



TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

COVID-19 AND URGENT CARE CENTERS

Lessons Learned for the Future

Note: This resource was published in 2020 and has not been updated. Contact ASPR TRACIE if you need technical assistance.



As the COVID-19 pandemic raged across the U.S., local community urgent care centers were often on the frontlines. ASPR TRACIE met with incoming Chief Executive Officer (CEO) Lou Ellen Horwitz, outgoing CEO Laurel Stoimenoff, and Chief Development Officer Kim Youngblood (who also leads the Urgent Care Foundation) from the Urgent Care Association (UCA) to learn more about their experiences, lessons learned, and plans to work with their local medical communities in the near future.

■ John Hick (JH)

Tell us about urgent care centers and the association. For example, how many urgent care centers are there in the U.S.?

■ Lou Ellen Horwitz (LH)

Founded in 2004, UCA is the largest association in the country representing the interests of the urgent care industry. Our membership includes both organizations and individuals, representing approximately 4,000 centers. We estimate that there are 9,600 urgent care centers across the U.S. and though there are a variety of models, they must all meet certain criteria, especially to be accredited. Our members diagnose and treat a wide range of illness and injury in individuals of all ages. Our services are typically broader than retail (drugstore) clinics or primary care offices, but not as broad as an emergency department (ED). Our walk-in accessibility and lower cost than the ED make us ideal for urgently needed testing and diagnosis such as we've experienced with COVID-19.

■ Laurel Stoimenoff (LS)

While our centers treat more than 160 million patients each year, the majority present with lower-acuity, community-acquired, infectious disease-related symptoms. UCA also works very closely and collaborates with the Convenient Care Association, the organization that represents retail clinics. There are about 3,300 retail health clinics in the country, and while we share a high degree of accessibility and there is some overlap with the services provided by retail clinics, urgent care centers are prepared to treat

higher-level acuity patients because of on-site lab and x-ray capabilities. Our centers are located in every area of the country from large urban areas to rural communities where they are often the sole primary care providers.

■ Kim Youngblood (KY)

The Urgent Care Foundation (UCF) is an affiliate of the Urgent Care Association and its mission is to serve the urgent care industry in the areas of research, education, clinical and practice management leadership, as well as innovation in new and emerging healthcare delivery models. The Foundation is very interested in partnering with ASPR TRACIE since emergency preparedness is of critical importance to our members and the industry. In fact, we initially launched an Emergency Preparedness Initiative to assist our members with Hurricane Harvey relief efforts and over the past several years, we have expanded our work in this area by leading initiatives to fund education and training for clinicians including our most recent efforts to support the urgent care industry with our COVID-19 Emergency Fund.

■ JH

How have things shifted since the 2009 H1N1 pandemic?

■ LH

The main lesson learned from H1N1 was that we had not set up adequate connections between state-based resources and urgent care centers. At that time, our industry was still relatively new and more fragmented and we did not have the bandwidth to conduct more expansive outreach. That has changed over the past decade and now urgent care centers are located in every area of the country and our efforts are more coordinated. UCA has mapped urgent care centers and they can be easily located by [visiting our website](#). We've also had time to build relationships, such as the one with ASPR TRACIE. While we definitely learned some valuable lessons on emergency preparedness after the H1N1 pandemic, I think we all fell into the trap of getting busy with our next initiatives and neglecting to really solidify the connective pathways so we could be better prepared for the next emergency. In fact, last year I presented on an ASPR TRACIE panel, and while our industry has matured, and our numbers grown significantly, we still had members in the audience unaware of the availability and accessibility of urgent care. We have more work to do so our fellow healthcare leaders fully understand our capabilities. They do not have to recreate the wheel in a pandemic situation like COVID-19 as we have already built it and are ready to roll.

■ JH

What are the key issues facing urgent care centers amid COVID-19?

■ LS

The COVID-19 pandemic has changed our industry. As an organization, UCA had to quickly respond and address the needs of our members. Some of the first positive COVID-19 patients presented at several urgent care centers in New York City. While most centers have emergency response plans as a result of previous pandemics such as seasonal

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COVID-19 will forever change how we respond to pandemics, and we will emerge from this crisis as a better industry and organization, forward thinking and proactive.

- Laurel Stoimenoff

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influenza, HIV, and H1N1, the U.S. healthcare community, like most of the world, was not prepared for COVID-19. As a result, UCA redirected its activities and dedicated one of our listservs solely to COVID-19 to provide a forum for the exchange of clinical and operational information regarding preparedness and testing. For the most part, discussions focused on the clinical side. Our members were thankful for this platform, since the pandemic created unique new challenges around testing, PPE shortages, patient safety, and protecting staff from a novel infectious disease all while managing the drop off in patient volume and furloughing employees.

Another challenge our members faced was being able to message communities and the field at large about their capabilities. We remain relatively fragmented, and while centers were perfectly capable of running the testing process, for example, they were not always seen as an option because many planners do not understand the varied scopes of practice.

This led to the creation of a COVID-19 centralized database to ensure that patients and the public health community understood our full capacity to provide testing. We have canvassed our members to note specific testing capabilities (e.g., PCR or antibody testing for COVID-19). We created this database in direct response to media and state departments of health inquiries regarding center capabilities. This will also allow us to quickly assess the number of urgent care centers that are equipped to provide COVID-19 vaccines when they are available.

■ JH

Early on, we were prohibited from taking COVID-19 test samples unless we were in an airborne isolation room, which most urgent care centers do not have. Then, that guidance was modified. As the landscape shifts, and guidance is modified, how do you adjust to these changes?

■ LH

We can move quickly, make changes, and adapt to different situations in urgent care. Walk-in medicine teaches you to embrace change on day one. We are an industry that is both proactive and consumer responsive, so as COVID-19 evolves, so will our members.

■ LS

In the beginning of the pandemic when guidance was very limited, one of our most respected clinicians noted on the listserv that “urgent care centers are not the appropriate sites for testing. We don’t have enough personal protective equipment (PPE), and we should be making referrals.” To which many members replied, indicating that they are the only sources of medical care in their areas and we needed to figure out how to provide testing. So, they went to work to develop protocols and source the needed supplies. We’ve surveyed our members every two weeks, and at first, only 30-40% were able to test for COVID-19 (many did not have access to PPE or testing kits). Now, 90% of our members have a mechanism for conducting some form of COVID-19 testing (PCR and/ or antibody). The time to get a test result has shortened as well.

■ JH

Tell us more about PPE challenges, from a programmatic and supply perspective.

■ LS

Historically, patients with infectious diseases (e.g., measles and influenza) visit urgent care centers to receive a diagnosis and treatment; urgent care centers are currently testing a disproportionate share of COVID-19 patients. From an accreditation perspective, we ensure members have procedures in place if there is some type of exposure, but for the most part, we do not have the in-room ventilation capabilities. There are some exceptions, such as those clinics created by converting an old ED. Our members were desperate for PPE in the beginning. About 10% of the industry was responding to our weekly surveys that they could not get basic surgical masks or gowns, and N95 masks were almost impossible to find. It has been a challenge to the entire health care industry and inexplicably urgent care centers are often very far down the PPE distribution list. In Pennsylvania, for example, urgent care centers were down in group 3, despite being on the front line of the pandemic. EDs were in group 1.

■ JH

What proportion of centers routinely used N95 prior to COVID-19? What other types of PPE are used?

■ LH

I came from a large health system with over 40 urgent care centers, and we didn't use them routinely in any of our centers, so it is very uncommon. When the COVID-specific guidance about masks initially came out, there was an enormous reaction and rush to get them, but within a couple of weeks, that guidance changed, too. I would assume most urgent cares have gone back to their regular level of PPE and are using more face shields than used to be routine. Workflow changes that conserved PPE and kept people from coming in before being screened have also been implemented. Use of telemedicine has also helped with that in many centers.

■ JH

How has provision of care changed since COVID-19, especially regarding screening?

■ LS

There are quite a few best practices emerging now; some screen patients in parking lots, others post messaging on their websites, instructing patients to call ahead if they have any symptoms. Other practices include bringing suspected patients in through the back door, separating sick from well patients in reception, and isolating rooms for two hours if a suspected case was treated within. We worked with the American College of Emergency Physicians to develop risk stratification and decide when to send a patient to the emergency department. We are currently working

on pediatric risk stratification data. Many centers are using an app that encourages patients to “check in” online, and report to the center at a specific time. We found it was critical to ensure that staff and consumers knew urgent care centers were a safe environment to work in and visit.

■ LH

It is important for the community to understand all the steps we have taken to keep them safe in our centers; we reassure them that it is still important to seek needed medical care. We know the entire field is facing this challenge.

■ LS

The Centers for Disease Control and Prevention recently conducted a study in Michigan, finding that vaccination rates for “traditional” diseases in children and adults have decreased 50% percent. That really resonated with me. It is interesting in part because commercial payers exclude urgent care centers from being able to do perform wellness activities including vaccinating people. When we conduct our annual benchmarking survey, we find that between 20 and 40% of consumers presenting at urgent care centers do not have primary care physicians, so it makes no sense that we cannot provide them with these services. We are trying to get the word out to the field at large; we should be able to administer an immunization and conduct a physical in addition to providing medical care for illnesses or injuries which require prompt attention.

■ JH

What areas of education and training have you devoted the most time and effort to and what do you see going into the fall as the biggest need?

■ LS

We have done both clinical and operational types of training. We had a clinical town hall for our members where we summarized listserv activity and had clinicians serve as panelists. Operationally, we shared strategies for recovering from the lost business, ensuring a safe environment of care and applying for the paycheck protection program and other ways the CARES Act can help centers remain open. We have also looked at the future; in Arizona, a firm conducted a consumer survey to determine top concerns. Reopening was one of their top concerns; they were afraid of sitting in the same room with someone who may be infectious, even if both people were wearing masks. It is important to visually demonstrate that in the centers and communicate it on their website, in person so the patient feels safe returning for a face to face meetings. The next clinical town hall will focus on fall surge—how to prepare for the dual impact of flu and COVID-19 patients.

■ LH

A lot of our work is done in collaboration with the College of Urgent Care Medicine (CUCM). Many centers already had some aspect of integrated telemedicine that they were able to set up very quickly. Major industry players on the electronic medical records side and patient queuing sides

were very quick to support us. Innovation in testing capabilities as we face a combined influenza/COVID-19 season is top of mind, and improved collaboration with the payer community in covering the costs of the new diagnostics (and ultimately vaccines) is critical.

■ JH

What are the key concerns of providers? Are you seeing issues with staffing?

■ LH

One of the major challenges has been keeping up with the ever-changing guidance as it applies to staff and other resources. It's difficult to strike a balance between not having enough PPE and being unable to see patients, furloughing staff until suppliers can ensure there is enough PPE to ensure patient and provider safety. As we addressed those challenges, and the guidance was still being clarified, our centers wanted to be able to jump back in to providing care as soon as possible. It is extremely difficult to know how long to close centers or furlough staff; they must be able to quickly ramp back up when they can. While there were excellent intentions and benefits behind increasing unemployment benefits, the temporary increase made it almost too attractive financially to be on unemployment.

From a clinical perspective, the main challenge is that we do not fully understand this virus yet. This makes managing patients and knowing the appropriate level of PPE to provide challenging. We are treating every single patient as a potential positive. Getting back to "normal" operations is hard to envision. It is hard to know what "adequately protected" means, even when employers are going above and beyond what has been indicated. With the variance in symptoms, this has also required us to do a deeper dive into patient history (e.g., comorbidities) than we would typically do with a sprained ankle, for example, because that patient could also be an asymptomatic positive COVID-19 patient.

■ JH

What do we need to do to get this right in fall and winter seasons?

■ LH

We still need to increase the state-based awareness of urgent care as an existing and viable opportunity for diagnosis and treatment. In Seattle, for example, they were using public funding and a football stadium to test and treat COVID-19 patients when there is ample capacity in urgent care centers in the city to assist. It's just a lack of awareness and connection that must be improved. To that end, we are connecting with DOH leaders across the country to provide our database of centers that are testing.

Our CUCM partners are leading discussions about what a flu/COVID seasons looks like from a clinical guidance standpoint. The flu guidance has traditionally been to treat for flu if a patient has symptoms versus waiting for test results. Now, should we test for flu and the COVID-19 virus both on all upper respiratory patients? A clear clinical approach coupled with collaborative patient direction is the key.

■ LS

I recently asked someone whose role is to monitor this type of data if they have seen a lot of urgent care centers closures. Many have weathered the storm because they had some telemedicine opportunities to care for patients. There was parity in payment that also helped. They are good at talking to patients and asking the right questions. That said, when and how we determine when patients should come in (and how do we educate and encourage patients to come in) to the center is equally important. Those are the algorithms we should be looking at now.

■ KY

UCA and the Foundation are also hosting a Clinical Consortium at the end of July to strategize on industry preparedness for the upcoming convergence of COVID-19 and the fall flu season. We're convening 40-50 CEOs and CMOs from the top urgent care centers, public health officials from across the country including from the CDC, to provide direction to our members for anticipated fall resurgence. We're going to curate all of the best practices, "lessons learned" and the latest resources with COVID, so our members can be fully prepared to provide the best possible patient care.

