

Decision and Transition of a Community-Based Emergency Department to an Urgent Care Center

Case Study Submission

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Introduction:

The executive leadership team of a pediatric hospital system (Hospital) appointed a steering committee to develop an urgent care strategy and operational plans for implementation. To assist with the evaluation, the team engaged a strategic planning consultant, who had experience with the Hospital, to facilitate this review. The steering committee was composed of hospital executives, physicians, administrative leadership, and key stakeholders from the hospital's community based EDs and their ambulatory network. Their charge was to evaluate and recommend an urgent care regional strategy.

The executive team approved the steering committee's recommendation to develop an urgent care model with sites in six (6) geographic regions in their primary and secondary markets. The intent was to supplement their primary care and ambulatory network with convenient services to serve a broader base of families in their market areas. This was driven by competition intensifying for convenient care options in the ambulatory market and feedback escalating from families to provide more accessible, convenient, and affordable services.

One focus of the engagement was whether one or both of their community-based emergency departments (EDs) – North and West - should be converted to urgent care sites. Key drivers leading to this evaluation were declining patient volumes in the community based EDs, families questioning co-pays prior to ED visit and deciding on lower cost options, Medicaid and commercial payors retrospectively determining acuity of patients as non-emergent and reducing reimbursement, and competitors driving new stakes in the market area. By not planning for transition of the community based EDs in a timely way, the executive team deemed that the Hospital would be pre-empted from market opportunities in the near future and eventually success as community based EDs would be eroded and not recoupable. The hospital based EDs on the two (2) main hospital campuses would be maintained and were not included in this evaluation.

Alternatives Considered

The first alternative was to maintain the two (2) community based EDs "as they are." The advantage would be no disruption of the current ED model. All was currently going well with staff satisfaction, as the staff work very well as a team and patients and families have been extremely pleased with the service, as evidenced by positive feedback on satisfaction surveys. The EDs also experienced good financial performance despite a trend of declining volumes. Disadvantages of keeping the EDs "as they are" would be business erosion over time. Since a very high percentage of patients are projected to have acuity that is non-emergent, maintaining this level of reimbursed care would not be sustainable. Payor feedback scrutinized non-emergent services rendered and with frequent decision to reduce reimbursement. Competitors were also capturing more share in the ambulatory market with lower cost, convenient options.

The second alternative was to transition both community based EDs to urgent care within the calendar year. Advantages would be placing urgent care services in the competitive marketplace in a timely way. The emergency patients, who sought services in the community based EDs, would have option for emergency services on the hospital campus, which was less than ten (10) miles away. Key advantage of the timeline would be adequate lead time to plan and operationalize the new urgent care model and transition the existing Emergency providers and staff to other venues. The disadvantage would be delays in getting the urgent care option in the market in a timely way while the competitive landscape intensifies.

A third alternative, to close both community based EDs and not offer services in those locations, was not an option promoted or considered by the executive team.

Process

The consultant provided in depth analyses of the current patient based served by each of the community based EDs. This included details of payor mix, patient acuity levels, diagnoses, treatment, and reimbursement. This was supplemented by a market analysis that addressed trends in population growth and the competitive landscape with details on volumes of competing EDs, hospital based urgent care centers, and retail convenient care clinics. Factors evaluated included market dynamics and supply of urgent care in community, perceived threat to private primary care physicians, payment rates for Medicaid, commercial, self pay responsibility, parental satisfaction and patient experience, provider supply, and financial projections in various urgent care scenarios.

Several databases and resources were accessed, such as professional contacts at multiple children's hospitals, urgent care practices, and advisory board and professional organizations. Analyses and visual displays of the Hospital's ED service data displayed trends and projections of utilization by acuity, disposition, non-emergent CPT codes, geographic site and submarket, service area radius, and penetration by geography. Conclusion from this review was that a significant portion of the hospital's community based ED visits was represented by low acuity and non-emergent services – roughly 70-80% of the volume.

Chosen Solution

After several meetings and deliberations of the steering committee over a three (3) month timeframe, they recommended the second alternative - transition of the community based EDs to urgent care within the next calendar year. The North site was selected as the first one to transition, as this community based ED had the lesser volume of the two (2) and was in a community where residents were intensely seeking convenient care services. The committee felt a sense of urgency to plan this new service delivery model, as competition in the market was developing quickly. Despite success of the financial model in the EDs, projection was that the margins would deteriorate over the next few years as payors continue to decline emergency payment for non-emergent services. Future focus would be on patient panel size and patient access, which would be driven by family choice of convenience and price sensitivity (appropriate co-pay levels for non-emergent services). Decision was made to run the urgent care locations as ambulatory services and not step down services of the EDs. Converting both EDs within the calendar year would provide adequate timeframe to develop the urgent care model, complete operational planning, convert the ED providers and staff, and promote the new urgent care service to patient and families.

At the time this recommendation was being made, an unexpected move in the primary market unfolded. A competitor was planning a new facility with pediatric services in the same geographic area (within ¼ mile) of the West community based ED. The executive team thoughtfully reviewed the steering committee's recommendation to convert the North community based ED to an urgent care center and approved with the caveat that the transition be applied first to the West site and that it occur within the next four (4) months.

Implementation

Next steps were to plan and implement the transition of the West community based ED to urgent care. There were several challenges that required substantial evaluation and planning to complete the urgent care transition within the four (4) month timeline. The urgent care leadership team was recruited from internal key leaders of the current community based EDs. The team's expertise in community based emergency services was felt to be an advantage to crafting the overall urgent care services and provide a strong connection with the main campus EDs for transition of emergent patients when they would present. One potential outcome with the appointment of this leadership team was that they would be emergency service minded rather than ambulatory or primary care minded. It was critical that the urgent care service be scoped to non-emergent services (no scope creep) and be streamlined with providers, clinical and administrative support for lower acuity services. This would also include building more volume and facilitating efficient patient throughput on a daily basis. In planning the scope and delivery of urgent care services, the leadership team focused on developing this ambulatory model.

Transitioning from an ED, the key areas impacted were:

- Organizational chart & reporting relationships

In the ED model, the providers reported to the Department of Pediatrics, clinical and support staff reported to the Department of Nursing, and the registration staff reported to the Finance Department. In the urgent care model, all providers and staff would report under one infrastructure in the Department of Pediatrics with the sites being organized under the ambulatory primary care structure. This directly impacted the realignment of providers, clinical and support staff, and administrative support.

- Clinical scope & service delivery

Despite most of the community based ED patients receiving services at an urgent care level, changes in the clinical scope of care from ED to urgent care required a significant shift from the emergency driven model. The service model was modified by narrowing the scope and intensity of services. Several scope modifications were made, such as treating only minor lacerations and injuries and no longer performing the more complicated or delicate (facial) suturing and trauma treatment. No longer would there be CT scan availability; basic radiology would be provided. Also, a full service in-house lab was converted to point of care testing. Goals of the model were to enhance access and attract a broader patient base and promote efficient throughput and quick turnaround to effectively serve families.

The operating hours were adjusted and no longer reflected expanded coverage of the community based ED. The urgent care hours would be more compressed. Point of care lab testing and couriered lab to the Hospital replaced the outsourced lab services in the same building. Pharmaceutical acquisition and storage changed as several medications were no longer needed in the urgent care model. Inventory of medical/ suturing supplies narrowed.

- Provider and staff model

The number of full-time equivalent (FTE) providers was decreased to match the lower acuity urgent care volume accompanied with the change from Pediatric Emergency Medicine (PEM) physicians to pediatricians and advanced practice professionals. There would be a pediatrician providing services at all times and at busier times an APP would supplement the provider staffing. This change necessitated a shift in the existing PEMs covering the North and West sites to the two (2) hospital based EDs in the Hospital system.

The clinical and support staff FTEs and skill mix were also adjusted. Although staff FTEs were decreased to align with the lower acuity levels in urgent care, no one lost their position in the system. The numbers of full time equivalent staff were decreased and the staffing mix changed to manage the lower acuity levels. This change proved to be a substantial challenge as the staff, who decided to remain in the urgent care model, were expected to convert their ED mindset to ambulatory. Some of the staff truly desired to stay in ED environment and requested transfer to one of the hospital based EDs. Changes in the required support for suturing in urgent care sites required changes in the suture tech program as the level and complexity of suturing would be reduced. The suture tech positions were converted to urgent care techs and would be responsible for a variety of functions beyond suturing, such as providing medical assistant functions.

- Electronic medical record

The EDs had been running on an emergency services electronic medical record (EMR). Decision was made to convert the urgent care services to the ambulatory EMR and not remain on the emergency model, so a conversion from the emergency based to ambulatory based EMR was required. This conversion entailed significant changes to the EMR build, which was driven by changes in the clinical content and work flow. Challenges ensued with provider/ staff adaptation to a new way of documenting as the tools in the emergency EMR were familiar and preferred.

The ambulatory EMR was based on the primary care model, which was enhanced to accommodate the nuances of urgent care. One significant adjustment was that in the ambulatory EMR there was not a patient tracking board as patient management relied on the queues and flags in the ambulatory EMR. At first, this was a big dissatisfier with the current ED staff transitioning to urgent care. Over time, as pediatricians and staff were on boarded from primary care sites and external practices, expectations changed and this was no longer considered a significant roadblock.

- Communications to families

Communications strategies were developed to identify and connect with the new patient base for urgent care services. Various tactics for promoting urgent care were developed, such as external facility signage, publications in the market area, and distribution of urgent care information to primary care practices and affiliated services in the community. Approaches included connections with existing patients and families who had visited the community based ED for non-emergent services. Patient specific letters were developed and frequent flyer families were individually contacted. Also, scripts for

staff answering the phones were developed and staff mentored on communications. The positive spin to appeal to families with lower co pays, more convenience, and ready access was developed in the messaging.

- Financial model

Renegotiating managed care contracts for urgent care rates takes time even when a plus for payors. From a payor perspective, this was a positive shift from ED billing to urgent care billing as primary care. Along with revising the place of service and ED pro and tech billing to ambulatory, most every billing and collection process was changed. Budgets were forecasted and management reporting tools developed. Financial projections, including break even analyses for various scenarios, were based on volume thresholds from 10,000 to 15,000 visits. The significant adjustment to the change in payment rates and collections meant less reimbursement. Urgent care operating costs would be lower, though volumes anticipated to be greater than the community based EDs.

It can not be understated how important the change management process had become. Not everyone in the community based EDs was initially supportive of the new service model. There was resistance expected in changing the existing infrastructure, so sensitivity was vitally important, but it turned out that there was more resistance than anticipated. Stakeholders from other areas (emergency, primary care) were engaged to support the transition to the urgent care model. Engaging and recognizing the existing ED team and facilitating people engagement was escalated as a priority. The staff transition was very challenging, as all were dedicated to their PEM leaders and one another. They were responsible for the start up and success of the community based EDs and regularly received accolades for the high quality of service and patient and family satisfaction. They truly owned their ED operations. As there was a significant, unanticipated impact on morale of the staff, the ED and Urgent Care leadership engaged the help of the change engagement team of the Hospital. As the operational planning was underway, there was a parallel project to manage the people side of change. Several sessions, including the current ED providers and staff, were held to talk thru the impacts of change and plan the transition to a new leadership team and a new model of care.

To guide the implementation of the urgent care model and transition of the ED sites, a multidisciplinary planning and operations team was appointed by the executives with leadership by the Vice President and the Chair of the Department of Pediatrics. Interim project leadership was engaged until the urgent care leadership team of Medical Director, Operations Director, and Clinical Manager were on-boarded.

Once the urgent care leadership team was in place, the implementation of the operational plans and provider and staff recruitment escalated. Substantial time was dedicated defining the scope of urgent care services, creating standard work, and developing communication tools for the services. The project team designed and built the urgent care model and transitioned the West community based ED to urgent care within the designated four (4) month timeframe.

Lessons Learned

- The reorganization and realignment of the reporting structure under the ED to the ambulatory infrastructure impacted the availability of the clinical staff pool for human resources support.

The provider transition was tough, as an established work force of pediatricians was not readily available. Recruitment escalated as a priority as substantial lead time was required to recruit a dedicated base of FTEs to urgent care.

- The people side of change can make or break project success - transitioning existing ED staff to the new Urgent Care model or to other options in the hospital was a sensitive process to engage support and expertise to make the transition as smooth as possible.
- Transitioning existing ED staff to the urgent care model comes with the inherent challenge of maintaining old ways of thinking. Urgent care does not operate like an ED, so there is potential for clinical scope creep if the staff performs in the way they were originally trained. Creating a new pace for clinical flow and standard work processes are critical to a successful urgent care model.
- Be open and agile to market changes. Although four (4) months to operationally plan and implement a new service model would be thought of as very challenging (more lead time a plus), the market forces pushed a shortened timeline, which was achievable when all stakeholder departments engaged.

Recommendations

What could have been done differently was affording more lead time to address critical success factors in the project management timeline:

First, engaging and transitioning the current ED physician leadership and onboarding the Urgent Care leadership team earlier in the project. Recommendation is to engage your physicians and staff from all system areas as soon as possible and keep communications at the forefront for the team that is transitioning and the team that is onboarding. When involved in a conversion of a system of care, promote the people side of change in the very beginning.

Second, the transition of the EMR system from ED hospital-based to Urgent Care ambulatory requires sufficient lead time to build, train, and implement the system – this became the key factor impacting timeline. Recommendation is to plan and develop Information Technology resources and system support early on in order to accomplish the timeline goal.

And third, approach the payors earlier in the process. Achieving Urgent Care rates becomes very challenging if payors not pursued and negotiated with early in the process. The payment default is to primary care ambulatory rates, which does not adequately cover the scope of pediatric services rendered. Recommendation is to negotiate early sharing the key benefit to payors that low level acuity ED visits, which are expensive, have opportunity to become reasonable priced urgent care visits.

Endnote:

Gindi, R. & Jones, L. (2014). Reasons for Emergency Room Use Among U.S. Children: National Health Interview Survey, 2012, *NCHS Data Brief*, 160

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Manuscript Tags

Key paragraph:

This case study addresses a pediatric hospital system's evaluation and transition of one of their community based Emergency Departments to an Urgent Care Center. This decision was driven by competition intensifying for convenient care options in the ambulatory market and feedback escalating from families to provide more accessible, convenient, and affordable services. Objectives of this case study are to outline the decision making process and share insights on critical success factors for implementing the transition in a short project management timeline. Factors evaluated and addressed include a market assessment, financial modeling, organizational restructure, clinical scope and service delivery model, change engagement with leaders and staff, technology and resources required for operations, and marketing and communications plan for patients and families.

Key words:

Urgent Care, Regional Strategy, Ambulatory Strategy, Emergency Department, Change Engagement, People Change, Ambulatory Competition, Ambulatory Market, Project Management, Financial Modeling