AMPLIFY

Bread-and-Butter Urgent Care: Mastering the 95%

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What this talk focuses on:

- What actually walks through the door
  - Emergency problems
    - Relatively rare in urgent care
    - Not the core of urgent care practice
- Efficient, real-world clinical decision-making
- Pattern recognition over rare diagnosis hunting
- This is NOT an academic talk
  - Built from frontline urgent care practice - not theoretical “edge” cases

- ***Clinical judgment should always guide individual patient care***

Why This Talk?

- No zebras
  - Focus on what actually hits the door
  - Making good, safe, efficient decisions in the real world of urgent care

- Urgent Care Reality Check
  - High-frequency, lower-acuity

- **Mastering fundamentals drives outcomes *and* efficiency**

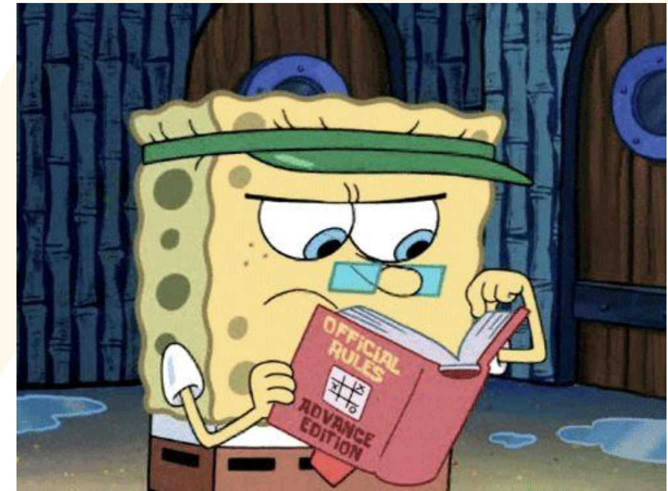
Efficiency matters: Clinically and Operationally

- Core Concept: Clinical Management

- Fundamentals – "Keep basic information on everything close at hand"
  - Know the medicine
  - Procedural Excellence
  - Staff support
  - Juggling tasks
  - Fast access to trusted resources
  - Clock management

- Keeping ears and eyes open and tuned in

Rules of the Road



- Pharmacology
  - Any drug can do anything to anyone at any time
- Extreme medical ideology
  - “Never” and “Always”
- Fear
  - The very young, the very old, the crazy

Rules of the Road

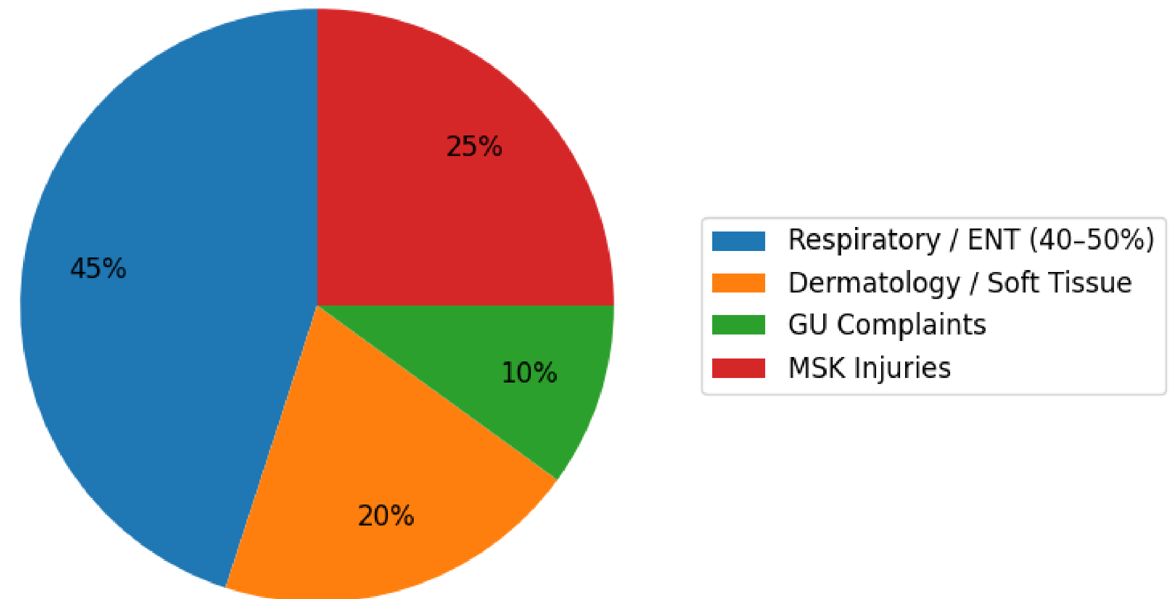
- Yer gonna make mistakes!
  - "If you ain't missin', then you ain't tryin'"
  - Learning good judgement
- Cocktail party approach
  - Always know two things about everything
- Always have an answer and a plan
  - Communicate – honestly and openly
  - KISS
  - "Give them something to go home with"
  - You gotta sleep at night!
- Time – our most precious resource

Clinical Management

- Example: “Seekers”
  - What kind?
  - When to fight (and when not to)
  - Tactics

What Actually Walks In the UC Door*

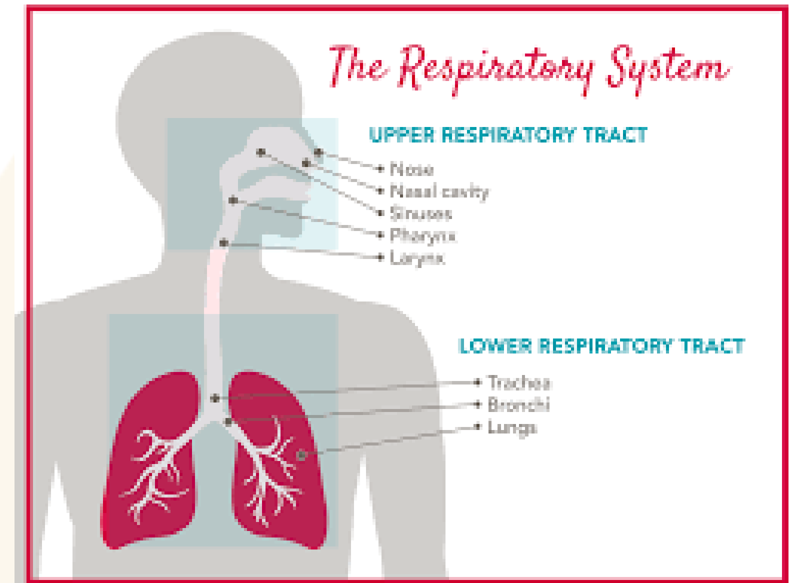
- Varies geographically and seasonally
  - Respiratory / ENT (~40–50%)
  - Dermatology / Soft Tissue
  - GU complaints
  - MSK injuries



**Reflects common urgent care visit patterns consistent with UCA benchmarking and national ambulatory data*

Respiratory Framework

- Upper
  - "The –itis"
    - Otitis, Sinusitis, Pharyngitis/Tonsilitis, Conjunctivitis, Rhinitis
    - Primary vs Secondary Infection, or associated sign/symptom
  - URI
- Lower
  - Bronchitis, Pneumonia, Asthma

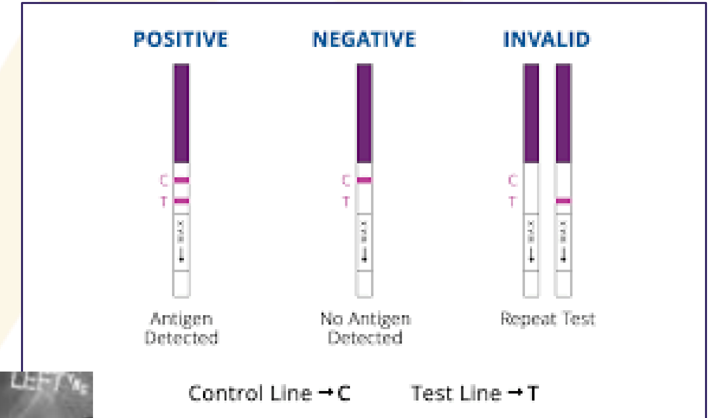


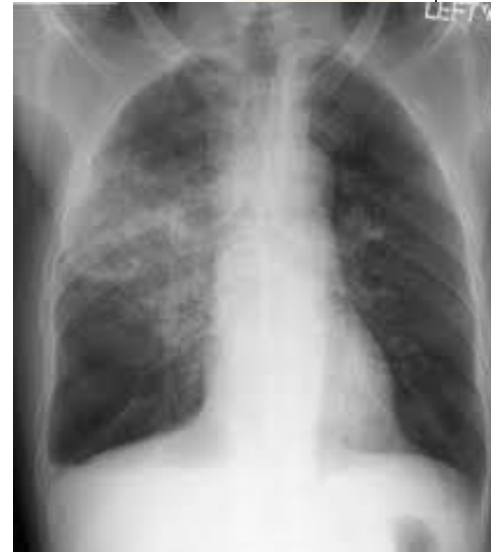
Respiratory: Cough

- Basic history
- Vital signs
- Basic exam
  - Look in the nose, look in the ears, look in the throat, listen to the chest
- To test, or not to test
  - Which tests

Respiratory - DDx

- So.....Is the cough due to
  - Upper?
  - or Lower Respiratory Problem?





Pharyngitis: Approach

- Centor Criteria
  - Fever
  - Exudates
  - Tender ACLNs
  - No Cough
- Halpert Criteria
  - Exposure
  - “Beefy Red” Injection w/ Petechiae
  - ACLNs
  - Fever
  - Abd sxns (kids)
  - Look Test (adults)

Pharyngitis: Approach

- So.....
  - To Test, or Not To Test

Pharyngitis: Approach

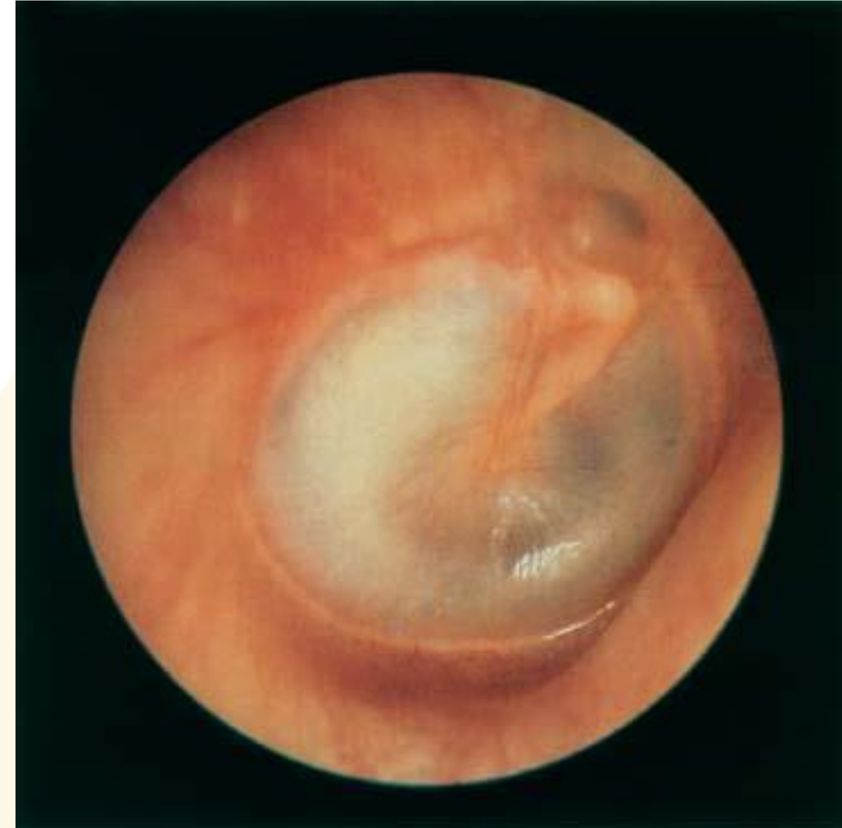
- Testing Pros and Cons
  - Diagnosis
    - RAT
    - Molecular
    - Culture
  - In-Office Management
    - Speed up vs Slow Down
  - Consumer Expectations/Satisfaction
  - “Dumbing Down” issues

Pharyngitis: Approach

- Test and Wait vs Empiric Treatment
  - If you are going to treat anyway based on clinical factors, why even test?
  - Remember: this is for strep pharyngitis not other kinds of infections.
  - Any exclusions to this?
    - Baseline data prior to introduction of abx tx
    - Is there a deeper tissue infxn?
      - Are antigens always surface expressed?
    - Was test technique poor?
  - Practices protocol

Acute Otitis Media

- Otalgia
  - Hearing
  - Discharge
  - Fever
  - Recent resp sxns
  - Foreign body
  - Air travel
  - Swimming/diving
- Basic exam
  - Look in the nose, look in the ears, look in the throat

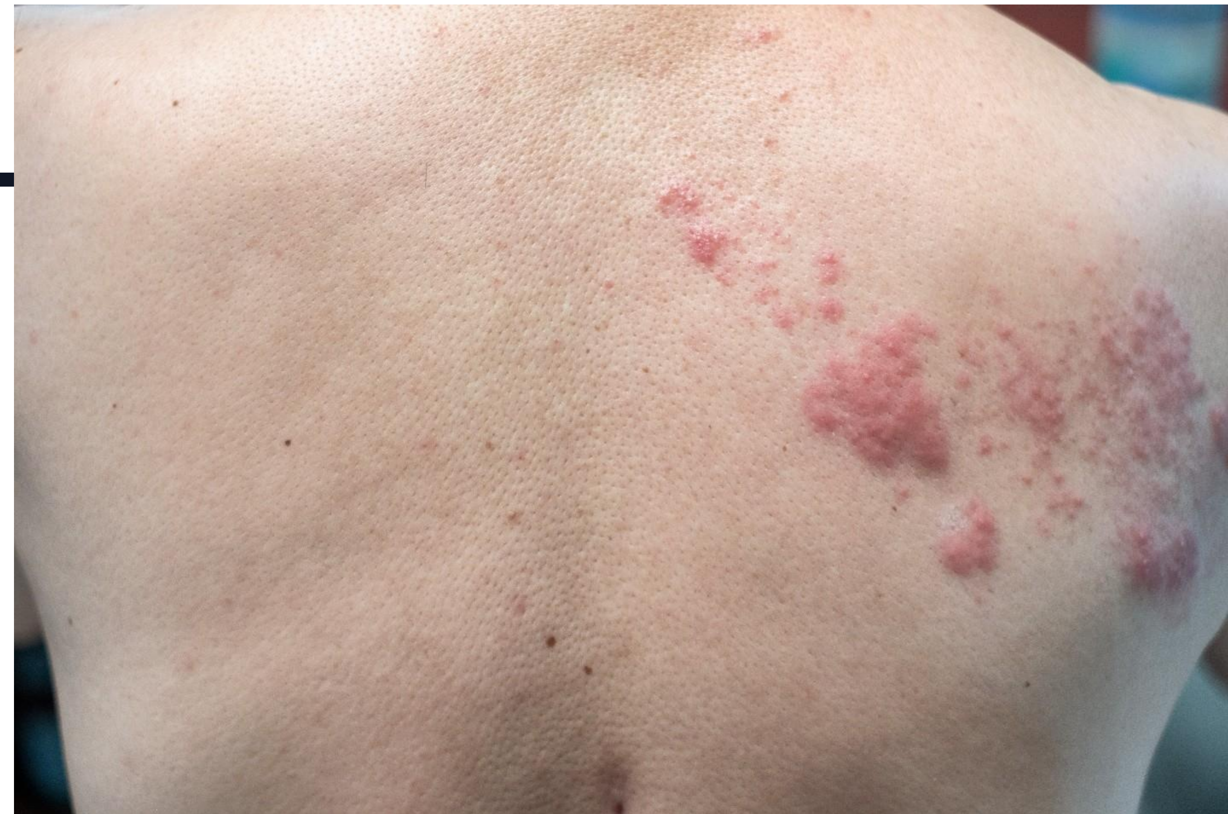


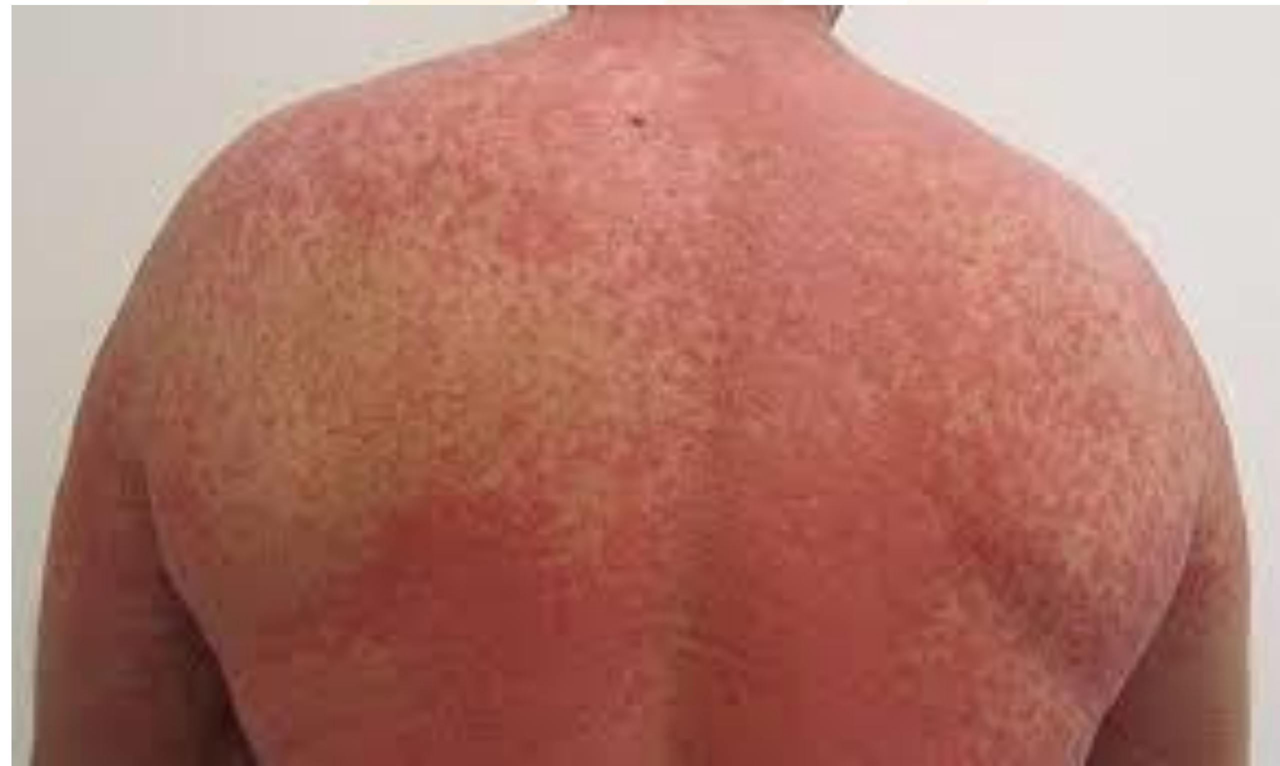
Rash Framework

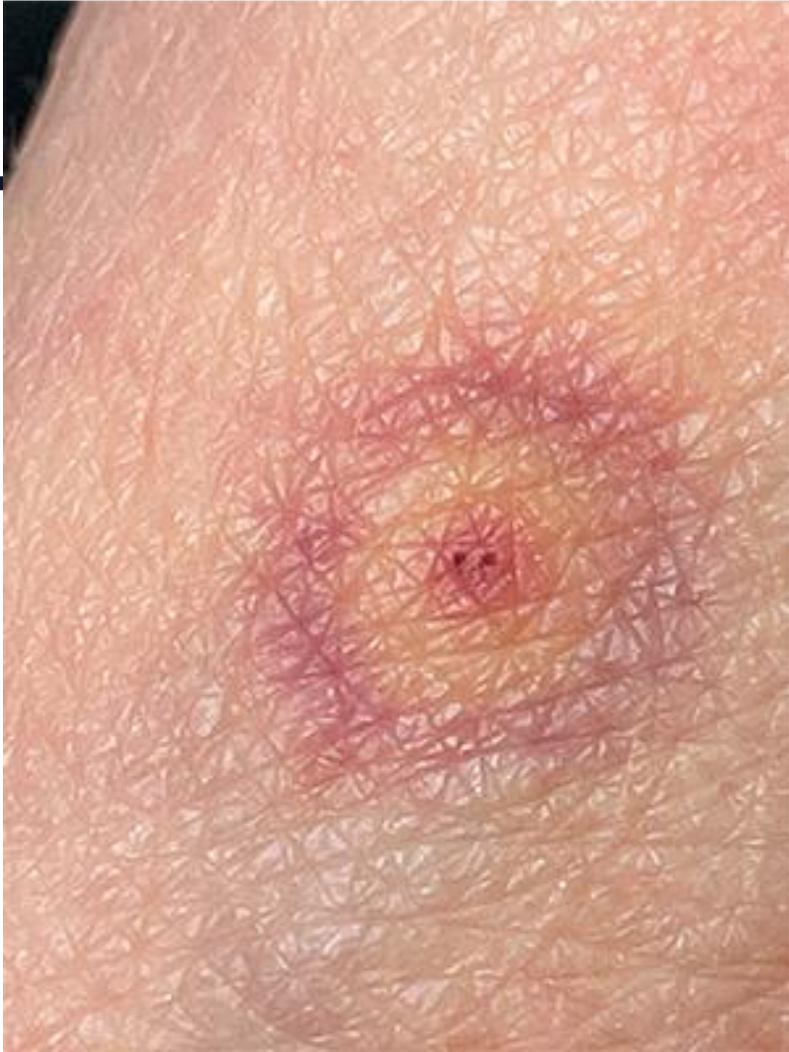
- Itchy/Painful/Both
- Recent travel, sick/rash contact
- Soaps/detergents/cosmetics/hygiene/meds
- Outdoor exposures
- Sick
- Prior Rash Hx/Dermatology
- Treatments so far

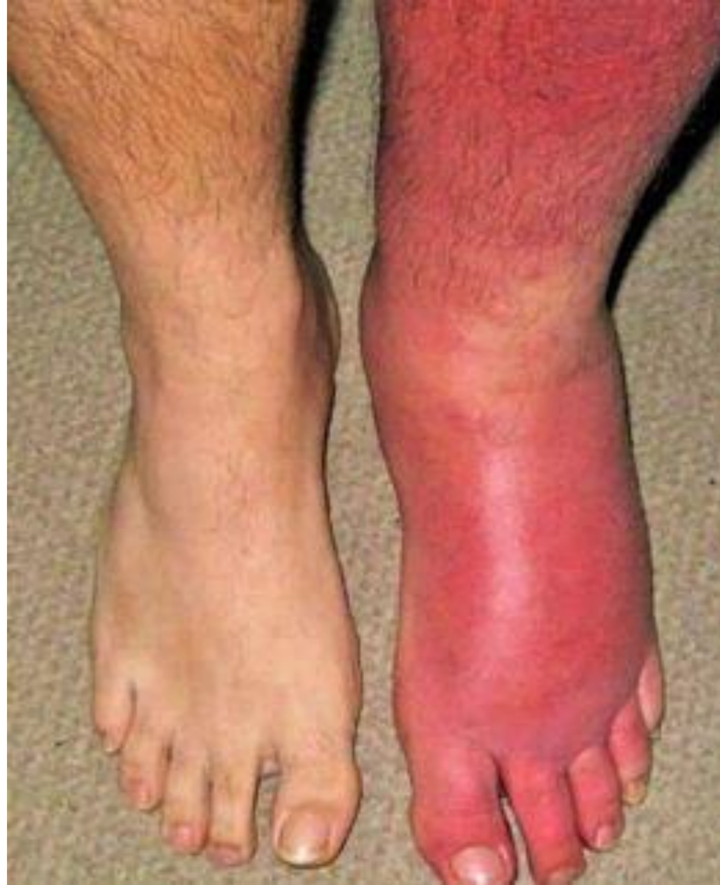
Dermatitis vs Cellulitis

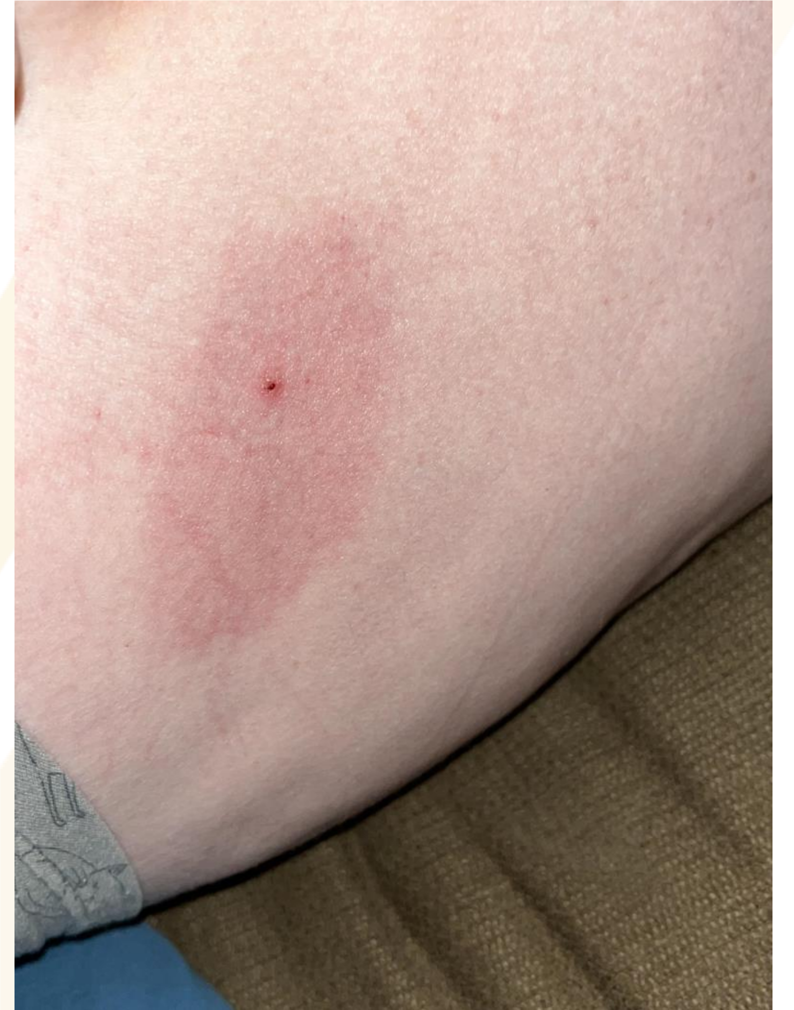
- What's the story?
- How's it look?





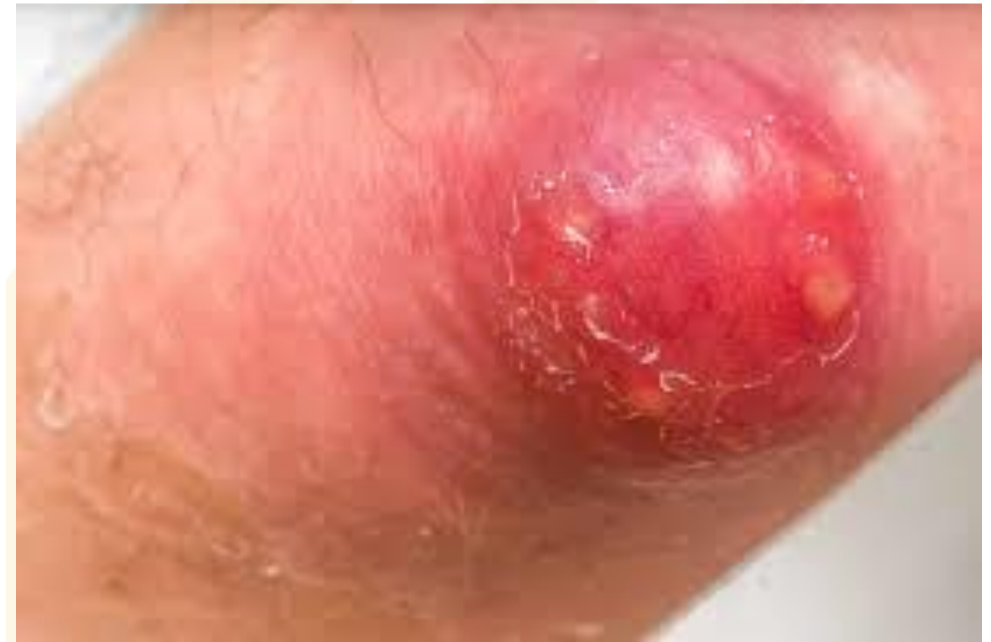






Cellulitis vs Abscess

- Fluctuance? Crepitus?
- Systemic symptoms?
  - Facial/Lymphangitis/Septic Joint/Osteo/Fasciitis
- Uninfected lesion?
- Culture?
- I&D vs. Abx



UTI Framework

- Cystitis vs Vaginitis?
- All about the history
- A "telemed" workup
  - EXCEPT
    - Need a culture/specimens
    - Pregnancy test very helpful
    - Any abdominal pain or systemic symptoms?
- Empiric tx?

MSK Injury and Imaging

- Ottawa Rules
  - ANKLE X-RAY if:
    - Pain in malleolar zone AND one of:
    - Bone tenderness at posterior edge/tip of lateral malleolus
    - Bone tenderness at posterior edge/tip of medial malleolus
    - Inability to bear weight (4 steps) immediately AND in clinic.
  - FOOT X-RAY if:
    - Pain in midfoot zone AND one of:
    - Bone tenderness at base of 5th metatarsal
    - Bone tenderness at navicular
    - Inability to bear weight (4 steps) immediately AND in clinic
- If NONE of the above → NO X-ray needed

MSK Injury and Imaging

- Ottawa
  - Used in alert, cooperative patients
  - Not valid in
    - Intoxicated patients
    - Distracting injuries
    - Significant swelling obscuring exam
  - When to Override
    - Gross deformity
    - High-energy mechanism
    - Clinical Gestalt doesn't fit
    - Concern for Achilles

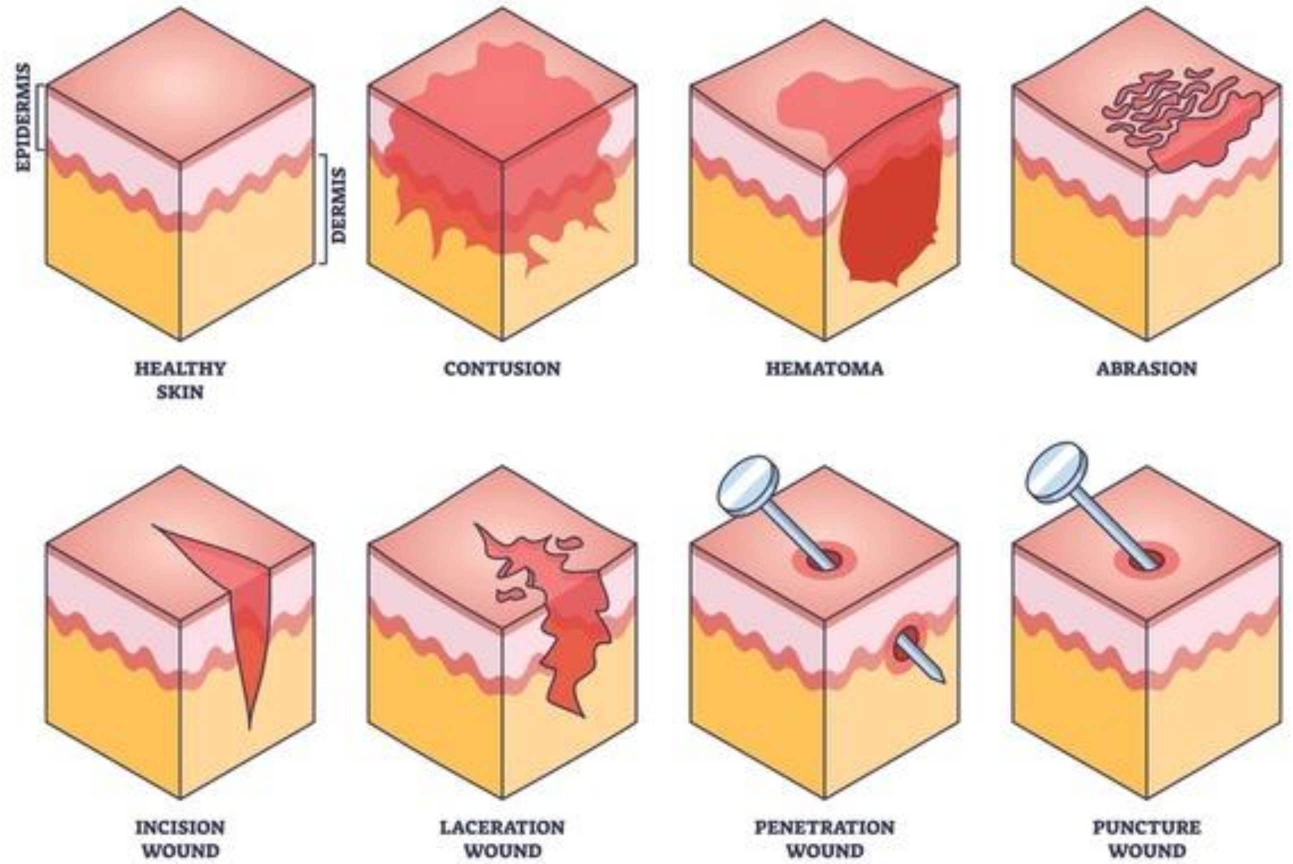
MSK Injury and Imaging

- Halpert's Rule:

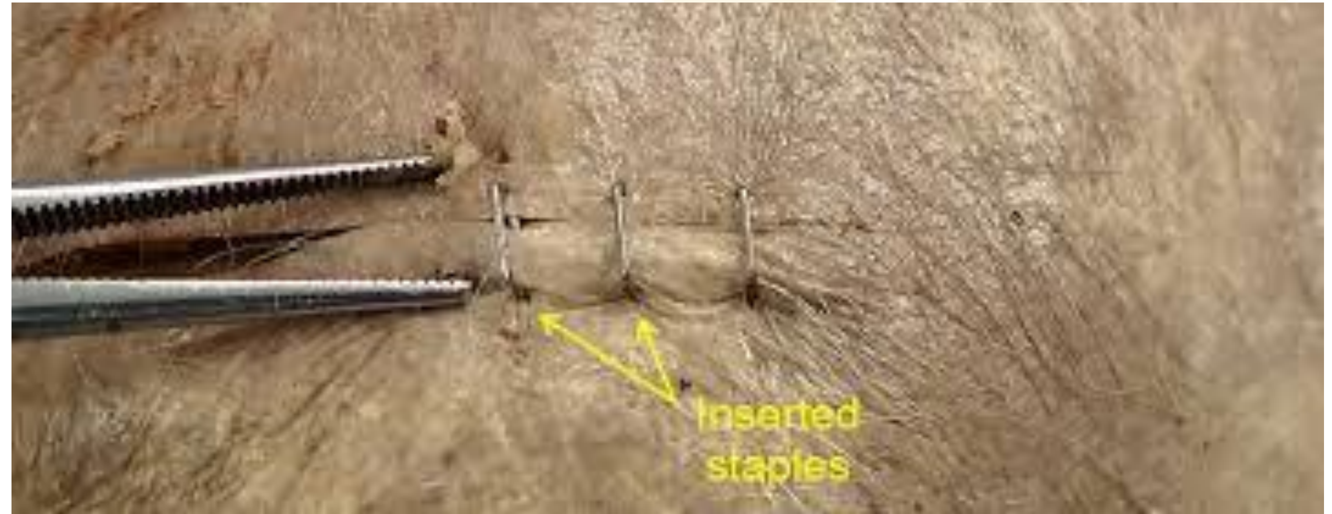
  - **If it hurts, film it.**

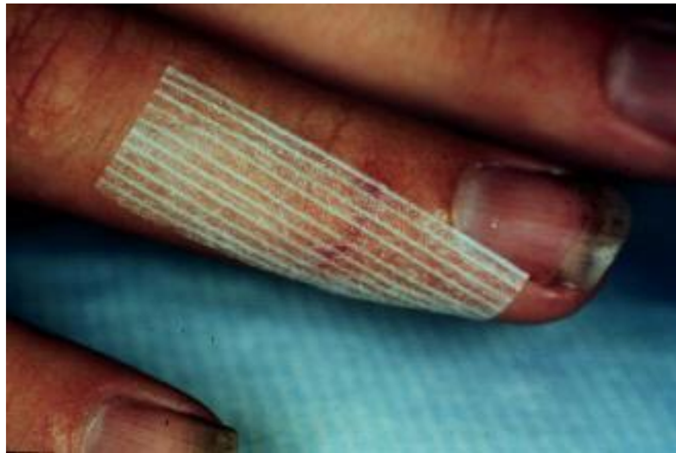
- Caveat: Sometimes X-rays miss stuff.

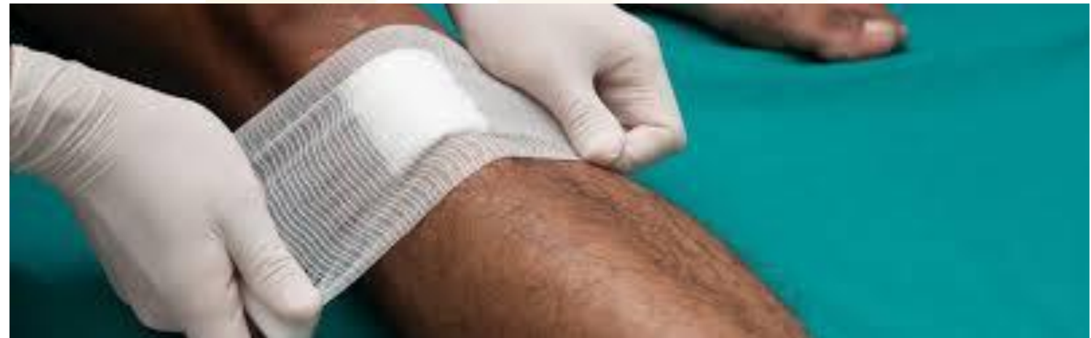
Wound Care



Wound Care

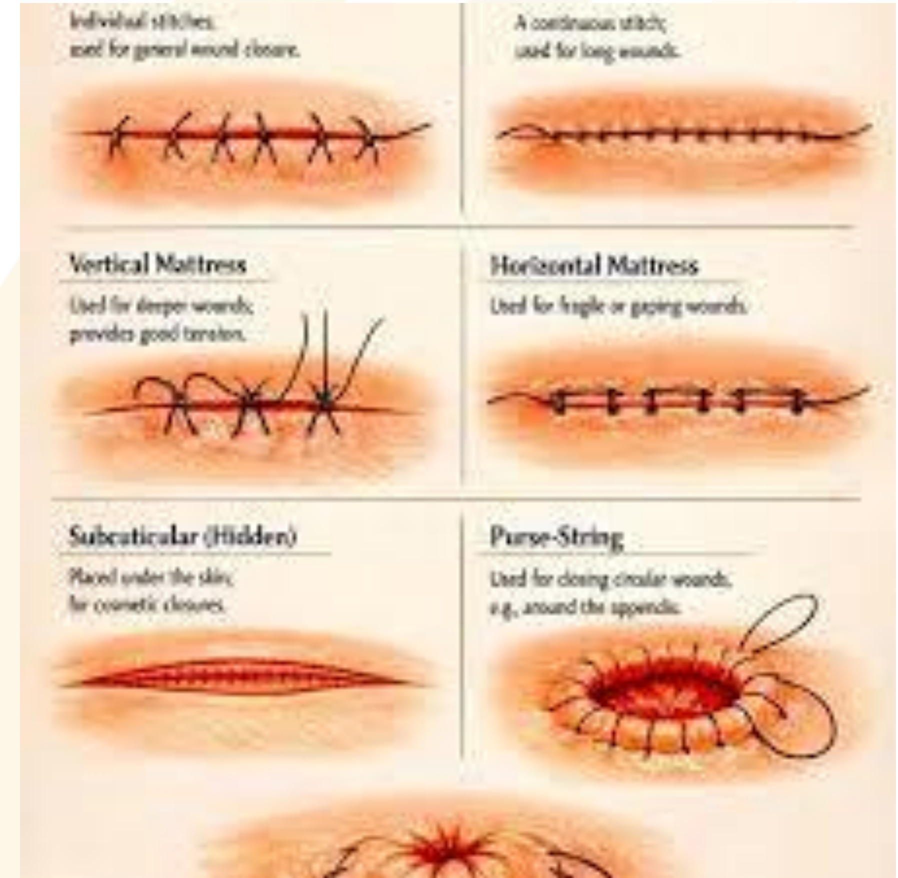






Wound Care

- When to close (or not)
- How to close
- The “whys and wherefores” of closure



Case - KB

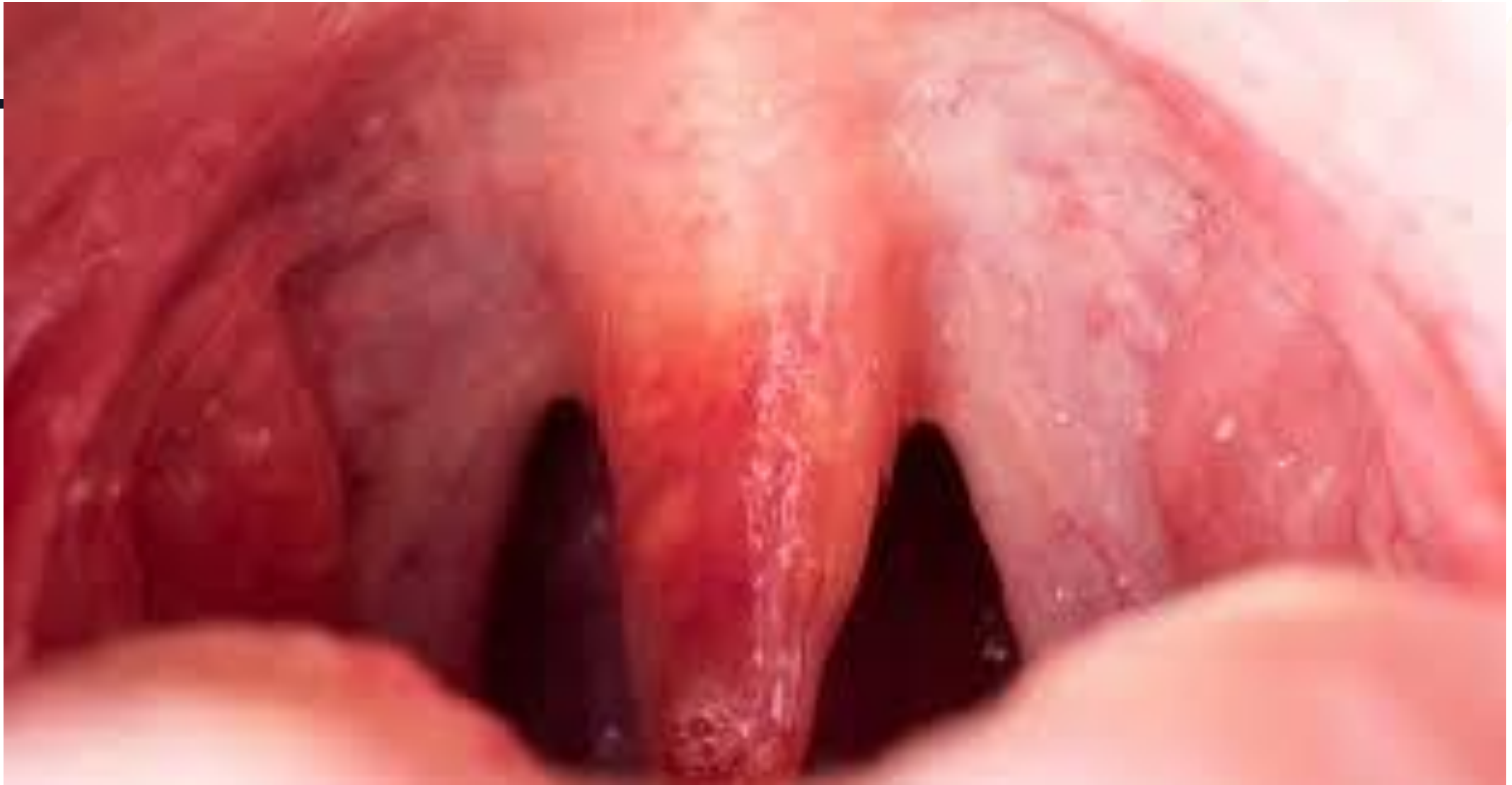
- 24-year-old female
- CC: Cough
- HPI - Worsening sore throat, harsh wet unproductive cough, body aches, fevers, fatigue. ST worse w/ swallowing and cough. Reports recent close GABS and RSV contacts. Seen at other urgent care earlier this week, dx'ed w/ strep throat p reportedly pos in-office RAST. Started on Cefdinir BID, today is D 5/10 and states no improvement in sxns, despite abx and IBU txs. States mild SOB w/ cough, no wheeze, now coughs to point of choking. States throat never looked red/inflamed/patchy.
- PFSH – Au Pair

Case - KB

- VS
  - T - 97.2
  - HR - 110
  - RR - 22
  - SpO2 - 98%
  - BP - 126/88

Case - KB

- PE
  - Gen – Mildly distressed, w/ intermit harsh hacking (annoying) cough
  - HEENT – face NTTP, trace clear nasal coryza b/l, OP nl appearing
  - Skin - Mod warm to touch, mod diaphoretic
  - LS – Coughing, worse w/ effort, decreased b/l BS



Case - KB

- Approach?
  - Repeat Temp (PO): 97.8
  - Swabs?
    - If so, which? and why?
  - Imaging?
  - Treat?

Case - KB

- Orders:
  - STC
  - Antitussive
  - Albuterol Neb
  - CXR

Case - KB

- Dx: PNA

- Plan:
  - Rest, fluids, OOW
  - Continue Cephalosporin to 10 days
  - Add Macrolide x 5 days
  - Continue IBU and add APAP PRNs
  - Add inhaled bronchodilators and antitussives PRN
  - 48-hour telephone recheck
  - 7-day UC recheck
  - ER for any worsening

The Art of Reassurance

- Medically informed explanations work well.
  - Evidence based are the best
  - Short scripts are most effective
- Provide documentation - assists the patient and protects you

High-Yield/Low-Hanging Pearls

- If you see it every day, get great at it!
  - Patterns matter
  - Don't ignore
    - Escalate when the pattern breaks
- Discharge instructions
- Follow up

Image & Content Credits

- **Images & Clinical Visuals**
  - Open-source medical image libraries
  - Publicly available educational resources
  - Online clinical reference materials
  - Images adapted for teaching purposes
- **Clinical Frameworks & Data**
  - Urgent care industry benchmarking
  - National ambulatory care data
  - Established clinical decision tools
    - Centor Criteria
    - Ottawa Ankle Rules

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And Finally.....

- Any Questions?

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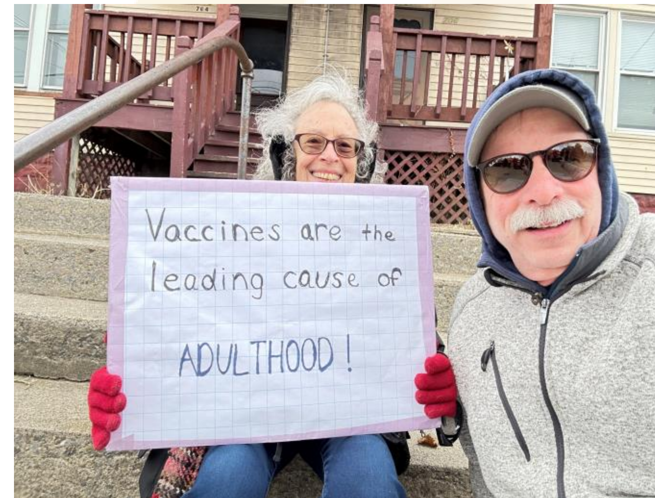
- Thank You For Your Attention!



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