



UCA

2021
SUMMER

BENCHMARKING REPORT

 URGENT CARE
ASSOCIATION®

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INTRODUCTION

Welcome to our Summer Benchmarking Report, the second issue of our new benchmarking format. We have been pleased to hear from many of you how much you appreciated the insights from the Spring report, and hope you'll continue to share your input so we can tailor upcoming issues to your needs.

Our new reports are intended to bring data and perspective – sometimes seasonal and sometimes global – so that you can make better decisions as you grow and we evolve together. We've curated insights from partner organizations who already have relevant data across large sample sizes as part of their daily business. We are thankful to them for donating their information to improve our reporting and give you access to these exclusive insights. We also continue to include Member Points of View to further illuminate data interpretation and are thankful to those individuals for donating their time and expertise.

We're taking a deep dive on Influenza in this issue, and you'll see some new original data from recent member surveys that add perspective on current events and concerns.

Please let us know what you think of the [Summer Report](#), and what you'd like to see in future publications. It's YOUR report – let us know what you need. We are honored to be part of your journey.



Lou Ellen Horwitz
Chief Executive Officer

A handwritten signature in black ink, appearing to read 'Lou Ellen Horwitz', with a long horizontal flourish extending to the right.

INDUSTRY PROFILE

BY THE NUMBERS

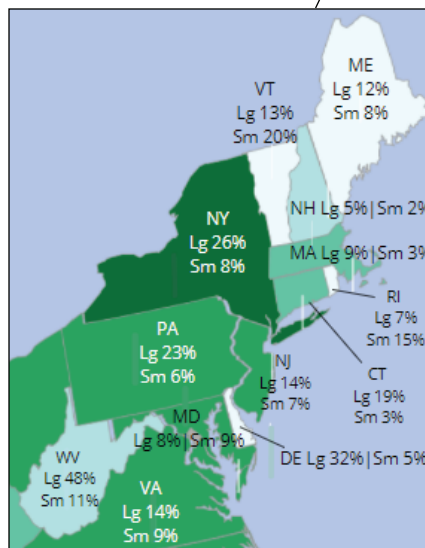
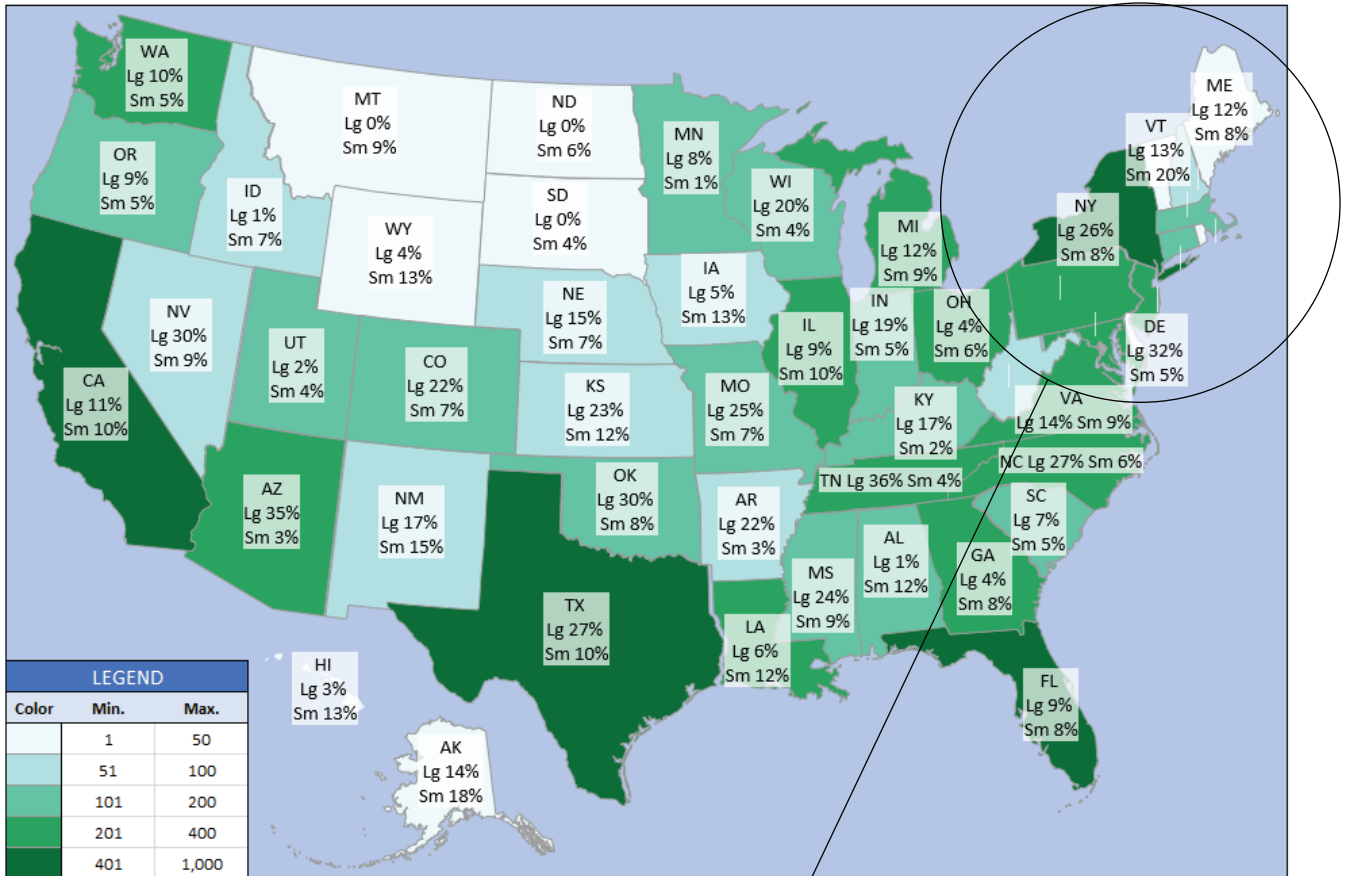
As of May 2021, the urgent care industry has 10,463 urgent care centers across the United States. The past year has brought several large organization mergers as well as continued center count growth. Are the large players taking over or do the single operators still have a hold on this very entrepreneurial industry? This edition's Industry Profile reviews just that.

We drill down into state-level distribution of large organizations (100+ centers) vs. the single center operators. If you are looking to open your first center or expand your current organization into new states, these insights will assist with your strategic growth plans.

INDUSTRY PROFILE

BY THE NUMBERS

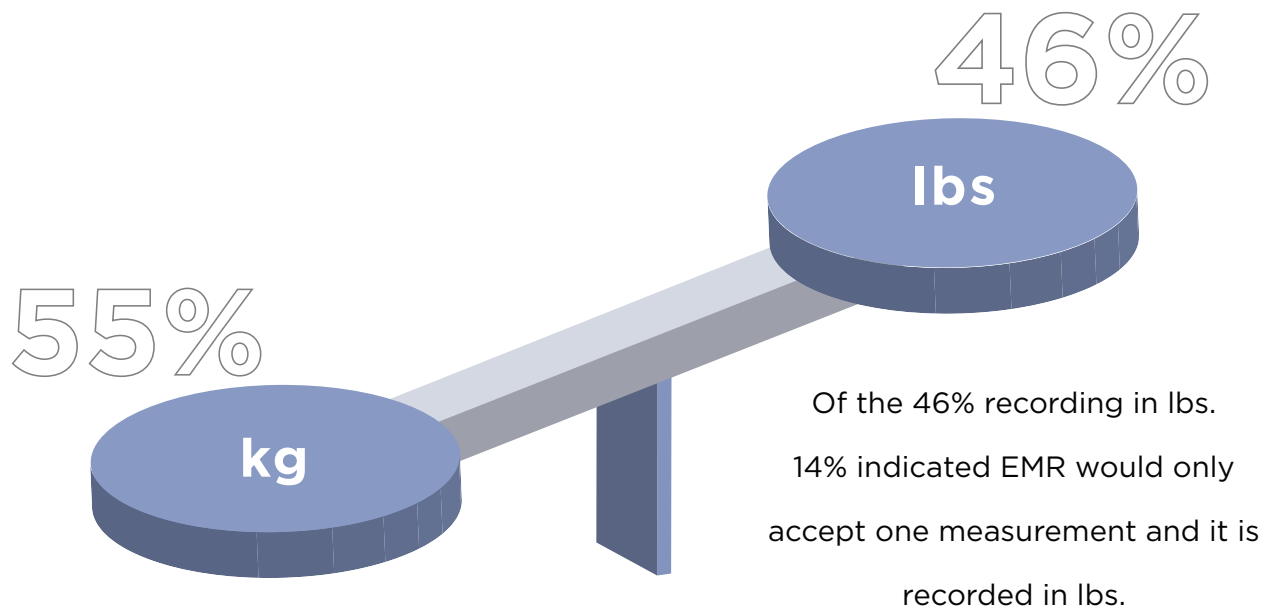
State Distribution By Organization Size



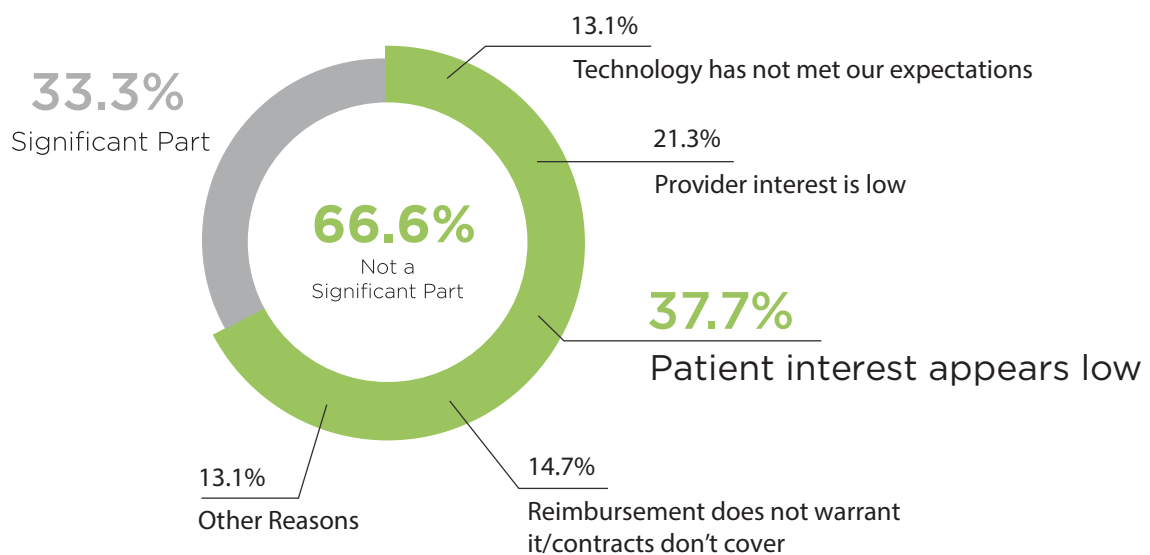
INDUSTRY PROFILE

FAST FACTS

DOES YOUR CENTER RECORD PEDIATRIC WEIGHTS
IN KILOGRAMS IN YOUR MEDICAL RECORD?



IN 2021-2022, IS TELEMEDICINE PART OF YOUR STRATEGY?



HOT TOPICS

INFLUENZA

Flu season (November – April) has typically been “busy season” for urgent care, but the 2020 flu season simply did not happen. What does that mean for 2021 and how can urgent care centers prepare for what might be?

If you cannot remember what “flu season” was like, a five-year review of influenza (since the 2016 flu epidemic) is in order. And although influenza didn’t materialize last year, flu testing did not decrease due to the similarities between flu and COVID-19.

There is some evidence that influenza and other respiratory diseases will return this fall – so preparation is key.

Whether you need to prepare your center or your patients for the coming season, the resources in this section will help you succeed.

External Contributors to Hot Topics: Quidel, McKesson

HOT TOPICS

INFLUENZA

THE COURSE OF INFLUENZA SINCE THE 2016 FLU EPIDEMIC & WHAT WE CAN EXPECT IN THIS COMING SEASON

INFLUENZA PANDEMIC HISTORY

Influenza has impacted human civilizations for thousands of years. The oldest surviving records describing what is believed to have been an influenza pandemic are from Greek authors writing in the 5th century BC. In the last 400 years epidemiologists estimate there have been 13 influenza pandemics or approximately one every 30 years. And, in the last 120 years there have been four Influenza pandemics likely killing more than one hundred million people globally--nearly one million of whom were in the United States (Table 1). Although records are incomplete, total global mortality for the severe 1918-1919 pandemic is 50 to 100 million people, constituting approximately 3–6% of the world's population. As many as 25 million people may have been killed in the first 25 weeks.

Table 1: Global and U.S. Death Estimates from Influenza Pandemics in Last 100 years

YEAR OF ORIGIN	INFLUENZA A SUBTYPE	GLOBAL MORTALITY	U.S. MORTALITY*
1918	H1N1	50-100,000,000	675,000
1957	H2N2	1,100,000	116,000
1968	H3N2	1,000,000	100,000
2009	H1N1	284,000	12,469

*Glezen WP. *Epidemiol Rev.* 1996. **Shrestha SS. *Clinical Infectious Diseases* 2011.

HOT TOPICS

INFLUENZA (CON'T)

This pandemic was caused by the H1N1 virus that was not discovered and fully sequenced until 2005. A variant of this virus reappeared in North America and caused the 2009 H1N1 pandemic. That virus could not be detected by the CDC's existing molecular tests, and the first two index cases in the U.S. were detected by the QuickVue Influenza A+B Assay in southeastern California near the Mexican border in late April 2009. Our assay targeted the influenza virus' internal nucleoprotein—as do all influenza antigen tests commonly used today. Importantly, the commercially successful rapid antigen tests for SARS-CoV-2 today target its functionally-related nucleocapsid protein.

INFLUENZA EPIDEMICS

There is no doubt that influenza pandemics have had tremendous and horrific consequences for millions of persons—not dissimilar from our own and the world's ongoing experience with COVID-19. But what about seasonal epidemics that are characteristic for influenza, usually lasting from November to April in the Northern Hemisphere every year? Let's consider what has happened in the United States in each of the last five influenza seasons, beginning with the 2016-2017 season. Can we learn anything from these experiences that might help us predict what we can expect in the coming 2021 fall and winter?

2016 AND 2017 INFLUENZA SEASONS

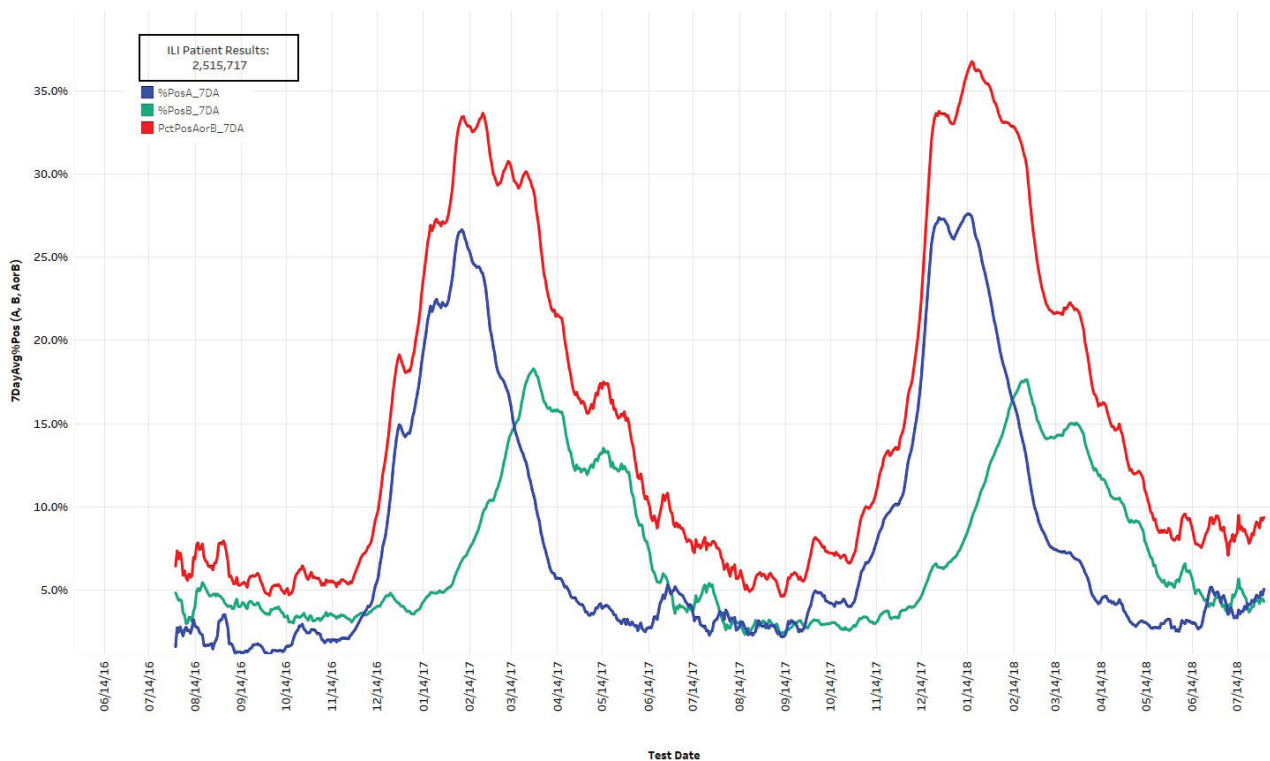
The course of influenza in the United States for the **2016-2017** and **2017-2018** seasons are depicted in **Figure 1 (page 10)** where the positivity rates for over 2.5 million patients with influenza-like-illness (ILI), reported by Virena, are shown. Their seasons were typical and show the seasonal arrival first of influenza A (blue), soon followed by influenza B (green) that often

HOT TOPICS

INFLUENZA (CON'T)

peaks about 5 to 6 weeks after influenza A. This profile is consistent with preceding influenza seasons going back several years. Note that the course of influenza in general with positivity rates for influenza types A+B combined is shown in red.

Figure 1: Course of Influenza A+B for the 2016 and 2017 Seasons* - 8/1/16 to 8/1/18



A = blue, B = green, A + B = red

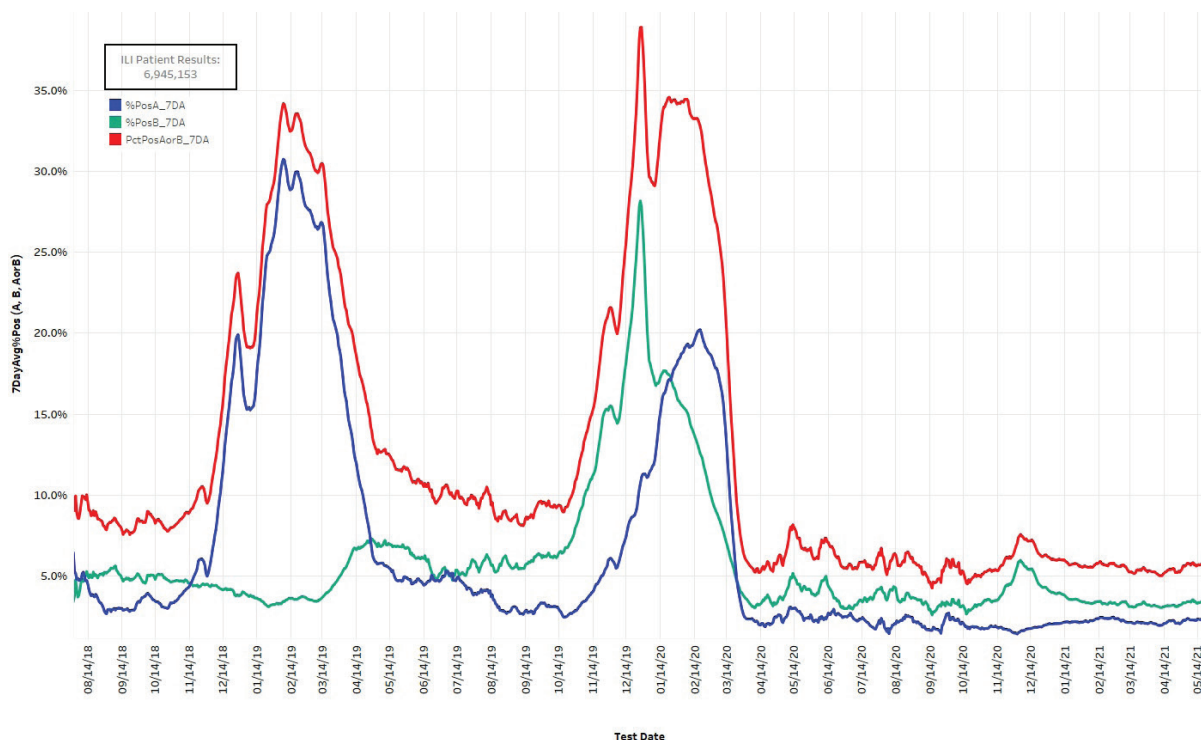
HOT TOPICS

INFLUENZA (CON'T)

2018, 2019 AND 2020 INFLUENZA SEASONS

However, the subsequent three seasons each had unusual and distinct profiles that are shown in **Figure 2**. These were NOT “normal” influenza seasons. The **2018-2019** season was a particularly strong influenza A season accompanied by remarkably low levels of influenza B with positivity rates always well below 10% across the nation and never peaking anytime during the entire epidemic. Then came the **2019-2020** season with influenza B arriving sooner than influenza A for the first time in a decade and achieving positivity rates higher than influenza A. The performance of influenza in the United States for both seasons was surprising to most epidemiologists and promised to make predicting the course of influenza in the **2020-2021** season difficult. But then the COVID-19 pandemic arrived globally, causing an abrupt end to the **2019-2020** influenza season in the northern hemisphere (note the sharp, rapid fall [arrow] of the positivity rates for influenza A and B in February-March in the United States).

Figure 2: Course of influenza A and B for Last Three Seasons* - 8/1/18 to 5/20/21



HOT TOPICS

INFLUENZA (CON'T)

INFLUENZA EPIDEMICS IN SOUTHERN HEMISPHERE

A few weeks after the abrupt decline in influenza positivity rates in the U.S., reports began arriving from Australia, indicating a profound drop in the incidence of influenza and other respiratory viral infections at the beginning of their 2020-2021 season that usually begins in May. This was believed due, at least in part, to the institution of social distancing, mask wearing, avoidance of crowds and other behavioral precautions that were aimed at limiting the spread of SARS-CoV-2. By the end of the Southern Hemisphere's 2020-2021 season, data showed a dramatic decline, >99%, in incidence of PCR-confirmed cases of influenza in Australia, South Africa and South America (Table 2).

Table 2: *Impact of COVID-19 on Incidence of Documented Cases of Influenza in Southern Hemisphere*

COUNTRY	YEAR OF ORIGIN		
	2018	2019	2020
Argentina	1517	4623	53
Chile	2439	5007	12
Australia	925	9933	33
South Africa	711	1094	6

From: K. Servick, 28 August 2020, Science 369 (6506), 890-892

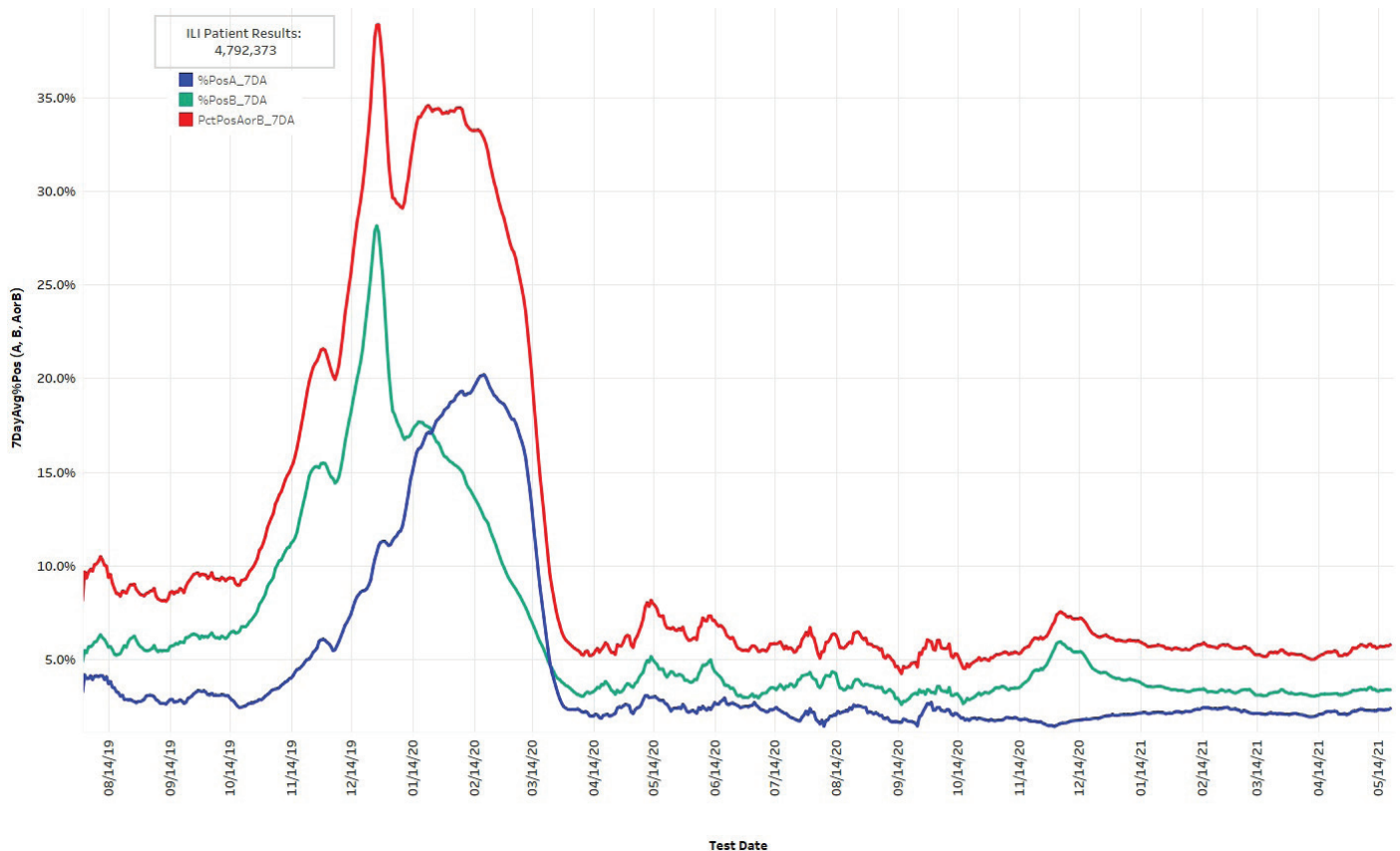
Had COVID not arrived in the winter of 2020, given the unusual absence of influenza B in one season and the surge of B and decline of A in the following 2019-2020 season—it would have been very difficult for epidemiologists to confidently predict what the influenza season for 2020-2021 season would be in the United States. But, as shown in **Figure 2 (page 11)** and **Figure 3 (page 13)**, with the arrival of COVID-19 the 2019-2020 influenza epidemic not only ended abruptly, but also the 2020-2021 season never even arrived in the Northern Hemisphere.

HOT TOPICS

INFLUENZA (CON'T)

In fact, the positivity rates for both influenza types—to this day—have rarely exceeded 5% and have now remained dramatically low for 13 consecutive months!

Figure 3: Course of influenza A and B by Sofia Influenza A+B FIA* - 8/1/19 to 5/20/21



INFLUENZA TESTING

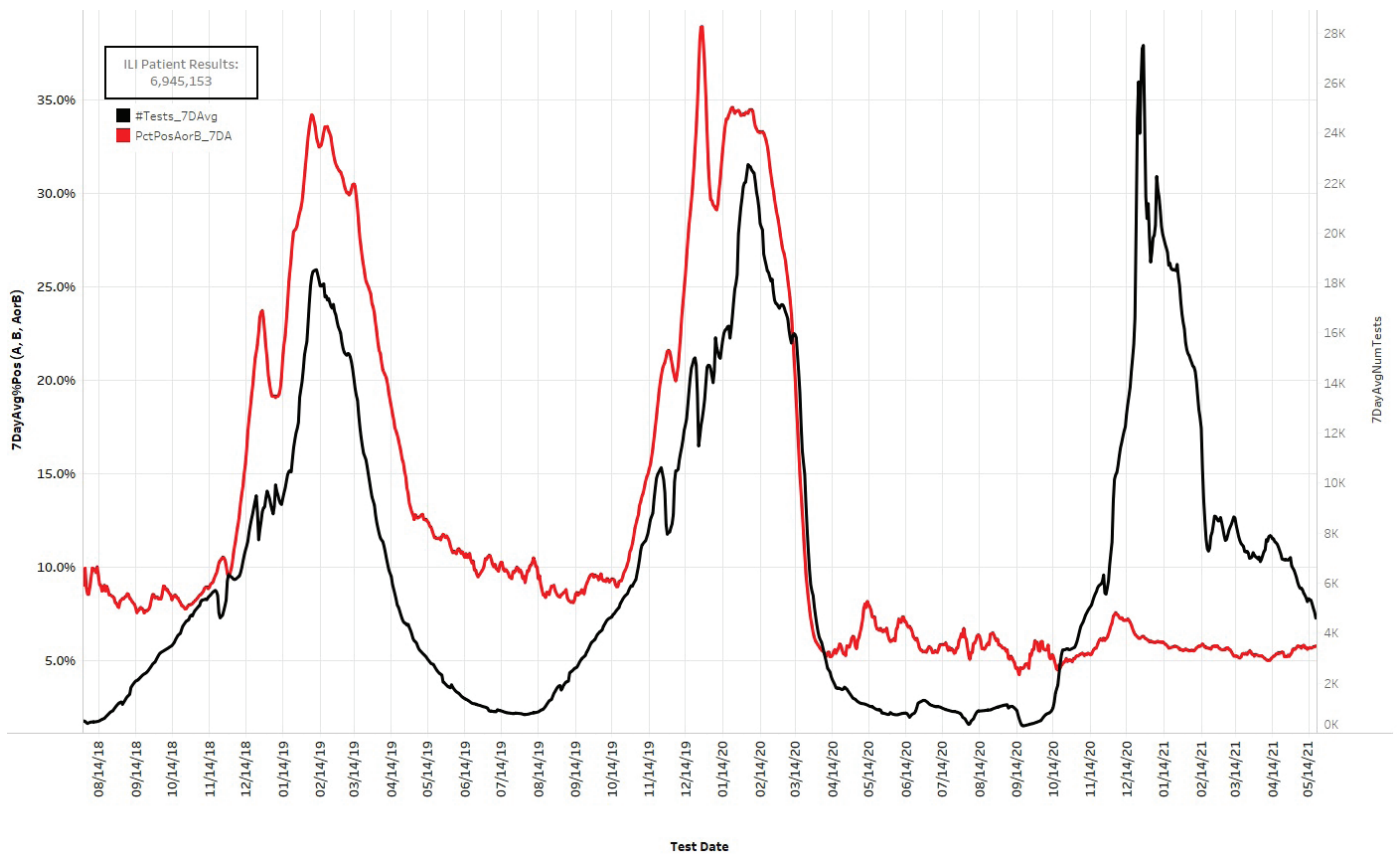
This decline in positivity rates was not simply due to the cessation of testing for influenza. COVID-19 and Influenza share many common signs and symptoms and even with the abrupt decline in positivity rates seen, e.g., in **Figures 2 (page 11) & 3 above**, testing for influenza, shown in black in **Figure 4 (page 14)**, continued at a high pace until specific tests for SARS-

HOT TOPICS

INFLUENZA (CON'T)

CoV-2 became available near the end of what might otherwise had been a typical respiratory season. Physicians and laboratory directors simply had to rule out influenza, given the similarity of signs and symptoms between ILI and CLI (COVID-like-illness).

Figure 4*: Testing for Influenza Has Continued from 8/1/19 to 5/20/21



HOT TOPICS

INFLUENZA (CON'T)

DRAMATIC DECLINE IN INFLUENZA-RELATED HOSPITALIZATION AND DEATHS IN U.S.A.

The profound decline of confirmed influenza cases in the Southern Hemisphere finally occurred in the U.S.A., as shown most clearly in **Figure 3 (page 13)** and in **Table 3 (page 16)**.

IN OUR RECENT 2020 SEASON,
HOSPITALIZATION RATES DECLINED FROM AN
AVERAGE OF 550,000 CASES FOR THE PREVIOUS
FOUR SEASONS TO ONLY 215 ACROSS THE U.S.!

AND CONFIRMED DEATHS FROM INFLUENZA
DROPPED FROM AN AVERAGE OF 38,800 TO 6!

HOT TOPICS

INFLUENZA (CON'T)

Table 3: U.S. Influenza Disease Burden for Seasons 2016 through 2020

SEASONS	SYMPTOMATIC ILLNESSES	MEDICAL VISITS	HOSPITALIZATIONS	DEATHS
2016	29,000,000	14,000,000	500,000	38,000
2017	45,000,000	21,000,000	810,000	61,000
2018	36,000,000	17,000,000	490,000	34,000
2019	38,000,000	18,000,000	400,000	22,000
2020	**	**	215	6
2021	?	?	?	?

*Source: CDC estimates reported in <https://www.cdc.gov/flu/about/burden/index.html>

** Not yet available. Most visits due to patients with COVID-19 symptoms.

FACTORS INFLUENCING THE DECLINE OF INFLUENZA

Most epidemiologists agree that the continued behavioral and societal precautions (Table 4) against the spread of COVID-19 have very likely blocked the appearance and spread of influenza, as well as other respiratory pathogens. We saw this first in Australia where the incidence not only of influenza infections, but also those caused by RSV, hMPV, adenovirus, parainfluenza, and seasonal coronaviruses dropped to near zero in their 2020 season. Other reports have shown a dramatic decline in bacterial infections by **S. pneumoniae** and even **S. pyogenes**, as well.

Table 4: Behavioral and Societal Factors Affecting US Influenza Burden (as well as that of SARS-CoV-2)

Social Distancing	Wearing Masks	Avoiding Crowds
Lock Downs	Travel Restrictions	School Closures
Working at Home		

HOT TOPICS

INFLUENZA (CON'T)

Whether Americans will continue to social distance and wear masks and take other precautions to prevent spread of respiratory disease is open to debate. The arrival of the UK variant that is rapidly spreading in the U.S. and threatening another surge could perpetuate this behavior.

FACTORS FAVORING A POSSIBLE RETURN OF INFLUENZA THIS WINTER IN THE U.S.A..

Obviously, trying to predict what is going to happen with influenza this year is extremely difficult. Even before the arrival of COVID-19 we experienced two very unusual and unpredictable influenza seasons that deviated from what had been typical for many years. And these were followed promptly by the COVID-19 pandemic with extreme consequences for influenza incidence as well as that for other respiratory diseases. Despite this, there is a growing list of factors that suggest a potential return of influenza this coming season as seen on **Table 5 (page 19)**.

The re-opening of schools which is eagerly anticipated and supported by CDC, other government officials and, certainly, parents and even children could facilitate the arrival of influenza and other respiratory infections, including RSV and Strep A. We know that schools are probably the sites where spread of influenza is most pronounced and enabling in a community.

HOT TOPICS

INFLUENZA (CON'T)

CHILDREN HAVE LESS IMMUNITY AND PRODUCE MORE VIRUS AND SPREAD DISEASE MORE QUICKLY AMONG THEMSELVES AND FAMILIES. IN ADDITION TO THESE FACTORS, 51.8% OF CHILDREN IN THE U.S. ARE NOT EVEN VACCINATED AGAINST INFLUENZA.



Most epidemiologists are concerned that the absence of influenza in our communities for the past year may certainly have resulted in a decline in the level of immunity in our population. Even mild influenza disease—which likely happens far more often than ever recognized—produces an immune response and builds immunity to fight future epidemics. The near absence of influenza last year, may be resulting in a more immunologically unprepared population than in many years.

HOT TOPICS

INFLUENZA (CON'T)

For those who do wish to get vaccinated, the absence of influenza in the Southern Hemisphere in the past 12 to 18 months, will make it very difficult for WHO, CDC, and epidemiologists to predict what four viral subtypes and lineages should be included in this season’s vaccine—in short the vaccine may be less effective than the 40-60% effectiveness commonly achieved.

Table 5: Factors Predisposing to RETURN of Influenza this coming Fall or Winter

FACTORS	CONSEQUENCE
Failure to adhere to behavioral precautions	Increases spread of respiratory viruses
Opening public schools	Children and schools are primary source of influenza outbreaks in a community
Waning natural immunity	Lack of exposure and even mild infections in past season diminishes our population’s immune preparedness
Uncertainty about optimal influenza vaccine constituent	Lack of circulating subtypes and lineages in Southern Hemisphere compromises effective vaccine design
Refusal to receive the influenza vaccine	Lack of herd immunity for influenza increases likelihood of incidence and spread of influenza. Even 51.8% of children in the U.S. are not vaccinated against influenza.
Effective SARS-CoV-2 vaccination program	Elimination or control of COVID-19 could reduce adherence to behavioral precautions—esp. for those not vaccinated; however, 51% of adults are refusing the vaccination in the U.S.
Decrease in pathogen competition	COVID-19 infection promotes interferon production and also has a number of other anti-influenza effects on potential target cells for influenza infection (pathogen competition). Elimination of COVID-19 will eliminate these non-specific anti-influenza (and other respiratory viral) threats.
Failure to Test for Influenza	Continuation of greatly reduced testing for influenza can result in poorly anticipated outbreaks and delay public health intervention

HOT TOPICS

INFLUENZA (CON'T)

TESTING FOR INFLUENZA THIS COMING FALL AND WINTER

The fact that influenza and SARS-CoV-2 share so many common signs and symptoms makes careful specific diagnosis of both extremely important. Treatments for each are available, but the timing of the administration of each is very important--often the windows for effective therapy are short and given as early as possible after onset of infections. In addition, we know that co-infections of influenza and SARS-CoV-2 do occur and with strong negative impact on morbidity, mortality, and demand for medical interventions.

The availability of high quality rapid POC diagnostic tests is critically important as the traditional respiratory virus season approaches. Perhaps even more important, the competent application of telemedicine, digital health, and OTC and prescription-use-only at-home COVID-19 tests should have a profound impact on the ability to manage the return of influenza in the midst of a continued intermittent incursion of SARS-CoV-2 infections. These could lead to an increase in co-infections. Distinguishing an ILI patient from a CLI (COVID-like-illness) patient is a challenge, but this must be done competently and quickly to save lives. A negative at-home SARS-CoV-2 test for a symptomatic patient must be followed up with an influenza test and with appropriate, rapid healthcare guidance. For that matter, the consequences of dual infection are so severe, confirmation of the absence of influenza in the presence of a positive COVID-19 diagnosis (and vice versa) should also be considered.

** The data depicted in the above Figures were generated using Quidel's Sofia Influenza A+B Fluorescence Immunoassay (FIA) results from a total of 9,228,848 ILI patients. The Sofia Analyzers wirelessly transmit test results within minutes to the Virena surveillance system that captures and automatically analyzes the HIPAA compliant patient results; these results are transmitted daily to participating laboratory administrators and directors as well as to government agencies requesting daily updates for surveillance of influenza and other respiratory pathogens, including, most recently, SARS-CoV-2.*



HOT TOPICS

A LOOK AT FLU VACCINE ACTIVITIES BY SEASON

The chart below breaks down your major flu activities –ordering flu vaccine, preparing for the season, vaccinating and treating patients–by when these activities occur within the year.

Spring ORDER	Assess your flu vaccine utilization from the previous flu seasons and account for any unexpected business changes that may add or subtract from your current usage. Finalize your pre-book and submit it.
Summer PREPARE	Select tentative dates for your Flu Vaccination Event. Review your pre-book and make adjustments if necessary. Order flu vaccination supplies (needles, syringes, gloves, alcohol prep pads, etc.).
Autumn VACCINATE	Get ready – most flu shots are given in the fall months, so be ready to administer flu vaccines on request. Finalize your Flu Vaccination Event dates after you have scheduled delivery of your vaccine. This will help minimize the need to reschedule due to unexpected delays.
Winter TREAT	Don't stop vaccinating–flu activity may not peak until February or March. The CDC recommends continued flu vaccination efforts throughout the season. Plan ahead–the CDC will soon be announcing the strain composition for the upcoming flu season. It's never too early to start planning next year's flu pre-book.

HOT TOPICS

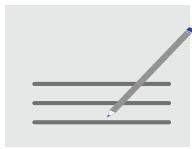
HELPFUL RESOURCES TO CONNECT WITH PATIENTS

Click on the images below to view each resource.



Banner ad

Share these banner ads on your practice website or use them for paid media. Sizes may need to be adjusted slightly depending on your website host



Email & letter template

Snail mail and emails are important ways to stay in touch with your patients. Letters add a personal touch and emails are a quick way to get a message out. Include your practice name on the envelope and subject line so patients know it's from you.



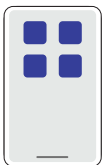
Voice messaging script

Patients may not pick up, but they'll listen to a voicemail. Say your practice name upfront so they know who's calling.



Text messaging template

Texting with your patients is a great way to stay connected with them! Keep messages brief and to the point, with an easy way for them to take action.



Social media template

If you don't already have a Facebook page for your practice, now is a great time to get started! Personalize posts by putting whose writing at the bottom like "Dr. Smith" and include a link to your practice website!



Parking lot signage

The parking lot has become the new waiting room. Print out this sign and hang it in a clear spot for patients to see.

OPERATIONS

PREPARING TO SELL: TOP NINE ESSENTIALS

Like most business transactions, selling an urgent care business typically takes years of preparation and effort. If you are considering this move, here are steps you should be taking now to help the process go smoothly.

- 1. Develop Relationships and Contacts Early.** The typical buyer pool for urgent care businesses includes local health systems, employee providers, other local urgent care owners or national urgent care chains. Start having preliminary conversations with these parties two or three years before officially launching a sale process. What you learn from these conversations can be invaluable in your planning.
- 2. Define Your Ongoing Role.** For many urgent care owners, the question of lifestyle after sale is difficult to address. Do you want to retire completely? Do you want to just work shifts long-term without the administrative hassle if you are an owner-operator? Knowing what you really want from a sale is important.
- 3. Identify Your Team.** You will need experts in law, accounting and finance to complete your transaction. You may not need a broker if you have narrowed your list of interested parties from conversations with buyers. Finding a team of partners you trust and collaborate well with is essential to completing a successful transaction.
- 4. Make Necessary Business Changes.** Whether you need to switch billing companies, re-negotiate contracts, optimize staffing levels, or improve your brand, this is no time for procrastination.
- 5. Keep Emotions in Balance.** Selling your business can be emotionally difficult. All the time and energy you have spent in your organization will now be turned over to someone else. It is important to keep perspective and remember what you want to accomplish.

OPERATIONS

PREPARING TO SELL: TOP NINE ESSENTIALS (CON'T)

6. **Consider Estate Planning.** A business sale can result in a significant amount of proceeds to its owners. There may be gift and estate planning techniques you want to explore prior to sale.
7. **Organize Information.** Financial statements, billing records, contracts, asset lists, operating protocols and licensures should be readily available, accurate and complete. Buyers will want to explore your payer mix, coding mix, expense trends and operating metrics and ensure they review final, signed versions of contracts and documents. For many operators, organization alone takes months to complete.
8. **Consider Ordering a Valuation.** A professional independent valuation may be beneficial for several reasons. It can (1) force you to organize information, (2) help provide reasonable expectations in the event of sale, (3) shed light on areas of improvement prior to sale, and (4) provide you practice for real conversations with potential buyers.
9. **Stay Focused on Business Operations.** Preparing for sale is NOT a reason to let operations slip. The sale process can take months and buyers will be keen to notice declining business trends.

The last point is especially important. It's easy to mentally move forward to life after a sale but maintaining strong operations will be the key to a successful transaction. Continue operating the business as if the sale were not going to happen...because it may not.

OPERATIONS

URGENT CARE VALUATION - WHAT YOU NEED TO PREPARE

Use the checklist below to prepare for any valuation. Typical range is 3 fiscal years.

CATEGORY	REQUEST / ITEM DESCRIPTION
A. Historical Financials	<ol style="list-style-type: none">1. Detailed income statements by site and consolidated2. Consolidated balance sheets3. Historical distributions4. Capital contributions since inception5. If available, statement of cash flows6. If available, audits
B. Statistics	<ol style="list-style-type: none">1. Charges, allowables, payments and units by CPT code by site2. Payer mix by site and consolidated3. Staffing roster table that includes position (e.g., admin, nurse, MD, PA, etc.), FTEs status, employee tenure and salary by site4. Any regularly reviewed management operating reports
C. Fixed Asset Ledger & Capital Expenditures	<ol style="list-style-type: none">1. Current fixed asset ledger including asset category, detailed description, in-service date, original cost and net book value2. Historical capital expenditures3. Anticipated future capital expenditures
D. Contracts and Agreements	<ol style="list-style-type: none">1. Company operating agreement and related exhibits2. Summary of terms with key vendors (i.e., billing, EMR, scheduling, telehealth, etc.) or any other material contract
E. Leases	<ol style="list-style-type: none">1. Summary of all facilities and leases (location, open date, square footage, lease end date, rent rate, renewal terms, etc.)2. Summary of any equipment leases
F. Other	<ol style="list-style-type: none">1. Quality metrics and customer satisfaction scores (e.g., certifications, accreditations, net promoter score, etc.)2. Listing and discussion of major competitors3. If applicable, details of corporate department including key personnel, services provided, detailed expense reports, etc.4. If available, budgets, long-range forecasts or pro formas including details for any new site openings5. If available, market share reports or details regarding primary and secondary service area coverage6. Any other information you feel relevant to our review

OPERATIONS

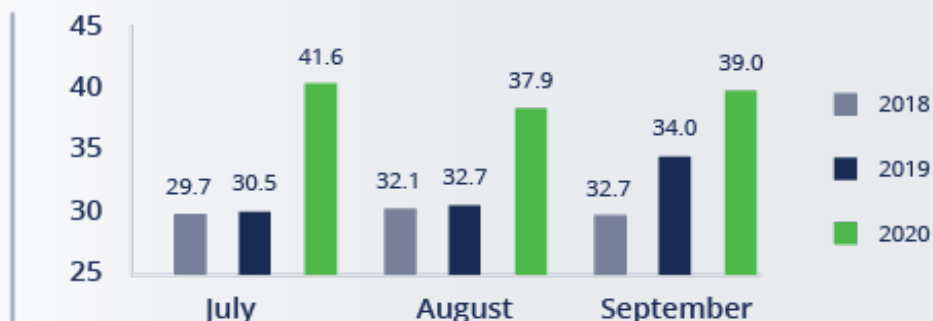
VISIT VOLUME

Average visit volume per clinic per day in 2018 and 2019 hovered right at the **32-visits-per-clinic-per-day** mark. 2020 will always be an outlier due to the COVID-19 Public Health Emergency—and the data shows it. After the roughest quarter in history, Q3 of 2020 marked the beginning of urgent care’s resurgence. On Monday, July 6, 2020 (the Monday after Independence Day), Experity customers reported 105,639 visits nationwide, surpassing traffic for our customers’ busiest flu day earlier that year (February 3, 2020).

The 2020 visit volume rollercoaster marks the start of a new era in urgent care. The 2020 Q3 average of **nearly 40 visits per clinic per day** due to COVID-19 testing continued to rise higher and higher through the end of the year, challenging urgent care to improve efficiency to keep up with demand.

How is visit volume trending in 2021? Visit volume continues to ebb and flow at the 2018 and 2019 rate of **30-40 visits per clinic per day**.

Average Visits per Clinic per Day
Year-Over-Year 2018–2020

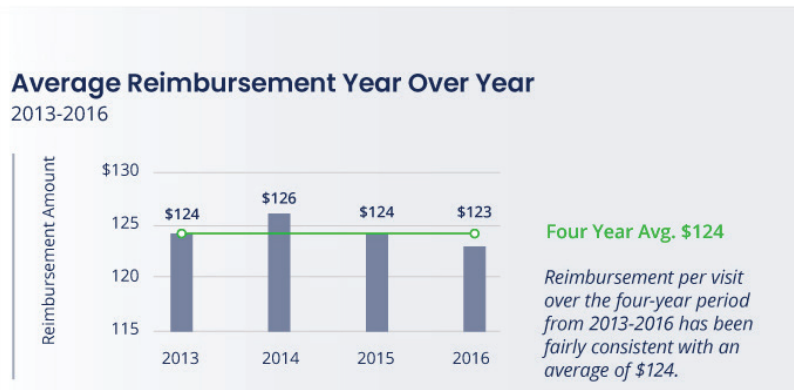


EXPERITY

OPERATIONS

THE EFFECT OF COVID-19 ON URGENT CARE REIMBURSEMENT

For reference, you can look back at where we were five years ago. From 2013 through 2016, average reimbursement overall was fairly consistent at an average of **\$124 per visit**.



EXPERITY

Patient care and balancing fluctuating visit volumes were the hallmarks of 2020 and continued to drive us through the first quarter of 2021 - and impacted revenue for many urgent care centers.

Average reimbursement per visit went up slightly during 2020, from **\$118.51** in 2019 to **\$121.62**. COVID-19 testing sent urgent care clinics a lot of first-time patients which had a direct impact on average reimbursement.

Average Revenue Per Visit Year Over Year

2019-2020

Year	NRPV
2019	\$ 118.51
2020	\$ 121.62

In 2019, average revenue per visit was \$118.51. That number increased by about \$3 in 2020 to \$121.62.

EXPERITY

OPERATIONS

THE EFFECT OF COVID-19 ON URGENT CARE REIMBURSEMENT (CON'T)

Average reimbursement for established patients went up from \$121.92 in 2019 to \$123 in 2020. Average reimbursement for new patients went down from \$152.24 in 2019 to \$150.72 in 2020. But the lower acuity of COVID-19 tests was offset by the sheer number of new patients to increase revenue per visit overall for 2020.

While 52 percent of clinics saw an increase in average revenue per visit in 2020, many saw declines. Others did not have significant fluctuation. For 42 percent of urgent cares, average revenue per visit was within five percent up or down between 2019 and 2020.

Average Revenue Per Visit Year Over Year by Segment

2019-2020

NRPV	Est.	New	No Visit	Total
2019	\$ 121.92	\$ 152.24	\$ 54.75	\$ 118.51
2020	\$ 123.00	\$ 150.72	\$ 60.99	\$ 121.62

COVID-19 resulted in a greater number of new patients, offsetting the lower acuity of COVID-19 tests. This resulted in an overall increase in average revenue per visit in 2020.

EXPERITY

PATIENT CARE PROCESSES

Engaging key clinical and management staff in developing and implementing best practices for the management of medications is critical in preventing avoidable errors.

The UCA Accreditation team visits hundreds of urgent care centers each year during site surveys. The assessment of these centers' processes has given our surveyors insight into areas where opportunities for improvement most often occur. This section reviews Patient Care Processes that can reduce your medication management errors.

This is a great time to review your current workflows and safeguards with your staff to determine if you have any gaps in how medications are managed. Doing so may not only improve patient care but may also save you money in medication supply utilization.

Contributor to Patient Care Processes: UCA Accreditation Surveyor Team

PATIENT CARE PROCESSES

MEDICATION MANAGEMENT - ERROR PREVENTION

Below are seven areas in medication management to focus on to improve efficiencies, boost team confidence, and increase patient safety. Regardless of your accreditation status, these areas are important for all urgent care centers.



UCA Accredited? Review Standards CUC4C, PCP1B, PCP5A-N, PCP5-1A-C, PCP8B, HRM4I, HRM4W-Y, HRM9D, HRM10A-B, PE1B, PE9C, PE11H, and QI5-6F.

- 1. Patient Identifiers:** A critical area in medication management is patient identification. Patient ID errors raise concerns in the quality of care received as well as have potential financial implications. Having a patient identification process that details how and when a patient's identity is confirmed. A patient's identity should be verified at minimum with every medication administered.
- 2. Reconciliation:** The review of medication orders is a critical step in avoiding potential drug interactions, duplications, and to uncover any dosing errors. Recalling a complete list of prescription and OTC medications can be difficult for the elderly or patients taking multiple prescriptions complicating the process. Asking both close-ended questions such as "Do you take any medications for your...?" and open-ended questions such as "What do you take for your...?" can help to gather a more complete history.
- 3. Storage for Safety & Efficiency:** For organizations with multiple centers the approach to storage maybe different for each based-on facility design, populations served, and other characteristics. In general, the following recommendations will work for everyone:
 - Do not put medications with similar packaging, names, or formulations next to each other.
 - Use color coding to help distinguish injectables.
 - Use sound alike, look alike warnings.
 - Device methods (e.g., month/year labels) to indicate the medications to be used first.
 - Store medications separate from other supplies i.e. lab reagents, specimens, etc.
 - Store oral, injectable' and topical medications away from each other, i.e., different shelves or cupboards if possible.

PATIENT CARE PROCESSES

MEDICATION MANAGEMENT - ERROR PREVENTION (CON'T)

4. **Expired Medications:** Implement a regular review process at least monthly, to remove expiring medications and call attention to short-date medications that will expire in the next 90 days.
5. **Know your formulary:** Regularly review your list of standard medication supplies. Some medications are staples of urgent care; others will vary based on the populations that you serve. Your formulary review should ask the questions:
 - What conditions do we need to address through medications?
 - Are we carrying the best/correct medication for treatment?
 - What formulations do we need to carry?
 - What should par level be?
 - Have there been any changes in side effects or are there supply chain issues?
 - Do we approve any off-label use?
 - Does our formulary include back up medications in the event of a product recall or out of stock situation?
6. **High Risk:** Medications for your low volume/high risk events are typically stored in your crash cart. Even though they will not be accessed as often they need to be included in the regular review process for expirations. Create and keep a binder with images of each medication and its storage location, packaging, and any administration protocols. A regular review of crash cart contents will keep your staff sharp for when an emergency occurs.
7. **Staff Involvement:** Your staff, as the administrators of medication, should be involved in processes and policies for medication storage and administration. Culture and collaboration are critical in developing and maintaining good processes. Create an open communication culture by engaging staff in decisions, having daily huddles with opportunities for learning, and praising those who share their opinions on medication management.

HEALTH RECORDS

DIAGNOSIS CODE TRENDS

Urgent care was built on treating a handful of acute illnesses throughout the year. In 2018 and 2019, the diagnosis codes were consistent and followed expected urgent care trends. In July, August, and September, upper respiratory infections, sore throats, and sinusitis topped the list. But in 2020, everything changed.

In quarter three of 2020, COVID visits were (not surprisingly) the most common of all urgent care visit types.

Top Three Primary Diagnosis Year-Over-Year 2018-2020

	2018		2019		2020	
July	J02.9	6.4%	J06.9	6.8%	Z20.828	30.6%
Aug.	J06.9	5.8%	J02.9	5.5%	Z03.818	11.8%
Sept.	J01.90	4.7%	J01.90	4.9%	Z11.59	4.4%

J06.9 Upper Respiratory Infection

J02.9 Acute Pharyngitis

J01.9 Acute Sinusitis

Z20.828 Contact with and (suspected) exposure to other viral communicable diseases

Z03.818 Encounter for observation for suspected exposure to other biological agents ruled out

Z11.59 Encounter for screening for other viral diseases

EXPERITY

HUMAN RESOURCES

Tackling a condition such as hypertension that affects almost 50% of Americans, most of which do not know they are hypertensive, may seem like an insurmountable objective in the urgent care setting, but the following the following original research study in the Journal of Urgent Care Medicine shows how small process changes in your center(s) can make a significant improvement in hypertension management.

Engaging and motivating your clinical staff as well as implementing patient education plans are inexpensive and effective strategies to for improving patient care and satisfaction.

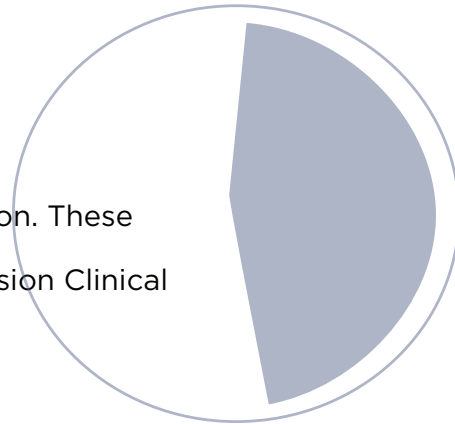
External Contributor to Human Resources: The Journal of Urgent Care Medicine

HUMAN RESOURCES

STAFF EDUCATION TO IMPROVE OUTCOMES FOR PATIENTS WITH HYPERTENSION

116.4 million, or 46%

of US adults are estimated to have hypertension. These are findings related to the new 2017 Hypertension Clinical Practice Guidelines



HTN Facts - Linked to a number of health disease burdens such as vision loss, renal disease, heart failure, sexual dysfunction, and peripheral artery disease, the annual HTN-associated healthcare costs total approximately \$131 billion. Perhaps most alarming, approximately half (46%) of those individuals with HTN do not even know it, leaving them at risk for years of damage before symptoms develop.

HTN Overlooked - Elevated BP in the urgent care setting is often thought to be related to pain, anxiety, or white-coat syndrome, with the assumption being that after discharge their BP will normalize. This results in a large majority of adult patients with asymptomatic HTN in the urgent care setting not being evaluated and being discharged without a HTN specific plan of care.

In an original research study, significant improvements in the management of adult hypertension in an urgent care setting were seen over an 8-week period through the implementation of 4 core interventional tools (CITs). A summary of the research methodology and outcomes is below. The complete study can be found in the March 2021 edition of JUCM - <https://www.jucm.com/wp-content/uploads/2021/03/2021-15625-32-Original-Research.pdf>

HUMAN RESOURCES

STAFF EDUCATION TO IMPROVE OUTCOMES FOR PATIENTS WITH HYPERTENSION (CON'T)

Tools Implemented and Their Impact

- 1. BP Measurement Checklist** - This checklist was laminated and attached to each vital sign monitor to effectively aid MAs with BP measurement accuracy. The was utilized in a total of 465 patients, improving staff BP measurement technique from **43% to 93%** in 90 days.
- 2. High BP Treatment Plan Tool** - Over the course of the study, 84% of patients whose BP met HTN Stage I or higher criteria (ACC/AHA, 2017) received HTN specific education with the clinician. Use of the Patient High BP Treatment Plan tool resulted in immediate improvement in patient satisfaction and comprehension of their BP results from **30% to 97%**.
- 3. High BP Best Practice Checklist** - A guideline-driven High BP Best Practice Checklist was made available for clinicians to use next to the charting station, resulting in a total of 163 checklists used throughout implementation and improvement in HTN chart audit rates from **11% to 80%** without adding additional time to patient intake.
- 4. Team Engagement Plan** - Employees play a vital role in driving the success of the organization and through the use of workforce engagement, employee productivity and performance were enhanced. Team collaboration improved the management of adult HTN in the urgent care setting from **28% to 88%**. Engagement strategies included thank you cards, motivational meetings and team group texts.

Conclusion - Over the course of 90 days, the effective management of adult HTN in the urgent setting improved through the guidance and direction of a clinician-led initiative. More importantly, its success in meeting all goals was a direct result of a combination of team and patient engagement strategies. Screening for undiagnosed HTN in the urgent care clinics offers an important opportunity to reduce the associated disease burden while helping to combat our nation's leading cause of death— heart disease.

PATIENT RIGHTS

Suspecting that a child or adolescent patient has been the victim of physical abuse is about much more than the identification and treatment of their injuries. All states require clinicians as well as health care administrators to report suspected abuse, but often your staff's involvement will not end there.

This Member Point of View by Dr. Thomas Tryon, chair of UCA's Pediatric Member Networking Section, provides both clinical and management considerations related to identifying, treating, and reporting suspected abuse.

PATIENT RIGHTS

CHILD ABUSE PRESENTING IN URGENT CARE | MEMBER POV



Thomas Tryon, MD, MBA, FAAP, FCUCM

Pediatric UC Physician/Professor of Pediatrics

Children's Mercy Hospital Urgent Care
Kansas City, MO

CUCM Physician member and UCA Board Secretary



Case Presentation: While working a busy urgent care, an 8-month-old infant presents with a chief complaint of a runny nose and a cough without a fever. While examining the infant, you notice bruises on the left side of the chest. When asked about the bruises, the father reports that he tosses the baby in the air and catches him and that is what he believes caused the bruises. No other bruises are noted on the infant. You obtain an x-ray of the chest and ribs and the radiologist calls you to notify you that there are multiple rib fractures in different stages of healing. As a mandated reporter, you realize the infant is the victim of child abuse. What do you do next?

152,250

According to the American Academy of Pediatrics, in **2004** 152,250 children and adolescents were confirmed victims of physical abuse in the United States. Physical abuse was second only to neglect, occurring in approximately 18% of these children.



In **2019** there were 656,243 cases of child abuse reported to Child Protective Services with 1,809 child fatalities. While the majority of those cases were due to child neglect, child physical abuse was still a significant percentage of cases. The age with the highest percentage of child abuse was infants under one year of age.

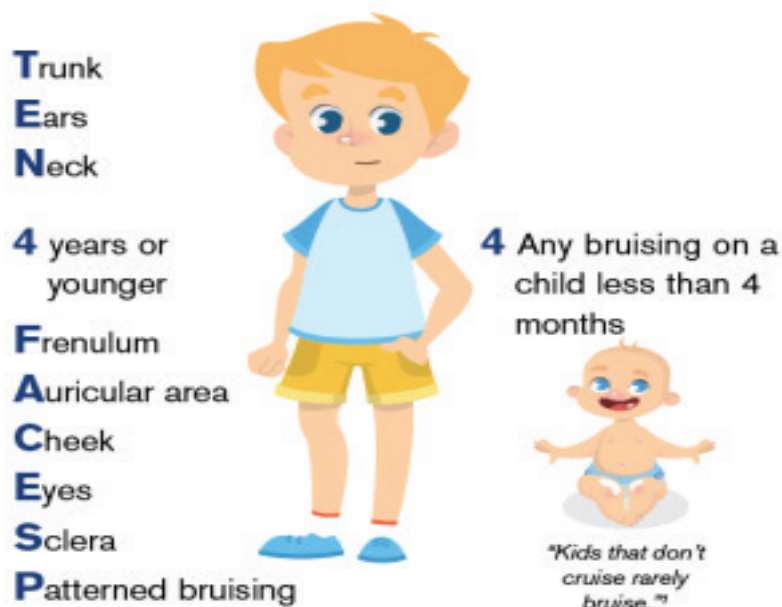
656,243

PATIENT RIGHTS

CHILD ABUSE MANAGEMENT IN URGENT CARE | MEMBER POV

With those statistics, any urgent care center providing care for child will see victims of child abuse – either presenting for that concern or as a finding in a child presenting with a different concern. Child abuse experts will tell you that with child fatalities due to child abuse, it is not uncommon for that child to have been seen multiple times by a healthcare provider in the preceding months or year before the death of the child. One recent small study looked at 37 child abuse fatalities under the age of 4 and found that 30% had been seen for documented healthcare visits other than routine well-child visits in the year before their death, with 19% being seen in the month prior to their death.

As a front- line provider, it is important that each of us always be vigilant to possible child abuse injuries. There is a mnemonic that I recommend being visible in every provider charting area of every urgent care center to continually remind providers and staff to be on the lookout for these injuries. Here is the mnemonic TEN4FACES-P (available from the [American College of Emergency Physicians](#)).



PATIENT RIGHTS

CHILD ABUSE MANAGEMENT IN URGENT CARE | MEMBER POV (CON'T)

Having seen a patient with suspected child abuse in your urgent care, what are your next steps. In our urgent care system at Children's Mercy Hospital in Kansas City, we have an established Scope of Service that has been approved by our Executive Leadership. We have chosen not to include evaluation and management of child abuse within that Scope of Service. We send these patients to our emergency departments for full evaluation and management. The reasons are many:

- 1. Trained Child Abuse Examiners:** We do not have trained child abuse experts working in all of our urgent care sites. Often these cases will wind up in court with healthcare providers called as witnesses for the district attorney's office. Having conflicting testimony between urgent care physicians and child abuse experts can be problematic. Further, since our niche is between a physician office and a community ER, this service requires more resources and is more complicated than we should be providing.
- 2. Have a Policy in Place:** Our hospital has a policy on how to handle these situations in off site locations. We also have a Division of Child Abuse and Neglect with staff who are on call all the time and can serve as a resource. Our hospital policy recommends involving them early and often. In your community, get familiar with your child abuse experts and determine when they are available for consultation.
- 3. Involve Social Work:** Our hospital policy also recommends involving Social Work early. They can access whether there is an open Child Protective Services case on this child and where that case stands. They may be able to ascertain if the parent or guardian has a history of child abuse. CMS is very clear that guaranteeing the safety of the child is the responsibility of the healthcare providers until that child has been fully evaluated, a safety plan is in place, and the child is being released to a safe home.
- 4. Skeletal Survey and Labs:** Many of the children with suspected child abuse injuries will need a full skeletal survey and may need laboratory tests to include PT/PTT or other labs that are not available in urgent care.

PATIENT RIGHTS

CHILD ABUSE MANAGEMENT IN URGENT CARE | MEMBER POV (CON'T)

5. Staff and Provider Safety: These situations are often very volatile and may result in a parent believing they are being accused of child abuse. Before confronting the family about your concerns, ensure that there are safety plans in place. Additionally, I also recommend having that conversation with the family with a witness; either a nurse or medical assistant working with you. Last, I recommend against standing in front of the door or blocking the door to the room. If the parent decides to scoop and run with the child, a staff member standing in the way may well be injured.

In summary, what actions should you take? The American Academy of Pediatrics recommends:

- Make sure your practice has a protocol in place to respond that is consistent with legal reporting requirements, state-based statutes, and utilizes appropriate community resources.
- If abuse or neglect is suspected, report to the appropriate authorities and ensure the child will be in a safe location.
- Contact your local child abuse provider resource.

Recognizing potential abuse and taking action may well save the life of a child. It will also be in keeping with mandated reporting requirements by the state and with our role as child advocates and care givers.

QUALITY IMPROVEMENT

While antibiotic resistant infections continue to rise each year in the US, patient demand for prescriptions for them continues to as well. The balance for urgent care providers between antibiotic stewardship and angry patients and their online reviews is challenging and sometimes costly.

The changes for evaluation and management (E/M) documentation and coding that took effect January 2021 allow providers to take the time to educate patients on appropriate antibiotic use and include that education in their documentation for code level support.

Contributor to Quality Improvement: UCA Coding Task Force

QUALITY IMPROVEMENT

E/M CODING AND ANTIBIOTIC STEWARDSHIP

According to a research study conducted by PEW Charitable Trust and the American Medical Association, 74% of responding physicians replied they receive moderate to high pressure from patients/parents to prescribe antibiotics.

The new 2021 coding guidelines provide the ability to account for the medical decision making (MDM) needed to determine an antibiotic is not warranted and even harmful and efforts to educate patients on the importance of appropriate antibiotic use - even when there is no prescription.

Appropriate documentation by providers of this element of their MDM not only reflects visit complexity more accurately and ensures appropriate reimbursement but reinforces urgent care's industry commitment to antibiotic stewardship.

ELEMENTS OF MEDICAL DECISION MAKING

Code	Level of MDM	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99204 99214	Moderate (multiple problems or significantly ill)	<p>Moderate problems</p> <ul style="list-style-type: none"> • 2 or more stable chronic illnesses OR • 1 or more chronic illnesses with exacerbation, progression or side effects of treatment OR • 1 undiagnosed new problem with uncertain prognosis OR • 1 acute illness with systemic symptoms** OR • 1 acute complicated injury <p>**See Definitions page(s) (below) for new exclusions from "systemic symptoms".</p>	<p>Moderate data (must meet the requirements of at least 1 out of 3 categories)</p> <p>Category 1: Tests, Documents or Independent Historian(s)</p> <p>Any combination of 3 from the following:</p> <ul style="list-style-type: none"> • Review of prior external note(s) from each unique source* • Ordering of each unique test* (note: FLU A/B test is now considered 1 test vs. 2) • Review of the result(s) of each unique test • Assessment requiring an independent historian <p>OR</p> <p>Category 2: Independent interpretation of tests</p> <ul style="list-style-type: none"> • Independent interpretation of tests by another physician or qualified health care professional (not separately reported) <p>OR</p> <p>Category 3: Discussion of management or test interpretation</p> <ul style="list-style-type: none"> • Discussion of management or test interpretation with external physician/ other qualified health care professional/ appropriate source (not separately reported) 	<p>Moderate risk of morbidity from additional diagnostic testing or treatment (would typically review with patient/surrogate, obtain consent and monitor, or there are complex social factors in management)</p> <div style="border: 1px solid red; padding: 5px;"> <p>Examples only:</p> <ul style="list-style-type: none"> • Prescription drug management (note: does not require a written prescription. Saying "no" to a medication [ex. antibiotic] or offering a medically indicated prescription the patient ultimately declines both count toward MDM) </div> <ul style="list-style-type: none"> • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

QUALITY IMPROVEMENT

ANTIBIOTIC STEWARDSHIP | MEMBER POV



J.D. Zipkin, MD, MA, FAAP, FACP

Chief Medical Officer

GoHealth Urgent Care

CUCM Physician Member and Chair of the UCF

Antibiotic Stewardship Taskforce



It is difficult to simply decline antibiotics, and in fact, research shows this is not the most effective technique to avoid unnecessary antibiotic prescribing. The recommended method for pre-emptively avoiding pressure to prescribe antibiotics is to take the following approach:



After your history and exam, summarize your pertinent positive and negative findings, specifically highlighting a lack of purulence or other signs of bacterial infection.



Next, provide your diagnosis, naming the infectious cause, such as "viral sinusitis" or "viral upper respiratory infection." This is a great place to inject empathetic statements about how those viral infections can come with miserable symptoms.



Provide the negative treatment plan, which is what doesn't work. "Unfortunately, antibiotics will not improve your symptoms, and only provide you side effects without benefit."



Follow quickly by the positive treatment plan, which are things that can address the symptoms and get your patient feeling better.



Lastly, go over indications that should prompt follow up or suggest a different diagnosis, such as fever in adults, or prolonged illness. Your patient should feel a sense of support from you and your greater urgent care group until the illness is resolved.

PHYSICAL ENVIRONMENT

AVERAGE EQUIPMENT/CENTER

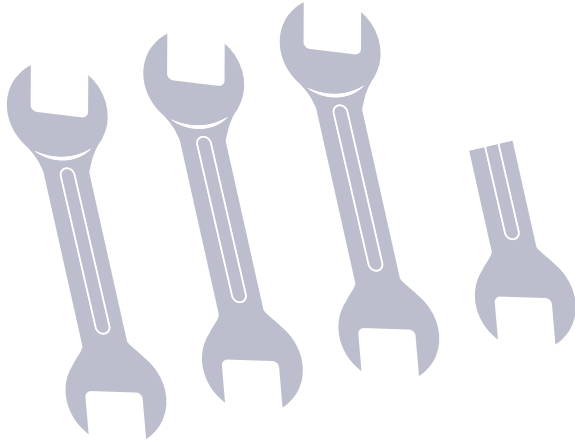
These are the most common devices and the quantity of those devices found in a 6-exam room urgent care center.

ITEM DESCRIPTION	QTY
Refrigerators	2
Defibrillator / AED	1
UV Magnifying / Woods Lamp	1
Vaginal Specula Light	1
Analyzers (Lab)	4*
Blood Glucose Meter	1
Urine Analyzer	1
Nebulizer	2
SpO2 Pulse Oximeter	4
Infant Scale	1
Digital Thermometers	6
Exam Table	6
Otoscope Wall Units	6
Exam Light	1
Benchtop Steam Sterilizer	1
Adult Scale	1
Vital Signs Monitor	2
ECG Machine	1
CBC Machine	1
I-stat	1
HemoCue	1
X-Ray System	1

*In 2020, this number has grown from 2 to 4 due to the high volume of COVID-19 testing.

PHYSICAL ENVIRONMENT

AVERAGE EQUIPMENT/CENTER (CON'T)



AVERAGE NUMBER REPAIRS
PER YEAR PER FACILITY

3.5



AVERAGE COST OF
BIOMED SERVICES

\$28/device

\$128/hour



MOST COMMONLY USED BRANDS IN AN URGENT CARE:

- Welch Allyn
- Ritter/Midmark
- HenrySchein
- McKesson

MOST COMMONLY DEVICES WITH ISSUES:

- Sterilizer
- Vitals Monitor



THANK YOU

We are very grateful to the contributors in the 2nd quarterly issue of the 2021 UCA Benchmarking Report: Experity, JUCM, McKesson, Quidel, Uptime Health and Weaver. Each of these companies are long-time UCA supporters, serving thousands of urgent care centers in their mission to provide on-demand, consumer-focused healthcare – all day, every day.

Because these companies serve such a wide swath of the industry, we were able to present a much more robust set of data points than we could have using the previous “survey” model – providing you with better information to help you benchmark your center.

By studying the data within this report, you have the ability to see if your center’s performance identifies a gap, showcases your success or provides insight into possible operational improvements.

Thanks also to UCA member Dr. Thomas Tryon and Dr. J.D. Zipkin who contributed to this issue, and to our UCA Accreditation surveyors and the UCA Coding Task Force.

We look forward to partnering with other vendor and member experts for future reports and sharing their expertise with you.

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To provide feedback or future topic recommendations, please [click here](#).

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SUMMER 2021 CONTRIBUTORS



Experity is a leading provider of integrated technology solutions that power urgent care. A trusted business partner of more than 5,700 on-demand healthcare practices nationwide, Experity's connected solutions include its patient engagement and clinic software (EMR and PM), billing software (RCM), teleradiology, and consulting services. Experity delivers a superior care experience to an average of 64,000 patients each day by driving innovation and efficiency for urgent care, primary care, hybrid clinics, and testing centers. A Warburg Pincus portfolio company, Experity is a fast-paced, high-growth company committed to improving the urgent care experience for everyone.

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JUCM, The Journal of Urgent Care Medicine® supports the evolution of urgent care medicine by creating content that addresses both the clinical practice of urgent care medicine and the practice management challenges of keeping pace with an ever-changing healthcare marketplace. JUCM is the Official Publication of the Urgent Care Association and the College of Urgent Care Medicine.

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As the leading supplier to Urgent Care Centers across the country McKesson Medical-Surgical provides a comprehensive array of medical supplies, lab products, equipment, pharmaceuticals and vaccines. The company also offers an unparalleled number of technology and productivity solutions all of which are supported by staff specialists and industry experts that help organizations grow and improve their operational, clinical and financial results.

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Quidel is a leading manufacturer of point-of-care diagnostic solutions, delivering a continuum of tests that improve the quality of health care. An innovator for over 40 years, Quidel pioneered the first FDA-cleared point-of-care test for influenza in 1999 and was first to market a rapid SARS-CoV-2 antigen test in the U.S. Quidel's comprehensive product portfolio includes tests for COVID-19. Quidel's mission is to provide patients with immediate and frequent access to highly accurate, affordable testing.

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SPRING 2021 CONTRIBUTORS



UptimeHealth is a software platform that automates compliance and medical device management for urgent care centers. Our system lets practice managers remotely monitor compliance log completions across multiple facilities, manage vendor contracts, receive status reports on equipment inspections/repairs, and utilize analytics to inform repair vs replace decisions.

We save our clients 100s of hours in admin time so they can spend more of their time with patients and other revenue-generating activities.

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Weaver understands the ever changing, complex landscape of health care. While you are focused on helping patients succeed, there are many regulatory compliance and business aspects that are vitally important to the health of an organization. Weaver can help. We have over 70 years of experience providing audit, advisory, and tax services to the health care industry, spanning from institutional healthcare providers to physician practices to life science and biopharmaceuticals.

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