URGENT CARE/PROCEDURE (UP) Clinic

Updated September 8, 2005

Foreword

Acute Care, Musculoskeletal Medicine (MM) and Office based procedures (OBP) are integral and fundamental to the practice of ambulatory medicine. A survey I conducted in 2000 in Sacramento area clinics revealed that there is a perceived disparity between the adequacy of training that primary care physicians receive in OBP/MM and the need to offer OBP, musculoskeletal evaluation or treatment. The ACGME citation re inadequate training of our housestaff in knee arthrocentesis is a surrogate indicator for this need in our ambulatory curriculum.

From a patient care standpoint, our ability to evaluate and treat acute complaints, including sports or minor trauma/injuries has been substandard. Many housestaff are uncomfortable with the management of STD’s, URI’s vaginal or rectal bleeding, and there is often too little time scheduled during a routine office visit to manage such acute complaints.

Likewise, our ability to diagnose acute fractures and joint injuries by plain films is hampered by our current clinic infrastructure, we lack the resources or equipment to treat or stabilize such injuries. The ACC facility provides a unique opportunity to develop rapid evaluation and treatment protocols for such injuries, particularly fractures, as the orthopedics and orthotics department are in the same building. For these reasons I have outlined the following curriculum for an acute care and procedure clinic for our housestaff.
URGENT CARE/ PROCEDURE (UP) CLINIC

Learning objectives:

- Provide a uniform, fundamental experience in acute care and office-based procedures for all housestaff.
- Understand the indications and contraindications, risks and benefits for each procedure.
- Provide uniform instruction in evaluating acute joint and musculoskeletal complaints.
- Develop a rapid access, diagnostic and therapeutic resource for resident clinic that provides ample time and staffing for learning and executing procedures and triaging of patients that may need hospitalization.

Didactic Learning

A 30 minute didactic session at the beginning of Tuesday and Friday clinics will be offered before seeing patients. To begin, the fundamentals of the following should be included:

Session 1
- Inservice on Urgent care clinic structure, goals and expectations
- Shoulder exam and treatment

Session 2 - Knee exam and treatment

Session 3 - Back, Hip, Ankle exam and treatment

Session 4 - Arthrocentesis and joint injection
Other Topics

- Myofascial Therapy – Traction, trigger point injections, Local Anesthesia digital blocks, ring blocks
- Primary Fracture Evaluation and stabilization techniques
- Skin Biopsies – Nevi, Skin tags, Bullae, HPV
- Toe Nail removal
- Minor surgery – I&D, cyst removal, wound care
- Management of STD’s
- Evaluation of vaginal bleeding
- Evaluation of rectal bleeding

Rapid triage and referral

In addition to housestaff education, the driving force for developing this clinic is to provide a resource for conducting semi-urgent or elective procedures in a timely manner. Second, the clinic provides a much needed urgent acute care resource. This increases clinic efficiency for all residents and enhances learning in both the continuity clinic and acute care clinic.

- The clinic maintains a rapid referral and triage system in place to provide a “near open” or “rapid”-access system for housestaff patients. This is managed first by the triage nurses and supported by the resource physician and UP clinic attending. Very often the resource physician and UP clinic attending are the same person.

- For procedures, a colored referral form is completed by housestaff and submitted for review by the UP clinic director or the medical director. This is usually approved within a half day and submitted to a scheduler or discharge clerk to book appointments.

- For patient’s that call a triage RN with an acute complaint, Triage RN’s use protocols to determine eligibility of patient’s to be see in this clinic. Acute care visits are limited to those that require evaluation per Briggs telephone triage protocol for RN’s “within 24 to 48 hours”. Those that require “immediate medical attention” are triaged to the ED. Ambiguities
regarding who should be seen within 24 to 48 ours must be clarified with resource physician or the attending physician that will potentially see the patient.

- Overflow - evaluation or re-evaluation of chronic problems can be included in this clinic whenever open slots are available

**Referral Process**

*Urgent Care* - Any patient complaining about an acute medical problem, particularly injuries will be triaged by a resource or triage RN. This is done on the phone or if a patient drops in to clinic. Resource and Triage RN’s will book patients into the clinic on their own or by approval of the resource physician, urgent care attending or the UP clinic director. Drop in patients can also be seen in the urgent care clinic if that is the triage decision of the RN. They will be booked into open slots designated for release on the day of the urgent care clinic. Continuity clinic patients that are LATE for their appointment will not be seen in this clinic unless they are triaged by an RN or MD.

*Procedures* - Patients that require an elective procedure that cannot be done in resident continuity clinic (i.e., skin punch biopsy, bursa injection), but needs to be completed within a week are to be referred to UP clinic. For referrals from resident clinic the referral form asks for a brief reason for the referral, patient info, resident contact info. The UP clinic director determines how soon the patient needs to be seen or ask the referring physician for more information. He also reviews and approves referrals and order tests if necessary pending an appointment.

The UP clinic serves the General Medicine and Geriatric clinic patients except in special circumstances that are approved by the UP clinic director.

**Clinic Appointments and Structure**

Three types of appointments would be scheduled

1) Procedure appointments - (P Slots)
   a) For any patient with a known problem that requires a procedure. The patient has been evaluated by a resident and staff physician and has been referred to the clinic for a procedure only. For example - a skin biopsy is requested, a skin tag needs to be
removed, and effusion needs to be tapped, a toe nail is infected and requires removal.
b) For any patient with an acute problem that has been evaluated over the phone by a physician or Triage RN and most likely needs a procedure. This includes assessment of vaginal or rectal bleeding because an extended exam will be needed. The procedure clinic physician will be allowed to add an additional twenty minutes to the appointment if the problem is complicated i.e., minor surgery, fracture reduction. An example would be a patient that was not seen by a physician that calls complaining of a painful skin mass that may need incision, drainage and packing.

2) Evaluation or Triage appointments – (T slots)

- A patient has an acute injury or complaint and needs evaluation within 24 to 72 hours and may require treatment with medications or splinting. For example, URI’s, dysuria, acute shoulder pain, hip pain after a fall, sprained ankle. Injuries that may require a procedure cannot be seen during these appointments. For example a laceration that may need suturing, a wound that may need packing or debridng, evaluation of vaginal or rectal bleeding cannot be seen during evaluation appointments. These would be seen during a procedure appointment. Criteria for acute medical problems would be specified under triage protocol. For example, acute abdominal pain, new onset jaundice, syncope.

Any remaining open slots can be used for drop in patients or to help decompress the continuity clinic.

3) Follow up appointments
Most patients should follow up with their PCP. The urgent care attending can use T slots for follow up that he/she feels is necessary. i.e., evaluating a s/p I&D&P wound, re-evaluating a severely injured ankle or shoulder. Wound care follow up can also be scheduled with an RN.

4) Teaching

- A weekly pre-clinic interactive conference will be conducted for 30 minutes before seeing patients on Tuesday and Friday afternoon clinics if time allows.

- In any down time or DNKA, additional interactive teaching can be implemented such as simple suture techniques or practice of arthrocentesis on joint models if we can purchase them.
• Urgent care clinic will be scheduled each half day of the week as room and staffing allows. Usually we schedule two residents and one attending. On occasions an extra resident will be allowed to precept interns, but will remain under the supervision of the attending physician. T* or P* slots are designated for CLEX exam of the intern.

5) Acute Care Structure

An example of an acute care process is outlined below:

• Triage RN notifies urgent physician of patient calling with complaint of acute injury.

• Ideally, the physician calls patient and assesses the complaint over the phone to determine if studies need to be initiated. For example, an injury sounds like sprain, dislocation or fracture injury - physician asks the triage RN to request for x-ray on a drop in basis.

• Urgent Care physician can see patient first or send them for X-rays to assess injury.

• Urgent Care clinic visit reveals connective tissue instability or fracture

• We stabilize the fractures or injuries with available splints and can request evaluation via orthopedics clinic or an orthotics referral. Refer to the fracture management manual in the procedure cart.

Personnel = Scheduler, MA, LVN, Resident and Attending

• Scheduler - Triage RN's and Discharge clerks manages most of scheduling with support from the UP clinic director or resource physician of the day. The UP clinic director advises how patients are scheduled – what day and duration of visit. The Triage RN contacts patients within 24 hours prior to the appointment, and has capacity to order X-rays prior to the appointment if requested by the physician. We do not see workman's comp cases, particularly those that have been evaluated by previous physicians. These must be seen by a physician or service designated by the patient's employer.

• MA - MA's are responsible for replenishing the procedure kits and carts with the LVNs. They are in serviced on the needs and roles in the UP clinic. They are shared with the MA’s associated with the continuity clinic
• **LVN/RN** - The RN or LVN in clinic are oriented to ordering supplies and guiding/mentoring the MA’s. Furthermore, the RN/LVN have developed a protocol for RN wound-care follow up for packed I&D patients, etc.

• **UP Clinic Director** - Joseph L. Melendres M.D. 762-3169

• **Housestaff Scheduling** - Chief resident, Heather Vierra M.D. 762-5611

• **Resource Physicians** - Jorge Garcia M.D., Craig Keenan M.D., Joseph L. Melendres M.D., Maya Mitchell M.D.

**Physician Roles** - Before clinic, the attending and resident review all the patients and develop a plan for each patient. They also review any previous pending orders or results. A procedure manual is maintained suite A (0400). Reference books and fracture management manuals are available at the procedure cart in suite 0400. A log book is kept in clinic to track labs and path samples. Housestaff conduct the visit and an attending staffs the patient with housestaff in the customary fashion.

For procedures, the attending instructs the resident and MA on how to prep the patient and discuss the procedure in front of the patient. The resident preps and consents the patient and gathers the materials for the procedure. The attending decides how to execute the procedure. Preferably, the attending demonstrates the procedure if the resident has never done the procedure. The residents are given as much latitude to conduct the procedure as allowed by the patient and resident's comfort with the procedure. Once the procedure is completed, the resident will write up the procedure. The attending cosigns all notes. The resident that conducted the procedure(s) will contact the referring resident(s) by voicemail or E-mail to notify them of outcomes from the procedure, follow-up expectations, labs to check, or biopsy specimens to follow. The urgent care attending must check on all pending labs and sign off on any that have been completed and followed up. Credit and assessment for completing procedures will be logged by housestaff on E-value and confirmed by the attending.

**Procedures**

*Dermatology*
- Shave or punch biopsies
- Skin tag removal

*GI*
- Diagnostic or Therapeutic Paracentesis
• External hemorrhoidectomy

Gynecology
• Endometrial biopsies
• Cervical polyp removal
• Cyst I&D

Musculoskeletal Medicine
• Arthrocentesis, joint injection, bursae injection, diagnostic or therapeutic injections
• Fracture evaluation

Podiatry
• Toe nail removal, wedge excision, avulsion, paronychia I&D, administration of local anesthesia
• Plantar fascia injection, plantar-wart paring or cryotherapy

Minor surgery such as
• I&D
• cyst excision
• laceration management

Post-Injury Care

Patient’s with severe injuries may require temporizing measures such as pain control, splinting or non-weight bearing measures. Ultimately they may need evaluation by a specialist, in particular, an orthopedist. Housestaff can contact Tanya of the orthopedic clinic (4-3397, 4-3827) to have patients treated or stabilized.

Materials to be maintained in Clinic
• Crutches
• Wheel chair for transport
• Slings
• Ace Wraps
• Knee immobilizers
• Thumb Spica splints
• Wrist Splints i.e., ulnar gutter
• Arm bands for lateral epicondylitis
• Joint injection tray
• Ankle splints
• Tib/Fib splints
Evaluations

Evaluations by attendings and housestaff would be managed via the E-value system. Minimums for number of procedures and criteria for competency are established per ACGME.

Appropriate Referrals

1) Patients evaluated in resident clinic and discussed with the attending physician.
2) Patients that need any non-emergent procedure listed above.
3) Patient verbally consents to the procedure during office visit with referring resident.
4) Acute injury or Problems determined by Triage RN’s Brigg’s telephone triage protocol to be seen within 24-48 hours and authorized by the acute care attending.
5) Drop in patient triaged by Clinic RN.

Inappropriate Referrals

1) Emergent problems – Patient’s that triage under “seek immediate medical attention” or “911” per Brigg’s telephone triage protocol.
2) Unstable patients.
3) Patients that decline evaluation for treatment or procedure
4) Workman’s comp – these must be seen by the workman’s comp physician of the employer.
5) Open Fractures.
6) Chronic Health Problems.
7) Late patients with non-urgent complaints.

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