Addressing the Data Drought

Urgent message: The second UCAOA Benchmarking Survey takes one small step toward filling the information gap in urgent care medicine.

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Although the practice of urgent care medicine is not a new phenomenon, there is a significant absence of reliable information about the industry.

One first step toward filling that void was initiated last year when the Urgent Care Association of America's Benchmarking Committee released the results of its first-ever benchmarking survey of UCAOA members and others in the industry. Results of this year's survey were released during the UCAOA Annual Convention in Daytona Beach, FL, last month.

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Both surveys share the common goal of beginning to gather data in specific areas of interest to urgent care owners, administrators, and practitioners. More rigorous study and surveys of greater depth are a priority for UCAOA and are planned for the upcoming years.

Among the issues covered in the first survey were hours of operation, ownership structure, payor data, per-patient charges, and more.

While UCAOA members are the first to see the results, the association's perspective is that the survey can play a small role in addressing the information needs of the entire urgent care industry.

An Overview

The latest survey was sent to individuals representing 1,200 urgent care practices in the United States, with a response rate of 13.4%. (For purposes of the survey and this article, a "practice" is defined as the total medical operation, while the word "clinic" will be used to describe a single, individual location; in other words, a practice may consist of any number of clinics under the same practice ownership). Respondents hailed from 40 states, with the majority representing Florida, Michi-

gan, Ohio, Texas, California, Georgia, and Illinois.

One of the important tenets of the committee's strategy is to ask some identical questions from year to year so, over years to come, trend lines might be identified in certain areas.

One of those areas pertains to the corporate structure of the practices (i.e., who owns them?). Results in 2006 indicated that about 47% of the responding practices were "freestanding" and 26% were "hospital-owned." One year later, the freestanding practices continue to pull ahead of the hospital-based practices, moving to 53% while hospitals fell to 23%.

The survey also posed a new question about whether practices were established as for-profit or not-for-profit ventures—and 74% of respondents report that their practices are for-profit. The majority (55%) of responding practices are also "solo" practices, meaning they are a one-site operation. Only 9% claim more than six clinics.

And while those clinics are busy, the average number of patients per clinic among the respondents has actually declined since the 2006 survey, falling to approximately 9,923 per clinic per year from last year's figure of 15,455. The perceived drop-off in patients-per-clinic could be a statistical anomaly grounded in the growth of the industry, however; an increase in the number of clinics that have been in business for a short period of time may be driving down the overall patient per clinic average.

Distribution
1,200 urgent care practices in the U.S.

Response rate
13.4%

Areas covered
Urgent care structure and organization
Facilities and operations
Patients and staffing
Patient record charting
Financial
Profitability

Staffing Models

Of the many questions posed to UCAOA staff, board members, faculty, and forum participants, the most prevalent concern staffing of urgent care practices: How do you decide how many physicians you need? How many mid-levels? In what ratio? This year's survey presented at least a snapshot of how participating practices are staffed, currently.

Staffing arrangements with physicians are split almost evenly between two models:

- employed practitioners (50%), and
- a combination of independent contractors (26%) and a mix of employed practitioners and independent contractors (24%).

A similar ratio exists among mid-level providers, with a slight advantage going to employed practitioners at 65%, and independent contractors or mixed splitting the remaining percentage.

Some of the most eagerly anticipated results were the ratios of different levels of staff to each other. For example, responding practices, on average, employ 3.47 physician assistants (PAs) or nurse practitioners (NPs) and 2.37 registered nurses (RNs) for every one physician.

For every RN hour, there are 0.46 hours of clerical staff time, and there are 2.21 radiology technician hours spent to every PA or NP hour. While these are complex calculations averaged over all responding practices, they will probably not hold true for all practices. Nonetheless, these results can be a good place for practices to start when looking at their own ratios.

Time Spent Per Patient

Another interesting finding concerns time spent per patient by different practice staff; these data show where the time of these individuals is going during a typical patient visit.

Physicians at responding clinics are spending approximately 19 minutes per patient, on average. Nursing assistants claimed the most time, edging out physicians by only one minute, with clerical/registration staff bringing up third with 17 minutes.

The Business of Medicine

Another area of the survey focused on the financial side of urgent care practice. How and when are practices

charging their patients? Who's paying for the care? Are urgent care practices profitable?

The results indicate that most practices (60%) charge patients as a part of registration. However, who actually *pays* for the care is much more spread out.

With regard to governmental payors: the majority of respondents reported that Medicare receives only about 10% of their charges, and Medicaid even less.

Private insurance is much more prevalent, with 67% of respondents billing private insurance companies between 30% and 70% of the time. Private pay makes up less than 20% of most practices, with workers compensation accounting for similar levels.

To bill and collect the patient fees, the vast majority (77%) of responding practices currently use in-house staff vs. contracting with outside vendors, to varying levels of success. Only 22% are collecting over 90% of their charges, and fully 41% of practices are collecting 70% or less. About half of the responding practices offer a "prompt" pay discount (generally, no more than 20% off if paid in full at time of service).

The good news is, almost everyone who responded is profitable, or at least breaking even (66% and 20%, respectively). The bad news is, if an urgent care practice is *not* in the black yet, it may take a while according to these results, as 30% of practices responding took longer than one year to reach profitability. Almost 10% made it in less than three months, however, and the results here show that after the first clinic is profitable, the second can reach profitability much more quickly—54% of those made it in less than nine months.

When it comes to reimbursement, only 16% of respondents are being reimbursed using problem-based coding. The moral of that story: Efforts toward more customized reimbursement for urgent care still have a long way to go.

While the same could be said for benchmarking data specific to urgent care medicine, the UCAOA surveys provide the basis for dialogue about how some practices are building on the foundation they have established. Subsequent UCAOA surveys are expected to take that initiative to the next level. ■

Note: The ability to draw broad conclusions from the results of this survey is limited by the small sample size and low response rate. However, as the only available source of data, the benchmarking survey provides unique, early insights into the urgent care field.