AMPLIFY

2026 Urgent Care Convention

THANK YOU

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Virginia & West Virginia

URGENT CARE ASSOCIATION®

COLLEGE OF URGENT CARE MEDICINE

Questions?

Anyone want to volunteer?

Let’s try this again..

This time utilizing standard operating procedures

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2026 Urgent Care Convention

From Front Desk to Discharge:

Standard Operating Procedures That Protect Patients, Providers*, and Performance

UCA URGENT CARE ASSOCIATION®

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Financial Disclosure

Nothing to Disclose

***UCA and the CUCM no longer utilize the terminology of "provider" and recommend that medical/health organizations use the term "clinician" to refer to physicians and advance practice clinicians.**

I just needed an alliteration!

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WHY LISTEN TO ME?

I have served in the urgent care industry for the majority of my 15-year career as a physician associate and currently serve as a clinical content specialist. During my tenure I have worked as a clinical education director, chaired educational committees, published organizational content, policies and procedures, and represented APCs in organization wide groups.

And I am a nerd…I love to read journals.

Current Employment

- Bon Secours Urgent Care
- US Acute Care Services at Sentara RMH Medical Center
- Urgent Care Association
- WVU Grant Memorial Hospital and Rapid Care

Martha M. Williams, DHSc, MS, PA-C

CONSISTENT AND EVIDENCE BASED CARE

The strive to provide great care is real; but if consistency is not a goal, then great care is not an option.

High Volume

Variable Staffing
-physician vs APC lead
-nursing vs MA

Multiple Sites (state law!)

Variations can cause inefficiencies, increase liability risk and cost, and provide the stage for burnout

VARIABLITY

McGlynn (2003) found of patient interactions in the United States, ONLY 54.9% is recommended care. And this varies significantly dependent on condition: with a variance of 10.5 to 78.7 %

SAME PATIENT--DIFFERENT CARE

- Triage
- PMH and Vitals
- POCT
- Discharge Planning

CONSEQUENCES

- Patient Safety Risk
- Coding Inconsistency
- Patient Dissatisfaction
- Staff Conflicts

PERSONALIZED MEDICINE

Personalized medicine, also known as precision medicine, is an innovative approach to healthcare that tailors medical treatment to the individual characteristics of each patient. This approach takes into account factors like genetics, lifestyle, environment, and unique biomarkers to design more effective treatments and interventions.

Canva, 2026

VARIATION IS NOT PERSONALIZATION

- Standard of Care
- Malpractice Protection
- Workflow Organization
- Staff Training and Continuing Education

APPLICATIONS OF PERSONALIZED MEDICINE

- Age, Medication, & Allergies
- Environmental Exposures
- Occupational Medicine
- Patient Education
- Access and Availability

STANDARD OPERATING PROCEDURES

SOPs = Shared Expectations

This is operational infrastructure

- Aligns team roles
- Reduces reliance on memory
- Standardizes decision points
- Manages patient expectations
- Uniforms overhead

CASE #1

A 22 year old male presents to the center complaining of sudden sharp shoulder pain.

CASE #2

A 45 year old female presents to the center with a migraine.

CASE #3

A 12 year old presents to the center accompanied by an adult for evaluation of a rash.

INSTITUTE FOR HEALTHCARE IMPROVEMENT (2017)

Reliability is the ability of a system to successfully produce a product to specification repeatedly. In the case of healthcare, that product is safe, efficient, person-centered care

- Standardizing triage, discharge, and templates
- Chest pain, procedure timeouts, medication safety verification

THE JOINT COMMISSION (2024)

Opportunities related to retentions included consistent adherence to policies, establishing a shared understanding or mental model across team members, and engaging in clear team communication before, during, and after a shared team task.

- Clinical assisting
- Emergencies

URGENT CARE ASSOCIATION (2023)

To ensure consistency in what is deemed an urgent care center, UCA created a program that defines what an urgent care center is, with its Certified Urgent Care program.

- Standardized criteria
- Defined scope of service

AMERICAN MEDICAL ASSOCIATION (2012)

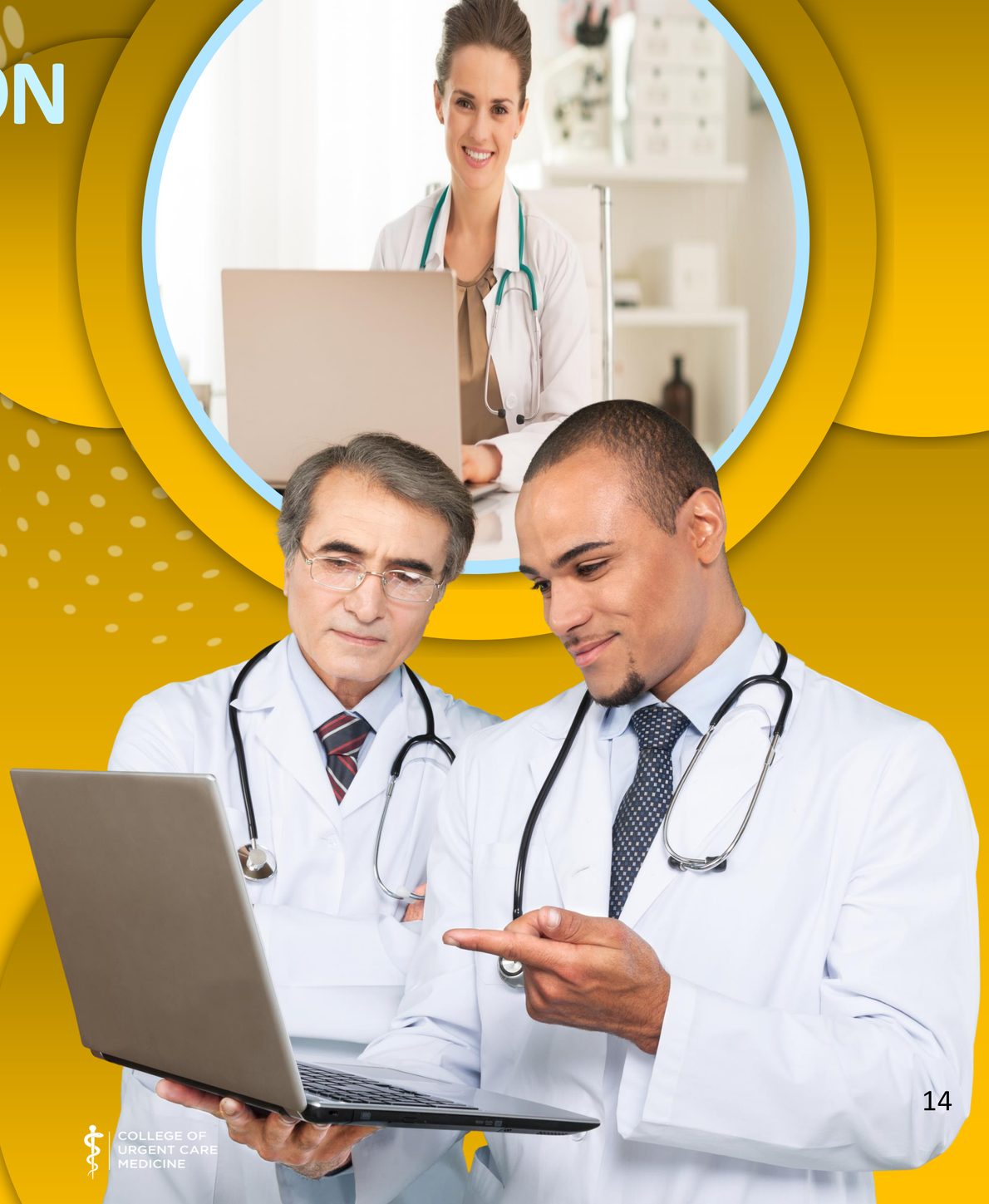
There need is urgent to bring US health care costs into a sustainable range for both public and private payers. A less harmful strategy (than reducing payments) is to reduce waste, not value-added care.

- Execution failures
- Lack of adoption of best care practices

SUPPORT MEDICAL DECISION MAKING & PROTECT PATIENTS

- Reduce cognitive biases that rely on intuitive and automatic thinking
  - confirmation bias
  - availability bias
- Reduce cognitive burdens
  - unclear quality measures
  - poorly designed EHRs
- Checklists have promising results in some fields of care
- Clinician training in specific diagnostic workflows reduce the risk of diagnostic error

(AHRQ, 2024)



CASE #1

A 22 year old male presents to the center complaining of sudden sharp shoulder pain.

Patient states pain started while playing basketball without specific injury just over an hour ago. He doesn't seem to have any worsening pain with range of motion or palpation but states that the pain is worse with deep breathing.

CASE #2

A 45 year old female presents to the center with a migraine.

Patient states a history of migraines. Patient states that this does feel more intense than what they are used to in the past but it is not dissimilar. She denies use of contraceptives.

CASE #3

A 12 year old presents to the center accompanied by an adult for evaluation of a rash.

Clinical evaluation and disposition is standard without memorable events.

WORKFORCE OPTIMIZATION

Most urgent care centers are increasingly hiring APCs. The current trend shows the ratio of physicians to APCs will reduce from current 2:1 to 1:1 in the next decade. And we are also seeing a similar trend for clinical staff where less than half of centers employ nurses at present.

- Employ SOPs that allow staff to practice to the top of their license and skill
- Organize networks of on-call chains
- Cross-training
- Task delegation

PROTECTION AGAINST EFFICIENCY KILLERS

- Inefficient registration
- Lack of contingencies
- POCTs standing orders
- Clinical staff doing non-clinical work

MULTI-SITE CONSISTENCY

Increasing dependency on enlarging revenue streams is leading to organizational expansion. And not only does this support generation of net income, but opens patient access. This is a win-win!

However the recognition of SOP need may seem difficult at first, but variation of Net Promoter Score can identify deficiencies in :

- staffing
- training
- supply chain
- infrastructure

Strive for the McDonald's experience????

CLEAR STAFF RESPONSIBILITIES AND EXPECTATIONS

PATIENT EXPECTATIONS OF AVAILABLE SERVICES

SUPERVISORY ROLES

STATE BY STATE RESTRICTIONS

INTEROPERABILITY

SHARED 80/20 EXPERIENCES

CASE #1

A 22 year old male presents to the center complaining of sudden sharp shoulder pain. Patient states pain started while playing basketball without specific injury just over an hour ago. He doesn't seem to have any worsening pain with range of motion or palpation but states that the pain is worse with deep breathing.

Since pain is out of proportion to his exam, a shoulder x-ray is performed. No acute bony pathology is noted by the clinician. Patient is discharged with a shoulder strain and informed that the final read is pending.

CASE #2

A 45 year old female presents to the center with a migraine. Patient states a history of migraines. Patient states that this does feel more intense than what they are used to in the past but it is not dissimilar. She denies use of contraceptives.

Patient is discharged home with a diagnosis of migraine with pain management and PC follow up

CASE #3

A 12 year old presents to the center accompanied by an adult for evaluation of a rash. Clinical evaluation and disposition is standard without memorable events.

Sixty days later, the center manager receives a call requesting billing clarification.

FINANCIAL IMPACT

- Front office
  - Face of the organization
- Clinical staff
  - reducing waste
  - reducing overtime
- Clinician
  - consistent documentation
  - coding integrity
- Patient experience
  - NPS growth (Reichheld, 2003)
  - trust

COST SAVINGS

CODING INTERGRITY

PATIENT EXPERIENCE

CLINICAL SUPPORT

DECISION MAKING TOOLS

SHARED KNOWLEDGE

CHARGE CAPTURE

CASE #1

A 22 year old male presents to the center complaining of sudden sharp shoulder pain. Patient states pain started while playing basketball without specific injury just over an hour ago. He doesn't seem to have any worsening pain with range of motion or palpation but states that the pain is worse with deep breathing. Since pain is out of proportion to his exam, a shoulder x-ray is performed. No acute bony pathology is noted by the clinician. Patient is discharged with a shoulder strain and informed that the final read is pending.

Radiology read comes in the following day noting signs of a spontaneous pneumothorax and on duty clinician cannot contact the patient as listed number is out of service.

CASE #2

*A 45 year old female presents to the center with a migraine. Patient states a history of migraines. Patient states that this does feel more intense than what they are used to in the past but it is not dissimilar. She denies use of contraceptives. P*atient is discharged home with a diagnosis of migraine with pain management and PC follow up.

Almost a year later, the clinician and organization are named in a medical malpractice lawsuit regarding this care and apparent cerebral venous thrombosis miss with subsequent poor outcome.

CASE #3

A 12 year old presents to the center accompanied by an adult for evaluation of a rash. Clinical evaluation and disposition is standard without memorable events. Sixty days later, the center manager receives a call requesting billing clarification.

In discussion of the billing with patient's guardian, the child presented to the clinic under the care of a neighbor who did not have permission to obtain care.

BURNOUT PREVENTION

Shanafelt et. al 2017 noted that with the increase in technology in medicine there was an increase in burnout symptoms among clinicians and clinical staff and that for every hour of clinical work there was two hours of non-clinical work .

For every 12 hours of patient care, a clinician could have up 24 hours of work.

Most workflows do not account for this administrative time required for an individual patient encounter, rather the well defined and accounted day.

The National Academy of Medicine noted in 2021 that improving the health both clinicians/clinical staff leads to

- enhanced care experience
- reduced costs
- advance health care equity

LEADERSHIP BUY-N

Burnout thrives in ambiguity while SOPs create clarity. It is up to leadership to provider the example

HOW TO DISPLAY SUPPORT

- Strategy session
- Culture of growth
- Reinforce use
- Peer review and education

IMPLEMENTATION

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MEASUREMENT

- THROUGHPUT
- DOCUMENTATION
- SAFETY EVENTS
- EMPLOYEE SATISFACTION
- CODING ACCURACY
- PATIENT SATISFACTION AND NPS
- COST RATIO

STANDARD OPERATING PROCEDURES

Protect Patients
Protect Clinicians
Protect Revenue

CASE #1

Front office registration procedures to verify with patient demographics (even those self entered). Procedures to educate clinicians in X-ray reads, particularly to recognize that the whole Xray read
Chest pain and shortness of breath protocol recognition in triage and during exam

CASE #2

Headache protocols can alert even non-clinical staff to recognize red flags.
Triage teams can easily perform screening algorithms
Clinical decision making tools can assist in medical decision making

CASE #3

A simple check in script can help to verify patient relationship without assumptions

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I need your feedback...

Scan the QR code to complete the survey digitally or, if you prefer paper, use the form provided at the session.

You can claim CME <u>after</u> the convention at
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