Shorter Visits Drive Greater Patient Satisfaction in Urgent Care

Urgent Message: Urgent care has long marketed itself as providing immediate care for acutely rising conditions, and true to this reputation, an analysis of clinical and administrative variables in electronic medical records shows the greatest predictor of patient satisfaction is visit duration.

Alan A. Ayers, MBA, MAcc

Citation: Ayers AA. Shorter Visits Drive Greater Patient Satisfaction in Urgent Care. *J Urgent Care Med.* 2025; 19(6):37-43

As a retail delivery channel, urgent care depends on future repeat visits and viral word-of-mouth recommendations from satisfied patients, including positive online reviews and social media mentions. That's why many urgent care centers evaluate the quality and effectiveness of their patient experience in terms of each patient's "likelihood to recommend."

The formal methodology is net promoter score (NPS), which is calculated by asking patients on a scale of 0-10 how likely they are to recommend a service—with higher scores indicating greater customer loyalty and positive perception of the brand. One benefit of NPS is that scores can be compared across industries or to leading brands, from Tesla and Apple to CVS to Kaiser Permanente.

When discussing NPS, 2 metrics are considered. First is the average response to the question: "Based on today's visit, how likely are you on a scale of 0 to 10 to recommend this urgent care?"

The second metric considers the distribution of responses as follows:

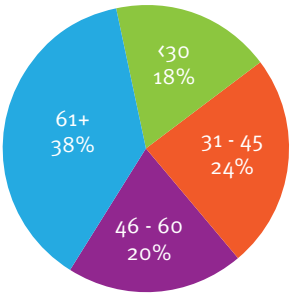
- 9s and 10s are classified as "promoters" because patients are indicating a strong likelihood to recommend the service. These are the loyal fans of a business who want to see it succeed and consider it their "go to" in time of need.

- 7s and 8s are "neutrals," thrown out from the calculation because they're "lukewarm" patients only loyal to the extent they don't come across a better option.
- 0-6s are "detractors," meaning dissatisfied patients with a high likelihood of speaking negatively about their experience. Lower numbers are associated with greater vitriol, which can manifest in negative online reviews, complaints to the medical board, and credit card chargebacks. Detractors seek "jus-

Author affiliations: Alan A. Ayers, MBA, MAcc, is President of Urgent Care Consultants and is Senior Editor of *The Journal of Urgent Care Medicine.*

Little to No Correlation with NPS
• Visits with Radiology • Visits with a Referral • Number of Procedure Codes per Visit • Percent of Visits with a Lab
Some Correlation with NPS
• Percent of Visits with a Prescription • E/M Level of Service • Provider Credentials
Strong Correlation with NPS
• Percent of Labs Performed In-House • Average Visit Duration (negative correlation)

Percent of Visits By Duration (minutes)



tice" by actively undermining a business. Service recovery efforts can "neutralize" detractors, if not turn them into promoters.

Applying this framework, NPS is literally the net of promoters over detractors—equal to the percentage of promoters (9s and 10s) minus the percentage of detractors (0s to 6s). Results are reported both as an average of the 1-10 scores and/or combined into a single number between -100 and +100 with higher numbers being better.

A review of nearly 33 million aggregated patient records in Experity's Electronic Medical Record system from 2024 indicates a nationwide urgent care net promoter score of 84 based on an average survey response of 9.4. This article seeks to identify the datapoints in patient records that are predictive of NPS to demonstrate where to focus patient experience efforts.

Clinical Care Weak Predictor of NPS

Although correlation is not causation, the data seems to indicate that urgent care patients expect to get in and out in less than an hour, receiving their lab tests on-site, and leaving with a prescription.

The complexity of the medical decision making (reflected in the evaluation and management [E/M] level of service) and the number of procedure codes billed per visit do not materially drive NPS. Neither do situations in which a patient receives x-rays or referrals to other providers. One assumption may be that a baseline standard of care occurs across all visits—thus reducing variance among these clinical variables—which leaves wait times to be the primary determinant of NPS.

When a patient must wait for reference lab results—particularly for sexually transmitted infections (STIs)—and also wait for a prescription, the act of leaving urgent care with unresolved issues may lead to a lower evaluation than if they had received a diagnosis and treatment on the spot.

Average Visit Duration Strong Predictor of NPS

The single greatest correlation among the variables studied is the visit duration, defined as the time lapse between check-in and discharge. Variance in visit duration explains almost half of the variance in NPS. The average visit duration nationally is 59.6 minutes, which indicates urgent care generally embraces patient expectations of "in and out in less than an hour." The correlation is negative in that an increase in wait times results in a decrease in NPS.

The chart above shows the percent of visits of various time ranges. Note 42% of patients are in and out in under 45 minutes, while 62% are in and out in an hour or less. Per the table below, visits greater than 60 minutes are associated with greater clinical decision-making.

E/M Level of Service

Evaluation and management (E/M) coding recognizes 4 types of medical decision making: straight-forward; low complexity; moderate complexity; and high complexity. And these 4 types are used across 5 levels of service in outpatient visits. It appears as the complexity of the visit increases, so does NPS—with the exception being service level 5. This is counterintuitive because visit duration likewise increases with the level of service. So, 1 conclusion may be that patients are more tolerant of wait time if they feel it's associated with a higher

Visit E/M Level	Average Visit Duration (minutes)	NPS	Average Visit NPS
1	54	82	9.29
2	56	83	9.31
3	59	84	9.40
4	63	87	9.50
5	70	77	9.07

Average Daily Visits	Average Visit Duration	NPS	Average Visit NPS	Average Daily Visit Count
<19	55	90	9.6	11
20-29	54	86	9.5	24
30-39	58	84	9.4	35
40-49	60	83	9.3	43
50-59	53	91	9.7	50
60-69	63	81	9.3	63
>70	55	83	9.3	82

level of service.

A level 5 service level indicates a patient with a complex medical situation, multiple chronic illnesses with severe exacerbations, or an acute life-threatening condition. A level 5 visit usually involves a longer consultation with the patient to discuss treatment options and potential risks. It may involve the time-consuming administration of oxygen or IV fluids, for example. Because visit duration is negatively correlated to NPS, the longer time required for a level 5 is likely why it results in a lower NPS.

Number of Visits Per Day

Providers in an urgent care setting typically have a capacity of 4 patients per hour or 1 every 15 minutes. In a busy clinic, the arrival of patients can be compared to an assembly line with which providers have to keep pace. We can assume that a provider with surplus capacity who is seeing only 2-3 patients per hour (24-36 over a 12 hour shift) will be less stressed and less likely to "fall behind" on patient throughput and thus get patients in and out more quickly.

The data confirms that as average daily visits increase, visit duration increases, and NPS falls. That is, until the center reaches 50 visits per day, which is typically the point a second provider is added. With a second provider added after 50 patients, NPS jumps as average visit duration falls.

The fall in NPS when reaching greater than 60 patients is likely due to increasing utilization of both providers. It's important to note that only 15% of centers see greater than 50 patients per day on average, so as volume goes up, the sample size decreases. It can be assumed a high volume center can attribute its success to above average service.

Seasonality

Urgent care is a seasonal business, driven primarily by respiratory conditions in the winter months. When staffing remains constant, increased volumes should result in longer waits and thus lower NPS. In both 2023 and 2024, there was an early, 4th quarter "quademic" (influenza, COVID, respiratory syncytial virus, and strep) that resulted in higher-than-average volumes. However, despite seeing a higher proportion of visits in the 4th quarter, there was little variance in NPS. Rather, NPS remained steady across quarters.

Credentials of Rendering Provider

Urgent care patients may be examined, diagnosed, and treated by a nurse practitioner, physician assistant, or physician. While the data indicates only 14.9% of 2024 urgent care visits were rendered by DO or MD physicians, visits delivered by a physician did receive higher average scores. While one might conclude that a physician brings a more authoritative bedside manner or greater efficiency in medical decision making due to more extensive training, whether a physician or advanced practice clinician is seeing patients is based on multiple other factors involving the clinic's ownership and operating model (individual vs hospital vs private equity), which can affect all the other variables impacting scores.

Payer Type

Urgent care centers typically bill insurance, including commercial plans and government programs like Medicare, Medicaid, and TRICARE. Being in-network means the urgent care is contracted and credentialled with a payer, is listed in payer directories, and accepts "assignment" of the insurance payment in full, subject to patient responsibility like co-pays, co-insurance, and

Seasonality of Urgent Care				
	Q1	Q2	Q3	Q4
NPS	85	84	84	83
Average Visit NPS	9.4	9.4	9.4	9.4
Percent of Yearly Visits	25%	23%	24%	27%
2023 and 2024				

Rendering Provider Type	NPS	Average Visit NPS
Nurse Practitioner	83	9.3
Physician Assistant	83	9.2
DO or MD Physician	90	9.5

Payer	NPS	Average Visit NPS
BUCA*	85	9.4
Medicare	92	9.7
Medicaid	85	9.4
Tricare	86	9.5
Self-Pay	85	9.4
**Blue Cross/Blue Shield, United Healthcare, Cigna, and Aetna.*		

Visit Type	Average Visit NPS	NPS	Percent of Visits
Employer-Paid	9.3	82	7%
Miscellaneous	9.4	84	4%
Private	9.4	85	86%
Workers' Compensation	9.2	79	3%

Patient Sex at Birth	NPS	Average Visit NPS	Percent of Patients
Female	85	9.4	57%
Male	85	9.4	43%

Patient Sexual Orientation	Average Visit NPS	NPS
Lesbian, Gay, or Homosexual	9.7	92
Patient Declines	9.5	88
Straight or Heterosexual	9.5	87
Unknown	9.4	85

Patient Race	Average Visit NPS	NPS	Percent of Patients
White Including Hispanic	9.5	87	71%
Black or African American	9.4	84	17%
Other or Multiple	9.3	82	7%
Asian	9.2	78	3%
American Indian, Native Hawaiian, or Alaska Native	9.4	85	1%

deductibles. Some patients choose to pay cash. The patient's insurance is generally not a determinant of NPS except for Medicare.

"Regarding patient age, NPS bottoms out when a patient is in their 20s but then increases after age 30."

Visit Type

A visit may be for a personal illness or injury (private), employer-paid services (EPS) like drug screens and physicals, or for workers' compensation handling a job-related injury.

Unlike a private visit in which the patient chooses to utilize the urgent care on their own, workers' compensation care is typically directed by an employer, entails multiple visits, and entails decisions involving causation, time off work, light or modified duty, and extent of long-term disability. Distinguished from "private," the "miscellaneous" category is a catch-all for non-provider visits like immunizations and blood pressure checks.

A greater number of detractors are found in occupational medicine visits, which may reflect that patients don't care for this type of employer-directed care because they didn't choose it themselves or that patients who disagree with findings of a drug screen or work restriction determination are expressing this dissatisfaction in their score.

Age, Sex, Sexual Orientation, and Race

An ongoing concern for healthcare professionals is identifying and addressing inequities in health care delivery. "Health equity" is the concept that everybody, regardless of circumstances, has a fair and just opportunity to attain their highest level of health.[1]

Interestingly, there is not only difference in NPS reported by patient sex, but those who self-identify as "lesbian, gay, or homosexual" report a higher NPS than those who identify as "straight or heterosexual."

When sorting by patient self-identified race, the highest NPS is among White (including Hispanic) patients, while Black or African-American and Native American patients report slightly less satisfaction. The lowest NPS by race is among patients who identify as Asian.

Differences in NPS by race could perhaps be attributed to historic past disparities in health care and health outcomes.[2]

Last, regarding patient age, NPS bottoms out when a patient is in their 20s but then increases after age 30.

Patient Age (years)	NPS	Average Visit NPS
0-6	82	9.3
7-12	85	9.4
13-18	84	9.4
19-29	74	9.0
30-39	81	9.2
40-49	84	9.4
50-59	87	9.5
60-69	90	9.6
70+	90	9.6

This is perhaps because Gen Z has greater impatience with waiting than older generations.[3] For patients younger than age 18, the survey is most likely completed by the Millennial or Gen X parent or guardian.

Intangibles

Considering the factors that drive NPS, still more than half of NPS is likely determined by non-quantifiable "intangibles." Online reviews frequently cite "rude" staff or providers who "didn't listen to my concerns," but short of asking patients directly, it's nearly impossible to measure patients' perceptions of the friendliness or competence of providers and staff. An overall focus on patient experience is more than getting patients in and out quickly but entails consideration of process, systems, facility, policies, pricing, and every other element of the service.

Conclusion

As a retail healthcare delivery channel, success in urgent care is dependent on providing patient experiences resulting in positive reviews and word-of-mouth referrals. To achieve a higher NPS score, the data indicates there's little more urgent care operators can actively do than focus on reducing door-to-door time while identifying the intangibles that differentiate the brand and cultivate positive emotions with patients. ■

References

1. Centers for Disease Control and Prevention. What is health equity? CDC. Updated October 14, 2022. Accessed January 27, 2025. https://www.cdc.gov/health-equity/what-is/index.html
2. Artiga S, Pham O, Ranji U. How present-day health disparities for Black people are linked to past policies and events. KFF. Published February 24, 2023. Accessed January 27, 2025. https://www.kff.org/racial-equity-and-health-policy/issue-brief/how-present-day-health-disparities-for-black-people-are-linked-to-past-policies-and-events/
3. Gassam J. Dear businesses: Generation Z does not want to hear "please hold." Forbes. Published November 11, 2019. Accessed January 27, 2025. https://www.forbes.com/sites/janicegassam/2019/11/11/dear-businesses-generation-z-does-not-want-to-hear-please-hold/