How to Mitigate the Effects of Acuity Degradation in Acute Care Practice

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Executive Summary

The viability of urgent care practice, and to a lesser degree, occupational medicine practice, is severely threatened by the “degradation of acuity” that exists regarding the type of care rendered for acute care conditions.

The predominant APP staffing model, global fee payer contracts, and the over-specialization of medicine in the US negatively impact the level of complexity of clinical care rendered in these practices.

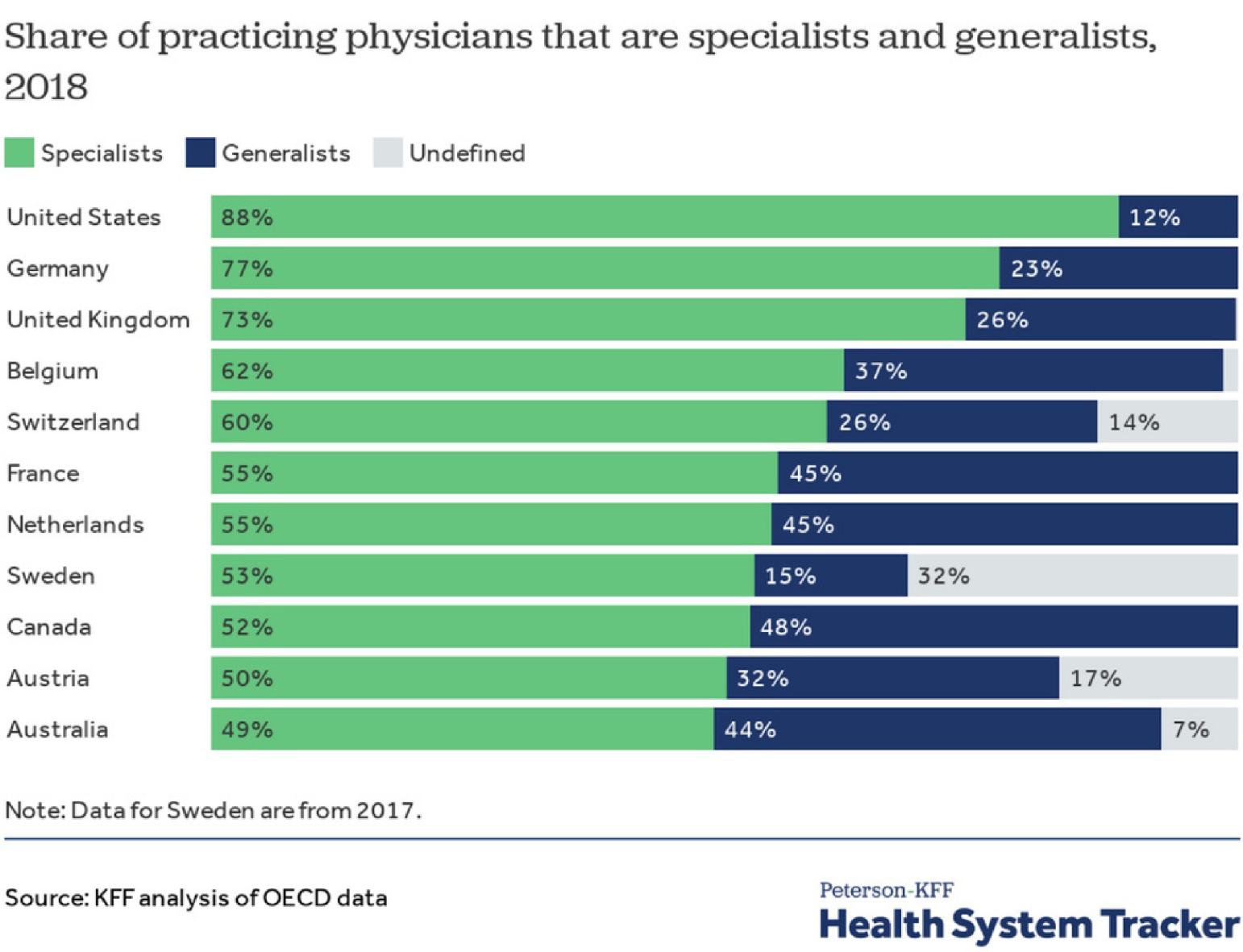
This leads to reduced revenues, disenfranchisement of patients and employers, and further scrutiny of payers as to the necessity to cover little more than “triage” care.

Mitigation strategies include training and technology to enhance expertise, the level of procedures and overall care provided, and to identify opportunities to facilitate revenue enhancement.

When we started in urgent care in the early to mid ‘80’s, our challenge was awareness. No one knew what urgent care meant. We knew we were creating a place people could go instead of the emergency room for “minor emergencies. Obviously the industry has matured and evolved, but not all for the better. The new challenge is the trend seen over the last decade or more of acuity degradation, also referred to as “glorified triage.” Many of us who have been around since the early days trained in emergency rooms or had surgical or orthopedic training and we were accustomed to performing high acuity procedures - lacerations, fractures, wounds, eye injuries, and the like, and prided ourselves on keeping patients out of the emergency room. Occupational medicine, especially worker’s compensation injury care, was a natural progression for many of us in urgent care, despite not having formal training in the specialty at the time. We didn’t have today’s analytics that put us in highly retail locations catering to local families. Our locations were perhaps as likely to be near industrial areas as residential, and in fact the occmed side of the practice often was the “make or break” factor in terms of viability of the practice.

Changing urgent care landscape

Today of course, much has changed. The predominant provider in urgent care and many occmed clinics is the APP, Advanced Practice Provider or Advance Practice Nurse or Physician Assistant. Now, the expansion of urgent care to every convenient location in the country would of course be impossible without APPs. However, the fact is that APPs, by the nature of their training and scope of practice, for the most part do not possess the same level of clinical expertise as physicians when it comes to higher level acuity conditions and injuries. Advanced Practice Nurses are registered nurses with additional education and clinical training at the master’s or doctoral degree level. At least 1000 hours of clinical practice in a focused area, such as pediatric, adult, or geriatric medicine, are required to earn an Advanced Practice degree. Physician Assistants (PAs), on the other hand, train for 2 years to obtain a master’s degree, completing at least 2000 hours of supervised practice before graduation. Contrast this with a typical family physician who completes 15,000 hours of clinical training over 5 additional years, including residency. In urgent care and occupational medicine practices this is most evident with procedures such as double layer laceration repair (and in some cases, suturing in general is not performed by APPs), minor fracture care, joint injuries and injections, eye injuries such as foreign body and rust ring removal, and other wound and burn care. Another factor is the frankly over-specialization of medical care in the US. In many other countries the “generalist physician” takes care of so many conditions and procedures that would be referred out to specialists here in the US.



The result is that the “acuity” of care rendered in urgent care and some occupational medicine practices for worker’s compensation injuries has declined overall

Consequences

Consequences of this acuity degradation are manifold. Employers count on their occupational medicine providers to be the “one stop shop” for most of their employee work-related health care needs.

They want twork related injuries treated at a facility that is not only competent to care for the injury, but to also be fully cognizant of the employer’s concerns regarding OSHA recordability, lost time and return to work.

When the case is referred out there is almost always a delay in return to work (assuming the care could have been rendered in-house) and the claim value, or cost to the employer, rises.

Community Experience

In urgent care, the community experiences the same thing. How many times will a family using an urgent care tolerate being referred out for an ankle sprain, a minor fracture, an eye injury or a laceration before they say, you know what, next time we have an injury we may as well go to the orthopedist or ortho urgent care right away, or the emergency room because we're going to wind up there anyway. Here's a typical urgent care complaint turned up on a local "Next Door" social media site: "4 weeks ago I sprained my ankle.. it didn't really start bothering me till a week later..I went to Urgent Care.. they took an X-ray.. nothing broken but I knew that cuz no pain. Dr Anne said ice, keep elevated n rest.. gave me a brace n follow up with <<Local hospital>> foot specialist.. 3 weeks later foot still swollen.. can't get into foot Dr for 2 weeks n that's not the Dr.. it's the PA.. good luck seeing a Dr! So now I'm at ER.. Place is packed.. I'll be here for hrs" in the Chicago area there are 47 orthopedic urgent care centers where these patients will likely start going instead of your "traditional" urgent care. In fact these ortho urgent cares assume you are referring most of these orthopedic cases out and will come courting you for those referrals.

Radiology Technicians

Another consequence of your injuries dissipating is staff satisfaction, particularly among radiology technicians. They already are among the more cross-trained individuals in an urgent care or occmed clinic, but if the xray orders start to dry up with patients going elsewhere for injuries, it will become increasingly difficult to keep radiology techs on staff. They will simply not be professionally satisfied doing drug screens, lab tests and paperwork/data entry without a reasonable number of xray procedures that they trained for and have primary interest in.

Margin Challenges

Urgent cares operate on ever-narrower margins. Staffing shortages and competition lead to wage inflation. Loss of revenue from injuries not coming through the door at all, or loss of follow up visits, xrays and DME supplies when referred out, will squeeze from the other side, and the margin suffers even more severely.

Payer Issues

Humana has stopped contracting in Florida with new urgent care centers. Payers are seeing this issue and have no compassion for your practice. In fact the declining reimbursements and case rates/global fee contracts are largely to blame for having to keep urgent care expenses in check by employing APPs in place of physicians in whole or in part. However, they are going to pay even less or not at all if only "triage care" is rendered.

Mitigation Strategies

What is your culture like? Do you attract providers who are interested in learning more and expanding their skills? Is the mentality “oh we get to do ortho and procedures and follow up the entire injury? What fun!?” Or is it less enthusiastic? Hire for aptitude, experience, and desire to do procedures. The ortho urgent cares are ALSO staffed with APPs. They’re just better trained. So why refer from APP to APP? And patients just plain hate getting referred to another provider when they expect to be treated by you. When hiring APPs and even physicians at the outset, make it clear that your practice takes care of minor fractures and eye injuries, that you perform joint injections and double layer wound closure, and you expect those skills among your providers.

Incentives

Consider incentive pay for higher performing providers. The procedures, additional follow up and higher level E&M coding will bring in more revenue. A portion of the provider compensation can, and should be productivity based.

Capture Your Codes

If you are in urgent care you undoubtedly are involved with global rate contracts. You simply must capture the codes that reflect the higher level procedures you are doing all year, once again for orthopedic injuries, lacerations, eye injuries, burns and other injuries, managed in-house and truly “ER - diverting”, in order for you to present these to your global rate payers and negotiate higher rates.

Brand for Injury Care

This must be front and center on your website, your advertising, communication with employers and other stakeholders that you provide this level of care as an alternative to the ED and more expensive specialty care.

Monetize the Care

Not only for higher level E&M codes, but all the associated procedure and admin codes that go along with injuries, with the right modifiers. If you are taking care of more injuries you must have a more sophisticated inventory and knowledge level of the DME supplies available. It makes no sense to send a patient out the door without the proper immobilization or therapeutic devices to alleviate pain and protect the injured part.Many practices make as much or more profit on the DME than from the E&M codes!

Training & Support Tools

Your providers may have the desire, but not the training or experience in performing these procedures. Leaders in urgent care and occupational medicine need to identify those providers that are not rendering these procedures and higher level E&M coding (indicating more complex cases), and provide them the data feedback that shows care that could have been rendered, and the training and tools to become competent and confident in providing that care.

The OccDocOne platform is an excellent source of online training for all of these common procedures with over 300 guidelines, 400 hundred procedural video tutorials, 200+ radiographic images and a complete guide to the evaluation, treatment and follow up plans for each injury.

The Exdionhealth ACE platform is an AI powered auto-coding, revenue enhancement and CDI platform that will audit every chart, every day, read the clinical documentation and assure the proper E&M code level and all associated procedure codes for the visit have been assigned.
The platform delivers one click visibility into clinical and financial intelligence to streamline training, elevating standard of care and patient experience. Medical directors and other clinic stakeholders are presented reports and a dashboard of location and providers to show relative E&M and other procedure codes to hone in on where additional training may be required.

Summary

The growth and changing landscape for acute care practices including urgent care and occupational medicine has necessitated and welcomed APPs as the predominant staffing model.
Global fee contracts create a disincentive to provide higher level acuity services. APPs may not have received additional training to provide these services.
Consequences of “Acuity Degradation” include declining revenues, loss of the injury care service line, and disenfranchisement of the public and employer clients expecting to receive this level of care as an alternative to the emergency department and specialty care.
Mitigation strategies include a commitment to and nurturing a culture of injury and other higher level care, training of providers to deliver that care, marketing to the public and employers of the availability of services, and analytics, coding and clinical documentation improvement (CDI) tools to identify areas of opportunity for better patient care and revenue enhancement.

Larry Earl, MD is the Chief Growth Officer for Exdion and President of NAOHP, the National Association of Occupational Health Professionals. He has owned and operated multi-site, multi- state urgent care and occupational medicine practices for over 30 years.

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John Koehler, MD founded Physicians Immediate Care in 1987, the pioneering hybrid Urgent Care / Occ Med clinic model which has now grown to over 50 clinics based in Chicago. He also serves as medical advisor to multiple Fortune 500 companies. His formal training is in Emergency Medicine and Occupational Medicine and practices the latter. Based on his experience he has created a web-based, guideline driven tool that supports both UC and Occ Med injury treatment and management called OccDocOne.

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