Urgent Care Service Lines in FQHC’s

NCCHCA Primary Care Conference

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Primary Care vs. Urgent Care

	Primary Care	Urgent Care
Purpose	Continuity of care, prevention, chronic disease management	Immediate treatment of acute conditions
Patient Relationship	Long-term, ongoing relationship	One-time or episodic
Visit Focus	Comprehensive, whole-person focus	Single-issue, problem focused
Care Planning	Includes risk stratification, follow-ups, referrals	Single-issue, problem focused
Documentation	Extensive: SDOH, Chronic Issues, Care goals	Brief: signs, symptoms, treatment
Staffing Model	Multidisciplinary, often with case management	Lean and streamlined for volume
Scheduling	Scheduled visits with some same-day availability	Primarily walk-in or same-day
Patient Expectations	Holistic-support, long-term problem solving	Fast relief, minimal wait, no long discussions
Quality Measures Impact	Integral to UDS metrics (screenings, continuity, chronic management, etc.)	May negatively impact scores if not integrated

Systems Thinking & Bridge Strategies

	Bridge Considerations
Purpose	**Must do:** Educate patients/staff on service distinctions and create clear signage, protocols, and messaging **Nice to do:** Locate the Urgent Care service line in an entirely different facility, or at minimum have a segregate entrance/exit for patient traffic
Patient Relationship	**Must do:** Train Urgent Care staff to route patients to Primary Care for follow-up; Train Primary Care staff to not look at Urgent Care for 'overflow' **Nice to do:** Ensure Urgent Care office notes are routed to patient's PCP; for patients with no PCP, give them an appointment to establish with yours before they leave Urgent Care. *Be the example and send office visit notes to PCP without them having to ask for it!*
Visit Focus	**Must do:** Encourage urgent care to address only acute needs and empower primary care to do follow up and chronic disease management. *Example: Urgent Care shouldn't provide DM/HTN refills* **Nice to do:** Develop a list of acute issues that Urgent Care addresses and post it throughout (signage, web site, etc. etc.)
Care Planning	**Must do:** Document referral and care plan handoff **Nice to do:** Configure EMR (if possible) to notify PCP care teams of their patient's UC visits automatically

Systems Thinking & Bridge Strategies

	Bridge Considerations
Documentation	**Must do:** Use structured templates that prompt UC to document referral to PCP care team
Staffing Model	Use care managers/care coordinators to track and follow-up with primary care patients post-urgent care visits
Scheduling	Consider scheduling blocks in Primary Care for Urgent Care follow-ups
Patient Expectations	**Must do:** Have clear and consistent messaging across all staff to reinforce boundaries of service limits and follow-up expectations
Quality Measures Impact	**Must do:** Follow UDS and HRSA Compliance Manual definitions for unduplicated patients and visit counts. **Nice to do:** Track Urgent-Care-Only patients and visits internally such that the impact is monitored through the QI program.

Step 1: Assess the Market

- **Section 1 (External): Demographics**
  - Total Area Population
  - 5-Year Population Growth Rate
  - % Under age 18
  - % Age 65 and Older
  - Prevalence of Chronic Conditions
  - Uninsured Rate
  - Medicaid Enrollment Rate
- **Section 2 (External): Healthcare Service Landscape (30-minute drive radius)**
  - Emergency Rooms
  - Other Urgent Care Centers
  - Retail or Walk-In Clinics
  - Average ER Wait Time
  - Ambulance Travel Time
  - Primary Care Practices with Walk-in Access

Step 1: Assess the Market

- **Section 3 (Internal): Access Barriers**
  - Transportation Issues
  - Lack of After-Hours Care
  - Cost/Affordability Issues for Established Patients seeking Urgent Care
  - Limited Appointment Availability for Same-Day Access
  - Patient Confusion
- **Section 4 (Internal): Demand Indicators**
  - Walk-in Attempts at Primary Care
  - Primary Care No-Show Rate
  - After-Hours Call Volume
  - Patients being redirected to ER
  - Community/Patient Feedback

Step 2: Assess Organizational Capacity

- **Available facility space:**
  - Separate Patient Entrance, Check-In/Out and Waiting for Urgent Care
    - Ideal Scenario: Don't co-locate in the same facility with Primary Care)
    - Establish a "Suite" with USPS if in same building – you will need it for insurance credentialing!
  - Ensure parking lot safety to accommodate EMS Transport
  - Ensure quick access for EMS transport into facility (consider the flow to include a patient on a stretcher)
  - Trauma Room: added privacy; stretcher to support minor procedures to critical care management and easy transport; crash cart (defibrillator, code drugs, airway management, etc.); easy access to minor procedure materials (suture, splinting, etc.)
  - Consider infection control (barriers, etc.) in waiting areas
  - Must have onsite xray
  - Consider safety – emotions can run higher in Urgent Care settings

Step 2: Assess Organizational Capacity

- **Staffing Model Readiness:**
  - Lead Provider MUST have ER/Urgent Care Background – you will need their experience; avoid ‘growing your own’ for the initial lead position
  - Consider scope for clinical support: RN vs. LPN vs. MA
  - Copay collection at check-in
  - BLS/ACLS/PALS
  - Competency/Privileging for clinical support staff to include triage (RN? Paramedic?)
  - Consider Urgent Care Provider PRN Pool

Step 2: Assess Organizational Capacity

- **EHR & Billing Workflow Readiness:**
  - Identify a way to document PCP name when Urgent Care patients see someone other than one of your own
  - Develop Urgent Care templates (Urgent Care doesn’t collect exhaustive histories, etc.)
  - Ensure procedures are built out to provide efficient documentation that will trigger billing
  - Ensure that Sliding Scale and Insurance Copays are applied appropriately for Urgent Care

Step 2: Assess Organizational Capacity

- **Cultural Readiness & Leadership Support:**
  - Commitment required from the Bottom Up and Top Down (including Board)
  - Add “Urgent Care” service and the ‘new’ facility (even if it’s a suite number) to HRSA scope
  - Add Urgent Care site to 340-B OPAIS
  - Get facility numbers and contracts (CMS, Third-party payers, etc.)

Step 3: Financial Analysis

- **Revenue Considerations:**
  - Copays for Urgent Care Services from Third-party payers are usually higher than Primary Care; They financially incentivize patients to utilize primary care
  - Using the above as a foundation – consider a higher sliding fee copay for Urgent Care services – you want it to ‘feed’ your primary care operation, not compete with it.
  - Urgent Care visits will be reflected in the same way that all other visits are captured in cost reports; as such, PPS rates will apply.
- **Expense Considerations:**
  - Vaccines and other billable preventive services are not usually part of Urgent Care visits; however, expect a higher medical supply expense than primary care.

Questions?

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