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The Top 10 Mistakes Hospitals Make in the Urgent Care Business

Urgent message: Hospitals are entering the urgent care marketplace at increasing rates. Fundamental mistakes early in the urgent care acquisition or buildout process can greatly hamper their performance further down the road.

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Introduction

It should not be surprising that when hospital executives and personnel sit down to discuss issues and problems around population health, accountable care organization (ACO) integration, network development, cost containment, new product lines, hospital readmission rates, care coordination, and related topics they often arrive at hospital-centric and hospital-based solutions to solve them.[1] As hospitals and hospital networks look to urgent care centers to address some of these issues through hospital/urgent care affiliations, joint ventures, hospital-owned urgent cares, and other models, the basic relationship between these partners can have some strikingly fundamental flaws. This paper discusses 10 common mistakes hospitals make when integrating with one or more urgent care groups.

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The List

This list is not presented in any particular order of importance, nor is it even close to exhaustive. The cases presented are actual cases. Some details have been omitted for confidentiality. If the reader gets the feeling that some of the cases could fit into several of the "mistake" categories, they're correct; most hospital systems don't make only a single error.

1. Not having a reason for getting in the urgent care game

Many hospitals don't have a good reason for even wanting to do urgent care in the first place. Some argue it's for population health. Others will straightout say it's because they want to keep their own patients within their network (ie, to decrease "leakage"). Some will go so far as to say it's to decrease the cost of care. The first thing a consultant is likely to say is, *Show me a program where you have used a population health model to decrease the overall cost of care.*[2] The second is, *Demonstrate a program where a local urgent care can directly admit a patient to a hospital service, thereby bypassing the hospital's emergency department and potentially saving the system/patient thousands of dollars in healthcare costs.* Most hospital executives are flabbergasted to know such programs actually exist. The

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question is whether they truly want to save the healthcare system money.[3]

Case: A large not-for-profit hospital system entered into a joint venture with a medium-sized urgent care company that was new to the region. The venture was started under the guise of population health management. The urgent care company then started opening and operating urgent care centers with a team of providers who were not credentialed in the hospital system, who were unfamiliar and not integrated with the local hospital-owned primary care practices, and who utilized a separate EMR that couldn't speak to the other practices. When the urgent care centers failed to see expected volumes, the hospital system had to figure out what they "really" wanted to achieve and how they needed to revamp their urgent care centers to do so. Urgent care is local, and it's community-based. *Interoperability* pertains not only to the EMR but to those providing care. If population health improvement is a goal, then care coordination has to be structured into the urgent care through seamless relationships with patient-centered medical homes, the local emergency departments, and subspecialists.[4,5]

Take-home point: Know why you want to be doing urgent care in the first place.

2. Selecting the wrong urgent care partner

For those hospitals who actually get over the initial hurdle of understanding why they want to get into urgent care (and hopefully develop metrics around measuring this) and who devise the appropriate business model, the next mistake is often choosing the wrong partner to help them achieve their goals. (In other words, the wrong deal with the wrong partner at the wrong time.) Some hospitals have chosen to partner with retail clinics, others with an urgent care group, and still others have built their own urgent cares alone or with urgent care partners.[6]

Case: A large hospital group wanted to place urgent care locations close to their EDs in order to decrease ED overcrowding. They decided on a joint venture with an outside urgent care company. The urgent care company's staffing model (they used medical assistants and not nurses) and set-up (they didn't have a CLIA-certified moderately complex laboratory on site) resulted in their not having the ability to perform many clinical activities that would have helped the ED (such as placing an IV and giving IV medications, etc.), thereby limiting the types of patients they could see in their urgent cares to offset ED volume.[7,8]

Take-home point: Make sure to select an urgent care company that helps you attain your goals.

3. Selecting the wrong hospital department

Many hospital systems decide they want to start an urgent care, and then they can't decide which department in the hospital to house them. Any department selected comes with leadership issues, department politics and constraints, and downstream consequences.[9]

Case: A large hospital system grew their urgent care centers organically, but as they acquired additional hospitals the urgent cares found it difficult to interact. One urgent care center was part of the primary care division in the Department of Medicine, another two urgent cares were under the Department of Emergency Medicine, and a fourth was a separate department entirely. One saw its mission as helping primary care physicians by being available when they weren't and doing procedures and caring for sicker patients in order to improve the patient flow in the primary care practices. The group under the ED umbrella treated the urgent care as a less capable offshoot of the ED. Hospitals need to make sure their original goals for having the urgent care, the mission of the urgent care, and the department they decide to locate urgent care in, all synch together seamlessly.[10]

Take-home point: Know the unintended consequences of where you decide to place urgent care in your organization.

4. Selecting the wrong urgent care leadership

Urgent care centers are not "mini-EDs;" nor are they walk-in clinics for the hospital's primary care offices. They can become either, however, if hospital leadership does not select the proper management team.

Case: A national urgent care group was new to a geographic area and growing quickly. Although there were several smaller community hospitals in the area, there was one large hospital group that controlled the majority of the primary care practices. The urgent care company hired a physician from the large hospital-owned primary care group in order to establish easy connections. Although the physician came with walk-in experience and knowledge of the patient population, he was not as familiar with the urgent care model and struggled to keep the urgent cares productive.

Take-home point: Leadership and management are not the same things, and hospitals have to understand the importance of selecting the right person to lead an urgent care facility in today's marketplace.

5. Selecting the wrong urgent care staff

When starting or operating a busy urgent care center, there is often a tendency to just get warm bodies to fill positions. They may understand the hospital mantra and even come from other positions in the hospital, but working in urgent care takes a certain mindset and a proactive disposition. Hospitals may be burdened by patient care ratios, hospital-specific skill set limitations for certain roles, staffing budget constraints, providers with non urgent care backgrounds, and more. You may be in a setting where a combination of these staffing factors negates the hope of efficient and smooth patient flow in an urgent care setting.[11]

Case: A large hospital-owned urgent care had a very busy practice but continued to lose 10-20 patients a day to walkouts due to long waiting times. The hospital's solution was to bring in additional providers to "speed up" the process rather than address other inefficiencies. When the nursing department saw additional providers being used, they argued successfully that more providers equated to the need for more nurses. Flow improved minimally, but at the high cost of adding not only a provider, but a nurse.

Take-home point: Finding the right staff is hard, but it's much better to do it up front than be left picking up the pieces after.

6. Selecting the wrong consultant

Many consultants understand the history of urgent care and how it continues to evolve. They understand the disruptive forces affecting urgent care: changing regulatory rules, increased healthcare costs, network development by hospital systems, freestanding EDs, retail clinics, and open-access primary care. Unfortunately, few urgent care consultants understand the implications of *all* these pieces as they might pertain to a client's local healthcare environment and the clinical practice of urgent care.

Case: A large national urgent care chain wanted to move into a new part of the country where they hadn't had a significant footprint in the past. The franchise owner suggested an individual who was a physician with great business ties and who had worked as an internist for many years in the area, but who only recently started working in an urgent care setting. The franchises opened and are doing OK, but not hitting projected patient targets because the internist was unaware two urgent care groups were opening sites blocks from his site.

Take-home point: Understand the expertise and knowledge gaps of the person who's giving you advice.

7. Not considering the impact of hospital policies, outside agency regulations, and lack of flexibility on urgent care operations

Not-for-profit hospitals are guided (burdened) by a myriad of local, state, and federal regulations, as well as internal hospital rules and external requirements from outside agencies (eg, JCAHO) that can make the practice of urgent care slow, at best. The list is exhaustive: who can triage, the time it takes to triage, who can dispense a medication, where a lab sample can be run, who can discharge the patient, and on and on. Hospital executives need to seriously consider whether their type of operation can mesh with urgent care, or whether their efforts are better spent integrating with an outside urgent care group who can meet their standards for high-quality ambulatory care.

Case: A hospital-owned urgent care was prevented from getting an onsite lab device for testing BNP, troponin-T, and d-dimer. Hospital laboratory policy, CLIA regulations, and other agency regulations were involved in the decision. This resulted in bloodwork needing to be sent to the hospital laboratory with a subsequent 2-4 hour turnaround time, increasing a patient's length of stay in the urgent care and increasing the number of patients directly referred to the hospital ED.

Take-home point: It's often difficult for hospitals to do urgent care well, and they need to honestly assess all their limitations.

8. Wrong location to carry out the plan

Talk to anyone in the urgent care business and they will recite the real estate mantra "location, location, location" when it comes to defining the number-one criteria for success. Hospitals may be limited in site selection by regulatory, cost, and sociopolitical issues regardless of their deep pockets. Often, their perception of a "good location" doesn't work out because they never matched their original goal for having an urgent care with the best location for achieving that goal. Please note: a not-for-profit hospital system partnering with an urgent care group may have multiple reasons for placing an urgent care in an underserved, resource-poor community vs an independent, private, equity-backed urgent care company.

Case: A large academic medical center was interested in developing urgent care centers. Their single goal was to decrease their emergency department utilization. With this in mind, they built their urgent cares literally

within walking distance and in sight of their ED. They were phenomenally successful in achieving their goal within months of opening. Despite political pressures to locate in a community, regulatory hurdles to pass because they were building so close to existing services, and cost constraints given the price of the property, they persevered and met their goal.

Take-home point: Location may be everything, but failing to understand the deeper importance of how location can affect your goal is critical.

9. Not understanding your local competition (now and in the future)

Urgent care, like any industry, can be at the mercy of the "next big thing:" telemedicine, open-access primary care, subspecialty urgent care, employer-located urgent care clinics, and more. Disruptive innovation can be your friend *and* your foe.[12]

Case: A large, urban, hospital-owned urgent care was doing extremely well as the "only show in town." It was seeing close to 40,000 patient visits a year, and although it was burdened by typical hospital regulations and compliance measures, it ran smoothly. Over the span of a few years, however, the area saw several new healthcare facilities open, including a large occupational health practice operated by a local orthopedic hospital and several freestanding urgent care centers. In addition, several of the larger primary care practices in the area became NCQA level III patient-centered medical homes that were mandated to see their own acute patients within a certain amount of time. While this was occurring, the primary care practices that referred patients to the urgent care were closing their patient panels to new patients due to the lack of primary care access. This wave of both external and internal events, all of which could have been dealt with in a coordinated manner if the hospital chose to address them in a coordinated fashion, led to the decimation of the urgent care to the point where it is seeing about half the patient volume it once was.

Take-home point: Have a clear understanding of your competition now and down the road—and be ready to have a response to that competition.

10. The myths of cost savings

You often hear hospital executives talk about "the right care, at the right time, at the right place." Notice that they never go on to say "at the right price." There are multiple reasons for rising healthcare costs, and urgent care can help with some; it is not, however, a panacea that any hospital can turn to without a lot of consideration. Healthcare economists will also chime in that the more access points to care and the more care coordination there are, the higher the cost of care will be. The answer returns to the four "rights."[2,5,13–15]

Case: A large not-for-profit hospital system had an outside-contracted ED group staffing its ED and a separate academic-affiliated group staffing their pediatric floors and ICU. The pediatric team was troubled by dehydrated pediatric patients sent from outside practitioners boarding in the ED for long periods of time. They devised a protocol with several of the local large urgent cares to direct-admit pediatric patients that met specific criteria to a same-day pediatric observation/short-stay unit for hydration and likely same-day discharge. The program was successful, but was curtailed when the ED group complained about lost revenue due to being bypassed.

Take-home point: Urgent cares don't have a magic formula for saving you a lot of money or making you a lot of money. Maximizing both benefits requires integrating urgent care into the continuum of care the right way. ■

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