A Biopsy of Urgent Care Quality: Insights from 3000 Chart Reviews

Roger Wu, MD, MBA, FACEP

April 13, 2026

Financial Disclosure

- No relevant relationships to disclose.

THE ORIGINAL
BEEF
OF CHICAGOLAND
FX
THE BEAR

THE ORIGINAL BEEF
CAUTION - HOT

“Yo, they’re goddamn forks!”

“What are you making?”

“I’m just peeling mushrooms for
the Lamb des Tournelles.”

“Peeling mushrooms?”

"It's just a nice little, fun detail, so when the diners see it, they know that someone spent a little time on their dish."

What are the “peeled mushrooms” signals in urgent care?

Roger Wu, MD, MBA, FACEP

Co-founder & CEO, Medraki

Attending Physician, Utah Emergency Physicians

Director of Medical Education, Carbon Health

Comparative Study > J Surg Educ. 2012 Jan-Feb;69(1):41-6. doi: 10.1016/j.jsurg.2011.05.015.
Epub 2011 Aug 27.

Monitoring universal protocol compliance through real-time clandestine observation by medical students results in performance improvement

Catherine A Logan [1], Brienne D Cressey, Roger Y Wu, Adam J Janicki, Cyril X Chen, Meena L Bolourchi, Jessica L Hodnett, John D Stratigis, William C Mackey, David G Fairchild

Joint Surgery / Emergency Medicine Morbidity & Mortality Conference

September 2, 2015
Roger Wu, MD, MBA
Chief Resident
Brown University / Rhode Island Hospital Department of Emergency Medicine

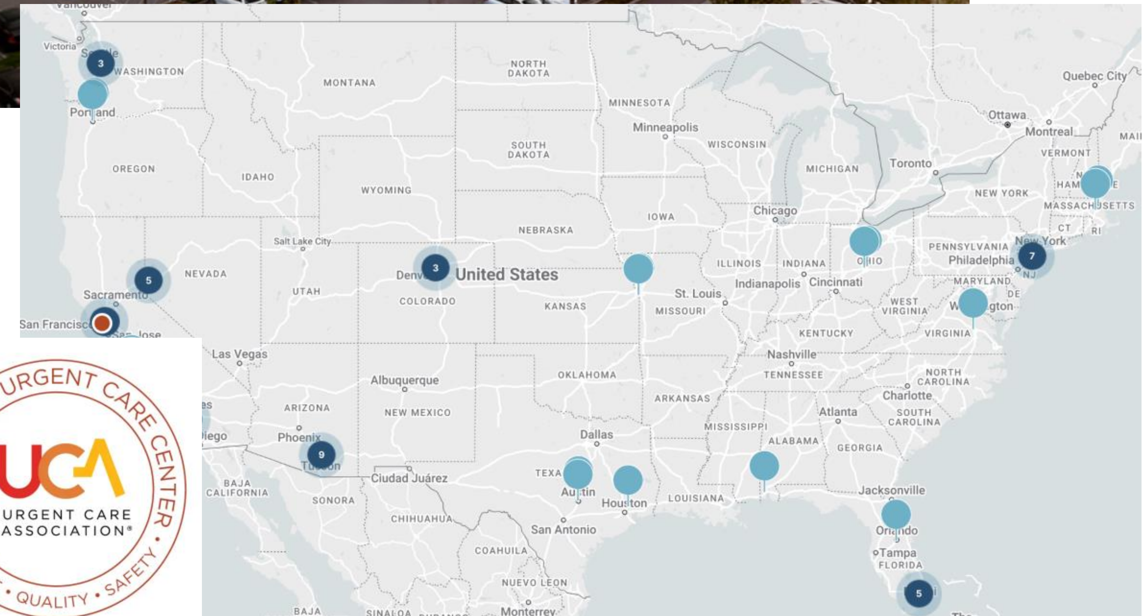
Comparative Study > J Surg Educ. 2012 Jan-Feb;69(1):41-6. doi: 10.1016/j.jsurg.2011.05.015. Epub 2011 Aug 27.

Monitoring universal protocol compliance through real-time clandestine observation by medical students results in performance improvement

Catherine A Logan [1], Brienne D Cressey, Roger Y Wu, Adam J Janicki, Cyril X Chen, Meena L Bolourchi, Jessica L Hodnett, John D Stratigis, William C Mackey, David G Fairchild

Joint Surgery / Emergency Medicine Morbidity & Mortality Conference

September 2, 2015
Roger Wu, MD, MBA
Chief Resident
Brown University / Rhode Island Hospital Department of Emergency Medicine



Financial Disclosures

Medraki (Booth 726)

Learning Objectives

- Describe the historical evolution of clinical quality measurement and its limitations when applied to urgent care settings.

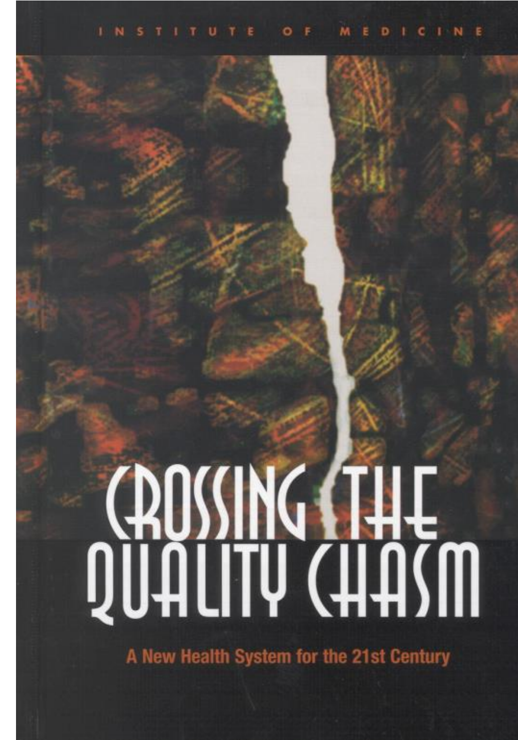
- Evaluate existing frameworks for measuring urgent care quality and identify the gaps each framework leaves unaddressed.

- Apply insights from ~~3000~~ 16,000 chart review data to identify patterned clinical quality failures and opportunities for improvement in urgent care practice.

A Brief History of Clinical Quality Assessment

Ernest Codman, 1910s

Avedis Donabedian, 1966



IOM's Crossing the Quality Chasm, 2001

Value-Based Care, 2010s–Present

Frameworks (Mostly Borrowed) for UC Quality

Framework	What It Measures	What It Misses
MIPS	Antibiotic stewardship	Clinical reasoning
UCA Accreditation	Organizational systems	Individual clinician performance
Press Ganey or NPS	Patient experience	Clinical appropriateness
Return Visit Rates	Downstream outcomes	Why the outcome occurred
Chart Reviews	Process and reasoning	Outcome linkage

Describe your current practice setting.

A. Solo owner-operated clinic

B. Multi-site practice (<10 sites)

C. Multi-site practice (10+ sites)

D. Multi-site practice across different states

E. Multiple service lines (e.g. primary care and workplace health)

F. Other

How does your practice currently measure clinical quality?

A. Patient experience (e.g. NPS and Google Reviews)

B. Incident reporting (e.g. Jira, medical malpractice, etc.)

C. Externally defined metrics (e.g. MIPS)

D. Chart reviews

E. None of the above

F. Other

Who in your practice currently performs chart reviews?

A. Supervising physicians

B. Medical directors

C. Peer-to-peer

D. Me

E. Other

Which charts are reviewed?

A. All charts

B. Random percentage of charts

C. Self-selected by the rendering clinician to send to the reviewer

D. Pre-defined criteria (e.g. chief complaint, age, procedures)

E. Cases flagged through incident reporting (e.g. complaints)

F. Clinicians being remediated or onboarded

G. Other

How are the charts reviewed and feedback given?

A. Informally (i.e. reviewers follow their own systems)

B. EHR inbox

C. Google Form

D. Email

E. Third-party software

F. Monthly or quarterly meetings

G. Other

Do you track whether feedback changes behavior?

A. Yes

B. No

You can tell the quality of the carpenter by looking at the back of the drawers.

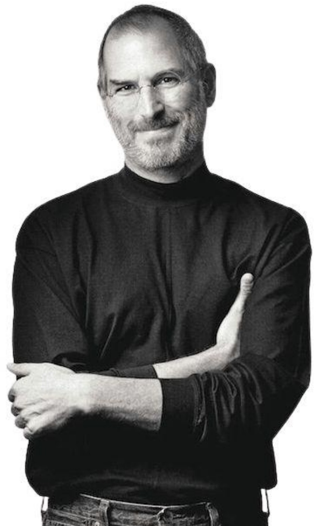


Chart Reviews (All Areas)

Your email will be recorded when you submit this form

* Indicates required question

Case #1

MRN #1 *

Your answer

Date of Service *

Date

mm/dd/yyyy

	Yes	No	N/A
Was the management plan justified in the MDM (e.g. CXR not ordered due to...)?	○	○	○
Were abnormal vitals addressed and repeated?	○	○	○
Were high risk conditions specifically considered and discussed in the MDM?	○	○	○
Was there a clear plan for follow up?	○	○	○

Feedback for Case #1

Your answer

A biopsy of urgent care quality…

16,236 individual case reviews across 678 clinicians by 155 reviewers

- Was the management plan justified in the MDM (e.g. CXR not ordered due to…)?
- Were abnormal vitals addressed and repeated?
- Were high risk conditions specifically considered and discussed in the MDM?
- Was there a clear plan for follow up?
- Free text feedback

A biopsy of urgent care quality…

Domain	Pass Rate
MDM Justified	96.6%
Follow-Up Plan	97.2%
High-Risk Considered	93.6%
Abnormal Vitals Addressed	72.4%

A biopsy of urgent care quality…

Domain	Pass Rate
MDM Justified	96.6%
Follow-Up Plan	97.2%
High-Risk Considered	93.6%
Abnormal Vitals Addressed	72.4%

Insight #1: Abnormal Vitals Are the Single Biggest Clinical Gap

- When a patient has an abnormal vital sign, clinicians fail to address and repeat it 27.6% of the time.
- Examples:
  - Elevated BP with no repeat
  - Tachycardia in a patient with a recent DVT
  - Borderline vitals in elderly patients

A clinician who addresses the abnormal vital sign, documents a reason or repeats it – that's someone who took the time.

Insight #2: Documentation and Diagnostic Reasoning Are the Dominant Feedback Themes

Theme #1: Justification Gaps

"Rx for antibiotic given but documentation did NOT justify the Rx."

"Why not I&D this? Would justify that in the MDM, since you called this an abscess."

"I don't have any understanding of why you sent this patient to the ED for vertigo. I also don't have a clue why you ordered a UA."

"Need to make a stronger justification for antibiotic use at 4 days of URI symptoms."

Theme #2: Internal Contradictions

“Antibiotics were prescribed, but MDM discusses waiting for CXR results."

"Exam documentation explicitly states 'there is no sign of bacterial infection' yet the patient was treated with antibiotics."

"Remember: just because a patient says they have recurrent UTIs does not mean they actually are UTIs unless culture confirmed. At this visit, her urine culture was actually negative."

"It was documented that the patient had RLQ pain but stated no signs of appendicitis — this is very contradictory. Patient should have been sent to ED."

Theme #3: Physical Exam Complaint/Exam Mismatch

"OP exam not noted, when chief complaint was sore throat. Not obvious why asthma implicated in acute sore throat as potential etiology."

"For an ear lavage, physical exam should demonstrate there is a cerumen impaction. There should also be a repeat exam to assess that the TM is intact."

"A focused examination of the injured body part should be done at every worker's comp visit. Right hand exam missing."

"Did you really do a HEENT exam as thorough as documented?"

Theme #3: Physical Exam Complaint/Exam Mismatch

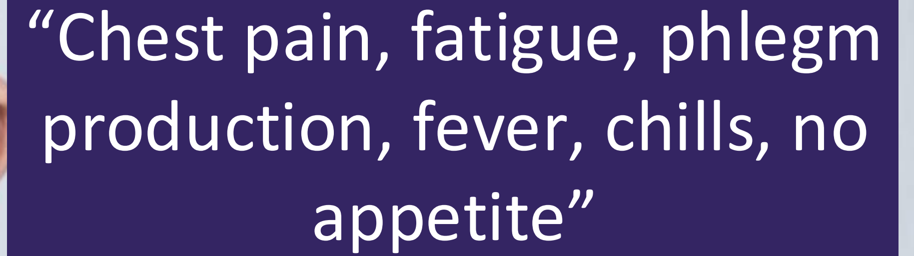
"Missing visual acuity exam — this is considered the vital sign of the eye. Very important to evaluate severity of eye injuries."

"Unclear why urgent ortho referral was made — knee exam not complete (e.g., presence of effusion?)"

"Given viral symptoms and fever, would add Kernig and Brudzinski test and specific mention of no meningismus, photophobia, phonophobia."

URGENT CARE

49yo M presenting with “General Urgent Care”



"Symptoms are localized to the chest, specifically the sternum"

2 days

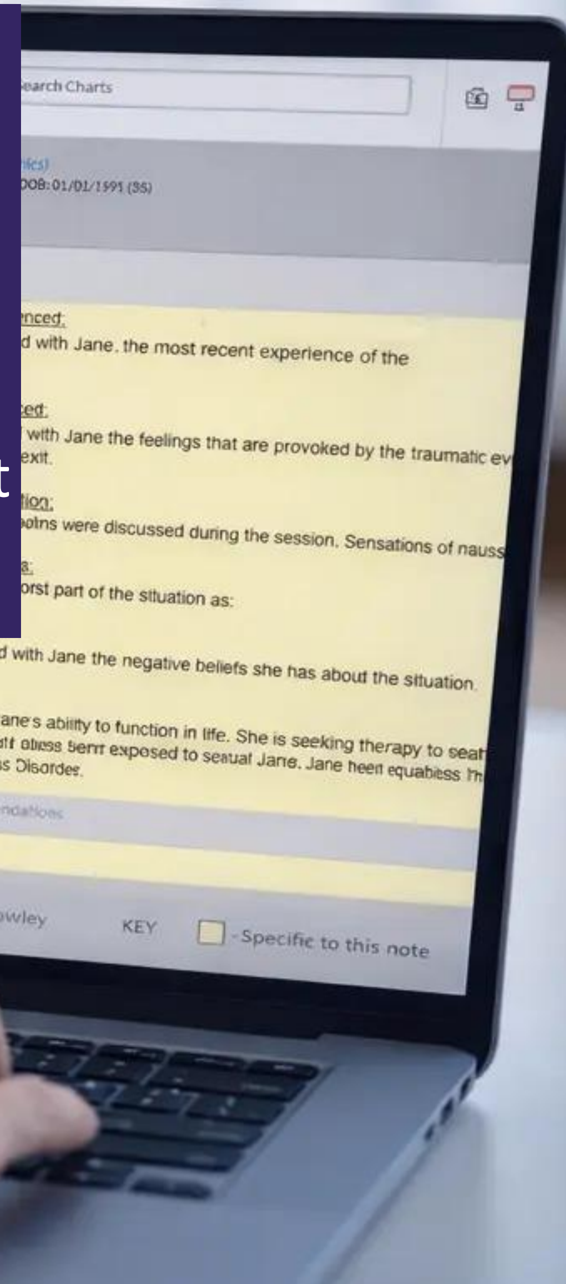
No sick contacts

"Cardiovascular examination revealed normal heart sounds with no murmurs, gallops, or rubs. Pulmonary auscultation was clear without crackles or wheezes.

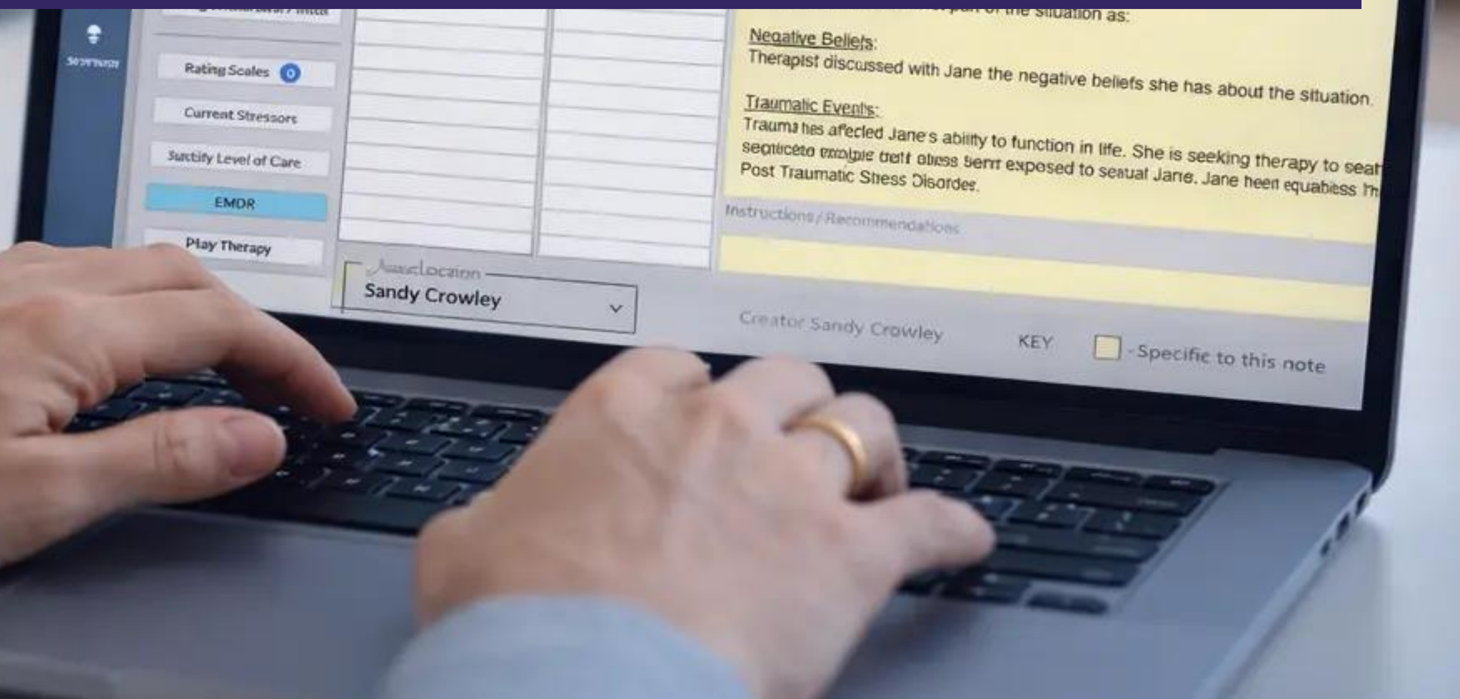
CXR WNL

Flu / RSV / COVID Negative

“Patient’s presentation today supports the diagnosis of a viral upper respiratory infection, given the symptoms of chest pain, fatigue, phlegm production, fever, chills, and loss of appetite, as well as clear lung auscultation and absence of bacterial infection signs in the ears and throat. Other diagnoses such as COVID-19, influenza, RSV, and bacterial pneumonia are considered but cannot be confirmed without further testing.”



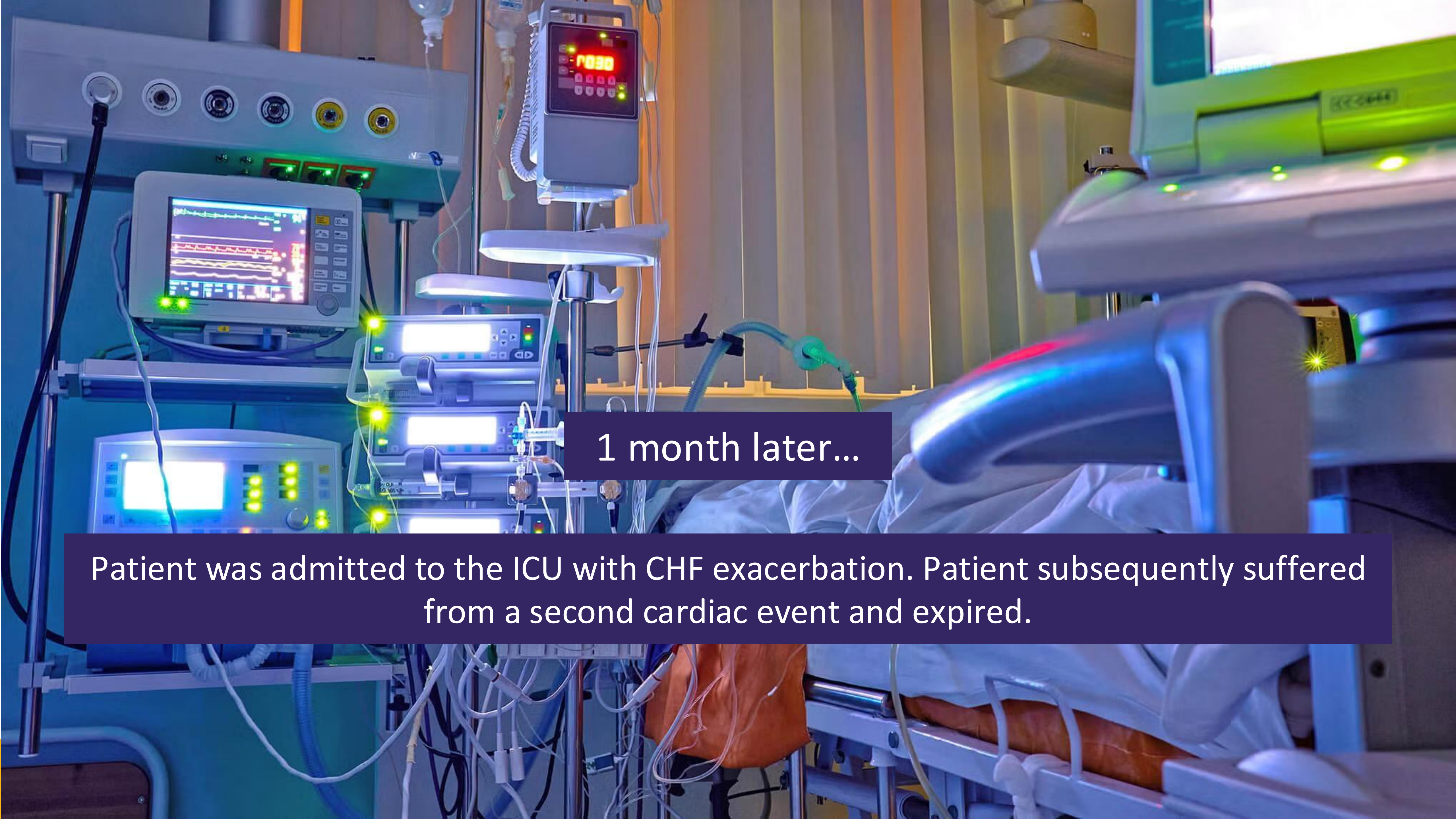
"- Prescribe Promethazine DM for nighttime cough suppression and drowsiness.
- Prescribe Benzonatate pills as a non-drowsy cough suppressant.
- Advise patient to rest until test results are received.
- Shared decision making with the patient regarding the need for chest X-ray.
- Return to clinic and emergency department precautions reviewed with the patient, who has verbalized understanding."

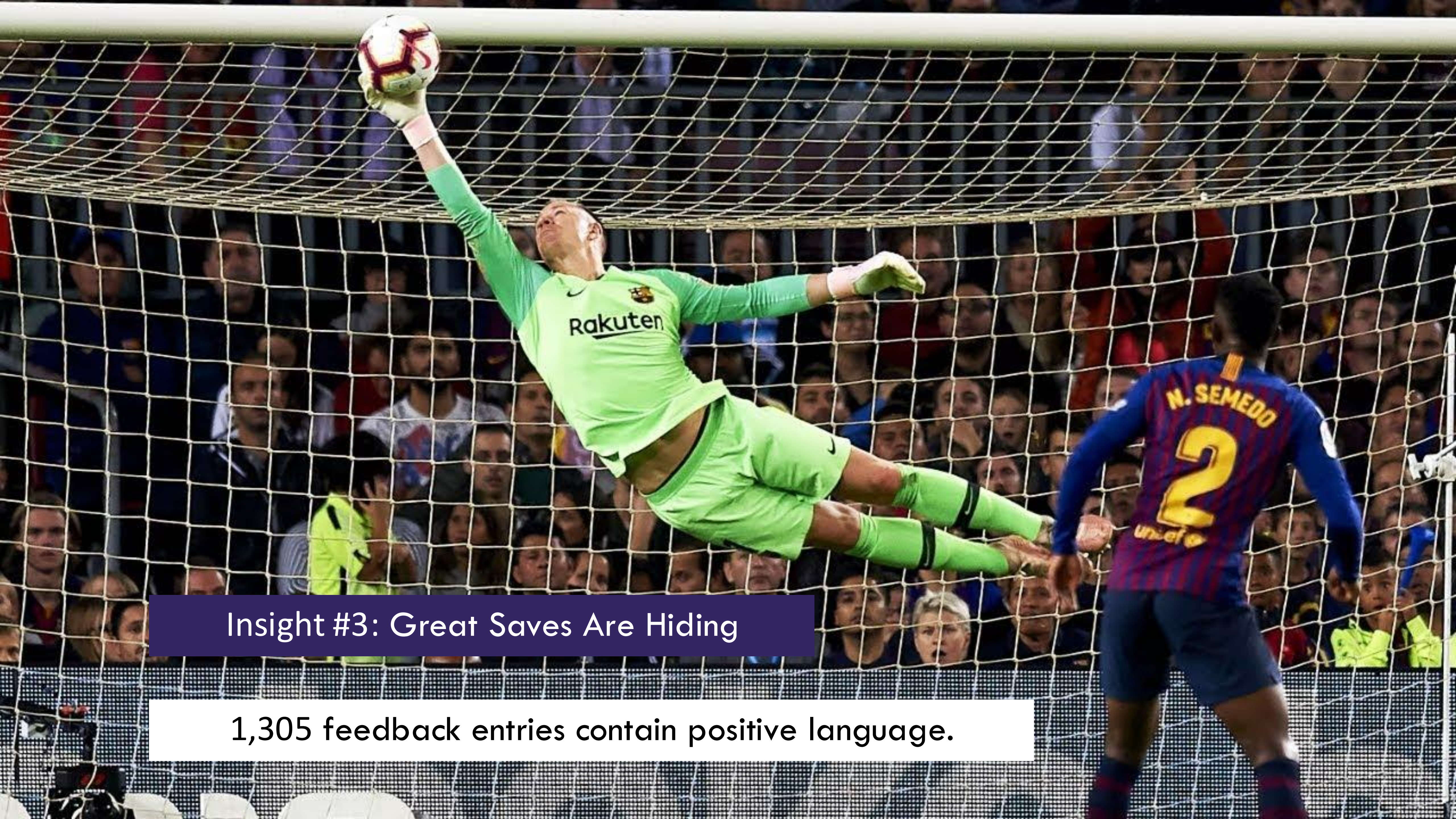


1. Acute cough
2. Essential (primary) hypertension
3. Atypical chest pain

1 week later…

"Patient called; states pain in chest is improving, having intermittent decreased exercise intolerance and trouble sleeping. Advised patient to go to ER if he had severe chest pain, swelling, or persisting pain. Advised patient if he had persistent mild symptoms to go to PCP assigned by HMO."


1 month later…
Patient was admitted to the ICU with CHF exacerbation. Patient subsequently suffered from a second cardiac event and expired.


Insight #3: Great Saves Are Hiding
1,305 feedback entries contain positive language.
Rakuten
N. SEMEDO
2

Great Saves

"Chief complaint: cold and flu symptoms x2 days. VS: HR 105, Temp 102.7, O2 90%, noted mild respiratory distress and conversational dyspnea. Dx: possible sepsis — discussed ambulance and EMS declined. Good job charting this. Really good chart — good catch."

"Great job. You picked up on: 1) LOC, 2) C-spine tenderness, and 3) abdominal tenderness — all red flag symptoms post-MVA. Good exam and appropriate ER referral."

"6-year-old female, chief complaint eye swelling. Dx: possible orbital cellulitis. ER transfer with ER referral form. Good catch."

The Ceiling of Manual Chart Review

Gap	What We Can't Answer
No diagnosis / chief complaint	Where do failure cluster?
49% of cases have no written feedback	Did the clinician learn anything from this review?
No reviewer calibration	Does "Yes" mean the same thing across 155 reviewers?
No longitudinal tracking	Does feedback actually change behavior over time?
5 charts / clinician / month sampled	Is that representative of anything?

What are the “peeled mushrooms” signals in urgent care?

What We're Building Together: UCA Quality Metrics 2025–2026

Measure (Draft)	Why It Matters
EKG for chest pain (age > 12)	Missed ACS is UC's highest-stakes miss
CT for anticoagulated head trauma	High-stakes miss
Epinephrine for anaphylaxis	Binary, high-stakes, no acceptable exceptions
No antibiotics for bronchitis	Most common stewardship failure
Correct antibiotic for bacterial sinusitis	First-line adherence is measurable and improvable

What We're Building Together: UCA Quality Metrics 2025–2026

Measure (Draft)
EKG for chest pain (age > 12)
CT for anticoagulated head trauma
Epinephrine for anaphylaxis
No antibiotics for bronchitis
Correct antibiotic for bacterial sinusitis

These are five measures for a setting that sees 160 million visits a year. This is just the beginning!

Key Takeaways

- The quality frameworks we've inherited — MIPS, satisfaction scores, return visit rates — were built for other settings and reveal only part of the quality picture. MIPS knows if you tested for strep. It has no idea if you considered PE in the tachycardic 40-year-old who just returned from Bali.
- Quality failures in urgent care are patterned, not random: unaddressed vital signs, incomplete or inconsistent exams, decisions lacking documented rationale. They're teachable and fixable.
- Chart review is not an audit. It's how our craft improves. Make your chart review process educational, not punitive. Celebrate the great saves alongside the gaps. The clinician who recognized sepsis in a patient presenting with cold and flu symptoms deserves to be recognized.
- The standards for urgent care quality are ours to define. The people best positioned to define them are in this room. Get involved with the UCA Quality Committee.

Thank you!

Please give me feedback – Scan the QR

Prefer paper?

On the form in front of you, please score me and the content I shared with you today.

AFTER THE CONVENTION

You may claim CME here www.urgentcareassociation.org/learning-center/cme/