EB MEDICINE

The Hidden Economics of Clinical Capability

5 WAYS UNDERTRAINING CAN QUIETLY ERODE URGENT CARE FINANCIAL PERFORMANCE

EXECUTIVE BRIEF



OPPORTUNITY/COST
How much are capability gaps already costing your system?

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Urgent Care Executives and Leadership Teams

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Urgent care organizations measure visit volume, patients per hour, net revenue per visit, labor expense, transfers, patient satisfaction, turnover, online ratings, and claims. But one of the forces influencing every one of those outcomes is rarely tracked with the same discipline:
CLINICAL CAPABILITY.



Executive Summary

When leaders evaluate clinical education, the conversation naturally begins with a familiar question: What will this training cost? But there is another question worth asking: What is undertraining already costing us?

The answer rarely appears neatly on a line item labeled education. Instead, insufficient clinical readiness may reveal itself downstream: a patient who could have been appropriately treated but is transferred; an otherwise-routine encounter that takes longer than necessary; a clinician who requires prolonged backup; an employee who never develops the confidence expected of the role; a patient whose disappointing experience becomes a public review; or a missed diagnosis that leads to a malpractice claim.

These five hidden costs — ***unnecessary transfers, wasted time, burnout and turnover, brand erosion, and risk exposure*** — should not be interpreted as five equally measurable consequences or five outcomes caused solely by training. They are better understood as five opportunities for clinical capability to dramatically improve enterprise performance.

The objective of this white paper is not to argue that training eliminates every transfer, wipes out wasted time, prevents turnover, guarantees patient satisfaction, or eliminates malpractice. It does not. The proposition is more measured: When gaps in clinical preparation contribute even modestly to recurring variation in frontline performance, their economic effects can compound across clinicians, shifts, locations, and patient encounters.

Clinical capability is more than an educational concern. It is an operating asset.

A credential gets a clinician in the door...



Capability determines where they go from there.

A license establishes authority to practice. Credentials establish qualifications. Neither automatically establishes readiness for every condition, procedure, diagnostic decision, or operational expectation encountered in a particular urgent care setting.

Clinical capability is more practical. Can the clinician recognize what cannot be missed? Can the clinician efficiently manage the common conditions the organization expects its centers to treat? Can routine procedures be performed confidently and safely? Can the clinician distinguish patients who can be treated in urgent care versus those who truly require escalation? Can those decisions be made consistently without unnecessary hesitation, testing, consultation, or handoffs?

When capability is strong, its effects are often invisible. The patient is evaluated. The procedure is completed. The chart moves. The patient receives an appropriate disposition. When capability is weak, organizations often measure only downstream symptoms and problems.

This distinction matters. A transfer may be entirely appropriate. A clinician may be slower because of workflow rather than knowledge. An employee may leave because of low compensation or scheduling conflicts. A patient may complain about parking.

Clinical capability is not the explanation for every performance problem. But it is a sufficiently important variable that leaders should be able to recognize it.

Figure 1. The Capability-to-Performance Model

Revenue Retention	Throughput & Capacity	Workforce Stability	Patient Experience	Clinical Risk
Can we keep the patients who need care we are equipped to provide?	Can clinicians make routine decisions and perform routine work efficiently?	Can clinicians reach proficiency and grow in the organization? Do they stay?	Can clinicians consistently deliver on the brand promise?	Can clinicians recognize risk, manage within scope, and escalate?

HIDDEN COST #1:

Avoidable Transfers = Dollars out the Door

Transfers are unavoidable if we are to provide safe urgent care. The goal is not fewer transfers at any cost. Appropriate escalation protects patients and systems. The operating issue is the unnecessary transfer: sending patients elsewhere for care that the center has the capabilities and resources to provide because the treating clinician lacks sufficient preparation, proficiency, or confidence.

Consider a patient who arrives for treatment of a traumatic laceration at a center that advertises injury treatment and laceration repair. The clinician is uncomfortable managing the wound and sends the patient to the emergency department. From the clinician's perspective, that decision may feel conservative, but it's important to ask: Was the transfer clinically necessary — or was it capability-driven?

If the patient could have been managed appropriately at the urgent care center, the organization has failed to convert existing patient demand into care/revenue.

The national median zero-balance net revenue per visit was $163.91. The range was $112.90 to $299.38.

Source: Experity. Based on visits recorded between Nov. 1, 2024 and Oct. 31, 2025

Current urgent care reimbursement data help establish the potential magnitude. An Experity analysis published in the *Journal of Urgent Care Medicine* examined 17,410,492 commercially insured urgent care visits recorded between November 1, 2024 and October 31, 2025. The national median zero-balance net revenue per visit (NRV) was $163.91. Results varied widely by state — from $112.90 to $299.38 — reinforcing why each organization should substitute its own actual revenue figure to gauge impact.[1]

Table 1. What One Retained Visit Per Week Can Represent in Revenue

System Size	Additional Retained Visits/Year*	Immediate Annual Visit Revenue
1 Center	52	$8,523
10 Centers	520	$85,233
25 Centers	1,300	$213,083
50 Centers	2,600	$426,166
100 Centers	5,200	$852,332

*This example assumes one additional appropriately retained visit per center per week, 52 weeks/year, and $163.91 NRV. It excludes procedure-specific incremental reimbursement, downstream visits, ancillary revenue, and patient lifetime value.

It takes a healthy mix of qualitative and quantitative data to estimate potential revenue lost to avoidable transfers. Mine for metrics within your EHR and operational dashboard and prepare to make a few scientific wild-ass guesses (SWAGs) to determine how often your clinicians should've/would've/could've retained patients — and fees — instead of transferring them elsewhere.

Table 2. The Cost of Avoidable Transfers

Metric	Useful Segmentation
Transfer rate	Site, clinician, diagnosis
Potentially avoidable transfer rate	Diagnosis/procedure, clinician tenure
Transfer destination	ED, specialist, other center
Training exposure	Pre-/post-onboarding, by skills program/CME source

Step 1 - IMMEDIATE VISIT REVENUE OPPORTUNITY	
Average avoidable/capability-driven transfers per center per week	
Number of centers	
Operating weeks per year	
Average NRV	$
ESTIMATED ANNUAL REVENUE FROM ADDITIONAL VISITS Formula: Transfers/week × # of centers × weeks × NRV	**$** 0

Step 2 - POTENTIAL PROCEDURAL REVENUE OPPORTUNITY Enter only revenue above your average NRV. For retained transfers already counted in Step 1, use the procedure visit's revenue minus your average NRV. For patients who were seen but referred out for a procedure, use the full procedure revenue.	
Average incremental procedure revenue associated with applicable encounters	$
Annual applicable encounters	
ESTIMATED POTENTIAL ANNUAL REVENUE FROM ADDITIONAL PROCEDURES	**$** 0

Step 3 - POTENTIAL REPEAT-CARE VALUE OPPORTUNITY	
Number of retained patients expected to return within 12 months	
Average number of total additional visits among returning patients	
Average NRV per visit	$
ESTIMATED REPEAT-CARE REVENUE Formula: Number returning × average additional visits/returning patient × average NRV per visit	**$** 0

HIDDEN COST #2:

Clinical Uncertainty Costs Time

Urgent care is fundamentally sensitive to time. Uncertainty in the form of repeated chart reviews, procedural hesitation, redundant testing, delayed disposition, or overreliance on experienced clinicians is costly. Losing or gaining a few minutes per encounter seems inconsequential, but losses or gains across thousands of encounters are a very big deal.

Clinical efficiency is not simply a personality trait. Efficiency can be developed through preparation, practice, repetition, and standardized approaches. That does not mean every slower clinician can simply be trained to work faster, and speed should never be pursued at the expense of safety. It means some sources of clinical friction can be identified to improve performance.

Table 3. Where Capability Friction Hides

Observable Clinician Behavior	Possible Capability Component	Operational Effect
Repeated consultation on routine presentations	Diagnostic confidence/readiness	Provider + supervisor time
Avoiding procedures	Procedural proficiency	Transfer + lost capacity
Excessive chart review	Diagnostic/documentation uncertainty	Longer encounter cycle
Redundant testing	Medical decision-making uncertainty	Time + cost + patient experience
Slow disposition	Risk/disposition uncertainty	Room occupancy + throughput
Frequent handoffs	Scope or confidence gap	Productivity loss due to staff interruptions
Prolonged double coverage	Extended and/or incomplete ramp up to independence	Labor inefficiency

Table 4. What Could Saving Five Minutes Per Encounter Mean for One Center?

152 hours recovered/year →	228 potential additional visits/year →	$37,290 potential annual revenue
35 encounters/week × 5 minutes saved × 52 weeks ÷ 60	Recovered hours × 1.5 additional visits/hour	Additional visits × $163.91 net revenue/visit

Small time savings can create meaningful capacity and revenue across a year.

Illustrative estimate per center. Revenue depends on sufficient patient demand, staffing, and scheduling to use the recovered capacity. Figures shown are rounded; calculations use unrounded values.



Table 5. Where Is Clinical Friction Taking Time? Could Training Improve Performance and Outcomes?

Metric	Baseline
Median/mean visit duration	
Patients per clinician-hour	
Backup/consult interruptions per shift	
Selected procedure duration	

Table 6. How Much Could Clinical Friction Be Costing Us?

RECOVERED ANNUAL HOURS	YOUR DATA
Eligible encounters per clinician or center per week	
Average minutes potentially recoverable per encounter	
Operating weeks per year	
RECOVERED ANNUAL HOURS FORMULA: Encounters × minutes × weeks ÷ 60	

POTENTIAL CAPACITY VALUE	YOUR DATA
Incremental visits per recovered hour	
Recovered annual hours	
Potential additional visit opportunities	0
Average NRV	$
UNADJUSTED CAPACITY VALUE	**$** 0

REALITY CHECK - CONVERTIBILITY	YOUR DATA
What percentage of recovered capacity realistically can be converted to additional visits?	
ADJUSTED ESTIMATED OPPORTUNITY	**$** 0

HIDDEN COST #3:

Burnout & Turnover Dilute Capability

Turnover may be one of the most directly measurable hidden costs because organizations can estimate both departure frequency and replacement expense.

SullivanCotter reports a median external APP turnover rate of 8.6% in its *2025 APP Compensation and Productivity Survey* data. Certain specialties, including emergency medicine and behavioral health, reported rates exceeding 14%.[2]

The financial impact is substantial. Using its *2024 APP Organizational and Leadership Survey* and market research with large APP groups, SullivanCotter estimates direct turnover costs at $93,000 at the 25th percentile, $120,000 at the median, and $147,500 at the 75th percentile.[2]

When indirect effects such as lost productivity, burnout, and patient care disruption are considered, the estimated total range rises to $150,000 to $250,000, with a median of $187,500.[2]

Those figures are broad benchmarks, not cost estimates specific to individual urgent care organizations. They help illustrate the scale of the problem and should be replaced with internal data when available.

The more useful concept is capability replacement cost. When an experienced clinician leaves, the organization does not merely replace an employee. It recruits, credentials, orients, onboards, covers schedules, absorbs a productivity ramp, and asks experienced staff to invest time and effort rebuilding the contribution of the former team member.

Figure 2. Costs of Clinician Turnover



Why Development Belongs in the Retention Conversation

Clinicians leave organizations for many reasons: compensation, schedule, workload, leadership, culture, family considerations, and burnout. Education is not a universal retention remedy, but it is a factor to consider.

A systematic review of 27 studies, predominantly in healthcare, found that continuing training or professional development opportunities were associated with stronger intention to stay and lower turnover intention.[7]

A separate systematic review of nurse and physician retention identified job satisfaction, career development, and work-life balance among the principal factors associated with retention.[8]

SullivanCotter's APP-specific analysis found that ineffective orientation was among the factors correlated with APPs considering departure. Its recommended strategies include stronger onboarding and mentoring, opportunities to practice at the top of their license, availability of clear paths toward career advancement, and training to expand procedural and clinical skills.[2]

Table 7. Estimate Your Clinician Replacement Costs

Cost Component	Your Estimate
Recruitment/advertising	$
Recruiter/HR time	$
Sign-on/relocation	$
Credentialing/licensure	$
Temp/locums/overtime	$
Paid orientation time	$
Mentor/preceptor time	$
Productivity ramp-up	$
Admin/leadership time	$
Other	$
EST. COST/DEPARTURE	**$** 0

# of APP departures/year
× Replacement cost/APP
= ANNUAL TURNOVER COST

What's your estimate?

$

If turnover decreased by _____ % per year, how much would you save in replacement costs?

What's your estimate?

$ 0

HIDDEN COST #4:

Clinician Capability Can Make or Break Your Brand Promise

Healthcare organizations frequently think of brand as something created by marketing. Patients experience it differently: They experience the brand when they arrive.

- How long do patients wait?
- Do clinicians seem prepared when they walk in the room?
- Do clinicians introduce themselves?
- Do they ask the "right" questions, and do they listen?
- Do they perform thorough exams?
- Is the center able to provide the service it advertised?
- Do clinicians explain why they order certain tests or perform needed procedures?
- Do they explain the diagnosis clearly?
- Do patients know what they are supposed to do after they leave?

Contemporary consumer research tells us that the clinician-patient relationship is increasingly important. In its 2024 survey of 1,000 healthcare consumers, Press Ganey reported that ratings and reviews of providers were the number-one selection factor during the consumer research phase. Survey results also showed that consumers read an average of 4.7 reviews before choosing a provider, and 83.5% said they at least occasionally use online reviews to validate a referral.[5]

How Do Consumers Choose?

- Favorable ratings/reviews are the #1 selection criteria
- They read an average of 4.7 reviews before choosing
- 84% use online reviews to validate a referral

Source: Press Ganey[5]

- 86% read online patient reviews
- 73% require at least a four-star rating; for urgent care, the average is 4.4

Source: Reputation.com[6]

Reputation.com's 2024 healthcare research reported that 86% of consumers read online patient reviews before selecting a provider and 73% required at least a four-star rating to consider a healthcare brand. Its urgent care data reported an average 4.4-star rating, placing expectations high in this sector.[6]

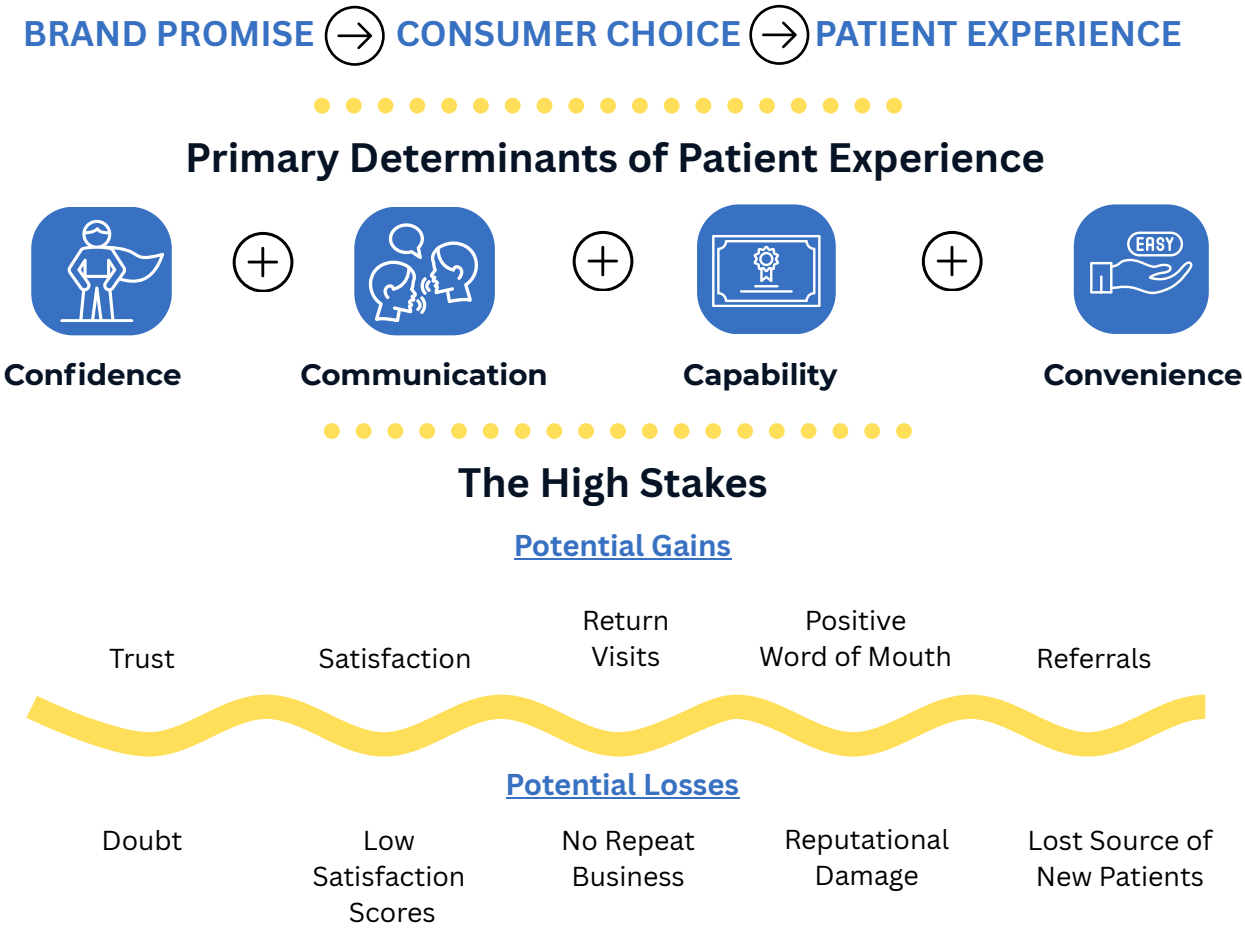
These findings do not prove that a particular capability gap causes patients to go elsewhere. They demonstrate something more defensible: clinical experiences now leave highly visible, searchable signals that can influence future healthcare choice.

Marketing makes the brand promise. Patient experience makes it believable…or not.

Table 8. Brand/Capability Audit

Review/Complaint Theme	%	Could Capability Be a Contributor? How So?
Long wait/slow visit		
"They couldn't treat me"/transfer		
Clinician uncertainty		
Poor explanation/communication		
Procedural experience		
Misdiagnosis/changed diagnosis		
Administrative issue		

Figure 3. The Association Between Brand and Patient Experience



HIDDEN COST #5:

Clinician Capability Gaps Are Risky Business in Urgent Care

The fast-paced, high-volume environment of urgent care creates a perfect storm for clinical risk. Complicating relentless pressure on throughput with the range of patient complaints, variable acuity, limited access to medical records, and fragmented follow-up sets the scene for diagnostic failure.

Whether attributable to faulty medical decision making, unseen red flags, or another medical misstep, incorrect diagnoses represent the single-largest driver of malpractice claims in urgent care.

While no strategy can eliminate risk, education is a powerful shield. Targeted training boosts clinician capability and confidence, sharpens medical decision making, improves diagnostic accuracy, helps protect against claims, and may reduce exposure to malpractice claims.

Based on these risk management benefits, investing in clinical education redefines a line-item expense as a vital layer of institutional protection that deserves high-priority executive consideration.

Table 9. Risk/Capability Crosswalk

Review each high-risk area using your organization's incident reports, claims and near-miss data, transfer patterns, chart audits, patient complaints, clinician assessments, and medical director observations. Identify where formal training exists, whether competency is assessed, and where additional action may be warranted. Add organization-specific risks as needed.

High-Risk Area	Event/ Near-Miss Frequency	Current Training?		Competency Assessed?		Capability Gap/Mitigation Plan
CARDIOPULMONARY & NEUROLOGIC	**%**	**Yes**	**No**	**Yes**	**No**	**Notes**
Chest pain/acute coronary syndrome		☐	☐	☐	☐	
Syncope		☐	☐	☐	☐	
Palpitations/dysrhythmias		☐	☐	☐	☐	
Dyspnea/acute respiratory distress		☐	☐	☐	☐	
Abnormal/high-risk EKG findings		☐	☐	☐	☐	
Acute dizziness/possible posterior circulation stroke		☐	☐	☐	☐	
Headache with secondary-cause red flags		☐	☐	☐	☐	
Focal neurological deficit/possible stroke/TIA		☐	☐	☐	☐	

High-Risk Area	Event/ Near-Miss Frequency	Current Training?		Competency Assessed?		Capability Gap/Mitigation Plan
INFECTIOUS, PEDIATRIC & WOMEN'S HEALTH	**%**	**Yes**	**No**	**Yes**	**No**	**Notes**
Sepsis/occult serious infection		☐	☐	☐	☐	
High-risk fever/febrile infant or child		☐	☐	☐	☐	
Anaphylaxis/severe allergic reaction		☐	☐	☐	☐	
Pediatric respiratory emergency		☐	☐	☐	☐	
Pediatric head injury		☐	☐	☐	☐	
Skin/soft-tissue infection & high-risk abscess		☐	☐	☐	☐	
Pelvic pain/ectopic pregnancy/torsion		☐	☐	☐	☐	
Pregnancy/postpartum red flags		☐	☐	☐	☐	
ABDOMINAL, TRAUMA, PROCEDURES & IMAGING	**%**	**Yes**	**No**	**Yes**	**No**	**Notes**
Abdominal pain/surgery		☐	☐	☐	☐	
Orthopedic injury/fracture/dislocation		☐	☐	☐	☐	
Hand injury		☐	☐	☐	☐	
Limb-threatening Injury		☐	☐	☐	☐	
Radiographic interpretation		☐	☐	☐	☐	
Lacerations/compound wound repair		☐	☐	☐	☐	
Foreign body/deep structure injury		☐	☐	☐	☐	
PRESCRIBING, DISPOSITION & DOCUMENTATION	**%**	**Yes**	**No**	**Yes**	**No**	**Notes**
Antibiotic selection/stewardship		☐	☐	☐	☐	
Steroid selection/stewardship		☐	☐	☐	☐	
General medication error		☐	☐	☐	☐	
High-risk disposition/failure to escalate		☐	☐	☐	☐	
Diagnostic test interpretation/failure to act		☐	☐	☐	☐	
Document red flags/rule-outs/follow up		☐	☐	☐	☐	

Build the Business Case for Clinical Capability

Start with the outcome you want to improve — and define how you will measure it.
Clinical education is easier to evaluate when it begins with a clearly identified capability need and desired operational outcome.

Table 10: From Opportunity to Outcome Roadmap

Complete this statement before selecting or implementing a capability-building clinical training program:

We believe strengthening clinical capability in _____

has the potential to improve _____, **which we**

currently measure as _____.

Steps	Your Input
1. Identify the capability opportunity.	
2. Define the desired operational outcome.	
3. Establish the baseline KPI.	
4. Define the clinician cohort.	
5. Select the capability-building intervention.	
6. Establish the investment required.	
7. Define the expected improvement.	
8. Measure capability after the intervention.	
9. Recheck the operating KPI at 30/60/90 days	
10. Calculate observed value and ROI, where appropriate.	

The objective is not simply to purchase education. It is to make a deliberate investment in clinical capability by identifying opportunity → establishing the baseline → intervening with education → measuring improvement → quantifying enterprise value.

Qualitative Value Variables

Patient Experience
Clinical Consistency
Clinician Confidence
Risk Recognition
Diagnostic Accuracy
Standardization Across Locations
Leadership/Mentor Time
Speed to Independent Proficiency

Not every important outcome needs to be converted into dollars to belong in the investment decision.

Table 11. Capability Investment Calculator

Project costs, benefits, and ROI before you invest.

1. Define the investment.	
Training program cost	$
Paid clinician training time	$
Implementation/administration	$
TOTAL	**$** 0

2. Identify where measurable value may be created. (Fill in data for those that reasonably apply.)

Potential Value	Current Annual Baseline	Expected Improvement	Dollar Input	Estimated Annual Value
Appropriate visits/avoidable transfers retained			$	$ 0
Additional capacity/throughput			$	$ 0
Appropriate procedural/service revenue retained			$	$ 0
Staff stability/turnover and replacement cost avoided			$	$ 0
PROJECTED ANNUAL VALUE				**$** 0

3. Calculate Projected ROI

[(Projected measurable value - total capability investment) ÷ total capability investment] x 100 = _____ %

Projected ROI

Figure 3. 5 Problems That Look Different on the P&L

Operational Observations	Traditional Owner	Executive Lens
1. Unnecessary transfer	Clinical operations	Revenue/demand conversion
2. Slow encounter	Operations	Capacity/throughput
3. Clinician burnout	Human resources	Capability replacement/EBIDTA
4. Negative patient experience	Marketing/patient experience	Brand/future demand
5. Adverse clinical incident/outcome	Legal/QA/medical leadership	Enterprise risk



What May Be Lurking Behind the Metrics

The metrics urgent care operators and leaders monitor so closely — transfers, throughput, turnover, patient experience, and clinical risk — may appear to work independently. But sometimes they share an upstream influence: clinical capability or lack thereof. Looking behind the KPI can reveal where greater readiness, proficiency, or consistency may improve performance.

The goal is not to assume training is the answer, but to ask better questions; identify where capability may influence outcomes; target the right intervention; establish a baseline; and measure what changes. This turns clinical education from an activity to assign to clinicians into a performance investment that can be evaluated against organizational outcomes.

Table 12. Connecting Performance Metrics to Clinical Capability

Dashboard Metrics	Questions Worth Asking
Transfer rate/retained care	Are clinicians unnecessarily transferring cases they are expected and equipped to manage? Which diagnoses/procedures account for potentially avoidable transfers? Do clinicians receive targeted training in those areas? After training, do transfer and procedure-completion patterns change?
Patients per hour/encounter efficiency	Where is clinical uncertainty adding time? Are clinicians losing time to repeated consultation, diagnostic hesitation, procedure uncertainty, redundant testing, or documentation? Which of those sources of friction might be improved through training? Does targeted education improve proficiency, time to decision, or throughput?
Backup dependence/ independent proficiency	Has the clinician reached expected independent proficiency? Which presentations or procedures most often require help from a senior clinician? Are those needs incorporated into onboarding and ongoing education? Does backup dependence decrease as capability improves?
Turnover/retention	Are onboarding, support, utilization, and professional growth meeting workforce needs? Do clinicians feel prepared for the work expected of them? Are capability and confidence improving during onboarding? Could stronger clinical development shorten the difficult transition to independent practice and support retention?
Patient experience, complaints, reputation, NPS scores	Are clinical execution issues contributing to unmet patient expectations? Are complaints or reviews associated with delays, transfers, inability to provide an expected service, clinician uncertainty, or poor explanation of the care plan? Could stronger capability improve the experience the organization promises and patients actually receive?
Clinical events, incident reports, near misses, claims	Are identifiable readiness gaps part of the risk picture? Which diagnoses, procedures, or disposition decisions recur in incident reports, peer review, near misses, or claims? Is training aligned with those areas of exposure? Are competency, red-flag recognition, escalation decisions, and documentation assessed rather than simply taught?

LOOK FOR CONNECTIONS: When a KPI reveals an opportunity, look upstream. Identify the clinical capability that may influence it, target the training, establish the baseline, and measure what changes.

We do not simply employ clinicians. We promote and nurture the clinical capability those clinicians need to perform. That capability develops over time through evidence-based education, thoughtful onboarding, mentoring, practice, feedback, standardization, assessment, and experience.



Executive Reflection

As an urgent care leader, you have an opportunity to evaluate clinical education as you do other investments in organizational performance: Identify the desired outcome, establish the baseline, define the investment, project a reasonable range of improvement, and measure what changes.

For one organization, the most immediate opportunity associated with boosting clinician capability may be retaining more clinically appropriate visits. For another, it may be shortening the time required for newly hired APPs to reach independent proficiency. Others may prioritize procedural capability, clinician retention, diagnostic readiness, patient experience, or consistency across locations as the highest priority.

Not every benefit of training needs to be monetized to pay off. And not every improvement can be attributed to education alone. But when an organization establishes its baseline before launching a training program or an educational initiative and measures both capability and operating outcomes afterward, leaders can move beyond assumptions and begin building their own evidence for value.

Over time, training becomes more than an annual budget overhead allocation. It becomes a measurable strategy for strengthening the capability of clinicians who direct and deliver patient care, thus driving financial performance. What you once thought of as the education budget will be better defined as a capability investment.

Clinical capability is more than an educational concern. It is an operating asset.

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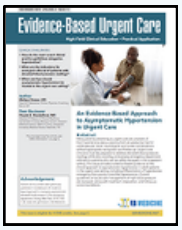
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Selected EB Medicine Capability-Building Courses:



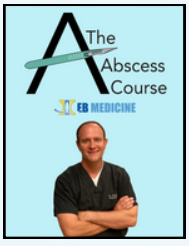


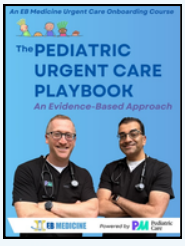


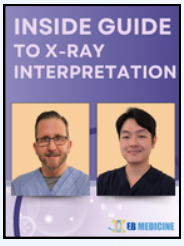






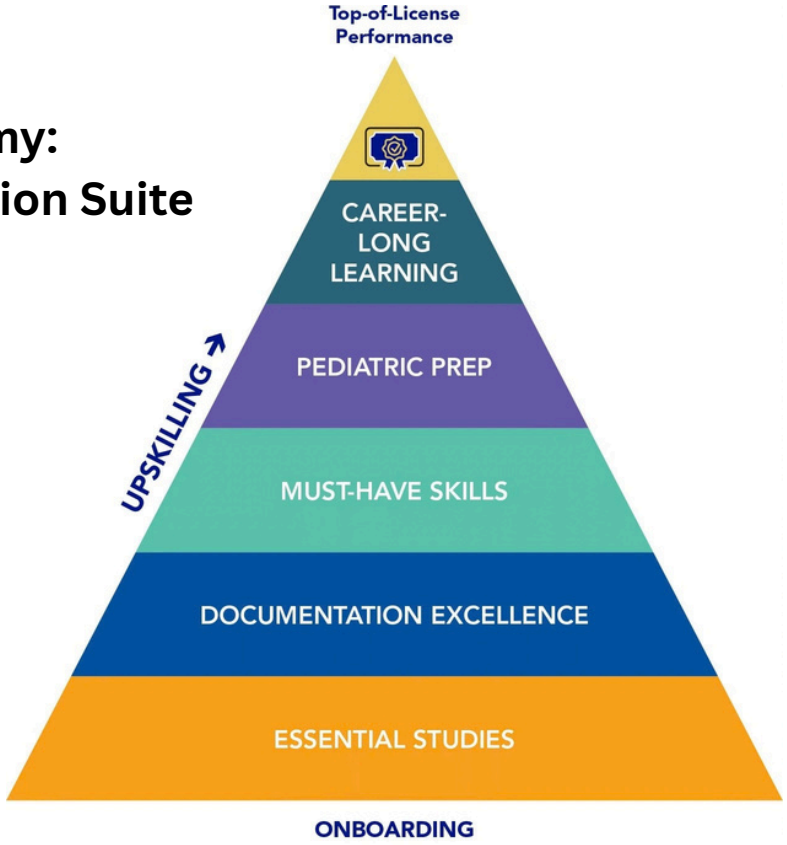






EB Medicine Upskill Academy: Urgent Care Clinical Education Suite

EB Medicine's Upskill Academy is a comprehensive onboarding and ongoing education program designed specifically for urgent care teams. It brings together evidence-based resources, hands-on procedural training, and practical documentation tools to standardize care, build clinical confidence, and strengthen compliance across all locations.



About Upskill Academy

Upskill Academy combines EB Medicine's full urgent care education library into one cohesive program, designed to meet the needs of both new and experienced providers. It includes:

- *Evidence-Based Urgent Care* monthly journal
- The Laceration Course
- The EKG Course
- The Inside Guide to X-ray Interpretation Course
- The Abscess Course
- Rightsizing Reimbursement: How To Code for What You're Owed
- Safeguarding Charting: Documentation Support That Will Stand Up in Court
- Pediatric Urgent Care Playbook
- Steroid Stewardship: Protect Your Patients & Your Practice from the Harms of Overuse
- Antibiotic Stewardship in Urgent Care Practice

KEY BENEFITS

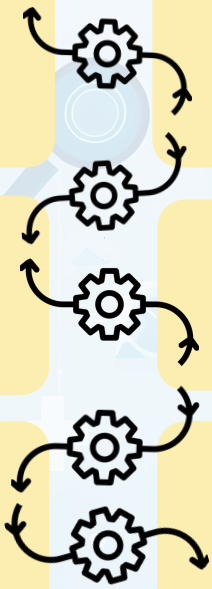
- **Build Procedural Confidence:** Structured, repeatable training for high-frequency skills such as laceration repair, abscess I&D, and EKG interpretation.
- **Standardize Care Across Clinics:** Evidence-based content developed by practicing urgent care clinicians to align clinical decisions and reduce variability.
- **Improve Documentation & Coding Accuracy:** Tools that reinforce proper documentation practices, safeguard against audits, and optimize reimbursement.
- **Streamline Onboarding & Remediation:** Assignable CME courses support structured onboarding and targeted remediation when needed.

Learn More: www.ebmedicine.net/upskill-academy
Watch the overview video (3 min) with Dr. Patrick O'Malley

Clinical excellence in urgent care is an upskill climb.

EB MEDICINE

START WITH ONE OPPORTUNITY...



... use what you learn to guide your next investment.

ABOUT EB MEDICINE:

EB Medicine partners with urgent care organizations across the country to strengthen onboarding, improve clinical consistency, and build clinician confidence. We help urgent care leaders reduce variability, identify training gaps, and equip clinicians with the knowledge, procedural skills, and decision support they need to deliver high-quality care on every shift.

Evidence-Based Urgent Care is a one-of-a-kind monthly resource that delivers timely, comprehensive, clinical content on common and can't-miss chief complaints. Urgent care groups also rely on a full suite of high-yield procedural and best-practices courses, such as *The Laceration Course, Rightsizing Reimbursement, The Inside Guide to X-Ray Interpretation, The Pediatric Urgent Care Playbook*, *Safeguarding Charting*, *The EKG Course*, and more.

These practical, evidence-based resources are key components of EB Medicine's Upskill Academy, a turnkey, enterprise-wide educational platform designed to meet urgent care groups' clinical, operational, and training objectives. The Upskill Academy is a fully customized clinical education solution, purpose-built to support exceptional urgent care.

Want to learn more?
Email: groups@ebmedicine.net
Call/text: 770-262-0339
Visit: www.ebmedicine.net/urgent-care-groups

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