

Eleven-Year Review of Volume, Financial, and Operational Results of a Physician-Owned Orthopedic Express Care Program: A Retrospective Benchmarking Study

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Objectives: To report the 11-year clinical volume, financial performance, patient demographics, payer mix, and operational outcomes of a physician-owned orthopedic express care (OXC) program, and to benchmark these against published emergency department (ED) utilization and cost data.

Design: Retrospective, observational, single-practice study with a narrative synthesis of implementation, operational, and governance considerations.

Methods: Patient visit volume, charges, revenue, expenses, net income, collection rate, and overhead percentage were obtained from internal practice financial and scheduling records across all OXC sites for the period 2014–2024 (11 years). Patient age distribution and diagnostic case mix by body part were reported for the most recent complete annual period (2025). Payer mix was compared between OXC and primary clinic settings. Previously published data from the authors' 2016 study served as the main benchmarking comparison for OXC versus ED wait times, visit duration, time-to-specialist, and cost per encounter.

Results: Annual patient visits increased from 2,562 in 2014 (single-site) to 21,693 in 2024, with a peak of 22,729 in 2023 (multi-site), reflecting a 747% increase over the period. Total charges grew from \$1,997,509 to \$9,712,336, and revenue rose from \$713,145 to \$4,461,752. Overhead stabilized at 75.2% after peaking at 100.6% during staffing model transitions (2020–2021), resulting in a net income of \$1,098,801 at maturity. Collection rates improved from 35.7% to 45.9%. The OXC captured a significantly higher share of commercially insured patients (64.7%) compared to the primary clinic (42.1%). Compared to published ED data, the OXC achieved 62% shorter wait times (17 vs. 45 minutes), 72% shorter visit durations (43 vs. 156 minutes), 65% faster access to specialists (1.2 vs. 3.4 days), and 94% lower cost per encounter (\$461 vs. \$8,150).

Conclusions: The physician-owned OXC model described was linked to sustained volume growth, a favorable payer mix, and financial stability over a decade of development, along with reductions in costs and better access compared to ED-based care. A phased implementation approach that includes dedicated APP staffing, surgeon oversight, and targeted marketing offers a reproducible framework for orthopedic groups considering OXC development.

Level of Evidence: Level IV – Retrospective Observational Study

Key Words: Orthopedic express care, urgent care, musculoskeletal, value-based care, healthcare economics, patient access

INTRODUCTION

Emergency department (ED) utilization in the United States continues to rise, reaching approximately 155 million visits in 2022, or nearly 47 visits per 100 people annually.¹ Overcrowded EDs, long wait times, and growing patient dissatisfaction have heightened concerns about access and efficiency in urgent care delivery. A large portion of these visits involves musculoskeletal conditions—estimated to make up nearly 30% of all ED and urgent care visits—many of which are low- to moderate-acuity injuries appropriate for treatment outside hospital settings.^{2,3} Usually, these patients are splinted and sent home with instructions to follow up at an orthopedic clinic, often after several days. This process is costly, inefficient, and worsens congestion for patients who truly need hospital-based emergency care such as trauma, stroke, or cardiac services.

Over the last decade, there has been a rapid growth of dedicated orthopedic express care (OXC), often owned and operated by orthopedic group practices. These centers offer prompt evaluation and definitive treatment of ambulatory orthopedic injuries, including fractures, sprains, and postoperative concerns. Recent studies have indicated that OXCs can reduce the time to see an orthopedic provider, shorten total visit duration, and significantly lower per-visit costs compared to hospital emergency departments.^{4–6} In addition to operational advantages, orthopedic urgent care models support broader health system efforts to shift care to lower-acuity, value-based settings, potentially leading to measurable system-level savings.⁷

A decade ago, the authors' large, single-specialty group opened their region's first OXC and reported a 32% increase in national ED visits (from approximately 102.8 to 136.1 million). It was concluded that dedicated OXCs could safely improve access, reduce ED congestion, cut wait times, and significantly lower the cost of care for ambulatory orthopedic injuries.³ Since that publication, the OXC landscape has evolved considerably, influenced by rising patient volumes, payer pressure for value-based care, and new digital modalities. This study revisits the implementation and growth of this essential ancillary service while sharing these strategies with other orthopedic surgeons.

METHODS

This manuscript offers a retrospective, observational, single-practice benchmarking analysis of three physician-owned orthopedic express care (OXC) centers operated by a large, single-specialty orthopedic group. Practice-level financial, operational, and clinical data are reported over time and compared to published emergency department (ED) utilization and cost data. No patient-level identifiers were used. This study was considered exempt from institutional review board oversight because it used de-identified, aggregate practice-level data.

The study period lasted 11 years (June 2014–December 2024), starting with the opening of the first OXC site and continuing through the development of three total sites (opened in 2014, 2015, and 2018). The practice setting is a single-specialty orthopedic group with 35 fellowship-trained surgeons and 26 advanced practice providers (APPs). It includes physician-owned ancillary services such as radiography, MRI, physical therapy, casting, durable medical equipment (DME), and an ambulatory surgery center (ASC). The catchment area covers approximately 827,000 people within a 300-mile radius and is served by 9 rural hospital EDs, 4 hospital-

based EDs, 4 free-standing EDs, and 15 urgent care centers.

Primary outcome measures included annual patient visit volume, total charges, collected revenue, operating expenses, net income, collection rate (revenue divided by charges), and overhead percentage (expenses divided by revenue), extracted from internal practice financial and billing records for each calendar year. Per-partner full-time equivalent (FTE) distribution was calculated for the years when partnership data were available.

Secondary outcome measures included patient age distribution and diagnostic case mix by body part, reported for the most recent complete annual period (2025; $n = 19,558$ patients; $n = 52,775$ coded diagnoses). Payer mix was compared between OXC visits and primary clinic visits using internal billing records, reported as the proportion of encounters attributed to commercial, Medicare, Medicaid, workers' compensation, self-pay, and other payer categories.

Benchmarking comparators were based on the authors' previously published retrospective review (Anderson and Althausen, 2016), which analyzed 12,722 OXC visits and 87,629 ED visits over a 12-month period at the same institution.³ Metrics examined included mean wait time, total visit duration, time from presentation to orthopedic specialist evaluation, and average charge per encounter. External benchmarks included CDC National Center for Health Statistics (NCHS) data on national ED utilization,¹ published literature on ED fracture miss rates,^{8,9} and cost-effectiveness studies of musculoskeletal urgent care models.^{4–7}

The impact of the COVID-19 pandemic (2020–2021) on visit volume, collection rates, and overhead was recognized as a natural experiment during the observation period. Transitions in staffing models—from nonoperative orthopedic surgeons to dedicated APPs to rotating APP schedules—were documented to provide

context for overhead variability. Descriptive statistics were used for all analyses; no inferential statistical tests were performed. All data were aggregated at the practice level and analyzed annually.

RESULTS

Volume Growth

Annual OXC patient visits increased from 2,562 in 2014 (partial inaugural year, single site) to a peak of 22,729 in 2023 across three sites, representing a 787% increase (Figure 1). Growth was fastest during the first five years, with volumes rising from 9,886 in 2015 (first full year) to 19,836 in 2019. There was a dip to 15,579 visits in 2020 during the COVID-19 pandemic, followed by a rebound to 20,320 in 2021. Volumes then stabilized in the 21,000–23,000 range from 2022 to 2024, indicating market saturation at three sites. It took about 5 years and 3 sites to reach the current volume plateau.

Financial Performance

Total charges increased from \$1,997,509 in 2014 to \$9,712,336 in 2024, while collected revenue grew from \$713,145 to \$4,461,752 over the same period. The collection rate improved from 35.7% in 2014 to 45.9% in 2024. Notably, the collection rate peaked at 49.2% during 2020, likely reflecting a shift toward higher-acuity, insured patients seeking alternatives to hospital-based care during the pandemic.

Overhead percentage showed notable fluctuations during staffing model changes, ranging from 68.0% in 2016 to 100.6% in 2021. Between 2019 and 2021, overhead stayed above 92%, with the OXC program incurring a net loss in 2020 (\$6,249) and 2021 (\$22,310). After stabilizing staffing with dedicated APP coverage, overhead decreased to 75.2% by 2024, resulting in a net income of \$1,098,801. The per-partner FTE distribution at maturity was \$52,672.

Patient Demographics

The OXC treated patients across all age groups (Table 1). The pediatric population (ages 0–18) made up

21% of visits (n = 4,014). The largest single age group was 65–74 years (16%, n = 3,104), and patients aged 75 and older accounted for 11% of visits (n = 2,238). The wide age range shows that OXCs serve the entire spectrum of ambulatory musculoskeletal injuries, not just young athletic populations.

Table 1: Age Distribution of OXC Patients (n = 19,558).

Age Band	# of Pts	%
0 - 18	4,014	21%
19 - 24	927	5%
25- 34	1,846	9%
35 - 44	2,232	11%
45 - 54	2,401	12%
55 - 64	2,796	14%
65 - 74	3,104	16%
75 - 84	1,809	9%
85 - 94	403	2%
95 and over	26	0%
	19,558	100%

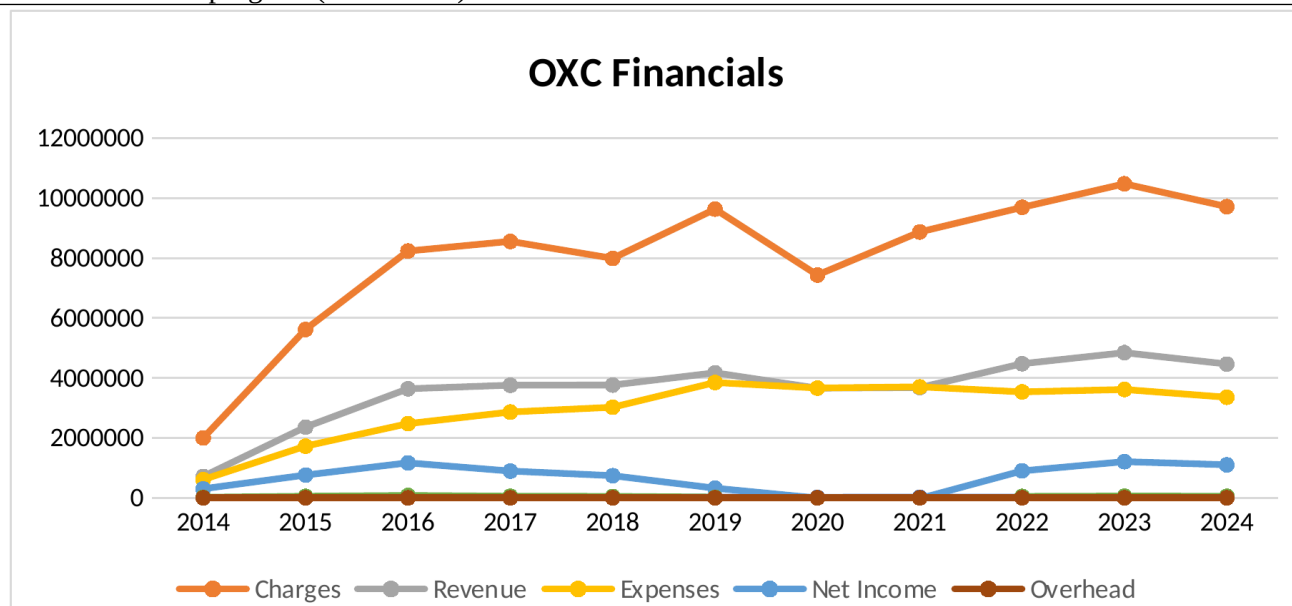
Diagnostic Case Mix

Foot and ankle diagnoses were the most common body regions treated (24%, n = 14,840), followed by the knee (21%, n = 13,229), shoulder (10%, n = 6,336), wrist (8%, n = 5,260), back (7%, n = 4,565), hand/digits (6%, n = 4,043), hip (4%, n = 2,351), and elbow (3%, n = 2,151) (Table 2). These eight body regions accounted for 84% of all coded diagnoses (n = 52,775).

Table 2: Leading OXC Diagnoses by Body Region (n = 52,775 coded diagnoses; 84% of total).

Diagnosis	Count	%
Foot/Ankle	14,840	24%
Knee	13,229	21%
Shoulder	6,336	10%
Wrist	5,260	8%
Back	4,565	7%
Hand/Digits	4,043	6%
Hip	2,351	4%
Elbow	2,151	3%
	52,775	84%

Figure 1: Eleven-year trends in patient volume, charges, revenue, expenses, net income, collection rate, and overhead for the authors' OXC program (2014–2024).



Payer Mix Comparison

The payer mix differed significantly between OXC and primary clinic settings (Figure 2). Commercial insurance accounted for 64.7% of OXC visits compared to 42.1% of primary clinic visits—a 22.6 percentage-point difference. Conversely, Medicare made up 25.7% of OXC visits versus 43.4% of primary clinic visits. Medicaid (5.2% vs. 5.9%), workers' compensation (0.3% vs. 2.6%), self-pay (0.2% vs. 0.05%), and other payers (4.0% vs. 5.9%) showed smaller variations. The higher proportion of commercial payers at OXC suggests better reimbursement prospects for practice revenue.

OXC Versus Emergency Department Benchmarking

Compared to previously published single-institution ED data from the authors' 2016 retrospective comparative study,³ the OXC showed significantly better performance across all measured areas. Average wait time was 62% shorter (17 vs. 45 minutes), total visit duration was 72% shorter (43 vs. 156 minutes), and the time from presentation to orthopedic specialist

evaluation was 65% faster (1.2 vs. 3.4 days). The average charge per encounter was 94% lower (\$461 vs. \$8,150), leading to an estimated system-wide cost reduction of about \$98 million over the 12-month period. Despite diverting orthopedic cases from the ED, overall ED volume and hospital surgical case volume stayed stable during the comparison period.

DISCUSSION

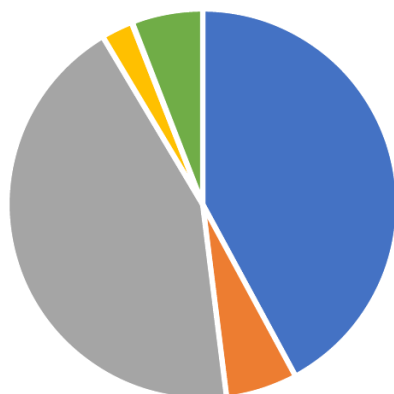
The following sections outline the operational, strategic, and governance considerations based on the authors' ten years of experience implementing and expanding a physician-owned OXC program. These insights are shared as an expert narrative synthesis to complement the quantitative findings presented earlier.

OXC Concept, Nomenclature, and Value Proposition

There are two main purposes of an OXC from a business perspective. First, to improve patient access to value-based care (VBC) outside of an emergency department (ED), and second, to enhance patient retention and follow-up with the practice.

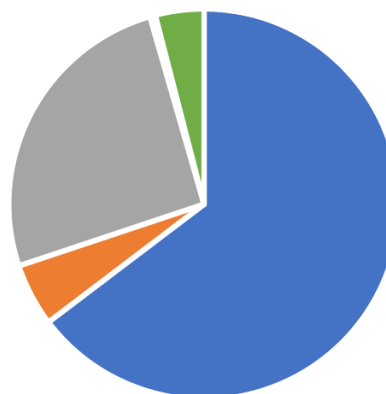
Figure 2: Comparison of payer mix between the primary clinic (left) and OXC (right) settings. Commercial insurance accounts for 64.7% of OXC visits compared to 42.1% of primary clinic visits.

Primary Office Payer Mix



■ Commercial ■ Medicaid ■ Medicare
■ Workers' Comp ■ Self-Pay ■ Other

OXC Payer Mix



■ Commercial ■ Medicaid ■ Medicare
■ Workers' Comp ■ Self-Pay ■ Other

However, practices should not view the OXC as just an additional revenue source in the traditional sense, given the immense value of access and retention. In reality, the OXC may even struggle to "break even" through direct revenue alone, but its true value lies in the indirect revenue it generates.

As the quantitative results above show, OXCs effectively redirect ambulatory musculoskeletal patients from EDs to specialist-focused settings. Besides volume and financial outcomes, diagnostic accuracy improves when musculoskeletal injuries are assessed directly by orthopedic providers. Studies indicate that a significant number of fractures are initially missed in the ED. One review found that 13–20% of pediatric fractures on ED radiographs were not identified on first interpretation, and another reported miss rates of up to 26% for specific fracture types such as hand phalanges.^{8,9} These findings highlight the potential benefit of orthopedic urgent care centers in enhancing diagnostic precision and prompt management. Injury-to-surgery times are also reduced as patients are immediately matched with the appropriate specialists.

Since an OXC is a direct extension of the primary practice, it should be stocked with the same supplies and durable medical equipment (DME) that are already widely available at practice locations. Dedicated treatment and casting rooms within an OXC enable basic procedures (e.g., injections, reductions, wound care) to be performed without the need to outsource to another location or ED.

The OXC can be referred to by various names in nomenclature. Many of these terms are familiar to patients, such as orthopedic urgent care, musculoskeletal urgent care, fast-track orthopedic services, and walk-in orthopedic clinics, to name a few. After much deliberation before the formation of the authors' first OXC, a very intentional decision was made to choose this terminology from both a patient perspective and a business standpoint.

First and foremost, OXCs are not usually considered urgent care centers in the strict legal sense. This can cause confusion medicolegally, but the term "urgent care" means something different from a tax perspective, requiring a separate tax ID and insurance arrangements. This was something that the authors'

practice, along with many others, chose to avoid because of the significant hassle involved. In many ways, designating a true urgent care center is like starting a new practice from scratch. Instead, by labeling OXCs as such, the centers keep the primary tax ID and insurance processes of the practice, using a doing business as (DBA) agreement. Overall, this approach is much simpler to implement and ensures patients pay typical specialist fees instead of high urgent care copays, aligning perfectly with the goals of VBC.

From a patient perspective, the OXC should represent speed, efficiency, and the highest quality musculoskeletal care possible. Generally, the terms urgent care and walk-in clinic can be confusing for patients and may imply services such as non-musculoskeletal treatment or social aspects of a needs-based “free” clinic. When seeking an OXC, patients who are knowledgeable enough to avoid the ED want quality care, interaction with specialists, and the confidence that they have made the best choice for their musculoskeletal needs. The OXC should have a separate entrance if a shared office space is used and should never accept appointments. A clear cash price list for services is essential for non-traditional payors to improve access and inclusivity, along with options to schedule and pay for services before the visit. In short, the OXC signals patient access, specialty care, and community recognition, all of which are vital to its success.

Medicolegal Considerations and Implications

Before exploring further details of OXC installation and management, it is important to outline the general regulatory and operational principles that govern ancillary services. Canton et al. previously described the basics of the Stark laws, along with their 2020 reforms, and the Anti-kickback statute (AKS).¹⁰ These rules provide the framework for compliance, ethical practice, and sustainable revenue distribution. Fortunately for orthopedic practices, these reforms have

simplified the process for physician-owned entities to stay compliant while pursuing growth. Orthopedic groups can confidently operate in-house imaging, PT, DME, urgent care centers, and ASCs as long as patients maintain freedom of choice and revenues are distributed through compliant models. Importantly, CMS has signaled support for physician ownership when it clearly enhances value, efficiency, and patient outcomes.^{11,12} In short, Stark law and AKS are not applicable to the OXC if it is a DBA of the primary practice.

Practice Setting and OXC Development History

The authors’ practice is a large, single-specialty orthopedic group with 35 surgeons and 26 advanced practice providers (APPs). The group employs fellowship-trained surgeons across all orthopedic disciplines, including trauma, sports, arthroplasty, spine, plastics-hand, foot and ankle, pediatrics, and oncology. Recently, the group has expanded its goal of offering the top limb preservation service (LPS) by hiring two fellowship-trained vascular surgeons to support its flap-capable plastic hand surgeons and trauma team. The practice is a fully integrated orthopedic group with physician-owned x-ray (XR), magnetic resonance imaging (MRI), physical therapy (PT), casting services, durable medical equipment (DME) supply, and an ambulatory surgery center (ASC). The city and surrounding 300-mile radius serve a population of 827,000. The area includes nine rural hospital emergency departments (EDs), four hospital-based EDs, four free-standing EDs, and fifteen urgent cares, many operating seven days a week.

In June 2014, the authors’ large, single-specialty practice opened the first dedicated OXC in the region staffed by physician assistants (PAs) and supervised by orthopedic surgeons. The OXC facility was not built as a standalone building but was developed on the first floor of the authors’ current 70,000-square-foot office building. A 2,000-square-foot center with three

examination rooms, a 15-person waiting area, a three-bay cast room, and a dedicated x-ray room was established. The urgent care was staffed daily by a nonoperative orthopedic surgeon or PA, a medical assistant, a cast technician, an x-ray technician, and two front desk personnel. Operating hours were Monday through Saturday from 7 AM to 7 PM. Patients were initially seen and treated by the nonoperative orthopedic surgeon or PA, and an initial care plan was created. A backup system was implemented for urgent or emergent referrals to ensure that surgical patients could see a specialist the same day. All follow-up appointments were scheduled with the orthopedic surgeon specializing in each diagnosis. Simple reductions, injections, wound closures, and other minor procedures were performed at the OXC. The business plan, construction, and daily operations were managed solely by the authors' practice administrators. No consulting fees or external costs were paid to third parties. Marketing efforts included billboards, radio, and newspaper advertisements.

In 2016, Anderson and Althausen's retrospective review of the physician-owned OXC evaluated and compared 12,722 urgent care visits to 87,629 emergency department (ED) visits over a 12-month period.³ The OXC achieved significantly shorter wait times (17 vs. 45 minutes), reduced total visit durations (43 vs. 156 minutes), and faster access to orthopedic specialists (1.2 vs. 3.4 days). The average charge per visit was \$461 compared with \$8,150 in the hospital ED, resulting in an estimated system-wide cost savings of nearly \$98 million. Despite diverting orthopedic cases, overall ED volume and hospital surgical cases remained stable. The urgent care generated substantial net revenue for the orthopedic practice, demonstrating that dedicated musculoskeletal urgent care centers can improve access, efficiency, and affordability of orthopedic care while benefiting both patients and providers. Since then, the authors' group has opened two additional OXCs, one in

2015 and another in 2018, with plans to open more locations in 2025 and 2026.

Over the past 10 years, the OXC has grown from 9,886 patients annually in 2015 to 21,693 in 2024. The data shows it took about 5 years and 3 sites to reach current patient volumes. Charges increased from \$1,997,509 in 2014 to \$9,712,336 in 2024, with revenues of \$4,461,752 and expenses of \$3,355,632 in 2024, leaving \$1,098,801 for distribution to the partnership as ancillary service revenue. This amounts to roughly \$52,672 per partner. Over the decade, the COVID-19 pandemic did not significantly reduce visits, as patients continued to avoid hospitals; however, the collection rate improved from 35.7% in 2014 to 45.9% in 2024, with a temporary peak of 49.2% during COVID-19. As the group experimented with different staffing models, overhead varied significantly from 68% to 100%, but has now stabilized at 75% (Figure 1).

Expansion Considerations

The decision for a practice to grow with the establishment of an OXC is complex and should be carefully considered. It is not suitable for every practice and should not be pursued solely to generate immediate ancillary income. A group must evaluate building costs, staffing, and market conditions, similar to the considerations involved when hiring a new physician, as described by Via et al.¹³

The initial step for a growing practice should be to add more hours and days to clinics for providers to increase access for their patients. Once this has been maximized, consideration for OXC establishment can start. An early decision in the process is whether the OXC should be a standalone facility. If space allows within the main practice location, adding an OXC can be a great option. If this isn't feasible or already implemented, and the group wants to expand further, practices need to choose their target geographic market. Options include placing the OXC near a competing

group or hospital, or in a completely new market. Practices can analyze patient volume from hotspot zip codes or strategically select areas with little to no access to specialty orthopedic care.

OXC Revenue and Marketing

As previously noted, developing an OXC should not be driven solely by hopes of direct revenue. Although the OXC has the potential to be profitable depending on market needs, its main goal is to increase access for patients, with additional profits and benefits coming from patient retention and follow-up visits. Interestingly, the authors observed that a larger share of patients with commercial insurance participate in visits at the OXC compared to primary clinics (Figure 2).

When marketing an OXC, it must be a carefully planned effort that focuses specifically on the OXC rather than the main practice. Independent marketing helps ensure consistent brand recognition and can range from low-cost methods to more significant financial investments for the group. The simplest approach is to start by promoting the OXC to current staff and patients through newsletters and emails. Educating staff about the purpose and presence of an OXC allows them to act as free ambassadors for the service. Additional efforts should include grassroots community outreach, such as engaging with local blogs and social media, daycare centers, school athletic programs, school training rooms and their athletic trainers, local sporting events, senior centers, parades and festivals, and chambers of commerce. Creating low-cost banners can produce substantial returns in these venues. More advanced tactics include donating medical supplies or kits to these organizations with consistent branding visibly displayed on the products. It's also essential to support the OXC with well-lit signage that complies with local laws and restrictions for 24/7 visibility. Higher-cost marketing channels like billboards, radio, television, and geofencing can be considered once the earlier options

have been used and only if the budget allows. The most effective choice among these costly options depends entirely on the target market for the OXC.

OXC Staffing and Oversight

Multiple options exist for staffing the OXC, and the authors have tried them all. The most effective approach appears to be having a base team of advanced practice providers (APPs) with specialized orthopedic training relevant to the OXC. These APPs can either be dedicated solely to the OXC or rotate from within the practice. However, practices must ensure that dedicated APPs do not become isolated from the primary practice and feel involved and valued as part of the overall organization. Occasionally, shifting duties to retired surgeons or other interested providers as needed can be beneficial for per diem staffing. The authors have observed that non-operative sports medicine and primary care physicians may not be as well-suited for staffing the OXC since they might lack the comprehensive knowledge needed for the full range of orthopedic conditions. The figures below illustrate that the OXC serves patients of all ages and conditions effectively, so APPs must be well-trained. Additionally, strategically placing dedicated casting technicians can help manage high demand and allow providers to focus on seeing new patients.

Regardless of staffing considerations, it is essential that each shift has immediate access to an "on-call" orthopedic surgeon. The "on-call" surgeon can be chosen based on specialty or follow the overall call schedule. The authors provide representative ages and diagnostic codes related to OXC visits (Tables 1 & 2).

The authors use a practice where a traumatologist, who sees patients in the primary clinic each day of the week, is available for immediate consultation by an APP of the OXC. This service provides direct, one-on-one consultation between the surgeon and the APP if there are any concerns about

patient management, follow-up, and temporization. Additionally, some traumatologists may choose to speak with patients live on the phone or have patients directed to the primary office or the surgery pre-op clinic for real-time management. This approach has significantly improved patient satisfaction, according to the authors' experience.

Each OXC location must also have a dedicated on-site manager to ensure the proper allocation of care and resources. Managers do not necessarily need to be a healthcare provider (HCP); however, they must have prior knowledge and experience with orthopedic centers. Often, these individuals are hired from within the practice and have previous experience with the organization. Overseeing the entire OXC operation must be an elected medical director who is a surgeon from the primary practice. The medical director's role is to address any concerns among OXC staff, patients, and providers of the practice. Since this can, and should be, an active and involved role, a stipend for this orthopedic surgeon is required.

Ensuring Quality of the OXC

Maintaining a consistently high-quality product is essential for success. A comprehensive curriculum should be developed for all new APPs to ensure they understand how the office manages patients and routine orthopedic conditions. Surgeons from each specialty must commit to ongoing education and lectures on key topics to keep OXC providers current and relevant. During the first 3-6 months of employment, APPs rotate weekly through each orthopedic service to learn how each specialty approaches the most common conditions seen in the OXC, as having a consistent approach is critical. Physicians have more training and education than APPs, and our policy states that patients initially seen at OXC should not receive follow-up care there; instead, they should see the most qualified specialist for their condition during their first follow-up. The authors

have found that APP follow-up after a patient has been initially seen at the OXC by an APP results in the lowest patient satisfaction scores. Practices must allocate appropriate clinic time for surgeons to see relevant patients after the establishment of care at the OXC. Furthermore, at the authors' institution, OXC providers are not permitted to order advanced imaging without surgeon follow-up at the primary practice.

Regular performance reviews are essential, and a physician from each specialty should be assigned to the OXC for consultation as needed. The authors have found that this should be a surgeon already in the clinic so that relevant imaging can be reviewed quickly, and advice provided within minutes. OXC staff should not send patients to the ED without consulting an on-call physician who will make this judgment based on the available data. All OXC providers at the authors' institution undergo a 6-month evaluation period, during which surgeons oversee and assess the provider's skill development. This further ensures consistent delivery of a service directly attributable to the primary practice.

Keys to OXC Success

There are many keys to success for OXCs. Extended evening and weekend hours allow access for working adults and attract pediatric patients injured during sports or recreational activities. Staffing models that depend on APPs or nonoperative orthopedists under close clinical supervision help maintain efficiency while reducing costs. Patients should leave with clear instructions and prompt follow-up in the outpatient office. Additionally, expanding OXC sites into strategic neighborhoods or communities enhances competitive positioning against other orthopedic groups and hospital systems. An OXC can serve as a good introduction to rural communities, offering specialty care at a reasonable price and improving access for a patient population in need. Physicians should never direct their postoperative patients to the OXC and must ensure they

are seen by other physicians of similar fellowship training in the outpatient clinic. OXC managers and the medical director are essential in addressing any concerns related to these issues.

Limitations

This study is limited by its single-practice design, reliance on retrospective administrative data, and use of previously published single-institution comparator data. The absence of a concurrent control group and the descriptive nature of the analysis prevent causal inference and highlight potential selection bias related to referral and access patterns. Findings may not be generalizable to practices of different size, specialty mix, or geographic setting.

CONCLUSIONS

In summary, the OXC is a transformative extension for orthopedic groups aiming to expand their practice. It bridges the gap between the ED and traditional outpatient clinics by providing immediate, specialty-driven care for ambulatory musculoskeletal injuries. OXCs improve access, diagnostic accuracy, and patient satisfaction while reducing ED congestion and supporting VBC initiatives. From a business perspective, OXCs enhance patient retention, streamline downstream revenue, and strengthen a practice's regional presence—even if direct profitability is modest. The authors' decade-long experience shows that when carefully designed, efficiently staffed, and clinically integrated within the primary practice, OXCs can become a cornerstone of modern orthopedic care, aligning patient-centered access with sustainable, physician-led growth.

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