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Expanding Access, Strengthening Community Presence: A New Hybrid Model for On-demand Care Delivery

How integrated emergency and urgent care partnerships can improve patient access, engagement and outcomes.

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Introduction

Expanding Access, Strengthening Community Presence: A New Hybrid Model for On-demand Care Delivery

How integrated emergency and urgent care partnerships can improve patient access, engagement and outcomes.

Health systems are under increasing pressure to improve access, expand ambulatory networks and meet rising consumer expectations while navigating capital and operational constraints. Integrated emergency department (ED) and urgent care (UC) models offer one approach, helping patients access the appropriate level of care while enhancing patient experience, strengthening community presence and supporting more efficient use of resources. These models also introduce important operational, clinical and regulatory considerations, including EMTALA screening and stabilization requirements, as well as partnership and joint venture structures that can support capital-efficient growth.

This e-book explores the strategies health care leaders are using to improve access, strengthen the front door of care and optimize ambulatory networks. It also examines how integrated ED/UC models and strategic partnerships can enhance patient experience, improve patient flow and create sustainable value across the care continuum.



5 strategies health systems are using to expand access, improve throughput and create sustainable value



1 **Reposition the front door around consumer needs, not care settings.** Health systems are exploring integrated access models that remove the burden from patients to determine where to seek care, enabling clinicians to direct individuals to the appropriate level of care while improving experience, reducing confusion and strengthening continuity of care across settings.

2 **Improve emergency department throughput by better matching demand with resources.** As health systems confront persistent ED crowding and capacity constraints, hybrid ED/urgent care models offer an approach for routing patients to the appropriate level of care within the same site following EMTALA screening and stabilization requirements, helping organizations preserve ED capacity, improve patient flow and support broader throughput goals.

3 **Create a more flexible and sustainable operating model.** As health systems navigate staffing and operational pressures, integrated care models can reduce duplication, better align resources with patient demand and improve operational efficiency while maintaining quality and patient safety.

4 **Expand access and capabilities through capital-efficient partnerships.** As health systems seek new avenues to expand services and strengthen care delivery, strategic partnerships can provide a lower-cost pathway to broaden access, add new capabilities, tap specialized expertise and bring services to communities more quickly while sharing development costs and operational risk.

5 **Address social, behavioral health and access barriers that drive ED utilization.** As health systems work to improve throughput and access, many recognize that ED demand is increasingly influenced by social needs, behavioral health challenges and gaps in primary care access. Expanding community-based services, strengthening care coordination and connecting patients to appropriate resources can help address underlying drivers of ED utilization while improving outcomes.

Participants



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MODERATOR SUZANNA HOPPSZALLERN *(American Hospital Association):* **What role do urgent care, freestanding emergency departments and other ambulatory access points play in your organization's front-door strategy?**

CATHLYN ROBINSON *(RWJBarnabas Health):* As vice president of emergency nursing operations for RWJBarnabas Health, I support 12 emergency departments (EDs) across our health system in New Jersey. We have 12 hospital-based EDs, including four dedicated pediatric EDs. The remaining departments care for both adult and pediatric patients.

We also operate a satellite ED attached to one of our larger facilities in northern New Jersey. It's a 23-bed facility that is highly functional and well equipped. It has its own laboratory and access to a full range of imaging services, including CT and MRI, because it is located within a facility that also houses a large outpatient radiology suite.

The challenge is that most patients who come to the satellite ED are walk-in, lower-acuity cases. At the same time, we occasionally see critically ill patients, such as infants in cardiac arrest or patients experiencing a stroke. In those situations, patients often need to be transferred to the main hospital, which can require emergency transport. The same challenge exists for patients who need admission and a higher level of care.

For the communities it serves, the satellite ED is an important resource. It's a beautiful facility, extremely efficient and equipped to handle a high volume of patients. Despite its size, it sees about 65 patients per day, and during peak respiratory season, that can increase to 80 to 90 patients daily. We've also discussed opening additional satellite locations.

Another challenge for smaller satellite EDs is maintaining readiness for high-acuity cases when most daily volume is lower acuity. Although nurses rotate between satellite sites and higher-acuity EDs, ensuring clinicians maintain the skills and confidence to manage critical events remains an ongoing focus.

REZA KALEEL *(Providence Southeast Washington Service Area):* We operate two hospitals in Eastern Washington, along with a freestanding ED, two urgent care centers and several lower-acuity Express Care sites. As we evaluate future expansion, we're balancing community access needs with changing payer dynamics and the financial realities facing not-for-profit health systems.

MODERATOR: How are you balancing access, affordability and financial sustainability across your ambulatory portfolio?

LISA ISHII *(Johns Hopkins Bayview Medical Center):* Our biggest challenge right now is ED wait times. We have a very high volume of patients coming through the ED, and while we're focused on improving hospital throughput, a significant part of the issue is that many patients present to the ED with social needs rather than acute medical needs.

In our community, factors such as homelessness, substance use disorders and other complex social issues contribute to pressure on the ED and have a major impact on care delivery. Patients often remain in the ED while we work to address those underlying needs and connect them with appropriate resources, which can contribute to crowding and longer waits. As these challenges grow, we're interested in how other organizations are addressing the intersection of access, throughput and social needs.

ROBINSON: Our nonprofit health system has 12 hospitals, and like everyone else, we're focused on ED

REZA KALEEL | PROVIDENCE SOUTHEAST WASHINGTON SERVICE AREA
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throughput. We've made significant progress and have driven our systemwide left-without-being-seen rate down to 0.5%, but that didn't happen because the emergency departments solved the problem on their own.

Throughput isn't an ED issue. It's a hospital issue. Success requires coordination across the entire organization, from inpatient units to care management to leadership. Everyone must work together to move patients through the system efficiently.

Even when you've optimized operations as much as possible, it remains a constant challenge. The pressures on hospitals continue to evolve, particularly as social needs increasingly affect patient care and discharge planning. Those factors add another layer of complexity to an issue that is already difficult to solve.

Like many health systems, we also see patients using the ED because they are uninsured, underinsured or lack access to primary care. Social challenges and behavioral health needs continue to place additional pressure on the ED. While we have behavioral health services and a strong team of clinicians, recruiting psychiatrists remains difficult, and demand continues to outpace available resources.

From a financial perspective, we're managing the same affordability pressures affecting health systems across the country. We are continually evaluating staffing, productivity and operating costs to ensure financial sustainability while maintaining timely access to care. The challenge is finding the right balance, operating efficiently without compromising the patient experience or creating longer wait times.

MODERATOR: Thom, what problem was the hybrid ED/urgent care model designed to solve, and what does it take to make the model work?

THOM HERRMANN *(Intuitive Health):* As a former hospital CEO, I noticed that many patients coming to the emergency department didn't actually require emergency-level care, yet they continued to choose the ED because they were unsure where else to go. Whether it's chest pain, a broken arm or another common condition, patients often can't determine the appropriate setting until they've been evaluated by a clinician. That insight led us to develop a hybrid model.

A hybrid emergency department/urgent care model combines the capabilities of a freestanding ED with the convenience of urgent care. Every patient receives an EMTALA-required medical screening examination, and care is delivered through a single, integrated clinical workflow. Patients who do not require emergency-level care typically receive lower-cost urgent care services, while those who need emergency treatment receive it in the same facility from emergency-trained clinicians.

Successfully operating the model requires specialized workflows, staffing approaches, training and

CATHLYN ROBINSON | RWJBARNABAS HEALTH

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technology. We work with health systems to support clinical education, optimize operations, adapt electronic health record workflows and provide expertise in staffing, facility operations and revenue cycle management. Today, we operate 25 joint ventures with health systems nationwide. Some partners use the model to expand access and better serve their communities, while others are looking to alleviate pressure on overcrowded emergency departments. Ultimately, the goal is to provide the right level of care, in the right setting, at the right cost while improving access and patient flow.

MODERATOR: What are the biggest gaps between your ambulatory strategy and your current access infrastructure?

ISHII: Many patients continue to come to the emergency department with conditions that don't require emergency-level care. Our focus has been on throughput and improving patient flow throughout the system. While we've concentrated on optimizing throughput, we're still facing the broader challenge of patients accessing care in settings that may not be the best fit for their needs and then encountering obstacles that limit timely discharge.

ROBINSON: What has made a difference is treating throughput as a whole hospital responsibility rather than an ED problem. For now, our primary focus remains optimizing hospital operations and maximizing the capacity and performance of the assets we already have. One of our strengths is that all 12 EDs operate as a unified service line with shared goals, metrics and accountability. Throughput is a systemwide priority, supported by efforts ranging from early intervention for patients with substance use disorder to improved inpatient logistics, creating more of a "pull" from the inpatient side so emergency departments don't become bottlenecked.

That has required a significant cultural shift. Patient flow responsibility can't rest solely with the ED. We've always focused on what happens at the front door, reducing left-without-being-seen rates, improving door-to-doc times and maximizing efficiency within the department. But once patients require admission, the rest of the organization has to be engaged. Beds need to be assigned quickly, and inpatient teams are increasingly held accountable for length of stay and patient throughput.

The biggest lesson is that throughput isn't an ED issue. It's a hospital issue. Improving patient flow requires engagement across the organization, from EDs to inpatient units and hospital leadership. What has made the difference is treating throughput as a shared responsibility rather than an ED problem.

When hospital leadership and staff view patients awaiting admission in the ED as their patients and embrace a culture of "pulling" these patients into inpatient beds, it changes the entire dynamic of the ED. It improves the experience for patients, their families and ED staff.



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INTUITIVE HEALTH

Founded in 2008, **Intuitive Health** pioneered the combined emergency room and urgent care model. Intuitive Health partners with established health systems nationwide to build, operate and launch retail healthcare facilities that provide urgent care and emergency room services under one roof. Intuitive Health partners with leading health systems nationwide, including Arizona, Delaware, Florida, Kentucky, Indiana, Ohio, Oklahoma, South Carolina, Texas, Virginia, and Washington.

Intuitive's patient-centric approach to immediate care has saved payors and patients hundreds of millions in unnecessary emergency care spending. In addition, the Intuitive Health model increases market share for partnered healthcare systems by expanding their footprint with conveniently located centers.

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