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Part I

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Traditional Care: Hospitals and Health Care in the United States

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Chapter 1

Hospitals and Spiraling Healthcare Costs

Key Terms

Acute care

Average length of stay (ALOS)

Hospitals

Non-proprietary

Outpatient

Proprietary

INTRODUCTION

Once upon a time, hospitals provided care almost exclusively; if people were sick, they either stayed home or were “hospitalized.” Today, the rate of hospitalization and the actual number of hospitals is decreasing as more and more services are being provided in **outpatient** care settings. Before the reader is introduced to numerous forms of outpatient care, to form a comparison between traditional inpatient care and the prevalent outpatient trends, we provide a quick overview of American hospitals.

TYPES OF HOSPITALS AND COMMUNITY HOSPITAL STATISTICS

Hospitals take numerous forms, such as federal (military hospitals, the Veterans Administration, or the Indian Health Service), state and municipal hospitals (hospital districts, county hospitals, or city hospitals), religious based (Catholic, Jewish, Methodist, etc.), or even specialty hospitals (women’s, children’s, or psychiatric). Hospitals usually provide short term (less than 25 days) or acute care. They can be small, serving rural areas, sometimes with 25 beds or less, or large, such as 800-bed centers delivering sophisticated and advanced levels of trauma care. Hospitals may also be physician-owned or a combination with a

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religious group; also, they may be **proprietary** (for-profit) or **non-proprietary** (non-profit), which is usually determined by the Internal Revenue Service.

Though it would appear from Table 1-1 that hospital admissions grew from 29,252,000 in 1970 to 35,239,000 in 2005, this is misleading. After adjusting for population increase, we see that admissions per population actually declined from approximately 160 per thousand to approximately 112 per thousand, and this is in spite of an aging U.S. population.

The number of hospitals also decreased during this time period, the number of beds per thousand decreased, and the **average length of stay (ALOS)** decreased. The alarming factor is the cost per day and the cost per stay for hospitalization. For the same time period it has literally skyrocketed.

In sharp contrast, the number of outpatient visits has increased, as has the number of outpatient visits per member of the population (Table 1-2).

Table 1-1 Selected Characteristics of All Hospitals With 100+ Beds

<i>Characteristics</i>	<i>1980</i>	<i>1990</i>	<i>2000</i>	<i>2005</i>
No. of hospitals	6,965	6,649	5,810	5,756
Beds (000)	992.0	929.4	823.6	802.3
Admissions (000)	36,143	31,181	33,089	35,239
Admits/thousand	159.6	125.4	117.6	112.0
Average length of stay (days)	7.6	7.2	5.8	5.6
Cost per day (\$)	245	687	1,149	1,522
Cost per stay (\$)	1,851	4,927	6,649	8,793

Source: Data from Statistical Abstracts of the United States, various years; National Center for Health Statistics and Health, United States, 2003: With Chartbook on Trends in the Health of Americans, 2003, Tables 95, 106, and 122.

Table 1-2 Growth in Outpatient Visits

	<i>1970</i>	<i>2000</i>	<i>2005</i>
Outpatient visits	133,545,000	592,700,000	673,700,000
Visits/person/year	0.66	1.89	2.1

Source: Data from AHA Hospital Statistics, 2007 edition and prior years.

Table 1-3 Number of Ambulatory Surgery Centers, 1997–2003

1997	1998	1999	2000	2001	2002	2003
2,462	2,644	2,786	3,028	3,371	3,597	3,735

Source: Data from MedPAC, Report to Congress, July 2004.

WHY OUTPATIENT PROCEDURES ARE GROWING

To further demonstrate this trend away from hospitals and toward outpatient care, one clear example is the growth of ambulatory surgery centers. In a recent short period (6 years) the number of centers increased by 50% (Table 1-3).

CHAPTER SUMMARY

The number of hospitals in the United States has been declining during the last 30 years, as has the number of admissions per person. The average length of stay has also declined. Costs, however, continue to spiral upward. Because of advances in technology that have led to quicker and less invasive procedures, coupled with increased pressure from third-party payers (Medicare, Medicaid, insurance companies), health trends have seen outpatient procedures trump that of hospitalization.

CHAPTER REVIEW

1. Why have inpatient hospitalizations decreased during the last 30 years?
2. Why have outpatient procedures increased dramatically?
3. What impact do physician-owned services have on the hospitals within their community? To protect themselves financially, should these hospitals form partnership relationships with these physicians?
4. What are several ways to classify hospitals?
5. What is the trend regarding the average length of stay in **acute care** hospitals? Why?

(One interesting trend is that hospitals are removing physicians from their hospital's staff if they are found to be in economic competition with the hospital. This could be in the form of starting, sharing in, or referring to outpatient imaging centers or surgery centers.)

Discussion: As the baby boomer demographic bubble ages, how long might the trend toward outpatient care continue?

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Chapter 2

The Physician's Office: Both a Primary Care Provider and the Gatekeeper for Other Types of Health Care

Key Terms

Allopathic doctors

American College of
Healthcare Executives (ACHE)

Back office

Certified nurse practitioner

Front office

Health Insurance Portability and
Accountability Act (HIPAA)

Medical Group

Management Association
(MGMA)

Medicaid

Medicare

Osteopathic doctors

Physician assistant

Primary care provider

INTRODUCTION

The general practitioner or **primary care provider** is many times referred to as the “gatekeeper of the medical system.” The general physician, practitioner, doctor, or primary care provider may simply answer questions or address concerns the patient may have or may refer the patient to a specialist, order a battery of tests or images, or prescribe medications. In any event, the primary care physician is usually the central point of entry into the healthcare system for all phases of health.

WHAT IS A PRIMARY CARE PROVIDER AND ARE THERE DIFFERENT TYPES?

Primary care physicians are those trained in general practice, family practice, internal medicine, obstetrics and gynecology, and pediatrics. To be referred to as

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a specialist in any of the foregoing fields, the doctor had to do a residency and then sit for a special examination; upon passing the physician is referred to as “board certified.”

More minor “general care” may be delivered by other allied health professionals. These professionals can be a **certified nurse practitioner**, a registered nurse with a master’s degree and additional training in the diagnosis and treatment of common problems, or a **physician assistant**, formally trained to assist a physician in the practice of medicine and working under the supervision of a physician or surgeon.

MDs and DOs

To this point, only general practitioners have been mentioned. However, they are different types of general practitioners: medical doctors (MDs) or, even more properly, **allopathic doctors** and **osteopathic doctors** (DOs). Both are physicians, but they have similarities and differences:

- Similarities
 - Both MD and DO applicants have 4 years of undergraduate education, usually with a heavy emphasis in science, usually biology and chemistry.
 - Both MDs and DOs complete 4 years of medical school.
 - After medical school, both DOs and MDs may specialize in areas such as surgery, obstetrics, and radiology.
 - Both DOs and MDs must pass a state licensing examination, very often finding themselves sitting next to each other and taking the same examination.
 - Both usually practice in the same licensed and accredited hospitals.
- Differences
 - DOs usually take a more general or holistic approach, whereas MDs more often become specialists.
 - DOs receive extra training in the musculoskeletal system and are more likely to manipulate the patient in a therapeutic manner.

THE PHYSICIAN'S OFFICE

The medical practitioner’s office is usually organized into the **front office** (waiting and reception, intake coordinator, appointments, billing, insurance verification, and sometimes a practice manager) and the **back office** (measurements area, laboratory, imaging, examination rooms, and consultation with the physician). Each function is discussed below.

Before the Appointment

Choosing the Physician

Many researchers marvel at how little thought and time goes into such an important and critical decision as choosing one's doctor. The physician, who can sometimes determine the health or even save the very life of the patient, is many times chosen because a friend of the patient referred the patient to the doctor with statements such as, "You will love this guy, his kids go to school with our kids, and all the magazines in the waiting room are usually current." More research and care might be taken to choose carpet color. At other times the prospective patient moves to a new town and simply searches the yellow pages to find a nearby doctor, relying on who happened to construct the telephone book marketing layout ad. In yet other cases, the patient has limited choices, constricted by which physicians may be in his or her insurance network of providers. At other times, prospective patients may choose to call the local medical society for a referral to a particular type of specialist.

Making the Appointment

After choosing the physician, the patient usually phones for an appointment. He or she inquires if the physician is accepting new patients and if the physician takes a particular brand of insurance. The intake coordinator inquires as to why the patient wishes to see the physician and how soon the appointment is desired. After checking the physician's schedule, a suitable appointment is arranged.

During the Appointment

The Front Office

After the appointment is secured, the patient travels to the physician's office and then enters the waiting area. This may be pleasant with a flowered walkway, current periodicals, and smiling staff; or it may be on the umpteenth floor of an office building, with a sickly crowded waiting room and harried staff members. It is surprising to many patients that physicians give so little thought to the hospitality aspect of their office.

The patient is usually asked to register, to relate a lengthy family and medical history, and to complete insurance forms. He or she will sign a **Health Insurance Portability and Accountability Act (HIPAA)** form and also a consent form for treatment. The intake coordinator will want to know the form of payment the patient plans to use (**Medicare, Medicaid**, third-party insurance, self-payment), and a paragraph on the form will state that in the event of rejection by the third-party

insurance company, the patient is still responsible for the bill. In most instances, the patient will pay an insurance copayment or must meet his or her insurance deductible for the office visit.

In the waiting area there may be a television, coffee or chilled beverages, games for kids to play, overhead music, and magazines to read. Also the patient will probably wait beyond the time of the appointment.

The Back Office

When the patient is finally called (and names should not be used due to HIPAA confidentiality requirements), they are taken to a measurements room to have his or her height and weight measured, blood pressure taken, and, if diabetic, his or her finger stuck to measure the current blood sugar level. The patient will then be quizzed by the nurse aid, physician's assistant, or certified nurse practitioner to record the reasons the patient is visiting the physician.

After the interview, notes are placed in the patient's medical record, and the patient is taken to one of several exam rooms to await the physician. This is actually an efficient way to see patients; each patient is prepped, interviewed, and placed in waiting rooms and the doctor merely moves from room to room, wasting little time and maximizing the number of people she or he treats each hour. (This is especially true when one considers how medicine was practiced just 4 decades ago with house calls. Gone are those days when one could simply phone the doctor and request a house call because the patient was too ill to go to the doctor's office.) In today's busy world, the impracticality of that type of doctor-patient relationship does not exist; most doctors will never spend "windshield time" driving from patient house to patient house.

The Physician

After yet another wait, the physician will enter the examination room, always accompanied by a nurse to make notes, hand supplies, or take additional measurements (and to protect the physician from later acquisitions of impropriety). During the discussion with the patient and the diagnosis, the physician will carefully tap, prod, push, peer, cajole, or otherwise investigate the patient's complaint, trying to rule out maladies and then determine what is causing the discomfort, sickness, or complaint.

More tests may be ordered. An image (x-ray, computed tomography, ultrasound, or magnetic resonance image) may be needed to assist in the diagnosis, or additional laboratory tests may be needed. Medications may be ordered, usually for an allergy or to relieve pain. The illness or pain may be beyond the scope of the physician and a specialist is needed; therefore, a referral is generated and a call is made to schedule the patient to see a more specialized provider.

After the Appointment

When the patient exits the office, a billing clerk, receptionist, or even the original intake coordinator will review the physician's report and, if necessary, make an appointment for a follow-up visit. If the physician is astute, a call will be made to the patient in a few days to elicit patient satisfaction information.

PROFESSIONAL PRACTICE ADMINISTRATORS

In the old days, a physician was boss of the practice; after all, he or she owned it. Physicians would hire and fire, buy supplies, take money to the bank and make the deposit, or one of their relatives would assist, such as their wife, son, or daughter.

Often, the practice would grow managers internally. For example, a person is hired to answer the telephones, but as a few years pass he or she becomes the insurance verification person or the billing person. A few more years pass and the person grows in trust and assumes more and more duties and evolves into the medical practice administrator, handling all business affairs for the physician. Although having many years of on-the-job training, the weakness of this model may be that the person who grew into the job may lack formal education in areas such as marketing, accounting, or management.

Therefore a new opportunity has risen for those interested in a career in healthcare administration. Instead of setting a goal to become the administrator of a hospital, many graduate students are finding quicker satisfaction, less competition, and nearly equal salary in the field of medical practice administration. These people finish graduate school in healthcare administration and sometimes walk into a position managing a physician's practice. They may have MBA skills, understand marketing and accounting, and, though not experienced in the front and back offices, lend their business skills to successfully managing the practice.

Often, physicians practice together, share facilities and employees, and divide overhead, linked together into an independent practice association, a partnership, or some other form of group practice. Members of these non-solo practices want to arrive at work, see patients, and then go home. They became doctors to treat patients, not to interview billing clerks, buy new office equipment, or attend advertising workshops. In contrast, the medical practice administrator is hired to manage the business side of the practice and is paid well to do so.

This career model is recommended for those students who are interested in quicker advancement as an alternative to hospital administration. The professional group for hospital administrators is the **American College of Healthcare Executives (ACHE)**; an equally prestigious professional group that is more focused on medical practices is the **Medical Group Management Association (MGMA)** and its educational wing, the American College of Medical Practice Executives. Jobs are more plentiful, students from graduate programs are more

competitive in the workplace than those individuals who have worked in practices but are not formally educated, and salaries are higher earlier in the individual's career (though the salary of a hospital administrator may outpace the medical group administrator in the long run).

Both the ACHE and the MGMA organizations have professional advancement criteria; demand attendance in workshops to gain credits to advance; have written examinations covering topics such as accounting, law, management of information systems, and human resources; and have many thousands of members. Perhaps the biggest advantage of membership in either organization is the list of hundreds of jobs that each organization displays. The author recommends membership in either or both as a way to professionally advance in either respective field.

CHAPTER SUMMARY

Primary care physicians are the gatekeepers of health care. These physicians, either MDs or DOs, are usually the first person to examine, diagnose, and offer treatment to the patient. From here the patient may receive further testing, imaging, or see a specialist for a more in-depth examination and care. Healthcare administration students may choose to pursue a career in assisting physicians in the efficient management of their practice.

CHAPTER REVIEW

1. How does a physician become “board certified”?
2. What is the difference between a DO and an MD? Are they both physicians? What is the difference in the state medical examination that each takes?
3. What is HIPAA, and what is its impact on the patient and the physician's office?
4. Why is consent for treatment absolutely necessary for each patient and each visit?
5. Why is follow-up after the office visit important to the physician's practice?

Discussion: A friend of yours has just moved into the area and asks you to recommend a physician. You haven't been there long enough to see a physician yourself. What do you say, and how would you advise your friend to find an appropriate doctor?

Chapter 3

Urgent Care Centers: “The Doc in the Box”

Key Terms

Ancillary services
Convenience clinics

Urgent care centers

INTRODUCTION

Urgent care centers are one of the most rapidly expanding sectors of the American healthcare industry. These are designed to be rapid access outlets for walk-in patients who require timely treatment of injuries or illnesses that are not severe enough to necessitate a trip to a hospital emergency department. These consumers do not want to wait for a scheduled appointment with their primary care physician and most often find the urgent care center quick, convenient, and affordable.

HISTORY

Urgent care centers first began operation about 30 years ago but did not see a rapid expansion until the mid-1990s. It is thought within the healthcare industry that urgent care centers were not accepted by consumers initially because there was no marketing for the centers; consumers simply did not know what services were available, what could be expected, or how much they cost. They simply put their trust in the local hospital's emergency department. An additional reason for the failed expansion is that hospitals were buying the centers as potentially profitable **ancillary services** while counting on patients to use the urgent care centers as an entry point into the hospital. Hospitals viewed their centers as a downstream part of the marketing chain, the hospital believing that for every group of patients,

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a few would need hospitalization. Because of high overhead (the centers were managed in the same manner as hospitals), the profitability of these centers did not evolve and in many cases they were closed.

“BUILD THEM AND THEY WILL COME”

With an understanding of public demand and an entrepreneurial spirit, many primary care and emergency physicians who are weary of “24/7” health care move into urgent care center practices. Burned out by the burden of traditional medical practices and looking for a change from the demanding schedules of office/hospital practice, some doctors, independently or collaboratively with hospitals, are opening new centers and fueling the growth of urgent care centers. These doctors are finding a new role in medicine by emphasizing high-quality care that is convenient. Marketing the urgent care center is similar to that of a 20-minute oil change center—“convenience, convenience, convenience” at a reasonable price.

In addition, many hospital emergency departments now operate urgent care centers that are often adjacent to or within the hospital facility. Patients can go directly to the center or may be assessed in the emergency department through a triage system; if determined to be a low acuity patient (lower than requiring care in a hospital emergency department), they can be sent to the urgent care center for treatment. This then frees the emergency department doctor for “true” emergencies. The new patient would most likely remain in the hospital’s treatment system and, if needed, would be provided continuing care of a more comprehensive nature, resulting in a healthier patient.

In a new trend, more and more urgent care centers are specializing in pediatric care. Instead of being in direct competition, they are working in concert with primary care pediatric practices. In many instances, these pediatric urgent care centers are open only during hours that pediatric physician’s offices are closed, such as evenings, weekends, and on holidays.

SCOPE OF URGENT CARE

Although all urgent care centers can treat many problems seen in the primary care physician’s office, they can also offer services not normally available in those offices. Examples include:

- X-ray facilities for basic radiology imaging in the treatment of minor fractures or for chest x-rays
- In-house laboratory departments for routine blood tests and other diagnostic procedures to prevent the inconvenience of sending to off-site laboratories

- Procedure rooms to set minor fractures and suture average lacerations
- Prepackaged prescription services (medicines can arrive in prefilled packages, eliminating a trip to the pharmacy to fill a prescription [this is dependent on state law])
- On-site physical therapy

No continuing supervision is given for chronic conditions.

Minor Injuries, Illnesses, Routine Care, and Diagnostics

A visit to an urgent care center would be appropriate for any of the following:

- Minor injuries
 - Sprains, strains, minor fractures
 - Minor injuries associated with automobile accidents
 - First- or second-degree burns
 - Minor eye injuries
- Minor illnesses
 - Fevers
 - Abdominal pain
 - Sore throat
 - Asthma
 - Ear or eye infections
- Routine care
 - Allergy injections
 - Sports and school physicals
 - Flu vaccines
- Diagnostic testing and imaging
 - Urinalysis
 - X-rays
 - Electrocardiograms
 - Pregnancy tests

Visits would not be appropriate for conditions that are life-threatening such as chest pain, (which could signal a heart attack), stroke, difficulty in breathing, severe bleeding or pain, loss of consciousness, or when there is any doubt about the seriousness of an illness or injury. Patients should then visit the nearest hospital emergency room or call 911 for help.

CONVENIENCE AND LOCATION

Urgent care centers are normally found in urban neighborhoods, in retail shopping centers, or in freestanding clinic buildings. Most are convenient and easy to locate, with urgent care centers located in most American cities and often with multiple locations. Consumers are usually elated that there is little or no waiting period to be treated for a minor injury or illness. They can drop in, be treated, pick up medicines, and go home with a feeling of relief in a short period of time. Gone are the long waits in the primary care physician’s office (if one can even secure an appointment) or in a crowded hospital emergency department where a patient may wait for hours to receive the same care that can be provided in an urgent care center in less than an hour and at a very fraction of the price.

WHO PAYS?

Most health insurance plans, including Medicare and Medicaid, cover urgent care, but patients should check their plans to confirm coverage for services and acquire prior authorization when necessary. In most cases, if a patient in a health maintenance organization (HMO) insurance plan contacts his or her primary care physician and is instead told to go to the urgent care center, he or she will pay for the visit directly or will pay a regular office copayment. Some health plans are now charging a higher copay to consumers who use the emergency department for non-emergency care such as bronchitis, ear infection, sinusitis, and strep throat. A call to one’s primary care physician or health plan’s hotline could help to determine whether to seek care at an urgent care center or in the local hospital emergency department.

It is rare that an urgent care center advertises that it will treat anyone regardless of insurance coverage or ability to pay. Usually urgent care centers are proprietary in nature, though at a fraction of the emergency department cost.

A few urgent care centers offer a discount membership plan to patients and their families who are without medical insurance. Although it is *not* insurance, the plan does offer urgent care at affordable rates with proper identification and a membership card at the time services are provided. A reduced fee may even be offered to clients who have high insurance deductibles or perhaps have had a lapse in their health insurance coverage.

For employees who suffer on-the-job injuries that can be treated as minor, workers’ compensation may be filled when the treatment is delivered, and the state usually accepts the treatment within the workers’ compensation claim process.

CUSTOMER SERVICE AND SATISFACTION

Extended hours, enhanced customer service, and low cost are positive characteristics of urgent care centers. There is an increased emphasis on customer service with some urgent care centers, allowing patients to register online through providing required information before going to the center. This advanced one-time registration may keep patients and their families coming often by lowering one of the barriers to entering the center's system. Some urgent care centers are offering to send reports to primary care physicians that describe visits patients have made to the center, yet another step in promoting customer service.

Many corporations and city municipalities are utilizing urgent care centers for occupational health. Employer-paid services include workers' compensation cases, employment physical examinations, and drug screening. Not only are the centers more convenient for employees and potential employees, they are more cost effective for employers than would be a primary care physician. Urgent care centers can reduce the time spent away from work for medical appointments thereby saving the employer money.

HOURS OF OPERATION AND STAFFING

As previously stated, most urgent care centers are open for extended hours. Typical hours are 8 a.m. to 8 p.m. Monday through Friday and 11 a.m. to 5 p.m. Saturday and Sunday; other centers provide limited hours on holidays.

Normally, at least one physician is on duty accompanied by a nurse practitioner or physician assistant. Additionally, there are medical assistants, lab technicians, x-ray technicians, and office staff. The number of staff depends on the size of the urgent care center and the patient load. Some smaller rural remote centers may have only a nurse practitioner or physician assistant and staff that perform more than one job, from registering patients to giving injections to completing the billing process. These centers, however, still have a physician available for consultation and to review care.

CONVENIENCE CLINICS

The latest offering in health care for the most basic medical problems at economical prices are **convenience clinics**, which are set up in retail and grocery chain stores. With multiple facilities, the chains have an advantage of consolidating costs to maximize profit, have name recognition through mass marketing, and, with increased visibility, have created a sense of "reliability" to consumers.

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Instead of a physician on duty, convenience clinics are most often staffed by registered nurse practitioners (registered nurses with master’s degrees who are allowed to prescribe medications) or with physician assistants who are qualified to evaluate, diagnose, and prescribe medications for common illnesses and to provide some vaccinations and screening as listed below:

- Common illnesses: allergies, bronchitis, ear infections, sore throat
- Additional treatment: laryngitis, swimmer’s ear
- Skin infections: athlete’s foot, cold sores, insect bites, minor burns, rashes
- Screenings: pregnancy, allergy testing (18+)
- Vaccines: flu, hepatitis B (adult or child), measles, mumps, rubella

Convenience clinic hours normally coincide with those of the host retail store. Patients outside the scope of services provided at the convenience clinic are referred to their physician, urgent care center, or emergency room and are usually not billed if they cannot be treated.

The negative side of convenience clinics is that there is not a physician on site, which creates a lower level of care and results in these clinics not being allowed to operate in some states. It remains to be seen if this limited level of health care will be widely accepted by the public.

FUTURE OF URGENT CARE CENTERS

Will the aging population create new demands for urgent care centers? Will the time it takes to secure an appointment with a primary care physician and/or the waiting time spent in overcrowded hospital emergency departments increase the popularity of urgent care centers? Will the millions of people without health-care insurance look to urgent care centers for affordable acute care? Will the competition between urgent care centers, primary care physicians, and hospital emergency departments make consumers the beneficiaries of improved health care through convenient, quick, and affordable services? It is the author’s belief that all of these questions will be answered with a resounding ‘Yes!’.

CHAPTER SUMMARY

Urgent care centers, a recent trend in the delivery of health care, provide a host of advantages to the consumer over the traditional hospital emergency department, not the least of which are money and time. Convenience clinics are even further on the cutting edge, by providing health care in large retail outlets and at

extended hours. These are not a be-all, end-all provision of care, but used appropriately these centers can provide cost savings and the all important time factor.

CHAPTER REVIEW

1. How do urgent care centers differ from hospital emergency departments? List several reasons that are positive and several that are negative.
2. Why are physicians attracted to urgent care practices, as opposed to the traditional family practice model?
3. What factors in society seem to be driving the opening of so many urgent care centers?
4. What care might you seek from an urgent care center? When would you instead choose a hospital emergency department?
5. If a physician assistant or registered nurse practitioner examines and offers treatment to patients, how does the law in your state address the frequency of review by a qualified physician?

Discussion: Should states regulate urgent care centers in a different manner from a physician's office practice or that of a hospital emergency department? Why or why not? Is the delivery of all health care the same, or do some delivery models merit different statutes and regulations?

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Chapter 4

The Virtual Doctor's Office

Key Terms

Third-party payers

Virtual office

INTRODUCTION

More and more citizens are seeking medical advice online, weighing options for treatment and researching more in-depth knowledge about their disease. This can be in advance of seeing their physician, whose office visit may take the inconvenient form of the patient (1) booking an appointment, (2) getting dressed up and driving while not feeling well, (3) finding a parking place and even paying to park, and then (4) discovering that the physician encounter itself may be limited to a 10- to 15-minute rushed affair (the limitations most often imposed by financial incentives or the insurance provider). In an alternative form, the patient's Internet research may follow the physician office visit, much in the manner of seeking a second medical opinion. In either event, the Internet is changing the manner in which primary health care is delivered.

In a step beyond the two forms just illustrated (before the physician visit or after the physician visit), many are seeking their physician's knowledge and advice over the Internet in place of *any* office visit. As patients grow confident in their own Internet skills and as an added result of their Internet medical research and evaluation processes, many patients evolve in their thinking and want to avoid sitting in their physician's office at all, where they would be with other sick people and stale magazines and suffer a long wait.

Physicians are very willing to accommodate this new market force and manner of practicing medicine, with many physicians now seizing the opportunity to practice online as both a supplement and complement to their office practice.

ADVANTAGES AND DISADVANTAGES

Offering secure consultations and treatment; charges for simple consultations, diagnosis, and treatment; and sometimes provision of prescriptions for non-complicated conditions can range from \$25 to \$50. This may be a real bargain for both parties.

The physician usually creates a website, letting patients and others know of the new offering of more convenient medical services. When logging onto the physician's site, the patient most often finds that the **virtual office** fee can be paid by a debit or a credit card. The patient then completes a thorough and systematic history for any of a long host of complaints. The physician, logging on at a convenient time, scans the list of virtual patients, completing a review of their provided information and deciding which patients may be treated in this manner and which patients need to be contacted for an in-person visit.

If the patient is not treatable online and must visit the physician, a big advantage is that the information is already in the patient's medical record, saving the receptionist, nurse, and doctor valuable time. This preregistration, insurance update, secure bill payment, prescription refills, lab results, and placement directly in the medical record are also, without a doubt, very convenient for the patient.

The physician benefits further because by the patients completing the form by keyboard, their answers are often more comprehensive, accurate, and in better chronological order than a verbal office interview with the patients sitting in their underwear in an exam room, with limited time, with the doctor distracted by other patients and their problems.

Another advantage of virtual medicine is that for many patients, discussion of flatulence, incontinence, or erectile dysfunction is easier when addressing their keyboard and computer than in person with the doctor. This virtual interaction may lead to more honest and comprehensive answers. Also, software questions tend to be non-judgmental, and as the software adjusts itself to the preceding answers, better questions and thus more information may be coaxed from the patient and a better diagnosis delivered.

Most patients using services of this kind already know their physician. Treatment of this nature can be less expensive for the physician because there is reduced office overhead. Treatment for the patient is also less expensive, and parking problems, inclement weather, and scheduling issues are avoided.

Treating patients online may also assist the physician in staying competitive with the increasingly popular simple retail health clinics that treat minor prob-

lems. Patients can be treated in the same manner, without leaving their home, and with help from their own physician.

A disadvantage of the virtual office, however, is that **third-party payers** (insurance companies, Medicare, and Medicaid) do not cover these online visits.

CHAPTER SUMMARY

Consumers of health care have grown accustomed to searching the Internet for answers to their maladies, aches, pains, and illnesses, perceived or otherwise. A step beyond this is a visit to their provider, over the Internet, without leaving their homes. The primary care physician can size up the problem, make recommendations, and even have a prescription delivered by only seeing the patient that is at the end of their keyboard, saving time and money for both parties.

CHAPTER REVIEW

1. What forms of healthcare delivery can the Internet provide?
2. What are the advantages and disadvantages of online physician visits?
3. How could third-party payers be persuaded to pay for virtual office visits?

Discussion: Should a physician always be familiar with or know his or her patient before offering medical advice online? What about problems with high blood pressure, chest pain, or skin allergies? Can these be treated without visually encountering the patient? Could home testing equipment, such as blood pressure cuff or a diabetic home testing system, or could even a web-cam, provide necessary information?

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