

LEVERAGING ORTHOPEDIC AND SPINE URGENT CARE CENTERS



What are the key considerations in developing orthopedic and spine urgent care strategies?

Overview

Demand for orthopedic and spine care is anticipated to surge over the coming decade. However, current capacity is already ill-equipped to meet today's demand. Many patients with an urgent orthopedic injury or spine condition currently find themselves in the ED or waiting days to get an appointment with an orthopedic surgeon. General urgent care facilities, meant to provide quicker access to lower-cost health care providers, often lack the expertise to quickly diagnose and treat orthopedic conditions. Leading orthopedic programs are developing orthopedic-specific urgent care centers to:

- Appropriately meet the rising demand for orthopedic care
- Decant lower-acuity volumes from the ED
- Offer convenient access at low cost
- Offer the specialization necessary for high-quality outcomes
- Capture lucrative downstream sports medicine volumes

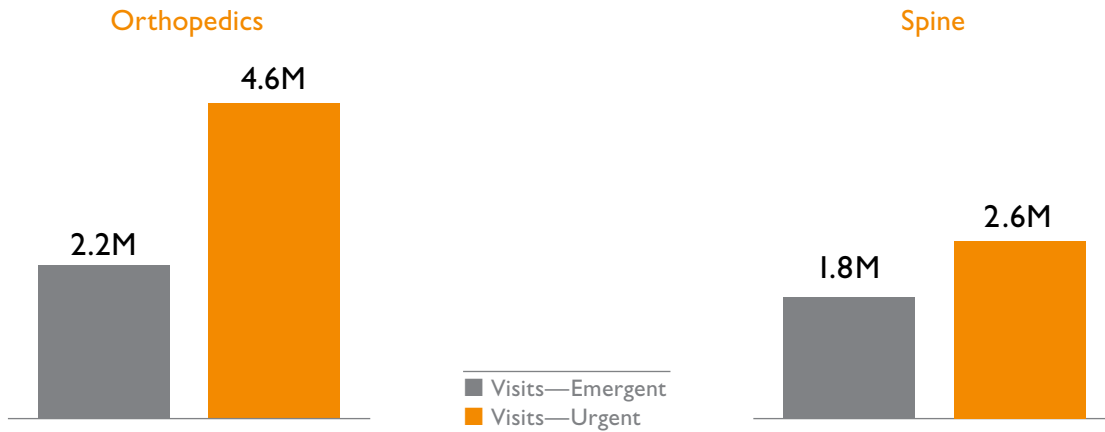
Development of these urgent care centers can occur as an extension of an existing orthopedic practice, an adjacency to existing urgent care offerings or through a partnership with third parties. Hospitals with ED backlogs caused by routine orthopedic injuries or hospitals simply looking to move orthopedic market share should find an orthopedic urgent care strategy successful.

Most Orthopedic and Spine Emergency Department Visits Are Nonemergent

Sg2 classifies emergency department visits as either emergent or urgent. Emergent visits are for potentially life threatening conditions and require immediate care. Contrarily, urgent visits are for non-life threatening conditions and typically can be treated without emergency department resources. Of US visits regarding an orthopedics injury or spine condition, 63% are classified as "urgent," indicating that these patients have the potential to be cared for in a lower-acuity, lower-cost setting.

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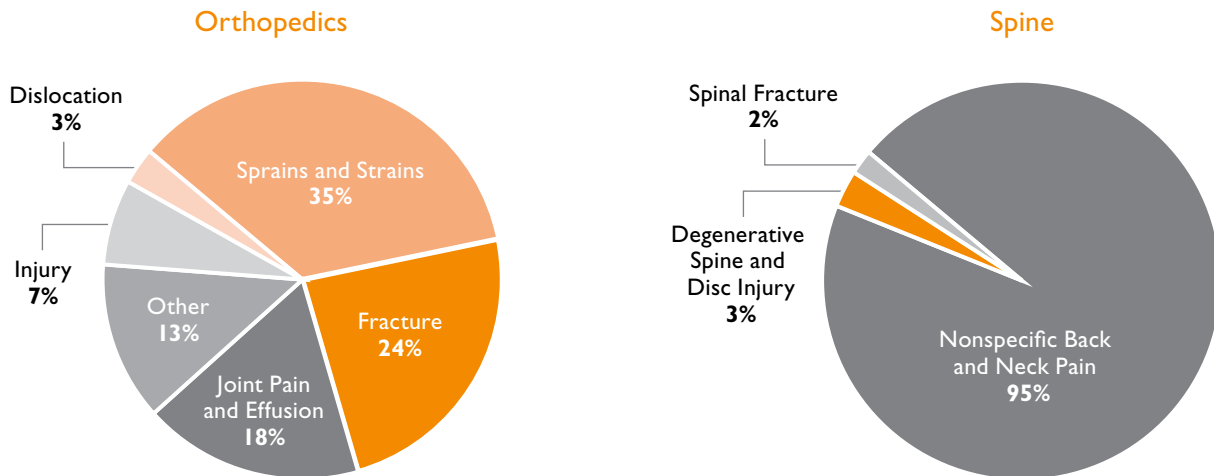
FIGURE 1. EMERGENCY DEPARTMENT VISIT TYPES FOR ORTHOPEDICS AND SPINE



Sources: Impact of Change® v14.0; PharMetrics; CMS; Sg2 Analysis, 2014.

The breakdown of diagnoses requiring an “urgent visit” is shown in Figure 2.

FIGURE 2. “URGENT” VISIT DIAGNOSES FOR ORTHOPEDICS AND SPINE



Sources: Impact of Change® v14.0; PharMetrics; CMS; Sg2 Analysis, 2014.

A high volume of urgent cases in the emergency department signals a need for better access to orthopedic providers in the community and underlies the business case for pursuing alternative access channels, including orthopedic-specific urgent care.

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Considerations for the Development of Orthopedic Urgent Care Centers

Location

- Urgent care facilities usually target a travel time of 15 to 20 minutes from the nearest hospital in an urban setting, and 30 to 45 minutes in a rural setting. An ideal location would:
 - Be proximal to an active, younger population (eg, school sports)
 - Be near a busy road or highway
 - Leverage adjacencies through co-location with an orthopedic surgeon's office or existing urgent care center
 - Have ample parking
 - Include visible signage with clear hours of operation and types of care provided
- Alternatively, co-location with an ED eliminates the need for patients to self-triage to the appropriate site of care. Patients who arrive at the ED with nonemergent orthopedic injuries can be “fast-tracked” through treatment.

Access

- Optimal hours of operation will vary depending on the busyness of the practice.
- Ideally, operations will be maintained from 9:00 am to 9:00 pm on weekdays and from noon to 4:00 pm on weekends. This allows the facility to capture workers' compensation cases during the day as well as injuries occurring during athletic events in the evening and on weekends (when access to health care services is typically reduced).

Staffing

- Orthopedic physician assistants (PAs) should be the first point of contact.
- Depending on state regulations, an orthopedic surgeon need not be physically present; rather, the surgeon can perform necessary consultations remotely by examining radiographs and directing manipulation of the patient by the orthopedic PA.
- In addition, consider the need for billing and collections personnel, a check-in attendant, medical technicians and x-ray technicians. Cross-training medical technicians as x-ray technicians can allow for more flexible staffing models.
- Continually monitor patient flow and adjust staffing models to meet the demands of times with highest traffic (typically 4:00 pm to 8:00 pm on weekdays, concomitant with athletic events).

Pricing

- Billing as a physician office visit (compared to an emergency department visit) can incentivize patients to choose care within an urgent care center for both convenience and price. As price transparency becomes more widely adopted, low-price facilities will have the opportunity to drive market share.
 - Contrarily, the ability to bill for code S9088 (an add-on code that recognizes the complexity of operating an urgent care center is greater than operating a physician office) along with a facility fee (which hospital-owned urgent care centers are permitted to do) can increase revenue per visit.
- If a managed care organization (MCO) insists on S9083 flat-fee reimbursement (which is unlikely to cover the cost of complex care, as for fractures), it is imperative to negotiate with the MCO and highlight the benefit of these patients avoiding ED visits. If the MCO insists on S9083 pricing, obtain “carve outs” for more complex procedures.

System of CARE

- Work with athletic trainers covering school events to build awareness of the urgent care center and refer injuries.
- Ensure employers (through employee health nurses, case workers or occupational health providers) are aware of the facility, so that workers' compensation cases can be treated rapidly and robustly (to **optimize maximize** return-to-work time). Many employers are frustrated with the return-to-work metric attained in orthopedic workers' compensation cases. The ability to improve return-to-work time because of this earlier intervention and the sharing of these data with employers can be a successful strategy for gaining business.

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- Co-location with physical therapy can enable patients with minor injuries to rapidly move onto the next phase of their recovery.
- Co-location with orthopedic surgeons' offices or within existing urgent care facilities can capitalize on redundancies in the need for imaging and other equipment.

Build, Outsource or Partner?

Hospitals and health systems have three primary choices when developing alternative sites of care:

- Build facilities in owned or leased spaces and manage all operations, including staffing and billing.
- Outsource staffing and operations to third-party management (while retaining billing in-house).
- Partner (joint venture or otherwise) with existing physician-owned practices or with commercial facilities, if present in the market.

Hospitals must carefully consider their relationships with orthopedic surgeons when developing orthopedic urgent care centers. It is important not to “compete” with loyal independent surgeons, but rather work with them on development of this site of care offering (eg, through joint venture).

CASE STUDY

OrthoNOW® Franchise

OrthoNOW® is developing a national network of franchised orthopedic-specialized urgent care centers, supporting various business domains of these nascent facilities.

TABLE I. OrthoNOW® BUSINESS FRAMEWORK

BUSINESS DOMAIN	DETAILS
Marketing	<ul style="list-style-type: none"> • Deploys a predeveloped marketing plan, including Internet, television commercials and print ads • Includes robust search engine optimization, including 122,500 keywords around orthopedic urgent care (which is notable considering that patients with urgent conditions typically leverage search engines to find the nearest available provider) • Provides exclusive market rights to OrthoNOW® brand within the region
Staffing	<ul style="list-style-type: none"> • Recommends first hiring a business development manager, who trains on-site with OrthoNOW® • Suggests a staffing model that includes orthopedic physician assistants, check-in attendants and medical technicians cross-trained as x-ray technicians
Operations	<ul style="list-style-type: none"> • Leverages a national network for centralizing billing and collection • Deploys a practice and procedure manual to which each clinic must rigorously adhere • Collects quality data monthly and shares it with the urgent care network quarterly for benchmarking purposes • Shares best practices of high-performing clinics proactively

Source: Sg2 Interview With OrthoNOW®, November 2014.

Ultimately, the decision to build, outsource or partner depends on the hospital's desire to outlay capital to develop and run the facility. As with outpatient rehabilitation, “big box solutions” can be efficient partners in delivering high-quality care while still filling a needed node in the System of CARE.

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Spine-Specific Urgent Care Centers

Back and neck pain patients also represent a significant portion of backlogged EDs. The vast majority of these patients can be treated nonsurgically, often with physical therapy alone. Therefore, co-locating spine-trained physical therapists with urgent care centers can serve to treat this patient population more effectively.

CASE STUDY

Greenville Health System, South Carolina

Of the over 14,000 employees and dependents insured by the Greenville Health System (GHS) group health plan, there is a high incidence of claims related to back or neck pain in a given year, resulting in concomitantly high health care costs and lost worker productivity. In response, this nonprofit hospital system partnered with Blue Cross and Blue Shield of South Carolina to develop care processes for GHS employees experiencing back and neck pain.

- GHS leveraged a preexisting system of geographically dispersed urgent care clinics already co-located with local physical therapy providers.
 - A physical therapist (PT) can evaluate patients and initiate therapy without a physician referral. However, provisions and insurance reimbursement vary by state.
- Patients who seek care for back and neck pain receive a rapid diagnosis by a PT and start on a treatment “track” the same day.
 - The PT performs the red flag exam, and, absent indications of high acuity, can initiate treatment on Track 1 (therapy only).
 - Red flags, including lack of strength or radiating pain, elevate the patient to Tracks 2 or 3, which include a physician consult, diagnostic imaging and administration of nonsteroidal anti-inflammatory drugs.
 - Track 4 is for chronic pain patients with repeat visits. Tracks 5, 6 and 7 are surgical.
- To encourage participation, physical therapy deductibles and coinsurance are replaced with a co-payment and negotiated with BCBS to reduce the co-pay amount.
- GHS plans to roll out rapid diagnosis services at GHS physician offices next year.

Results

- 85% of patients are now successfully treated with physical therapy only.
- Only 13% of patients in this program received imaging, compared to 47% of patients outside of the program.
- Back pain volume in the emergency department has decreased.
- Local employers are expressing interest in the program.

Source: Sg2 Interview With Greenville Health System, 2014.

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Key Considerations, Downstream Impact and Strategic Opportunities

As organizations ponder their orthopedic-specific urgent care strategies, they must ask themselves the following questions to justify investment:

- Is there a significant capacity issue regarding “urgent” visits for low-acuity orthopedic injuries or spine conditions within my emergency department?
- Is there opportunity for partnership with local employers to improve access for musculoskeletal (MSK) injuries?
- Is there significant competition from generalized urgent care centers or from orthopedic physician offices with extended hours?
- Am I in a growing middle-class community that is dense enough to support a new medical enterprise?
- Are state laws favorable toward urgent care centers?
- Are payers and physicians open to working with urgent care centers?
- What is the most effective staffing model using physicians and midlevel providers?
- How would the urgent care center improve continuity of care?
- How would an urgent care center complement the organization’s overall orthopedic care and ED strategy?

For organizations with the primary goal of new referral channels, an orthopedic-specific urgent care center can be an important strategy. Downstream utilization will depend on market need, an organization’s community footprint and relationships with orthopedic surgeons. Some potential referral streams from an urgent care center to the hospital are:

- ED services via transfers
 - Hospitals and health systems that partner with or own urgent care centers will have protocols in place to transfer patients to emergency departments if necessary.
- Surgical services
 - Orthopedic urgent care centers are typically staffed by orthopedic PAs. For patients ultimately requiring surgery (15% to 20% on average), these nonphysician providers can refer patients to orthopedic surgeons aligned with the parent organization.
- Overall services via broadened catchment area
 - Diligent placement of urgent care centers can increase catchment area and brand recognition for an organization, allowing entry into a new market.

There are over 9,000 urgent care centers currently in the US, and this number continues to grow. Sg2 expects urgent care centers to continue to expand into new markets, seeking to fill gaps in the System of CARE. Hospitals can choose to either compete or cooperate with these new access points; however, patients will continue to seek out the convenience these access points provide regardless of which organization’s name is on the building.

RELATED Sg2 RESOURCES

- System of CARE Guide: [Linking Urgent Care Centers to Systems of CARE](#)
 - Performance Guide: [Getting Back Pain Patients to Appropriate Sites of Care](#)
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Sources: Sg2 Interview With OrthoNOW®, November 2014; Sg2 Interview With Greenville Health System, 2014; Medicare Payment Advisory Commission. *Report to the Congress: Medicare Payment Policy*. March 2014; Impact of Change® v14.0; PharMetrics; CMS; Sg2 Analysis, 2014.