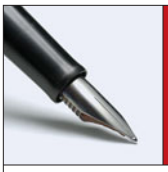

Pediatric Urgent Care—*Specialized* Medicine on the Front Lines

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Thirty years ago, there was widespread concern that specialty medicine was "a problem." Consumers were self-selecting specialty (vs primary) care for routine ailments, thus driving up the cost of healthcare. Without restrictions, consumers could choose neurologists for headaches, orthopedists for ankle sprains, and dermatologists for acne—all very appropriate with complexity, but unnecessary and costly for routine problems. Hence came the dawn of managed care armed with gatekeepers, referral requirements, and preferred networks to limit the use of specialty care and maximize cost containment by expanding the role of primary care.

Now urgent care is anchored in the marketplace as an alternative to these traditional models. As our industry continues to grow in number and scale, specialty urgent cares are becoming more prevalent. Particularly in dense metropolitan areas where there is room for differentiation, specialty urgent cares feature personnel who have additional training and some services and equipment that may not be available at other urgent care facilities. But most of all, differentiated urgent care centers have brought specialization back to the forefront, often *without* the excessive costs that helped carve the path to managed care years ago.

Pediatric urgent care (PUC) was a natural "specialized" step in the evolution of this growing urgent care industry. Combining pediatric expertise with the equipment and an environment customized to children, a niche field was born wherein parents could choose pediatric specialists on-demand.

While PUC is fundamentally unique, its evolution is not dissimilar to how pediatric emergency medicine (PEM) was formed. In the 1990s, there were mounting concerns that general emergency departments lacked the expertise and equipment to care for severely ill and traumatically injured infants

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and children. The field of PEM was born to diagnose and treat this unique and vulnerable population, with PEM physicians training for 5-6 years after medical school, and the field becoming accredited by the American Board of Pediatrics. Pediatric EDs grew in number and scale, and became an alternative to the care traditionally provided in a general ED. Unlike other specialty care that was traditionally more expensive, however, pediatric EDs were typically *not* more costly and were often heralded for reducing costs through more judicious lab testing and radiology utilization, lower admission rates, and more reliance on clinical exam to guide decision-making.

Today, as in general urgent care, freestanding PUCs are growing out of private and academic sectors; about half are hospital-affiliated and half independent. Another similarity is that the vast majority of ED care delivered to children could be shifted to urgent care.

While this ED–UC shift is not unique in pediatrics, it's perhaps more weighted in children where the solutions are commonly reassurance, supportive therapy, or simple treatment rather than advanced diagnostics. The vast majority of children seek care for relatively straightforward problems (eg, asthma, fractures, foreign bodies, etc.) that tend to be uncomplicated in otherwise healthy children. This shift may threaten the future of community PEM, as some institutions consolidate or restructure hospital-based pediatrics, with low-acuity pediatric ill-

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nesses and injuries being handled more frequently in ambulatory environments or at tertiary centers.

The success of freestanding PUCs is anchored by the ability to rapidly earn trust with a family. While many general urgent care staff do an excellent job caring for children, the experience may not be uniform in the eyes of the parent. Pediatric urgent care promotes an experience specific to children with every encounter and by every staff member. However, the specialization that PUCs offer is very different than other "retail" businesses that contour to the needs of children. The kids' haircut shop, for example, may feature the same product but packaged in a child-friendly environment, with staff who are more patient with the needs of children. What PUC offers is fundamentally unique, and the result is a very different product from general UCs. Some of the distinguishing characteristics include:

- **Complementary to the "medical home."** Unlike many adults who seek urgent care, pediatric patients invariably *have* an accessible primary care physician in the pediatrician, many of whom offer walk-in hours for sick visits. Therefore, the use of PUC may be weighted more as a complement rather than an alternative to the primary doctor. With increasing risk-sharing contracts and insurance subsidies, primary care practices are incentivized to keep children out of the ED and may be more likely to partner with urgent care centers to deliver care when the pediatrician's office is closed.
- **Hours of operation.** Because of the emphasis on after-hours services and because of the evening peaks for respiratory and fever care, many pediatric urgent care centers are open later than many general UCs—often until 11 PM or midnight.
- **Procedural care.** Many PUCs are capable of procedural care in anxious young children, which may be beyond the comfort level of general UCs who lack anxiolysis and distraction therapy.
- **Acuity/observation.** Many otherwise healthy children will turn around with several hours of respiratory or fluid therapy. As such, PUCs are more likely to provide observational care if there is sufficient capacity. This may feature IV fluid hydration, IV antibiotic administration, and prolonged respiratory management which may not be commonplace in other urgent care centers.
- **Staffing.** While the staffing at PUCs varies nationally, the core models feature personnel with pediatric expertise. The physicians are typically pediatricians, often with ED experience or with additional fellowship training in PEM. Similarly, nurse practitioners are often PNPs rather than FNPs, and nurses often have experience in hospital pediatrics. Because pediatric residency programs may lack some of the trauma and efficiency training necessary for urgent care, several fellowship and apprenticeship programs have spawned, with great results.
- **Volume trends.** The hourly visit trends for kids are unique because children are dependent on parents for transportation *and* because respiratory illnesses and injuries often peak at certain times of day. For example, croup and asthma flares commonly peak in the evening, and childhood injuries often occur more on weekends and later in the afternoon, when pediatricians are not available.
- **Chronic illness.** Children with chronic illnesses may be more likely to seek care from specialized PUCs because of greater comfort with pediatric staff who have expertise with these conditions. This may include developmental disorders such as autism spectrum or medical device problems such as gastrostomy tube malfunction. Also, patients with medical disease such as type I diabetes or chronic asthma may use a PUC as triage to help determine if an ED visit is really necessary.
- **Advocates for children.** When children need further specialty care, PUC providers connect with the specialists in the community who best care for each particular problem. Since pediatric specialists are far fewer in number than adult specialists, staff at PUCs work with these experts in the community more consistently and are adept at advocating for children who need continuation of care for acute and chronic problems such as hernias, glomerulonephritis, uveitis, and recurrent urticaria.

This is all to say that the future of PUC is promising. Specialized urgent care offers consumers the self-selection of specialty care combined with the convenience and accessibility of urgent care.

Many PUCs report that about 50% of patients are less than 5 years old, so patient capture occurs at a young age, allowing the family to become PUC customers for the next 18+ years. As PUC brand-awareness increases, consumers can expect a replicable experience. And with increasing costs of hospital-based care and the greater consolidation of hospital-based pediatrics, PUC will continue to grow and may be the ultimate intermediary between routine pediatric practices and tertiary children's hospitals. ■