URGENT CARE ASSOCIATION

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URGENT CARE INDUSTRY WHITE PAPER 2018 (Unabridged)
The Essential Role of the Urgent Care Center in Population Health

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INTRODUCTION

Our nation's health and healthcare delivery processes are at a time of unprecedented change in clinical practice and policy. Healthcare spending has escalated to 17.8% of the U.S. Gross Domestic Product—a reportedly unsustainable cost that continues to climb[1]. There is a high prevalence of care inefficiencies and burdensome administrative expense. Healthcare decisions often do not align with overall goals of patients or within evidence of effectiveness[2]. These issues can increase unnecessary spending and increase the complexity of care for both patients and providers. Urgent care medicine has experienced meteoric growth across our country with convenience, high quality, an ability to significantly lower the cost of care and enhance access and entry to health care for millions of people each and every year. This $18 billion industry is expected to continue to grow 5.8% annually through 2018[3], offering services that extend beyond those of a typical primary care office, including extended hours, weekend and holiday access. Growth is also being stimulated by a well-documented shortage of primary care physicians.

This White Paper will outline the urgent care industry's value proposition in the U.S. Healthcare delivery system. We will review the foundations of the urgent care market and the progress of urgent care medicine with respect to quality, cost and patient satisfaction. Also included is an update regarding industry statistics; ownership, services, patients, payment, business drivers, staffing and models of care. We review how and where urgent care integrates the continuum of care for patients: primary care providers, specialty care, hospital care, government and commercial insurers, and self-insured employers. We will also present examples of collaboration with urgent care groups which bridge transitions of care that have been shown to improve care, reduce cost and increase patient satisfaction. Urgent care serves an essential role in its capacity of providing urgent and primary care while also offloading overcrowded and costly emergency departments. This White Paper will illustrate potential care delivery models of the future. These care delivery models support the Patient Centered Medical Home (PCMH) and national value based care. The models also support population health and disease management goals, while contributing to an efficient and effective low cost, high quality healthcare system.

THE URGENT CARE ASSOCIATION

The Urgent Care Association ("UCA") has served as the leading organization for the urgent care industry since 2004. UCA's membership includes more than 2,700 urgent care centers representing approximately 27,000 urgent care clinical and business professionals from the United States and abroad. Urgent care meets a vital need in modern society for on-demand ambulatory health care that is not only expert and reliable, but also patient-focused, convenient and cost effective. UCA exists to advance and distinguish the role of urgent care medicine as an essential, valued and collaborative healthcare destination.

UCA supports its members through education, advocacy, community awareness, benchmarking and promoting standards of excellence. UCA hosts numerous educational activities, such as clinical and practice management on-line webinars, a peer reviewed medical journal (The Journal of Urgent Care Medicine or JUCM), as well as annual conventions and conferences. UCA also supports a nationally recognized Urgent Care Center Accreditation program and an urgent care medicine post-graduate clinical fellowship in accredited Family Medicine residency programs. UCA's mission is enhanced through its partnership with both the College of Urgent Care Medicine (CUCM) and the Urgent Care Foundation, a 501(c)3 organization.

UCA also offers industry specific clinical, operational and practice management resources to its diverse membership that includes individual physician owners, small and large healthcare systems and multi-site, multi-state organizations. UCA not only accredits urgent care centers for scope, quality and safety standards but also certifies over one thousand urgent care centers based on their scope of care and accessibility.

UCA is headquartered in Warrenville, IL (a Chicago suburb). The Association does not own or manage any urgent care centers.

THE URGENT CARE INDUSTRY

NUMBER OF URGENT CARE CENTERS

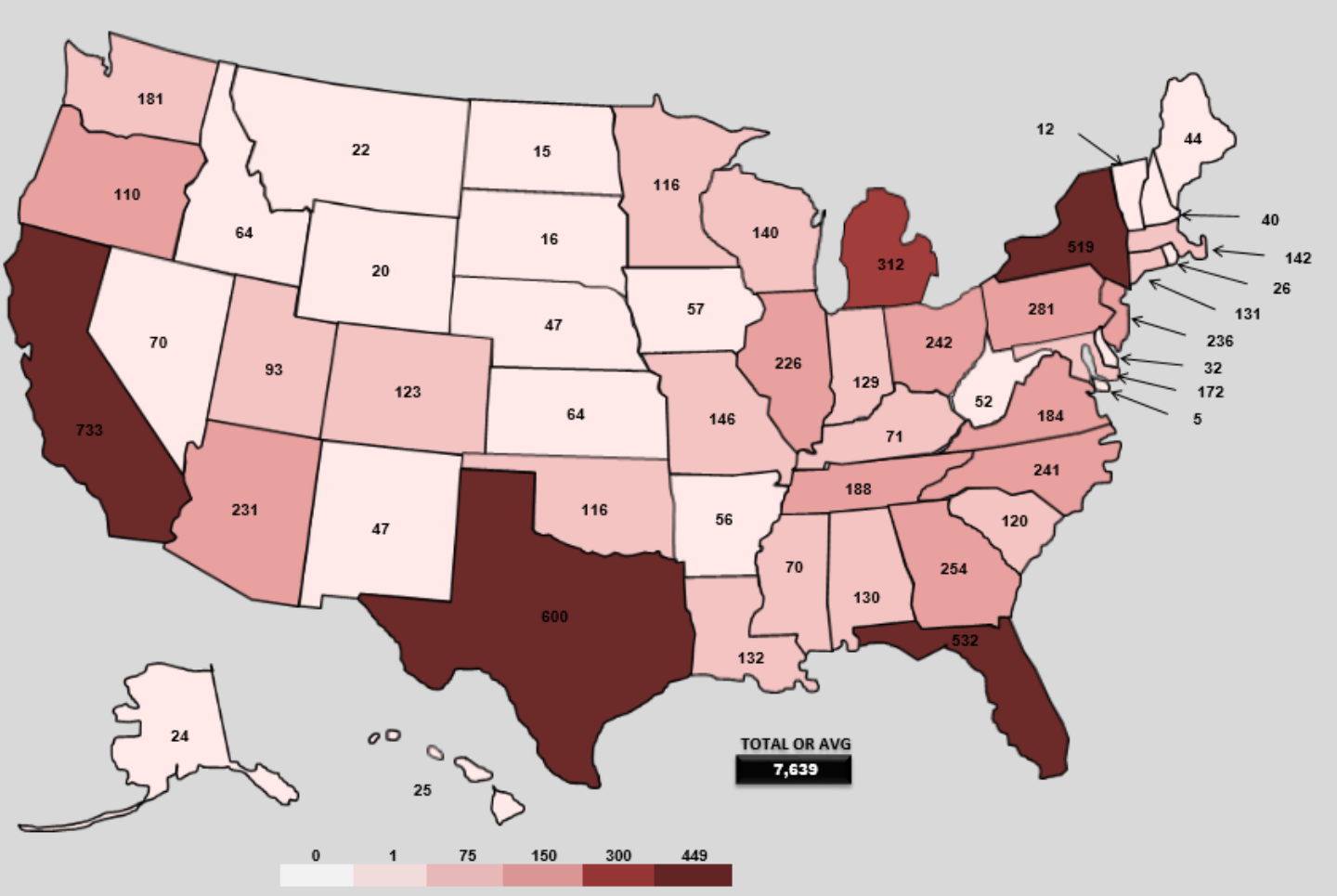
UCA defines an urgent care center as a medical clinic with expanded hours that is specially equipped to diagnose and treat a broad spectrum of non-life or limb-threatening illnesses and injuries. Urgent care centers are enhanced by onsite radiology and laboratory services and operate in a location distinct from a freestanding or hospital-based emergency department. Care is rendered under the medical direction of an allopathic or osteopathic physician. Urgent care centers accept unscheduled, walk-in patients seeking medical attention during all posted hours of operation.

The reported number of urgent care centers ("UCCs") in the United States can vary. Based on the previous definition, UCA's mid-2017 count totals 7639 centers.

In UCA's quest to accurately identify urgent care practices offering walk-in care for non-emergent and non-life or limb-threatening illnesses and injuries during all posted hours, we reviewed websites and other resources to refine our calculation. This database does not include (1) retail clinics housed inside retail operations and typically alongside in-house pharmacies or (2) traditional family practices with extended hours for their patients.

Year over year urgent care center growth continues, fueled by consumer behavior, industry investors, existing owner densification and expansion, hospital system strategies, and even payer interest in the urgent care value proposition. UCA has historically reported industry growth of approximately 400- 500 new centers per year. The 2017 number and accompanying heat map represent those centers in the UCA database through June:

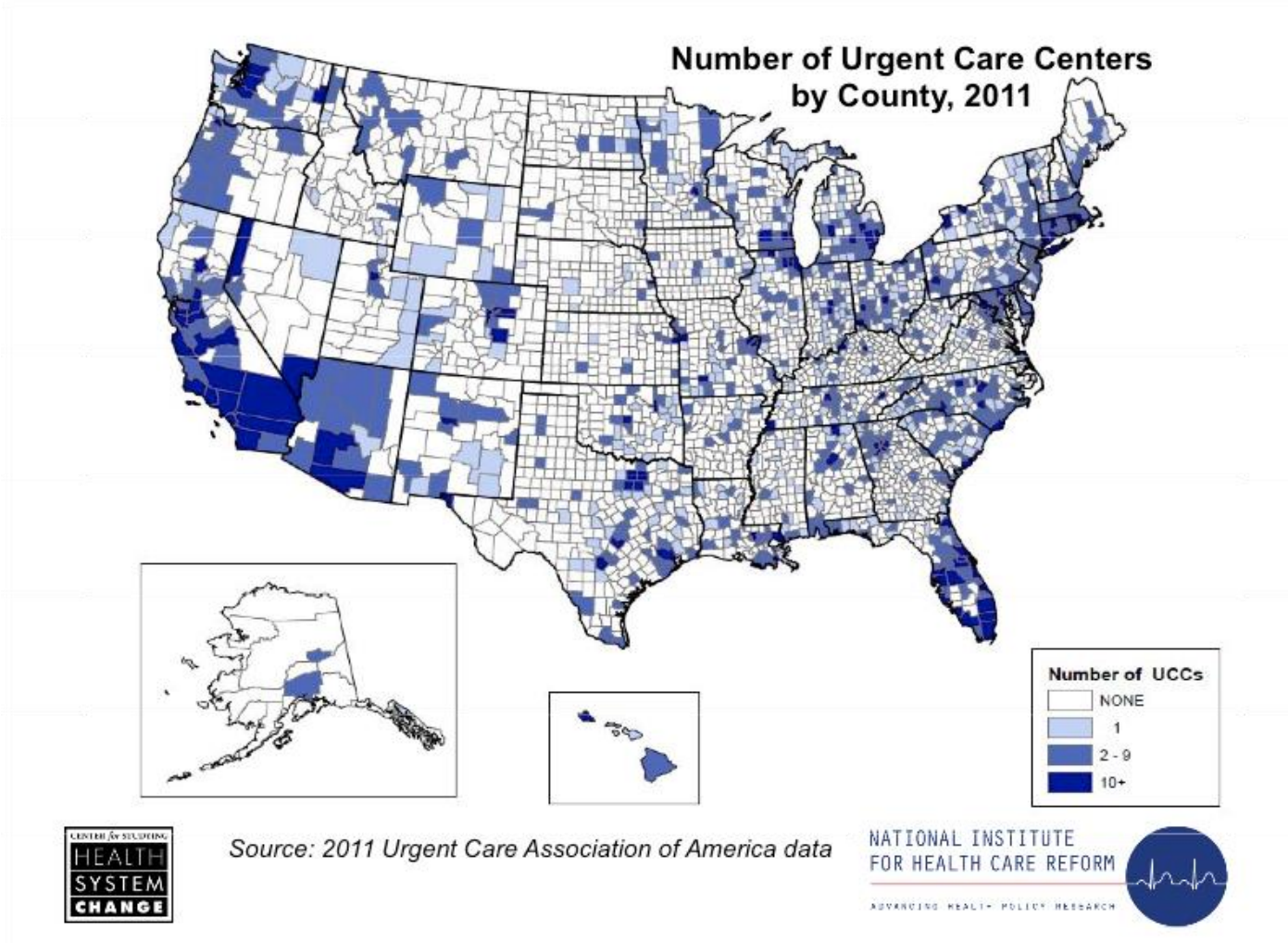
- YR 2014 - 6400 Centers
- YR 2015 - 6946 Centers
- YR 2016 - 7271 Centers
- YR 2017 - 7639 Centers



GEOGRAPHIC DISTRIBUTION OF URGENT CARE CENTERS IN THE U.S.

UCA's database and map illustrate that California, New York, Texas and Florida have the most urgent care centers of all states in the US[4]. Although urgent care centers exist in various sizes of communities across the nation, detail utilizing data sources including UCA, the American Hospital Association, the US Census 2010, The American Community Survey 2012, the Area Resource File 2011 from HRSA, noted 31,022 communities with non-hospital-based urgent care centers[5]. Communities with UCCs were more frequently in and around metropolitan areas and had higher income levels and higher percentage of privately insured people. Interestingly, also noted was that communities with UCCs had a higher population of minorities and a lower percentage of elderly when compared to communities that did not have UCCs[6]. It is suggested that although UCC growth has not been uniform and had a predilection for suburban areas, going forward, the higher percentage of minority patients noted above could aid in reducing healthcare disparities that currently exist in the U.S. Urgent care centers can provide improved, consistent access to healthcare for this oftentimes underserved population, thereby reducing the overall cost of care.

See Map below for distribution of UCCs.



PATIENT VOLUME & MIX

The UCA Benchmarking Report provides an annual snapshot of the industry. Centers participate and self-report on a number of criteria, including average patient volume. The retrospective review seeks feedback from a full prior calendar year.

In a recent benchmarking report (2015 data year), respondents reported a median patient volume of 32 patients per day (50th percentile) and 47 patients per day in the 75th percentile. Reported volume varies year over year based on the sampling, length of time since the center opened, and proximity to competitors. The optimism for future growth remained steadfast at 90% in the sampling. Urgent care volume can be seasonal, typically spiking during late fall and winter. Annual patient volume often correlates to the intensity of the flu season where urgent care centers play a significant role as part of the safety-net in caring for afflicted patients in communities they serve.

If conservatively the median number of patient visits per day remains stable at 32, and UCA's database of 7,639 urgent care centers are open 365 days per year, urgent care centers are providing access and care to over 89.2 million patient visits per year.

According to 2013 data reported by the CDC's National Ambulatory Medical Care Survey (NAMCS), outpatient physician office visits were reported as follows[7]:

- ✓ Number of visits: 922.6 million
- ✓ Number of visits per 100 persons: 296.7
- ✓ Percent of visits made to primary care physicians: 53.2%
- ✓ Most frequent principal illness-related reason for visit: cough
- ✓ Most commonly diagnosed condition: essential hypertension

Therefore, assuming ambulatory care visits remained consistent with activity reported in 2013 and primary care visits represent 53.2% of all visits (or 491 million), urgent care represents over 18.2% of all primary care visits and 9.7% of all outpatient physician visits. This illustrates the significant role urgent care centers are playing in the delivery of primary and ambulatory patient care in any given year. Urgent care centers are access points into the healthcare spectrum. They support and collaborate with the patient's primary care physician and have the ability to identify disease processes requiring referrals to primary and specialty care. Early disease identification and care can increase quality and longevity of life and decrease healthcare expenses.

A spring 2015 survey conducted by Fair Health revealed the types of patients by ethnicity that were more likely to use urgent care for non-emergent medical conditions[8]. While those using urgent care were relatively consistent across ethnic groups (14-16%), the Latino population was most likely to seek care at an Emergency Department, even when the condition was believed to be a non-emergency. That same study went on to state, "While all age groups are most likely to visit a primary care facility in a non-emergency situation, consumers aged 45 and older are more likely than younger adults to rely on primary care, whereas millennials (ages 18-34) and younger Gen Xers (ages 35-44) are significantly more likely than their older counterparts to visit an urgent care center." When asked, "In the event you require treatment for a non-emergency or non-life-threatening situation, where would you most likely go for care?" respondents replied as follows:

Age	Primary Care	Emergency Room	Urgent Care	Walk-in Clinic at a Pharmacy or Retail Center
18-34	43%	25%	21%	7%
35-44	54%	21%	19%	3%
45-54	64%	19%	8%	5%
55-64	62%	16%	13%	7%
65+	59%	22%	9%	4%
Total Population	55%	21%	15%	5%

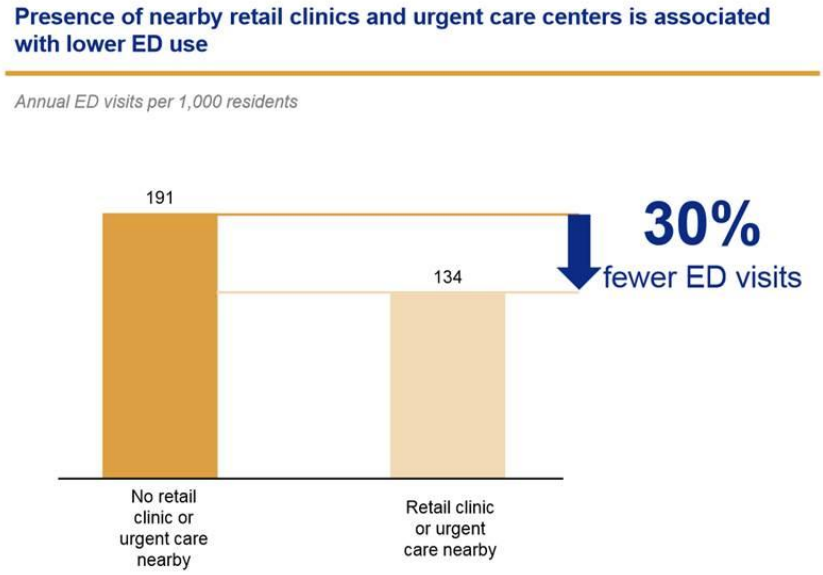
This data is supported by historical UCA Benchmarking survey statistics. The likelihood to be affiliated with a medical home increases with age, particularly in senior populations with a greater propensity to have associated chronic health conditions. However, when access barriers to the medical home exist, patients in all age groups are seeking alternatives, including the urgent care center. Despite the proliferation of urgent care centers around the country, 21% of total respondents continue to report that they would seek care in the emergency department for non-emergencies demonstrating a substantial opportunity for cost-savings.

PAYER MIX/PAYER MODELS

Just as in other care settings, the payer environment has been in transition for urgent care centers. The traditional fee for service may now be blended with some global rates whereby the payment is the same irrespective of the acuity or complexity of the case. The dominant payer group remains the commercial payer market, largely a product of the age demographic seeking care.

A recent UCA Benchmarking Report based on 2015 data revealed that 97% of urgent care respondents accept Medicare. In contrast, fewer respondents accepted straight or managed Medicaid. Urgent care operators cite substantially inadequate reimbursement for Medicaid services provided, often far below their costs to deliver the same visit, onerous enrollment or authorization processes and challenges being paid. Nonetheless, 61% of respondents represented that they accept straight Medicaid in their state and 70% accept managed Medicaid.

As states seek opportunities to divert Medicaid patients seeking care for non-emergent conditions out of the emergency room, payment schedules and ease of participation should be aggressively pursued for urgent care providers. A 2015 Cost Trends Report *based on 2014 data* provided by the Massachusetts Health Policy Commission supports the benefits of urgent care centers in communities, indicating that 40% of emergency department visits did not require that level of service, but are often the only option for after-hours care[9]. It also went on to provide data indicating that emergency department visits were **reduced by 30%** in communities where there was access to walk-in, no-appointment medical care.



A 2017 article entitled, "Comparing Utilization & Costs of Care in Freestanding Emergency Departments, Hospital Emergency Departments and Urgent Care Centers" was published in the Annals of Emergency Medicine. The study was based on an analysis of all E.D. and UCC claims submitted to BCBS of Texas between 2012 and 2015. It concluded that when compared to urgent care, there was a 60% overlap in the top twenty diagnoses seen in hospital-based emergency departments[10]. The cost to care for the same diagnoses in the emergency departments was ten times higher for these same diagnoses when compared to the urgent care centers. Of note, this peer-reviewed article was published in February 2017. According to its publisher, it has been temporarily removed from the website for data verification. UCA actively seeks opportunities to collaborate and support solutions to patients accessing the right level of care in the right setting.

82% of urgent care centers reported billing as a place of service 20, specific to an urgent care location and not typically associated with an additional facility fee. Some, but not all, hospital systems may elect to submit claims as an on-campus or remote hospital department (Place of Service 22 or 19 respectively) where a facility fee does typically apply along with associated policies and processes in order to maintain compliance with this election.

As more urgent care organizations integrate with primary care and other networks, more value based payment models will emerge as urgent care is a solution to off-load both overcrowded emergency departments and over-burdened primary care providers. Integrated and coordinated care models will allow the PCP to focus on the costly patients requiring comprehensive disease management, supported by the urgent care's strength in providing same-day care for acute episodic illness and injury.

OWNERSHIP MIX

The urgent care industry's ownership mix has shifted significantly since inception. Urgent care centers emerged largely as a physician or physician group strategy. In an early UCA Benchmarking Report based on the calendar year 2008, 54.1% of centers were physician owned while hospitals represented 24.8% of the total. By 2014, physician ownership had dropped to 40% and hospital ownership increased to 37% of respondents. Healthcare

systems such as Dignity Health, HCA, Aurora Health, Intermountain Health and Carolinas Healthcare have all made significant commitments to urgent care in their communities and beyond. Urgent care aligns with many healthcare systems' objectives of providing cost effective, accessible care, particularly when integrated with other ancillary, specialty and primary care strategies.

Many multi-site urgent care centers have taken on private equity partners to fuel ongoing growth and enter new markets, and the payer community has accelerated its ownership in the on-demand healthcare delivery sector. Optum recently announced its acquisition of DaVita Medical Group, including its 35 urgent care centers. It had already acquired multi-state MedExpress Urgent Care in April 2015, now increasing its portfolio to over 235 sites. Humana had made a similar investment when it acquired Concentra Urgent Care centers, however it divested its ownership in 2015 to Select Medical. Additionally, Aetna's proposed vertical merger with CVS Health would provide the insurer access to over 1,100 retail clinic sites inside CVS stores.

SERVICES IN URGENT CARE CENTERS

Urgent care centers provide immediate care, screening and diagnostic services. They provide walk-in, extended-hour access for acute illness and injury care that is either beyond the scope and/or the accessibility/ availability of the typical primary care practice or clinic. Among the most common conditions treated in urgent care centers are fevers, sprains and strains, upper respiratory infections, lacerations, contusions, and back pain. Most centers also treat fractures and provide intravenous fluids while offering onsite X-ray, laboratory and phlebotomy services. As a service to the patients and where allowed by state law, many UCCs also dispense commonly prescribed pre-packaged medications. Urgent care centers do not care for life (or limb) threatening situations, but will stabilize patients while securing emergency transport. The majority of urgent care centers employ family practice and emergency physicians, as well as licensed healthcare professionals, including physician assistants, nurse practitioners, radiology technicians and registered nurses.

Not only do urgent care centers care for patients presenting with pink-eye (conjunctivitis), upper respiratory and ear infections, they can also provide care for other non-life or limb-threatening illnesses & injuries such as:

Asthma
Cough/cold/influenza
Sore throat
Pneumonia
Allergy relief
Rashes
Minor skin injuries
Lacerations, including suturing
Dehydration
Headaches/ Migraines
Gastrointestinal disorders
Gynecology infections and disorders
Urinary tract infections
Sexually transmitted infections
Skin infections, including incision and drainage
Sprains/strains
Minor fractures
Detection of complications of chronic illness
Detection and initial treatment of a more serious condition with subsequent referral or transfer

DIAGNOSTIC TESTING

Urgent care centers provide laboratory testing both on-site as well as those that can be sent out to regional or national laboratories. Examples of available testing may include blood testing services such as Complete Blood Count, Comprehensive Metabolic Profile, Diabetic testing (hemoglobin A1c, finger-stick glucose), urine pregnancy, urinalysis, rapid strep throat cultures, and rapid influenza testing. UCCs also routinely offer Tuberculosis testing, drug screens from urine, hair and saliva as well as cultures for STDs and Urinary Tract Infections.

Diagnostic imaging is available in urgent care centers. Most diagnostic imaging is in the form of computerized radiography (CR) imaging (x-ray diagnostics). However, many UCCs are moving towards digital imaging (DR) in response to CMS payment reductions for non-DR x-ray options. Although most UCC's refer externally for more advanced imaging such as ultrasound, Computerized Tomography (C-T) scans and Magnetic Resonance Imaging (MRI), a few organizations provide these services in-house.

OCCUPATIONAL HEALTH

Prevention and treatment of workplace injuries, chronic and acute illnesses, improves the health of the employees as well as the overall work force. Urgent care centers are successful at pre-placement physicals, urinary drug screening and post-injury testing, annual physicals, flu immunizations, and workforce health education on injury/illness prevention. The opportunity for seven days per week access for treating immediate injuries and continuing the medical care until returning patients to full duty is a significant benefit for many employers.

Attention to employee health in the workplace to prevent occupational injuries and illnesses is a common service offered in UCCs. Many UCCs also participate in the Department of Transportation driving physicals for motor carriers employing certified examiners.

TELEHEALTH

Telemedicine allows many UCC providers to treat lower acuity conditions. Many employers have onsite telemedicine portals for urgent care of acute illnesses and injuries. This is a fast-growing service in many urgent care centers that utilize telemedicine to more rapidly evaluate patients by transmitting the care of patients to less busy centers in their system, thereby enhancing patient flow. 8% of respondents to UCA's most recent Benchmarking Survey indicated that they had integrated a telemedicine service into their centers. A survey conducted by Deloitte's US Health Care Consumers in 2016, discovered that consumers were open to the idea of telehealth. Near half of consumers said they would use telemedicine for post-acute care or chronic condition monitoring, even if they currently did not have a chronic condition[11]. The survey went on to show that about one-third of the consumers said they had no concerns with telemedicine. However, 43% were concerned that the quality of care would diminish compared to seeing a clinician face-to-face, and 35% had concerns about privacy and security. Even with such apprehensions, telehealth is anticipated to grow in the coming years as the market and payers respond to consumer expectations and provide solutions to these concerns.

PATIENT SATISFACTION

One of the key reasons for the popularity of utilizing urgent care centers for medical care is the focus on service and resulting high satisfaction from consumers. UCCs promote convenience in a health care industry system that has historically been complex for patients to navigate. Convenience in locations of the centers; convenience in the operating hours; and convenience in the opportunity to walk in, without an appointment, and complete a clinical evaluation from a licensed provider, including onsite diagnostic testing and obtaining discharge pharmaceuticals in under an hour.

Centers use multiple resources to evaluate patient satisfaction. Recent survey data reveals that 50% of clinic respondents provide follow-up patient calls. 20% use a standardized national company's written survey either during or after the visit, thereby allowing benchmarking of their performance against other centers (combining national standardized survey administered on-site and post-visit).

According to a study published in the Journal of Medical Practice Management, most patients who gave their healthcare providers low scores did so because of perceived bad service, not poor medical care[12]. In fact, 96% of complaints in an analysis of 35,000 online reviews were related mainly to communication and wait times. Just one in 25 patients who gave their provider one or two stars (on a five-star scale) said they were unhappy with their exam, diagnosis, treatment, surgery, or outcome. The study's lead author, Ron Harman King, crystalized the findings by saying "the waiting room trumps the exam room" when it comes to keeping patients happy (and, ostensibly, coming back for more). The data supports the position that patients will be drawn to urgent care because of its efficiency in getting patients cared for with many reporting 'under an hour' throughput times. These efficiencies are frequently supported by online scheduling programs that allow the patients to wait at home until their room is ready. The combination of positive clinical outcomes and a patient-centric model of care delivery will continue to catalyze industry growth.

URGENT CARE STAFFING

STAFFING: MEDICAL PROVIDERS

Physician-directed models continue to dominate the industry. Over 90% of centers report having a physician covering shifts, and 40% reported always having a physician providing care during all patient care hours. The dominant model is a hybrid of physicians and Advanced Practice Clinicians (APCs) or Nurse Practitioners (NPs)/Physician Assistants (PAs) working independent shifts[13]. Nurse practitioners have become increasingly independent in their scope of practice, as states respond to primary care shortages and healthcare access issues in rural and other underserved areas. A 2016 report by Health Affairs indicated that twenty-one states and the District of Columbia allow NPs to practice under their own licenses without supervision[14]. Numerous other states have similar legislation pending. The Congressional Budget Office has suggested that, in order to increase primary care physicians' services by 18% by 2023, physician assistants, nurse practitioners, and retail clinics must provide primary care services as well[15]. UCA supports the suggestion presented by the CBO and adds that urgent care centers are oftentimes misconstrued as being the same as a retail clinic. Urgent care centers can help increase primary care services alongside retail clinics, NPs, and PAs. As demonstrated in UCA's Benchmarking report (2015 data), 17% of respondents indicated that they have a mix of urgent care while also providing longitudinal care for basic primary care such as blood pressure maintenance[16]. The remainder is either specialty centers or fully integrated hybrid urgent care and primary care centers offering urgent and ongoing care for episodic and longitudinal care, including wellness[17].

STAFFING: CLINICAL SUPPORT STAFF AND X-RAY SERVICES

Urgent Care clinical support staff have a variety of skill sets and scope of practice allowances. Most states require a license or certification to operate radiography equipment, and 93% of centers use X-ray Technicians or Radiologic Technologists. Other staff members include certified and uncertified/registered Medical Assistants (MAs), Registered Nurses (RNs), Licensed Practical Nurses (LPNs, LVNs), and Certified Nursing Assistants. There is no standard staffing model for urgent care centers. Some operators elect to centralize all administrative functions while others provide them at the center level.

Laboratory testing is typically conducted by trained medical assistants, nurses and, in some cases, radiologic technologists. Laboratory services levels are typically either CLIA waived or CLIA moderate.

STAFFING: PHYSICIAN RECRUITMENT

Physician demand is expected to steeply accelerate, with an anticipated shortfall of 40,000 primary care physicians by 2025[18]. A 2016 staffing report produced by Merritt-Hawkins states that for the tenth consecutive year, family physicians were "number one on the most requested staffing assignments" for the group, demonstrating both an opportunity and a threat for the urgent care operator[19].

Potential solutions include innovation in delivery, greater use of technology, improved use of all health professionals on the care team including NPs and PAs, and an increase in federal support for residency training. However, the shortage is anticipated to persist despite such measures. This anticipated shortage has been one of the many drivers supporting the growth of the urgent care sector. Recruitment of qualified physicians and medical providers remains one of urgent care's ongoing challenges, as centers are seeking those individuals who excel in both clinical and service excellence.

INTEGRATION – PARTNERSHIPS – COLLABORATION

URGENT CARE CENTERS: IMPROVING ACCESS TO CARE

Access to healthcare is a key contributor to the growth and success of urgent care medicine in our communities. One of the important consumer centric values is the convenience for patients. Convenience in locations of urgent care centers, convenience in hours of availability and convenience in breadth of services offered. Most urgent care centers offer a one stop shop environment from the scope of practice, offering pediatric to geriatric evaluations, to on-site diagnostics including imaging and laboratory. Many also dispense pre-packaged medications, allowing patients immediate access to dozens of routine medications without having to visit a 24-hour off-site pharmacy or wait for the next day to receive necessary medical treatment. Urgent care centers are structured, staffed and equipped for optimal efficiency and patient flow – very different from the typical primary care, specialty care, retail care and emergency care services.

There is no doubt that urgent care medicine will continue to play a key role in accessing healthcare as our delivery system evolves, as well as improving the quality of care by offering the ability to evaluate patients sooner and act as an entry point in the medical care system. This is especially true as there is increasing focus and pressure to reduce hospital readmissions – now primary care clinicians can partner with UCCs to evaluate discharged patients *before* emergent issues arise which would require readmission. A good example of improved access includes patients no longer having to wait over nights, weekends and holidays to connect with medical providers that will evaluate and recommend treatment after communicating with busy, overburdened

or physically unavailable primary care clinicians.

The reason behind the dramatic improvement of access to acute care medicine by urgent care centers lies in the limitations from other options for patients; specifically, from primary care medicine and emergency care medicine. According to The Association of American Medical Colleges, there is a deficit of primary care physicians, which should reach 40,000 too few PCPs by 2025[20]. Unfortunately, only 1 in 9 U.S. medical school seniors chooses a primary care specialty when requesting residency. Although there has been a recent push to increase the number of medical students, very limited changes have occurred in Family Medicine residencies. The fact is that many medical students leave medical school with student loans in excess of $150,000 and the average specialty pay for cardiology, dermatology, surgery subspecialties are double and triple the earning capacity of primary care physicians. Also note that the numbers for other primary care specialties are skewed, as many internal medicine and pediatric residents end up in sub-specialty post graduate studies to become pulmonologists, gastroenterologists, as examples – not primary care specialties. The Medicare Payment Advisory Commission reported that 28% of Medicare beneficiaries (and a similar percentage of commercially insured patients) had difficulty even finding a primary care provider[21].

On top of the limited availability of primary care physicians, the Affordable Care Act (ACA) has increased the volume of patients requiring medical services by over 20 million. When Massachusetts implemented required insurance coverage to over 98% of its population in 2010, the demand for primary care services exceeded available supply. The average wait time for a new patient visit for a primary care physician before implementation was 6 days. After implementation, the time required for a new patient visit exceeded 6 weeks. This PCP deficit will not be solved in the next decade, although CMS is recommending increased reimbursement for primary care physicians to hopefully help increase the overall number of PCPs.

Additionally, for those patients who have a PCP, availability for acute care remains woefully lacking. One of the main barriers to acute care in PCP practices is their busy schedule. This makes routine access extremely challenging and discourages after-hours access as well. One study reported that only 40% of PCPs in the U.S. evaluated patients after-hours[22]. 57% of Americans report difficulty with same day or next day access to appointments, and 63% of patients with PCPs report difficulty with access on evenings, weekends and holidays[23]. 22% of patients reported waiting 6 days or more to receive care for acute problems according to a study from The Commonwealth Fund.

Patients always have the option of seeking care at the local Emergency Department (ED). Recent data indicate that there were over 138 million ED visits in 2014[24]. The American College of Emergency Physicians reported that most EDs are 'operating at or over capacity.' ED visit rates increased at twice the rate of US population growth from 1997-2007, and today there are fewer Emergency Departments than 20 years ago. Unfortunately, the average wait time in EDs remains over 4 hours and the cost for the average ED care is ten times that of an urgent care visit for the same diagnosis, according to a three-year study of BCBS of Texas claims. At a minimum, the estimated annual cost savings from utilizing urgent care services instead of ED services for appropriate care is in excess of $4.4 billion dollars[25].

UCA POSITION TO IMPROVING ACCESS TO URGENT CARE CENTERS

Patients deserve access to timely, high quality healthcare that is appropriate to the clinical condition, which includes access to urgent care centers for non-emergent acute, episodic care. The use of UCCs should be facilitated through patient education, adequate urgent care provider reimbursement, and the removal of

barriers, such as prior authorization and other restrictive insurance coverage policies that can unnecessarily steer patients to emergency departments.
Payers should also consider the incorporation of UCCs in the testing of innovative payment and healthcare delivery models. Payers and regulators should include access to UCCs when considering provider network adequacy, including adequacy of primary care providers.

URGENT CARE CENTERS PROVIDE COST SAVINGS

Urgent care's value proposition includes the opportunity to improve the overall cost of medical care. Healthcare in the United States is upwards of 17% of the national gross domestic product. Although the annual growth in cost has slowed in recent years, the overall growth is untenable. While recent research has approximated that the annual savings from utilizing UCCs for non-life or limb-threatening medical care to more appropriate settings would save $4.4 billion, UCCs are being utilized in many other settings to enhance quality as well as save costs of care[26]. Numerous integrated healthcare organizations include UCCs in hospital discharge planning. This allows full community resource utilization for at risk patients to prevent costly readmissions as well as accessing clinical evaluation services after typical office hours including weekends, evenings and holidays. This practice covers new clinical problems that discharged patients may experience and permits collaboration between the primary care provider and the urgent care provider – avoiding expensive emergency room use and/or duplicative testing.

Urgent care center use may also lower Medicaid costs in every state given the proper incentives and reduction in barriers for urgent care operators. Recent data indicated that the estimated number of emergency department Medicaid visits was expected to rise to about 47 million in 2016, compared to 36 million in 2010[27]. Studies support that the majority of these patients could be treated in less costly sites of service, including UCCs. According to the 2010 National Hospital Ambulatory Medical Care Survey, emergency department visits by non-elderly Medicaid patients were for symptoms suggesting urgent (40%) and semi-urgent (37%) medical conditions[28].

Lastly, research indicates that UCCs are in many ways, similar to Family Medicine practices[29]. Not only does the average urgent care reimbursement per patient visit closely resemble primary care visits at Internal Medicine and/or Family Medicine practices, but the average annual physician salary is similar to a Family Physician salary. Since there are significant deficits to primary care providers that will not be resolved anytime soon, utilizing UCCs for episodic acute care has been a significant cost savings initiative for many large integrated groups. In fact, as higher reimbursement favors care of chronic diseases and coordinated care, many savvy primary care practices are partnering with UCCs for episodic acute care while they focus their energies on those patients with costlier chronic conditions requiring ongoing disease management.

URGENT CARE CENTER INTEGRATION INTO EXISTING HEALTHCARE SYSTEMS

As the US Healthcare system moves away from the fragmentation of fee for service delivery system, urgent care centers are effectively partnering with medical organizations and systems focused on coordinated care for patients. Integrated care models including Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMHs) and bundled payment systems are utilizing the access and savings opportunities that urgent care centers provide.

Recent surveys note that over 60% of urgent care patients have a primary care physician. However, fewer than 40% of primary care practices offer radiology and minor surgery services. Combining this with data supporting

that more than two thirds of non-emergent ED visits occur after-hours, the convenience of urgent care centers is a fast-moving trend.

With walk-in access to urgent care centers, which have a 95% patient satisfaction approval rating, more hospital systems and integrated healthcare organizations are partnering with urgent care groups to care for after hour patient needs or to support the system when there are barriers to accessing prompt care.

Urgent care centers are a perfect complement to the PCMH model. With higher reimbursement for chronic care and coordinated care in primary care practices and increased focus on preventive care, primary care groups are most efficient and cost effective by referring acute care patients to affiliated urgent care organizations. These PCMH groups are finding that directing their overflow patients during the day as well as after hours, evenings, weekends and holidays, not only affords them the time to care for those patients needing more intensive disease management but they also benefit from more favorably reimbursed chronic care examinations.

It is important to note that UCCs support primary care practices as an extension of the primary care clinical team. Over 75% of urgent care clinical providers are primary care trained and choose to treat urgent care patients, but understand the need for continuity of care. A major key to success for the integrated model is communication. Technological support via EHRs is making partnering across all aspects of patient care easier. Notifying primary care providers that their patient has received care in the UCC and ensuring transfer of clinical and administrative information is an operational must.

The Joint Commission-sponsored recommendations of ensuring the quality of care for urgent care centers during transitions of patient care focuses on the issues of coordinating care in multiple venues for increasing successful outcomes[30]. The Urgent Care Association's accreditation standards also require evidence of integrated care processes within accredited UCCs.

More integrated healthcare groups are also utilizing UCCs for follow up after hospital discharge. The high cost of hospital readmissions has resulted in greater scrutiny on the barriers to care post-hospital discharge. Access to weekend and evening appointments not only allows recently hospitalized patients a prompt follow up appointment, but also an opportunity for earlier evaluation and intervention should problems arise after hours. Instead of an examination in an emergency department, care can be delivered more efficiently and cost-effectively.

UCCs are acting as entry points to health systems. Approximately 30-40% of urgent care patients are unaffiliated with a primary care physician. A large demographic that often chooses urgent care for their acute needs are young, healthy adults requiring episodic care.

As the country continues to move forward in efforts to support innovative delivery systems to better coordinate care, reduce cost and improve quality, urgent care centers are a solution to many issues facing delivery of healthcare in the U.S.

URGENT CARE CENTER SCREENING OPPORTUNITIES TO IMPROVE POPULATION HEALTH

The material percentage of patients who seek care at UCCs who are unaffiliated with a primary care provider provides an opportunity for UCCs to identify potential health issues that could require additional interventions, yet payers often limit the urgent care center's ability to offer wellness or screening services unless a test or service is directly related to the chief complaint or reason for the visit.

Urgent care centers could potentially provide a great service to population health if contractual and payment barriers were lifted to appropriate screening. As an example, a study published in the October 2016 Journal of Urgent Care Medicine revealed that when previously undiagnosed pre-diabetes or diabetes patients presented to an urgent care center and were determined to meet specific screening eligibility criteria, 10.9% of those tested were determined to have prediabetes and 4.7% produced the diagnosis of diabetes. It concluded that this early detection diabetes pathway (EDDP) "is an effective and feasible method for diabetes screening in urgent care centers"[31]. Early diagnosis could lead to fewer complications, improved health and substantial savings. The payer community oftentimes views and limits urgent care centers to care of episodic illness and injury, thereby eliminating the opportunity for UCCs to participate in the early identification of at-risk patients who could subsequently be referred to the care of a PCP or specialist.

URGENT CARE COLLABORATION WITHIN THE MEDICAL CONTINUUM

Patients are utilizing urgent care centers for convenient, quality visits and lower cost care. In response, major medical organizations are recognizing the opportunities to partner with UCCs to drive a more efficient and effective healthcare system. Numerous large, integrated healthcare organizations use UCCs as access points for their primary care, specialty care and post-acute care activities. Geisinger, Mayo Clinic, Ochsner as well as educational institutions such as Duke, University of Massachusetts, University of Florida, and Louisiana State University have all added urgent care medicine to their successful continuum of care and as a key component of their future strategies.

In fact, urgent care medicine supports the joint principles of the Patient Centered Medical Home (PCMH) model as outlined by the Institute of Medicine (IOM). "Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community"[32]. The term "integrated" in the IOM definition encompasses "the provision of comprehensive, coordinated, and continuous services that provide a seamless process of care"[33]. Urgent care centers are designed, staffed and available to absorb patients from different practices in the community. UCCs are encouraged to use a transition of care practice to facilitate communication between all providers and patients as they utilize timely options for optimal care.

Similarly, major medical associations such as The American Academy of Family Physicians (AAFP) and The American Academy of Pediatrics (AAP) have partnered with The Urgent Care Association in sharing major policy and journal articles about urgent care of adult and pediatric patients. These include recommendations of training, supplies, equipment, and processes/protocols supporting clinical care of patients. The AAFP established an Emergency Medicine/Urgent Care Member Interest Group to promote workforce policies, educational goals and credentialing standards in 2010. The American College of Emergency Physicians (ACEP) recognized in a policy statement that urgent care centers have a role to play in the healthcare delivery system and can provide short-term treatment for relatively simple problems such as flu, fever, earaches, nausea, rashes, animal and insect bites, minor bone fractures and minor cuts requiring stitches. However, the ACEP does go on to note that urgent care centers are not a substitute for the emergency department, and the urgent care industry concurs that patients with life or limb threatening illnesses or injuries should be transported or report to Emergency Departments.

To date, approximately 2-4% of patients are transferred from an UCC to the emergency department[34]. Urgent care center transfers to the Emergency Department may be via the use of emergency transport personnel or, when appropriate, simply referring a patient who is not in an emergent state to a higher level of care or where prompt access to specialties is available (e.g., deep laceration of a digit which may involve a tendon).

All organizations recognize the need for collaboration and communication between these leading organizations in medicine. UCCs and all physician offices should prepare for emergencies that may occur by training staff and having a relationship with a local emergency department.

Currently, although an increasing number of board-certified family physicians and board-certified emergency medicine physicians are choosing urgent care medicine, there is no data that reflects an impact in the workforce of either group. Many family medicine residency-training programs include rotations in urgent care centers, and there are three accredited family medicine residency programs offering a postgraduate fellowship in urgent care. Many hospitals joint venture or own urgent care centers in an effort to expand their footprint into existing and new communities, offload the workload of their emergency and primary care providers, and benefit from the associated referrals that may naturally emanate from the centers.

THE FUTURE OF URGENT CARE

IMPROVE APPROPRIATE CARE IN APPROPRIATE SETTINGS

In the healthcare era to come, the appropriate setting takes on multiple meanings. Not only does it imply care be directed to providers with necessary training at an appropriate cost structure, but it requires directing patients back to the organization bearing risk as described earlier in this paper.

The *right setting* for patient care involves avoiding the emergency department/hospital in non-life/limb threatening episodic care, while also requiring referrals to be directed to the best provider and in the right system, as in the case of an ACO. Utilization patterns will be increasingly monitored for appropriate use of resources and testing such as advanced imaging (MRIs) when patients present with uncomplicated low back pain.

Urgent care centers can contribute greatly as an appropriate and high-value ambulatory point of care.

A CMS informational bulletin in January 2014 noted that Medicaid beneficiaries use the Emergency Department at nearly twice the rate of privately insured patients. It suggests that the higher utilization may be due to unmet health needs of this patient population due to lack of access to appropriate settings. Not surprisingly, one strategy recommended in the bulletin was to increase urgent care access to reduce emergency room visits to more appropriate settings[35]. While the UCA Benchmarking Report shows a trend toward a greater acceptance of Medicaid as a payer, the state fee schedule in many areas makes it difficult for urgent care operators to accept Medicaid without putting a level of financial stability at risk. The Kaiser Family Foundation (KFF) publishes a Medicaid-to-Medicare Fee Index by state. While the national average for Medicaid payment to primary care physicians is 59% when compared to the Medicare fee schedule, the fee schedule is so low in some states that it is well below the costs to deliver care. As an example, Rhode Island's Medicaid fee schedule is only 32% of Medicare, California's is at 42% and Michigan's is at 44%[36].

CHALLENGES TO ACCESS ISSUES

While the urgent care industry has matured significantly since its inception, questions and challenges about patient access remain. Central to those questions and challenges is the theme of insurance accessibility. Having one's insurance accepted at an urgent care facility has long been understood to significantly impact a patient's decision on whether to use urgent care and which facility to visit.

Network access has resulted in some urgent care centers accepting only a limited number of insurers and thereby potentially driving patients into the much costlier emergency department. Additionally, payers typically attempt to place the patient copayment responsibility at a higher price point than that of a primary care physician. This fails to take into consideration the percentage of patients seeking care at the UCC who are unaffiliated with a PCP, are unable to secure a timely PCP appointment or are geographically displaced from their PCP due to travel.

Urgent care centers play an essential role in the delivery of primary and urgent care services. Creating disincentives to seeking care due to high copayments or deductibles delays timely care which can ultimately impact outcomes and raise the cost of care. Under the ACA, high deductible plans have deterred some patients from accessing primary care services. This manifestation has resulted in some payers considering eliminating the deductible for primary care services. Based on the services provided in the urgent care center, we believe that urgent care should be included in any such modifications to eliminating patient responsibility for primary care services.

New research is shedding light on the multifaceted considerations patients weigh when utilizing urgent care. Insurance accessibility is certainly a significant factor, but a study indicates that beyond economic considerations, patients pick urgent care due its convenience and timely care[37]. This would appear to indicate that as the urgent care industry and its locations grow, so too will the number of patients reached.

FUTURE OF URGENT CARE GROWTH

Healthcare delivery systems will continue to align around the consumer. The complex and fragmented systems that exist today will move towards opportunities for improved access to care and seamless coordination of care for patients and providers alike. Urgent Care utilization should increase as we shift to value-based care and the delivery of cost-effective healthcare services.

The volume of patients seeking care in the emergency department for non-emergent conditions alone could support ongoing growth in the urgent care sector. Therefore, insurers and large healthcare organizations will continue to invest in the urgent care delivery model.

Healthcare reform has increased the number of insured patients by over 20 million in an already stretched primary care system. This increase in the number of patients seeking access to care in an overburdened or at capacity Patient Centered Medical Home should inspire primary care providers to collaborate with integrated UCCs for acute episodic care.

We are also likely to see more nurse practitioner and physician assistant staffed urgent care center models predominate as the primary care physician deficit continues and more states legislate enhanced scope of practices for these advanced practice clinicians (APCs).

As value-based payment evolves, more urgent care organizations will begin to penetrate rural areas access to care solutions in underserved areas. Urgent Care services are anticipated to diversify to include more

occupational medicine and ancillary services such as weight loss, smoking cessation and immunizations. Also, more varieties of specialty urgent care centers will appear such as pediatric, orthopedic, allergy related and even behavioral health urgent care practices.

Payers must also begin to consider compensating urgent care centers for wellness services, recognizing that the UCC may be the only point of care for many individuals. Medicaid reimbursement must be commensurate with the services provided in order to divert appropriate patients currently seeking services in the emergency department.

The $18 billion urgent care industry is expected to continue to grow 5.8% annually through 2018[38]. The future for continued integration of urgent care into mainstream healthcare delivery and technology should promote improved coordination of care for patients and providers alike. The Urgent Care Association's vision is "to be the catalyst for the recognition of urgent care as an essential part of the health care system." UCA is confident that current and future urgent care providers across the country are integral to the successful reduction in the cost of care and same-day access to acute primary care services.

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If you are interested in learning more about the Urgent Care Association, becoming a member, or about one of our many programs such as Accreditation & Certification, please visit our website at www.ucaoa.org.

UCA provides benefits and resources for urgent care centers, clinicians, business professionals/practice managers, and companies/suppliers. UCA also has a weekly eNewsletter called UCAccess and a printed or online monthly issue of the *Journal of Urgent Care Medicine*. Conferences and Conventions are held annually for furthering education, along with informative webinar sessions.

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