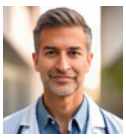
Are We Ready for a Day Without Urgent Care?

Rajesh Geria, MD; Patrick O'Malley, MD

Every year, our nation's 14,000 urgent care (UC) clinics care for nearly 206 million patients, equating to 564,383 patients every day across the country.[1] Imagine what would happen if there was no urgent care for just a single day. Now imagine that if that possibility lasted not just a day, but indefinitely. Unfortunately, many communities are at risk for this reality coming to pass. Decreasing reimbursement, clinician burnout, and administrative burdens make keeping the doors of UC centers open increasingly challenging.

Our healthcare system narrowly avoided collapse during the COVID-19 pandemic, largely thanks to the existence of UC. The Urgent Care Association (UCA) and the College of Urgent Care Medicine (CUCM) quickly mobilized to work with key government agencies and stakeholders, such as the American College of Emergency Physicians, to develop testing protocols, surge management strategies, and vaccination rollout plans.

While many physician offices closed or refused to care for patients with possible COVID-19 infection, they instead offered a blanket, default guidance to patients: "Go to urgent care." During this time, it was not uncommon for up to 150 patients to visit a single UC center within a 12-hour shift. Although most of that volume was related to COVID test requests, UC was able to care for those patients successfully, keeping them out of the emergency department (ED)—the only other option they might have had left for unscheduled, acute care needs. Simply put, urgent care saved the day. Let's explore what the U.S. healthcare landscape might look like in a counterfactual world without UC.



Rajesh Geria, MD, is an urgent care and emergency physician affiliated with CityMD and Envision Health in East Brunswick, New Jersey. **Patrick O'Malley, MD** is an urgent care and emergency physician affiliated with Newberry County Memorial Hospital in Newberry, South Carolina.

Ripple Effects

If UC centers were to close, even for a day, the ripple effects would be felt across the entire healthcare system. UC centers fill the very real gap between primary care providers (PCPs) and emergency departments. It is common for patients to call PCP offices only to be told there are no available appointments for weeks or months. The common refrain is, "Just go to urgent care. Go to the ED if you are sick." Experts have written about what would happen if there was a day without the ED.[2]

If UC clinics were to close for a day, the immediate effects would be felt across the healthcare system, starting with the patients who rely on these facilities for quick, accessible medical attention. Minor, unexpected nuisances are a part of every aspect of life, and human health is no exception. When these situations arise unpredictably (as they always do, by definition), patients are left to determine how they should handle the non-life-threatening injuries and new symptoms through self-triage.

Before the advent of UC clinics, patients would usually call their PCP and request an urgent visit. However, this was predicated on PCPs having capacity for urgent visits. This is rarely the case in current times. Current statistics on the number of Americans who have a primary provider are clear that fewer and fewer patients have a PCP.[3,4] Meanwhile, wait times for appointments that are measured in months are commonly encountered, which is not ideal if you have an abscess that needs draining or sudden onset of vomiting and diarrhea. Increasingly, patients are also using UC for complaints like low-risk chest pain, abdominal pain, dizziness, weakness, head injury, cellulitis, shortness of breath, and headache. Most of these UC patients are also able to avoid the stress and expense of an ED visit thorough clinical evaluation, basic point-of-care testing, coordination and guidance for follow-up, and shared decision-making surrounding the nearly ubiquitous, lingering diagnostic uncertainty.

If UC centers were all to close, patients who called their PCP offices for guidance would more often be directed toward an ED designed to handle severe and life-threatening conditions. ED waiting rooms would become even more overcrowded, and the already problematic wait times would balloon. Most critically, the additional load of over a half million visits for patients who might have otherwise been seen in UC would almost certainly divert resources from more critical patients. This strain would not only affect patients, but undoubtedly add to the already considerable stress and workload placed on emergency medical staff. The inefficiency of seeing patients with low-resource needs in a high-resource setting would significantly increase healthcare costs. More than 2 out of 5 Americans currently have healthcare-related debt—more than any other nation in the world.[5] The proportion of individuals in this unenviable position, however, could be much higher if acute care were delivered exclusively in ED settings.

"The closure of UC clinics, even temporarily, would highlight their role in the healthcare ecosystem as vital pressure valves."

Over recent years, the availability and use of telehealth platforms has dramatically increased. Fueled by the COVID-19 lockdown, both clinicians and patients alike were forced to adapt to this new mode of accessing care nearly overnight. It is certain that telehealth offers benefits in reducing cost and improving convenience of accessing healthcare. After 2021, however, U.S. telehealth utilization has trended down overall, suggesting that when it comes to healthcare access, many Americans still are prioritizing face-to-face interactions with their clinicians over convenience.[6]

Another near certain phenomenon that would occur if UC centers were to all close would be many patients choosing the "none of the above" option. Not seeking care due to fears of financial implications is tremendously common in U.S. One quarter of U.S. adults surveyed in 2022 admitted to not seeking medical care that they thought they needed because of cost concerns.[7] It's quite probable that this number would be much higher if the ED was the only option for acute, unscheduled care needs. Additionally, this would increase healthcare disparities as individuals with annual household incomes below $40,000 were more than three times less likely to avoid seeking care than those with household incomes greater than $90,000.[7]

The closure of UC clinics, even temporarily, would highlight their role in the healthcare ecosystem as vital pressure valves. These clinics not only provide a cost-effective solution for minor medical issues but also help to segment the patient population based on the severity of their conditions, thereby optimizing the overall flow and management of healthcare resources. Urgent care centers also increase healthcare accessibility with over 14,000 locations nationwide throughout the U.S., offering extended hours of operation on nights and weekends.[1] For this reason, the public health functions of UC cannot be underestimated.

The Promise of UC

Experts estimate the average margins in 2024 for UC centers in the United States to be in the low single digit percentages, perhaps as low as 1% or less. Unlike critical access hospitals and federally qualified health centers, which receive governmental support to help keep their doors open for the purposes of maintaining healthcare accessibility, such federal financial assistance for UC is very rare.[8] If these grim financial circumstances continue unabated, we face a threat that a reality without urgent care may be more than just hypothetical.

We salute the tens of thousands of UC clinicians who showed up when they were needed most throughout the pandemic and who continue to show up every day for every patient who walks through their doors. The legitimate concerns about managing costs from UC owners and operators foster a continuous situation where both human and physical resources can be frustratingly limited. This situation will not abate unless significant changes are made. Equitable reimbursement for care—as opposed to the increasingly common payer practice of using case rates—is central to this change. Additionally, federal and local governmental support commensurate to the vital role UC plays in preventing collapse of our healthcare infrastructure is needed. With increased funding, other important changes, such as improved worker protections, compensation, and patient access, will allow UC to more assuredly deliver on the promise of delivering high-quality care to our patients.

The situation is unfortunately not likely to improve if we do not advocate for the value we bring to the table and the needs we have if UC is to survive. We implore

you to get involved in some way. If you're not a UCA member, please join. Join your regional UCA organization as well (such as the Northeast Regional Urgent Care Association). Get involved in local UC advocacy efforts and meet with or write to your state and federal representatives in congress. Join the CUCM. Attend regional and national UC conferences. Register and attend the many free educational webinars that each of these organizations have every year. Share them with your colleagues. Read *JUCM* and submit articles. Grow the specialty. Not everyone has to do all of these, but if we each contributed something in the area where we felt most passionate, we might very well spare the public who rely on us from ever having to experience the terrifying possibility of even a day without urgent care. ■

"The situation is unfortunately not likely to improve if we do not advocate for the value we bring to the table."

References

1. Urgent Care Association website. Urgent Care Industry White Paper The Essential Nature of Urgent Care in the Healthcare Ecosystem Post-COVID-19 August 2023. Accessed at: https://urgentcareassociation.org/wp-content/uploads/2023-Urgent-Care-Industry-White-Paper.pdf
2. Mulligan T. LinkedIn post. Get ready for A Day Without the ER. Accessed at: https://www.linkedin.com/pulse/get-ready-day-without-er-terrence-mulligan-do-mph/
3. Association of Community Health Centers. Closing the Primary Care Gap. March 1, 2023. Accessed at: https://www.nachc.org/wp-content/uploads/2023/06/Closing-the-Primary-Care-Gap_Full-Report_2023_digital-final.pdf
4. Levine DM, Linder JA, Landon BE. Characteristics of Americans with primary care and changes over time, 2002-2015. *JAMA Intern Med*. 2020;180(3):463-466.
5. The Commonwealth Fund website. Survey: 79 Million Americans Have Problems with Medical Bills or Debt. Accessed at: https://www.commonwealthfund.org/publications/newsletter-article/survey-79-million-americans-have-problems-medical-bills-or-debt
6. Lucas JW, Wang X. Declines in telemedicine use among adults: United States, 2021 and 2022. National Health Statistics Reports; no 205. Hyattsville, MD: National Center for Health Statistics. 2024. DOI: https://dx.doi. org/10.15620/cdc/154767.
7. Kaiser Family Foundation website. Health Care Debt In The U.S.: The Broad Consequences Of Medical And Dental Bills. June 16, 2022. Accessed at: https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/
8. HRSA website. Critical Access Hospitals. June 2024. Accessed at: https://www.hrsa.gov/opa/eligibility-and-registration/hospitals/critical-access-hospitals