Mistaken Identity

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For as long as I can remember, Urgent Care has defined itself in the context of something else. We're "more than primary care but less than emergency," and "we're like those drugstore clinics but we can do a lot more." Or "we fill a gap in on-demand access." I guess that is necessary when you are new and small and unknown.

The problem with this kind of definition is that it's so other-dependent. The way we talk about ourselves often sounds like it would be *better* if no one needed Urgent Care at all, and that continues to make it okay for us to be marginalized.

For example, there's a narrative out there that if we could fix the primary care access problem, there would be no need for Urgent Care. There's another that Urgent Care is doing *too good a job* because more people are getting care, so we are *overfilling* the gap. Both are wrong, but because we are letting ourselves only be defined in our relation to other aspects of healthcare, it's impossible for us to be properly valued. It perpetuates a sense that we exist only because another problem (or set of problems) can't be fixed. It puts us adjacent to the "real system" on the national healthcare org chart.

This is not just an industry problem. Over 2 decades, Urgent Care clinicians have worked to be understood and recognized as specialty providers but have been faced with a similar dilemma. Are we a separate and definable medical specialty that can stand alone, or can we only describe ourselves as the center of a Venn diagram where primary care and emergency medicine overlap? It's an understandable image and has worked well in introductory conversations, but it's still dependent on the fluctuating scopes and definitions of others.

I wonder if we've gotten so used to being the underdog, the red-headed stepchild, the gap-filler, and the unrecognized that we have inadvertently become the self-limited.

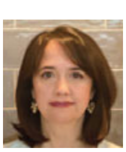
If you ask a patient why they come to Urgent Care, they probably no longer say, "I couldn't get into see my primary," or "I didn't want to go to the emergency room." Patients aren't burdened by our history. Patients come to Urgent Care because they were sick or hurt, it's awesomely convenient, and we are nice. For them it's very simple.

In my own life, I love that my favorite coffee place has thousands of locations because when I want coffee, it's uncomplicated and easy to get. I know it's going to be good. And that's just coffee. If you asked your patients, they'd love to have a good Urgent Care on every corner because when they or their loved one are sick or hurt, the last thing they want to do is spend time figuring out where to go for help. For them, Urgent Care is just awesome, period. Wouldn't it be lovely if everyone in the world could feel like that when they are sick or hurt?

So why should we be stuck defining ourselves in the context of others, and how do we break this little habit of ours? We need some new language, but it's going to take some work to figure out what it sounds like.

Let me give you an example from the Urgent Care Association's advocacy work. As you all know, we've finally gotten inclusion in official publications of the Centers for Medicare and Medicaid Services (CMS) via a request for information in their 2025 Physician Fee Schedule. This means that we have finally managed to get our foot in the door and our seat at one of their tables. This is our moment, and we have to make the most of it before it passes us by.

So, now that someone extremely important (CMS) has actually asked us what we want for ourselves, what do we ask for? We ask for a new Place of Service (POS) code that recognizes all that we really are and do (no offense, POS 20). We ask for a G-code that can be attached to every visit that compensates us for the ongoing investments we make to enable us to do all that we do. We ask to be recognized for the real role we play in today's healthcare system. We ask to be seen. ■



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