Site Selection
Overview and General Guidelines

Like any other business, an urgent care center will be successful only if there is a large enough base of paying customers to utilize it on a regular basis. Although urgent care operating models are highly localized—and what works well in one community may not work in another—urgent care centers that have been successful generally follow the same guidelines for site selection:

- Population of 40,000 or greater unless the community can pull from a larger catchment area (in some rural areas, consumers will drive 30 miles or more to access urgent care).
- Lack of (or weakness in) direct competition in urgent care and walk-in family practice.
- Primary care practices that are not accepting new patients (or take days/weeks to get an appointment) and/or emergency rooms operating at capacity (with long wait times).
- Referral base from primary care including overflow and weekend/after-hours coverage.
- High concentration of individuals insured with plans paying favorable rates for urgent care (large populations on Medicaid or capitation-rate HMOs squeeze margins).
- Opportunities for ancillary service offerings including occupational medicine, physical therapy, and travel health.
- The physical space for an urgent care center can range from 2,500 to 8,000 sq. ft. depending on volume and range of services offered. A center that provides physical therapy, advanced imaging, and drug testing—or has multiple practitioners working simultaneously—may require a larger facility with multiple waiting areas.

The typical freestanding urgent care center requires a site that meets the following characteristics of population density and a patient base of busy families with good jobs and employer-paid health insurance:

- Daytime (working) population of 30,000 or greater within a 10-12 minute radius.
- Nighttime (residential) population of 30,000 or greater within a 10-12 minute radius.
- High traffic count (number of cars per day) in front of the center and through nearby intersections—20,000 is a common threshold for a retail area.

Demographic factors that lead to high utilization and indicate good insurance coverage:

- Median household income in top 30% for the community.
- High percentage of adults age 21-49 (prime working years).
- High percentage of personal employment (cross-market for occ med).
- High homeownership percentage (indicates stability).
- Larger household sizes (families with children).

It's also important to look at population growth rates. Is an area growing—with homes being constructed and new or expanding businesses? Or is an area in decline? Growth rates may be considered for a larger market (city or state) or a neighborhood or suburb within a market.

Average commute times indicate the presence of employers in an area—an important factor when considering occupational medicine services—as well as how far people are willing to drive for services.

Retail Industry Examples

It is often said that first, second, and third factor in retail success is "location, location, and location." National retail chains have sophisticated data models for placing stores in the locations that will capture the greatest number of shoppers (and generate the most sales).
The following retail chains appeal to the same demographic segments that are typically associated with urgent care utilization:

- Kohl’s—women in their prime working years—ages 25 to 54—who often work full-time outside the home and tend to be the key decision makers in regards to household finances.
- PetSmart—family households with dogs also tend to be family households with children and good disposable incomes.
- Lowe’s—appeals to middle- and upper-middle income homeowners.

As an independent urgent care operator, it’s possible to leverage these retailers site selection expertise by starting your search with the high-traffic retail areas in your community and then emulating the facility attributes that lead to retail success.

Retail criteria for potential locations include:

- High concentration of complimentary retail businesses (measured by gross leasable space) within one mile.
- Free-standing or end-cap locations with adequate visible separation from adjacent businesses.
- Visibility from primary thoroughfare with easy and safe entry/exit (from both directions-pay particular attention to left turns or availability of u-turn). Visibility may be influenced by the density or speed of traffic passing in front of the center.
- Sufficient frontage (at least 30 feet wide and not more than 100 feet from primary thoroughfare) to assure drive-by visibility.
- Maximum signage allowed by local law (that illuminates at dusk) to serve as advertising for passing motorists. Signage should include panel sign on the building as well as space on a common monument or pylon sign.
- Category exclusivity (there should be no other urgent care, occ med, or retail health clinic in the development).
- Dedicated or reserved parking near the entrance for urgent care patients.

**Occupational Medicine**

Workplace injuries, employment-related physicals, and drug screening patients typically come to the center straight from work so a location near businesses associated with high utilization of occupational medicine is a key success factor for this service line. High utilization businesses include manufacturing, construction, warehousing, and transportation industries, as well as municipal entities like school districts, and police, fire and sanitation departments.

Ideally, an urgent care center offering occupational medicine should balance the daytime presence of employees and nighttime presence of consumers—but depending on the locality—such is not always possible. Employers may be hesitant to send employees too far away for services and during evening and weekends, consumers are unlikely to seek medical care in industrial areas.

There are several sources of information available on employment levels:

First, the federal government requires every employer to submit a report—when it pays its unemployment premiums—listing at each physical worksite the number of employees and their total salaries. The government then makes this data available in the aggregate by SIC Code. This report is called an ES202. ES202 data is available from the Bureau of Labor Statistics for State, County, and Metropolitan Statistical areas at: [http://www.bls.gov/cew/#databases](http://www.bls.gov/cew/#databases)
The problem with aggregated government data is that for large metropolitan areas, the data does not narrow down to the specific neighborhoods served or differentiate employment levels near "Intersection A" versus "Intersection B."

Second, there are private vendors who sell lists of business names in specific SIC codes within a zip code or within an XX mile radius of an address.

Vendors include:
Manta:  [http://www.manta.com](http://www.manta.com)

The advantage of these listings is that the specific company names provided can be used as lead sources for selling occupational medicine services. The downside is that data does not always accurately report how many people work at a specific location—often the entire workforce of a large company is attributed to one corporate office while branch locations are omitted from the listings. Another downside is cost, although many university and public library systems have subscriptions to these services that you might be able to access free of charge.

**Professional Support**

A host of national and local vendors assist urgent care developers with site selection and evaluation. Using the factors that have made urgent care centers successful in other markets, these vendors can provide suggestions as to the best location in a market to capture drive-by traffic, leverage referral sources, and reach out to high utilization households.

Once the feasibility of an area is validated for urgent care, a local commercial real estate broker can find available spaces that meet requirements of visibility, signage, and square footage—at rental rates and contract terms that make sense for the business.

**Lessons from the Field**

Common mistakes of start-up urgent care centers related to site selection include:

- Opening an urgent care center without understanding the determinants of demand, where there is insufficient traffic or population to support the center (including moving into a growing area prematurely), or where there is excessive competition.

- Allowing the developer or broker to drive site selection. There is always space to lease and the job of these intermediaries is to secure tenants. If a space has been vacated by previous retail or medical tenants, determine whether there are issues with the property that will undermine success as urgent care. Many urgent care start-ups find some nice space near (but not directly in) high-traffic areas but if the visibility, signage and accessibility aren't quite right—it will take longer for the center to realize a profit.

- Leasing too big of a space in anticipation of future growth. Often a center will lease an entire facility because it's available and plan on subletting or growing into unused sections. It is a difficult and time-consuming process to find subtenants that complement the urgent care and unused space adds unnecessarily to overhead during the ramp-up phase.

- Spending too much money on the build-out. Many owners hire best-in-class architects, select top-of-line furnishings, and purchase cutting edge equipment that can never be
supported by the revenue or margins generated by an urgent care center. An urgent care center must have sufficient start-up capital to sustain first year operating losses. Digging too deep of a hole prior to opening can exhaust capital that would be better spent on advertising or other activities to drive traffic. And because furnishings, fixtures, and equipment are depreciated over a period of years, recurring hits to the financial statement may keep a center from ever being profitable.

- Depending on landlord tenant improvement allowance for financing the build-out. Landlords are often willing to finance the build-out through a one-time tenant improvement allowance, but such financing raises monthly payments for the entirety of a lease, making the time to profitability much longer. The effective interest rate on funds used may also be difficult to determine versus a conventional bank loan.

- Underestimating competition. Existing urgent care centers may respond to a new center by increasing advertising, negotiating lower rates or discounts with payers, blocking hospital privileges, or starting rumors about a new center and its providers. Potential referral sources may start their own walk-in clinics. Instead of fighting incumbent competitors in a saturated market, a start-up urgent care can more effectively utilize advertising dollars in markets without competition. Many underserved communities are grateful to have walk-in medical services-and will give great press "welcoming" an urgent care center.

- Looking at prospective sites only in the community where the founders live. There may be other communities with less competition, better demographics, or lower costs to start an urgent care center than the one in which the founders live. Location should be based on what's going to make the business work, not the owner's personal preferences.

**Appendix 1: Questions for Urgent Care Location Feasibility:**

The following questions may be asked in the planning process for a walk-in facility:

**What is the ownership model?** An independent urgent care center may chose to locate in shopping or medical areas while a hospital-owned facility may prefer to locate on the campus of a hospital or ambulatory health center close to referral relationships.

**What is the scope of services offered?** Will the center perform just urgent care-and if so, will the scope of urgent care include advanced procedures and treatment for orthopedic injuries that require equipment like x-ray, EKG, nebulizer, and expanded lab capabilities? Integration of primary care, occupational medicine (testing/physicals/injury care), physical therapy, or ancillary services influence the size, fixtures/equipment, and appearance of the facility.

**What is the staffing model?** Potential volume and types of cases served will dictate the staffing model. A busy center with multiple business lines may employ full-time physicians or a combination of physicians and mid-levels. A center with lower acuity cases and lower volume may only need a mid-level. Mid-levels may also provide after-hours care. Physicians generally perform procedures such as suturing and casting while mid-levels treat low-level cases such as respiratory or urinary tract infections. Ancillary services may require some specialized training.

**What is the payer mix?** What percent of patients are covered by private health insurance (HMOs, PPOs)? Will Medicaid be accepted or a charity care policy in place? How do private plans reimburse for urgent care (capitation rate vs. level of service), are there any requirements for insurance utilization (PCP referral, pre-authorization), and are reimbursement rates sufficient to cover costs? Also, what is the potential for employer direct contracting or building a base of cash-only patients?
What is the patient mix? What types of patients will utilize the center including age, insurance, and health conditions? Are there existing relationships with patients or will new patients be acquired from the community? How will the patient mix change over time? Also, are there any historically underserved niche segments requiring bilingual services or a different pricing model?

Where are potential customers located? Potential customers include employers for occupational medicine and direct contracting of urgent care services, as well as individual consumers paying cash or utilizing health insurance. An urgent care center should be near employers if it is serving the employer market and near homes if it’s serving consumers directly.

Is there an important source of referrals? An urgent care that depends on other practices for referrals (such as overflow/after hours from primary care, Level 4 referrals from retail store clinics) or refers patients to specialists (such as imaging or PT) may want to locate near these referral relationships.

Are there any external restrictions on the operating model or scope of services? Are there any laws or agreements in place that prohibit an urgent care center from offering ancillary services or otherwise restrict the operating model? Does the walk-in facility need to be licensed or is there a certificate of need process?

What urgent care competitors are in the market and where are they located? Competition includes walk-in primary care offices, other urgent care centers, retail health clinics, and emergency rooms (including ER fast tracks and service guarantees). Unless a competitor is weak or a market is growing, generally it’s best to avoid head-to-head competition.

What is the distance to the nearest emergency room? Is there an emergency room where the clinic can refer/squad out emergency and critical cases? Accessibility to an emergency room (including wait times) may influence the scope and acuity of cases served at an urgent care center.

What is local utilization of emergency room services? What is the distribution of cases (by level) seen at local emergency rooms, do local ER’s offer fast track services or service guarantees, and what are average wait times?

What is the accessibility of primary care? How accessible is primary care in the community? Do any primary care offices offer walk-in or after-hours service? How long does it take to get an appointment for a new patient?

What is the count of food, drug, and mass retailers are nearby? Food, drug, and mass retailers appeal to consumer needs for convenience and accessibility. A walk-in clinic can leverage these qualities by locating in an area near these types of retailers. The presence of these retailers also indicates potential sites for retail health clinics which may serve as competition or referral sources.

What is the seasonality of the market? Seasonality may drive the acuity of cases, reimbursement rates, and staffing models. For example, a center in a cold climate may have a busy season for cold/flu in the winter months accompanied by orthopedic injuries from slip/fall on snow and ice but a slow season during the summer months when people are on vacation. By contrast, a summer tourism destination may be able to attract a high number of cash pay consumers during the summer months with blisters, sun burn, dehydration, and other conditions.

Appendix 2: Urgent Care Site Selection Data Points
Local Research (Yellow Pages, Internet):
- Count/location of primary care offices, hospital emergency rooms, and retail store clinics.
- Count/location of competing urgent care facilities.

United States Census Bureau (http://www.census.gov):
- Population (ZIP Code)
- Population Density (People/Sq. Mi.)
- Foreign Language in Home
- Spanish Language in Home
- Family Households
- Households with Children Under 18
- Households Age 65 and Over
- Average Household Size
- Average Family Size
- Home Ownership
- Percent High School Graduate or Higher
- Percent Bachelors Degree or Higher
- Median Home Price
- Median Family Income
- Mean Travel Time to Work
- Percentage Uninsured

Additional Data Points:
Sources: Centers for Medicare and Medicaid Services (http://www.cms.hhs.gov/)
Henry Kaiser Family Health Foundation (http://www.kff.org/)
United HealthCare Foundation (http://www.unitedhealthfoundation.org/)

CURRENT UTILIZATION OF ER/OUTPATIENT SERVICES
- Emergency Room Utilization by CPT Levels 1-3
- Emergency Room Visits Per 1,000
- Hospital Outpatient Visits Per 1,000
- Average Expenditures for Physician/Clinical Services

PERSONAL HEALTH OUTCOMES ANALYSIS
- Percent Uninsured
- Prevalence of Smoking
- Prevalence of Obesity
- Occupational Fatalities (per 100,000)
- Infectious Disease (per 100,000)
- Children in Poverty
- Immunization Coverage
- Per Capita Spending on Public Health
- Poor Physical Health Days
- Cancer Deaths
- Cardiovascular Deaths

HEALTH INSURANCE ANALYSIS
- Employer Insurance
- Individual Insurance
- Medicaid
- Medicare
- Other Public Program
- Uninsured
- Adults as a Percentage of Medicaid
- HMO Penetration Rate
- Percent of Small Employers <50 Offering Insurance
Percent of Large Employers Offering Insurance

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