

## CASE STUDY

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## how urgent care centers can enhance volume and revenue

One group practice reduced hospital ED use, increased its capitation margin, boosted revenues, and attracted new patients by operating two urgent care centers.

### AT A GLANCE

Providers that operate urgent care centers should:

- > Allow time and resources to build a successful UCC
- > Include dedicated midlevel providers
- > Offer key diagnostic tests after hours
- > Foster referral relationships from other physicians
- > Manage patient flow from the practice
- > Seek special designation from payers to add revenue
- > Integrate workflow with the rest of the clinic

Growing demand for convenient urgent care and after-hours medical services strains hospital emergency departments (EDs) and has led to a proliferation of walk-in clinics in retail outlets. It also creates opportunities for urgent care centers (UCCs) operated by hospitals and medical groups to build market share by offering convenient laboratory and clinical services beyond those available at walk-in clinics at costs below hospital EDs.

The Staten Island Physician Practice (SIPP) is one urban multispecialty group that has seized this opportunity. By opening UCCs, SIPP was able to expand its patient base, reduce hospital ED costs for capitated patients, and increase specialty referrals and practice revenues over a two-year period. SIPP's experience shows that with proper planning and execution, UCCs can be an effective business development strategy.

### Practice and Market Background

Providing primary and specialty care to approximately 10 percent of local families, SIPP is the oldest multispecialty group in Staten Island, N.Y. With two office sites located on each side of the island, SIPP has 23 primary care physicians (PCPs) and 28 specialist physicians. SIPP provides a full range of medical and surgical, diagnostic, and nuclear medicine services, and has one large capitated contract and fee-for-service agreements with most national and local third-party insurers.

With about 85 percent of residents routinely seeking medical care on the island, the Staten Island market is robust and competitive. When SIPP began considering opening UCCs in 2005, two hospitals with EDs and a handful of physician practices were offering services after hours. Nonetheless, access to urgent care services in the market was limited and service often was poor. Only 8.3 percent of physicians offered Sunday hours and only 6.6 percent were open on Friday night. Patients often waited up to

three hours for care in hospital EDs. Potential demand for both urgent and follow-up care was high. Surveys of existing practice patients found that they would greatly appreciate access to off-hour services. A significant percentage of walk-in patients did not have a regular PCP, making it possible to recruit unaffiliated patients into the practice. The situation clearly presented an opportunity for the practice to get into urgent care.

Other competitors also have recognized the market opportunity. Since 2005, competing medical groups have opened UCCs, and walk-in clinics at pharmacies and other retail outlets have proliferated. At the same time, local hospital EDs have sought to reduce waiting time and strain on their facilities by referring appropriate cases to UCCs, particularly centers with on-site diagnostic services, labs, and physicians, such as those operated by SIPP. Insurance companies have also recognized the value of well-equipped UCCs as a lower cost alternative to hospital EDs. Over time, the Staten Island market, like many urban and suburban markets, has stratified into hospital EDs for the most severe illnesses and injuries, free-standing UCCs with convenient after-hours primary and preventive care for a wide range of non-life-threatening emergency needs, and retail clinics for minor complaints. UCCs are growing throughout the United States, with more than 8,000 currently operating, according to the National Association of Urgent Care Centers.

### Strategic Goals and Challenges

By definition, UCCs operate as a “safety valve” for patients who cannot wait for care, due to either the urgency of the condition or an inability to schedule a convenient time with an established PCP. SIPP responded to this market opportunity in 2005 by opening two UCCs. The move was part of a strategic plan to increase market share, reduce unnecessary hospital ED use by practice patients, and improve patient satisfaction and loyalty. Major goals were to:

- > Provide convenient services for established patients in need of urgent or off-hours care, generating additional revenues from serving

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fee-for-service patients and cost savings from serving capitated patients

- > Generate clinically appropriate referrals for practice specialists
- > Recruit patients in market who did not have established relationships with PCPs
- > Reduce pressure on primary care practices to schedule patients who need urgent care
- > Capture revenues for urgent care services that might otherwise be lost to competing clinics, UCCs, and hospital EDs
- > Improve the profitability of capitated contracts by reducing unnecessary hospital ED costs
- > Increase patient satisfaction and loyalty by providing a convenient, cost-effective option to hospital ED care

Opening UCCs also entailed significant challenges, including:

- > Initial costs for facilities, staffing, and marketing
- > Ongoing staffing costs
- > Integration with existing services
- > Potential competition
- > Building enough volume to cover costs
- > Expanding the scope and complexity of services

### Evolution of SIPP UCC Operations

To take advantage of the market opportunities without incurring excessive operating costs, SIPP opened two UCCs in its two existing locations as extensions of its primary care services. In addition to providing walk-in urgent care services, the UCCs were also used to see established patients seeking same-day appointments. Services were offered daily, including weekends,

from 9:00 a.m. to 9:00 p.m. Target waiting times are less than one hour and diagnostics, including full radiology and laboratory tests, are available on site.

Originally, the UCCs were staffed by SIPP PCPs supplemented by other employed physicians. Physicians who were available saw patients in the UCCs during normal working hours and for additional pay after hours.

As the UCC program matured, its growth was hampered by a lack of dedicated clinical management. Practice leaders decided to hire an emergency medicine physician to oversee the program.

Midlevel providers, including physician's assistants and nurse practitioners (most with emergency medicine experience), were hired to provide the bulk of the services. The two sites are now typically staffed by two midlevel providers and a physician clinical coordinator. The nursing and technical staff positions dedicated to the UCC are filled by existing SIPP employees, who are either scheduled for the positions or offered the positions as overtime. SIPP's department of diagnostic imaging has extended hours to accommodate the growth in UCC volume. Immediate access to standard X-rays and mammography has been supplemented with computed tomography (CT) and magnetic resonance imaging (MRI).

## What Is Urgent Care?

Urgent care centers (UCCs) provide medically necessary services required for an illness or injury that would not result in further disability or death if not treated immediately ("urgently"), but require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours.

Illnesses include:

- > Colds, flu, and other viral illness
- > Bronchitis, pneumonia, and asthma attacks
- > Ear, throat, and sinus infections
- > Bladder infections
- > Superficial eye infection
- > Rashes, poison ivy, and allergic reactions
- > Nausea, vomiting, diarrhea, and dehydration
- > Allergic reaction management
- > Minor gynecological problems

Injuries/procedures include:

- > Fractures, sprains, strains, and dislocations
- > Minor surgical procedures
- > Contusions
- > Wound repair and abscess drainage
- > Abrasions (scrapes) and splinters
- > Work-related injuries
- > Laceration repairs
- > Simple fracture care (including finger tuft fractures, radius buckle fractures, ankle avulsion fractures, and others)
- > Abscess incision and drainage

- > Thrombosed hemorrhoid excision
- > Joint aspirations and injections
- > Ganglion cyst aspirations and injections
- > Coumadin® check

Often, the motivation to use a UCC is that patients "cannot wait" (clinically or personally) for an appointment with their customary primary care physicians (PCPs) due to heavy office scheduling after hours or on holidays. Urgent care services are provided by PCPs, emergency medicine board-certified and urgent care physicians, midlevel providers (physician assistants, nurse practitioners) or family practice, general practice, pediatric, or internal medicine physicians. Urgent care was not developed as a substitute for primary or preventive care, but as scheduling and access to PCPs has become more constrained due to heavy caseloads, UCCs have taken on this focus.

UCCs can often easily provide:

- > Physicals for sports, employment, pre-employment, and U.S. Department of Transportation
- > Medical evaluations for executives, workers' compensation, and return-to-work approvals
- > Workplace immunizations and vaccinations
- > Flu and allergy shots
- > X-rays, laboratory work, electrocardiography, and intravenous fluids on site
- > Occupational medicine for workplace injuries

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The change to a dedicated midlevel practitioner model was made for two major reasons. First, as volume at the UCC grew, physicians from the primary care staff at the clinics were not always available to serve walk-in patients. Second, analysis of the types of problems presenting in the UCCs revealed that about 80 percent did not require direct physician care. Staffing the centers with dedicated midlevel providers overseen by a physician gave more flexibility to meet patient needs, and reduced operating costs. Compensation, malpractice coverage, and overhead are all lower for limited-license providers compared with PCPs in similar roles. Switching to midlevel providers is forecast to decrease professional service costs and associated fees by approximately 12 percent and increase throughput by an estimated 15 percent.

On the business side, the UCCs were initially opened as extensions of the physician practice

because this structure did not require any additional licensing or credentialing, and permitted the practice to take advantage of existing fixed overhead. Over time, insurers began developing special payment categories, some of them global payments, with lower deductibles for patients using UCCs rather than hospital EDs when appropriate. Designation of the UCCs by insurers as specialty providers increased payment by as much as 30 percent, but it also subjected the UCCs to additional credentialing requirements and occasional insurance inspections. The trade-off was made to help increase revenues, volume, and patient satisfaction.

Advertising is also extensively employed to promote the UCCs to both existing SIPP patients and nonaffiliated patients. Two major hospitals with EDs, a few identified UCCs, and retail clinics all vie for patients' attention. Bus shelters,

billboard, magazine, newspaper, and other media advertising, partial sponsorship of local sports franchises, and other local events are all employed promotional methods.

The total costs of the UCC start-up were minimal. SIPP identified available reserves to cover both capital and initial operating costs. There were no space “build out” or special equipment requirements because a reorganization of physician schedules permitted existing, underutilized primary care office space and staff to be used. Physicians were paid fee-for-service based on a prenegotiated fee schedule.

One nurse, one receptionist, and two medical assistants were reassigned to the day shift from the currently employed staff pool (an opportunity cost to SIPP), and an equivalent new staff complement was recruited for the after-hours UCC. SIPP also hired a security guard to the UCC for after-hours work. Radiology extended its staffing for conventional radiology (X-ray and sonography) by two hours each day. Total annualized salary and benefits costs for nonphysician/mid-level staff at both UCC sites amounts to approximately \$400,000, including 78 additional staff hours per week after hours and on weekends. Some of the additional salary costs are attributable to overtime, because there is less control of patient scheduling in urgent care settings.

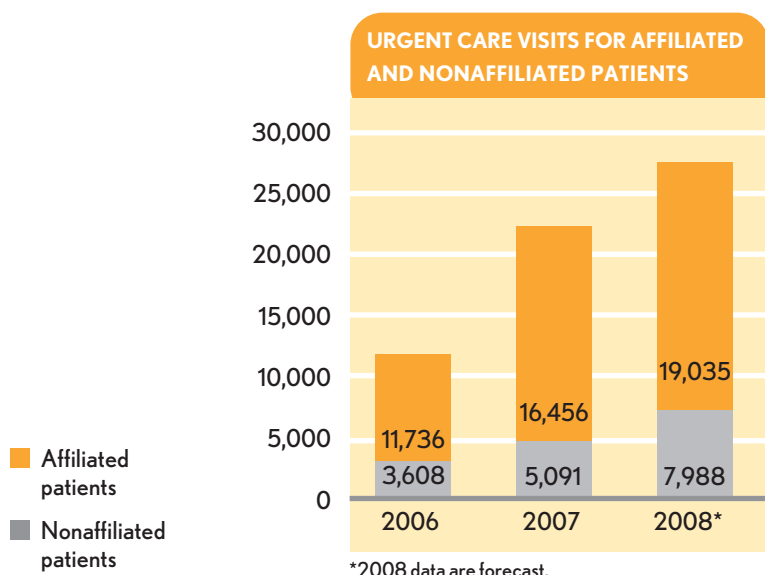
## SIPP’s experiences with its two UCCs show that urgent care facilities can be an effective business development strategy.

Marketing materials (brochures, flyer, and other handouts) were developed in house, printed locally, and distributed passively to existing patients. Total marketing costs were less than \$5,000. Staffs were actively encouraged to participate at no charge to SIPP in community events as speakers on urgent care topics. New signage with lighting was installed at a cost of \$15,000, and billboard advertising was added to an existing contract at a cost of an additional \$11,000. Other media advertising was of minimal expense and organized entirely by existing staff. For example, SIPP sponsored an open house for local press and public, hosting 120 guests for a breakfast that resulted in positive articles in local newspapers and newsletters.

### Results of First Two Complete Years

After more than three years in operation, SIPP’s UCCs have met many of their strategic objectives. Current performance is reflected in data that SIPP was able to gather from 2006 (the UCC’s first full year of operation) through 2008.

Growth in patient visits has been significant: From 2006 through 2008, patient visits increased by 76 percent from 15,344 to a forecast 27,023. SIPP continues its focused marketing to the general Staten Island public, and the fastest growing segment in the UCC has been among the nonaffiliated patients (SIPP’s data indicate a 121 percent increase from 2006 through 2008). Today, growth in nonaffiliated patient visits to UCCs continues to increase at a rate of 100



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additional visits per month and shows no signs of slowing. Meanwhile, ED visits by SIPP-affiliated patients have dropped: The three-year data indicate these visits declined 32 percent as UCC visits were increasing—and the decline in ED visits is continuing.

The insurance mix is broad based but does not reflect the general distribution of state and federal third-party insurance plans on Staten Island. There are fewer Medicare and Medicaid patients than might have been forecast. Charges to patients for office visits range from approximately \$40 to \$90 plus collections for associated diagnostic tests on a fee-for-service basis, and \$100 to \$120 when such visits are paid globally.

Along with the reduction in costs achieved by reorganizing to a midlevel provider care model, the increases in volume have been sufficient to

make SIPP's UCCs financially successful, and that success was already evident within the first two years. The growth in nonaffiliated patients as well as referrals to SIPP primary care and specialist physicians also has resulted in increased volume and revenues for the group as a whole. The reduction in use of hospital ED services for capitated patients has also reduced out-of-network charges for these patients, increasing the profitability of some risk contracts.

More difficult to assess is the impact on patient satisfaction and loyalty. Although growth in the absolute number of patients might indicate a relatively high level of satisfaction with the SIPP UCCs based on convenience or quality (both perceived by the patient and real), this effect has not been measured. Similarly, the fact that new patients are being recruited into the practice through the UCCs suggests these patients are

sufficiently satisfied with their UCC experience to trust their regular care to the practice. However, there is a real need to understand more of the patient’s care experience from the patients’ perspective to attract and address future growth. This year, SIPP is undertaking a telephone survey to generate definitive data on these issues. The methodology for this survey typically generates response rates in excess of 90 percent, making it a far more reliable research and development tool than mail-in surveys or those administered to patients in the office.

**Lessons Learned**

Although SIPP’s UCC strategy has succeeded, it has taken careful planning, ongoing monitoring of performance, and a willingness to make management and operational changes as circumstances have changed. SIPP has learned several significant lessons from this experience.

*It takes time and resources to build a successful UCC.*

Creating public awareness and building a patient base for a UCC can take time. Hospitals or groups pursuing a UCC strategy should be prepared to fund several months of operating deficits, and budget for sufficient advertising and marketing to get the operation established.

*Dedicated midlevel providers should be part of the strategy.* Staffing the centers with part-time PCPs proved both organizationally problematic and expensive. When it became clear that most UCC cases could be adequately handled by midlevel providers, the switch was made. The result was less disruption to physicians’ schedules, better service to patients, and lower costs for services. However, the presence of a physician in the facility remains an important feature. It reinforces the positioning of the UCC as a more comprehensive alternative to retail clinics, and may be a significant market differentiator. Further, some insurers will not pay for midlevel directed UCC visits, which further underscores the need for active physician involvement.

*Key diagnostic tests should be available off-hours.*

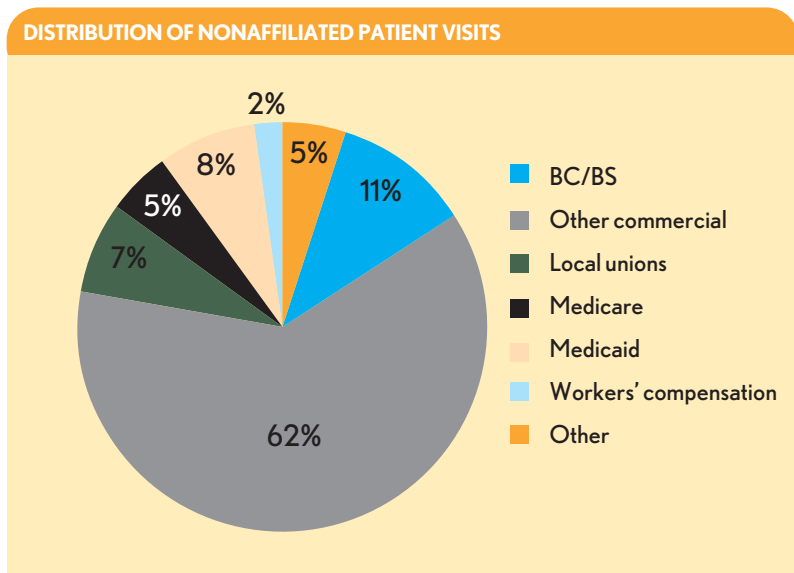
The practice’s diagnostic imaging department extended its hours to accommodate growth in UCC volume. Immediate access to X-rays and mammography has been supplemented with CT and MRI. Availability of these services has been another key market differentiator for the SIPP UCCs. Patients know they can get more comprehensive services at a UCC than at a retail walk-in clinic at a lower price and shorter wait than at a hospital ED. This makes the UCC a more convenient choice than the other two options.

*Many UCC patients already have physicians.*

Although the flow of unaffiliated patients has grown, many of them already have PCPs. In many cases, these physicians actually directed the patients to the center for off-hours care, with the expectation that the patient and a clinical note would return. SIPP has had to be careful not to aggressively recruit these patients and damage referral relationships.

*The practice should manage patient flow.* Despite the growth of unaffiliated patients, most UCC visitors are from the practice. These patients need to be managed to avoid losses from risk contracts. A registered nurse has been designated to manage flow of patients from the practice.

*Special designation should be sought from payers to add revenue.* The practice has selectively sought



and received special designation from some health insurers, under which members have an incentive to use the UCCs instead of other off-hours facilities. This has increased collections as much as 30 percent from some plans, but it also requires submission to occasional external regulations and scrutiny.

*The workflow should be integrated with the rest of the clinic.* For example, billing and electronic health record (EHR) operations were extended into the UCC in a coordinated fashion, concurrent with a relaunch of the EHR system throughout the group practice.

**Future Prospects**

The practice recently completed a renovation of one of the UCCs and will take further steps to improve UCC operations to improve in the following areas.

*Accurately measure patient satisfaction.* To get better information on patient experience and preferences for future development, SIPP is undertaking a telephone-based patient satisfaction survey. Although more expensive than other survey methods, the phone survey consistently achieves participation rates greater than 90 percent. Each provider's personal manner and skills will be evaluated, as well as the discharge process and the patient's overall satisfaction with the experience. Subsequent surveys every six months will be used to monitor progress and guide future development.

*Target Medicare patients with ads.* A new promotional campaign will focus on attracting more Medicare beneficiaries. Currently, Medicare and Medicaid represent 31 percent of patients in Staten Island community practices but only 13 percent at the UCCs.

*Partner with hospital EDs.* SIPP leadership has discussed with ED directors at the two local hospitals the possibility of redirecting some ED patients to the UCCs as a way to reduce long ED wait times. Interest focused on "frequent flyers," patients who use the ED for routine care. SIPP is also

considering extending the UCC's hours of operation, seeking to serve as non-hospital-based observation units and possibly creating a free-standing ED in partnership with local hospitals.

**Meeting Goals with UCCs**

SIPP's experiences with its two UCCs show that urgent care facilities can be an effective business development strategy for a group practice looking to better serve patient needs and capture new market share while making the practice more profitable.

Special attention needs to be paid to structuring and operating the centers so that they are financially and operationally stable, and integrating their business and clinical operations with overall group operations to achieve strategic and financial goals. In this case, these goals included capturing patients not already affiliated with PCPs in the community and decreasing use of local hospital EDs by its patients. The goals were achieved, resulting in significant enhancements of revenues and market share for the group as a whole. ●

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