Contents

Urgent Care Background

History

The urgent care model developed in the 1970's with physicians opening up practices with extended hours targeted toward acute but non-emergent care. It is estimated that there are anywhere between 9,000 and 20,000 urgent care providers throughout the United States, with potentially as many as two new urgent care facilities opening each week[1,2,3]. There is no estimate for how many urgent care providers exist in New York State.

The history of the urgent care model includes periods of growth and decline, with declines being partially attributed to quality issues around staff training[4]. Other potential reasons for decline include growth in hospital-owned urgent care facilities that subsequently folded due to mismanagement (urgent care providers are not necessarily designed for hospital management with union wages and exhaustive protocols), and a lack of public understanding of the role of urgent care providers[5].

What is the Urgent Care Model?

The scope of operations, hours of operation, scope of services, and the nature of the physician-patient relationship are all important elements that define the urgent care model.

Scope of Services

Urgent care providers serve ambulatory patients with acute illness or minor traumas that are not life-threatening or permanently disabling.

Urgent care providers provide outpatient diagnosis and treatment services. Services can include a medical history physical examination and treatment services such as those provided by a physician's practice. Example services include intravenous hydration, suturing of minor lacerations and providing occupational medicine therapies. Some urgent care providers also include advanced imaging services, in-house lab services for immediate point-of-care testing, and point-of-care dispensing of pre-packaged pharmaceuticals.

Urgent care providers provide referral services for patients whose needs exceed the services they offer.

Scope of Operations

Urgent care providers are outpatient facilities that primarily run on an unscheduled walk-in basis, serving patients as needed.

Hours of Operation

Urgent care provides typically offer extended hours beyond 9AM-5PM weekdays. They often include early and late weekday hours and weekend hours, and are often open on holidays. Some urgent care providers operate 24 hours a day, seven days a week.

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[1] McNeeley, S. "Urgent Care Centers: An Overview," *American Journal of Clinical Medicine*. Summer 2012. Vol. 9, No. 2.
[2] The Urgent Care Association of America. www.ucaoa.org/info/statistics.html.
[3] Stern, David. "Status of Urgent Care in the U.S. – 2005," *Business Briefing: Emergency Medicine Review. www.touchbriefings.com/pdf/1334/Stern.pdf.*
[4] McNeeley, S. "Urgent Care Centers: An Overview."
[5] California Healthcare Foundation "*No Appointment Needed…" (pg. 7).*

Physician-Patient Relationship
There is no expectation of an ongoing physician-patient relationship at an urgent care facility. Once the acute illness or trauma has been treated, the patient is expected to continue ongoing care with their primary care physician or is referred to a specialist.

What they are NOT
Urgent care providers are not intended to provide well care, chronic disease management, or inpatient care or hospitalization. They also are not intended for emergency intervention for critical, major trauma, life-threatening or potentially disabling conditions or to be used as emergency rooms and, therefore, are not subject to the Emergency Medical Treatment and Labor Act (EMTALA), requiring acceptance of patients without regard for the ability to pay.

Some urgent care providers operate as physician practices (termed "Urgent Care Practices"). Some primary care practices may have an urgent care component, with designated hours for walk-in acute care. Larger urgent care facilities operate as licensed Diagnostic & Treatment Centers and are considered urgent care clinics or centers ("UCC"). UCC generally serve a large range of urgent care services including in-house diagnostic imaging and lab services.

While urgent care facilities may fall into these two over-arching groups from an operational standpoint, there can actually be a broad range of urgent care models[6], as presented in the table below.

Basic level urgent care	Limited waive testing; hours 8-12, some weekend and afterhours component; may be cash clinic or retail
Basic level urgent care	Expanded waive testing; hours 8-12, with some weekend and afterhours component, no x-ray
Moderate level urgent care	Expanded waive testing; hours 8-12, with some weekend and afterhours component; EKG, basic plain film x-ray
Moderate level urgent care	Expanded waive testing, draw station with same day results; hours 12 or greater, with some weekend and afterhours component, basic plain film x-ray
Advanced level urgent care	Waive testing with point of care blood tests; hours 12 or greater, with expanded weekend and afterhours component; EKG, basic plain film x-ray and CT scanning +/- ultrasound
Advanced level urgent care	Expanded waive testing with point of care and on-site STAT lab (CBC, comprehensive metabolic, liver function tests); hours 16-24, open 7 days per week with afterhours component, EKG, radiology/Imaging center (plain films, ultrasound, CT scan).

Note: Under the Clinical Laboratory Improvement Amendments (CLIA) definitions, waived tests are categorized as "simple laboratory examinations and procedures that have an insignificant risk of an erroneous result," as determined by the Food and Drug Administration. Only those tests that are CLIA-waived can be performed by a laboratory with a Certificate of Waiver.

[6] Boyle and Kirkpatrick, *The Healthcare Executive's Guide to Urgent Care Centers and Freestanding EDs*, 2012; pg. 13, Figure 1.2.

Perceived Benefits of Urgent Care Models
Urgent care providers create savings for the healthcare system by diverting non-emergency patients from emergency departments that have substantially higher costs. Urgent care providers can handle patient overflows from existing entities and serve when physician practices are closed. Urgent care providers have a reputation for short wait times compared with emergency departments, and often emphasize strong customer service as one of their tenets.

Staffing
The staffing models at urgent care facilities can vary. Physicians may work alongside many medical assistants and office staff, and depending on patient volume, also have physician assistants and nurse practitioners; some models include medical technicians instead of registered nurses in order to reduce costs[7].

Quality
Over the past thirty to forty years, the urgent care industry has been establishing urgent care as a unique specialty of care, distinct from emergency care. The American Board of Medical Specialties does not currently recognize urgent care, and so board certification for urgent care has not been established. The Urgent Care Association of America (UCAOA) advocates for certification and accreditation of urgent care centers to further legitimize this area of medicine and establish high quality standards.

Accreditation
There are a few organizations that currently provide accreditation for Urgent Care.

- The Joint Commission (JCAHO): The Joint Commission accredits urgent care centers as a subset of ambulatory care[8].
- Accreditation Association for Ambulatory Health Care (AAAHC): The AAAHC website lists "Urgent and immediate care" centers as one of the types of organizations it accredits[9].
- National Association for Ambulatory Care (NAFAC): NAFAC has created a program that both accredits and certifies Urgent Care Centers[10].

Ownership, Organization and Governance of Urgent Care Centers
In the United States, the lines between urgent care models are at times blurry. In 2009 the Journal for Urgent Care Medicine published a study demonstrating that more than half of urgent care centers in the U.S. are physician-owned (see below), but did not specify how licensing varies[11]. Urgent care facilities are owned and operated under a few different models:

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[7] California Healthcare Foundation. "*No Appointment Needed: The Resurgence of Urgent Care Centers in the United States,"* 2007, (pg. 14). http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/N/PDF%20NoAppointmentNecessaryUrgentCareCenters.pdf

[8] The Joint Commission. "Seeking Urgent Care Accreditation." http://www.jointcommission.org/accreditation/ahc_seeking_urgent_care.aspx

[9] Accreditation Association for Ambulatory Health Care. "Accreditation." http://www.aaahc.org/accreditation/

[10] National Association for Ambulatory Care (NAFAC). "National Urgent Care Practice Standards Certification." http://www.urgentcare.org/CertificationStandards/tabid/134/Default.aspx

[11] Weinick RM, Bristol SJ, Marder JE, DesRoches CM. "The Search for the Urgent Care Center," *The Journal of Urgent Care Medicine* 2009, vol. 3, pg. 438-40. http://jucm.com/2009-jan/ucupdate2.shtml.

Ownership Model	% in U.S.
Owned by a corporation as part of a chain or network	**17.5**
Independently owned by one physician	**21.8**
Independently owned by two or more physicians	**32.3**
Hospital-physician joint venture	**3.8**
Hospital-owned on campus	**2.8**
Hospital-owned off campus	**22**

Study: "The Search for the Urgent Care Center," *The Journal of Urgent Care Medicine*, 2009.

- **Corporate Urgent Care Chain/Network:** Urgent Care Chains are generally small, with an average of 2.7 locations[12]. Urgent Care chains consolidate costs over multiple physician practices across a region to save costs. Having multiple locations can aid in negotiating for occupational medicine contracts and generate name recognition among patients.
- **Private Multispecialty Group Practice:** Within the realm of "Independently owned by two or more physicians," some urgent care facilities are owned by larger multispecialty physician practices. The benefits of this arrangement are capturing patient overflows from nearby providers/healthcare facilities and expanded hours for their patients. This arrangement secures that patients served by the multispecialty practice will have continuity of care after an urgent care event.
- **Hospital Ownership:** A 2006 survey by the Urgent Care Association of America found that a little more than a quarter (26%) of urgent care facilities were hospital owned, consistent with the above table. Some hospitals run their urgent care facilities as a separate product-line, away from their medical campus, while some have UCC on-site, serving patient overflow. One potential benefit to the urgent care facility being able to bill a facility fee under this model. Many urgent care physicians do not maintain hospital admitting privileges. When a patient is referred to the hospital, they are either admitted through the Emergency Department, or admitted directly into the appropriate department, depending on existing arrangements between the urgent care facility and the hospital[13].
- **Hospital-Physician Agreements:** The nature of hospital-physician agreements can vary.
    - ***Professional Service Agreements (PSAs)***
    - ***Hospital-sponsored independent practice associations (IPAs)***
    - ***Physician–hospital organizations (PHOs)***
    - ***Hospital-sponsored management services organizations (MSOs)***

Payment

It is widely accepted that the cost of care in urgent care settings is significantly less than in a hospital emergency room. According to one study of urgent care coding and billing, insurance companies do not see urgent care visits as fundamentally different from primary care visits from a billing perspective[14]. Urgent care practices and urgent care centers would be treated the same in this case. However, for larger more robust urgent care providers with the full range of urgent care services, expenses are generally higher than physician practices and the current level of payment and reimbursement is not always sufficient.

[12] Dale, J. *"Benchmarking Your Urgent Care"* Presented at the Urgent Care Association of America Conference, April 2006, Lake Tahoe, Nevada.

[13] California Healthcare Foundation. "*No Appointment Needed: The Resurgence of Urgent Care Centers in the United States,"* 2007, (pg. 18). http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/N/PDF%20NoAppointmentNecessaryUrgentCareCenters.pdf

[14] California Healthcare Foundation. "*No Appointment Needed…"* 2007, (pg. 20).

According to the Urgent Care Association of America, in 2008 the Payer mix for urgent care providers was Private Insurance 50.8%, Medicare 14.5%, Medicaid (or similar public option) 9.99%, uninsured out-of-pocket 12.1% and Occupational Medicine 12.7%[15]. It is unclear if this analysis included urgent care practices, or just licensed UCC.

It may be beneficial for urgent care provides to use Problem-Based Coding (PBC) when filing reimbursement claims, but this must be negotiated with Payers in advance; many prefer to use the Evaluation and Management (E/M) coding model; other alternatives used by urgent care faculties to get higher payments to cover their generally higher expenses as compared to primary care facilities are to reimburse at Specialist rates or negotiating higher fee schedules with Managed Care Organizations[16].

Some urgent care facilities are advocating for facility fees to make up lost costs from low reimbursement, and according to the UCAOA some urgent care providers that are affiliated with a hospital are already implementing this strategy. Strength of contracts with insurance companies depends on influence of urgent care providers in the region, and rural urgent care providers are more successful in negotiations because of the more prominent role they play in the local healthcare system than urgent care providers in populated areas, where there is more patient choice.

[15] Urgent Care Association of America, *2008 Benchmarking Study* (data points provided via email).
[16] Stern, David, MD, CPC on behalf of UCAOA, *Problem-Based Coding (PBC) for Evaluation and Management (E/M) in Urgent Care Medical Coding*, http://www.ucaoa.org/info/files/problem_based_evaluation_&_management_(E&M)_urgent_care_coding.pdf