

Urgent Care: Planning a Regional Model

Case Study Submission

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Introduction:

As the ambulatory network expanded in a pediatric hospital system (Hospital), feedback from the community revealed concerns with lack of convenience and access to primary medical care. Many families, who could not access appointments at convenient times, were finding their way to retail convenient care clinics, emergency departments, and competitor services. More and more families were seeking weekend hours (Saturday and Sunday) to immediately access care for their child and not waiting until Monday to access services. Frequently, high end emergency services were inappropriately accessed by patient and families for non-emergent services.

The executive leadership of the Hospital appointed a steering committee, with support from a strategic planning consultant, to evaluate options for a regional pediatric urgent care model. The model would supplement the services provided by their primary care and ambulatory network, owned and operated by the hospital system. The primary goal of the urgent care strategy would be to align services with the Hospital's regional footprint to better serve patients and families in their market. The committee's charge was to define an urgent care model and identify key geographies and priorities for establishing urgent care services in outlying communities. The executive team believed that if status quo was maintained, other competitors – health care providers, retail market – would step in to manage pediatric services in their market. Without an urgent care option, some families would also continue to access high end emergency services for non-emergent conditions.

Alternatives Considered

The executive team of the Hospital appointed a steering committee composed of the hospital executive and departmental physician and administrative leaders overseeing emergency and ambulatory services. The committee worked closely with a strategic planning consultant, who had a long history with developing the hospital's strategic plan and had expertise and ready access to key pediatric data resources for the engagement. The consultant provided an in depth analyses of the pediatric population and growth expectations, the pediatric market and demand projections for urgent care, and supply of health care providers and retail shops providing urgent care services in the primary and secondary markets. Several geographies were explored, which fell within fifty (50) miles of the main Hospital campus. Alternatives to go or no-go with urgent care services were evaluated.

The first alternative was not to engage in the development of a regional urgent care model. The advantages would be the time and resource savings, including capital outlay and start-up expense, planning and implementing a new service line. This was uncharted territory for the Hospital, so there would be a steep, but quick learning curve to pull off the strategy effectively. Maintaining the status quo would also not disrupt the attention and workload of key stakeholders, who would be involved in the implementation. The key disadvantage was not promoting a look to the future and positioning the Hospital for new customer expectations. Foregoing this strategy could be a missed timely opportunity to create a new model of care for families seeking lower cost options and convenience.

The second alternative was to create a regional urgent care model with services offered in the primary service area. The advantages would be ease of implementation in established properties and opportunity to expand quickly into new sites in familiar geographies. Higher concentration of pediatric population and brand name recognition by families would be key contributors to success. Financial investment in facilities and start-up would be focused on sites in these

geographies. The disadvantages would be the limited focus and not mirroring the primary care and ambulatory regional expansion. There would be missed opportunity to connect with a broader pediatric base and align services to complement regional growth in the primary and secondary service areas.

The third alternative was to create a regional urgent care model with services delivered in the primary and secondary service areas. This would be accomplished with new building sites and sharing existing sites with regional primary care and specialty services. The advantages would be synergy and coordination of care with referrals and the cost effective use of shared space and staffing. There would also be flexibility to locate and place in best geographies and in the most accommodating facilities. Disadvantages would be that established sites may not be best geography for urgent care services based on the population data and demand estimates. There may be potential erosion of the primary care business with close proximity of urgent care services. Inserting urgent care services on top of established services in the same building/ space may pose challenges with patient wait, check-in, and exam room usage. Also, overall success of the urgent care facilities has some inherent financial risk relative to the pediatric demand levels.

Process

Steering committee deliberations ensued over a three (3) month period. The team worked closely with the strategic planning consultant to review and understand data on trends in the pediatric population, forecast of ambulatory market demand, and the supply of urgent care providers. Analytics were tackled from several angles with scope that included assessment of the external environment, the hospital systems experience with short and long term projections, and the urgent care business potential. Intelligence was solicited from several hospitals/ pediatric urgent care centers, professional pediatric and non-pediatric organizations, and benchmarking through informal surveys. Specific analytics and data review included:

Demographics of service area

Pediatric population density and projected pediatric population growth displays were reviewed overall and by sub-market. The consultant compiled population data and projected market trends from various references such as Nielsen Claritis, state hospital association, and other data reflective of emergency departments, urgent care, and retail clinic markets for the 0-18 years age group. Maps of each sub market identified targeted areas for urgent care. Key findings from the market analytics identified trends by payor (Medicaid vs. commercial), age cohort, diagnoses, other.

Competitive landscape

Assumptions were made as to competition in the market by other emergency departments, hospital-owned and independent urgent care sites, and retail clinics in the 20 county service area. Local urgent care/ retail clinics were profiled by submarket with specific information regarding ownership, hours of operation, patient ages served, Medicaid acceptance, scope of services provided, ancillaries offered, and provider profiles. As an informational resource, a national profile of pediatric urgent care operations was obtained through informal survey and personal connection with other pediatric hospitals offering urgent care. Comparisons included organizational structure, clinical and operating model, scope of services, financial goals, provider and staffing mix, and plans for expansion.

Hospital experience

Actual performance data was extracted from the Hospital's information systems to identify and represent various service volumes of non-emergent visits throughout the system. This included emergency visits, observation visits, and other outpatient visits categorized by specialty and geographic site. Maps and graphs were prepared to depict the current state and reflect concentration in each geography. Analytics included review of emergency visits by acuity level, peak arrival times, days of week, age cohorts – 0-4, 5-9, 10-14, 15-18, 19+ years; geographic location, disposition, payor mix (commercial, medicaid, self-pay), diagnoses/ procedures and cross reference to CPT code.

Urgent Care business potential

Estimated demand by submarket, new business potential, and volume forecasts were prepared to make the business case for urgent care. The methodology was based on review of statewide data on emergency department- outpatient visits, urgent care center visits (hospital off-site), and estimated other urgent care and convenient care center visits in each geography. Service areas for urgent care were defined within a fifteen (15) mile radius. Adjustments were made for roadways, travel patterns, patient migration, nature of competition in the area. Market demand and volumes were forecasted with assumed constant use rates, market share of providers, and population trends. Volume assumptions were based on forecasts of new growth and cannibalization from current hospital services in geographies in the primary and secondary service area with calculation of draw rates per 1,000 population. Through these analyses, six (6) key market geographies were identified for establishing urgent care sites.

Financial analyses

A high level pro forma was crafted based on assumptions for operational structure, payor mix, anticipated urgent care payment rates, projected capital outlay, start-up and ongoing expenses. Managed care fee schedules for medicaid and commercial payors were surveyed by the managed care department staff. Best and worst case scenarios were profiled for variations in projected visit volume, payor mix, and operating hours. Net revenue, expenses, and operating margin were forecasted, along with break-even analyses at the 12,000 – 15,000 visit levels.

Chosen Solution

The steering committee recommended the third alternative: create a regional urgent care strategy in the Hospital's primary and secondary service areas. Six (6) priority geographies were identified for the initial roll out of the urgent care sites. Urgent care geographic selection was based on several factors: strategic priorities of the hospital system and protection/ growth of market share, current urgent care options in the area, projected volume growth, facility availability and investment in new properties, and financial performance. Based on those identified geographies, the availability of properties was reviewed. The initial plan was to create urgent care centers in six (6) sites co-located within the hospital's multi-specialty hub sites in the outlying geographic regions. A timeline was proposed for implementation over the upcoming year.

The plan was presented to the Hospital's executive team for approval. The executive team weighed the pros and cons and approved the urgent care model, geographic selection, identification of site locations, and timeline and sequencing of the six (6) urgent care sites.

Implementation

Once the plan was approved by the executive team, leadership for operational planning and implementation was delegated to both the Vice President and the Chair of the Department of Pediatrics. They had administrative and operational responsibility for the primary care and medical ambulatory network. The first task at hand was to recruit and appoint the urgent care leadership team of Medical Director, Operations Director, and Clinical Manager. Very capable internal recruits were interested and available and all three (3) leaders were recruited and transitioned to their new positions within a two (2) month timeframe. They transitioned into the urgent care leadership team and had overall responsibility and oversight for the development, startup and ongoing operations of the urgent care sites.

To develop the project plans and get implementation activities off the ground, the urgent care leadership team activated an operational steering committee. The Medical Director and Operations Director were responsible for overall leadership. They set weekly and bi-weekly meetings with the VP and Chair, and devised committee meetings twice per month to assure follow thru of each of the workgroups. The committee included representation from the following areas and was supported by several work groups behind the scenes. Each of the subgroups worked tirelessly behind the scenes to establish new processes and operations for urgent care. These had to be developed from scratch, as the urgent care service line was not primary care, not emergency medicine, so did not previously exist. Each and every medical, informational, financial, legal, accrediting system was challenged and reformulated. A project management work plan was established and urgent care specific processes developed, which included:

Urgent Care Clinical & Operational Model – In collaboration with the Chair and VP, the urgent care leadership team evaluated and recommended the proposed scope of services (services to be included and excluded), documented the definition of urgent care for the community and created an informational flyer, established clinical protocols for ambulatory management, and devised processes for management and transition of high acuity emergency patients who may present. Service scope and triage guidelines were established for urgent care (simple sutures, IV starts, x-ray, labs, vaccinations, sports physicals). It was strategized that this model be pediatric specific with services provided by pediatricians and supplemented by nurse practitioners – the pediatric focus would be the marketing edge of this service. Medical staff credentialing issues were addressed as to clinical scope of procedures and services performed in urgent care. The operational model was defined by geographic location and included the timeline of site roll out, hours of operation, and other key factors.

Human Resources – The urgent care leadership team developed the provider and staff recruitment plan with the Hospital's recruitment office. The plan included provider site staffing and provider mix, strategy for recruitment of pediatricians and advanced practice professionals, creative options for direct employment, contracting arrangements, moonlighting for existing staff, creative work shifts and scheduling, and use of locum tenens contracts. Planning non-provider staffing covered the staffing mix and ratios for the Registered Nurses, Medical Assistants and Techs and registration staff, pay scales, new position descriptions, onboarding, training, competency assessments, and creative scheduling. This was the most challenging aspect of the urgent care roll out as provider staffing and availability on evenings and weekends was critical as these shifts prove to be the toughest to fill.

Ancillaries & Supplies – Leaders from Lab, Radiology, and Pharmacy defined the requirements for those respective areas. Structure included point of care testing, required equipment, supplies,

processes for outside lab and radiology referrals, result reporting and interface with electronic medical record, pharmaceuticals storage on site with med select system, and charging conventions as an urgent care center.

Telecommunications & Information Technology

There was extensive analysis and evaluation of the decision to roll out the electronic medical record in the hospital based (emergency) vs. ambulatory electronic medical record (EMR). Decision makers included the urgent care leadership team, EMR and IT leaders, key providers, and administrative leaders. Several system reviews were conducted by this multi-disciplinary team and in-depth analyses of the pros and cons formulated. Recommendation was made to adopt the ambulatory EMR, which meant that the primary care EMR build would be updated to reflect the nuances of urgent care. This was very controversial as key professionals were very familiar with the emergency electronic system and advocating for its implementation. Decision to adopt the ambulatory EMR was based on the premise that the urgent care centers were to run as an ambulatory model, not an emergency model. Several months ensued to design the new urgent care build in the ambulatory EMR. This was followed by end-user training on the system, ongoing education of providers and staff on urgent care work flows, and establishing charge capture and billing in the ambulatory system. To assure effective training and support in the evening and weekend hours, an EMR SWAT team was developed to train and support providers and staff at each and every go-live.

Revenue cycle, Patient Accounting, & Finance

Revenue cycle processes were structured to capture urgent care registration, charge posting, billing, collection, and accounts receivable management. Point of service processes were created to clearly define patient and family responsibilities with co-pays, provision of health plan information, and expectations with billing and collection. Budgets were structured for each projected urgent care location and financial statements and financial reporting processes established. The Managed Care Department ensued ongoing negotiations with top payors for urgent care rates and coordinated with payors for the credentialing of new providers, communications of new places of service, and billing conventions.

Marketing & Public Relations

Branding of the urgent care services fell under the Hospital umbrella. The key strategy was to brand and market as a pediatric focused service as the urgent care centers would not be part of an adult health care delivery model. Several tactics and communications deliverables were developed for communications within the health care system and external to the community and patients and families who would be served. Internal communications to inform of the new services included staff presentations, email notifications, newsletters, and printed mailings to hospital employees. External communications to the community and patients and families were distributed via local billboards, newspaper announcements, and letters to homes in the market areas. Specific communications were created for families currently receiving services in the hospital system, so that information on urgent care offerings were shared throughout the primary care and ambulatory subspecialty practices.

Facilities

The administrative lead for hospital properties and the urgent care leadership team facilitated space planning. Development included finalizing the plans for building and space design, new property acquisition, lease arrangements, external and internal signage, and assessment for operational readiness. Facilities management included processes for maintenance, safety, cleaning, security, and designation of responsible parties and timelines.

Legal & Compliance

Several legal considerations were addressed such as the organization and reporting structure of the urgent care services. Also, accrediting (Joint Commission) and compliance (Medicaid, other) factors were evaluated for creating the service as ambulatory not emergency based. Compliance with commercial payor expectations was also taken into consideration.

The Urgent Care Medical Director, Operations Director, and Clinical Manager were delegated responsibility to drive the project management, daily oversight, and overall leadership of urgent care service implementation. The roll out schedule was expedited at request of the executive team. The initial location went live within four (4) months of plan approval by the Hospital executive team. The next two sites went live six (6) and nine (9) months later and the fourth site is scheduled to occur one year from the initial site go-live. Within a one year period, four (4) urgent care locations were planned and operationalized. The UC leadership team continues to meet weekly and the operational steering committee meets on a monthly basis to plan upcoming sites and evaluate the progress of the existing sites. The work groups meet on an ongoing, as-needed basis.

Lessons Learned

- Recruitment of providers dedicated to urgent care is very challenging, as it is difficult to pull together a dedicated pool of providers for evenings and weekends. Creative options for work schedules, compensation, incentives will facilitate the process. In retrospect, developing the provider coverage model within an existing provider structure at the hospital (hospitalists or primary care network) would provide a better opportunity to leverage providers' schedules. Start early with provider recruitment to give sufficient lead time to attract and schedule providers and be creative with scheduling and incentives to assure a firm base with capacity and flexibility.
- Knowing pediatric emergency, primary care, and subspecialty services, does not translate to knowing urgent care operations. Networking with pediatric urgent care providers can provide valuable information as to the pros and cons of infrastructure and the design of service options.
- Achieving urgent care volumes to break even requires a critical mass, which can be very challenging to achieve in a pediatric focused model. Volume growth builds as patients and families shift from expensive emergency care options and seek timely services at convenient site locations that promote a quality pediatric experience.
- Loading urgent care on top of established services in the same building space requires negotiation and planning. Competition for exam rooms and work space may resurrect, especially when the operational hours overlap. Some facilities turned out not to be the right fit and now other properties are being scouted.
- Structuring urgent care in a hospital-owned ambulatory model was accomplished through change up of many hard wired processes. Hospital systems were impacted; more than anticipated. Every operational, revenue cycle, and information system was reconfigured for urgent care. Teamwork throughout multiple departments and with professionals at all levels was required to design, reformat, and roll out operational support in short order.

- The initial plan for six (6) new urgent care sites in one calendar year was aggressive. Four (4) sites were accomplished within the one year timeframe amidst other Hospital priorities for growth and expansion.

Recommendations

- Be flexible and open to a variety of alternatives and options. Keep an eye on the external environment and the pulse of change in the market. Competitors may move in new directions, which may escalate and drive realignment of your short and long term plans.
- Solicit engagement by key stakeholder areas and don't forget about the support staff behind the scenes. Your urgency is not necessarily the supporting departments' urgency; buy-in and support are critical for a timely go live. Continual communication and engaging stakeholders at all levels build team support for new initiatives.
- Celebrate your success – it happens because of great people. Make sure that they know how much you appreciate their passion and engagement as embarking on new ventures takes dedicated time and resources to execute successfully.

Endnotes:

Gindi, R. & Jones, L., (2014). Reasons for Emergency Room Use Among U.S. Children: National Health Interview Survey, 2012, *NCHS Data Brief*, 160

American Academy of Pediatrics (2005). Pediatric Care Recommendations for Freestanding Urgent Care Facilities, *Pediatrics*, 116(1)

Boyle, M. & Kirkpatrick, D. (2012). *The Healthcare Executive's Guide to Urgent Care Centers and Freestanding EDs.*, Danvers, MA, HealthLeaders Media

Yee, T., Lechner, A., & Boukus, E. (July 2013). The Surge in Urgent Care Centers: Emergency Department Alternative or Costly Convenience? *HSC Research Brief*, 26

Urgent Care: Planning a Regional Model

Manuscript Tags

Key paragraph:

This case study focuses on a health system's creation and implementation of an Urgent Care regional model. Market changes escalated the development of a strategy with layout of a geographic plan for urgent care services in the system's primary and secondary markets. Objectives of this case study are to share insights on the evaluation process, analytics to support decision making, and the development of the project management plan for urgent care operations. The plan addresses the clinical model, human resources, revenue cycle and billing, marketing and communications, facilities, legal and compliance and key factors for success.

Key words:

Urgent Care, Regional Strategy, Urgent Care Strategy, Urgent Care Model, Urgent Care Operations, Change Engagement, Project Management, Market Analysis, Financial Modeling