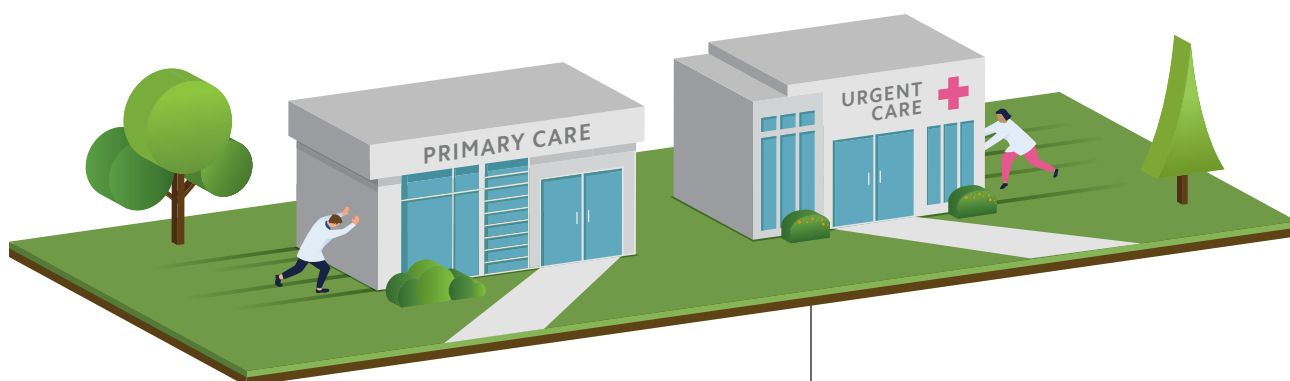


Putting Immediate (Urgent) Care and Primary Care Under One Roof: A Promising Model



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Co-locating primary care and immediate care boosted practice revenue and physician compensation, improved patient access, and mitigated burnout in these clinics.

P rimary care is the most underfunded and undervalued part of our health care system.¹ To provide truly comprehensive primary care, physicians would require a 27-hour workday.² With the ideal team-based approach, the number shrinks to about nine hours per day,² but unfortunately current billing mechanisms are inadequate to support the required dietitians, counselors, nurses, and care managers.

Over the last few years, 71,000 physicians have left the workforce, with primary care and mental health hit hardest.^{3,4} The result is that more than 100 million Americans now lack access to primary care⁵ — meanwhile, health care costs and the prevalence of chronic disease continue to rise.

Despite these headwinds, we will describe in this article a model that can stabilize primary care within our current health care system. By co-locating primary care and “immediate” care — essentially urgent care without urgent care certification — under the same operational umbrella, we improved fiscal solvency, patient access, and clinician satisfaction. While our specific model is no

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longer in effect due to changing institutional priorities, we still believe it holds promise.

IMMEDIATE CARE PLUS PRIMARY CARE: HOW WE DID IT

From 2015 through 2022, we operated three clinics, each offering immediate and primary care. Immediate care took walk-ins, with the ability for patients to make

Our model gave patients the continuity of a primary care clinic with the convenience of an urgent care center.

“on-my-way” appointments, while primary care required advance appointments. The clinics were open for 12 hours on weekdays and 10 hours on Saturdays and Sundays, with the exception of one clinic located in our city’s business district, which was open eight hours on Saturdays and closed on Sundays. Here’s how we ran our operations and paid our employees.

Operations. Our clinics were staffed each day by at least one primary care physician (usually a family medicine physician) and one immediate care non-physician clinician (NPC), such as a physician assistant or nurse practitioner. Each clinician was based at one “home” clinic, but we could rotate them between the three clinics based on staffing needs. If we had open shifts, we made them available for physicians or NPCs at a predetermined hourly rate we had negotiated, and we paid out for them quarterly. We split weekend duties, with

no physician or NPC asked to work more than two weekend days per month. We limited full holidays — when all of the clinics were closed for the day — to Thanksgiving, Christmas, and New Year’s Day. On Memorial Day, July Fourth, and Labor Day we had abridged hours.

Leadership across the three clinics consisted of a medical director, director of operations, and a nurse manager responsible for clinician scheduling, medical assistant training, and quality. Each clinic had one or two front-desk registrars, one medical assistant per clinician, and an office manager. We trained support staff to handle patient flow differently for immediate care versus primary care. For example, primary care patients underwent traditional screenings and medication reconciliation during check-in. Conversely, staff performed check-in and triage faster for immediate care patients, focusing on their presenting complaints and including point-of-care testing and procedure preparation, if necessary.

Immediate care accounted for 70% of total visits. Each clinic saw an average of 45 patients per day, or 3.75 patients per hour, for immediate care. The patient load was not evenly distributed, as two clinics had notably higher volume than the third, which was located in a more residential area.

Each clinic saw an average of 25 patients per day, or 2.1 patients per hour, for primary care. This was also not evenly distributed, as two clinics tended to have lower patient acuity and thus were able to have shorter visits and higher daily volume.

Contracts and compensation. Contracts for our clinicians and ancillary staff were based on hourly or shift rates (similar to emergency medicine), rather than the more traditional days or half days. We defined full-time employment as an annual hourly clinical commitment of 1,716 clinic hours per year (roughly 40 hours per week minus four weeks for paid time off, five days for CME, and 10% for administrative time). That worked out to 33 hours of patient-facing time per week. Shifts for both primary and immediate care were 12 hours on weekdays and 8-10 hours on weekends, meaning most of our full-time employees worked three days per week. Because we focused on an annual hourly commitment, clinicians could front-load or back-load shifts

KEY POINTS

- By combining immediate (urgent) care and primary care under one roof, the authors’ clinics improved patient access, clinician satisfaction, and financial sustainability.
- The hybrid model gave primary care physicians on-site access to resources such as X-rays and medications, while giving immediate care clinicians on-site access to the primary care physician’s input.
- Despite a payer mix that included 31% Medicaid patients, the three clinics had a profit margin of about 5%, while paying clinicians above regional averages.

to accommodate vacations or conflicts. We gave NPCs bonuses based on hours worked and productivity, with small factors for “citizenship” (eagerness to pick up additional shifts, cover for colleagues, etc.). Our primary care physicians had work relative value unit (wRVU) expectations based on costs and Medical Group Management Association (MGMA) averages, with a higher threshold for bonuses, paid out at \$35 per wRVU with a max bonus of 20% of clinical salary.

Although we were part of a large academic medical system, the clinics operated semi-autonomously. We reported to a chair, but had significant latitude to determine staffing, compensation, and service lines.

Inventory and services. Each clinic offered X-ray services, electrocardiogram, point-of-care ultrasound, vaccines, IV fluids, sutures, foreign-body removal, and wart removal. Medications available on site included ceftriaxone, ketorolac, ondansetron, diphenhydramine, promethazine, lidocaine, triamcinolone, and dexamethasone. We also stocked point-of-care tests for influenza, mononucleosis, streptococcus (strep), COVID-19, hemoglobin A1C, and urinalysis, along with ipratropium and albuterol nebulizers and portable oxygen tanks. We contracted with a national laboratory service to provide a phlebotomist on-site at no overhead charge to the practice.

Synergy between primary care and immediate care. Our model gave patients the continuity of a primary care clinic with the convenience of an urgent care center. Primary care physicians and patients had access to immediate care services such as IV fluids or X-rays as needed without having to wait for appointments. Immediate care NPCs had access to real-time, on-site consultations with available primary care physicians and complete patient histories (because of our shared electronic health record system). All of this was available seven days a week.

FINANCES

Our immediate/primary care model was profitable after one year, despite some administrative obstacles that other clinics might not face.

Paneling issues. Accurate patient panel attribution proved to be a challenge.

HOW TO COMBINE PRIMARY CARE WITH IMMEDIATE CARE

- Offer walk-ins for immediate care and advance appointments for primary care.
- Train staff to triage differently, with traditional screenings and medication reconciliation for primary care and shorter check-ins focused on presenting complaints for immediate care.
- When possible, notify primary care physicians when their patients seek immediate care and allow them to consult to maintain continuity.
- Consider establishing separate Tax Identification Numbers (TINs) for immediate and primary care, especially if a large percentage of practice revenue comes from value-based payment (VBP) models that rely on quality metrics and proper attribution.
- Consider seeking certification as an urgent care center (POS-20). This increases payments for immediate care but may require a certificate of need and increase patient co-pays.

Medicare Accountable Care Organizations (ACOs) — and therefore most payers — attribute patients based on the plurality of visits to a primary care specialty under a specific Tax Identification Number (TIN). Because our entire institution functions under a single TIN, payers sometimes inappropriately attributed patients to physicians who co-signed immediate care notes or picked up immediate care shifts.

For example, a 35-year-old man on vacation who isn't already attributed to a primary care provider could seek immediate care from our clinic for strep throat. Under Medicare rules, an ACO could attribute this patient to the primary care doctor who co-signed for the NPC who saw him. In turn, that physician could be penalized for failing to meet key primary care metrics (such as conducting a depression screen). This impacted the accuracy of our patient panels and thus negatively affected our quality metrics. However, because only about 5% of our revenue came from value-based metrics, it had little effect on our bottom line.

Clinics that derive a high percentage of their revenue from value-based payment contracts could avoid this problem by creating separate TINs for immediate/urgent care clinicians and primary care clinicians. We discussed this, but differing institutional priorities prevented us from registering an additional TIN. ►

Urgent care certification. Another administrative factor that negatively affected profitability was our lack of urgent care certification, which is required to bill with place of service 20 (POS-20). Certified urgent care centers are usually able to command 30% higher payments per visit compared to walk-ins at immediate or primary care clinics that bill with POS-11.⁶ Given that 70% of our visits were walk-ins, this would have significantly increased revenue.

However, when it comes to seeking POS-20 certification as an urgent care center, practices should consider the following:

- Many states require a certificate of need,
- Payers often maintain stricter medical necessity requirements, which could increase payment denials,
- Patients usually face higher co-pays compared to POS-11 office visits,
- To maintain compliance with Centers for Medicare & Medicaid Services rules, primary care and urgent care services must be distinct, with separate workflows. For example, primary care should be reserved for disease prevention and chronic disease management, while urgent care should be focused on acute injury or illness.^{6,7}

We discussed seeking urgent care certification, but limited organizational bandwidth and differing institutional priorities ultimately prevented us from pursuing it, hence our use of the label “immediate care” instead.

We estimate that with urgent care certification our profit margin would have approached 6%, rather than 5%.

Revenue and expenses. Our payer mix was also somewhat challenging financially, with about 31% of patients across all clinics covered by Medicaid (compared to about 19% of patients nationally).⁸ Of the remainder, 59% were commercially insured and about 10% were covered by Medicare. We did not see uninsured patients, but did take self-pay. With our combined mix, gross revenue averaged \$148 per visit. Total expenses averaged \$141 per visit, yielding a

reliable net profit margin of about 5% that held up at scale. During our last academic year of operation (2021-2022), our total revenue was \$7.9 million, while expenses totaled \$7.5 million.

Salary and benefits were our largest expense, at about 56.5% of revenue that year (compensation for our clinical staff roughly doubled that of non-clinical staff). We paid all of our clinicians above the 50th percentile, based on Mid-Atlantic region MGMA averages. Starting in our second year, we gave all clinicians annual bonuses, which usually totaled half of our profit margin. The other half we carried over for investments or emergencies.

We spent \$1.58 million, or about 20% of revenue, on required overhead to our academic medical institution, which included billing, insurance, legal, and administration. We estimate that if the clinics were operated independently, these expenses would be significantly lower. Rent, utilities, and medical supplies for our three urban office spaces consumed around \$1 million annually, or roughly 13% of revenue. This could differ widely for clinics based on real estate costs in their area. Bad debt (uncompensated care or services denied by payers) consumed about 3.5% of revenue, and we spent 1.5% on miscellaneous expenses, such as advertising and continuing medical education.

We estimate that with urgent care certification our profit margin would have approached 6%. Despite the lost potential, we deemed our 5% margin remarkable for a primary/immediate care clinic with more than 30% Medicaid patients and significant academic overhead that paid employees above regional averages. Unfortunately, changing institutional priorities resulted in our clinics and staff being folded into a larger department with a more traditional practice model.

A BETTER MODEL FOR PATIENTS AND CLINICIANS

By running immediate/urgent care and primary care under the same roof, our clinics were able to make significant strides in patient access, clinician satisfaction, and fiscal sustainability.

Clinicians reported high levels of satisfaction with our model in voluntary surveys

administered using SurveyMonkey. More than 70% reported compensation that met or exceeded their expectations, more than 70% reported a high level of satisfaction with their work-life balance, and more than 50% reported that our practice model helped mitigate burnout.

Additionally, more than 80% of clinicians reported that the model improved patient access. The improved access came from having primary care open on weekends and extended hours during the week. Having immediate care in-house meant low-acuity and urgent visits for new and established patients were taken off physicians' schedules, which increased their availability for more critical and complex cases. Immediate care also served as a truly significant referral source, both to subspecialists and to empanel new patients for primary care.

Sharing resources gave primary care patients access to phlebotomy, radiology, pharmaceuticals, and other services and procedures often reserved for high-volume urgent care clinics. Patients had one place with the same staff and same EHR to handle acute issues as well as complex chronic disease management and prevention, mitigating siloed care.

Our model also proved flexible enough to handle the immense disruptions in primary care caused by the COVID-19 pandemic. Within days, our clinics pivoted to COVID-19 testing on the immediate care side and implemented telehealth for both immediate and primary care visits. By fall 2022, our three small clinics had conducted 18,834 COVID tests, surpassing the number of tests administered by the rest of our 2,500-employee academic medical organization.

Through our seven years, the reliable revenue from immediate care stabilized the fiscal challenge of providing primary care, especially to high-need populations. Our profit margin remained consistent at around 5%, suggesting a sustainable practice model.

Primary care is the most fundamental part of a health care system. Yet, in the U.S., where fee-for-service predominates,

it is also the most neglected. The question, then, is not how to fashion a better mouse-trap, but how to make our current one less malign.

If our goal is to improve patient access, clinician satisfaction, and fiscal viability

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without a systemic revolution, our hybrid immediate/primary care model can work — and scale. While not a panacea, combining high-volume urgent care with high-quality primary care is one way to weather the storm. **FPM**

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