

Medical Surge and the Role of Urgent Care Centers

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Executive Summary

In the U.S., approximately 8,100 urgent care centers—medical clinics with expanded hours that are equipped to diagnose and treat a broad spectrum of non-life and limb threatening illnesses and injuries¹—provide care to 30 to 50 patients each per day on average.² They are a growing presence in the healthcare marketplace, with the number of urgent care centers increasing by nearly 10 percent in the most recent year for which data is available.³ Their convenient locations, affordable costs, evening and weekend hours, and relatively short wait times make urgent care centers an appealing care site to consumers. Additionally, previous research suggests that urgent care centers could be an alternate setting for at least 13 percent of emergency department visits.⁴ A more recent study in Texas found a 60% overlap in the top 20 diagnoses between urgent care centers and emergency departments.⁵ These characteristics of urgent care centers suggest they could have a role in the delivery of care for low, and possibly moderate, acuity illnesses or injuries during a community-wide emergency or disaster. However, there is limited information available about the role that urgent care centers envision for themselves in such incidents.

The U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE) interviewed 18 urgent care physicians and administrators associated with urgent care centers in 44 states to collect their perceptions on the role their urgent care centers could play in the nation's healthcare preparedness and response activities. These urgent care leaders participated in one-on-one telephone interviews and shared their perspectives based on their current position in their center as well as their knowledge and experience in the urgent care industry generally.

ASPR TRACIE characterized the interview responses under five major themes: willingness, capabilities, engagement, sustainment, and knowledge. Based on the interviews, ASPR TRACIE identified the following key findings:

- There is a high level of willingness among urgent care centers to participate in emergency preparedness and response activities.

- Urgent care centers have the staffing, supplies, equipment, space, and other resources needed to treat lower acuity patients and could contribute to decompression of hospital emergency departments during a surge response.
- While few urgent care centers have developed formal emergency plans and training programs, they do have: protocols for more common/typical facility-level emergencies like power outages, experience with seasonal patient surges, and, in some cases, involvement in past incidents.
- There is limited knowledge about how to sustain extended operations or the legal and financial implications of their participation. Additionally, there is limited recognition of how their roles may differ in a long-lasting epidemic versus a sudden onset mass casualty incident.
- Communities – potential patients, hospitals, private physician offices, emergency medical services, and others – are aware of the day-to-day roles of urgent care centers. However, it is unclear whether communities perceive urgent care centers as a potential resource during emergencies and few integrate them into medical surge planning.
- Some urgent care centers have learned lessons through past experience responding to emergencies that may be transferable to the field.

Additionally, ASPR TRACIE summarized lessons learned by those with disaster experience and suggestions that interviewees had for improving the readiness of urgent care centers. ASPR TRACIE also identified a preliminary list of resources that urgent care centers can refer to for additional information and guidance.

While there are significant differences in the business models, readiness levels, and resources among the urgent care centers associated with the interviewees, the insights shared by the interviewees suggest that opportunities exist to improve the readiness of centers and the communities in which they operate. ASPR recommends that this could be accomplished by:

- Increasing the engagement between urgent care centers and healthcare coalitions through inclusion in notification systems, invitations to attend training, and participation in exercises, for example.
- Exploring the feasibility of direct transport by emergency medical services or secondary referral of low acuity patients from emergency departments to urgent care centers.
- Clarifying misunderstandings and uncertainties about the legal and financial implications of participating in an emergency response.
- Highlighting the experiences of those urgent care centers that have implemented preparedness programs or gained experience during real-life incidents.

- Building upon the everyday protocols that urgent care center staff have developed for situations they regularly experience.
- Providing urgent care centers with easy-to-use tools and templates that could be modified and customized to meet their unique needs and circumstances.

ASPR TRACIE recognizes that 18 interviews with volunteers may not provide a complete and accurate picture of the current and potential roles of urgent care centers in our nation’s healthcare system preparedness and response for medical surge. The findings and recommendations are a first step toward greater awareness and engagement.

Introduction

ASPR TRACIE conducted a project to determine what role urgent care leaders think their facility type can play in the nation’s healthcare system preparedness and response activities. Urgent care centers are a growing presence in the healthcare marketplace and seem to have capabilities that might be helpful to communities’ and healthcare coalitions’ ability to withstand adversity and enhance the medical response system⁶, but their willingness to participate in such activities and their capabilities and capacities have not been well documented. ASPR TRACIE sought to address this information gap through a convenience sample of interviews with interested urgent care center leaders¹. Because there is considerable variation in the size, services, staffing, management, and populations served by urgent care centers, ASPR TRACIE does not intend to provide a complete picture of the state of emergency preparedness across the urgent care center industry. Rather, this report offers a snapshot of the experiences and perceptions of a sample of urgent care center leaders from across the country and their willingness to be engaged in disaster preparedness and response activities.

Background

Urgent care centers are a rapidly growing segment of the healthcare marketplace. According to data from the most recent [benchmarking survey by the Urgent Care Association of America \(UCAOA\)](#), the number of centers increased nearly 10 percent in one year, from 6,701 centers in 2015 to 7,357 in 2016.⁷ The survey also found that in 2015, 96% of urgent care centers reported

¹ Interviews were conducted in accordance with the Paperwork Reduction Act under Office of Management and Budget Control Number 0990-0391, approved September 1, 2017.

an increase in the number of patient visits and 73% acquired or built a new facility; 90% anticipated additional growth in 2016.⁸

There are limited regulations and requirements for urgent care centers and they follow a range of business models in terms of their size, ownership, populations served, and hours of operation, but they are generally characterized as being able to provide onsite x-rays, care of minor acute illness or injury, and suturing for minor lacerations on a walk-in or unscheduled basis, including during evening and weekend hours.⁹ They are also able to conduct laboratory tests and some offer preventive services such as influenza vaccinations or employment physicals. The UCAOA defines an urgent care center as “a medical clinic with expanded hours that is specially equipped to diagnose and treat a broad spectrum of non-life and limb threatening illnesses and injuries. Urgent care centers are enhanced by on-site radiology and laboratory services and operate in a location distinct from a freestanding or hospital-based emergency department. Care is rendered under the medical direction of an allopathic or osteopathic physician. Urgent care centers accept unscheduled, walk-in patients seeking medical attention during all posted hours of operation.”¹⁰

Urgent care centers appeal to consumers with acute but non-life-threatening illnesses or injuries. The top five reported diagnoses in 2015 were acute upper respiratory infection, acute sinusitis, acute pharyngitis, cough, and acute bronchitis.¹¹ Urgent care centers are usually staffed by at least one physician, and supported by some combination of mid-level providers, medical assistants, radiologic and respiratory technicians, nurses, and front desk staff. In some urgent care centers, mid-level providers – a physician assistant or nurse practitioner – are the highest-level providers on site. Most patients who present at urgent care centers understand the type of services they provide; only three percent require transfer to a hospital emergency department.¹²

Centers also appeal to those who seek to avoid long hospital emergency room waiting times or who cannot access a timely appointment with a primary care provider. According to UCAOA data, 92% of urgent care center patients consult with a provider in 30 minutes or less.¹³ Their extended hours provide an option other than the emergency room during hours when physician offices are typically closed. They also provide a non-hospital option for out of town patients who cannot visit their normal primary care physician. Additionally, previous research suggests that the cost of a visit to an urgent care center is similar to that of a primary care physician visit and less than an emergency department visit,^{14,15} further increasing their appeal to some consumers. Based on data from the Centers for Disease Control and Prevention,

UCAOA estimates that more than 18% of all primary care visits and nearly 10% of all outpatient physician visits occur in urgent care centers.¹⁶ A recent survey suggests that urgent care centers may be particularly appealing to younger patients; approximately one in five patients in the 18 to 34 and 35 to 44 age ranges responded that they would seek treatment at an urgent care center versus a primary care physician office, emergency room, or retail clinic, which is nearly twice the percentage of adults in the 45 and older age ranges.¹⁷

Urgent care centers are present in all 50 states and the District of Columbia.¹⁸ They are frequently located in convenient locations such as strip malls and are often found in medical office buildings or mixed use buildings.¹⁹ Some are also freestanding locations.²⁰

Due to their increasing numbers, widespread geographic presence, and convenience to consumers, urgent care centers could play a role in supporting the overall healthcare system response to emergencies. However, ASPR TRACIE found limited information in open source materials regarding the level of urgent care center engagement in healthcare preparedness efforts or whether centers have the willingness or capabilities needed to participate.

The delivery of unscheduled, episodic treatment for relatively low acuity injuries and illnesses by appropriately trained medical providers suggests that these facilities could be essential partners in providing certain types of care during disasters and emergencies.

18 interviews conducted with leaders from centers in 44 states and 1 territory

Methodology

ASPR TRACIE engaged several urgent care experts to identify and recruit urgent care center leaders willing to share their perspectives on the role of urgent care centers in emergency preparedness and response. Primary recruitment was conducted through the UCAOA and the American Academy of Urgent Care Medicine to their respective memberships. Secondary recruitment through personal contacts and online searches enhanced the quantity and representation of project participants.

ASPR TRACIE conducted one-on-one telephone interviews with a convenience sample of 18 urgent care center leaders during the time period of October 2017 to January 2018. The Interview Guide is included as Appendix A. Interviewees included physicians and administrators serving in roles such as facility owners, chief medical officers, operations directors, attending physicians, and regional managers. Interviewees were located in 13 states and were affiliated with urgent care centers located in 44 states and one territory. The size of urgent care centers

represented ranged from a single location to several hundred sites. They were independently owned and operated facilities, health system-owned, or a combination of both. Some focused on specific patient populations or issues, such as pediatrics or occupational health. Interviewees shared information based primarily on the knowledge and experience gained through their everyday roles and secondarily on their awareness of enterprise-wide activities and the urgent care industry in general. Appendix B summarizes some of the characteristics of the interviewees and the urgent care centers with which they are affiliated.

Of importance, the project did not include interviewees affiliated with retail clinics, which are generally located within retail stores and offer a limited menu of preventive services and low-acuity treatment by non-physician providers on a walk-in basis.²¹ Similarly, free-standing emergency departments were not a focus of this project, though some of the urgent care networks affiliated with the interviewees include these facilities. While both retail clinics and free-standing emergency departments are similar to urgent care centers in that they serve patients on an unscheduled basis and during extended hours, the level of care offered and the type of providers delivering that care are distinguishing factors. Additionally, the project did not include other outpatient primary care sites, such as federally-qualified health centers or primary care physician practices.

Interviewees shared their perceptions about the role of urgent care centers during emergencies and their willingness to participate in a response, their capacity to engage in an emergency response, to what extent their personnel and facilities have planned for and are prepared for an emergency, what legal and financial impediments might affect their ability to respond, and additional ideas they have related to the participation of urgent care centers in emergency response. Interviews lasted up to one hour.

Key Findings from Interviews

Due to the limited number of interviews, the findings should be viewed as a snapshot of the readiness of **some** urgent care centers rather than a representation of the state of preparedness among urgent care centers overall. The interview findings are characterized under five major themes: willingness, capabilities, engagement, sustainment, and knowledge. These themes along with representative quotes from the interviewees are shown in Figure 1.

Figure 1: Interviewee Quotes

- We're always looking for ways to serve our community where our clinics are located and without a doubt we would help the communities without hesitation.

- I think urgent cares are uniquely positioned to help take the load off emergency departments and take care of, in any disaster situation, a lot of people that run out of medication, need check-ups otherwise, and have other non-life threatening things going on as well as minor and moderate injuries and illnesses that are typically seen in urgent care settings. I think it frees up the emergency departments from being overwhelmed by the walking wounded or injured or sick otherwise. I don't think, I'll just say, that urgent cares can serve as a point for severely ill or severely injured people in any way, shape, or form.

Engagement

- We would [engage] if we had the opportunity. If someone called us up and said, "Hey, we'd like you to be part of our disaster preparedness response as an urgent care center with capacity to take volume", then, yes, we would.

- Do we have an entire supply room at each center? The answer to that is yes. Could we handle some things where we could manage stabilization of wounds, manage stabilization of burns or lacerations? The answer to all of that is yes.
- It's a big issue with cold and flu season that eventually it's going to take its toll on staff as well.
- You don't ever expect infrastructure to be wiped out, but it can be. How do you work around that?

- Most of us are emergency room docs. We kind of know what we can and can't do at our facilities.
- What's the legality of treating someone who has no ID and no insurance?

Willingness

Interviewees expressed a strong commitment to the communities in which they serve and this willingness to provide care extends to emergency and disaster situations. They were equally willing to participate in a response to a slow-moving, long-lasting epidemic and a sudden onset, short duration mass casualty incident. Uncertainties surrounding reimbursement for provided services, questions about legal protections for personnel and facilities, and limited knowledge about community healthcare surge plans were among the potential obstacles identified by interviewees. However, the interviewees were able to imagine potential roles for their urgent care centers despite these concerns.

Capabilities

Urgent care centers are led by physicians and mid-level providers with support from a mix of medical assistants, radiology and respiratory technicians, emergency medical services

providers, nurses, and administrative staff. They are able to conduct diagnostic tests, including taking x-rays and performing Clinical Laboratory Improvement Amendments (CLIA)-waived laboratory tests. They are also able to provide basic fracture care and to assess potentially serious symptoms like chest pain or respiratory distress for either treatment or stabilization and immediate transfer to a higher level of emergency care. Assuming they are able to maintain or supplement staffing and their facilities are not adversely affected by infrastructure disruptions, interviewees anticipated being able to maintain these capabilities during an emergency. Interviewees most often suggested that these capabilities would enable urgent care centers to contribute to decompression of hospital emergency departments by taking on lower acuity patients. Other roles suggested as being appropriate during an emergency response included assisting with triage, serving as a site for field hospitals, providing a temporary safe haven, and contributing personnel to other medical treatment sites, such as medical shelters and mass prophylaxis clinics.

Engagement

Despite their high level of willingness and appropriate capabilities, few interviewees were aware of their urgent care centers being engaged in ongoing preparedness activities in their communities. Most often, this lack of engagement was attributed to the absence of an invitation to participate. Interviewees associated with larger urgent care networks or centers affiliated with a health system were more likely to have plans, protocols, and training in place. Despite their lack of engagement in formal preparedness activities, many interviewees described informal relationships with partners or have developed protocols for situations more likely to occur in their centers, such as power outages. Interviewees were also able to share ideas about how their communities might engage them during a response and the type of support their centers might need to contribute to the response effort.

Sustainment

Interviewees frequently described the urgent care industry as operating under a “lean” business model. In the short term, interviewees believed they could accommodate a patient surge by extending their operating hours, calling in additional personnel, using areas such as hallways and administrative offices as treatment space, and restocking supplies through rapid ordering or borrowing from others. Because of their efficient staffing, limited available space, and variable supply inventories, it was difficult for interviewees to predict how long their urgent care centers could effectively sustain a response. Disasters that sicken or injure personnel or their family members, disrupt supply chains, or damage infrastructure would all hinder the ability of urgent care centers to sustain their response.

Knowledge

Urgent care centers are staffed with personnel who have the knowledge, training, and experience to provide care to low- and sometimes moderate-acuity patients during emergencies. However, this knowledge of how to deliver patient care does not necessarily extend to knowledge about managing operations of an urgent care center under emergency conditions. Those interviewees from urgent care centers that have been engaged in preparedness efforts are more likely to have considered potential obstacles during emergencies and developed policies and procedures to enable their continued operations. Those interviewees from less engaged urgent care centers frequently have mistaken beliefs or make inaccurate assumptions about emergency operations, including that existing staffing will be sufficient, supplemental personnel will be available, supply chains will not be significantly disrupted, and written plans and preparedness training are unneeded. Regardless of their level of engagement, nearly all interviewees expressed uncertainties and questions about the legal and financial implications of their urgent care centers' participation in an emergency response.

Details about the key findings as well as extensive quotes from interviewees may be found in Appendix C.

Lessons Learned from Past Incidents

Several of the interviewees have been involved in the response to various types of healthcare emergencies and were able to share insights and lessons learned from those experiences. In summary, they noted the following:

- Pre-planning is critical to the ability to maintain operations during the incident or to quickly restart operations once the danger has passed.
- Back-up plans are important for operations likely to be affected by infrastructure disruptions (e.g., arranging temperature control for medications, replacing electronic medical records with paper, etc.).
- The health and safety of personnel is paramount. Personnel and their family members will become ill during epidemics, have their homes destroyed during disasters, and will encounter obstacles reaching or leaving the workplace if infrastructure is compromised.
- Having multiple means of communication is essential to make contact with personnel and community partners.
- Patients will arrive at urgent care centers if they are open.
- Regardless of preparedness efforts, unanticipated challenges will arise.

Quotes from interviewees may be found in Appendix C.

Suggestions from Interviewees

Interviewees were provided an opportunity to share their recommendations and ideas to improve the readiness of the urgent care industry for healthcare emergencies. They offered suggestions for their urgent care colleagues, ASPR, professional organizations, and community partners, including hospitals, emergency management, and public health. Suggestions included:

- Increasing engagement between urgent care centers and community partners in planning, training, and exercising for emergencies, including guidance on how to initiate this engagement.
- Identification and promotion of urgent care patient surge capabilities, both at the individual center level and across the industry as a whole.
- Clarification of legal issues that hinder urgent care center participation.
- Building a culture of preparedness in the urgent care community, starting with those centers or leaders that express an interest and are able to share their experiences with others.

Detailed recommendations from interviewees may be found in Appendix C.

Recommendations

While there are significant differences in readiness levels and resources among urgent care centers, interviewees indicated a high level of willingness to contribute to the healthcare response to emergencies in their communities. The following are recommendations to improve the preparedness of urgent care centers and the communities in which they operate.

- **Increase engagement of urgent care centers with health care coalitions.** The most frequently offered reason for why urgent care centers do not participate in emergency preparedness activities is that no one has asked them. Identifying urgent care centers in a community and inviting them to participate in health care coalition activities can improve awareness among urgent care centers of how they can enhance the readiness of their facilities and personnel for potential emergencies. It can also improve the community's understanding of whether and how the urgent care centers in their area can contribute to an emergency response and anticipate what support urgent care centers may need to effectively contribute. Such engagement also presents an opportunity to develop, when appropriate, written memoranda of understanding/agreement between urgent care centers and health system response partners, including hospitals, EMS, public health, and emergency management.

- **Explore the feasibility of direct transport by EMS or secondary referral from the emergency department of low acuity patients to urgent care centers during emergencies.** One of the interviewees is in a region that has developed a diversion mechanism by which local EMS agencies can make decisions during a disaster to take low acuity patients to the urgent care center instead of the emergency department. The region has not had to implement this mechanism yet, but other areas of the country have developed similar practices.²² Further investigation is needed to explore whether these practices have resulted in better distribution of patients during an emergency or if they have led to poorer patient outcomes or other unintended consequences.
- **Consider whether some urgent care centers are more prepared than they realize.** Urgent care centers have written plans and protocols and training for a wide range of more likely to happen incidents in their facilities, including fires, power outages, lost children, recognition of infectious patients, and cardiac events. This suggests an inclination toward preparedness. Even in the absence of a full preparedness and response plan, procedures and training to address the types of patients likely to be seen during a disaster would increase readiness. Training on the proper use of PPE, contact lists for local health care coalition members, or a checklist on how to prepare the facility for a hurricane are examples of things that could be easily adopted or adapted from resources already developed by others. These preliminary efforts could be a stepping stone toward the development of a written plan that describes the roles and responsibilities of the facility during a community emergency, defines an incident command structure, specifies notification and information sharing procedures both within the urgent care center and with community partners, and guides continuity of operations.
- **Highlight the experiences of those urgent care centers that have implemented emergency preparedness programs or that have gained experience in response to real-life incidents.** Due to limited engagement in formal preparedness efforts and few experiences with actual disasters, many urgent care centers are unsure what to expect should an incident occur in their community or may not have thought through some of the secondary issues that could impede their operations. Hearing from those who have lived through such experiences would offer a relatable and actionable message for interested urgent care centers. Experienced urgent care centers can also provide insight on the costs of both preparing and not preparing.
- **Clarify identified questions about the legal and financial implications of participating in an emergency response.** While questions about liability and reimbursement may not prevent urgent care centers from participating in emergency response efforts, they do create concern and anxiety. Providing information, education, and training about legal

issues for medical providers, best practices for documenting care during a response, and the types of assistance available during declared disasters and emergencies would improve knowledge and boost the confidence of urgent care centers in deciding to what level they want to participate.

- **Provide resources to urgent care centers to help them improve their readiness.** Many urgent care centers do not have staff with the time and expertise to develop and implement a comprehensive emergency management plan. Appendix D includes resources that urgent care centers may find useful in learning more about the current readiness state of the nation’s healthcare system and guiding their own preparedness and response efforts. These resources are a starting point; urgent care centers would benefit from customized, easy-to-use checklists, plan templates, exercise guides, and training materials.

Additional investigation is needed to determine whether the interview findings and resulting recommendations reflect widespread perceptions among those working in urgent care or the limited view of a self-selected group who participated in an interview due to their interest in the topic. Input from additional urgent care professionals, especially from those who have experience in disaster response or have developed comprehensive emergency management programs, will shed light on existing gaps and promising practices to address them.

Finally, this document focuses exclusively on urgent care centers. ASPR TRACIE recognizes there is some overlap in the services provided by urgent care centers with the growing numbers of freestanding emergency departments and retail clinics as well as other healthcare settings such as federally-qualified health centers and primary care physician practices. ASPR TRACIE plans additional outreach to representatives of these other healthcare settings to similarly gauge their capabilities and willingness to participate in emergency preparedness and response activities.

Appendix A: Interview Guide

Preliminary Discussion

Do you have any questions for me before we begin?

I'd like to start by better understanding the type of urgent care centers you manage.

- 1) Are the centers/Is the center you manage owned by a hospital, part of a large chain of clinics, part of a small group of clinics, or an independent facility?

As I ask the following questions, primarily think about how your center(s) would address the needs of an infectious disease outbreak that is affecting your entire geographic region. Under this scenario, there would be high demand on the healthcare system, which is dealing with patients infected with the disease as well as the worried well on top of the normal range of provided services.

Perception and Willingness

- 2) Based on the scenario I described, to what extent do you think that urgent care centers would be involved in addressing healthcare needs related to such an outbreak?
 - a) PROMPT: What do you think the role of urgent care centers would be?
- 3) What obstacles might prevent your center(s) from assisting in this situation?
- 4) What would trigger your involvement in responding to these types of events?
 - a) PROMPTS:
 - i) Do you think it would happen naturally based on patients arriving at your center(s)?
 - ii) Would another entity request your involvement? Who would you expect to make such a request?
- 5) Under your normal operations, do you have any existing protocols, arrangements, or agreements for those with minor illness or injury to be sent to your center from a partner hospital or other healthcare facility in your area?
 - a) If no: To what extent would it be possible to implement such arrangements during an emergency? What obstacles would you expect to encounter?
- 6) Would any of your previous answers change if an incident like a plant explosion or a natural disaster suddenly resulted in large numbers of injured in your community instead of an infectious disease outbreak?

Capacity

- 7) Under your normal operating conditions, does your center(s) provide the following types of services and care?
 - a) Radiology – plain x-rays?
 - b) Radiology – CT scan?
 - c) Laboratory – blood counts, electrolytes, urine testing?
 - d) Fracture care?
 - e) Are chest pain and respiratory distress evaluated at your center or transferred to emergency care?
- 8) Would any of the services I just listed change under any of the types of emergency scenarios I've mentioned today?
- 9) Are your staff limited by a set of protocols or a set of conditions that they are allowed to treat, or are they able to operate within the full scope of practice for their positions?
- 10) What are the essential supplies that you keep on hand should an emergency occur? To clarify, by essential supplies I'm referring to a cache of disaster supplies for multiple patients at once rather than a crash cart for a single patient.
 - a) PROMPTS:
 - i) How frequently do you normally order supplies?
 - ii) How quickly would you expect ordered supplies to be delivered during an emergency?
- 11) How would you modify your physical space and manage your resources to handle a large influx of patients above normal operating conditions?

Planning and Preparation

- 12) To what extent do you participate in emergency preparedness activities with your local healthcare coalition, health department, emergency management agency, hospital, or other partners?
 - a) What support would you need from these partners to effectively participate in an emergency response like some of the scenarios we've discussed today?
 - b) Have you discussed with your partners potential roles for your staff? For example, could they provide shelter care, minor care at first aid sites, assist at mass prophylaxis/vaccination sites, or similar roles?
- 13) Do you have a written plan for handling surge events that would bring large numbers of patients to your door?
 - a) If no: What is the reason you don't have one?
- 14) Has your staff received emergency preparedness training?

- a) If no: Why have they not been trained?
 - i) PROMPT: Do you provide training or information to your staff on unusual experiences they may encounter (e.g., active shooter, how to shutdown or restart operations due to a power outage)?
 - ii) PROMPT: Do you provide information to your staff when a potential threat is identified (e.g., during the Ebola outbreak)?
- b) If yes: What has the training focused on?
- 15) Do you have written job aids that staff – both clinical and administrative – can refer to during an emergency? By job aid, I mean written descriptions of all roles that may be needed during an emergency accompanied by a list of tasks to be completed.
- 16) Have you conducted any emergency preparedness exercises, such as testing your ability to contact staff during off hours, identify a patient with a specific condition (e.g., Ebola), or notify other partners?
 - a) If no: Why not?
 - b) If yes: What scenarios or functions have you tested? For example, have you tested your communications, patient triage process, incident command activation, or use of your supply cache?
- 17) In what ways do your planning, training, or exercising activities address surge staffing strategies? In other words, have you considered how to adequately staff your center during a surge response?
 - a) PROMPTS:
 - i) Would you be able to handle a patient volume 20% above normal? 50%? 100%? At what point would your center(s) be taxed beyond its ability?
 - ii) Would your center(s) have the ability to extend operating hours?
 - iii) What provider types would be available, for example, physicians, physician assistants, nurse practitioners, registered nurses?
 - iv) How long could you maintain that staffing mix during an extended emergency response by extending shifts, calling in additional staff, or other strategies?
- 18) Do you receive notifications about mass casualty incidents?
- 19) Do you receive health alerts from your public health department?

Models for Care Provision

- 20) Independent urgent care centers/small chains only:
 - a) Has a disaster occurred in your area in the last five years? If yes: did you change any plans, policies, or procedures based on that experience?
- 21) Chains and hospital-owned urgent care centers only
 - a) Does your chain/hospital system have a process in place to involve urgent care centers in a surge response? If yes: How has it worked during a real emergency?

Legal and Financial

- 22) Are you aware of any policies or procedures that make it easier for urgent care centers to provide care during emergencies?
 - a) PROMPTS:
 - i) Does your center's liability insurance cover treatment of patients who are diverted from other facilities to your center(s)?
 - ii) Is there legislation or do you have liability insurance that protects providers during disasters?
- 23) Would you expect the reimbursement process for services rendered during an emergency to be different than the reimbursement process for providing usual care?
 - a) PROMPTS:
 - i) Do you have any concerns about your center or your providers being compensated for services delivered during an emergency?

Thank you. Those are all of the questions I have for you today. Is there anything else you'd like to share that you believe will be helpful to our project?

Appendix B: Characteristics of Interviewees

Role of Interviewee	Size of Urgent Care Network (# of Centers Interviewee is Affiliated With)	State Where Interviewee is Located	Ownership Model of Represented Urgent Care Center
Administrator/Physician	Small (1-5)	New Jersey	Independent
Administrator/Physician	Small (1-5)	Ohio	Independent
Administrator/Physician	Small (1-5)	North Carolina	Independent
Physician	Medium (6-30)	Texas	Health System-Owned
Administrator/Physician	Medium (6-30)	New Jersey	Hybrid
Administrator	Medium (6-30)	Texas	Independent
Physician	Medium (6-30)	South Carolina	Independent
Physician	Small (1-5)	New York	Hybrid
Administrator/Physician	Large (31+)	Illinois	Independent
Administrator/Physician	Large (31+)	Oregon	Hybrid
Administrator	Large (31+)	Washington	Health System-Owned
Administrator/Physician	Large (31+)	Texas	Independent
Administrator	Medium (6-30)	Missouri	Independent
Administrator/Physician	Small (1-5)	California	Independent
Administrator	Large (31+)	Louisiana	Hybrid
Administrator/Physician	Medium (6-30)	Texas	Independent
Administrator	Large (31+)	North Carolina	Independent
Administrator	Medium (6-30)	Georgia	Independent

Appendix C: Additional Details about Key Findings and Interviewee Comments

Willingness

Core to the urgent care business model and approach to care delivery is a focus on providing consumers with timely, convenient, affordable access to urgent treatment by trained medical providers. This is reflected in their operating hours, their locations, and the visibility of their locations. Urgent care center leaders have a clear sense of where urgent care fits in the day-to-day healthcare delivery system and they feel a strong commitment to the communities they serve. The goal is to quickly assess patients, provide treatment within the urgent care center's capabilities, and either send the patients home or, if additional care is needed, stabilize and refer them to an appropriate healthcare setting. As one interviewee explained:

- *It is unfair to the patient if there are facilities that can treat their illness better than we can do it. We're not in the hero business, we're in the urgent care business. So if somebody needs to go to the emergency room, we will send them. ~ administrator/physician; small, independent network²*

This approach toward patients under normal operations extends to disasters. Interviewees were asked to consider two scenarios: One involved an infectious disease outbreak slowly evolving over time to affect the entire community and the other was a sudden onset emergency resulting in a large number of injured patients. Interviewees were asked whether they perceived urgent care centers having a role in responding to either scenario. Under both scenarios, interviewees expressed a high level of willingness to participate in the medical surge response. The following is a sampling of how urgent care center leaders expressed their commitment to contributing to emergency responses in their communities:

- *We're always looking for ways to serve our community where our clinics are located and without a doubt we would help the communities without hesitation. ~ administrator; medium, independent network*

Hurricane Harvey Experience:

We're a children's urgent care, so we only see kids. But during response and recovery from Harvey, I told my providers, "We see everybody." ~ administrator/physician; medium, independent network

² Consistent with the interview protocol approved by OMB, interviewees are not personally identified in this document. Descriptors are provided to give readers context on the interviewees' roles and the settings in which they operate. Additionally, quotes are captured as spoken by the interviewees and may not be grammatically correct.

- *Most of us have become physicians or providers or practitioners because we want to help and we want to take care of people and save lives. ~ administrator/physician; small, independent network*
- *If we had something going on, we'd stay there as long as we're needed. If we had to be open 24 hours to take care of a situation, we would do it. ~ administrator/physician; small, independent network*
- *What would trigger our involvement would be knowing the need of the community because our owners are very hands-on and love to be in the community. Just knowing the need would trigger our involvement in any natural disaster or any need for healthcare in the surrounding area. ~ administrator; medium, independent network*

During day-to-day operations, urgent care centers do not necessarily accept every patient (e.g., the type of insurance is not accepted, they only serve certain populations, the patient is uninsured and does not want to pay cash, etc.). However, several interviewees believed they would waive current policies and treat all patients who came to their doors during an emergency. Many interviewees noted obstacles that might complicate or hinder their participation, including uncertainties about whether they would be reimbursed for provided services, a lack of clarity about liability protections for their providers and facilities, and limited knowledge about preparedness efforts in their community surrounding the distribution of patients. Despite these concerns, all interviewees identified potential roles for their urgent care centers. The following demonstrates their perspectives about providing care during emergencies:

- *As a private center, we turn away non-emergent people who, you know, we don't take their insurance or don't want to pay cash, that kind of thing. That's just the reality. I would suspend that in an emergency. So if somebody comes in and they have Medicaid and we don't accept Medicaid but they're having chest pains, we treat them fully anyway. So it's automatically suspended for emergencies, but I would have no problem suspending it for any patient so we're not going to, in the middle of a disaster go, "Hey, you don't have insurance, go somewhere else." ~ administrator/physician; independent center*
- *For example, like with Hurricane Harvey that we just experienced here in Houston, we opened our doors and, though we're an urgent care for children, we started seeing adults as well. So even with the inability to pay or if they had insurance or not, we accepted them into our facilities to take care of them and I'm sure we would do the same thing if some sort of outbreak happened here. ~ administrator; medium, independent network*

- *Treat first, ask questions later. I think most providers are that way even though they say, “No, I’m not going to work without getting paid.” When it comes right down to it, they’re going to do what they have to do. And even if there’s no protocols in place, most people in healthcare know that you have to do the right thing for the patient regardless of what protocols say. I’d like to think that everything would work out in the end. ~ physician; small, hybrid network*
- *I think that it’s important to include non-“large hospital-based” systems in these types of responses and have some sort of a joint response plan in place. We have not really participated in that, but we would certainly be willing to. We certainly are interested in doing our part to help assist with any of those types of situations. ~ administrator; large, independent network*

Capabilities

All of the interviewees are affiliated with urgent care centers staffed by physicians. The rest of the staffing mix is dependent on the patient volume of each center, but includes a mixture of mid-level providers, medical assistants, radiology technicians, licensed practical nurses, paramedics and emergency medical technicians, respiratory technicians, clinical technicians, and front desk staff. In some cases, physicians are not present during all of the hours that the urgent care center is open. In those instances, the urgent care is primarily staffed by a mid-level provider – either a physician assistant or nurse practitioner. Interviewees frequently described their staffing as lean, and many cross-train their staff so their roles may be shifted as needed, for example, radiology technicians are also trained for front desk duties. For the most part, interviewees believe they have the right staffing mix to contribute to an emergency response, though some did express concerns about their ability to maintain staffing over an extended period of time and acknowledged that some of their staff would be limited in what they could do. Examples of urgent care staffing capability include the following:

- *Perhaps we’d have to increase our staffing, educate our staff on whatever particular illness was facing the location, address the personal protective equipment issues, and, basically beef up the existing policies and what we’re doing. ~ administrator/physician; independent urgent care center*
- *It really gets back to the severity or the complexity of the patient and the acuity. Again, our particular model in the urgent care environment is relatively lean, meaning it’s typically a provider plus one or two radiology techs or medical assistants and possibly a scribe. So it’s an appropriate model, but it’s not built to manage the extremes of complexity and severity and there are limitations around*

volume that can be absorbed. ~ administrator/physician; large, independent network

- Some of our offices have registered nurses, but the majority are medical assistants who are certified, but they're not licensed health care professionals so their scope is limited to support. They can give injections in some states. They can draw blood. But other things, they can't do. ~ administrator/physician; large, independent network

Interviewees were asked about their urgent care centers' imaging and laboratory capacity. All of those interviewed indicated that their urgent care centers are capable of taking x-rays. Very few have CT scan capability, but most have identified facilities to which they can refer patients who need this service. Those who do have CT scan capability tend to be part of networks and locate the equipment at one centrally-located facility to which other nearby urgent care centers in the network can refer patients. All of those interviewed are able to conduct Clinical Laboratory Improvement Amendments (CLIA)-waived tests²³ and a smaller number can perform moderate complexity tests. Interviewees believed they could maintain these services during an emergency as long as the diagnostic needs did not exceed their capabilities and infrastructure was intact. As several urgent care leaders explained:

- The only time that they would change would be if it was a natural disaster and we didn't have power. We do not have generator power so if the power grid is down, then we would not be able to provide radiology services or lab services. ~ administrator; large, independent network
- The vast majority of urgent care, and all of ours as well, are CLIA-waived labs. If it was something that required higher levels of testing, you'd be sending all of that out. Our ability to do that level of diagnosis, if it were required, would be delayed. We could still do the draws and swabs. But we wouldn't be able to have results. ~ administrator; large, health system-managed network

All of the interviewees indicated that their urgent care centers can provide basic fracture care, such as splinting and minor reductions. More complex fractures are referred to orthopedic providers or a hospital emergency department. Symptoms such as chest pain or respiratory distress are evaluated and, if needed, transferred to a hospital emergency department. Interviewees described protocols instructing front desk staff to immediately alert providers of patients arriving with certain symptoms. Providers rapidly assess the patient and provide treatment for issues that are appropriate to manage in an urgent care setting. For more serious issues in need of emergency care, urgent care staff call 911 and provide stabilizing care until emergency medical services (EMS) arrives. All interviewees believed that EMS would arrive and

provide transport to a hospital within minutes of being called under normal circumstances. Interviewees anticipate that the roles of urgent care centers during an emergency response would be a natural extension of these day-to-day roles within the healthcare system, and in some cases they could expand their capabilities in minor ways. They described:

- *As long as it's something that could be handled as an outpatient, that's certainly something we could handle. ~ physician; small, hybrid network*
- *Urgent cares are absolutely perfect because there's so many of them, they're everywhere, they have immediate capacity to treat non-life-threatening conditions, and they want the business. ~ administrator/physician; large, independent network*
- *Right now our standard is if someone needs IV fluids you give them one bag and if they need more than that they have to go to the hospital. We could probably do more than that if we thought the patient could be discharged. The other situation would be wound repair. A lot of times if it's something that's complicated we'll send it out, but if the hospital was overwhelmed, we could do it later or we could do our best and then have it followed up and dealt with later. I could picture going a little outside our capabilities in the case of an emergency, definitely. ~ physician; small, hybrid network*

Urgent care centers are accustomed to treating acute but non-life-threatening illnesses and injuries and interviewees believe those are the types of patients they could care for during an emergency. Interviewees commonly envision their role as treating appropriately triaged “greens” and possibly “yellows” following a mass casualty incident³. Regardless of the type of incident, interviewees most often responded that they view urgent cares as an appropriate setting to help decompress overcrowded hospital emergency departments by taking on lower acuity patients and allowing the hospitals to focus on patients needing a higher level of

Superstorm Sandy Experience:

*“We reached out to some of the practices – primary care, regular internal medicine practices – that were severely impacted by the storm and we knew weren't opening to let them know, yes, we are open and we will take care of your patients in the interim until you get your offices open again. And then we also reached out to the health department and the hospital to let them know that we were there for any of that overflow that they felt they couldn't handle with people waiting.”
administrator/physician; medium, hybrid network*

³ Most mass casualty triage systems use a color-coded scheme to prioritize patients. “Greens” are those with minor illness/injury or the walking wounded who can wait for more thorough assessment and treatment. “Yellows” are those with serious, but not immediately life-threatening illness/injury whose care is delayed until “reds” who need immediate care are prioritized. Patients are re-triaged to account for changing symptoms and availability of resources.

care. Some interviewees thought that hospitals that are part of an integrated health system that includes urgent care centers may be more likely to view urgent care centers as able to contribute to decompression of hospital emergency departments. Some interviewees expressed uncertainty about whether hospitals they are not affiliated with would be open to referring lower acuity patients to them. Additionally, some interviewees saw potential in serving as a temporary safe haven, establishing field hospitals on their property, or providing personnel to staff other medical treatment sites, including medical shelters and mass prophylaxis sites.

Volcano Experience:

I remember when that volcano in Iceland went off and they couldn't send planes. We had a community here of a couple hundred Europeans who couldn't get back. On the fifth or sixth day of them just hanging around, a bunch of them started running out of their medications and they can't walk into a pharmacy. We volunteered to write them a prescription. In the U.S. you can't write a prescription without doing a good faith physical exam so we had to see them all. Every day we'd see 15 or 20. administrator/physician; small, independent network

- *Things like second degree or split thickness burns on less than 10% of the body, we can treat that. Non-life threatening trauma and lacerations, we can do that. When I imagine these ERs during an emergency, what I see is a sea of people sitting in chairs with bandages on their heads and their arms in slings and things like that waiting hours and hours to be seen because the ER is doing the life-threatening stuff. Those are the ones that I think urgent cares can help off-load from the ER. So we could definitively take care of a lot of stuff if they need some wound care and give them some antibiotics. ~ administrator/physician; small, independent network*
- *I think urgent cares are uniquely positioned to help take the load off emergency departments and take care of, in any disaster situation, a lot of people that run out of medication, need check-ups otherwise, and have other non-life threatening things going on as well as minor and moderate injuries and illnesses that are typically seen in urgent care settings. I think it frees up the emergency departments from being overwhelmed by the walking wounded or injured or sick otherwise. I don't think, I'll just say, that urgent cares can serve as a point for severely ill or severely injured people in any way, shape, or form. ~ administrator/physician; medium, hybrid network*
- *Urgent care, we're not going to replace the emergency department. We're not meant to. We shouldn't. It would be inappropriate. But it's also, I think, urgent cares can serve a definite role and should be included in the planning for that, you know, the walking wounded, the ones who don't necessarily require an emergency*

department but require care before things get worse, including fractures, lacerations, illnesses, and other things even just as simple as, say a diabetic or others that need medication refills. ~ administrator/physician; medium hybrid network

- For minor emergencies, urgent cares are perfect because they have minor suturing and bandaging capabilities. They have capabilities as triage. ~ administrator/physician; small, independent network
- Any high acuity urgent care can function as a triage center. They can treat minor injuries. They can treat some major injuries. They do a lot of occupational medicine and exposure treatments anyways and serve as a center where patients would go and with upstaffing and upmanning they could function as a field hospital or field triage center. ~ administrator/physician; medium, independent network
- We are around manufacturing plants. If something acutely happened and we didn't have time to plan, then what we would probably do is obtain more providers and supplies on a short term notice and that would probably help to triage patients. We could at least triage them before they were sent on so we could help from that standpoint. ~ physician; medium, health system-managed network
- There have been situations where urgent cares have set up tents outside in their parking lot and acted as triage. If they're closer to the scene, they can decide who needs to go to the hospital and who doesn't need to go to the hospital. And I could certainly see urgent cares doing that. Some of them have done it now with some of the natural disasters. ~ physician; small, hybrid network
- All of our providers are employed by our system partners and our medical directors also report up through their clinical team. Any activities that the systems put together, we're able to leverage our staff and have the flexibility to adapt and provide care – vaccinations or other treatments, that's at the ready. ~ administrator/physician; large, independent network

Engagement

Despite their willingness and capabilities, very few interviewees indicated that the urgent care centers they are affiliated with are currently engaged in ongoing preparedness activities in their communities. This is consistent with an earlier study that found 27% of urgent care centers have been designated by community officials as a site for the evaluation and treatment of non-emergent disaster victims and only 22% take part in community and hospital disaster planning, exercises, and drills through EMS and public health systems.²⁴ The most common reason that

interviewees offered for why their urgent care centers are not engaged in preparedness was that no one had invited them to participate. They explained:

- *If you ever came to me and said, “Hey, would you like to sit in on a meeting”, I’d be happy to. If they were to reach out to us, that would be the thing that would start it. ~ administrator/physician; independent urgent care center*
- *We would [engage] if we had the opportunity. If someone called us up and said, “Hey, we’d like you to be part of our disaster preparedness response as an urgent care center with capacity to take volume”, then, yes, we would. ~ administrator; large, independent network*
- *Very little [involvement] and it’s not for lack of trying. We’ve reached out to them, but they’ve not seen a need to include us in drills or anything like that at this point. ~ administrator/physician; medium, hybrid network*
- *It’s something that urgent care does want to be involved with. It’s just OEM [office of emergency management] and the hospitals haven’t really recognized the niche that urgent care would play in offloading the emergency departments so they can focus on the more serious cases. ~ administrator/physician; medium, hybrid network*

Political Convention Experience:

“They were anticipating a lot of problems. I don’t know if it was the health department or the city or somebody who reached out to us and we went through a whole exercise with them. We upgraded our staff during that time. We extended our hours. We did a lot of different things with whatever agencies we were working with. Nothing came of it, but we were prepared for anything that happened during the convention. ~ administrator/physician; large network of independent centers

Among those interviewed who are engaged in preparedness activities, most are large independent chains or affiliated with a health system. Preparedness activities are often coordinated at the corporate level – sometimes by dedicated emergency management staff – and distributed to all of the individual urgent care centers within the network. Some urgent care centers use the preparedness planning by their headquarters or health system partners as a basis on which to build more in depth policies and procedures for their specific center. Examples include:

- *We actually have company-wide protocols in place for infectious disease emergencies. A few include state specific requirements. We have processes in place with local public health departments regarding the role of our urgent care facilities. Basically, with an infectious disease outbreak, most facilities don't have separate ventilation systems for isolation rooms so we have protocols in place to*

designate specific rooms for high alert patients. We have protocols in place already with public health for how we contact them, and the numbers that are posted. We have the personal protective equipment suits on site at each facility for when we do have infectious disease cases. We have arrangements already made with our ambulance facilities with their protocols since we'll have to work together. The role of the urgent care that we've established is to basically detect and contain and contact local public health. And they will come to our facilities and take over from there. ~ administrator; large, hybrid network

- *In terms of an infectious disease or natural disaster response, we generally build it out as part of our partner's disaster response plan and we augment those services as we collaborate heavily to support their general disaster plans. Deep clinical integration in a coordinated network. ~ administrator/physician; large, hybrid network*
- *We train when hired and then annually and then as incidents occur throughout the year. Our training is through an e-learn system and also on-site. We have mock drills every month. Fire drills, mass casualty drills, child abduction drills, different things like that. I think our training is pretty advanced compared to most urgent cares we associate with. A lot of them actually reach out to us for our training and our plans. ~ administrator; large hybrid network*
- *We have protocols in place for internal incidents, external incidents, environments, and mass casualties. We train on those throughout the year. We do have occasions when we have frequent plant explosions and things like that, unfortunately, so we do have scenarios to where we are involved in those. Our facilities are strategically located around some of these areas and we do get those cases. We have protocols in place, serious injury, illness protocols, of what we can treat on site and what we transport out. In addition, from a corporate entity standpoint, we staff our medical providers on-site after an accident for follow-up care as they work to rebuild the infrastructure. Let's say, after a plant explosion, we'll actually staff on-site 24/7 to provide additional medical care. And as far as staffing obstacles, we also have protocols in place where our staff and supplies will be allocated to the affected areas where they're needed. We can move staff from one location to another within affiliated organizations. And our providers are credentialed at multiple locations so that's not an issue, pulling in extra providers when needed. ~ administrator; large hybrid network*

Though they may not be formally engaged in preparedness activities in their communities, many interviewees described informal relationships with other entities in the community that they believe would come into play during an emergency. Many other interviewees have had experiences that they view as transferrable to a large-scale emergency in their community.

Others regularly undertake activities that improve the readiness of their urgent care centers – such as protocols for incidents ranging from infectious patients to active shooters, drills for fires and power outages, or the development of staff phone lists and personal protective equipment (PPE) caches – though they often do not consider these as preparedness activities. They described:

- *We have no formal written arrangements in place. Whenever there is a disaster, the local hospital and our centers will reach out to us and ask if we can take patients. These arrangements with the offices are a common thing. We typically get, on average, 18% of our referrals of patients walking through the door from a primary care office that can't see them that day so they send them to the urgent care. Also, a lot of times that's on their recording so if someone gets their voicemail recording, it will say "if this is an emergency, go to the emergency department. If it's a non-emergency and needs to be dealt with otherwise, please go to urgent care now." That's how it is, but there's no formal, written arrangement set up. ~ administrator/physician; medium, hybrid network*
- *After hours, our health system's primary care and/or specialists routinely refer to us for care. After hours, weekends, but it could also easily be same day business hours when they just don't have the capability to see so, say, it might be a laceration that the primary care isn't capable of seeing but they believe it can be treated in an urgent care environment instead of an ER. That happens quite often. And we are contacted on occasion for overflow if facilities are doing any kind of specific project or something like that. We try to be a seamless extension of our health system partner including all of their physician group entities whether it be primary care or orthopedics or pediatric, etc. ~ administrator; large, hybrid network*
- *We've been in town long enough that the hospitals know where we're located. Hospitals do not funnel directly to us, but we do get patients from retail clinics if they think they have something they can't handle. We'll have local, private doctors send stuff to us if they can't see them. People just coming in or catching things by word of mouth on the news. We'll get patients that come in and they'll say I think my son or daughter has strep throat and there's been three other cases just this past week in class, or there's been a bunch of kids out with flu this week and I think they've got flu symptoms. Things like that. ~ administrator/physician; small, independent network*
- *I think we are currently in the process of such a thing right now with the flu outbreak. We're still seeing patients on a normal basis so we still have those people coming in and then we're also taking care of those people who are positive*

flu. Right now, you can see there's a tad of a bit of an epidemic. We've increased our volume tremendously. We're still seeing spillovers from primary care offices as well as emergency rooms due to the long waits. ~ administrator; medium, independent network

- *We've done it before. Not quite plant explosion level, but we'll take 10 patients who were exposed to chemical fumes at a factory because we do occupational medicine. We could take 50 people, but we'd tell them you're going to be waiting a long time, and then we can call in more staff. We would have our own emergency response from a staffing level to help out. ~ administrator/physician; large, independent network*
- *We have triage protocols. They're based on anybody coming into our clinic so we do have triage protocols with standing orders and things like that. They are more geared toward our everyday patient care, but they could certainly be expanded and would be reasonable in the event that we had a surge due to a disaster. ~ administrator; large, independent network*
- *On a smaller scale, if we lost electricity at our facility, we have a checklist of things that need to be removed from the clinic because they'd probably go bad, like our medications, and who to contact if this happened. If we take on water or anything in the clinic, we have things in place for our employees and we have a certain checklist that we all have to go by before we can clear out a clinic. ~ administrator; medium, independent network*
- *We do have in place where we can contact all our employees. We have a system that will send out a mass alert to all our employees via text and automated phone calls and we also have our operations manager who can go into the system and make outgoing calls to every one of our employees. ~ administrator; medium, independent network*

Even if they have not engaged in preparedness efforts, interviewees were able to envision how the healthcare response to an emergency might evolve and the type of support their urgent care centers would need to contribute to the effort. They offered:

- *Going back to Sandy, the community knew us well. We were there. People just naturally showed up. ~ administrator/physician; medium, hybrid network*
- *To a certain degree, I believe patients self-triage knowing that certain things we just aren't going to handle based on the reputation of urgent care in the community. ~ physician; medium, independent network*
- *We could care for the non-life-threatening types of injuries. And our employers and the community – ambulance services and so forth – know that so I don't think we*

would be receiving patients who are in need of critical care services. ~ administrator/physician; large, independent network

- *I think the first contact would be the department of public health to come in to integrate, to help us – the others that work at director or above level – how to integrate into the system, what resources we can provide, what resources they can provide, and what’s expected. ~ administrator; medium, independent network*
- *I think the biggest support that we would need would be good communication, such as a point of contact, and clear chain of command so that we could execute the mission appropriately. I think it would be good to have involvement at the table ahead of time so that we clearly were part of a disaster response plan, understanding exactly what our role would be, and providing them with access phone numbers, etc. I think those are probably the biggest issues and then on our end we would just need to bump up our staffing. And with a natural disaster, in addition to power, depending on what the natural disaster is, we’d have to make certain our staff could actually get to the clinic as well. ~ administrator; large, independent network*

Many urgent care centers are small, independent businesses that lack the resources and expertise to implement their own preparedness plans. Some of those interviewed view their potential role as an extension of their normal activities and not in need of a special plan. Very few urgent care leaders said their centers receive notifications about mass casualty incidents or similar emergencies in their communities. However, a number of the interviewees have personally signed up for emergency alert services managed by their local emergency management agency or similar entities. Most urgent care centers do receive health alerts from their local or state health department. While these alerts are often for sexually transmitted diseases or small, localized outbreaks, the notification systems have also been used to distribute guidance and other information on recent situations like the Ebola outbreak and emergence of Zika and would likely be a trusted source of information during future incidents. Many interviewees also described receiving information from hospitals, medical societies, and other entities about things circulating in the community that they should look out for.

Sustainment

One of the most frequent descriptors used by interviewees to characterize the operations of their urgent care centers was “lean.” Their staffing is determined by trends in the number of patient visits. They have a limited amount of space available. Supplies on hand are based on par levels or regular inventories. While urgent care centers may be willing to participate in the response to a healthcare emergency, it is unclear how long they could sustain that participation

without support from others, either within their own health system or urgent care network or from the broader community. While interviewees often predicted they could as much as double the number of patients they could see in the short term, they were unable to say how long that level of response could be sustained given uncertainties about the type of incident, the type of resources required to respond, and the effects on their personnel and the community.

Staffing is one of the primary limitations to a sustained response. In general, interviewees believed that their urgent care centers would extend their hours to handle additional patients as this is something routinely done when numerous patients are waiting at closing time. Those that are part of larger networks could temporarily move personnel from an unaffected location to an urgent care center where additional staffing is needed. Many also have pre-identified sources of additional staffing, which they tap into during surges such as influenza season or tourist season. However, many interviewees recognized that staffing could be challenged by personnel and their families becoming ill or unable to reach the urgent care center due to blocked roads or other infrastructure effects. As one interviewee described:

- *It's a big issue with cold and flu season that eventually it's going to take its toll on staff as well. ~ administrator; medium, independent network*

A second challenge is supplies. There is wide variation among urgent care centers in the amount and type of supplies they have on hand due to differences in the size of the urgent care center and its patient volume and type. Many set par levels to maintain their inventory. Some order supplies on a regular schedule. Others designate a staff member to monitor inventory levels and order additional supplies as needed. A few have electronic systems that automatically indicate when re-orders are needed. All interviewees indicated that their urgent care centers expect next day delivery of ordered supplies. Very few interviewees noted that their urgent care center had a cache/stockpile of disaster supplies, which is consistent with a previous study that found only 28% of urgent care centers have assembled an emergency or disaster kit.²⁵ Interviewees said:

- *Most urgent care centers will not have disaster supplies or trauma and triage supplies available in a way that they can be used in an emergency response. Now, they might be able to run around and pull that stuff together from the different rooms, but the traditional way of thinking of an emergency response where you pull a box out or a kit out and pop it open and you've got everything you need, most centers won't have that. ~ administrator/physician; small, independent network*

- *Do we have an entire supply room at each center? The answer to that is yes. Could we handle some things where we could manage stabilization of wounds, manage stabilization of burns or lacerations? The answer to all of that is yes. If we had multiple respiratory illnesses and stuff like that, we could manage. As far as doing multiple treatments, like respiratory treatments, we could manage probably a good half dozen at one time, but that might tax us after that. ~ administrator; medium, independent network*
- *We would stock up, like we just did for multiple hurricanes. Because of new technology, we have plenty of warning where they're going so we're able to stock up extra supplies for those clinics, including bottled water, extra paper – because, you know, the protocols would go into place so if the internet goes down, as an example, we still need to be fully functioning just on paper to be able to continue to treat patients. ~ administrator; large, hybrid network*
- *Where I would get challenged would be if it was significantly above our daily volume and the disaster, whatever it was, broke supply chains. How many days could you operate at double, triple capacity type of thing, which is possible with some of these disasters and the number of people involved that you would need to see, so that would be a concern and something on the back end of how are you getting supplies and everything in in the short and long run. ~ administrator/physician; medium, hybrid network*

Ice Storm Experience:

*"I think it was an opportunity to create a little more robust communication network. A little more planning around which centers are closer to the main arteries, roadway arteries, and easier to access and centers we would typically close first and which ones would we work toward keeping open. That was probably the big takeaway."
administrator/physician; large, hybrid network*

A third challenge is the potential breakdown of the normal infrastructure on which urgent care centers and their communities depend. As previously noted, power outages would prevent most urgent care centers from providing imaging and laboratory services, potentially leading to their closure until power is restored. Electrical outages would also prevent the use of electronic medical records and require urgent care centers to transition to paper only. Generators are uncommon due to their expense; only one interviewee mentioned having a generator and the facility where it is located is a free-standing emergency department rather than an urgent care center. Interruptions to the water supply or its quality would create similar challenges. Disruptions in landline and wireless services would also hinder operations. This would

complicate efforts to reach and call in additional staff and prevent communications with other entities in the community. Interviewees explained:

- *Communications and a way of doing that even if the phone lines were down – sometimes it's phone, we still have electric – that we had a way of communicating with the office of emergency management and the hospital, whether it's a dedicated radio at our site or something like that has been discussed. Just becoming, not being fully included at this point of, ok, we have a radio, but who are we talking to, what are we doing. But that was a thought as a back-up system for us for communicating with both police and the hospital. ~ administrator/physician; medium, hybrid network*
- *You don't ever expect infrastructure to be wiped out, but it can be. How do you work around that? ~ administrator/physician; medium, hybrid network*

Knowledge

There is no question that urgent care centers are staffed with personnel who have the training and experience to care for low and some moderate acuity patients during an emergency. Physicians are certified in primary care or specialties, most frequently family practice, internal medicine, pediatrics, occupational medicine, and emergency medicine. Physicians and other personnel also have experience working in emergency rooms, emergency medical services, and combat medicine or have volunteered to provide medical care in disasters or humanitarian emergencies through efforts such as the Medical Reserve Corps or a Disaster Medical Assistance Team. Interviewees explained:

- *Most of us are emergency room docs. We kind of know what we can and can't do at our facilities. It's not that we don't have the knowledge; it's just that we don't have the same resources as an ER would. ~ administrator/physician; small, independent network*
- *There are much more urgent care centers than there are ERs. And there are much more physicians and mid-levels at urgent care centers who can handle trauma than there are ERs. They may not have the depth and breadth of training as an ER does, but a lot of people retire from ER medicine to urgent care centers and a lot of primary care physicians who are looking for higher acuity go to urgent cares. So they draw a mindset that can handle urgent situations or emergent situations much better than the other primary care or minute clinic or those types of things. ~ administrator/physician; medium, independent network*
- *The emergency medicine folks will generally do more than the family medicine people who are less comfortable with doing difficult, complicated, or life-*

threatening things. A lot of it is provider preference. ~ physician; small, hybrid network

- *During an emergency, depending on how long the emergency might last, or be expected to last, we could upgrade to a bit higher level of care where we could provide IVs and some basic medications if the emergency departments are completely filled up and on hold status. So I think we could elevate the acuity level of our care to a degree. That would somewhat be dependent on the experience and background and training of the physicians at those facilities. Some of our docs are emergency medicine docs and they'd be fine with it. Some of them are internists who were hospitalists, they'd be fine with it. Some of them are family practice docs who since their residency probably haven't started an IV and they would be less comfortable with it, but in an emergency situation I think they would rise to the challenge. ~ administrator/physician; large, independent network*

Urgent care centers that have been engaged in community preparedness efforts or have staff who are personally interested in preparedness are more likely to have considered potential obstacles and developed policies and procedures to enable their continued operations. For example, they have established call-down procedures, which in some cases have been drilled, to check in on the status of their personnel and to request additional personnel report to work during unscheduled hours. They have provided instructions and documentation to their personnel to enable their access to their urgent care centers during emergencies. Urgent care centers have developed checklists and protocols to prepare for known threats, such as an imminent hurricane or snowstorm, and guide shutdown and reestablishment of operations. They have conducted drills and exercises, either on their own or with partners, for likely threats. They have plans in place to move personnel, supplies, and other resources from one urgent care center to another within a network or to an urgent care center from another facility within a healthcare system. Urgent care centers adapt and build upon these preparedness efforts as their knowledge and experience grows. Some examples include:

- *We have a specific website and emergency line for our employees to refer to. So any decision that's made, that goes down the emergency call tree. We had road closures, bridge closures, and curfews all enacted this past weekend due to an event so I was sending out email updates and making real-time decisions on theoretical closures, updates on road closures, and on curfews. ~ administrator; large, hybrid network*
- *We have a process in place where all our employees carry on their person a dedicated personnel letter from our company HR department that we're designated personnel that are required to report to this facility. You run into the*

roadblock or you get pulled over after curfew, at least you've got that saying you're a designated emergency personnel performing medical services. ~ administrator; large, hybrid network

- *We already had in place our shutdown procedures, but we didn't have a good way of getting back up and running. ~ administrator/physician; medium, independent network*

However, among those urgent care centers that have not been engaged in preparedness activities, readiness to treat patients during an emergency does not necessarily indicate readiness to maintain facility operations during an emergency. While many interviewees recognized that a sustained response would be challenging, many others viewed emergencies as short-lasting situations that could be handled with existing resources or believed they could quickly obtain additional resources on their own or through the assistance of others to sustain operations. Most interviewees do not have a formal plan for emergencies because they do not believe it is needed, which is consistent with a previous study that found 73% of urgent care centers did not have an established disaster plan for events involving their facility and the surrounding community.²⁶ Indicators of this include beliefs that:

- **Assumption 1. Existing staffing would be sufficient.** Many interviewees expected that urgent care center operations could be extended through longer shifts or by calling in additional employees. Many have not thought through how long this could be sustained during extended emergencies, for instance, during an influenza pandemic. Most do not know how many days staff could work extended hours before beginning to burn out. They also did not all consider the effects of the emergency on personnel and their families, such as becoming ill from an infectious disease or not being able to access the facility due to infrastructure damage.
- **Assumption 2. Additional staffing would be available.** Many interviewees believed that additional staffing could be obtained to relieve their existing staff. They cited pools of temporary or part time workers who they have engaged in the past for tourist season or seasonal influenza surges, for example. However, they have

Mass Flooding Experience:

“With the flooding situation that happened to our clinic, we were prepared. We had processes in place to remove our medications, remove our temperature sensitive supplies, but what we didn't account for was the road closures and being able to get them somewhere. Definitely we got processes in place where we have a better timeline now to gauge that type of thing that we used in one of our clinics for Harvey. Three days before, they started preparing to secure their computers, medications and that type of thing.” ~ administrator; large, hybrid network

not all considered that other entities in their communities, such as hospitals, may be expecting to rely on these same personnel pools. Other interviewees expected that additional personnel would be sent to help by various entities, including hospitals, public health, emergency management, governors, or the Federal Emergency Management Agency (FEMA).

- **Assumption 3. *Supply chains would not be significantly interrupted.*** Many interviewees believed that they would be able to continue to order supplies for next day delivery during an emergency. Some believed that supplies could be delivered even quicker during an emergency. Not all recognized the potential for supply chain disruptions due to infrastructure damage. Even fewer recognized the possibility that supply orders might not be able to be met due to increased demand.
- **Assumption 4. *Written plans and advanced training are not generally needed.*** Because many of the interviewees viewed emergencies as temporarily ramping up what they do daily, they did not see the need for written plans, personnel training, or drill and exercise experience that might identify trouble spots or mistaken assumptions. They did not anticipate that the lack of plans and training could result in confusion within their centers or an inability to coordinate with other community partners due to the absence of an incident command structure.

In particular, interviews revealed a great deal of uncertainty related to legal and financial issues that could affect urgent care center operations. Some interviewees have given these issues a great deal of thought, but are not necessarily sure they understand the implications. Others assume they understand these issues, but it is unclear whether those assumptions are correct. Still other interviewees had not considered these issues until asked during the interviews.

From a legal perspective, interviewees generally assumed that an emergency would have no impact on the malpractice or liability insurance for the facility or its providers, that is, once a person becomes a patient, the coverage would be in effect. They were less sure about whether such coverage would extend to care they might deliver off-site at the request of other entities in the community. Several interviewees expected that their actions during an emergency would be protected by their states' Good Samaritan laws, while others were sure that Good Samaritan laws would not apply to them as professional medical providers. Others were very aware of requirements under the Emergency Medical Treatment and Labor Act (EMTALA). Though they are not subject to EMTALA requirements during normal operations, they questioned the implications of EMS directly transporting patients to their urgent care center from the incident scene or transferring lower acuity patients to them from a hospital. A few interviewees questioned their ability to meet Health Insurance Portability and Accountability Act (HIPAA)

requirements if modifications to their physical space to accommodate additional patients inhibited their ability to protect patients' privacy.

Similar uncertainties exist related to financial implications. Many of the interviewees recognized that increased patient volume would challenge complete and accurate data collection for medical records and, therefore, complicate billing for reimbursement. Fewer interviewees considered that electronic medical records might not be available and have a paper back-up plan in place. Several interviewees expected that some patients might arrive without identification or proof of insurance. There was a wide range of expectations among interviewees on whether they expected to be reimbursed for all of the services provided during an emergency. Similar to the uncertainties surrounding altered legal protections during disasters, few interviewees understood whether their urgent care centers could be eligible for financial assistance during declared emergencies.

Regardless of their uncertainty about the legal and financial implications, very few interviewees expected these concerns to affect their delivery of care. The following examples reflect the knowledge of interviewees about legal and financial issues during an emergency:

- *A woman loses her purse and she has no ID. How do we know who she is? What insurance? What's the legality of treating someone who has no ID and no insurance? The obstacle is the legal and the financial. ~ administrator; medium, independent network*
- *Do you think the people in Las Vegas cared if they got reimbursement for what they did? No. They were taking care of an emergency and they were taking care of what's going on. It would be nice if urgent cares could get reimbursed for supplies. If part of the emergency response, it would be nice for urgent cares to be able to pay the employees. But in a mass casualty or emergency situation, physicians are not looking to strike it rich. ~ administrator/physician; small, independent network*
- *We always hope to get paid for everything. I think in a disaster you end up doing what you need to do to help out your community. It would be nice to make sure we get paid for our services, but I don't think that would be a priority in the short term. ~ administrator/physician; medium, hybrid network*
- *In a disaster, we're not thinking about if a patient can pay. We're thinking about how we can help them. ~ administrator; medium, independent network*
- *You are treating what you can treat as an emergency, in an emergency setting. You should be using emergency coding. However, because it's a mass casualty/mass*

- trauma situation, you're making medical decisions. You're not notating it like you would in a calm situation. You're not keeping records as well as you would during a calm situation. It is an entirely different process. ~ administrator/physician; small, independent network*
- *When you have an emergency with a lot of people, then of course the billing and the reimbursement gets backlogged. ~ physician; medium, health system-managed network*
 - *Because you may not have power or electronic communications, you might have to go to paper charting, which is going to impact reimbursement and revenue cycles. I don't think what you bill and code would change, but your ability to capture financial information would potentially be impacted. ~ administrator/physician; large, hybrid network*
 - *I think we would assume that a lot of that would end up being charity care. ~ administrator; large, health system-managed network*
 - *I think for something like an epidemic or an infectious disease outbreak or something along those lines, patients coming in would have an insurance card and we would run that and do the usual stuff. But if there's a plane crash down the street, I think we would do whatever we had to do for those patients and I'm not sure we would ever expect to recoup anything from that. Maybe good will. ~ administrator/physician; large, independent network*
 - *I guess the question I should ask would be, and I don't know how this is handled at the federal level, but assuming a patient cannot pay out of pocket, would we be willing to bill that patient? We certainly have a humanitarian side to us as well. Obviously we would bill insurance just as we always do. There would be no difference there. And then we would have to come up with a plan to either try to bill the patient or if we would be reimbursed at some other level from a federal response fund then certainly we would be willing to do that. ~ administrator; large, independent network*
 - *I would think because once the governor declared an emergency, there would be an incident number that we would compile all those records and then maybe in 120 days maybe FEMA would send us a check. That's just how it works. ~ administrator; medium, independent network*

Lessons Learned by Interviewees

Only a portion of the interviewees have been involved in the response to an emergency. Those who have were asked to share lessons learned or things they had not thought of ahead of time that they are incorporating into planning for future incidents. They shared:

- *What's written on paper doesn't always work. It looks good, but until you actually live it you don't realize all you need. ~ administrator; large, hybrid network*
- *We stayed open as long as we reasonably could with the storm approaching. We moved, but we needed to give ourselves time to move, all electrical equipment up off the floor. We sandbagged any doorways or entranceways into the facilities. Just kind of prepped, shut everything down appropriately so if there were a power surge or anything we didn't lose, because we're very computer dependent. So, we put a lot of time and energy after we closed prepping for the storm and that's why we were able to actually, I think, reopen so quickly. As soon as the power came back on, we just went through and tested our systems and the next morning we were open based on that. It was some little tweaking of stuff, but we actually spent a fair amount of time prior going through things. ~ administrator/physician; medium, hybrid network*
- *The biggest one was staffing and supplies because what happened was some of the staff were stranded during a flood event and they stayed at the facility for a couple of days. And, of course, more patients kept coming in. I think what we need to be able to do is get more providers and staff and supplies in. We have life flights where we are [EMS helicopters and transport]. I think if those kinds of resources could be available to these kinds of places that would be excellent. It's a very big facility and a helicopter could land there. We all kept thinking how we would fix this because the providers were stranded and the supplies were running out. That's a big lesson learned. ~ physician; medium, health system-managed network*
- *What we recently did was survey all of our employees to make sure everyone was ok, who can access the roads, who can get to the clinic. From there, we would schedule out. We don't want to schedule someone who can't make it in so we check their availability and then we ask what hours they can work and then we'll schedule according to that. ~ administrator; medium, independent network*
- *We didn't think people would show up during a natural disaster but they flooded with people. That's another lesson learned. You think that people are not going to try to get to you, but they will and they did. They got in there because they had different types of issues that they had to deal with. A lot of infections, burns, some people were electrocuted because they were trying to help and there were downed*

power lines. Most of it was skin infections. And they had a lack of medicines because the pharmacies closed. People came in with high blood sugars and those sorts of things because everything stopped for about a week. ~ *physician; medium, health system-managed network*

- *The main thing is I wish we had better communication with the hospitals and we let them know we were open, but there needs to be more planning ahead of time. The thing overall that probably shocked me most about Sandy was the lack of communications with people. ~ administrator/physician; medium, hybrid network*
- *We had a significant flu outbreak where all of the emergency departments were getting overrun. That's when the health system realized that our triage/patient steering was not good enough. Very few people need to be going to the ER because they have the flu so we were able to revisit why that was happening and a lot of it had to do with the hours [of physician offices]. Ultimately, I don't think we ended up making any changes on staffing or process. It was just a matter of pre-season patient education on where they should be going with those things and when. ~ administrator; large, health system-managed network*
- *One of the needs that [the nearby airport] identified was a place for people with disabilities in wheelchairs who can't get around. From time to time they have to evacuate one of the terminal buildings. It's the middle of summer and it's 90 degrees and you've got these older people who are in wheelchairs who cannot seek cover. Our agreement was that they could bring them over to the urgent care center. ~ administrator/physician; small, independent network*
- *We actually had to decrease our hours in some places because it's hard to see standing water once it's dark. We cut down our hours so people could get home safely. ~ administrator/physician; medium, independent network*

Interviewees were also asked to share ideas of things they are implementing in their own urgent care centers to improve their readiness. Suggestions included:

- *One of the things that came about after the flood that was a little unexpected because we're not licensed by the state, was that we were contacted by CLIA and DEA office wanting proof of how we disposed of our adulterated meds and supplies that we didn't use on patients. So we put that on our recovery checklist to be sure that we're noting the disposal of medications and things that were not temperature controlled. ~ administrator; large, hybrid network*
- *What we're looking at right now [during a seasonal influenza outbreak] is adding a scribe so that scribe follows the provider and that kind of frees the provider up to*

do that kind of work [patient treatment]. It's kind of a different concept. ~ administrator; medium, independent network

- *Our Puerto Rico clinic [free-standing emergency department] does have a whole facility generator and without that we would not have been able to effectively treat patients. In fact, at one point, we were the only low grade emergency room capable of treating patients in the city/town that we're located in. There's two other hospitals there, but both of their generators blew up at some point and we were the only game in town. So, having that generator is something that is an additional cost. I don't know if it's justified inside the continental U.S., but certainly in Puerto Rico it was hugely advantageous that we put it in when we built the facility. ~ administrator; large, hybrid network*

Finally, all interviewees shared recommendations on what would help urgent care centers in general become more prepared. Ideas included:

- *I think we need guidelines for bringing different players together in the community and serving them. I would welcome any of the findings and outcomes of this project because we can help, whether through the urgent care association nationally and/or our regional urgent care association, get this out to members and get them involved in their communities. ~ administrator/physician; medium, hybrid network*
- *My concern was always why haven't we all gotten together with the hospital systems and said, "Hey, look, these are our capabilities here. If you've got something that we can handle, you can send it to us instead of the ER and plugging you guys up even more". That's one thing that hasn't happened. If your efforts can get every major city in the country to get the urgent cares near the surrounding areas of a large metropolitan area in contact with the local or nearby hospitals, that would be very valuable. ~ administrator/physician; small, independent network*
- *I know how hospitals do it. They have arrangements and sign agreements that they will do certain things and have certain supplies on board. Perhaps that would be a good way to get certain urgent cares. ~ administrator/physician; small, independent network*
- *If the facility has an emergency management plan and it's part of the emergency response system with their people trained to do that, those centers have the space and capability to spin up very quickly. As long as they can get the personnel and supplies there, they can set up tents in the parking lot and function as a field*

- trauma center, where it's a triage-based trauma center. ~ administrator/physician; medium, independent network*
- *If you made emergency management aware, for example, that in a major disaster urgent care can handle 10-15 patients an hour, then they could either direct people there on their own or via EMS and say if you're non-critical, go to the urgent care since hospitals are only taking the critical patients. That could be put into a disaster plan and could help. I think it would depend on funding, but once you have a list of these participating urgent cares, you could run educational programs for them, like if we have pandemic flu, this is how we could use you and this is what you would need to do. I think that would help sway urgent cares. I think they could be supplied with kits and personal protective equipment. ~ administrator/physician; independent center*
 - *My vision is that in field triage, put 20 "green" patients on buses and send them to 18 locations so now we've got 360 patients off your incident and that's only one agency you had to call. That's my vision of this cooperative. Because if people are going to have cuts, we can do suturing. And handle people with broken bones. We're not going to be able to handle gunshot wounds since we're not set up for surgery. But those people that have got broken ankles, get them out of there, get them on a bus and to an urgent care, that's my vision. So I'd say at least 20 patients at each clinic per a one day event would not tax our system. ~ administrator; medium, independent network*
 - *The urgent care association should have a team of regional experts. I just see this as the next step to help make a difference. ~ administrator; medium, independent network*
 - *Insurance companies are promoting on a mass scale to go to urgent care versus the ER. There hasn't been a big issue around people going to the urgent care for things they should be going to the ER for, but as urgent care starts to get more comfortable for people and it's cheaper, I think there's a potential that we could start seeing higher acuity things. Actually, that's my current prediction for urgent care is that it does start to see higher acuity and therefore we'll be even more important in this role that you're talking about. That volume will shift automatically to the urgent care. Change is slow. It may still be a few years away, but that's why I think this groundwork is important now. ~ administrator; large, health system-managed network*
 - *I'm going to tell that the system isn't going to change unless it's federally-regulated nationally and that system will have significant political headwinds because of the current thought process and the current lack of regulation and lack*

of understanding of the urgent care system. But if you partner with the American Academy of Urgent Care Medicine and the American Board of Urgent Care Medicine in educating urgent care physicians and making that part of their education, then I think it would be quite easily overcome in a three to five year period. ~ administrator/physician; small, independent network

- *Maybe having some sort of agreements and some training material for certain urgent cares. And it might be that even though there's 10,000 urgent cares, you may only identify 5% that may be willing and able and have the capabilities that would be helpful and who have sort of a community involvement mentality. How are you going through 10,000 urgent cares to find a couple hundred that are the ones that you want to deal with? I don't know. I think that ignoring urgent care is a mistake because our docs are there, they're ready, we have capacity, we have treatment rooms, and there's no reason to funnel everyone through the emergency room. ~ administrator/physician; small, independent network*

Appendix D: Helpful Preparedness and Response Resources for Urgent Care Centers

While some of the resources in this appendix were developed for specific audiences – such as physician offices or hospitals – they contain information that could easily be modified for use by or applied to urgent care centers.

ASPR TRACIE Resources:

- Topic Collections
 - Ambulatory and Federally Qualified Health Centers (FQHC)
 - Continuity of Operations (COOP)/Failure Plan
 - Emergency Operations Plans/Emergency Management Program
 - Epidemic/Pandemic Influenza
 - Explosives (e.g., bomb, blast) and Mass Shooting
 - Healthcare-Related Disaster Legal/Regulatory/Federal Policy
 - Mental/Behavioral Health
 - Natural Disasters
 - Responder Safety and Health
 - Training and Workforce Development
 - Utility Failures
- Other ASPR TRACIE-Developed Resources
 - After the Flood: Mold-Specific Resources
 - Disaster Behavioral Health: Resources at Your Fingertips
 - EMTALA and Disasters
 - Health Care Coalition Influenza Pandemic Checklist
 - HIPAA and Disasters: What Emergency Professionals Need to Know
 - Hurricane Resources at Your Fingertips
 - Select Health Care Coalition Resources
 - Tips for Retaining and Caring for Staff after a Disaster

Other Resources:

- ASPR
 - Hospital Preparedness Program (HPP)
 - HPP Infographic
 - Planning for Power Outages: A Guide for Hospitals and Healthcare Facilities

- [Planning for Water Supply Interruptions: A Guide for Hospitals and Healthcare Facilities](#)
- [Public Health Emergency Declaration Q&As](#)
- [Working Without Technology: Hospitals and Healthcare Organizations Can Manage Communication Failure](#)
- **American Academy of Family Physicians**
 - [Actions to Take After a Disaster](#)
 - [Business Planning Checklist to Prepare Family Medicine Offices for Pandemic Influenza](#)
 - [Checklist to Prepare Physicians' Offices for Pandemic Influenza](#)
 - [Disaster Response and Recovery](#)
- **American Academy of Pediatrics**
 - [Preparedness Checklist for Pediatric Practices](#)
- **Association for Professionals in Infection Control and Epidemiology**
 - [Infection Prevention for Ambulatory Care Centers During Disasters](#)
- **Centers for Disease Control and Prevention**
 - [Medical Office Preparedness Planner: A Tool for Primary Care Provider Offices](#)
 - [Selected Federal Legal Authorities Pertinent to Public Health Emergencies](#)
- **Centers for Medicare and Medicaid Services**
 - [Emergency Medical Treatment and Labor Act \(EMTALA\) Requirements and Options for Hospitals in a Disaster](#)
- **Community Health Care Association of New York State**
 - [Working with Your Community: Preparing for Emergency Response](#)
- **Drexel University Dornsife School of Public Health**
 - [Primary Care Medical Practices and Public Health Emergency Preparedness](#)
- **Emergency Medical Services Agency, Los Angeles County**
 - [Ambulatory Surgery Center Guide to Disaster Preparedness and Response](#)
- **The Joint Commission**
 - [Standards Sampler for Urgent Care Centers](#)
- **The National Academies of Sciences, Engineering, and Medicine**
 - [Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response](#)
- **National Association of Community Health Centers**
 - [Developing and Implementing an Emergency Management Plan for Your Health Center](#)

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