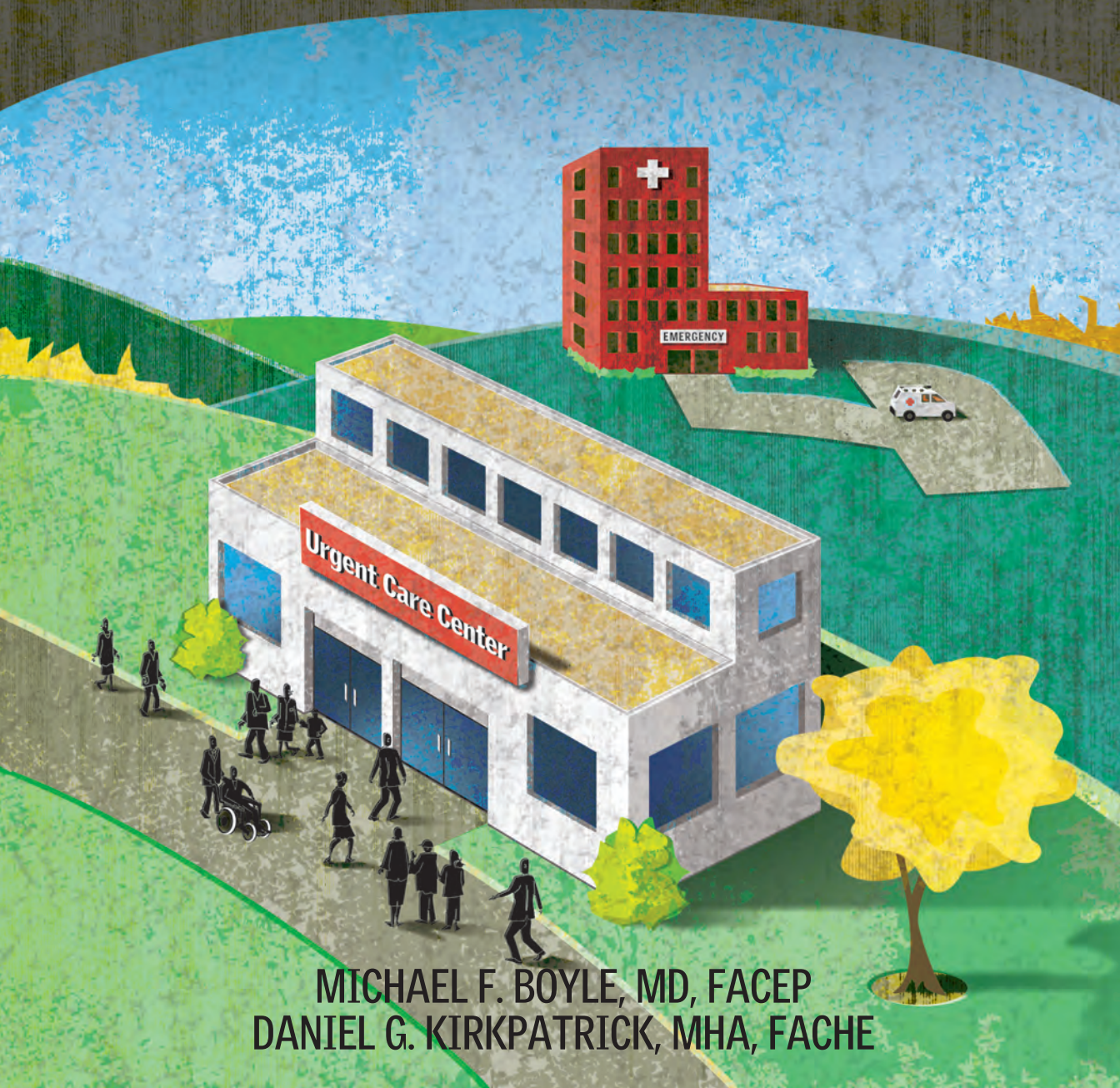
THE HEALTHCARE EXECUTIVE'S GUIDE TO URGENT CARE CENTERS AND FREESTANDING EDs



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Dr. Boyle has traveled extensively providing consultation for emergency department management, hospital wide flow improvement, and patient satisfaction. His main focus is hospital-affiliated programs for emergency services, occupational medicine, and urgent care. Dr. Boyle currently oversees three urgent care sites, and he will soon be opening an additional urgent care and free standing emergency department. Dr. Boyle received his degree from Eastern Virginia Medical School in Norfolk, Virginia, and completed his emergency medicine residency at Wright State University of Medicine in Dayton, Ohio.

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Daniel G. Kirkpatrick, MHA, FACHE, has more than 30 years of healthcare management experience in consulting, staff, and administrator roles. He leads

client services at BestPractices, Inc., an emergency medicine leadership and staffing practice affiliate of EmCare. Mr. Kirkpatrick has extensive consulting experience working with group practices and hospitals in meeting operational/financial goals, as well as enhancing service, leadership, safety, and sustainability performance.

Prior work experience in public accounting, administrative roles in hospitals (for-profit, nonprofit, specialty medical-surgical, and behavioral health), and extensive practice management for medical practices (primary care, specialty, and hospital-based) provide him sensitivity to the complex issues confronting healthcare providers. Dan holds a BA in Psychology from the College of Wooster and an MHA from The Ohio State University.

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—Michael F. Boyle, MD, FACEP

I've had the privilege of befriending and working with Mike Boyle over the past six years, and a truer colleague doesn't exist! Having this opportunity to collaborate on a work that "teases out" some of the nuances of this burgeoning field of urgent care medicine has been wonderful.

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—Daniel G. Kirkpatrick, MHA, FACHE

Introduction

The intent of this book is to provide both the healthcare executive and entrepreneurial physician basic tools to research and consider implementing an urgent care center. The following are the major aspects of urgent care centers covered in this book:

- The major political changes leading to the development and rapid increase of urgent care centers and freestanding emergency departments (ED) in the past five years
- The certificate of need and other statutes for the corporate practice of medicine regarding urgent care centers
- The different types of urgent care, including retail clinics, cash clinics, moderate- and high-level urgent care, and freestanding EDs, along with indications for the development of each
- The five basic reasons for a healthcare system to expand into the urgent care market
- A step-by-step analysis of the urgent care business plan development process, urgent care site selection, and proforma development

- The various staffing levels required based on the intent of the urgent care site including medical technicians, licensed vocational nurses, registered nurses, nurse practitioners, and physicians
- The basic marketing plans and patient satisfaction methods to promote growth and volume for the site
- The benefits of developing a full-service occupational medicine program
- The methods for urgent care center expansion, such as the performance of physical examinations, travel medicine, and immunization clinics
- The unique challenges faced by freestanding EDs

We hope that this information provides adequate guidance for administrators in the basic understanding of urgent care programs. In addition, we strive to provide the physician with necessary information for the development of an urgent care site in the hope that appropriate planning leads to future success of the clinic.

CHAPTER 1

Healthcare Market for Urgent Care Centers and Freestanding EDs

Healthcare costs continue to escalate in both the public and private sectors. Reasons for this include the increased cost and availability of advanced technology (e.g., MRI, CT), poorly controlled costs with end-of-life care, overtesting by providers due to fear of litigation, overtesting at the demand of the patient (e.g., MRI tests for back pain), fraud and abuse of Medicare/Medicaid, excessive charges for prescription drugs, and cost shifting by hospitals to cover uninsured and/or indigent care, among others.

The economic downturn in 2008, starting with the collapse of the mortgage industry, has resulted in further pressures on the U.S. healthcare system. For example, the unemployment rate was more than 9% in 2011,[1] which lead to people losing healthcare coverage, delaying elective surgeries, and forgoing treatment. The current economic climate has still not yielded answers or improvement to rising healthcare costs. U.S. companies continue to decrease reimbursement for healthcare coverage by increasing cost sharing (increased copays) with employees or eliminating coverage altogether.[2]

As a result of these market pressures, the number of people without insurance has escalated and will likely exceed 50 million in 2012.[3] This number does not include people who are underinsured. A significant number of the uninsured population is probably unable to afford the average $1,500 per month cost of insurance. There is, however, a select population of young and healthy employed individuals who elect not to purchase health insurance and play healthcare roulette by avoiding the premium expense.

Changing Insurance Landscape

As health insurance has gone from covering only catastrophic healthcare events, which are a large cause of financial ruin and bankruptcy in the United States, to routine care, the general public has the expectation that there will be very little out-of-pocket expense. But now, the pendulum is rapidly shifting to greater costs forced onto the consumer and away from the employer as companies eliminate coverage or increase the portion employees pay.

The original intent of insurance was the development of financial risk shifting from the patient to the insurance carrier.[4] Due to the economic conditions after World War II, wage increases were frozen by the government, forcing employers to look for alternative incentives to improve a financial package for prospective employees. This was the beginning of the provision of healthcare and other benefits as a means to supplement income, also known as the "fringe benefit error." Employer-sponsored health benefits were untaxed income to the employee. But during the past few decades, insurance benefits have grown from simple catastrophic care to include routine physical exams, health

screenings, prescription drugs, and hospitalization. These added benefits come with a cost to the purchaser of the policy: the employer.

The cost of healthcare became too high for many employers to continue to foot the bill, in part because, with limited out-of pocket costs, consumers often utilize greater healthcare services. The classic example of this trend is end-of-year medical care. After consumers have used up their annual health insurance deductible, they will try to schedule an elective surgery or colonoscopy screening because of the decrease in the out-of-pocket costs they are responsible for once their deductible has been met. If the procedure or test will not cost the consumer money, utilization will likely be higher.

Between 2000 and 2009, employer-sponsored private health insurance declined from 67% to 58%.[5] As a result, patients became more responsible for their personal healthcare costs through increased copays, provision of their own insurance, or paying out of pocket for healthcare services. It is likely that patients will be more discriminating in expenditures when cost of care comes out of pocket versus from an insurance company or government source. Part of the discrimination will include both cost and quality—especially as this type of information becomes more easily accessible and just a keystroke away on the Internet through the Hospital Compare and Hospital Consumer Assessment of Healthcare Provider and Systems websites. Patients are also becoming better-educated consumers of healthcare.

Major purchasers of healthcare will begin to steer patients to more cost-effective alternatives to receive care, such as urgent care centers versus hospital emergency departments (ED). One major change is the source of healthcare funding. In our

experience as a large provider of emergency and urgent care services, 2011 was the first year that Medicare and Medicaid accounted for greater than 50% of all billed patients, which means that the bulk of healthcare is financed by state and federal resources. The majority of healthcare costs involves hospital care, physician/provider fees, and prescription drugs.

Costs of Care

Much of our discussion reviews costs of care and patient charges. In this context, we use cost to identify how much it costs healthcare facilities to provide the care. From the patient aspect, we identify charges as the fee paid by the patient.

In some cases, the cost of caring for a patient in urgent care clinics may be lower and the charge to the patient for this care may also be lower in urgent care clinics. The reason for these differences in cost is most often related to the lower overhead of these types of facilities (e.g., size of the facility and the cost of staffing). Retail clinics, for example, often have minimal space and are staffed by a single nurse practitioner resulting in both minimal costs and minimal charges.

As urgent care clinics grow in complexity, from offering basic to advanced services, the clinic must pay for additional office space and staffing requirements, such as clerical personnel, that result in both cost and charge increases. Obviously, staffing urgent care centers with physicians versus nurse practitioners or physician assistants is a more expensive alternative but would be required to deliver higher levels of care.

When the urgent care center is affiliated with a hospital, it will often see and treat all patients (including Medicaid and self-pay) without collecting fees prior to delivery of services resulting in bad debt and cost shifting, whereas privately owned facilities sometimes do not accept Medicaid or self-pay patients unless cash is paid up front.

As we discuss later in Chapter 6, a major cost advantage of urgent care clinics over EDs is the lack of overnight coverage. EDs must have the staff available 24 hours per day, 7 days per week, which can be expensive when volumes are typically lower from the hours of 2 a.m. until 7 a.m. Urgent care clinics are usually open during peak flow hours and benefit during the entire time of operations, which maximizes productivity and minimizes costs.

A key point for both healthcare executives and governmental officials to understand, however, is the vital need for full-service, hospital-based EDs and the unique reasons for differences in both facility cost and patient charges. The number of EDs in the United States continues to decline in the approximately 4,700 hospital-based facilities nationwide. According to *USA Today*, closures of nonrural EDs exceeded 27%, with a drop from 2,446 to 1,779 from 1990 through 2009.[6] Yet, our nation's EDs represent only 3% of the national healthcare expenditure, which exceeds $2 trillion dollars.[7] The general population, media, and politicians believe that EDs are expensive places to receive care, but when you understand the fundamental staffing costs of an ED visit at 2 a.m., the marginal cost for an emergency visit is actually very low.[8]

On the other hand, the cost to keep an urgent care clinic open past 11 p.m. may be too high to remain viable, suggesting that EDs are still the most viable option in the late evening and early morning hours for some nonemergent cases. According to Robert Williams, MD, the marginal costs of care for minor patient injuries are low in the ED.[9] We firmly believe that both costs and charges for nonemergent cases can be reduced in urgent care clinics but argue that urgent care centers that stay open 24 hours per day lose a significant component of costs savings and result in charge increases.

Access to Care

One of the key challenges the U.S. healthcare industry grapples with is access to care. There are roughly 50 million Americans who lack healthcare insurance.[10] Healthcare reform addresses this need and offers funding paying for services. According to the Congressional Budget Office, more than 30 million Americans will have access to healthcare coverage when healthcare reform under The Patient Protection and Affordable Care Act (PPACA) takes effect.[11]

Yet, providing healthcare coverage to more Americans does not ensure healthcare access. Coverage also must provide competitive reimbursement to have physician practices open their doors to these patients, as we learned from Massachusetts healthcare reform. In 2006, the state of Massachusetts mandated universal healthcare coverage. The law stated that residents of Massachusetts obtain a state government-regulated minimum level of healthcare insurance coverage. It provides free healthcare insurance for residents earning less than 150% of the federal

poverty level (FPL) who are not eligible for Mass Health and also partially subsidizes healthcare insurance for those earning up to 300% of the FPL.[12]

The state covered more than 430,000 patients, combining individual mandates, insurance reforms, and publically subsidized insurance product starting in 2006.[13] The majority of these patients were covered through the state's Medicaid program that eliminated costs as a factor for avoidance of healthcare that has been suggested by many.[14] Massachusetts boasts one of the highest primary care physician–to–population ratio compared to many states, but many residents continue to have difficulty with access to care.[15] ED utilization continued to increase despite healthcare reform, and access to care continued to be problematic for the newly insured population.[16] Primary care physicians with closed patient panels may be a significant reason for access issues despite the increased per-capita availability of physicians in Massachusetts.[17]

Roughly 60 million Americans, or nearly one in five, lack adequate access to primary care due to a shortage of primary care physicians in their communities.[18] In many areas, access to primary care is challenging even for patients who have an established relationship with a physician. Same-day or next-day appointments are still difficult for these patients to obtain.[19] People without insurance have little to no access to a primary care office outside of urgent care centers and EDs for minor medical conditions. Evaluation for minor illness and injuries are often referred to the ED rather than being seen in the private office, and fewer physicians accept patients with Medicaid due to poor levels of reimbursement.[20]

Physician access is further impaired by shortages of primary care providers across the United States, with a projected deficit of more than 60,000 physicians by 2015.[21] According to the American Association of Medical Colleges, up to one-third of the physician population will retire in the next decade.[22]

One solution to access includes a change in the continuum of care. Many primary care physicians will become responsible for health maintenance, routine care of common medical conditions (e.g., asthma/chronic obstructive pulmonary disorder [COPD], diabetes, hypertension, etc.), with little time to focus on acute illnesses. Urgent care centers fill in this niche to deliver unscheduled healthcare services for illness and injuries. Expansion of hours beyond normal physician office hours and offering weekend and holiday access makes urgent care centers a vital component in the healthcare system that can help answer the need for increased patient access to healthcare.

Urgent care centers can also reduce costs of care, alleviate the strain of over-stretched hospital EDs, and become profit centers when planned and managed appropriately. According to the Urgent Care Association of America (UCAOA), there are more than 8,700 urgent care centers in the United States, with projected growth of 300 additional centers per year. Most of these sites are owned by physicians or physician groups, with less than 30% being under hospital or healthcare system ownership.[23]

SUPPORTING URGENT CARE

To our knowledge, there are three national organizations dedicated to providing resources, education, and leadership for the urgent care practice of medicine. These include:

The Urgent Care Association of America (UCAOA) founded in 2004 (*www.ucaoa.org*)

The National Association for Ambulatory Care (NAFAC) founded in 1973 (*www.urgentcare.org*)

The Convenient Care Association (CCA) founded in 2006 (*www.ccaclinics.org*)

This list excludes professional practice associations with urgent care sections, including the American College of Emergency Physicians, American Academy of Family Physicians, American Association of Pediatrics, and the American College of Physicians.

During the past decade, retail urgent care clinics, also known as miniclinics or convenient care clinics, have also grown in popularity. These clinics are located in retail stores, such as Walgreens, CVS Caremark, and Walmart, and are focused on providing convenient access to care for minor medical conditions and immunizations. There are currently more than 1,000 retail medical clinics located in national pharmacy and grocery store chains.[24]

In addition, freestanding EDs—both hospital affiliated and private venture supported—are starting to appear in large urban areas. The American Hospital Association estimates that there are approximately 179 freestanding EDs, with the majority being hospital or healthcare system owned.[25]

WHAT PATIENTS WANT REGARDING NONEMERGENT CARE (BASED ON DEMOGRAPHICS)

1. **Young families** want care that is quick and available after hours.
2. **Young urban professionals (YUPPIE)** may be insured or uninsured but know that they have options in healthcare. They will discriminate based on price and convenience, and they have the resources to do so.
3. **Baby boomers** know what they want from healthcare providers. They are time and price conscious and will change providers for better, cheaper service.

Market competition plays a role in the development and expansion of both urgent care centers and freestanding EDs. Entrepreneur physicians and investors target markets capturing the insured population, similar to the boutique hospital competition for orthopedic, cardiovascular, and oncology services. Until now there have been limited choices for patients seeking access to immediate care, so by default hospitals have been receiving the revenue from paying patients for the treatment of minor ailments. Now, competition from urgent care centers can erode the patient population utilizing traditional hospitals for these services and result in financial struggles for these same hospitals. Healthcare executives should consider what the needs will be for the influx of newly insured Americans as a result of PPACA. Urgent care delivery models are one solution to providing cost-efficient medical care for those that are insured, on Medicaid, Medicare, or self-pay.

Defining Urgent Care Facilities

In general, an urgent care center is defined as:

The delivery of ambulatory care in a facility dedicated to the delivery of medical care outside of a hospital ED, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an ED. Often urgent care centers are not open on a continuous basis, unlike a hospital ED, which would be open at all times.[26]

However, there is a mixed opinion among healthcare providers on what exactly constitutes an urgent care facility. For example, some healthcare professionals exclude retail medical and cash clinics from the definition of urgent care centers. We believe, however, that retail clinics are part of the entire spectrum of care and include these sites in our definition (see Figure 1.1 and Figure 1.2). We define urgent care facilities as follows.

Retail medical clinic: These sites are typically one or two rooms located in retail pharmacies, grocery stores, or chain stores. Staffing is a single provider, most often a nurse practitioner. These clinics are usually open during store hours, making visits convenient. They provide care for minor medical ailments, medical screening for cholesterol and diabetes, and provision of immunizations.

Cash clinic: These sites are commonly developed or sponsored by large healthcare organizations. They are most often cash only and provide a menu of options for care, including basic examinations, charge for additional lab work, and may perform minor procedures. They provide low-cost care for minor illnesses and

FIGURE 1.1
URGENT CARE SPECTRUM

Physician office	Routine care, chronic care, and health maintenance
Retail clinic/cash clinic	Minor illness care (sore throat, upper respiratory infection, urinary tract infections, and rashes), immunizations, and minor injuries (sprains, strains, and simple lacerations)
Moderate urgent care	Greater testing ability, waive testing, and care for the above illnesses, extends to more advanced injuries that require an x-ray
Advanced urgent care	Advanced injuries including fracture care, intravenous fluids therapy, repetitive dose aerosol breathing treatment, advanced diagnostics including computed tomography (CT) scans for evaluation of head injury, kidney stones and abdominal complaints
Freestanding ED	Care for all levels of injury—minor to advanced, typically exclude major trauma, may treat and stabilize all levels of medical care, typically include advanced imaging (CT, plain film radiography, ultrasound), full service lab
Acute care hospital	Care for all levels of illness and injury, including major trauma

injuries. Some have been developed as medical homes and are often staffed by nurse practitioners to maintain lower costs.

Urgent care center: These sites provide various levels of service, ranging from minor testing to complete labs and radiographic capability, approaching levels of an ED. Most centers are open extended hours, with some providing care 24 hours per day. They do not accept ambulance traffic and are most often staffed with

FIGURE 1.2

LEVELS OF URGENT CARE DEVELOPMENT

Basic level urgent care	Site with 1–3 beds: Limited waive testing, hours 8–12, with some weekend and afterhours component, (may be cash clinic or retail clinic)
Basic level urgent care	Site from 2–6 beds: Expanded waive testing, hours 8–12, with some weekend and afterhours component, no x-ray
Moderate level urgent care	Site from 6–10 beds: Expanded waive testing, hours 8–12, with some weekend and afterhours component, EKG, basic plain film x-ray
Moderate level urgent care	Site from 6–10 beds: Expanded waive testing, draw station with same day results, hours 12 or greater, with some weekend and afterhours component, basic plain film x-ray
Advanced level urgent care	Site from 6–10 beds: Waive testing with point of care blood tests, hours 12 or greater, with expanded weekend and afterhours component, EKG, basic plain film x-ray and CT scanning +/- ultrasound
Advanced level urgent care	Site from 6–10 beds: Expanded waive testing with point of care and on-site STAT lab (CBC, comprehensive metabolic, liver function tests), hours 16–24, open 7 days per week with afterhours component, EKG, radiology/Imaging center (plain films, ultrasound, CT scan)
	Freestanding emergency department

family practitioners, emergency physicians, nurse practitioners, physician assistants, or experienced internists.

Freestanding emergency departments: These sites provide all levels of care and stabilization, with the exception of those requiring major procedural interventions, such as a cardiac catheterization lab. Most freestanding EDs do not have the capability to admit patients but may provide extended observation for cases

including gastroenteritis and asthma. They are usually hospital owned, but many recent centers have been private ventures supported by physicians.

The above definitions do not include free clinics or physician offices providing some urgent care services. In Chapter 2, we briefly discuss federally qualified healthcare clinics as a hybrid model under cash clinics. Our concept for this book was to avoid the medical home and focus on episodic care of illnesses and injuries.

ED and Urgent Care Interface

Urgent care centers are a potential source to decompress hospital EDs. ED visits continue to grow, with more than 123,000,000 patients in 2008, according to the Centers for Disease Control and Prevention (CDC). Many experts argue that up to one-third of these patients could be seen in other facilities; however, the American College of Emergency Physicians estimates that only 8% of these patients present for nonurgent medical care.[27] According to the CDC, only 12.1% of emergency visits are nonurgent and can be delayed or wait 2–24 hours for care. These statistics are significantly lower than the numbers espoused by the general media.

The majority of ED overcrowding is related to inpatients boarding in the ED.[28] The U.S. baby boomer population is aging, resulting in increased use of emergency services by geriatric patients with more complex medical histories that require longer and more detailed medical evaluation than younger patients. This patient group often requires hospitalization, further straining in patient hospital

capacity. In the United States, there are approximately 5,800 registered acute care hospitals, with close to 950,000 hospital inpatient beds. Hospital inpatient capacity has also been significantly reduced as reimbursement changes occurred for inpatient care during the 1980s related to the Tax Equity and Fiscal Responsibility Act.[29]

Emergency departments are also affected by federal regulations for patient care unlike physician offices, private hospitals (not accepting Medicare or Medicaid), and clinics. Acute care hospitals that accept funding from Medicare and Medicaid programs are required by federal law through the Emergency Medical Treatment and Active Labor Act (EMTALA) to provide a medical screening exam and stabilizing treatment to any patient presenting to the facility with an emergency medical condition. If an emergency medical condition is not found, the patient may be referred to other facilities for care.

Given increased volumes of patients seeking treatment in EDs, strains on inpatient capacity, and the reduced number of hospital-based ED facilities, there is a vast opportunity for EDs and urgent care centers to work harmoniously to better deliver care to patients. The development of a strong relationship between the two types of facilities will be critical for smooth patient transitions. Depending on the level of care and staffing, most urgent care centers will need to transfer higher-level cases to the ED, for example patients with acute stroke symptoms. Likewise, to decrease utilization of the ED by nonemergent patient volume, many hospitals have developed screening programs that refer nonemergent cases out of the ED. In addition, urgent care centers can also serve as a temporary referral site for ED cases including wound checks, cellulitis rechecks,

follow-up evaluation for musculoskeletal injuries, and follow-up evaluation from hospital discharge.

For example, Memorial Hermann Healthcare developed an ED screening program in 2003. The program uses nurse practitioners to screen patients with a set of clinical protocols and then refer patients without an emergency medical condition to a local cash clinic.[30] This clinic was supported and staffed by the healthcare system. In addition to these types of cash clinics, several hospitals are actively referring patients to local federally qualified healthcare centers after ED care has been provided. The desire is to reduce unnecessary ED visits for minor conditions.[31] These programs benefit the patient by providing a medical home, benefit the clinic with volume growth, benefit the hospital by alleviating overcrowding in the ED, and benefit the state by reducing healthcare costs.

By working more closely together, hospital EDs and urgent care centers can better provide the appropriate level of care to patients in the appropriate setting and potentially reduce healthcare costs. The goal should be for the right patient to be cared for at the right facility for the lowest cost.

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THE HEALTHCARE EXECUTIVE'S GUIDE TO URGENT CARE CENTERS AND FREESTANDING EDs

Michael F. Boyle, MD, FACEP
Daniel G. Kirkpatrick, MHA, FACHE

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