The Case for Urgent Care

Abstract: *Urgent care centers have been open in the US for over thirty years and see between 71 and 160 million patient visits each year. As the US healthcare system faces issues with access to care, increasing patient needs, growing demands on the primary and emergency care systems and rising costs, it is striking that urgent care centers are rarely included in solution development at the legislative level. Independent studies have shown that urgent care can improve access, while lowering costs, but no global review has been done. To help address this absence, the authors performed an environmental scan of the recent literature with the ultimate goal of educating the public and policymakers about the current and possible future roles of urgent care centers in healthcare delivery.*

Introduction

Since the early 1980s, urgent care centers have been operating in the US. Since the mid 1990s the industry has grown rapidly[1] to between 4,000 and 9,000 facilities according to the Urgent Care Association of America, the industry's trade association.[2] There have been studies of the industry by established research institutions such as the California Health Care Foundation, the Institute for Health Policy at Massachusetts General Hospital and RAND. There are articles supporting the benefits of urgent care found in publications ranging from the *Wall Street Journal* to *The New York Times* to *HealthLeaders*. Yet there appears to be no inclusion of urgent care in any of the recent federal healthcare legislation.

The current dialogue around healthcare delivery reform emphasizes use of the Patient Centered Medical Home (PCMH, also called Advanced Primary Care) and the primary care physician as the solution for lowering the costs of care.[3] Urgent care has significant existing potential to participate in this model, yet its role has not been examined. Urgent care has been noted in studies to reduce overcrowding in the Emergency Department in several local programs[4,5], yet there is not yet a national discussion about that success.

This paper attempts to bring together the results of the many national and regional studies and articles of recent years to illustrate the role urgent care centers are currently playing in improving access to and lowering costs of healthcare. In addition, it will review both current and future potential roles for urgent care centers, and highlight the need to include urgent care centers in healthcare delivery reform solutions at all levels.

Overview of Urgent Care

The broadest definition of urgent care, as defined by the Urgent Care Association of America, is healthcare provided on a walk-in, no-appointment basis for acute illness or injury that is not life or limb threatening, and is either beyond the scope or availability of the typical primary care practice or retail clinic. There are approximately 9,000 facilities in the US that meet this definition.[6]

The majority of urgent care centers provide services in episodic primary care, occupational medicine, routine immunizations and school physicals, and at least half of them (4,000+) also provide lab tests, x-rays, fracture and laceration care, and intravenous fluids.[7] They are typically open significantly beyond standard nine-to-five office hours, including nights and weekends. Urgent care centers are owned by physicians, groups of physicians, hospitals and corporations, and are typically staffed with physicians, with approximately half also employing physician assistants and nurse practitioners as additional providers.[8]

Urgent care centers see, on average, 342 patient visits per week.[9] Therefore these 4-9,000 centers are seeing between 71,136,000 and 160,056,000 patient visits each year.

ACCESS TO CARE

Current Physician Access vs. Patient Demand

According to the Department of Health and Human Services (HHS), as of June 2011, there are 66,615,059 people living in a primary care Health Professional Shortage Area in the United States.[10] A 2009 study by the National Association of Community Health Centers (NACHC) placed the number of individuals "lacking access to primary care" at 60 million. Only 2 years earlier that number was 56 million. That increase occurred *despite the fact* that community health centers added two million people to their patient rolls over the same period. [11]

For Americans who **do** have a regular physician, only fifty-seven percent (57%) of Americans report having access to same or next-day appointments with that physician and sixty-three percent (63%) report difficulty getting access to care on nights, weekends or holidays without going to the emergency room. Twenty percent (20%) of adults waited six (6) days or more to see a doctor when they were sick in 2010.[12]

Whether or not patients have a formal relationship with a primary care or "regular" physician, there is a current national challenge in accessing care, especially on an "urgent" basis: with no appointment, evenings, weekends and holidays. In contrast to traditional physician offices, urgent care centers are *by design* already open evenings, weekends and holidays and do not require appointments to see patients.

Projected Physician Access

In the coming years, physician access issues will almost certainly worsen. There are four contributing factors:

1. Continued primary care physician shortages. By 2020, there will be 45,000 too few primary care physicians.[13]
2. Growing population of patients with greater share of healthcare needs. By 2025 the over-65 population will grow to 80 million,[14] further taxing primary care resources.
3. Increase in patients with insurance. The Patient Protection and Affordable Care Act (PPACA) provides healthcare coverage for a new group of approximately 32 million individuals.[15] These individuals ***add*** to the shortfall described above.
4. Further expansion of primary care physician role as envisioned by the PPACA and PCMH.

Primary Care Physician Realities

The role of the primary care physician is expansive and in the process of becoming even more so. The American Academy of Family Physicians (AAFP) defines family medicine as providing continuing, comprehensive health care for the individual and family. It is a specialty that integrates the biological, clinical and behavioral sciences. It encompasses all ages, both sexes, each organ system and every disease entity.[16] It includes health promotion, disease prevention, health maintenance, counseling, patient education, and diagnosis and treatment of acute and chronic illnesses.[17]

The Patient-Centered Medical Home initiative calls upon family physicians to also have an ongoing relationship with patients to provide first contact and continuous, comprehensive care; lead a team of physician and non-physician providers who collectively take responsibility for the ongoing care of those patients; and provide for all the patient's health care needs or take responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care, chronic care, preventive services and end of life care.

The PCMH asks family physicians to accept accountability for continuous quality improvement by voluntarily engaging in performance measurement and improvement; purchase and utilize information technology to support optimal patient care, performance measurement, patient education, and enhanced communication; undergo a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model; and create programs that involve patients and families in quality-improvement activities at the practice level.

Lastly, family physicians are asked to provide "enhanced access" to care through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician and practice staff.[18]

These expansions of an already full role will likely further limit the time these physicians have to see scheduled patients, not to mention the unscheduled patients entering the practice via open scheduling.

Enhanced Access Options

Primary care physicians can achieve the enhanced access requirement of the PCMH in one of two ways: by expanding their own office hours and accepting more unscheduled patients, or by partnering with urgent care centers to handle episodic urgent care visits in a collaborative and mutually supportive manner. Given the projected shortfall in primary care physicians over the next decade and their substantially expanded role and obligations under the PCMH model, it seems clear that a partnership with urgent care centers for episodic care is better both for patients and for the primary care physician. Handling unscheduled visits is what urgent care centers are designed to do and a collaborative approach preserves the PCMH model and provides enhanced patient access while maintaining low costs. Recent studies found that the average cost of an urgent care visit is slightly *below* the average primary care visit - $155 vs. $165. [19,20]

Partnering with an urgent care center that is already open, available, designed and staffed to episodically absorb patients from many different practices in the community seems a logical alternative to the possibility of further taxing primary care physician offices with open scheduling or extended hours. The only alternative besides urgent care for these unscheduled or after hours visits in most communities is likely the emergency department.

Emergency Department Realities

The traditional emergency department is open 24 hours a day, staffed by highly trained physicians, and has access to most medical technology. It is also true that EDs are experiencing chronic overcrowding and are a high-cost facility for non-emergency care.

- The majority of the nation's emergency departments report they are operating "at or over" capacity.[21]
- Crowding threatens the ability of emergency physicians to provide timely patient care and results in prolonged pain and suffering for patients. In a recent survey, two hundred emergency physicians said they knew of a patient who had died because of the practice of "boarding, holding admitted patients in the ED rather than moving them to an inpatient bed."[22]
- Emergency department visits hit a new high in 2008 — up to 124 million – (222 visits a minute) in the US[23], while the number of EDs is falling[24].
- Emergency department visit rates increased at twice the rate of growth of the US population from 1997 to 2007, and nearly two-thirds of emergency departments are now classified as safety-net hospitals — defined as providing a "disproportionate share" of services to Medicaid and uninsured patients.[25]
- Rates of emergency department visits by the elderly are increasing more rapidly than any other group, which study authors predict would lead to "catastrophic" overcrowding.[26]
- Average ED visit times have increased in each of the past several years, rising to over 4 hours in 2009.[27]

In addition to patient boarding, a documented contributor to overcrowding is non-emergency care delivered in the emergency department. Recently several state Medicaid directors have begun organizing state-funded programs to reduce ED visits used for primary care.[28] National and regional studies from 2008-2011 found that 8-57% of ED visits were for non-emergencies.[29,30,31,32,33,34] This broad range of study results speaks to significant differences in measures, methodologies or samples over these years. The most recent national, academic study put the national number at 27.1% of visits.[35]

Even at the very lowest level these visits contribute to access problems in the emergency department, and urgent care centers have a role to play in the solution. With collaborative patient education programs, over time these non-emergency visits could be redirected to an urgent care center and help ease emergency department overcrowding. Where urgent care centers can make an even more significant contribution, however, is in lowering the cost of this non-emergency care.

For hospitals and their emergency departments, costs that are high today will likely only rise. The population ages and gets sicker, requiring more care. Technological advances provide insight but expand costs. Physician and nurse shortages require paying for being on call as well as higher wages. Requirements for IT investments continue to increase, and the annual costs of uncompensated care had risen to $39.1 billion as of 2009. [36,37] The potential solutions for lowering those costs are challenging, complex and slow in coming. The interconnected issues of high costs for hospitals in general and backlogs in the emergency department due to boarding require operational, regulatory and policy changes to address and will not be solved in the near future.

Measuring and Lowering Costs

Using the Centers for Disease Control figure of 116.8 million ED visits per year[38] and the most recent national estimate of 27.1% of visits, non-emergency care accounts for approximately 31.64 million of those ED visits.

The difference in cost between an urgent care visit and an emergency department visit *for the same diagnosis* ranges from $228-583. [39,40,41] At 31.64 million non-emergency visits the cost savings of using an urgent care instead of an emergency department could range from 7.22 - 18.45 billion dollars annually.

This difference in cost is the most significant issue with the use of the emergency department as a panacea. It is appropriate that care in the emergency department should cost more (higher overhead, higher staffing costs, higher risks, 24/7 availability) than in other settings. For an emergency room to fulfill its ultimate functions, it should be fully equipped to do so, and that comes at a cost. However, it seems equally appropriate that care that *could* be provided safely in a lower cost setting such as an urgent care *should* be.

Urgent care centers already have extended hours. The majority of centers are open from at least 8am-8pm on weekdays and Saturdays, and 9am-7pm on Sundays.[42] Non-emergency care can, by its nature, wait until morning. Therefore the availability of urgent care as a lower cost option for non-emergency care seems viable. Urgent care centers are also found in all geographic settings: urban locations = 25% of centers, suburban locations = 55%, and rural locations = 20%.[43]

Pilot Programs for Lowering Costs

Some payers have begun recognizing the cost-savings opportunity that urgent care represents and have efforts underway to make patients aware of alternatives to seeking care in the emergency room for non-emergencies.

One of Wellpoint's health plans, Anthem Blue Cross and Blue Shield in Virginia, reviewed their visit data and found that more than 60% of ED visits for its members were for diagnoses that could have been treated in urgent care centers. After launching a patient education initiative on ER alternatives, Anthem saw a fourteen percent (14%) decrease in ED visits in one year among members who were part of its program. [44] Such strategies could be emulated by payers in all markets where urgent care is available.

If Anthem's findings are true on a national level, then approximately 70 million of the 116.8 million ED visits are for non-emergency care. Continuing the calculations from the previous section, this represents possible savings between 15 and 40 billion dollars each year.

Urgent Care Centers – Industry Capacity for Current and Future Roles

In earlier years when urgent care was not available in every community, these centers did not present a viable option on a national scale for non-emergency care. With the industry's growth, however, urgent care should now be considered an essential part of the solution.

Patients have learned about urgent care centers to date primarily on their own. Even with a national growth rate of around 300 centers per year (3%-4%) since 2008 (the first year the full industry was measured), per-center visits had increased by 28 visits per center per month (an 8% increase) by 2010. [45,46] This rate appears to indicate a significant growth in total overall visits to urgent care in only two years.

Current Capacities

The most compelling element of the viability of urgent care centers for creating access while keeping care costs low is in their ***existing capacity*** to absorb the episodic primary care visit and the non-emergency ED visits – without the need to build one more center. To calculate exactly: If there are 9.34 million (8%) to 66.58 million (57%) non-emergency ED visits that could be seen in an urgent care center, and approximately 8,500 centers to absorb those visits, there would be an increase (on average) of 21-151 visits per center per week. The lower number would likely be easily managed by existing facilities at only 3 additional visits per day. The higher number could stress capacity in some centers, indicating continued room for additional centers in those communities.

These figures, however, use only the current non-emergency ED visits and do not include any new episodic primary care patients that may manifest through the 32 million newly covered individuals under the Patient Protection and Affordable Care Act.[47] Given that consideration, there is likely room for growth in the number of centers in all communities.

As a bellwether, from late 2006 to late 2008, 430,000 new individuals obtained healthcare coverage in Massachusetts. Analysts found that the increase in coverage led to a surge in the demand for primary care and that much of that care was for chronic conditions. [48] If this holds true for the newly covered 32 million individuals, traditional family medicine offices are likely to be overwhelmed with a flood of new patients. For episodic urgent visits, these patients may have to choose between an urgent care center and an emergency department. Given the demonstrated cost differences in these two sites, an educational program for these individuals on ED alternatives similar to the Wellpoint initiative should be considered.

In reviewing the increase in centers and visits cited previously, it appears that even without concerted federal or state efforts, use of urgent care centers is on the rise. Current capacity in most communities appears to be more than adequate based on an average patient wait time of less than 20 minutes for seventy-four percent (74%) of patients,[49] and the growth rate indicates continued building of capacity to absorb additional visits. What is missing is a national discussion of this capacity and the potential that lies within it, even beyond the access and cost improvement already illustrated.

Future Roles

For example, urgent care centers could be considered as key sites for non-emergency treatment in a disaster. If hospitals are overwhelmed with serious injuries, urgent care centers could be designated as treatment sites for less critical patients. Similar to the ED, they are accustomed to managing an unscheduled, walk-in population, unlike traditional physician offices. Community officials could establish a network of the centers in their areas and include them in public notifications of disaster planning programs.

In another example, as various entities work to form Accountable Care Organizations in the coming years, urgent care centers should be considered in that planning. Since these centers "cover" for many different primary care providers in off-hours or more serious medical situations, and can reduce ED visits for non-emergency care, continued open access to urgent care for ACO patients could be vital to the success of the ACO. Without the urgent care option, these patients may be encouraged to visit the ACO's ED and overall costs will escalate, thereby reducing the savings an ACO is designed to effect.

However, for urgent care to play any of these kinds of roles in the future, these centers must be part of the collaborative design efforts both at the local and federal levels.

Conclusions and Recommendations

Urgent care centers are now so numerous and so well-positioned in the US to assist the nation's emergency departments and primary care system, that it is surprising not to see them included in virtually any discussions of health care reform. With their scope of services, barrier-free access and low overall costs, these centers seem to be a logical part of the solution to the problems the US is facing today and will continue to face in the years to come.

These centers have been playing a role in healthcare delivery for over 30 years[50] and seem poised to continue to expand into even more communities across the US. 13% of centers surveyed in 2010 indicated that they would be expanding their number of locations in the next 12 months, 5% planned to expand to a larger facility, and 68% expected growth in their current location.[51]

Further study of the industry is certainly warranted. As these centers have not historically been singled out by payers as a separate type of delivery system, there is little detailed data on their true utilization and impact except that done by the industry itself, or the wide range of estimates that have been made by the few external studies that have been cited in this paper.

This review suggests that the role urgent care currently plays in healthcare delivery should be better recognized and understood, better incorporated into the rest of the delivery system and encouraged to flourish. The roles that centers can play in the future should also be better explored, piloted, and incorporated into planning at the local, state, and federal levels.

Endnotes

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[1] *No Appointment Needed: The Resurgence of Urgent Care*. Weinick, R., Betancourt, R., California HealthCare Foundation. September 2007, p.5.

[2] Urgent Care Association of America. Accessed July 19, 2011. http://www.ucaoa.org/home_abouturgentcare.php

[3] Fact Sheet: Medicare-Medicaid Advanced Primary Care Demonstration Initiative. HealthReform.gov. Accessed August 16, 2011. http://healthreform.gov/newsroom/factsheet/medicalhomes.html

[4] *Urgent Care Pushed in Howard: County's only hospital emergency room sees less crowding*. Carson, L. May 24, 2011. The Baltimore Sun.

[5] Emergency Room Interventions Using Google Maps and Education Empower Consumers to Choose ER Alternatives for Non-Emergency Conditions. June 23, 2011. The Wall Street Journal online. Accessed August 16, 2011. http://online.wsj.com/article/PR-CO-20110623-906872.html

[6] Urgent Care Association of America. Accessed July 19, 2011. http://www.ucaoa.org/home_abouturgentcare.php

[7] Merchant Medicine. Accessed September 1, 2011. http://www.merchantmedicine.com/Home.cfm?view=UrgentCare

[8] *Urgent Care Centers in the U.S.: Findings from a National Survey.* Weinick, R. Bristol, S. DesRoches, C. 2009. BMC Health Services Research: 9:79. DOI:10.1186/1472-693-9-79.

[9] 2010 Urgent Care Benchmarking Survey Results: Visits. February 2011. Urgent Care Association of America. www.ucaoa.org.

[10] *Designated Health Professional Shortage Area Statistics*. Office of Shortage Designation, Bureau of Health Professions, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services. Accessed July 5, 2011. http://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry&rs:Format=HTML3.2

[11] Primary Care Access: An Essential Building Block of Health Reform. March 2009. National Association of Community Health Centers. Accessed June 22, 2011. http://www.nachc.org/client/documents/pressreleases/PrimaryCareAccessRPT.pdf

[12] *2010 Health Policy Survey in Eleven Countries*. Schoen, C. and Osborn, R. The Commonwealth Fund. Accessed July 5, 2011. http://www.commonwealthfund.org/Content/Surveys/2010/Nov/2010-International-Survey.aspx

[13] Center for Workforce Studies, Physician Shortages to Worsen without Increases in Residency Training. Association of American Medical Colleges. Accessed July 5, 2011. https://www.aamc.org/download/150584/data/physician_shortages_factsheet.pdf

[14] Ibid.

[15] About the Law. Healthcare.gov. Accessed July 5, 2011. http://www.healthcare.gov/law/about/index.html

[16] American Academy of Family Physicians. *Family Medicine, Definition of*. Accessed July 6, 2011. http://www.aafp.org/online/en/home/policy/policies/f/fammeddef.html

[17] American Academy of Family Physicians. *Definition #2 – Primary Care Practice*. Accessed July 6, 2011. http://www.aafp.org/online/en/home/policy/policies/p/primarycare.html

[18] *Joint Principles of the Patient Centered Medical Home*. February 2007. Patient Centered Primary Care Collaborative. Accessed July 6, 2011. http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home

[19] *Many Emergency Department Visits Could be Managed at Urgent Care Centers and Retail Clinics*. Weinick, R., Burns, R. and Mehrotra, A. Health Affairs, 29, no.9, (2010) 1630-1636. Accessed June 22, 2011.

[20] *Comparing costs and quality of care at retail clinics with that of other medical settings for 3 common illnesses*. Mehrotra A, Liu H, Adams JL, Wang MC, Lave JR, Thygeson NM, Solberg LI, McGlynn EA. September 1, 2009. Annals of Internal Medicine. 151(5):321-8.

[21] *How Overcrowding Affects Your Access to Emergency Care*. n.d. American College of Emergency Physicians. Accessed July 6, 2011. http://www.acep.org/Content.aspx?id=25906&terms=overcrowding.

[22] Ibid.

[23] *National Hospital Ambulatory Medical Care Survey: 2007 Emergency Department Summary*. Niska R, Bhuiya F, and Xu J. National health statistics reports; August 6, 2011. no 26. National Center for Health Statistics. 2010.

[24] *National Hospital Ambulatory Medical Care Survey: 2006 Emergency Department Summary*. Pitts S, Niska R, Xu J, Burt C. National health statistics reports; August 6, 2010. no 7. National Center for Health Statistics. 2008.

[25] *How Overcrowding Affects Your Access to Emergency Care*. n.d. American College of Emergency Physicians. Accessed July 6, 2011. http://www.acep.org/Content.aspx?id=25906&terms=overcrowding. Further details about the definition of and problems associated with "boarding" are also described in this resource.

[26] Ibid.

[27] 2010 Emergency Department Pulse Report. Press Ganey. Accessed August 17, 2011. http://www.pressganey.com/newsLanding/10-09-19/Emergency_Department_Pulse_Report_2010.aspx

[28] *As Hospitals Push ERs, States' Medicaid Budgets Pressured*. August 22, 2011. Galewitz, P. Kaiser Health News. Accessed August 24, 2011. http://www.kaiserhealthnews.org/Stories/2011/August/23/ER-Diversions-Washington-Post.aspx

[29] The Facts About unnecessary emergency room visits in upstate New York. Spring 2010. Excellus (Blue Cross Blue Shield). Accessed July 6, 2011. https://www.excellusbcbs.com/wps/wcm/connect/c4f1758042992547b080b2dc5c9c0b98/ER+Visits+FS-EX+FINAL.pdf?MOD=AJPERES

[30] *Emergency Department Utilization After the Implementation of Massachusetts Health Reform*. Peter B. Smulowitz, Robert Lipton, J. Frank Wharam, Leon Adelman, Scott G. Weiner, Laura Burke, Christopher W. Baugh, Jeremiah D. Schuur, Shan W. Liu, Meghan E. McGrath, Bella Liu, Assaad Sayeh, Mary C. Burke, J. Hector Pope, Bruce E. Landon, Annals of Emergency Medicine, In Press, Corrected Proof, Available online 12 May 2011, ISSN 0196-0644, DOI: 10.1016/j.annemergmed.2011.02.020. http://www.sciencedirect.com/science/article/pii/S0196064411001338

[31] A Report on Frequent Users of Hospital Emergency Departments in South Carolina. February 2011. South Carolina Public Health Institute. Accessed July 6, 2011. http://scphi.org/2011/02/a-report-on-frequent-users-of-hospital-emergency-departments-in-south-carolina/.

[32] Study shows Solantic can save Jacksonville patients $112 million per year. October 13, 2008. Press Release, Solantic Urgent Care.

[33] *Many Emergency Department Visits Could be Managed at Urgent Care Centers and Retail Clinics*. Weinick, R., Burns, R. and Mehrotra, A. Health Affairs, 29, no.9, (2010) 1630-1636. Accessed June 22, 2011.

[34] *Comparing costs and quality of care at retail clinics with that of other medical settings for 3 common illnesses*. Mehrotra A, Liu H, Adams JL, Wang MC, Lave JR, Thygeson NM, Solberg LI, McGlynn EA. September 1, 2009. Annals of Internal Medicine. 151(5):321-8.

[35] *Many Emergency Department Visits Could be Managed at Urgent Care Centers and Retail Clinics*. Weinick, R., Burns, R. and Mehrotra, A. Health Affairs, 29, no.9, (2010) 1630-1636. Accessed June 22, 2011.

[36] *The Cost of Caring: Drivers of Spending on Hospital Care*. March 2011. American Hospital Association. Accessed July 6, 2011. http://www.aha.org/aha/trendwatch/2011/11mar-tw-costofcaring.pdf

[37] Uncompensated Care Cost Fact Sheet. December 2010. American Hospital Association. Accessed July 6, 2011. http://www.aha.org/aha/content/2010/pdf/10uncompensatedcare.pdf

[38] *National Hospital Ambulatory Medical Care Survey: 2006 Emergency Department Summary*. Pitts S, Niska R, Xu J, Burt C. National health statistics reports; August 6, 2010. no 7. National Center for Health Statistics. 2008.

[39] *Many Emergency Department Visits Could be Managed at Urgent Care Centers and Retail Clinics*. Weinick, R., Burns, R. and Mehrotra, A. Health Affairs, 29, no.9, (2010) 1630-1636. Accessed June 22, 2011.

[40] Comparing *costs and quality of care at retail clinics with that of other medical settings for 3 common illnesses*. Mehrotra A, Liu H, Adams JL, Wang MC, Lave JR, Thygeson NM, Solberg LI, McGlynn EA. September 1, 2009. Annals of Internal Medicine. 151(5):321-8.

[41] Study shows Solantic can save Jacksonville patients $112 million per year. October 13, 2008. Press Release, Solantic Urgent Care.

[42] *Urgent Care Centers in the U.S.: Findings from a National Survey.* Weinick, R. Bristol, S. DesRoches, C. 2009. BMC Health Services Research: 9:79. DOI:10.1186/1472-693-9-79.

[43] 2010 Urgent Care Benchmarking Survey Results: Structure. February 2011. Urgent Care Association of America.

[44] Emergency Room Interventions Using Google Maps and Education Empower Consumers to Choose ER Alternatives for Non-Emergency Conditions. June 23, 2011. Wellpoint, Inc. Accessed July 8, 2011. http://ir.wellpoint.com/phoenix.zhtml?c=130104&p=irol-newsArticle&ID=1579424&highlight

[45] *About Urgent Care*. Urgent Care Association of America. Accessed July 8, 2011 http://www.ucaoa.org/home_abouturgentcare.php.

[46] 2010 Urgent Care Benchmarking Survey Results: Visits. February 2011. Urgent Care Association of America. www.ucaoa.org.

[47] Understanding the Affordable Care Act: About the Law. Healthcare.gov. Accessed August 16, 2011. http://www.healthcare.gov/law/about/index.html

[48] *Massachusetts Health Care Reform: Three Years Later*. Kaiser Commission on Key Facts: Medicaid and the Uninsured. September 2009. Accessed July 8, 2011. http://www.kff.org/uninsured/upload/7777-02.pdf

[49] 2010 Urgent Care Benchmarking Survey Results: Visits. February 2011. Urgent Care Association of America. www.ucaoa.org.

[50] *No Appointment Needed: The Resurgence of Urgent Care*. Weinick, R., Betancourt, R., California HealthCare Foundation. September 2007.

[51] 2010 Urgent Care Benchmarking Survey Results: Future of the Industry. February 2011. Urgent Care Association of America.

Additional resource for the public: www.urgentcarecenter.org