers

5. Provider Relations/Contracting/ Member Benefit Design

   Add UC billing to hospital contract annual review
   Copayment incentives to frequent UC's over Eds

6. Pilot Programs: EMT’s triaging to UCC’s/ PCPs

UC Integration Quality Initiatives
Best Practices for Safe Care Transitions

- Ask patient name of his/her PCP
- Send summary clinical information to PCP in 24 hours
- Send summary clinical information to ED physician upon patient referral
- Perform modified medication reconciliation after UC visit
- Provide patient with effective education after visit
- Provide patient with written discharge instructions

*(The Joint Commission Journal on Quality and Patient Safety, 2014)*
Other Innovators

- Medical Discount Programs
  - Modest Annual or Monthly participation fee (e.g. $50/year with other family members at $20/year)
  - Greatly discounted services within the UC scope of care including lab, x-ray, illness & injury care
  - Cash pay/ Notice to patients that it is “Not Insurance”
  - Supportive of individuals with no insurance (versus burdening the E.D.)
  - Option to supplement those selecting high deductible plans

UCC Industry Challenges

- 37% of patients present without a PCP yet insurers may not pay for basic services such as Tetanus vaccines if the visit was unassociated with an injury/event
- Increasing pressures to regulate UCC’s despite the fact that they are essentially primary care offices with additional services (lab/x-ray...both which are already regulated)
  - Certificate of Need regulations
  - Uninsured/ Medicaid Mandates
  - Provider mandates/ restrictions beyond those of the state medical boards
- Disincentives to save$: EMTALA/ payments to EMT’s to transport to UCC’s/ PCP’s versus hospitals, etc.
- Narrowing networks by major payers
- Relatively low margin business facing reimbursement pressures without the bonus incentives associated with disease management
- Urgent Care Medicine is not a recognized specialty
- Existing regulatory climate: CLIA/ COLA, radiology boards, medical boards, pharmacy boards, state departments of health, variable payer mandates, CMS, Meaningful Use, HIPAA
Takeaways...

• Recognize urgent care access as a contributor to the solution of reducing cost while increasing quality and satisfaction
  ▫ Post-hospital discharge follow-up programs to reduce readmissions
  ▫ ED Diversion

• Recognize urgent care as an essential and integral extension of the primary care practice/ PCMH (some now offering both primary and urgent care)
  ▫ PCP obligations associated w/ disease management can be supported by collaborative UCC’s handling the episodic illnesses & injuries

• Engage UC’s in the discussion regarding regional or national crises (e.g., Access to care for veterans/ Care in the event of flu or other epidemics)

• Recognize the tremendous value access to the urgent care center versus the E.D. can create for plans and consumers when evaluating network adequacy ($4.4B at risk from ER Diversion alone)

Thank you...