

# Practice Management

## Urgent Care Solutions for Health Systems to Improve Access

**Urgent message:** Although the Patient Protection and Affordable Care Act expands health insurance coverage to millions of previously uninsured, many of the newly insured grapple with lack of access to quality, on-demand care, which leads to increased emergency department use. Urgent care provides a solution for health systems to expand access, reduce the number of unnecessary emergency department visits, and realize the goal of integrated population health management.

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### Introduction

Integration of urgent care centers into large health-care systems enables improved access for patients and provides outstanding care for minor acute illness and injuries at cost-efficient prices, creating a viable alternative to emergency departments (EDs). Population health care requires patient access, integration throughout the health-care system (preventive care, primary health care, tertiary care, and return to the community), cost-effective measures for care, and quality review to ensure appropriate care provision. In shifting to population health care and bundled payments, administrators must understand the beneficial cost aspects of urgent care programs and increasing competition from for-profit vendors.

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### Urgent Care Overview

Urgent care facilities provide unscheduled evaluation and treatment for minor illness or injuries. The spectrum of services provided varies based on the population served and purpose of the site. Urgent care centers often expand services to include immunizations, occupational medicine, health promotion, sports and executive physical examinations, physical therapy, and preventive medicine (smoking cessation and weight loss).<sup>1</sup> These sites are often distinguished by size, capability, and purpose.

This review broadens the traditional definition of urgent care services to include any location where >50% (exclusive of federally qualified health centers, or FQHCs) of medical care is unscheduled and episodic in nature, exclusive of location (telephonic, via the Internet, or in person), the method delivered, or level of the provider responsible for care:

- Cash-only clinics
- Centers in grocery stores, drugstores, and mass retailers (e.g., Walgreens, Target)
- Hospital-affiliated urgent care centers
- Private urgent care centers (physician-owned, corporate-owned, venture capital-owned)
- Community health clinics and FQHCs (because of the possibility of their ability to provide unscheduled care for episodic injury or illness, behavioral health, and dental services)

The definition excludes the following:

- Hospital-based EDs
- Freestanding EDs
- Free clinics

### Lack of Access Drives Emergency Department Use

EDs have historically served as the safety net in health services for uninsured or underinsured patients. Patients with similar complaints cared for in EDs versus urgent care centers are charged far different amounts. ED charges are skewed by hospital cost-shifting and unreimbursed care. In addition, ED charges often far exceed actual collections by over 70%.<sup>1</sup> Urgent care clinics, on the other hand, have much lower overhead and provider costs, resulting in an overall lower cost structure. Use of EDs versus urgent care clinics varies by geographic location, social class, and payor status. Charges are far different than actual costs of care, as all hospital administrators are well aware. Though the marginal costs of ED care for patients with lower-acuity illnesses and injuries may be as low as \$24, the patient charges are far higher.<sup>2</sup> Comparison of the cost of care (without

any testing) for the patient with a simple sore throat suggests that the following are an average range for the patient or insurers:

- Cash clinic: \$45–\$50
- Retail clinic: \$65–\$75
- Urgent care: \$100–\$120
- Primary care: \$120
- ED: >\$200

Access to care is often a limiting factor causing increased use of EDs for lower-acuity conditions.<sup>3</sup> Even for patients who have insurance, urgent same-day or next-day appointments are difficult to obtain from primary-care providers. The reasons for this lack of access vary, but they include a lack of primary-care physicians, which is predicted to worsen, with a projected deficit of over 20,000 providers by 2020. Passage of the Patient Protection and Affordable Care Act of 2010 (PPACA) means that another 30 million patients may become insured, further straining access. As Massachusetts experienced when it mandated that all residents carry health insurance, improvements in coverage without increases in access result in volume increases for EDs of patients with lower-acuity illnesses and injuries.<sup>3</sup> Urgent care centers provide a solution to this challenge, but they must include extended evening and weekend hours; the most common hours of operation are from 9 a.m. to 9 p.m.

### Increasing Access Requires New Care-Delivery Channels

Access to health care in 2014 occurred telephonically, via the Internet, at retail clinics staffed by nurse-practitioners and physician assistant, in urgent care centers, at primary-care offices, and in EDs. One of the fundamental flaws in the Massachusetts health-care reform program and many state Medicaid programs is the lack of access with the alternative of no care or trip to the ED.<sup>4,5</sup> With the advent of PPACA, new alternatives for patient access require exploration. The following section describes types of access (telephonic versus in person), followed by levels of access (retail clinic to complex-level urgent care).

Telemedicine recently gained acceptance with corporate integration, insurance carrier support, and health-care system use.<sup>6</sup> Communication via telephone between family physician and patient has occurred for many decades. Recent programs allow triage to be conducted via computer software, where patients are screened by a nurse or allied health-care provider and forwarded to a physician available to take the patients'

calls. Patients with higher-acuity conditions are screened out at the triage point and referred to providers of higher levels of care. Most such programs do not permit prescribing of narcotic medications, and there is very limited prescribing of psychotropic medication. Pricing ranges from \$45 to \$60 per call, with patients' prescriptions electronically transmitted to a preferred pharmacy. Fees are often completely covered by the patient's insurance; if not, the patient may pay out of pocket, often in the range of \$49.<sup>7</sup> The majority of these patients use such services for the convenience and lower costs that they offer.<sup>6,7</sup> Diagnoses are similar to those seen in retail clinics, including a large number of cases of urinary infections (Table 1).

Focusing on the traditional bricks and mortar, urgent care centers are far more efficient than many EDs. Data from the most recent survey by the Urgent Care Association of America show that there are over 9000 urgent care centers in the United States, with an expansion rate of 300 to 400 new centers per year, excluding retail clinics.<sup>4</sup> This article describes the entire spectrum of services and several proposed models for integration, along with coordination of services within a health-care system. Strategies for these programs depend on the intent and objectives to be met.

Much of urgent care center growth was spurred by anticipated volume increases from newly insured patients after passage of the PPACA. With health reform, shifts are occurring away from a fee-for-service model toward population health care. This change relies heavily on controlling costs of care and provision in the most cost-effective environment while maintaining equal quality of care. To assist this reduction of health-care costs, it is critical to develop health-care options for a patient safety net rather than EDs. Urgent care centers provide potential solutions for rapid and unscheduled care at a cost-effective price.

Further aggravating the access challenge is that the number of nonrural EDs has decreased from 2446 in 1990 to 1779 in 2009 because of financial instability and lower profit margins.<sup>4</sup> At the same time, the number of ED visits continues to escalate, and now exceeds 130 million patients, producing prolonged waits and unsatisfied patients. The reasons for this are multifactorial, but congestion of patient beds and holding of patients awaiting admission to the hospital are a primary result rather than large volumes of patients with lower-acuity issues.<sup>5</sup> However, reduction in the volume of patients with lower-acuity issues presenting to EDs is a goal of many state Medicaid programs<sup>8</sup> and many insurance carriers.<sup>9</sup>

**Table 1. Retail Clinic Use by Top 10 Discharge Diagnoses by ICD-9-CM Code**

1. Upper respiratory infection (460, 465)
2. Sinusitis (461, 473)
3. Bronchitis (490, 466)
4. Pharyngitis (462, 463, 034)
5. Otitis media/externa (380,381,382)
6. Conjunctivitis (372)
7. Allergic rhinitis (477)
8. Influenza (487)
9. Unspecified viral infections (079)
10. Immunizations

Data from Ashwood JS, Reid R, Setodji CM, et al. Trends in the retail clinic use among the commercially insured. *Am J Manag Care.* 2011;17:e443-448.  
ICD-9-CM = International Classification of Diseases, Ninth Revision, Clinical Modification.

### Evolution of the Urgent Care Model

As we progress to population health management, the focus will shift from fee for service to shared risk. Hospital administrators will need to understand the models of urgent care as differentiated by purpose, target populations, access, market preservation/competition, and cost structure.

Urgent care centers vary in capability. The 10 most commonly treated conditions are listed in Table 1; routine physical examinations and immunizations are the next most common.<sup>10</sup> Many clinics expand services to include occupational medicine, physical therapy, laboratory draw stations, travel medicine, and aesthetic services.<sup>1</sup>

The first level of urgent care center has limited space and uses cost-efficient staffing models. These centers include the **cash clinic** and the **retail clinic**. Population targets are different for the two, but they share common themes. Limiting care to specific low-acuity conditions and staffing by nurse-practitioners or physician assistants make these sites the most cost-effective model for face-to-face care. Hospitals may consider either option depending on the community and intent of the clinic. Direct referrals from an ED may be done prior to treatment (after an appropriate medical screening examination) or after treatment for care of the next episodic illness or minor injury.<sup>1</sup>

Retail clinics provide care in the commercial environment with a presence in many retail pharmacy chains, grocery stores, and large chain stores.<sup>11</sup> They often encompass two-room areas with a small footprint in the local pharmacy or store. The most common staffing model uses nurse-practitioners with remote physician oversight as needed. Information

**Table 2. Groups Served by Federally Qualified Health Centers**

1. Underserved and low-income people
2. Migrant and seasonal agricultural workers and families
3. Homeless adults, families, and children
4. Residents of public housing

technology is maximized with the use and integration of kiosk registration, patient Internet portals (registration, medications, and treatment information), scanning of insurance and licenses for billing and demographic purposes, collection (cash, credit card, and direct insurance billing), and an integrated electronic medical record. The discharge information is computer-generated and may be efficiently delivered to primary-care providers. Utilization statistics suggest that patients often live within 20 minutes of the facility (with greatest use within 1 mile), are between 18 and 44 years old, do not have an established primary-care provider, are healthy (fewer than two chronic conditions), and have a higher household median income than the rest of the local population.<sup>10</sup>

**Health-care systems** often affiliate, partner with, or develop retail clinics to maintain a referral base for both the hospital and primary-care providers, develop a closer consumer relationship, or experiment with nontraditional health-care-delivery methods.<sup>11</sup> Large health-care systems that have developed retail clinic relationships include the Cleveland Clinic, Mayo Clinic, and Memorial Hermann Healthcare System.<sup>12</sup> Growth in retail clinics continues to increase. The findings of multiple studies show that the quality of care and satisfaction is similar to traditional options but at a lower cost.<sup>11</sup> When health-care systems are investigating affiliation, it must be done with care, and the relationship must be at arm's length to avoid physician referral issues under the Stark law. These programs include affiliation, co-branding, joint venture, and ownership. Systems may offer physician oversight of the nurse-practitioners and/or physician assistants providing retail clinic care. They may also provide marketing support, support for information technology, integrated electronic medical records, support for referrals to primary-care providers and specialists, and support for hospital admission. Most clinics treat only episodic illness or injury and require follow-up for a patient to establish a medical home. Research indicates that the reason use of retail clinics by the uninsured or underinsured is lower may be because the average visit cost is \$60 to \$70.<sup>13</sup>

### Solutions for Improving Access for the Poor

The best alternative in the low-income population is the **cash clinic** or **community clinic** (excluding free clinics) often sponsored by hospitals, religious organizations, civic organizations, and local government. The optimum site would include three or four examination rooms located close to high-volume EDs and accessible by public transportation.<sup>1</sup> Some such clinics may include laboratory testing, but radiography is discouraged because of increased costs. If the goal is to reduce ED use by patients with lower-acuity conditions, then screening programs can be developed in the ED for direct referral of these patients to the clinics.<sup>1</sup> This option must be offered in a manner compliant with the Emergency Medical Treatment and Labor Act (EMTALA). A workable price point would be close to \$45. Lower-cost staffing and a volume of more than 20 patients per day cover break-even costs.<sup>1</sup> This amount is a very rough estimate and depends on expenses such as staffing, rent, and supplies. Administrators should also determine the savings to the system by avoidance of a more costly ED visit.

Another area of growth under PPACA, **FQHCs** may be private (not for profit) or public entities receiving federal funding for implementation and provision of services. FQHCs are an alternative to the cash clinic for indigent populations and for patients with Medicaid coverage. Development of these programs are labor intensive, but funding occurred under both the American Recovery and Reinvestment Act and PPACA.<sup>14</sup> Section 330 of the Public Health Service Act covers such clinics as Indian health services, community health centers, migrant health centers, health care for the homeless programs, and public housing primary-care programs.<sup>15</sup> They would not be traditionally considered urgent care but have the capability to provide unscheduled services to treat minor illnesses and injuries. FQHC benefits include cost-based reimbursement for Medicare-eligible patients, steep pharmaceutical discounts, free coverage of medical malpractice insurance, and access to National Health Service Corps providers (**Table 2**). Funding availability may occur even after a clinic has been in operation. The purpose of FQHCs includes provision of patients with a medical home that includes primary care, preventive care, often dental services, mental health services, and treatment for substance abuse. These sites are nonprofit, applying for federal funding under Section 330 of the Public Health Service Act, and they serve the uninsured, underinsured, and Medicaid populations (**Table 3**). These centers require a great deal of commitment and com-

**Table 3. Medically Underserved Populations**

1. Low ratio of primary-care physicians to the population
2. High infant mortality rate
3. High percentage of the population living below the federal poverty level
4. High percentage of the population aged 65 years and older

*“Federally qualified health center benefits include cost-based reimbursement for Medicare-eligible patients, steep pharmaceutical discounts, free coverage of medical malpractice insurance, and access to National Health Service Corps providers.”*

munity involvement for both application and continued management through community governance, service-delivery coalitions, and qualification as part of a Health Professional Shortage Area (HPSA). Further, centers must demonstrate accessibility, quality of care, and cost-control standards.<sup>15</sup> Lack of services is determined by federal designation as an HPSA, including primary care, mental health, and dental care.

**Rural health clinics (RHCs)** may be a different option for nonurban health systems. Staffing can include physicians, physician assistants, nurse-practitioners, and nurse-midwives. They must provide rural health-care services at least 50% of the time, accept Medicaid-eligible patients, and accept Medicare assignment payment rates. Reimbursement is cost-based for Medicare-eligible patients and prospective payment for Medicaid services. Pursuit of this structure requires determining the HPSA designation for the area and obtaining an HPSA score.<sup>16</sup>

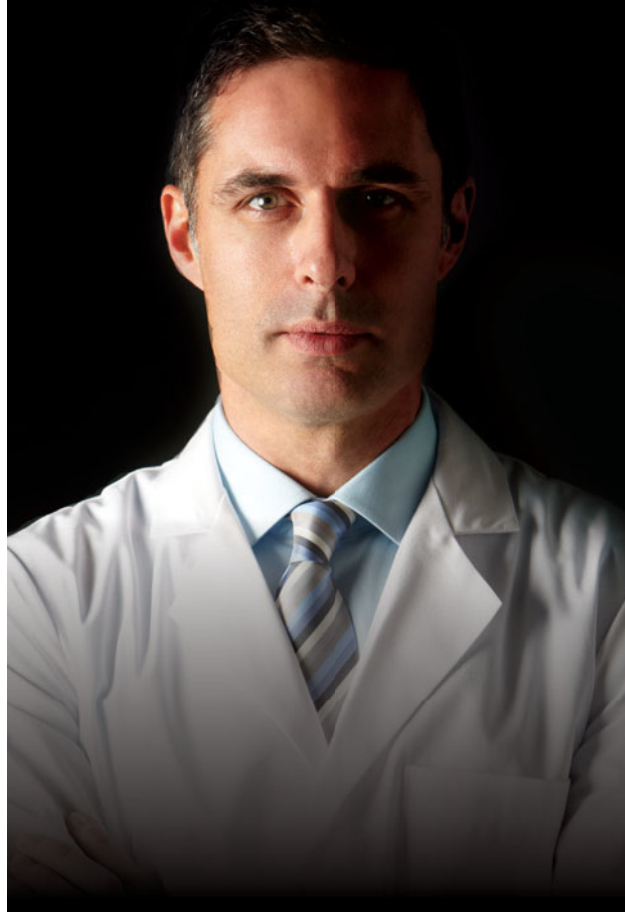
#### **Health System Considerations for Urgent Care**

The majority of urgent care centers fall under the classic definition, providing episodic injury and illness care under a fee-for-service or flat-rate model. The Urgent Care Association of America determined, via a recent nationwide survey, that ownership was 32% corporate, 21% joint venture with a hospital, 14% single physician, 13% hospital, 12% multiple physicians, and 9% other.<sup>17</sup> Sites are often 3000 to 5000 square feet in size, include five to eight patient-care rooms, and have some type of plain radiology suite. With a 12-hour schedule, this model routinely generates a volume of two to three



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**Table 4. Reasons for a Hospital to Expand into Urgent Care Services**

1. Prevent loss of patient population to competition
2. Off-load lower-acuity cases from the emergency department
3. Establish a geographic footprint in a new region
4. Provide overflow capacity for primary-care offices
5. Provide a lower-cost alternative for patients with low-acuity conditions
6. Population management of lower-acuity conditions in a cost-effective environment

patients per bed per hour, resulting in potential volumes of well over 50 patients per day, depending on location, marketing, and hours of operation. Productivity per provider ranges from 2.5 to 3 patients per hour, with one provider managing three to five beds. General perceptions in productivity are often far higher, exceeding 3 patients per hour. It is because of documentation challenges and other factors that this more conservative figure is suggested.

Administrators consider urgent care center expansion in that configuration for maintenance of referral base in a population with lower-acuity conditions, decongestion of an ED, or expansion into a new region<sup>18</sup> (Table 4). Geographic benefits include locations away from the central campus with ease of parking, reduced congestion, and expansion of a health-care system footprint. **Hospital-affiliated sites** are often larger and benefit from an expansion of services that include occupational medicine, imaging services, physical therapy, and laboratory draw stations. Several sites boast a medical center concept, including a full imaging center with plain radiography, ultrasound, computed tomography, and dual-energy x-ray absorptiometry scanning. The combination of imaging and urgent care provides dual marketing benefit. Use of the imaging center provides marketing for the urgent care center, and vice versa. This concept may be implemented to reduce volume loss from competitors' imaging programs, but it is an expensive alternative, and service duplication should be avoided.

Health systems may consider developing their own footprint; however, many choose a joint venture or affiliation with **private urgent care**. This option is less costly and often is of mutual benefit. Hospitals offer integrated medical records, access to information technology, potential access to capital for expansion, referral gateways for admission, and specialty care.<sup>18</sup> The urgent care center

offers better patient access, a geographic footprint, overflow relief for the ED and primary-care practices, and an alternate treatment site in the event of a disaster.<sup>1</sup> Systems need to consider urgent care centers as a middle option in the patient-care spectrum outside of the ED and primary-care offices. The most critical detail to investigate is facility location. Poor location for any urgent care center, hospital-affiliated or unaffiliated, leads to failure.<sup>1</sup>

### Conclusion

The spectrum of unscheduled injury and illness health care includes use of telemedicine, cash clinics, retail clinics, private urgent care centers, and large hospital-affiliated urgent care centers. These sites offer convenient care for lower-acuity conditions at a cost-effective price. Hospital and clinically integrated networks benefit from these types of facilities by off-loading lower-acuity cases from an ED, expanding a health-system footprint, and providing lower-cost care with concurrent patient satisfaction. Models vary, and integration depends on the intent of the clinic and population served. Facility location is critical to success. ■

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