Are Urgent Care Centers Alleviating or Perpetuating the Continued Marginalization of Medically Underserved Patients?

A socioecological analysis of the impact current utilization of UCC has on the health disparities faced by patients in Washington State residing in designated medically underserved or health care provider shortage areas with the highest needs.

Ogochukwu Angel Eto, PA-S, LSWAIC; Daytheon Sturges, PhD, MPAS, PA-C, DFAAPA, MCHES®

Introduction

Why:

The cause of health disparities faced by medically underserved populations is a complex dynamic interaction of multiple systems consisting of social, structural, and individual determinants of health. The multifactorial intersectionality of these constructs ultimately results in unmet health needs and reflects how social structures and socioeconomic patterns are the major determinants of population health.[1] This is reflected in the health behaviors of patients in medically underserved areas and their overutilization of the emergency department (ED). The overutilization of ED results in poorer health outcomes for several reasons, such as limited availability of providers to attend to high acuity diagnoses, further burdening the health care system.

Who and Where:

People residing in areas designated as medically underserved or having health provider shortage areas with the highest need who are utilizing Urgent Care Centers (UCC) in Washington State. The WA Dept of Health defines medically underserved populations as a shortage of primary care healthcare services for a specific population subset within a geographic area.[2]

How:

Urgent Care Centers were developed as a response to the overutilization of EDs. This study aims to utilize a socioecological model of medicine to analyze how the current utilization of UCCs are alleviating or contributing to the continued marginalization of patients residing in medically underserved or healthcare provider shortage areas.

Literature Review

- EDs deliver important healthcare services and commonly serve as the point of entry to the hospital system or as a means of connecting patients to after-hours care, particularly those without a primary care provider (PCP).[3]
- UCCs were formed in the 1970s to address the extensive wait times in the ED by providing a facility to treat lower acuity diagnoses.
- UCCs primarily treat lower acuity diagnoses. There main scopes of practice are family and emergency medicine. UCCs are equipped to treat a wide range of conditions, including minor injuries, illnesses, and infections that require prompt medical attention but are not serious enough to warrant a visit to the emergency room.[3]
- IBIS.com states in the US, industry statistics show the market size of emergency and other outpatient care centers to be $220 billion, with a 6.1% business growth in 2023 and 7.2% US annualized business growth between 2018 and 2023.[5]
- Despite urgent care medicine being a thriving medical specialty, there are few studies on the impact UCC have on ED visits and even fewer studies on the empirically tested hypothesis of the impact of UCC on ED visits.
- UCCs tend to be in close proximity with other clinics, typically within 3-5 miles of another UCC.
- The typical UCC patient profile is younger than 65 years old, privately insured, uninsured, or Medicaid-insured patients.
- Uninsured patients with the lese uptake of ED services are an indicator of the financial and structural determinants of health uninsured patients living in MUA and HPSA experience.
- There is no current government oversight of UCCs.
  - American Academy of Urgent Care Medicine (AAUCM)
  - Urgent Care Association of America (UCAA)

Methods

County name	HPSA Discipline	HPSA score	HPSA type*	Last update date of HPSA score	Rural status	MUA score*	MUA designation date	Last MUA update
Franklin county	Primary care	15-18	Facility, population group	9/21-12/21	Partially rural	42.7	9/10/82	9/10/82
Grays harbor (Quinault service area)	Primary care	13-16	Facility, population group	9/21 12/21 12/22	Rural	50.1	4/21/82	4/21/82
King county	Primary care	15-17	Facility, population group, geographic	9/21 10/21 11/21 3/23	Non-rural	0.0	7/29/92	2/3/94
Kitsap county	Primary care	17-18	Facility, geographic area	9/21 8/22 9/22	Non- Rural	0.0	5/27/93	1/31/94
Lewis County	Primary care	13-18	Facility	9/21 1/22 4/23	Rural	0.0	10/7/93	1/31/94
Pend Oreille County	Primary care	16	Facility, population group	8/5/21	Rural	50.7	11/1/78	11/1/78
San Juan County	Primary care	13-15	Geographic area	9/21 11/21	Rural	0.0	5/18/94	6/20/94

WA state counties designated as medically underserved areas with the greatest need for healthcare providers

- *Each HPSA score is assigned from 0-26 with highest score indicating greater need*
- *HPSA type -*
  - *Facility (federally qualified Health Center; Indian Health service, tribal health, urban Indian health organizations; rural clinic, correctional facility, federally qualified health center look a like)*
  - *Geographic area (geographic HPSA)*
  - *Population group (low income, homeless migrant farmworker population HPSA; low-income populations HPSA, Medicaid eligible population HPSA)*
- *Each MUA score is assigned from 0.0 to 100 with lowest score indicating greatest need.*
- *Each data point was extracted from https://data.hrsa.gov/tools and condensed into this table for the purpose of this study.[13]*

Results

Distribution of Urgent Care Centers in Kitsap County, WA.

Distribution of Urgent Care Centers in Grays Harbor County, WA.

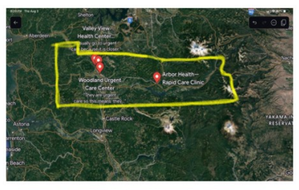
Distribution of Urgent Care Centers in San Juan County, WA.

Geospatial depictions of location discrimination in current UCCs representing 7 MUA and HPSA counties in Washington state with the highest need.[6]

Distribution of Urgent Care Centers in King County, WA.

Distribution of Urgent Care Centers in Pend Orielle County, WA.

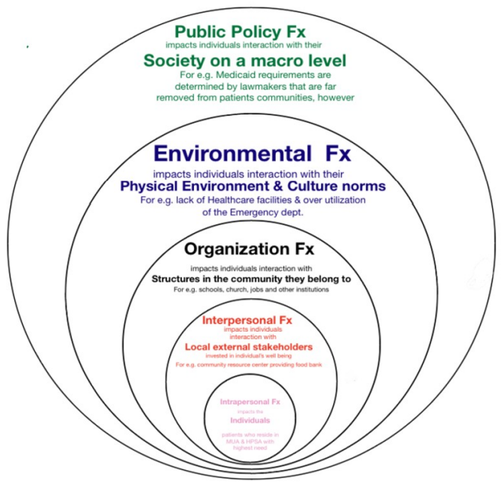
Distribution of Urgent Care Centers in Franklin County, WA.



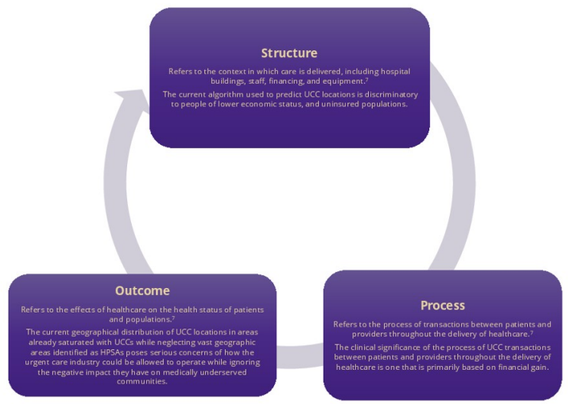
Distribution of Urgent Care Centers in Lewis County, WA.

Visual Discussion

A visual depiction of a socio-ecological analysis of the impact of UCC on health disparities among federally designated MUA and HPSA with the most needs in Washington State.



Visual depiction using the Donabedian Framework to evaluate UCC quality of care in MUA and HPSA



The cyclic nature of structure, process and outcomes of UCC perpetuates further marginalization of patient in MUA and HPSA designated areas.

Conclusion

If UCC can reduce wait times in ED as these wait times are partially due to underserved/under-resourced communities and the uninsured patients using ED for PCP needs, then broadening the scope of urgent care medicine to utilize UCCs to address non-emergency medical needs and to possibly provide PCP services will not only reduce wait times in ED but will further reduce the wait time in ED by providing an alternative option for seeking PCP services.

Expanding the scope of practice of UCC may result in the following benefits:

- Long-term implications on the overall health and wellbeing of patients in underserved communities by providing preventative and healthcare maintenance for the patients in MUA and HPSA.
- UCCs could be an effective intervention to combat health disparities in MUA and HPSA by increasing access to adequate health care and; therefore, bolstering health equity to address the needs of our most vulnerable populations
- Establish continuity of care, increased quality of life for patients with chronic disease, increased likelihood of early disease detection, and overall promotion of better disease management.
- Societal benefits as healthier individuals can contribute more collectively.

Consideration

If UCCs continue to open in communities with predominantly privately insured individuals, within a 3–10-mile radius of other UCCs, and solely for financial profit without attempting to address health disparities and/or prioritize health equity among MUA and HPSA, they are inadvertently engaging in discriminatory practices. These practices perpetuate the cycle of harm that exists in our national health system and continue to disenfranchise the very populations we pledged to advocate for in our medical oath

Future Implications and Recommendations

a. Policy oversight that encourages every UCC established in a community already saturated with UCCs, to be required to simultaneously establish UCC companion sites in a MUA and HPSA to hopefully benefit underserved populations and assist in alleviating the health provider shortages in the area.

b. Policy restrictions on the number of UCCs within a particular radius to encourage providers to open UCCs that will have a wider reach to more under-resourced populations.

c. Broaden the scope of urgent care medicine to allow UCCs to provide more than non-emergency medical treatment by equipping them with the structure, tools, staff, and operational oversight to perform adequate primary care.

d. Widen Medicaid eligibility/enrollment of patients in underserved areas who utilize UCC.

e. Adopt a collaborative approach to develop mitigating UCC practice to address barriers to UCC utilization among medically underserved populations involving policymakers, community organizers, and medical providers from various disciplines, etc.

f. Timely Medicaid payments as an incentive to providers to encourage the treatment of Medicaid-insured patients.

g. A collaborative effort with Medicaid to increase the percentages of payout provided to providers for their services to encourage more treatment of Medicaid-insured patients.

h. Partnering with local health professions schools training RNs, MD, MSW, PA, RT, etc. as a training opportunity to attract a robust clinical workforce that has fostered ties and connections within the community.

i. Collaborative partnerships with community health workers, community health clinics, retail clinics, and other medical facilities to encourage dynamic collaborative care of patients across health systems.

j. Consider establishing formal relationships between EDs and local UCCs to enhance communication, and ease of transfer, and bolster both patient and clinician satisfaction.

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