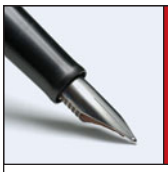

Why is the Waiting Room Still Empty? Perspectives from a Pediatric Urgent Care Physician

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In February 2020, the first U.S. case of community-spread COVID-19 was identified at a pediatric urgent care center in Seattle, reinforcing the fact that UC is on the frontlines of healthcare. Between March and May 2020, the majority of healthcare services saw a significant downturn in volumes as patients quarantined and businesses shutdown. But as the number of domestic COVID-19 cases increased, many general urgent care centers saw unprecedented volume surges that continued throughout 2020.

Pediatrics, on the other hand, has struggled. And now, more than 12 months since the dawn of this pandemic, pediatric acute care is still searching for its place.

By April 2020, the eerie silence of empty queues and restless staff captured the unexpected challenge pediatric providers would face during this pandemic. The combination of social distancing and stay-at-home orders diminished the demand for children to be evaluated in cases of routine illness. Even when acute care was needed, families often delayed seeking pediatric care for fear of exposure.

Most urgent care centers pivoted to become community testing hubs; however, the demand for testing children has not been as great. While many adults are gradually returning to work, many schools, daycares, camps, and sports activities have remained closed, limiting both the spread of disease but also the need for testing for clearance to return.

Pediatric testing has also been more complicated procedurally. Young children often cannot self-swab or may need to be restrained. Car seat-bound children make drive-thru testing difficult.

Many pediatric-specialized UCCs rapidly implemented or increased the use of telemedicine to provide virtual care for children whose caregivers were hesitant to seek in-person care. Children's Hospital of Wisconsin UCCs, for example, demonstrated a 10-fold increase in daily telemedicine visits during the initial peak. Use of telemedicine has its limitations in pediatrics, however, because almost half of pediatric acute care visits are for respiratory complaints where basic video telemedicine is lacking in the ability to auscultate the lungs, take vital signs, or look in the ears.

Pediatric UCCs have adapted their practices in a number of ways to serve patients and remain financially viable. To minimize risk for families who seek in-person care, some pediatric-specialized UCCs have separated patients with respiratory symptoms to designated areas of the building and assigned dedicated staff for these patients for the duration of a shift. In an effort to minimize losses and risk to staff, some multi-location urgent care operators have closed some locations and furloughed staff. Many pediatric UCCs temporarily adjusted their age restrictions to reduce the burden of the adult care centers. Pediatric nurse practitioners who are typically restricted to caring for patients <21 years of age have been granted exemptions in most states to care for adults as part of crisis forgiveness. At Children's Mercy Kansas City, the UCCs have shifted their hours to complement primary care availability and to limit exposure risk for patients with chronic diseases who require care in subspecialty clinics, which commonly share spaces with primary care.

In addition to managing the loss of the core respiratory patients and adapting to the challenges of infection control, pediatric providers were additionally tasked with recognizing the developing entity known as the multisystem inflammatory syndrome in children (MIS-C). This syndrome is a rare inflammatory cascade associated with COVID-19 in children and young adults. Pediatric-specialized UCCs capable of laboratory testing quickly developed protocols to screen febrile children

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for MIS-C using onsite or local STAT labs to evaluate for key biomarkers such as C-reactive protein (CRP), B-type natriuretic peptide, and ferritin, in addition to routine blood counts and chemistry tests.

Additional trends have been observed unexpectedly among the presentations at pediatric UCCs during the pandemic. Many pediatric-specialized UCCs reported increases in injury management and patient acuity as a result of the apprehension to seek hospital-based care. Delays in care were evidenced by the increased rate of perforated appendicitis cases reported nationally.

Families were not only delaying care for acute illnesses and injuries; they were also delaying routine exams and vaccinations, making threats of measles and varicella outbreaks more likely. With the interruption of normal life and continued closures of schools, camps, and daycares, there have been reports of greater numbers of child abuse and neglect presenting to acute care settings.

Behavioral health problems have also become more prevalent during this pandemic. Social anxiety, physical separation, loss of family members, and lack of connection are all factors contributing to greater behavioral health needs, including suicidality. Pediatric-specialized UCCs have played an increasingly important role in recognizing major depression and suicidal ideation among adolescents and preteens who have felt isolated during the pandemic. Many pediatric-specialized UCCs were already performing mental health screens on patients >12 years of age prior to the pandemic. Now, however, screening for mental health issues has become a vital part of the acute care visit in these age groups.

Being a frontline provider during this pandemic has been neither comfortable nor convenient. Yet, pediatric urgent care providers have remained available to care for acutely ill and injured children when a medical home was not available and emergency care was undesirable. Many primary care physicians shut their doors in this crisis. Even 12 months later, many still offer only limited (if any) in-person acute care. Pediatric urgent care has persevered and proven to be an adaptable, resilient frontline solution for the safe and effective care of children.

Many families have discovered pediatric-specialized urgent care for the first time during this crisis—a promising sign for the role urgent care centers will play in the acute care landscape for years to come. While we never hope for illness or injury to strike, we do hope that a return to normalcy will mean a return of the pediatric patient to urgent care so we have more frequent opportunities to provide the community acute care that defines us. ■