up to half of women diagnosed with an ectopic pregnancy have no identifiable risk factors, some potential risk factors include fallopian tube pathology, pelvic inflammatory disease, previous ectopic, and pregnancy while an IUD is in place.[2]

The most common long-acting, reversible contraceptive method used worldwide,[12] IUDs provide up to a 99% effective prevention rate.[2] However, when pregnancy occurs with an IUD, the risk for an ectopic pregnancy is significantly increased, up to 53%.[2]

POCUS is a cornerstone of efficient, effective diagnosis of first trimester pathology, is standard of care for symptomatic pregnant patients in the ED[3,4,13] and is becoming more common in UC, as well.[14] POCUS decreases time to diagnosis, time to obstetrics consult, and time to definitive management for ruptured ectopic pregnancy when compared with ultrasound conducted by a radiologist or ultrasound technician.[6-11,15-17] POCUS has also been found to enable nonsurgical treatments to be offered more frequently; for example, in cases of early detection of cervical pregnancy, methotrexate may be offered.[18]

POCUS Findings

Stone, et al demonstrated a simple transabdominal POCUS protocol to assess for the presence of ruptured ectopic: 1.) evaluate for IUP, 2.) evaluate for free fluid in the pelvis and 3.) evaluate for free fluid in the RUQ/LUQ.[16] A full bladder assists with visualization of IUP and pelvic free fluid, but should not cause delay of evaluation. The presence of an intrauterine yolk sac seen as a hyperechoic ring within an anechoic fluid collection is the first definitive evidence of an IUP. This can generally be seen on transabdominal ultrasound at around 6 weeks of gestation.[11] Most ectopic pregnancies are tubal and can be seen as an extra-uterine yolk sac or embryo.[11] The incidence of heterotopic pregnancy outside of assisted fertilization is very rare.[11] Outside of these relatively uncommon risk factors, the presence of an intrauterine pregnancy makes an ectopic pregnancy unlikely.[11,17]

In women presenting with a positive pregnancy test and symptoms of pelvic pain and/or bleeding, a POCUS showing lack of an IUP and the presence of free fluid in the pelvis and/or RUQ is strongly suggestive of ruptured ectopic pregnancy.[19]

Conclusion

This case illustrates the importance of avoiding premature closure and anchoring bias. It also highlights the value of POCUS use in UC, specifically in evaluation of first trimester pregnancy presentations and protection against cognitive biases. Relying too heavily on initial pieces of information (presence of IUD and report of a negative home pregnancy test) would have limited the differential in this case, delayed the diagnosis and endangered the patient. Without POCUS, evidence of a ruptured ectopic would have been significantly delayed, preventing prompt transfer for definitive management.

The patient described in this case report consented to its publication.

References

1. Pregnancy Mortality Surveillance System | Maternal and Infant Health | CDC. Published June 23, 2022. Available at: https://www.cdc.gov/reproductivehealth/ maternal-mortality/pregnancy-mortality-surveillance-system.htm. Accessed August 17, 2022.
2. Hendriks E. Ectopic Pregnancy: diagnosis and management. *Ectopic Pregnancy*. 2020;101(10):8.
3. Durham B, Lane B, Burbridge L, Balasubramaniam S. Pelvic ultrasound performed by emergency physicians for the detection of ectopic pregnancy in complicated first-trimester pregnancies. *Ann Emerg Med*. 1997;29(3):338-347.
4. Hahn SA, Lavonas EJ, Mace SE, et al, American College of Emergency Physicians Clinical Policies Subcommittee on Early Pregnancy. Clinical policy: Critical issues in the initial evaluation and management of patients presenting to the emergency department in early pregnancy. *Ann Emerg Med*. 2012;60(3):381-390.e28.
5. ACEP Board of Directors. Ultrasound Guidelines: Emergency, Point-of-care, and Clinical Ultrasound Guidelines in Medicine. *ACEP Policy Statement*. Published online 2016. Available at: https://www.acep.org/globalassets/new-pdfs/policy-statements/ultrasound-guidelines—-emergency-point-of-care-and-clinical-ultrasound-guidelines-in-medicine.pdf. Accessed March 3, 2023.
6. Urquhart S, Barnes M, Flannigan M. Comparing time to diagnosis and treatment of patients with ruptured ectopic pregnancy based on type of ultrasound performed: a retrospective inquiry. *J Emerg Med*. 2022;62(2):200-206.
7. Casadio P, Youssef A, Arena A, et al. Increased rate of ruptured ectopic pregnancy in COVID 19 pandemic: analysis from the north of Italy. *Ultrasound Obstet Gynecol*. 2020;56(2):289-289.
8. Dvash S, Cuckle H, Smorgick N, et al. Increase rate of ruptured tubal ectopic pregnancy during the COVID-19 pandemic. *Eur J Obstet Gynecol Reprod Biol*. 2021;259:95-99.
9. Gaetani SL, Garbade GJ, Haas SI, et al. A ruptured ectopic pregnancy in a patient with an intrauterine device: a case report. *Radiol Case Rep*. 2021;16(12):3672-3674.
10. Jones D, Kummer T, Schoen J. Ruptured ectopic pregnancy with an intrauterine device: case report and sonographic considerations. *Clin Pract Cases Emerg Med*. 2020;4(4):559-563.
11. Moake MM, Price AB, Titus MO, Barnes RM. Point-of-care ultrasound facilitates management of ruptured ectopic pregnancy. *Pediatr Emerg Care*. 2021;37(5):282-285.
12. Buhling KJ, Zite NB, Lotke P, Black K. Worldwide use of intrauterine contraception: a review. *Contraception*. 2014;89(3):162-173.
13. Blaivas M, Sierzenski P, Plecque D, Lambert M. Do emergency physicians save time when locating a live intrauterine pregnancy with bedside ultrasonography? *Acad Emerg Med Off J Soc Acad Emerg Med*. 2000;7(9):988-993.
14. Jackson DN, Planinic P. An urgent care approach to complications and conditions of pregnancy part 2. *J Urgent Care Med*. Available at: https://www.jucm.com/an-urgent-care-approach-to-complications-and-conditions-of-pregnancy-part-2. Accessed July 9, 2022.
15. Rodgerson JD, Heegaard WG, Plummer D, et al. Emergency department right upper quadrant ultrasound is associated with a reduced time to diagnosis and treatment of ruptured ectopic pregnancies. *Acad Emerg Med*. 2001;8(4):331-336.
16. Stone BS, Muruganandan KM, Tonelli MM, et al. Impact of point-of-care ultrasound on treatment time for ectopic pregnancy. *Am J Emerg Med*. 2021;49:226-232.
17. Moore C, Todd WM, O'Brien E, Lin H. Free fluid in Morison's Pouch on bedside ultrasound predicts need for operative intervention in suspected ectopic pregnancy. *Acad Emerg Med*. 2007;14(8):755-758. doi:10.1197/j.aem.2007.04.010
18. Casikar I, Reid S, Condous G. Ectopic pregnancy: ultrasound diagnosis in modern management. *Clin Obstet Gynecol*. 2012;55(2):402-409.
19. Scibetta EW, Han CS. Ultrasound in early pregnancy. *Obstet Gynecol Clin North Am*. 2019;46(4):783-795.

Manuscript submitted September 30, 2022; accepted October 25, 2022.

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Tightening the Belt: Rethinking Costs and Efficiency in Urgent Care

Urgent message: Urgent care operators must be mindful of costs and labor efficiency to navigate the challenges of rising and falling revenue in what's been a highly seasonal business.

Alan A. Ayers, MBA, MAcc

For much of 2020 and 2021, the COVID-19 pandemic drove both uncertainty and higher volumes (and thus profits) to urgent care centers. With the 2022-2023 flu season behind us, it's back to "business as usual" and operators are expressing an increased interest in improving efficiency and managing operating costs.

So, what do urgent care operators need to consider?

Reducing expenses and rethinking resource-hungry strategies adopted during the pandemic is essential in the coming months.

Volume-Driven Business

Urgent care has always been considered a volume-driven business because once there's sufficient visits to cover a "skeletal" staffing model, each additional visit accrues to the bottom line.

In this sense, labor in an urgent care center is a fixed cost because without a provider, the center cannot serve patients. As with any fixed cost, profitability is increased as labor expense is spread across more patients.

Due to these basic economic factors, urgent care centers have always emphasized volume. In fact, one key performance indicator (KPI) that drives site selection, scheduling, and financials is patients per hour per provider.

Historically, urgent care has been a business that breaks even for 9 months of the year but then sees a windfall during flu season, when volume increases dramatically. This is why sustained COVID volume was so profitable for urgent care—COVID had added a second, year-round flu, in essence.

But what happens when this pattern isn't followed? The last quarter of 2022 saw an abbreviated "quadremic" crisis of flu, COVID, strep, and RSV that ended abruptly compared to previous years. The impact was regionalized, with the greatest volume seen in states like Texas and Utah that have disproportionally large pediatric populations.

This is a reminder that flu season is not a guarantee. Many operators are still overstaffed from pandemic levels. With volumes levelling, finances will likely be tight this year, so finding ways to maximize efficiency—

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"Flu season" can hit any time between October and April, quickly filling excess capacity in urgent care centers and delivering outsized seasonal profits. But there's no guarantee of the occurrence, duration, strength or timing of flu. That's why urgent care needs to evolve beyond financial dependence on a yearly phenomenon.

especially during the slower months—is essential to the survival of any urgent care business.

Managing Labor Costs

Labor, particularly provider labor, by far is the greatest expense of an urgent care center; generally, we assume it constitutes about 85% of operating costs. But without a skeletal staff of at least one provider and someone to support the front desk, an urgent care cannot operate. Creatively managing your workforce and finding new ways to maximize efficiency are powerful tools to increase your profitability.

Maximize Patients Per Hour Per Employee

In any business, revenue equals volume times rate. Since reimbursement rates are set by payers, assuming optimized coding and collections practices, this leaves operators with only one major lever to manipulate—volume. So, when managing your labor costs, your approach needs to be volume-driven and guided by data.

Focus on the KPI of patients per hour per employee. Improving this metric is key to increasing your volume while not overspending on additional staff.

The efficiency of employees varies by position (see **Table 1**). While four patients per hour per provider (ie, one patient every 15 minutes) is a good rule of thumb, some operators would argue it's "too slow" (ie, the number should be six) while other providers will argue it's "too fast," resulting in quality or safety issues (and that somewhere between two and three is a better number).

Attainable patient-per-hour efficiencies are affected by many factors, including patient demand in a trade area, patient acuity, scope of services offered, pacing vs ebb-and-flow of patient arrivals, use of standing orders, provider urgent care job experience and confidence, and the use of lean processes, support staff, automation, and technology.

Urgent care centers were so profitable during the pandemic because many providers were able to see eight to 10 patients per hour. However, this isn't sustainable when demand is low, and your urgent care shouldn't be using flu season extremes to guide year-round decisions.

Many operators get stuck in a mindset that the staffing model is set and consistent from site to site. This typically entails one receptionist, one medical assistant, and one provider…regardless of volume. Add that the front desk or medical assistant is also a radiologic technician and "fixed" labor costs per hour raise the bar on needed patient visits to break even.

These operators don't think that a center seeing less than 20 patients per day can function with 1:1 staffing, meaning one provider and one cross-trained medical assistant/front desk person. When you have a rigid staffing model that disregards volume, your staff becomes idle and your center loses money each hour.

Because offering seasonal employment is highly impractical given credentialing and training requirements, what happens if a center schedules staff for "average" volume but then sees a sudden influx of patients? The answer is simple: Your staff works harder and patients wait.

That's where technology that enables patients to join the waitlist and wait comfortably from home comes into play.

Such queuing and registration systems pace arrivals to provider productivity, reducing stress and average wait and resulting in a better patient and provider experience. Wait times expand or contract based on provider productivity, and patients receive text message updates as their check-in time approaches.

An urgent care operator should continually focus on increasing the efficiency of existing staff by eliminating waste. "Waste" constitutes non-value-added activities that consume time. Shift administrative tasks like registration data entry to patients, utilize standing orders to test patients for flu, COVID, or strep before the provider exam, and simplify provider documentation to enable your team to handle more patients per hour. By doing so, you'll avoid the need to hire more people. Remember, adding additional staff drops the efficiency of your entire team.

Rethink Your Staffing Model

Aligning an urgent care center's staffing model with patient demand plays a major role in managing labor-related costs. Maintaining a high "headcount" of full-time employees is expensive. To save money without sacrificing the quality care your center offers, a smarter

Table 1. Efficiency of Employees by Position

	Providers	Medical assistants (MAs)	Front desk staff
Patients per hour	4 (1 every 15 min)	2 (1 every 30 min)	4
Patients per 12-hour shift	50	25	50

approach is needed.

When there's insufficient volume to justify a dedicated, full-time role, cross-training is one strategy.

Nurse practitioners (NPs) and MAs can function as basic or limited-scope x-ray operators in many states. MAs can work the front desk in slower locations.

To take this a step further, ensure each of your staff members practices at the top of their licensure and/or training. In urgent care, this means utilizing NPs or physician assistants over more costly MDs and DOs, or hiring an MA with a limited-license x-ray certificate instead of a fully licensed radiology tech.

Operators also need to take a serious look at benefits. Offering personal time off requires your center to have backup coverage when employees take it, in turn creating redundancy, excess capacity, and double the benefits costs. Instead, consider swapping or flipping the schedule for providers who work 3.5 days per week so they can have contiguous days off for travel or whatever they please.

For health benefits, limit coverage to spouses who don't have benefits from their job. Consider offering a high-deductible health plan with discounts for healthy habits like preventative testing and tobacco abstinence.

Finally, realistically examine the staffing needs of your center. Your volume isn't always at peak levels. So don't stay locked into a rigid schedule. Instead, have a list of flexi- or traveling staff members or PRN providers ready. Then, when your regular staff becomes too busy, you can call in reinforcements.

Add Additional Services

What happens when the efficiency of your staff is maximized to patient demand, but you still have excess capacity? Adding additional services is one avenue for increasing profitable revenue in urgent care. Keep in mind, however, not all services result in profit. Though you may generate more revenue, if that revenue isn't profitable, it doesn't meet your goals.

Enhancing revenue from existing visits is low-hanging fruit. For example, assume the front desk is verifying coverage, entering data correctly, and collecting copays on every visit. Where deductibles apply, consider a credit-card preauthorization service. Ensure visits are being coded appropriately and optimize EMR usage to capture codes appropriately. Doing so generates more revenue from reimbursement without any additional cost. Increasing the clinically appropriate use of lab services and x-ray, such as for diagnostics, can also be effective.

Finally, adding convenience services like medication dispensing can capture more revenue from each patient who visits your center.

Many operators fall into the trap of ignoring new opportunities. Don't forget your patients need a wide range of healthcare services. Is your urgent care center able to add them?

Orthopedic specialty services are the number-one referral from urgent care centers. Rather than sending orthopedic patients to another local facility, consider bringing in an orthopedist one day a week with a management services organization arrangement. Doing so lets you keep the follow-up visit, and its revenue in your center.

When revenue from flu season-related services isn't coming in, adding new services and optimizing existing processes can help buffer your bottom line.

Urgent care centers face an "incremental labor problem." If optimized provider and staff efficiency is four patients per hour, or 50 patients per 12-hour shift, a center that sees 50 patients per day will necessarily be more profitable than one seeing 72 patients. That's because when a second provider is added, the efficiency of both providers falls. In this example, 72 patients per 12 hours per two providers is only 3 patients an hour, or 75% less productivity than the optimized single provider. So, while we say urgent care is volume-driven, the constraint is the capacity of the staffing model.

"Cut out unneeded spending where possible and focus on funneling your dollars back into your center in ways that improve your services and create growth opportunities."

Managing Operating Expenses

While generating profitable revenue is never a bad thing, urgent care operators also need to take a hard look at cutting their expenses as we move into 2023.

The COVID pandemic and its related effects led many centers to increase spending. Some of this spending is inflation-driven—particularly of wages and supply costs—but others are surplus. Now, even with revenues slowing down, those centers may have not scaled back their spending accordingly.

Reducing operating expenses is essential for centers struggling to weather the "drought" months outside of flu season. In practice, this can take many forms.

Supply Inventory Management

Saving on non-labor operating costs begins with managing your supply inventory and acquisition. Centers may use the same supplier for years without researching offers from competitors. To ensure your center is getting the best price, always solicit bids from several suppliers (Medline, McKesson, Henry Schein, et al).

Moreover, be mindful of your ordering habits. Order less frequently to take advantage of the lower shipping costs of larger orders.

Does your center have an abundance of supplies sitting unused in the cabinetry of patient rooms? If so, have you noticed the staff doesn't get the supplies they need from those cabinets, but rather, the central supply closet?

Sitting inventory is money you're wasting when you could use the capital to help cover operating expenses. In fact, one recommendation is to just eliminate cabinetry that's a magnet for unused supplies.

Next, aim to reduce formulary SKUs to the essentials, eliminating duplicate items that serve the same purpose, and switching from branded to generic or private-label products.

Focusing again on the issue of volume, reduce your inventory levels and order frequency to match the demand your center sees. Without massive surges of COVID (and especially outside of flu season), you don't need to hoard supplies.

It's time to re-examine how much supply inventory your center goes through over time and pace your orders accordingly.

Lowering Occupancy Expenses

The amount paid for your space is unavoidable in that it's typically locked in by your lease. However, you can save money by taking a few steps.

First, consider renegotiating your lease renewals at the updated market rate. Real estate prices are changing all the time. If your initial lease contained TI (tenant improvement) that's been fully amortized, or if "escalators" resulted in annual rent increases in excess of actual market rent, then you should try to negotiate a renewal lease reduction. Do your research and don't pay more than you should.

Many landlords are also unfamiliar with the ebb-and-flow nature of urgent care volumes. With this in mind, operators may want to ask for flexibility in rent payments during slow periods to ease some pressure.

Occupancy expenses don't just cover rent. Operators should also consider the third-party services they spend money on. For example, does every center need daily professional cleaning? Or could a center with less traffic assign MAs to clean during the day and bring in professional cleaners once a week?

The same is true when considering services like printer and copier maintenance, window washing, document shredding, and bottled water delivery to name a few. Often, a cheaper alternative is available.

Try cutting down the number of printers/copiers at your center, handling documents electronically rather than printing and faxing, having staff clean the windows, purchasing shredding machines, or installing water filters for staff to refill their bottles. This might not be glamorous, but for many centers, it's low-hanging fruit.

Conclusion

In today's world of tight margins and fluctuating revenue, tightening your belt is simply part of running a successful urgent care. Cut out unneeded spending where possible and focus on funneling your dollars back into your center in ways that improve your services and create growth opportunities.

Focusing (or refocusing) on the basics will allow your center to thrive in the face of economic uncertainty as our industry continues adapting to the post-COVID world. ■