FROM THE UCA CEO

Differential Competitive Advantage

■ LOU ELLEN HORWITZ, MA

In the May issue of *JUCM*, Josh Russell, MD, MSc, FCUCM, FACEP wrote in his Letter from the Editor-in-Chief about thinking differently about follow-up. If you are not a physician, physician assistant or nurse practitioner and decided to skip his letter that month because it seemed too clinical, I urge you to go back and read it.

One of the aspects of Urgent Care that separates us from other kinds of healthcare operations—or used to—is the tight collaboration between administration and medicine. At the beginnings of Urgent Care this was because administration and medicine were often the same person! All aspects of managing the center and practicing medicine in the center went through the same "double-mesh" filter of the single owner, ensuring that both perspectives were always included.

As we've grown—either we've gotten busy in a single center or expanded to multiple centers—we've had to specialize our teams to be able to manage broad geographies or large numbers. This is just a part of growth, but I think we might have already lost something in the transition that's affecting how we do things every day in our centers, and how we interact with the larger healthcare environment. Josh's letter outlines one example of this perfectly.

Making good decisions in medical operations is extraordinarily difficult. One has to balance the risky, messy, customized aspects of practicing medicine on thousands of unique individuals with the needs for structure, consistency, measurability, and predictability to successfully run a business that will be successful in the long term. We all know this, but I'm not sure we are paying enough attention to the "balance" part lately. We seem to be shifting slowly but inevitably into the "us vs them" dynamic within *our* centers that is typical in most healthcare institutions, and there's danger there.

Desperation makes us want to fall back on the easy things. We are tired of being understaffed, tired of being underpaid by payers, and still tired from the pandemic—and that makes one tired of fighting to be better, because being better is hard. But here's another thing we all know—being worse is even harder.

I'd like you to reconsider what "being better" looks like in your Urgent Care and suggest that it looks like closer collaboration between medicine and administration. If those have drifted apart in your centers, look hard at why and figure out how to fix it and try again. One guess as to why: both administrators and clinicians have gotten so absorbed by their "sides" of the organization, because the stakes have been so high for so long, that the specialization of your work has pulled you apart and now you've stayed there vs coming back together. It just seems easier to stay in your lane.

If you look at classic decision-making charts, the more collaborative the decision-making, the longer it takes. In an industry with "urgent" in the name, time pressure is always there. But what we have also learned is that the quality of the decision making *and* the stickiness of the decision that's made also go up with more collaborative approaches. It takes longer but it also lasts longer, because it's a better decision when it includes diversity of perspectives.

There's another classic concept: differential competitive advantage. This speaks to something that you can do that makes you different from competitors and is hard to duplicate. Classically, this looked like advanced technology, a patent, a strong brand identity, or superior personnel. In today's world, however, most of those are either easier to duplicate or easier to completely disrupt than ever before. The rest of healthcare has caught on to the value of medical assistants, walk-ins are doable for almost everyone, and patient experience has become a universal focus—so does Urgent Care even have a differential competitive advantage anymore? I'd like to suggest that we could, and that it's an iron-clad collaboration between medicine and management for taking Urgent Care forward.

Every other healthcare institution spends more time trying to implement decisions rather than make them, because of the isolated ways the decisions were made in the first place. I'll admit, I hate making decisions collaboratively because it almost always derails the neat, clean vision I had in the first place, but it almost always leads to better long-term outcomes. ■

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