201

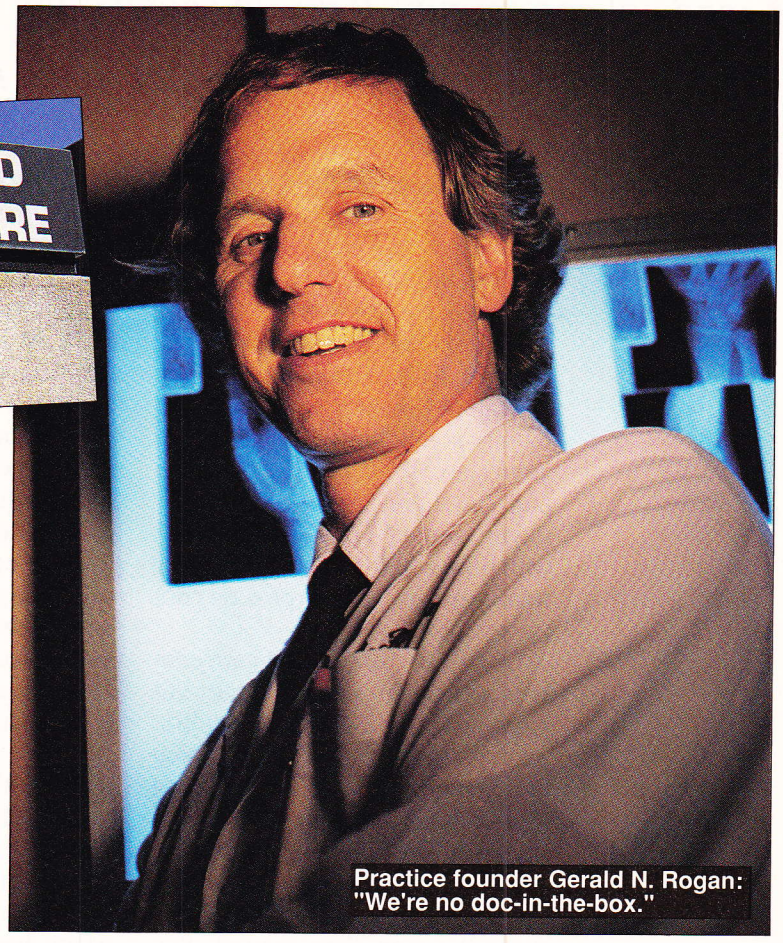
NOV 16 1992

Urgent care and family practice don't mix?

Here they do

Evening and weekend appointments are a big patient draw. And creative scheduling keeps each doctor's hours reasonable.

By David Azevedo
WEST COAST EDITOR


Practice founder Gerald N. Rogan: "We're no doc-in-the-box."

At first glance, it looks like a typical large family practice. The waiting room is busy, and patients are efficiently shuttled in and out of exam rooms. But a sign near the reception area betrays that this is no ordinary doctors' office: Hours–Monday through Friday, 8-10, Saturday 9-6, Sunday and holidays 9-5.

The practice name is also revealing: Family & Urgent Care of Walnut Creek. These doctors have successfully melded a traditional family practice with a walk-in urgent-care center. But this is no doc-in-the-box, explains founder Gerald N. Rogan. "We're not primarily an urgent-care facility. We're family doctors who stay open late and offer urgent-care services."

Each of the group's six full-time doctors and one of its three part-timers has his or her own private patients, but also cares for a number of urgent-care patients. The other two part-timers handle only urgent care. "Urgent care is the hook that brings a lot of people into the practice," says FP Neil S. Fruman, a partner. "It's also

One key to success: The practice is accepted by the medical community. It doesn't steal other doctors' patients, and it downplays its role as a competitor to the local hospital ER.

the glue that keeps them here."

The idea of combining the two types of practice came from Rogan, an FP board-certified in emergency medicine. For five years in the mid-1970s, he worked in the emergency room of John Muir Medical Center in Walnut Creek, a bedroom community about 25 miles east of San Francisco. Tired of the "treat 'em and street 'em" nature of the ER, Rogan wanted a private practice in which he could put his emergency training to use yet also provide continuity of care.

By the late '70s, urgent-care centers had begun to proliferate. But working in one didn't appeal to Rogan. "Treating non-life-threatening emergencies is the most boring kind of medicine," he says. "Treating an ankle sprain is only interesting if you get to see how the patient does, and can modify your treatment the next time around. You can't do that in the ER, and I couldn't have done it at a typical urgent-care center, either."

Moreover, Rogan questioned how many patients would opt for anonymous treatment on a regular basis. "Urgent-care centers were being promoted as the wave of the future in 1980," he remembers. "But my experience was that people in the ER for less-serious problems were only there because their family doctor wasn't available."

So Rogan decided to start a practice in which a family doctor was almost always available. He soon hooked up with Fruman, an FP who moved over from the next town. "It was far enough that I only took about 20 percent of my patients," says Fruman. "But with the foot traffic created by urgent care, the practice was bursting at the seams almost immediately."

That was a mixed blessing. With just two doctors trying to keep the practice open almost 90 hours a week, Rogan and Fruman soon found themselves dedicating their entire lives to work. And their 900-square-foot office was too small to accommodate a third doctor.

A victim of its own popularity

In 1984, the practice moved down the block to a suite in a new medical building, and merged with an established local FP, Preston G. Thompson. Rogan, Fruman, and Thompson are still their group's only partners, though they hope some of the other staff doctors will buy in soon.

The large new office solved the group's space problem, but created a financial one. The suite was big enough for at least five physicians, and needed that many to cover expenses. For the first year, though, there were just the three. Overhead skyed to 70 percent of collections for two months and averaged 60

percent for the rest of the year. It wasn't until they'd hired two additional physicians that expenses dropped to a more respectable 50 percent or so.

Even five FPs couldn't keep up with the practice's booming volume, however. As their regular practices filled up, the doctors had less time to devote to urgent care, which brought in 20 patients a day. They tried designating a "walk-in" physician each day, who would schedule only one appointment per hour. But that system crowded out the regular patients, who often had to wait a month for routine care.

Adding a part-time doctor for evenings helped for a while, but soon the number of daily urgent-care patients swelled to 30, and another problem arose. Patients with appointments sometimes had to wait while walk-ins got to see a physician right away. "That caused some unhappiness," says Rogan.

To restore peace, the doctors added a separate area for daytime urgent-care patients. It has its own reception area, waiting room, and exam rooms. They also brought in a sixth full-time doctor. Now, with four physicians in the office during the day, things run more smoothly, even though walk-ins are up to about 45 a day.

Long hours benefit both doctors and patients

The typical weekly schedule for a full-time doctor now includes three days of seeing patients from 9 to 5, one day from 2 to 10, and one day off. Each full-timer also works every seventh weekend. And while some people might balk at working nights and weekends, these physicians point to a list of benefits that make their unusual arrangement easy to live with.

For instance, there are the ways extended hours enhance patient care. "We're able to see a last-minute patient who might have gotten much sicker overnight," explains Fruman. "We can see a patient twice a day if we need to, and we take care of a lot of people who otherwise would have to go to the hospital. The patient's records are all here, and he gets treated either by his own family doctor or by someone his doctor works with."

"The way we're set up, we can sometimes use a moment of crisis to stress preventive care," notes Rogan. "For example, if a smoker shows up with pneumonia, we can encourage him to kick the habit. Then, if he comes back and is still smoking, we can use the earlier illness to reinforce the importance of stopping."

Patient satisfaction is another motivator for these doctors. "The patients you see during extended hours appreciate your efforts more," says Fruman. "They feel they're getting something beyond the ordinary. They particularly take notice when you're open on holidays. If you feed off that appreciation, as I do, it makes up for the inconvenience to your personal life."

The practice charges extra for an appointment or urgent-care visit after 5 or on weekends. But each doctor has the option of waiving the surcharge in individual cases. "If I see a patient for a Pap smear in the evening, I won't charge extra," says Rogan. "But if someone comes in with a cut, I will. For patients just taking advantage of our convenient hours, I consider it good public relations to charge the same as during the day. But if I'm seeing someone who otherwise would have gone to the emergency room, I have no problem with the extra fee."

The bottom line is satisfying, too

About 20 percent of revenues come from urgent-care patients, and the surcharges help push the practice's gross income well above what a typical family practice brings in. Net income for each full-time-equivalent doctor in 1991 was significantly higher than the national median of $101,160 for FPs, as reported in the MEDICAL ECONOMICS Continuing Survey. And the three partners do even better, thanks to income from the practice's lab and X-ray facilities, and management fees they earn for running the group. In some years, says Rogan, he has netted more than twice the national median.

Expenses for the practice were 53.9 percent of gross in '91. The group employs 27 non-physician staffers, whose salaries account for 24 percent, compared with a national median for FPs of 19.2 percent. Rogan attributes much of the practice's higher costs to running the urgent-care side.

Each doctor's income is based on the collections he or she generates, less a share of expenses, which the group divides into four categories: fixed (such things as rent, telephone, and seven front-office salaries); variable (supplies, remaining office salaries); business-required (pagers, malpractice insurance); and business-

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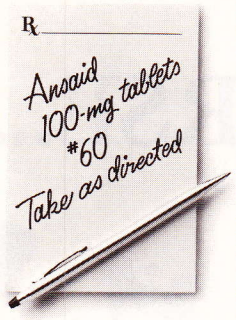
INDICATIONS: Acute and long-term treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis.

CONTRAINDICATIONS: ANSAID is contraindicated in patients who have previously demonstrated hypersensitivity to it. ANSAID should not be given to patients in whom ANSAID, aspirin, or other nonsteroidal anti-inflammatory drugs induce asthma, urticaria, or other allergic-type reactions. Fatal asthmatic reactions have been reported in such patients receiving this type of drug.

WARNINGS: Risk of Gastrointestinal (GI) Ulcerations, Bleeding, and Perforation With Nonsteroidal Anti-inflammatory Therapy: Serious GI toxicity can occur at any time, with or without warning symptoms, during chronic treatment. Minor upper GI problems, such as dyspepsia, are common and usually develop early in therapy; however, remain alert for ulceration and bleeding during chronic treatment, even in the absence of previous GI tract problems. In clinical trials, symptomatic upper GI ulcers, gross bleeding, or perforation occurred in about 1% of patients treated for 3 to 6 months and in about 2% to 4% treated for 1 year. Inform patients of signs and symptoms of serious GI toxicity and what to do if they occur. No subset of patients not at risk has been identified. Except for a prior history of serious GI events and other risk factors associated with peptic ulcer disease (eg, alcoholism, smoking, etc), no risk factors have been associated with increased risk (eg, age, sex). The elderly and debilitated tolerate ulceration and bleeding less well, and most spontaneous reports of fatal GI events are in this population. Study data are inconclusive concerning the relative risk of various nonsteroidal anti-inflammatory agents in causing such reactions. High doses probably carry a greater risk, although controlled clinical trials showing this do not exist in most cases. When considering use of relatively large doses (within recommended dosage range), sufficient benefit should be anticipated to offset the potential increased risk of GI toxicity. GI ulceration and bleeding can occur without warning symptoms, and patients treated chronically should be followed and informed of the importance of this follow-up.



PRECAUTIONS: General: Impaired Renal or Hepatic Function: Use ANSAID cautiously. Pharmacokinetics have not been studied in patients with decreased liver function. **Renal Effects:** Rats developed renal papillary necrosis at dosages equivalent to human therapeutic levels, as did monkeys given 20 to 40 times the human dose. In clinical studies of ANSAID, renal effects were similar to those seen with other nonsteroidal anti-inflammatory drugs. A second form of renal toxicity has been seen in patients with prerenal conditions that reduce renal blood flow or blood volume. A nonsteroidal anti-inflammatory drug may cause dose-dependent reduction in prostaglandin formation and precipitate overt renal decompensation. Patients with impaired renal or hepatic function, heart failure, those taking diuretics, and the elderly are at greatest risk. Drug discontinuation usually leads to recovery. Monitor renal function in high-risk patients on chronic treatment if they have signs or symptoms that may be consistent with mild azotemia, eg, malaise, fatigue, loss of appetite, etc. Occasionally BUN and serum creatinine may be elevated without signs or symptoms. Flurbiprofen metabolites primarily are excreted by the kidneys, and elimination of 4′-hydroxy-flurbiprofen is markedly reduced by end-stage renal disease. Therefore, monitor patients with significantly impaired renal function, and consider reducing dosage to avoid accumulation of flurbiprofen metabolites. **Liver Tests:** Borderline elevations of liver function tests may occur in up to 15% of patients and may progress, remain unchanged, or disappear with continued treatment. Meaningful elevations of ALT or AST (SGOT) were reported in less than 1% of patients in controlled clinical trials. Patients with signs or symptoms, or both, suggesting liver dysfunction or with an abnormal liver function test require further evaluation. **Anemia:** Anemia may be aggravated. Determine hemoglobin values periodically in patients treated long-term who have initial hemoglobin values under 10 g/dL. **Fluid Retention and Edema:** Fluid retention and edema have been reported; use ANSAID with caution in patients with conditions such as cardiac decompensation or hypertension. **Vision Changes:** Blurred or diminished vision, or both, has been reported. Patients with eye complaints should have ophthalmologic exams. **Effect on Platelets and Coagulation:** Platelet aggregation is inhibited, and bleeding time has been prolonged after single and multiple oral doses. Carefully observe patients who may be adversely affected. **Information for Patients:** Because the side effects of ANSAID, like those of other drugs in its class, can cause discomfort and, rarely, hospitalization, and even fatal outcomes, physicians and patients may wish to discuss potential risks (see WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS sections) and likely benefits. **Drug Interactions: Antacids:** In young volunteers, the administration of ANSAID under fasting conditions or with antacid suspension yielded similar serum flurbiprofen-time profiles. Rate, but not the extent of flurbiprofen absorption, was reduced in geriatric volunteers. **Anticoagulants:** Bleeding parameters are affected, and serious bleeding has been reported; use with caution. **Aspirin:** Flurbiprofen levels were 50% lower with concomitant administration; concurrent use is not recommended. **ß-Adrenergic blocking agents:** Flurbiprofen pretreatment attenuated the hypotensive effect of a single dose of propranolol but not atenolol in men with mild uncomplicated hypertension; pharmacokinetics and heart-rate reduction were not affected. Monitor patients taking both flurbiprofen and a ß-blocker to ensure that a satisfactory hypotensive effect is achieved. **Cimetidine, ranitidine:** In volunteers, cimetidine caused a 13% increase in area under the flurbiprofen serum concentration curve. **Digoxin:** Studies in healthy men did not show a change in steady-state serum levels of either drug. **Diuretics:** Studies in normal volunteers show that flurbiprofen can interfere with the effects of furosemide. Nonsteroidal anti-inflammatory drugs that inhibit prostaglandin synthesis have been shown to interfere with thiazide diuretics in some studies and with potassium-sparing diuretics. Closely observe patients receiving furosemide or other diuretics to make sure the desired effects are obtained. **Oral hypoglycemic agents:** In one study, there was a slight reduction in blood sugar concentrations during concomitant administration of flurbiprofen and glyburide, metformin, chlorpropamide with phenformin, or glyburide with phenformin; however, there were no signs or symptoms of hypoglycemia. **Carcinogenesis, Mutagenesis, Impairment of Fertility:** No evidence of carcinogenesis or fertility impairment. **Teratogenic Effects: Pregnancy Category B:** No teratogenic effects in animals. Not recommended for use in pregnancy. **Labor and Delivery, Nursing Mothers, Pediatric Use:** Use is not recommended during late pregnancy or in nursing mothers. Safety and efficacy have not been established in children.

ADVERSE REACTIONS: In premarketing studies, 9.4% of 4,123 patients dropped out because of adverse events. **Incidence > 1%:** (* = occurred in 3% to 9% of patients) Gastrointestinal - Dyspepsia,* diarrhea,* abdominal pain,* nausea,* constipation, GI bleeding, flatulence, elevated liver enzymes, and vomiting. Central nervous system - Headache,* CNS "stimulation" (eg, nervousness, anxiety, insomnia, reflexes increased, and tremor), and CNS "inhibition" (eg, amnesia, asthenia, somnolence, malaise, and depression). Respiratory - Rhinitis. Dermatologic - Rash. Special senses - Dizziness, tinnitus, and vision changes. Genitourinary - Signs and symptoms suggesting a urinary tract infection.* Body as a whole - Edema.* Metabolic/Nutritional - Body weight changes. **Incidence < 1% (Causal Relationship Probable):** Gastrointestinal - Peptic ulcer disease (see WARNINGS), gastritis, bloody diarrhea, stomatitis, esophageal disease, hematemesis, hepatitis, and cholestatic and noncholestatic jaundice. Central nervous system - ataxia, cerebrovascular ischemia, confusion, paresthesia, and twitching. Hematologic - Decrease in hemoglobin and hematocrit, iron deficiency anemia, hemolytic anemia, aplastic anemia, leukopenia, eosinophilia, ecchymosis, and thrombocytopenia (see PRECAUTIONS). Respiratory - Asthma and epistaxis. Dermatologic - Angioedema, urticaria, eczema, pruritus, photosensitivity, toxic epidermal necrolysis, and exfoliative dermatitis. Special senses - Conjunctivitis and parosmia. Genitourinary - Hematuria, renal failure, and interstitial nephritis. Body as a whole - chills, fever, and anaphylactic reaction. Metabolic/Nutritional - Hyperuricemia. Cardiovascular - Heart failure, hypertension, vascular diseases, and vasodilation. **Incidence < 1% (Causal Relationship Unknown):** Gastrointestinal - Periodontal abscess, appetite changes, cholecystitis, and dry mouth. Central nervous system - Convulsion, meningitis, hypertonia, cerebrovascular accident, emotional lability, and subarachnoid hemorrhage. Hematologic - Lymphadenopathy. Respiratory - Bronchitis, laryngitis, dyspnea, pulmonary embolism, pulmonary infarct, and hyperventilation. Dermatologic - Alopecia, nail disorder, herpes simplex and zoster, dry skin, and sweating. Special senses - Ear disease, corneal opacity, glaucoma, retrobulbar neuritis, taste change, transient hearing loss, and retinal hemorrhage. Genitourinary - Menstrual disturbances, vaginal and uterine hemorrhage, vulvovaginitis, and prostate disease. Metabolic/Nutritional - Hyperkalemia. Cardiovascular - Arrhythmias, angina pectoris, and myocardial infarction. Musculoskeletal - Myasthenia.

OVERDOSAGE: Although some overdoses in children have produced no symptoms (200 mg to 2.5 g ingested), the following have occurred in children who ingested 150 to 800 mg: drowsiness, dilated pupils, semiconsciousness, pinpoint pupils, diminished tone, and elevated enzymes. Although some overdoses in adults have produced no symptoms (3 g to 5 g ingested), the following have occurred in adults who ingested 1 g to 6 g: coma and respiratory depression, drowsiness, nausea, epigastric pain, dizziness, headache, and agitation. One 70-year-old man with a history of chronic obstructive airway disease died; toxicologic analysis showed acute flurbiprofen overdose and a blood alcohol concentration of 100 mg/dL. One patient who took 200 mg to 400 mg of flurbiprofen and 2.4 g of fenoprofen had disorientation and diplopia. Treat overdose with vomiting or lavage and supportive treatment; some patients have been given supplemental oral or intravenous fluids and required no further treatment.

Store at controlled room temperature 15°to 30°C (59°to 86°F).

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optional (travel, auto expenses).

The three part-time doctors, who produce about 12 percent of practice receipts, have that proportion of the fixed expenses allocated to their accounts. The six full-time doctors split the remaining 88 percent equally. They share variable expenses in proportion to their collections. Both required and optional business expenses are billed directly to individuals.

"By sharing expenses this way, doctors who want to take longer vacations or more days off make less money," says Rogan. "The doctor who wants to work hard is doubly rewarded: He generates more billings, and lowers his percentage of the fixed overhead. We want to reward those who work harder, because they're benefitting the entire practice. If the lower-income doctors aren't happy, they can work more."

Will the concept spread elsewhere?

One key to the practice's success, says founder Rogan, is that it has always been part of the traditional medical community. "There has been a schism between a lot of urgent-care centers and mainstream medicine," he says. "The centers often foster resentment by sending out direct mail to solicit other doctors' patients. We've never done that. We'd rather advertise to the doctors, to market ourselves as a service to them."

To that end, in the practice's early days, Rogan and Fruman took call for all 26 family doctors on staff at Muir Hospital. "We told their patients they should go back to their own doctors for follow-up," says

Rogan. "We were careful not to steal patients." These days, the practice charges to take call for outside physicians. Six local FPs continue to use them.

By working with the Muir doctors, the group also downplayed its role as a competitor of the hospital ER. "The hospital was concerned at first, but there's been no problem. Relations are cordial, we send patients to them, and they refer patients to us–just as they do for the other FPs."

Could other groups successfully adopt Walnut Creek's blueprint? Yes, says Fruman, though he doubts that many will. "One problem is the prevalence of managed care and capitation," he says. "With fixed reimbursement, there's no incentive to provide extraordinary service. And if you make your office too accessible, you're going to lose your shirt. HMOs were 20 percent of our business a few years ago, but even with tight internal controls, it didn't pay off. We're down to 10 percent HMO now."

Adds Rogan: "One HMO had no co-pay, so patients were free to see us for every little thing, which they did. Today, we won't contract with an HMO that doesn't have a co-pay."

Fruman points out one more compelling reason the urgent-care/family-care marriage may not become widespread: "Most doctors don't want to be in the office nights and weekends." ■

Looking for advice? Maybe we can help

Got a question about running your practice or managing your finances? We'll query experts to find the answer and share it with your colleagues in one of our departments. (Sorry, but the volume of mail makes personal responses impossible.) Just write: Editor, Practice Management (or Money Management), MEDICAL ECONOMICS, Five Paragon Drive, Montvale, N.J. 07645-1742.

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It's called talking. If your older patients don't ask you about the prescriptions they've been given, make it a point to tell them what they need to know. Make sure they know the medicine's name, how and when to take it, precautions, and possible side effects. Encourage them to write down the information and ask you questions about things they don't understand.

You'll also want to take a complete medications history including both prescription *and* non-prescription medicines. The history can alert you to the potential for drug interactions and help you simplify their regimen.

Re-introduce the oldest advance in medicines. Make talking a crucial part of your practice. Because good, clear communication about medicines isn't a thing of the past. It's the way to a healthier future.

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