

JUCM[®]

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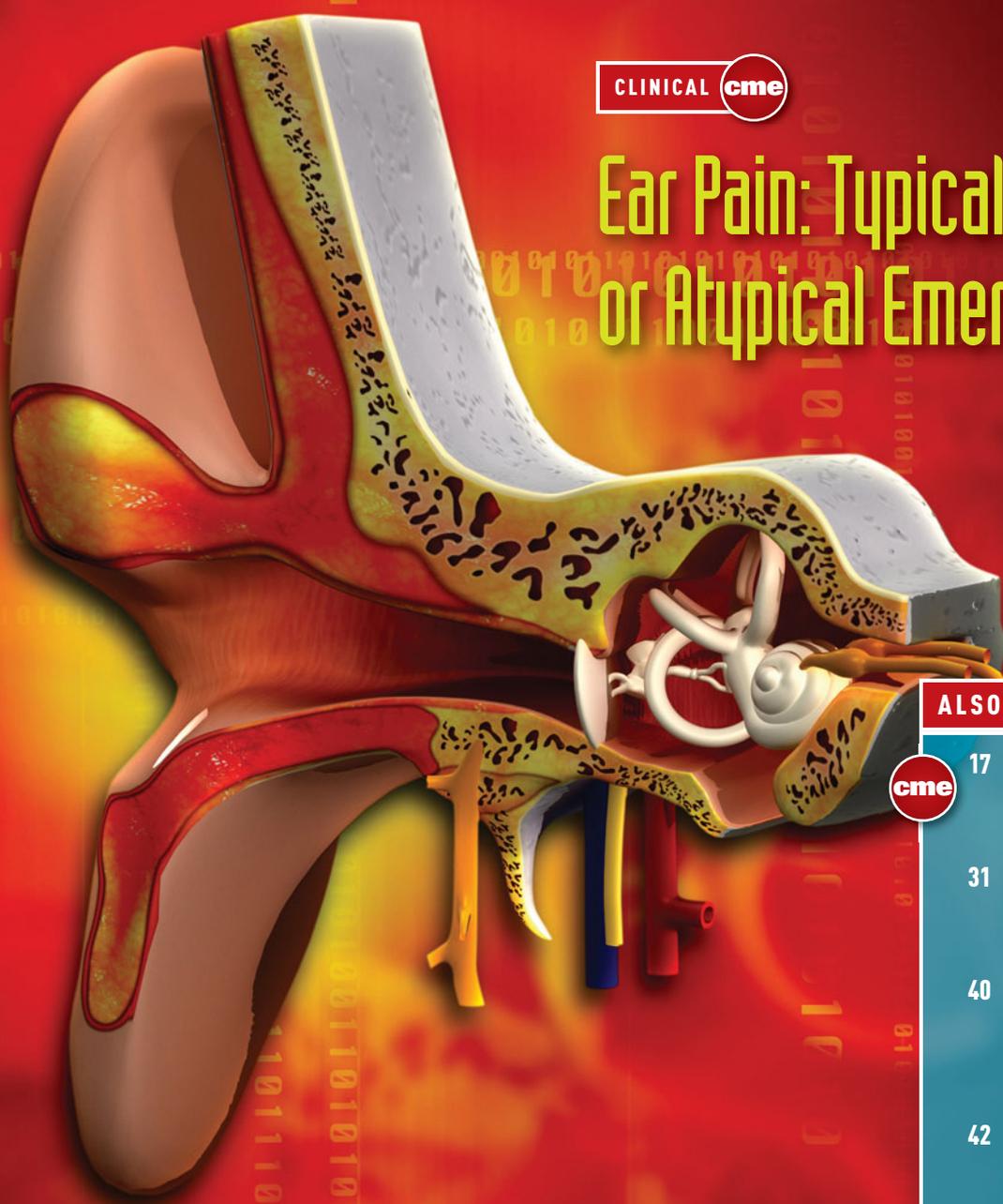
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CLINICAL **cme**

Ear Pain: Typical Infection— or Atypical Emergency?



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LETTER FROM THE EDITOR-IN-CHIEF

For Auld Lange Syne, Many Great Years



The year was 2006: Saddam Hussein was executed for crimes against humanity. The Wii gaming console debuted. Pluto lost its planetary status. *High School Musical* and *Borat* were the talk of the town in entertainment. And *JUCM, The Journal of Urgent Care*

Medicine was born—the first and only peer-reviewed journal in the industry (which it remains to this day).

Well, let's just say that *JUCM* was the undisputed highlight of 2006!

The whole idea for *JUCM* was given life in a small rented conference room at O'Hare Airport in Chicago. Dr. David Stern, myself, and two accomplished medical publishing experts, Stuart Williams and Peter Murphy, consummated what would become a 13-year relationship and, for me, a personal and professional journey I will never forget.

As with all great adventures, there comes a time when it is best to hang up the cleats and entrust the responsibility to others to keep the fun going and the ideas fresh. And in this column, my last as editor-in-chief, it is my honor to officially pass the torch to others to lead us into the next decade of success at *JUCM*.

I have been privileged to serve as the editor-in-chief of *JUCM* since our founding, which for those counting at home, means over 140 issues and columns like this one. The early years were learn-as-you-go for all of us. Our fledgling journal needed reliable content and recurring advertisers, neither of which proved easy to come by. But the editorial team found a way to cultivate credible authors while our publishing partners mined for ad dollars to keep the lights on. Over time, we built a more consistent pipeline of both, and that allowed us to expand the journal to include more diverse topics from a wider network of experts.

The Urgent Care Association and College of Urgent Care Medicine have also provided valuable support, bringing in new talent and content throughout my tenure, for which I am very grateful.

I would be remiss without recognizing our incredible and talented editorial team, without whom we would never have made it to this moment: Harris Fleming, our first managing editor, and back again after a short hiatus to re-energize and stabilize all the editorial work that goes into each and every issue. Tom DePrenda,

"This endeavor has always been about giving a voice to urgent care and a forum for the discussion of things that matter to us most."

our one and only art director, and a multiple award-winner for his cover work and graphics. While Harris and Tom work largely behind the scenes, the journal would not exist without their contributions. And, last, but certainly not least, our associate editors, Alan Ayers and Dr. Michael Weinstock. Alan and Mike do all the dirty work to ensure our content is trusted and fresh. They both work tirelessly to recruit and mentor authors, and when they're not editing others' work, they are delivering powerful articles of their own. *JUCM* continues to evolve along with our industry and attract the best and the brightest of emerging urgent care thought leaders, as evidenced by recently expanding the editorial team to include Dr. David Mathison as associate editor for pediatrics.

The urgent care industry owes a big debt of gratitude to these incredible people. And for me, no better time to highlight their work and my personal admiration for everything they do.

Of course, none of this matters without readers, and *JUCM* has some of the most knowledgeable and loyal. Over the years, I have tried to develop a relationship with our readers that speaks to their needs and celebrates the industry and clinical practice we love.

This endeavor has always been about giving a voice to urgent care and a forum for the discussion of things that matter to us most. All great disciplines are born out of the conversation and debate among their constituent professionals. If I have made even a small contribution to that for urgent care, I am satisfied.

So, thank you all for 13 great years as editor-in-chief at *JUCM*. For the next 13 years, I look forward to joining the readers! ■

Lee A. Resnick, MD, FAAFP
Editor-in-Chief, *JUCM, The Journal of Urgent Care Medicine*



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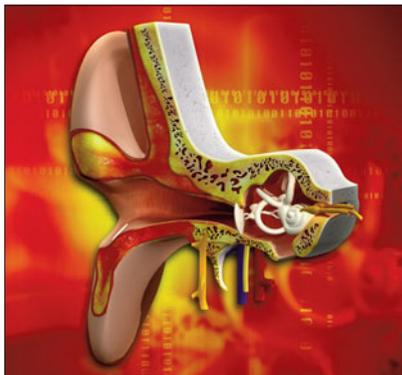


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CLINICAL

11 Ear Pain Mimics: It's Not All About Otitis Media

Ear pain is among the most common complaints of patients presenting to urgent care. That's doesn't mean every presentation is run-of-the-mill, however. Assessing and treating it shouldn't be, either.

Beth Phelps DNP, ACNP, CNP and Kelly Phelps, JD, RN

CASE REPORT

17 Atypical Chest Pain in a Fibromyalgia Patient Presenting to Urgent Care



A patient's "explanation" of what is wrong can easily lead your mind astray. That dynamic may be especially challenging (and dangerous) if the patient has emotional issues.

Tracey Quail Davidoff, MD

GUIDELINES UPDATE

31 Updated IDSA Guidelines Stress Early, Appropriate Treatment for Community-Acquired Pneumonia + Influenza



'Tis the season for influenza and comorbidities that could prove life-threatening. So, the Infectious Diseases Society of America's new guidelines on community-acquired pneumonia + influenza couldn't arrive at a better time.

Cornelius O'Leary, Jr., MD

PRACTICE MANAGEMENT

34 Rural and Tertiary Markets: The Next Urgent Care Frontier



Historically, rural markets are tough places for urgent care to do business. What if that's changing, however, and they're ripe for explosive growth—a modern-day, healthcare equivalent of the California gold rush?

Alan A. Ayers, MBA, MAcc

HEALTH LAW AND COMPLIANCE

40 Can Urgent Care Patients Be Treated Anonymously?



The simple answer is, *Not unless you're willing to take on tremendous risk.* To really hear and respond to such queries responsibly, however, you need know the context and why you should decline.

Alan A. Ayers, MBA, MAcc

IN THE NEXT ISSUE OF JUCM

Staphylococcus aureus is a common pathogen, for which there is effective treatment—unless, of course, it's of the methicillin-resistant variety, in which case it can lead to abscess, sepsis, and even death. MRSA is a significant problem in all healthcare settings, certainly including urgent care. In the January 2020 issue of *JUCM*, we present an original article that looks at the challenges of identifying and managing MRSA in patients who present to urgent care.

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editor@jucm.com

EXECUTIVE EDITOR
Harris Fleming
hfleming@jucm.com

EDITOR, PRACTICE MANAGEMENT
Alan A. Ayers, MBA, MAcc

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CONTRIBUTING EDITORS
Cornelius O'Leary, Jr., MD
Monte Sandler

ART DIRECTOR
Tom DePrenda
tdeprenda@jucm.com

**BRAVEHEART
PUBLISHING**

185 State Route 17, Mahwah, NJ 07430

PUBLISHER AND ADVERTISING SALES

Stuart Williams
swilliams@jucm.com • (201) 529-4004

CLASSIFIED AND RECRUITMENT ADVERTISING
Samantha Rentz
samantha.rentz@communitybrands.com • (727) 497-6565 x3322

Mission Statement

JUCM The Journal of Urgent Care Medicine (ISSN 19380011) supports the evolution of urgent care medicine by creating content that addresses both the clinical practice of urgent care medicine and the practice management challenges of keeping pace with an ever-changing healthcare marketplace. As the Official Publication of the Urgent Care Association and the College of Urgent Care Medicine, *JUCM* seeks to provide a forum for the exchange of ideas regarding the clinical and business best-practices for running an urgent care center.

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JUCM CONTRIBUTORS

In some ways, a complaint of ear pain is where the rubber meets the road for healthcare providers.

X-rays won't help you arrive at a diagnosis, and lab values are of minimal help. You need to talk to the patient, take a thorough and accurate history, and examine the source of the complaint up close. Given that ear complaints are high on the list of concerns that bring patients to the urgent care center, this is an especially important topic for *JUCM* readers. So, we're appreciative that **Beth Phelps DNP, APRN-FPA, ACNP-C** and **Kelly O. Phelps, JD, RN** took the time and initiative to craft an article on the subject for this month's issue.



As the title implies *Ear Pain Mimics: It's Not All About Otitis Media* (page 11) looks beyond the most likely cause to consider the vast array of possible diagnoses, offering tips on assessment and treatment in the process.

Dr. Phelps is a visiting clinical instructor at the University of Illinois - Chicago College of Nursing, as well as a nurse practitioner/site investigator at Springfield Clinic Urgent Care.

Fighting the urge to take things at face value is also central in this month's case report, *Atypical Chest Pain in a Fibromyalgia Patient Presenting to Urgent Care* (page 17). In that article,



Tracey Q. Davidoff, MD, FACP, FCUCM recounts the presentation of a "frequent flyer" whose complaint was too-readily attributed to known health problems.

Dr. Davidoff is an attending physician at Advent Health Centra Care in Orlando, FL, as well as a member of the *JUCM* Editorial Board.

Sometimes the bodies that issue clinical guidelines need to take a closer look at things, too. For example, the Infectious Diseases Society of America recently released an update of their advisory on treating patients with community-acquired pneumonia who have also tested positive for influenza. **Cornelius O'Leary, Jr., MD** has provided an overview of the most urgent care-relevant aspects. You can read his article, *Updated IDSA Guidelines Stress Early, Appropriate Treatment for Community-Acquired Pneumonia + Influenza*, starting on page 31.



Dr. O'Leary is an urgent care physician with Emergency Care Dynamics, San Diego, CA and regularly contributes reviews of new literature for *JUCM* in *Abstracts in Urgent Care* (page 20).

Another aspect of the healthcare landscape that's changing is how underserved areas of the U.S. might fare in the emerging primary care shortage. Rural America comes to mind. In truth, the urgent care business could be more robust at this point in time—but that likely means there is ample opportunity for growth. In *Rural and Tertiary Markets: The Next Urgent Care Frontier* (page 34), **Alan A. Ayers, MBA, MAcc** takes a broad look at that market

and offers insights into what it might take to both provide much-needed services and gain the benefits of becoming the go-to clinic outside of more populated urban suburban hubs.



Mr. Ayers, who is chief executive officer of Velocity Urgent Care and practice management editor *JUCM*, also penned this month's Health Law and Compliance article. In *Can Urgent Care Patients Be Treated Anonymously?* (page 40) he looks at the potentially thorny issue of saying *No* to patients who ask that you treat them without their providing an identifying information.

We're happy to introduce you to a new contributor in this issue. The always valuable (literally) Revenue Cycle Management column previously written by David Stern, MD will now be contributed by **Monte Sandler**, executive vice president, revenue cycle management at Experity. His first piece, *Three Tips to Optimizing Patient Collections*, begins on page 42. We have appreciated Dr. Stern's many, immeasurably valuable columns on revenue cycle management, as well as billing and coding questions, since the inception of *JUCM*.



The same can be said, in spades, of **Lee Resnick, MD, FAAFP**, who has appeared on top of our masthead since the very first issue of *JUCM* in 2006. As he notes in the Letter from the Editor-in-Chief on page 42, this month's marks his last in that role. His stewardship has been instrumental in making *JUCM* not only essential for urgent care providers and operators, but a top-notch medical journal that has stood up to much older and larger publications in national awards competitions. We thank him for leading the journal to where it is today. (More on his successor to come.)



Thanks for Our Peer Reviewers

We rely on the urgent care professionals who volunteer to serve as peer reviewers to ensure the content we publish is relevant and unbiased. This month, we thank:

- Alex Ambroz, MD, MPH**
- Gina Nelson, MD, PhD**
- Lou Ellen Horwitz, MA**
- Edward Zompa, MD, PhD ■**

Correction

In the September issue of *JUCM*, we made an error in listing one of our authors' credentials. Joel Kaye, co-author of *An Unusual Etiology of Chronic Subdural Hematoma: Case Report and Review of the Literature*, is a fourth-year medical student at Rutgers Robert Wood Johnson Medical School, and not an MD (yet) as we identified him.



CONTINUING MEDICAL EDUCATION

Release Date: December 1, 2019
Expiration Date: November 30, 2020

Target Audience

This continuing medical education (CME) program is intended for urgent care physicians, primary-care physicians, resident physicians, nurse-practitioners, and physician assistants currently practicing, or seeking proficiency in, urgent care medicine.

Learning Objectives

1. To provide best practice recommendations for the diagnosis and treatment of common conditions seen in urgent care
2. To review clinical guidelines wherever applicable and discuss their relevancy and utility in the urgent care setting
3. To provide unbiased, expert advice regarding the management and operational success of urgent care practices
4. To support content and recommendations with evidence and literature references rather than personal opinion

Accreditation Statement



This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Urgent Care Association and the Institute of Urgent Care Medicine. The Urgent Care Association is accredited by the ACCME to provide continuing medical education for physicians.

The Urgent Care Association designates this journal-based CME activity for a maximum of 3 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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Member reported no financial interest relevant to this activity.
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CONTINUING MEDICAL EDUCATION

JUCM CME subscribers can submit responses for CME credit at www.jucm.com/cme/. Quiz questions are featured below for your convenience. This issue is approved for up to 3 AMA PRA Category 1 Credits™. Credits may be claimed for 1 year from the date of this issue.

Ear Pain Mimics: It's Not All About Otitis Media (page 11)

1. Noninfectious fluid can persist in the middle ear for up to 12 weeks in which of the following?

- a. Otitis externa
- b. Chronic serous otitis media
- c. Mastoiditis
- d. Barotrauma
- e. All of the above

2. Barotrauma can result from:

- a. Diving
- b. Flying
- c. Being slapped with an open hand
- d. All of the above

3. The first-line agent for treatment of Ramsey Hunt syndrome is:

- a. Valacyclovir
- b. Cephalexin
- c. Amoxicillin
- d. Cefdinir

Atypical Chest Pain in a Fibromyalgia Patient Presenting to Urgent Care (page 17)

1. Differential diagnoses for cardiomyopathy should include:

- a. Myocardial ischemia
- b. Cocaine effects
- c. Takotsubo cardiomyopathy
- d. Alcoholic cardiomyopathy
- e. All of the above

2. Which of the following would be considered to be a clinical feature of myocarditis?

- a. Chest pain
- b. Palpitations
- c. Shortness of breath
- d. Fatigue
- e. All of the above

3. Patients with myocarditis are most likely to exhibit all of the following except:

- a. Tachycardia
- b. Hypotension
- c. Hypertension
- d. Heart failure
- e. Cardiomegaly

Rural and Tertiary Markets: The Next Urgent Care Frontier (page 34)

1. According to the Urgent Care Association's 2018 Benchmarking Report, what is the breakdown of suburban vs rural locations of urgent care centers?

- a. Half suburban, half rural
- b. 90% suburban, 10% rural
- c. 78% suburban, 4% rural
- d. This has not been studied

2. Potentially, oversaturation of urgent care in a given market could result in which of the following?

- a. Difficulty in finding and securing prime real estate in highly competitive trade zones
- b. Longer ramp-up periods for new centers to reach breakeven, requiring more working capital to launch a new urgent care or add new locations
- c. Higher overall operating costs—including rent, advertising, and labor
- d. Insurance companies refusing urgent care contracts and/or "location adds" to existing contracts for urgent care centers
- e. All of the above

3. What percentage of Americans have been unable to access healthcare when they needed it in recent years?

- a. 26%
- b. 73%
- c. 10%
- d. 50%
- e. 33%



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■ LAUREL STOIMENOFF, PT, CHC

Next month is National Mentoring Month. This initiative was launched in 2002 by MENTOR, the National Mentoring Partnership, and the Harvard T.H. Chan School of Public Health. It has focused primarily on the importance of mentors and our responsibility to develop and create access to good mentors for young mentees hungry for that next step. Yet, we now need to think outside the traditional definition of a mentor—typically one selected individual and oftentimes the mentee’s boss. Organizations are now creating mentorship programs that expand the talent pool by surrounding an employee with a team of experienced individuals—each contributing to the development of the mentee in different and complementary ways.

A UCA Board member and entrepreneur, Mike Dalton, CPA, has spoken on leadership to standing-room-only audiences at UCA and regional conferences. One of his most compelling messages is that each of us needs to create our OWN Board of Directors. Not the formal one that we may have for our organizations, but a personal board of handpicked individuals who we believe will help us find and achieve personal and professional goals. So, the profile of the mentor has changed, along with that of the mentee who was typically a young person who appeared to have the rudiments of a future leader or star.

My takeaway from Mike’s presentation was that it’s never too late to find one’s mentors. And *mentor* and *mentee* are not exclusive roles. We can and should aspire to be both throughout our careers.

I’m Making the Commitment

I have had some great mentors in my life, yet I have always thought of them in the traditional sense. They were typically



Laurel Stoimenoff, PT, CHC is Chief Executive Officer of the Urgent Care Association.

“Personal and professional development has no limitations—not by today’s age, title, or level of success.”

my boss and it was clear that they had my best interest at heart. They invested in my professional growth and despite busy schedules always seemed to have the bandwidth to be a sounding board and provide thoughtful counsel. No matter what our age or stage of life, we should consciously surround ourselves with our *personal* board. As life’s goals change, so may individuals on your board, but our lives will be enriched by identifying individuals who can facilitate growth. As I reflect on individuals who have had tremendous success in their personal or professional lives, I realize that most did exactly as Mike Dalton suggested: they established and leveraged key relationships to achieve, and oftentimes exceed, their goals.

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¹ <https://knowledge.wharton.upenn.edu/article/workplace-loyalties-change-but-the-value-of-mentoring-doesnt/>

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Ear Pain Mimics: It's Not All About Otitis Media

Urgent message: Though ear pain is often due to otitis media or externa, it is important to consider other diagnoses, some of which could be life-threatening, “can’t miss” causes.

BETH PHELPS, DNP, APRN-FPA, ACNP-C and KELLY O. PHELPS, JD, RN

Introduction

Patient complaints of ear pain (otalgia) are seen frequently in the urgent care setting. It can be frustrating for patients and providers when a patient’s ear pain has no obvious cause. Differential diagnoses include several primary and secondary causes of otalgia. (See **Table 1.**)

Lab values or radiological films are rarely helpful; the best diagnostic tool for ear-pain complaints is a focused physical examination of the patient’s head and neck.

Common Differential Diagnoses

Otitis media

General

Acute otitis media (AOM) is an inflammatory and sometimes infectious process of the middle and inner ear which may be suppurative or from a sterile effusion. Chronic serous otitis media (CSOM) is not painful. Non-infectious fluid found in CSOM can persist in the middle ear for up to 12 weeks.

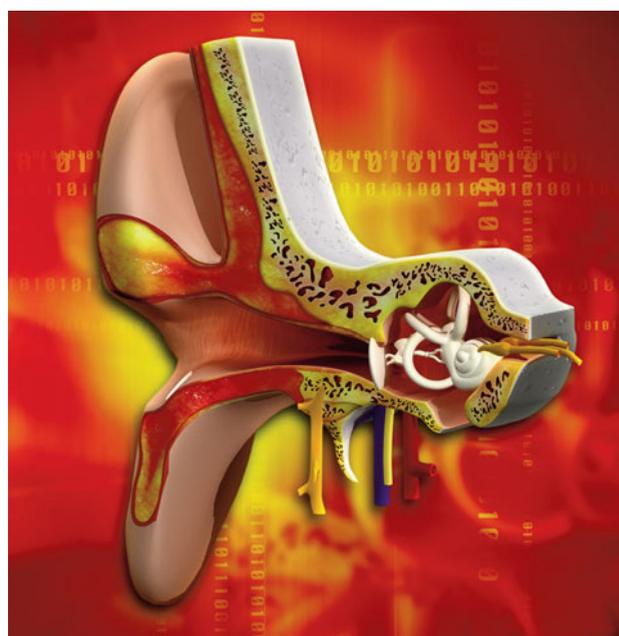
The peak incidence of AOM occurs in children under the age of 2 and is more common in boys than in girls. By age 6, 90% of children will have had at least one ear infection. Viral infections are the cause of 70% of these ear infections.^{1,2}

The most common viral causes are:

- Respiratory syncytial virus
- Rhinovirus
- Coronavirus
- Influenza
- Parainfluenza

The most common bacterial infections are:

- *Streptococcus pneumoniae*
- *Haemophilus influenzae*



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- *Moraxella catarrhalis*
- Gram-negative enteric bacteria
- *Staphylococcus aureus*

Mixed viral and bacterial infections occur frequently.³ The incidence of mixed infections reported in the literature varies from 20% to 60%.⁴

Ear infections occur most frequently in the winter months. Risk factors include bottle-feeding, exposure to second-hand smoke, attending daycare, allergies, family history, and craniofacial abnormalities. The patients may describe widely different patterns of onset, pain, aggravating and relieving factors.

Beth Phelps, DNP, APRN-FPA, ACNP-C is a visiting clinical instructor at the University of Illinois - Chicago College of Nursing, and a nurse practitioner/site investigator at Springfield Clinic Urgent Care. The authors have no relevant financial relationships with any commercial interests.

Table 1. Causes to Consider in Diagnosing Ear Pain Complaints in Urgent Care	
Otitis media	Tonsillitis
Otitis externa	Sinusitis
Herpes zoster/Ramsay Hunt syndrome	Nasopharyngeal tumor
Mastoiditis	Wegener's granulomatosis
TMJ/bruxism	Temporal arteritis
Barotrauma	AMI; angina pectoris; CAD
GERD	Thoracic aneurysm
Migraines/neuralgia	Foreign body
Carotidynia	Cerumen impaction
Dental causes	Cellulitis, chondritis, perichondritis
Aphthous ulcers	Salivary gland disorder
Trigeminal neuralgia	Cholesteatoma, osteoma
Mandibular osteomyelitis/tumor	Psychogenic
Eagles syndrome	Idiopathic
Acoustic neuroma	

History

Include previous ear infections, ear surgeries, and environmental allergies and treatment in your patient's history. Ask your patient about any recent travel, flying, or trauma. A pediatric history should include birth, delivery, immunizations, current development, secondhand smoke exposure, allergies, and daycare attendance.

If your patient has fluid in their middle or inner ear they will have decreased, muffled, or absent hearing; this can be assessed with finger rub and whisper tests. Positive Weber and Rinne tests will specifically indicate a conductive hearing loss if there is fluid present in your patient's middle or inner ear.

Exam

Upon otoscopic examination, air-fluid levels may be present with or without purulence and erythema. Observation of drainage in the ear canal is indicative of acute suppurative otitis media. Submandibular and deep cervical chain nodes are usually the first to become swollen in patients with AOM; however, palpation of the head and neck may or may not demonstrate any swollen lymph nodes. Pneumatic otoscopy is 70%–90% sensitive and specific for determining the presence of middle ear effusion.⁵ In most cases, visualizing a bulging, ery-

thematos tympanic membrane is sufficient for diagnosis.⁵ Cloudy tympanic membrane is 90.8% sensitive, 91.7% specific.⁶ Bulging TM is 61.2% specific, 96.9% sensitive. Ear rubbing is 42% specific, 87% sensitive.

AOM is not particularly common in adults. According to the most recent American Association of Pediatrics (AAP), oral antibiotics are recommended for AOM (bilateral or unilateral) in children 6 months and older with severe signs or symptoms. Severe AOM is defined as moderate pain for 48 hours and fever greater than 102.2° F. Antibiotic therapy should be used for bilateral AOM in children 6 months through 23 months of age without severe signs or symptoms.

If AOM is unilateral, close follow-up is appropriate. Monitoring with close follow-up is recommended for patients with less-than-severe symptoms who are greater than 12 months old. Close follow-up can be accomplished via phone call or office visit. Resolution of acute pain and purulence is typically seen within 48 hours of onset without antibiotic therapy.^{2,7}

Antibiotic therapy is summarized in **Table 2**.^{2,3,7,8}

If an individual has myringotomy tubes or a perforated eardrum, use drops. Do not irrigate. You will know if patients with tubes have an ear infection because their tubes will drain. Insert 2-3 drops in the affected ear three times daily; ear canals are small and cannot hold more liquid than 2-3 drops. **Table 3** gives an overview of antibiotic ear drops.^{2,3,7,8}

Otitis Externa

General

Otitis externa (swimmer's ear) is an infection of the outer ear canal. It is a very painful condition and can be associated with radiation of pain, pruritus, hearing loss, or drainage. Patients often complain of a feeling of fullness in the affected ear. Onset of otitis externa may be rapid or slow and may, or may not, be associated with a fever.⁹ Pain may be worse with motion or manipulation of the ear.

Otitis externa is caused by an infectious pathogen entering the skin of ear canal, often due to microabrasions from Q-tips, ear buds, or hearing aids.

History

Inquire about swimming and other potential sources of moisture, such as earplugs, eczema, psoriasis, dermatitis, or acne. The most common bacterial pathogens are *Pseudomonas aeruginosa* and *Staphylococcus aureus*. Ten percent of these infections are fungal, typically *Aspergillus* or *Candida*.³ Otitis externa is often caused by more than one pathogen.³

Table 2. Antibiotic Recommendations and Dosing			
	Drug	Dose	Frequency
1 st line therapy	Amoxicillin	Children: 90 mg/kg/day total Adults: 875 mg	3 times daily 2 times daily
Pt treated with antibiotic in past 30 days	Augmentin	Children: 90 mg/kg/day total Adults: 875 mg	3 times daily 2 times daily
PCN allergy	Azithromycin	Children: 10 mg/kg 1 st dose, then 5 mg/kg doses 2 thru 5 Adults: 500 mg 1 st dose, then 250 mg doses 2 thru 5	Once daily Once daily
Alternatives	Cefdinir	Children: 14 mg/kg/day Adults: 300mg	Once daily 2 times daily
	Cefuroxime	Children: 30 mg/kg/day Adults: 250 to 500 mg	2 times daily 2 times daily
	Cefpodoxime	Children: 10 mg/kg/day Adults: 100 to 400 mg	2 times daily 2 times daily
	Ceftriaxone	Children: 50 mg/kg (max 1 gram) IM Adults: 1 to 2 g IM	Once daily Once daily

Table 3. Antibiotic Eardrops: An Overview		
Bacterial		
2% acetic acid	Inexpensive	2-3 drops in affected ear 3 times daily. Use for 7 to 10 days
Neomycin otic	Contact dermatitis develops in 15% of patients	
Polymixin B	Avoids neomycin sensitivity Ineffective against Staph and Gram + bacteria	
Aminoglycosides	Ototoxicity risk	
Fluroquinolones	Well tolerated Expensive Risk of ATB resistance if used frequently	
Combination ATB with steroids	Can be very expensive	
Fungal		
2% acetic acid	Inexpensive	2-3 drops in affected ear 3 times daily. Use until infection is resolved
Clotrimazole solution	Works on both <i>Candida</i> and <i>Aspergillus</i>	
Itraconazole	Resistant aspergillus may require oral therapy	
ATB, antibiotic		

Exam

Visual inspection may reveal redness, swelling, or scaling of the external ear. There may be visible drainage (otorrhea). Lymphadenopathy may be palpable at the base of the ear. Hearing will be decreased in the affected ear. Otoscope exam may be difficult if there is drainage. If there is no drainage, mucopurulent debris is seen in the

ear canal. Fungal debris may be fluffy white (*Candida*) or dark in color (*Aspergillus*).

Eczema and other skin conditions can be particularly troublesome for patients. Dry skin around the ear can cause itching. Controlling the eczema is necessary to prevent otitis externa from developing. Steroid creams such as triamcinolone can be used up to three times

Figure 1. Ramsay Hunt Syndrome

A 65-year-old woman with a rash that appeared with onset of ipsilateral facial palsy, as well as ear pain and hearing loss. She was diagnosed with Ramsay Hunt syndrome.

Image courtesy of Logical Images, Inc. (www.VisualDx.com/JUCM)

daily. A referral to dermatology or otolaryngology for these patients should be considered.

Management

Otitis externa treatment starts with cleaning of the ear canal. The underlying skin is usually very macerated and inflamed; irrigation with water can be performed after a perforated eardrum is excluded.

An ear wick may be inserted if the canal is swollen. Ear wicks should fall out within 24-48 hours. Patients should be seen 2-3 days after insertion of an ear wick to ensure the ear wick fell out and the patient's infection is resolving. Severe pain out of proportion to physical exam findings may be from malignant otitis externa; emergent referral is recommended. For patients in whom a wick is poorly tolerated, or cases where the canal is blocked, oral antibiotics may be needed.

Patients should be strongly encouraged to refrain from inserting anything into the ear for the purpose of cleaning the ear. Swimmers should consider getting custom earplugs made by an audiologist.

Ramsay Hunt Syndrome

General

Ramsay Hunt syndrome is caused by the varicella zoster virus in patients who have previously had chickenpox; the virus lays dormant until a shingles outbreak occurs. Ramsay Hunt syndrome is characterized by a unilateral vesicular facial rash, which involves portions of the patient's ear, mouth, neck, and scalp. Cardinal signs also

include paralysis of facial nerves on the affected side and a loss of taste on the anterior two-thirds of their tongue. Either the rash or the facial paralysis may come first. Symptoms can last for several weeks. Symptoms may be permanent. Pain characteristics, aggravating factors, and relieving factors can vary widely. Symptoms are persistent and may include tinnitus and/or dizziness.

History

Obtain a history of childhood illnesses and vaccinations. The patient may have a recent history of shingles or similar rashes. Ask if there is any previous history of vertigo, hearing loss, or facial paralysis. Also, inquire about new medications (specifically immunosuppressive therapies and steroids), history of stroke, blood clots, or vascular disease.

Exam

Visual inspection will demonstrate a vesicular rash on the external ear, face, and scalp. Look for signs of infection to the eye. Complete a neurological exam. Have your patient raise their eyebrows, smile showing their teeth, and stick out their tongue. Facial weakness on one side will be noticeable. Whisper and finger rub testing will reveal diminished hearing on the affected side. Weber and Rinne will indicate sensorineural hearing loss. You may observe vesicles inside the ear canal upon otoscopic examination.

Management

Treatment is most effective if started within the first 72 hours after the rash develops. Antiviral medications have demonstrated a decrease in the duration of illness and reduced incidence of post herpetic neuralgia. Patients over the age of 50 years have the largest benefit from treatment. Valacyclovir 1,000 mg by mouth three times daily for 5 to 7 days is the first-line therapy, but acyclovir and famciclovir may also be used. A prednisone taper has been shown to decrease pain in patients over 50 years of age.¹⁰ Cool, wet compresses can help with itching and painful rash. Moisturizing eye drops should be used during the day. Eye lubricants may be needed at night. The affected eye should be taped shut to prevent injury.

Mastoiditis

General

Mastoiditis is a potentially life-threatening infection of the mastoid air cells behind the ear. This infection is caused by *Streptococcus pneumoniae*, *Streptococcus pyogenes*, *Staphylococcus aureus*, *Haemophilus influenzae*, or

Moraxella catarrhalis.¹¹ Symptoms are present 2-6 days after the onset of acute otitis media. Mastoiditis is more prevalent in children but can also occur in adults.

Onset of mastoiditis is gradual and usually follows an episode of otitis media or upper respiratory infection. Pain is severe, constant, and isolated to the affected ear. It may be described as sharp, dull, or aching. Pain may persist for days or even weeks. Aggravating factors typically include palpation, chewing, swallowing, and walking.

History

The medical history should include an inquiry about antibiotic use within the past 30 days. Obtain a history of hearing loss. Inquire whether the patient has a history of diabetes, stroke, blood clots, or myringotomy tubes. Consider ruling out blood clots in the brain if there have been any changes in vision or headache.

Exam

On examination, the patient will have retro auricular pain and tenderness over the mastoid. Erythema, warmth, and swelling behind the auricle of the affected ear should raise a strong suspicion for mastoiditis.

Testing

A CT scan with and without contrast of the temporal bones should be ordered if mastoiditis is suspected based on exam findings. Emergent referral to ENT or transfer to the ED is recommended.

Immediate referral to ENT is needed if mastoiditis is present. These patients frequently require hospitalization and close monitoring.

Temporal Mandibular Joint Dysfunction

Temporal mandibular joint (TMJ) dysfunction includes pain in the muscles of mastication or the TMJ joint. It is most common in women between the ages 20 and 40 years of age. It is the second most common cause of orofacial pain.^{12,13} Trismus, spasms, myositis inflammation, trauma (dislocation/fracture), degenerative arthritis, or infection can all cause TMJ pain.

Past medical history may include recent dental work, grinding teeth (bruxism), braces, baby teeth falling out, or eruption of adult teeth. Aggravating factors can include chewing, yawning, jaw clenching, and walking. The pain is often characterized as dull, achy, poorly localized, intermittent, and unilateral.

Physical examination includes special attention to the temporalis, buccinators, and zygomaticus muscles. Make sure to palpate the masseter muscle at the back of the

jaw. It is located behind the teeth, and it is necessary to palpate in the mouth with a gloved hand. This muscle opens and closes the jaw. Sometimes it is the only location patients will feel pain on palpation. The masseter muscle forms the front wall to the ear and is often the reason pain is felt in the ear. Have the patient open and close their mouth while palpating the TMJ joint. Feel for popping, clicking, or dislocation of the joint with opening and closing of the mandible.

Treatments include: no gum chewing, soft diet, NSAIDs, and alternating ice and heat to the affected area for 20 minutes, three times daily. Muscle relaxers may be of benefit for some patients with severe pain.¹³ Cyclobenzaprine 10 mg up to three times a day can be prescribed. In older patients or those with contraindications to cyclobenzaprine, baclofen 10 mg up to three times daily may be a better alternative.^{14,15} Referral to a dentist that treats bruxism may be necessary for some patients.

Barotrauma

Barotrauma is caused by significant atmospheric pressure changes and results in damage to the tympanic membrane and other ear tissues. Barotrauma usually occurs during diving or flying. It can occur when a patient is slapped with an open hand. Patients with congestion prior to flying can be susceptible to barotrauma. It is common for patients to report allergies or nasal congestion prior to the incident giving rise to their barotrauma diagnosis. A history of chronic ear infections or myringotomy tubes may predispose a patient to barotrauma injury. Physical examination will reveal a visible perforation or fluid or blood in the canal.

Management

Symptomatic management includes healing with time; antibiotics, steroids and decongestants have not been shown to improve healing. Nonemergent surgery may be necessary for severe injuries.

Prevention

Patients with nasal congestion may use a nasal decongestant—two squirts in each nostril prophylactically when traveling on a plane. This will open the Eustachian tubes and help equalize middle ear pressures. A steroid nasal inhaler, two squirts in each nostril, twice daily for two weeks prior to flying will also help to shrink the turbinates and the lining of the sinus cavities.¹⁶ This aids in maintaining normal inner ear pressures. Likewise, frequent swallowing also helps equalize inner ear pressure. It can be helpful for patients

susceptible to barotrauma to have water, chewing gum, and hard candy available when flying.

Gastroesophageal Reflux Disorder

HPI

Gastroesophageal reflux can cause a multitude of symptoms, including otalgia, globus sensation (feeling of a lump in the throat), heartburn, chest pain, radiating pain, hoarseness, throat clearing, nausea, and regurgitation of food. The first symptoms for them may be globus sensation or ear complaints.¹⁷ Past medical history may include heartburn or treatment for reflux. Physical examination will be unremarkable. This diagnosis is made based on history.

Discuss dietary modifications such as limiting caffeine, nicotine, and alcohol. Other things to avoid are whole milk products, chocolate, peppermint, cinnamon, tomatoes, and anything that aggravates symptoms. The initial treatment is H₂ blockers or proton pump inhibitors (PPIs). Patient should be encouraged to take these medications 30 minutes prior to eating on an empty stomach.⁸ Patients need referral to the emergency room if they are having trouble swallowing or breathing. Referral can also be made to otolaryngology to confirm the diagnosis.

Other Potential Diagnoses

Other diagnoses to consider were listed in **Table 1**. Most are caused by an insult or aggravation to a cranial nerve. Some causes of otalgia are simple, such as embedded foreign bodies, cerumen impaction, or cellulitis. Some causes of otalgia can be life-threatening, such as acute myocardial infarction and thoracic aneurysm.¹⁸ Otalgia is frequently caused by otitis media; nevertheless, the provider should consider the causes enumerated in **Table 1** when formulating a differential diagnosis during an atypical examination.

Conclusion

Complaints of otalgia are frequent in the urgent care setting, with patients often believing they have an ear infection that warrants a prescription for an antibiotic prescription. Consideration of an expanded differential may lead the provider to discover an alternative diagnosis. Approach each patient with an open mind and look for the clues that will help formulate an accurate diagnosis. ■

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Key Takeaways

- The most common *viral* causes of **acute otitis media** are respiratory syncytial virus; rhinovirus; coronavirus; influenza and parainfluenza. The most common *bacterial* infections are *Streptococcus pneumoniae*; *Haemophilus influenzae*; *Moraxella catarrhalis*; Gram-negative enteric bacteria; *Staphylococcus aureus*.
- In **chronic serous otitis media**, noninfectious fluid can persist in the middle ear for up to 12 weeks.
- **Barotrauma** is caused by significant atmospheric pressure changes, usually while diving or flying, resulting in damage to the tympanic membrane and other ear tissues. Antibiotics, steroids, and decongestants have not been shown to improve healing. Symptomatic management includes healing with time. Nonemergent surgery may be necessary for severe injuries.
- **Ramsay Hunt syndrome** is characterized by a unilateral vesicular facial rash, which involves portions of the patient's ear, mouth, neck, and scalp. Antiviral medications have demonstrated a decrease in the duration of illness and reduced incidence of post herpetic neuralgia. First-line treatment is valacyclovir 1,000 mg by mouth three times daily for 5 to 7 days.
- **Mastoiditis**, caused by *Streptococcus pneumoniae*, *Streptococcus pyogenes*, *Staphylococcus aureus*, *Haemophilus influenzae*, or *Moraxella catarrhalis*, is potentially life-threatening. Emergent referral to an ENT or transfer to the ED is recommended if mastoiditis is suspected.



Atypical Chest Pain in a Fibromyalgia Patient Presenting to Urgent Care

Urgent message: Underlying medical and psychiatric conditions can cloud judgment and lead to cognitive errors, which may result in potentially serious medical errors.

TRACEY Q. DAVIDOFF, MD, FACP, FCUCM

Case Presentation

A 31-year-old woman with a medical history significant for fibromyalgia, migraines, bipolar disorder, and anxiety presents with 2 hours of severe bilateral neck spasms, left shoulder and arm pain, and chest pain which began soon after taking a new prescription for olanzapine. She also has worsening in her chronic anxiety and relates similar symptoms related to her fibromyalgia in the past. She requests ketorolac as this has worked for her in the past.

In addition:

- PMH: Negative
- PSH: Negative
- FH: Negative
- SH: She denies drug use

The nurse states the patient is a “frequent flyer” and suggests you look through previous visits before making a decision on the management and disposition. Review of the EMR indicates that the patient has had multiple visits for neck pain, back pain, shoulder pain, and joint pain, always with an overlay of anxiety and relieved with ketorolac.

Physical

Vital signs:

- Pulse: 65 bpm
- BP: 125/72RR: 18
- Oxygen saturation 99% on room air

General: Agitated and anxious; trouble sitting still; difficulty focusing on the history and physical

Neck: Tender with muscular palpation over the neck,



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upper back and shoulders

Chest: Chest wall tender, patient complains that the ECG leads are hurting her and reproducing her pain

Lungs: Clear to auscultation

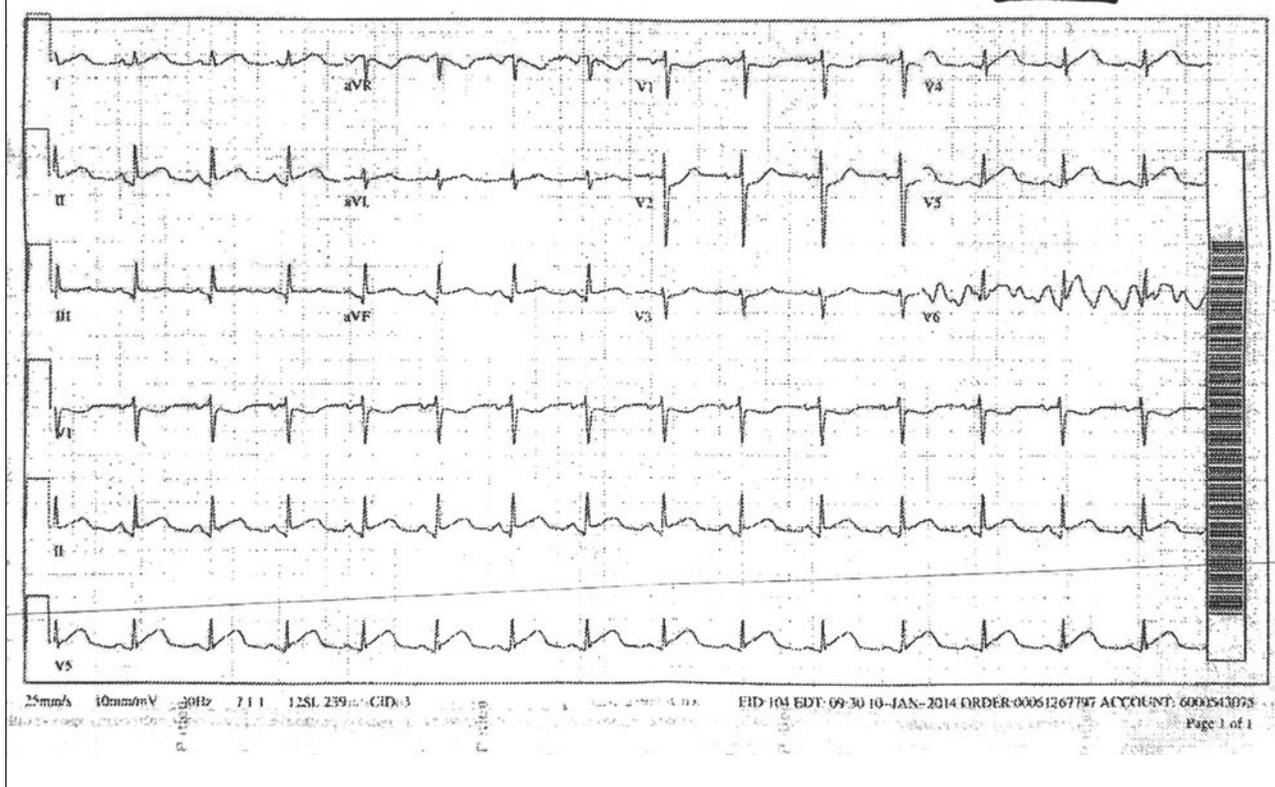
Heart: Regular rate and rhythm; no murmurs or gallops heard

Abdomen: Soft, non-tender

Extremities: Symmetric, normal tone, normal range of motion

Tracey Q. Davidoff, MD, FACP, FCUCM is an Attending Physician at Advent Health Centra Care in Orlando, FL, and a member of the JUCM Editorial Board. The author has no relevant financial relationships with any commercial interests

Figure 1.



Neurologic: Awake alert and oriented; non-focal motor exam

ECG: See **Figure 1**. The ECG is interpreted as normal sinus rhythm with inferior Q waves and ST changes (leads II, III, aVF) concerning for inferolateral ischemia.

“Clinical features of myocarditis may include chest pain, palpitations, shortness of breath, and fatigue...but these findings may be subtle. Patients may exhibit tachycardia, hypotension, signs of overt heart failure, cardiomegaly, heart block, arrhythmia, and sudden cardiac death.”

Discussion

Differential diagnosis includes myocardial ischemia,

cocaine effects, normal variant, past history of infarction, myocarditis, and takotsubo cardiomyopathy. The HEART score (H=history, E=ECG, A=age, R=risk factors, T=troponin) is a quick and simple way to risk-stratify patients with chest pain for acute coronary syndrome, with a low score (0–3) making the risk of a major adverse cardiac event (MACE) very unlikely.²

While tempting to use, we do not have a troponin result; of note, the score should not be used with ECG findings of acute ischemia.

The patient denies drug use, but even if cocaine is present that may still indicate ischemia due to vasoconstriction and increased platelet aggregation. Without a previous ECG, we cannot assume a normal variant and will need to assume there is acute ischemia.

The Q waves may indicate a previous infarction.

Myocarditis is a difficult diagnosis, as initial symptoms may be subtle, sometimes with isolated chest pain and tachycardia. Takotsubo cardiomyopathy (broken-heart syndrome or stress cardiomyopathy) is a cardiomyopathy that occurs in the absence of atherosclerotic heart disease.³ Onset frequently occurs in periods of extreme

emotional stress, such as the death of a close relative, financial crisis, or broken bone. The illness mimics MI, but the coronary arteries are found to have no occlusions. Catecholamine surge is the suspected cause of this disorder. Patients are subject to the same complications as any other myocardial infarction patient.

Outcome

Despite the patient's past history of fibromyalgia and symptoms of anxiety, the ECG was very concerning for ischemia; however, the patient was not willing to stay and signed out against medical advice (after appropriate discussion and documentation).

Two days later, she went to her primary care doctor with the similar complaints, with a focus on the neck and shoulder pain. Curiously, she did not mention the chest pain. The primary care provider apparently did not look at the previous visit or the ECG, and reassured the patient that she would be fine with rest and her usual medications.

She was found dead in her home later that day.

The patient had an autopsy, which revealed a ruptured left ventricle with a hemorrhagic pericardial effusion. The microscopy on the myocardium was consistent with inflammatory changes due to a myocarditis. The coronary arteries were clean. It was later discovered that the patient had an upper respiratory infection a couple of weeks prior, which the pathologist felt may have been the cause of the myocarditis.

Myocarditis

Clinical features of myocarditis may include chest pain, palpitations, shortness of breath, and fatigue, but this is a difficult diagnosis as these findings may be subtle. Patients may exhibit tachycardia, hypotension, signs of overt heart failure, cardiomegaly, heart block, arrhythmia, and sudden cardiac death.⁴

The most common causes of myocarditis include viral infection, bacterial infection, Lyme disease, cardiotoxins, cocaine, hypersensitivity reactions, and systemic inflammatory diseases.⁵

Markers of inflammation such as ESR and CRP are usually elevated, as is troponin. Echocardiogram will reveal focal or global myocardial dysfunction and a reduced ejection fraction. Pericardial effusion may be present.

Although not *always* required, an endomyocardial biopsy *may* be required to establish the diagnosis. Prognosis depends on severity of illness and underlying cause. Transplantation may be lifesaving.

Debrief

This patient was a frequent visitor to urgent care. She had presented multiple times with similar symptoms, leading both the provider and the patient to believe that her symptoms were related to a flare of fibromyalgia. The overlying symptoms of bipolar disorder and anxiety, and the history of the recent initiation of olanzapine, further complicated the diagnostic process.

“The astute clinician needs to evaluate each visit as a separate entity so serious underlying pathology is not missed. Past medical history should be used as a tool to assist decision-making, but not guide it.”

It would have been very easy to dismiss her symptoms based on her previous visits, fibromyalgia, the olanzapine, or her anxiety. This type of cognitive error constitutes posterior probability error, or the “history repeats itself” bias.¹ In this error, the urgent care or emergency department staff (as well as the patient) may estimate the likelihood of disease, in this case fibromyalgia flare, based on the previous visits and diagnosis.

The astute clinician needs to evaluate each visit as a separate entity so serious underlying pathology is not missed. Past medical history should be used as a tool to assist decision-making, but not guide it. As an example, patients with migraines still may be susceptible to subarachnoid hemorrhage and need to be carefully assessed for other potentially more serious causes of headache at each visit.

In this case, had this provider diagnosed the patient with fibromyalgia or anxiety symptoms and not ordered an ECG, he or she would have missed a serious life-threatening condition. Sadly, identifying the abnormal ECG did not improve the outcome in this case. ■

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ABSTRACTS IN URGENT CARE

- Guidance on Management of Patients with E-cigarette, or Vaping, Product Use-Associated Lung Injury
- One More Option to Stem Consequences of Flu
- CDC warns STD Rates Skyrocketing
- FDA Update on NDMA-Containing Medications
- Management of Patients Presenting with Acute Upper GI Bleed

■ CORNELIUS O'LEARY JR, MD

More Advice on Inquiring About—and Assessing—Vaping and EVALI

Key point: Physicians should inquire about e-cig or vaping use in a nonjudgemental but thorough manner. Ask about specific products, frequency, and associated drug use.

Citation: Siegel DA, Jatlaoui TC, Koumans EH, et al. Update: Interim Guidance for Health Care Providers Evaluating and Caring for Patients with Suspected E-cigarette, or Vaping, Product Use Associated Lung Injury—United States, October 2019. *MMWR Morb Mortal Wkly Rep.* 2019;68:919–927.

The Centers for Disease Control and Prevention, Food and Drug Administration, and local health departments continue to investigate multistate outbreaks of pulmonary injury associated with use of e-cigarettes or vaping of cannabis, nicotine, or home brew associated products. Prompt recognition of warning signs and transfer of patients for admission or observation may save lives. Patients suspected to have e-cigarette, or vaping, product use-associated lung injury (EVALI) should have a chest radiograph.

Criteria for admission to the hospital may include patients who have a pulse ox of less than 95% on room air, or who are in respiratory distress. Providers should consider the empiric use of a combination of antivirals, antibiotics, or steroids as clinically appropriate and based on clinical context.

As of October 2019, 1,300 cases of EVALI have been reported in the U.S. with 26 deaths; 70% were male; median age was 24; 80% were less than 35 years old and 15% less than 18 years of age.



Cornelius O'Leary Jr, MD is an urgent care physician with Emergency Care Dynamics, San Diego, CA.

The CDC notes that “EVALI is considered a diagnosis of exclusion because, at present, no specific test or marker exists for its diagnosis. Healthcare providers should consider multiple etiologies, including the possibility of EVALI and concomitant infection. In addition, healthcare providers should evaluate alternative diagnoses as suggested by clinical findings and medical history (eg, cardiac, gastrointestinal, rheumatologic, and neoplastic processes; environmental or occupational exposures; or causes of acute respiratory distress syndrome).

Management of Patients with EVALI

Admit to the hospital if patients have a pulse oximetry of less than 95%, if they have respiratory distress, or if they have comorbidities that decrease pulmonary reserve, such as COPD and asthma.

Outpatient treatment can be considered for patients who are clinically stable, and for whom follow-up within 23-48 hours can be assured. Healthcare providers should specifically counsel patients that symptoms can rapidly worsen within 48 hours and that they should call 911 and go to the nearest emergency room if symptoms worsen. Any worsening of symptoms or respiratory distress in the setting of possible EVALI should be referred to the ED.

Community-acquired pneumonia and influenza should be considered for all patients who complain of symptoms related to e-cigarettes due to symptom overlap. Recent guidelines advocate dual antiviral (within 48 hours) and antibiotic therapy for patients with CAP who test positive for influenza.

The CDC noted that empiric evidence points to a potential for clinical improvement with corticosteroids. With one subset of patients reported to the CDC, over 80% showed clinical improvement with glucocorticoids. Treatment should be tailored based on clinical risks/rewards on a case by case basis.

Follow-up

Patients treated for possible EVALI should have a follow-up visit that includes pulse oximetry within 1-2 weeks, and clinicians should consider repeating the chest radiograph. These guidelines contrast with recent updates in guidelines for CAP that do not recommend follow-up chest radiographs. Repeat CXR may be helpful for the continued evaluation of patients with EVALI. Spirometry should be performed within 1-2 months after initial concern for EVALI.

Smoking and e-cigarette/vaping cessation should be emphasized for patients. The CDC urges providers to consider whether the patient has had exposure to vaping during follow-up. Patients who stop vaping may have a more rapid resolution of clinical symptoms, while those who continue to vape, especially in the setting of comorbidities such as cardiopulmonary disease, may experience repeat symptoms or progression of clinical disease requiring admission or intubation.

At this point, the CDC has not identified a common cause of EVALI. It is important for clinicians to know that it is not only THC but possibly nicotine-containing products that cause EVALI, and the safest recommendation is for patients to stop all e-cigarette, vaping, and cigarette use. ■

Another Weapon in Preventing and Minimizing Risk for Influenza

Key point: As flu season intensifies, the FDA has expanded the indication of one medication beyond patients with influenza infection, to include those merely at high risk for infection.

Citation: FDA Approval of Xofluza (Baloxavir Marboxil) for People at High Risk of Developing Influenza-Related Complications. Available at: <https://www.gene.com/media/press-releases/14817/2019-10-17/genentech-announces-fda-approval-of-xofl>. Accessed October 31, 2019.

The FDA has expanded the indications of Xofluza (baloxavir marboxil) to include patients at high risk of complications from influenza. The initial indication was for the treatment of patients with influenza within the first 48 hours of symptoms. Single-dose Xofluza is the sole antiviral medication indicated for patients at high risk of developing serious complications from flu.

The Centers for Disease Control and Prevention defines people at a high risk of serious flu complications as those with:

- Asthma
- Chronic lung disease
- Heart disease
- Diabetes
- Morbid obesity
- Age 65 years or older

The authors note that the expanded indication for baloxavir follows the CAPSTONE-2 a Phase III multicenter randomized

double-blinded trial which evaluated single-dose Xofluza (40 or 80 mg based on weight in kg) in patients 12 and older who have developed symptoms of influenza in the previous 48 hours. The study compared single-dose baloxavir with placebo and with oseltamivir.

“There was an alarming increase in congenital syphilis (22% from 2017 to 2018), resulting in between 77 and 94 deaths, between 2017 and 2018. Incidence of all gonorrhea and chlamydia rose, as well, during that period (though not as dramatically as syphilis did).”

Baloxavir significantly reduced the time to resolution of symptoms in patients at high risk of significant complications from the flu from 102 to about 73 hours ($p < 0.001\%$). It is a first-in-class antiviral medication which affects a cap endonuclease and inhibits viral replication. Baloxavir has shown efficacy in oseltamivir-resistant strains and avian strains in nonclinical laboratory studies. Baloxavir is currently being studied in children less than 1 year of age and severely ill hospitalized patients. The ability of baloxavir to reduce the transmission of flu from infected to healthy people is also being assessed. There may be more indications in the future.

Side effects were mild and baloxavir was well tolerated with the main side effects being diarrhea, bronchitis, sinusitis, nausea, and headache. Serious side effects and allergic reactions have occurred, so urgent care providers should advise patients to seek medical attention if serious side effects are noticed; these include:

- Dizziness or lightheadedness
- Throat swelling
- Trouble breathing
- Skin rash or hives

Baloxavir is not indicated for children under 12 or women who are pregnant or breastfeeding. Inform patients that baloxavir can be taken without respect to meals, but should not be taken with dairy products, laxatives, antacids, or foods or beverages containing calcium, iron, selenium, zinc, or magnesium. ■

STDs Continue to Rise, Led by Record Syphilis Infections

Key point: The CDC warns that combined cases of the three most frequently reported sexually transmitted diseases reached an all-time high in the U.S., according to its annual Sexually Transmitted Disease Surveillance Report.

Citation: Centers for Disease Control and Prevention. New

CDC Report: STDs continue to Rise in the U.S. October 8, 2019. Available at: <https://www.cdc.gov/nchhstp/newsroom/2019/2018-STD-surveillance-report-press-release.html>. Accessed November 8, 2019.

The Centers for Disease Control and Prevention warns that there was an alarming increase in congenital syphilis (22% from 2017 to 2018), resulting in between 77 and 94 deaths, between 2017 and 2018. Incidence of all gonorrhea and chlamydia rose, as well, during that period (though not as dramatically as syphilis did).

“The CDC notes that factors behind the increase in STDs include decreased condom use; testing; high-risk behaviors; and socioeconomic issues; and encourages all stakeholders to increase testing, treatment, partner treatment, and education of patients.”

Syphilis

There were 115,000 cases of syphilis reported during the period covered by the report. Primary syphilis presents with a painless sore (a chancre) between 3 weeks and 3 months post infection. This chancre lasts 3 weeks to 6 weeks. The patient still has syphilis if not treated, however. Secondary syphilis presents with fever, lymphadenopathy, joint pain, and a rash involving the palms of the hands and soles of the feet. This has historically been called a “nickel and dime rash.” Primary and secondary infections increased by 14%, to over 35,000 cases. This represents the largest number of cases in the U.S. since 1991.

Be prepared to recognize signs and symptoms of syphilis in your clinic. Syphilis has traditionally been called *the great masquerador* due to the nature of the symptoms. Many patients deny any sexual activity and may even refuse testing. In addition, the *Morbidity and Mortality Weekly Report* has reported an increase in methamphetamine, heroin, fentanyl, and other hard drug use in heterosexual patients with syphilis and men-who-have-sex-with-men and have syphilis.

Of paramount importance for physicians, the CDC reports that the number of congenital syphilis cases rose more than 40% to over 1,300 cases. Given that these are confirmed reports, the actual number of cases may be much higher.

The authors note that the national rise in syphilis cases mirrors the national rise in syphilis among women of childbearing age. “The national rise in congenital syphilis parallels increases in syphilis among women of reproductive age. From 2017 to 2018, syphilis cases increased 36% among women of childbearing age. Addressing rising syphilis incidence is critical to prevent congen-

ital syphilis. Women can protect themselves by practicing safer sex, being tested for syphilis by a health care provider, and if infected, seeking treatment immediately and asking her partner to get tested and treated to avoid reinfection.”

The World Health Organization states: “Congenital syphilis is the second leading cause of preventable stillbirth globally, preceded only by malaria.”

Gonorrhea

Gonorrhea cases grew 5% to more than 580,000 from 2017 to 2018. This is also a record high in the U.S., and the highest number of cases since 1991.

Chlamydia

Chlamydia cases increased 3% to over 1.7 million cases—the most ever reported to the CDC.

Chlamydia can be cured in most cases with a single 1 g oral dose of azithromycin. Many young women are asymptomatic carriers of this infection.

The CDC reminds clinicians that “antibiotics can cure syphilis, gonorrhea, and chlamydia. However, left untreated, STDs can be transmitted to others and produce adverse health outcomes such as infertility, ectopic pregnancy, and increased HIV risk.”

General Considerations

The CDC reports that it is essential that women who present to a physician for the first time about their pregnancy be tested for STDs, including syphilis. Education about STDs, prevention, testing, and treatment are important. The authors note that women who are at high risk should be tested early during the third trimester and at delivery. A simple discussion about the dangers of STDs during pregnancy can be helpful.

Urgent care providers should consider ordering a full STD panel when testing patients for STDs (as opposed to testing only for a specific infection).

The CDC notes that factors behind the increase in STDs include decreased condom use, testing, high risk behaviors, and socioeconomic issues. The CDC encourages all stakeholders to increase testing, treatment, partner treatment, and education of patients to decrease the prevalence of STDs. ■

FDA Reaffirms Stance on NDMA-Containing Products

Key points: The FDA says its recommendations for patients remain unchanged: Patients using OTC ranitidine or nizatidine “can consider” using OTC alternatives, like famotidine or omeprazole. Those using prescription ranitidine or nizatidine should talk with their clinicians about other options.

Citation: Food and Drug Administration. FDA updates and press announcement on NDMA in Zantac (ranitidine). Available at: [https://www.fda.gov/drugs/drug-safety-and-avail-](https://www.fda.gov/drugs/drug-safety-and-avail)

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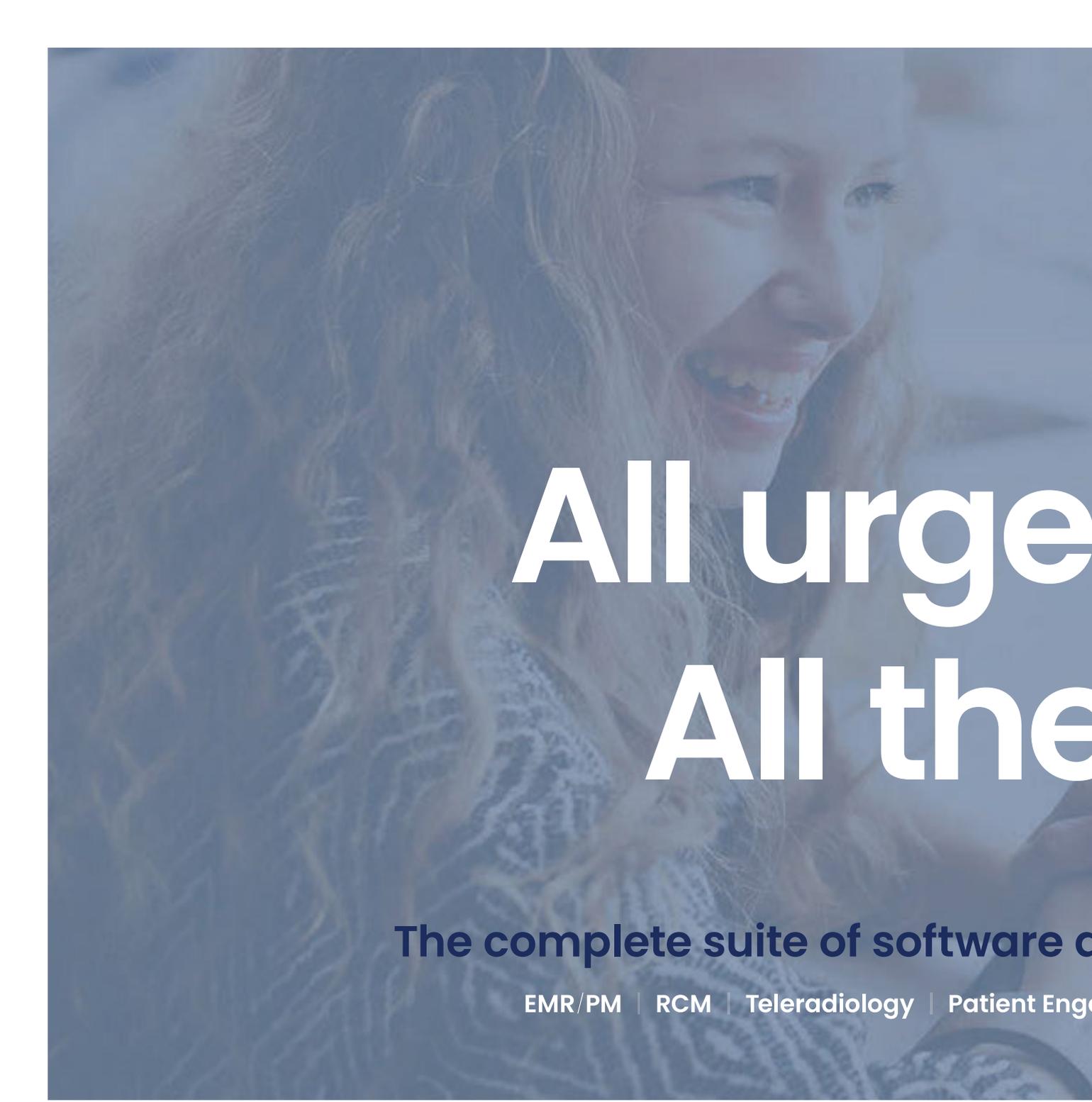
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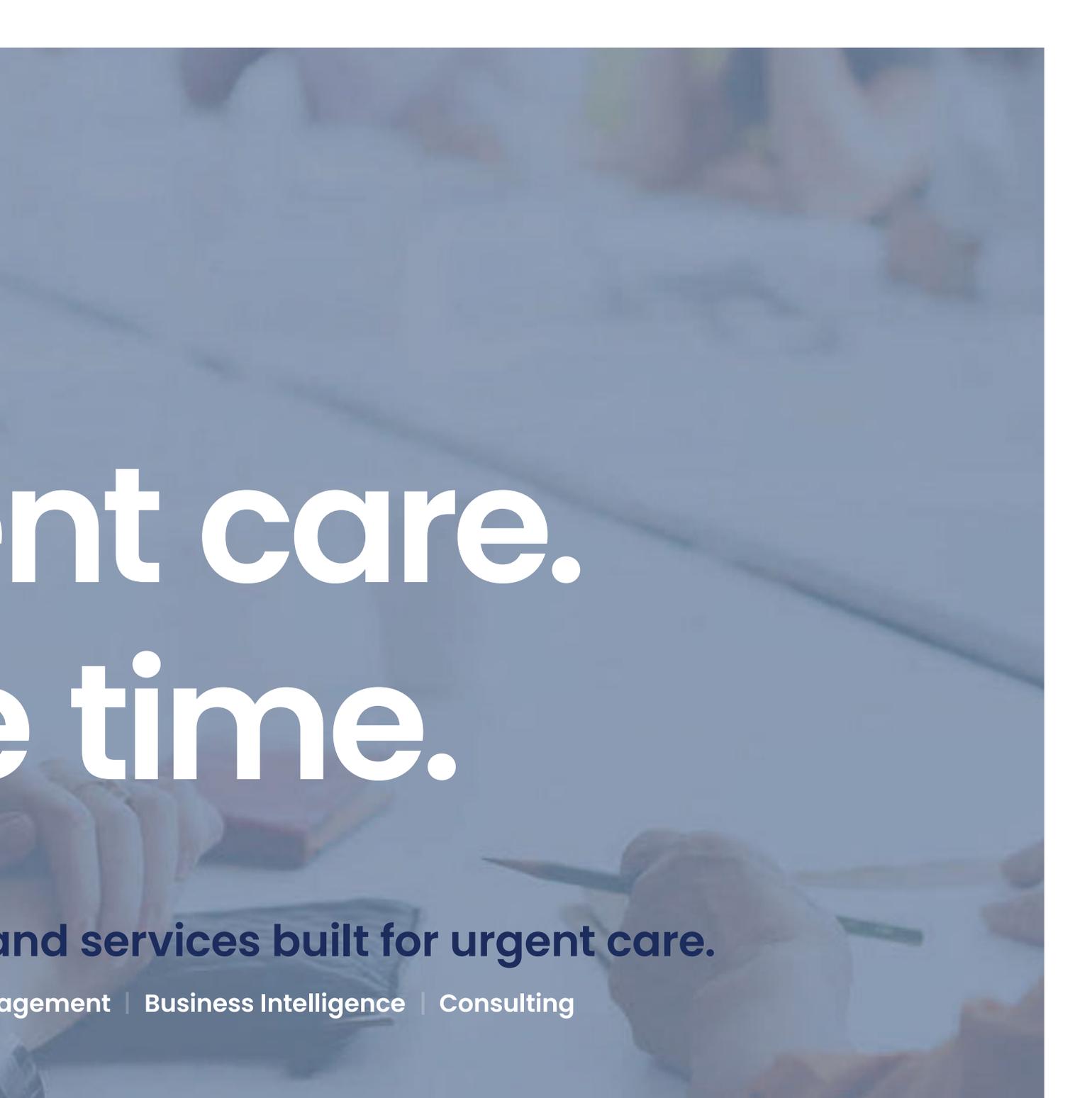
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ability/fda-updates-and-press-announcements-ndma-zantac-ranitidine. Accessed November 8, 2019.

The FDA reports that over-the-counter alternatives to ranitidine do not contain traces of N-nitrosodimethylamine (NDMA), a potentially carcinogenic substance. Further, the FDA states that both brand name Zantac and generic products carried by several stores had trace amounts of NDMA and were recalled.

Patients may ask the urgent care provider questions regarding alternatives and FDA claims that no traces of NDMA were found in several alternatives, including:

- Famotadine (Pepcid)
- Cimetidine (Tagamet)
- Esomeprazole (Nexium)
- Omeprazole (Prilosec)
- Lansoprazole (Prevacid)

The FDA submitted an additional news release on November 4, 2019 stating that the amount of NDMA seen in ranitidine products is similar to the amount of NDMA in “common foods like grilled or smoked meats.”

An Update on Managing Patients with Nonvariceal UGIB

Key points: *Patients with an acute upper gastrointestinal bleed should be transferred to the ED immediately. Patients with hemodynamic instability should receive resuscitation with IV fluids, stat labs, IV proton pump inhibitors and upper endoscopy within 24 hours. Specialist treatment of bleeding foci is described. The group recommends proton pump inhibitors for patients with history of a bleeding ulcer who require antiplatelet therapy or anticoagulation for cardiovascular disease.*

Citation: Barkum AN, Almadi M, Kuipers EJ, et al. Management of nonvariceal upper gastrointestinal bleeding: guideline recommendations from the International Consensus Group. *Ann Intern Med.* October 29, 2019. [Epub ahead of print]

This article represents an update of the 2010 International Consensus Recommendations on the Management of Patients with Nonvariceal Upper Gastrointestinal Bleeding (UGIB). As such, its content is important when evaluating a patient who may not be compliant with follow-up after emergency care for an acute UGIB or with a history of acute UGIB. The expert panel used an iterative approach with regard to the expert panel examining existing guidelines and the analysis of systematic reviews to construct a GRADE (Grading of Recommendations Assessment, Development and Evaluation) based set of guidelines based on PICO (patient population, intervention, comparator, and outcome).

The authors note that, similar to the 2003 and 2010 guidelines, this update focuses on resuscitation and risk assessment;

preendoscopic, endoscopic, and pharmacologic management; and secondary prophylaxis for recurrent UGIB.

- For patients with acute UGIB, the group suggests using a Glasgow Blatchford Bleeding Score of 1 or less to identify patients who are at very low risk for rebleeding or mortality and thus may not require hospitalization or inpatient endoscopy.

“The goals of fluid resuscitation are to restore end-organ perfusion and tissue oxygenation while steps are taken to control bleeding.”

The Glasgow–Blatchford can be utilized on smartphone apps such as MDCALC and involves the systolic blood pressure, tachycardia, factors such as melena, syncope, and CBC/BUN. This score should be calculated using labs; only one or two factors (since some are worth +2 points) are needed to ensure the patient should be hospitalized. If all risk factors are ruled out, the thinking is that the bleed may have spontaneously resolved, however direct visualization with endoscopy is certainly safer for the patient. This system espouses fluid resuscitation prior to any stratification. The guidelines go on to recommend against using the AIM65B score.

- For patients with acute UGIB and hemodynamic instability, resuscitation should be initiated.
- For the urgent care clinician, the most important guideline is the initiation of IV fluid resuscitation in patients with or who may be developing hemodynamic compromise.

The authors further note that hemorrhagic shock may lead to multiorgan failure and death. The goals of fluid resuscitation are to restore end-organ perfusion and tissue oxygenation while steps are taken to control bleeding.

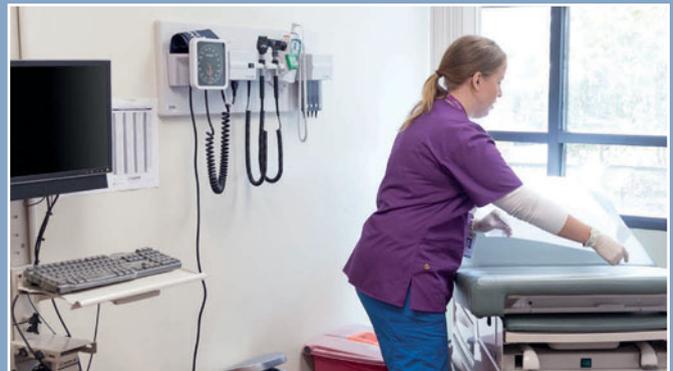
The guidelines go on to recommend a threshold of 8g/dL for transfusions of patient without significant cardiovascular disease but recommend a higher threshold for patients with significant CV disease. They recommend upper endoscopy is not delayed for patients taking anticoagulation.

- The committee recommends upper endoscopy within 24 hours for patients with acute UGIB. The guidelines continue to discuss specialty endoscopy hemostatic recommendations, outside of the scope of the urgent care provider.

The committee recommends that patients with a previous UGIB taking antiplatelet therapy or anticoagulation receive proton pump inhibitor therapy vs no therapy. ■

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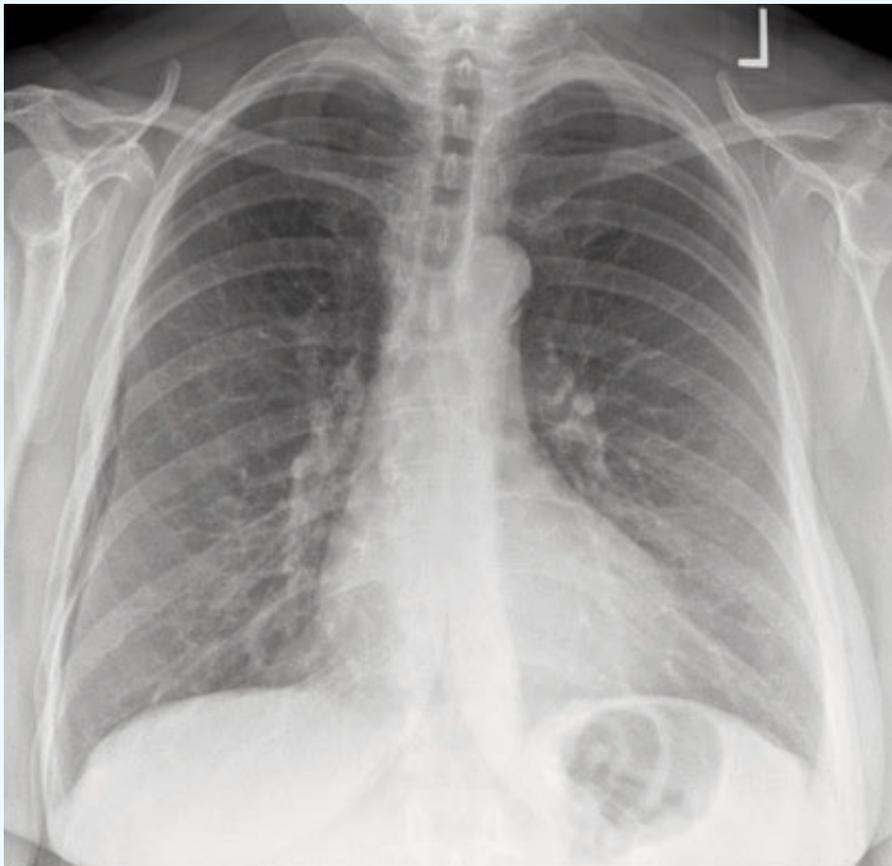


In each issue, *JUCM* will challenge your diagnostic acumen with a glimpse of x-rays, electrocardiograms, and photographs of conditions that real urgent care patients have presented with.

If you would like to submit a case for consideration, please email the relevant materials and presenting information to editor@juqm.com.

A 57-Year-Old Man with Rib Pain with Deep Breathing

Figure 1.

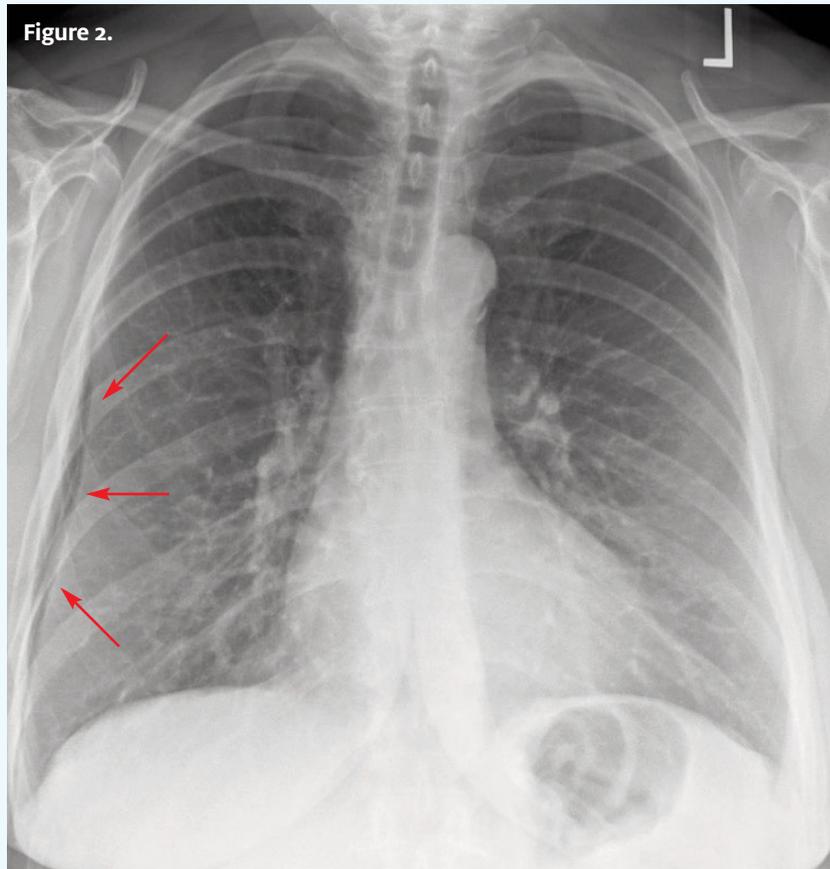


Case

The patient is a 57-year-old man who reports to urgent care complaining of right-sided pain in his ribs when taking deep breaths. He reports that he worked out at his health club that morning before work, but denies any pain at the time or potential cause of injury related to that. Rather, he said the pain began suddenly a couple of hours later while he was at work.

View the images taken and consider what the diagnosis and next steps would be. Resolution of the case is described on the next page.

THE RESOLUTION

**Differential Diagnosis**

- Pneumothorax
- Skin fold
- Rib fracture
- Sternal fracture

Diagnosis

The initial x-ray demonstrates vertical lucency in the right lateral chest—possibly indicative of pneumothorax or skin fold. Skin fold is favored as air does not extend to the apex. The second image, with the arms pulled away, shows resolution of a finding consistent with skin fold.

Learnings/What to Look for

- The radiographic appearance of pneumothorax depends primarily on the positioning of the body
- Pneumothorax shows conformity of linear shadows with visceral pleural anatomy; skin folds do not

- Typically, skin folds do not demonstrate lateral lucency, but there is a pitfall—perception of relative lucency lateral to the added density of the skin fold due to Mach effect

Pearls for Urgent Care Management and Considerations for Transfer

- Short-term use of a topical steroid will reduce inflammation in the area
- If the area is infected, an antifungal agent may be necessary
- Patient education should focus on preventing future incidence and include recommendations to avoid tight-fitting clothing; keeping skin as dry and cool as possible; and drying thoroughly after bathing or swimming before getting dressed
 - Female patients should be advised to ensure brassieres have adequate support

Acknowledgment: Images and case provided by Experity Teleradiology. (www.experityhealth.com/teleradiology)



A 65-Year-Old Man with Epigastric Pain, Dyspnea, and a 'Clammy' Feeling

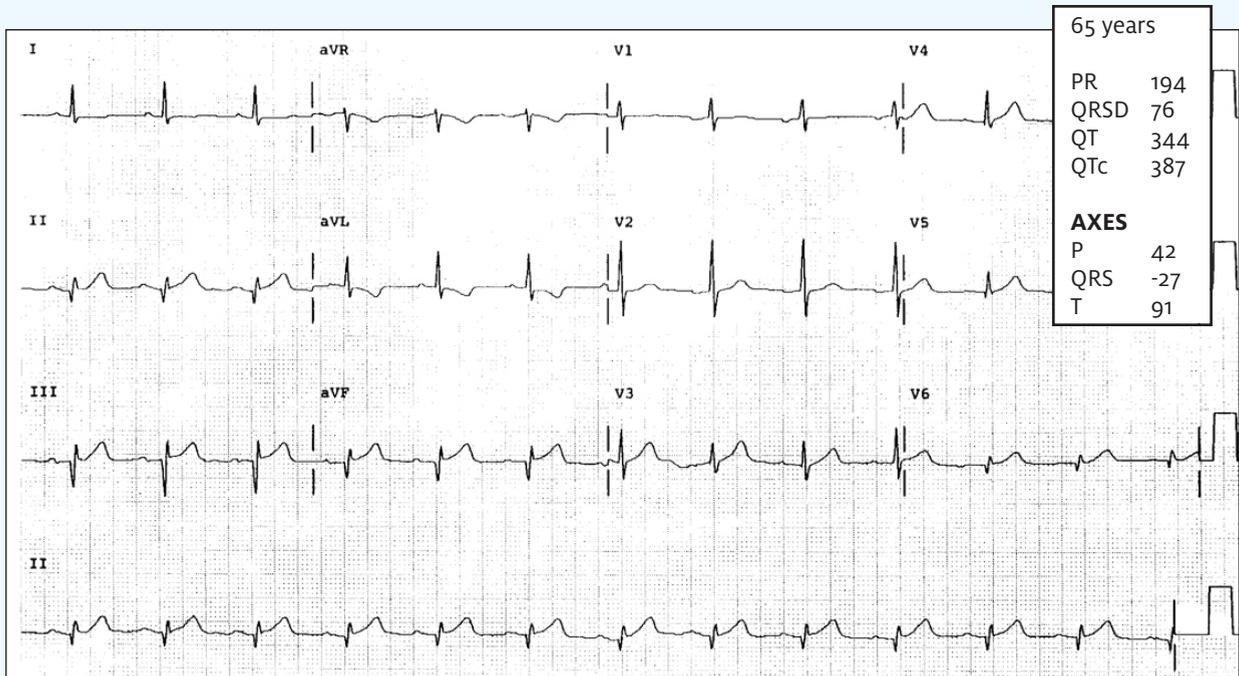


Figure 1.

Case

The patient is a 65-year-old man with symptoms of epigastric pain over the last 2 hours, with some dyspnea and a “clammy feeling.” He has a history of GERD and has used both an oral antacid and omeprazole within the past hours without relief.

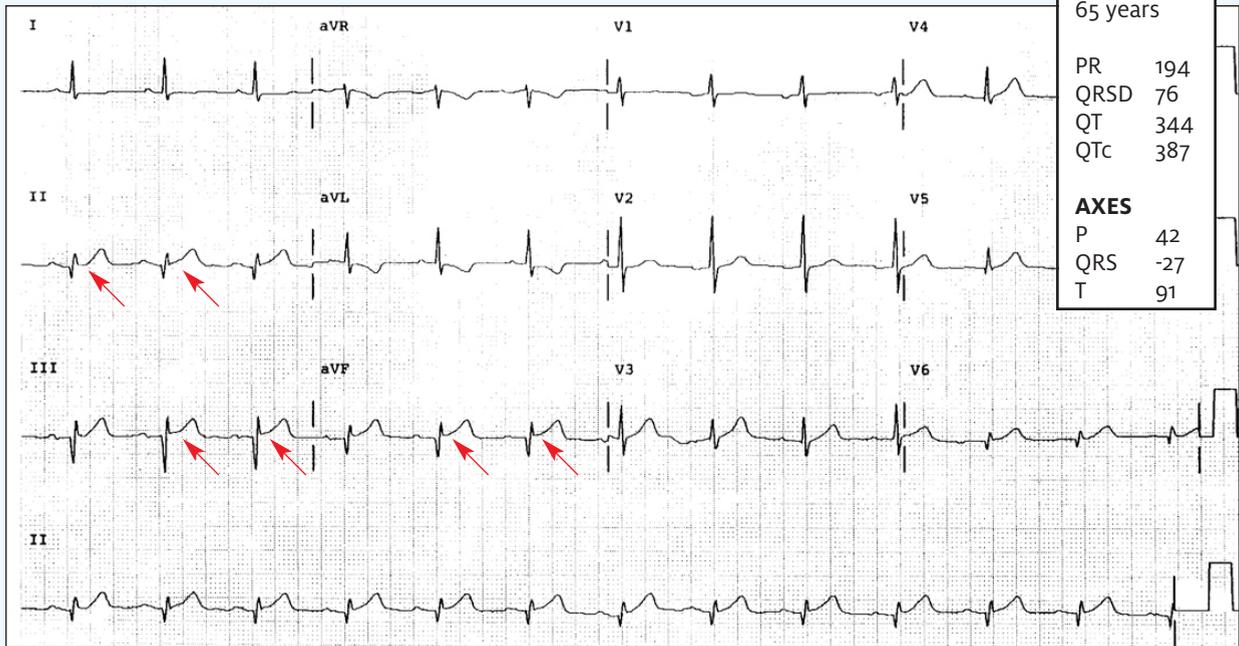
Upon exam, you find:

- **General:** Alert and oriented. Skin cool and moist
- **Lungs:** CTAB

- **Cardiovascular:** Regular rate and rhythm without f/r/g
- **Abdomen:** Soft and nontender without rigidity, rebound, or guarding. No epigastric pain with palpation
- **Ext:** No pain or swelling of the LE, pulses equal

View the ECG and consider what your diagnosis and next steps would be. Resolution of the case is described on the next page.

THE RESOLUTION



Differential Diagnosis

- First-degree AV block
- Supraventricular tachycardia
- Inferior lateral STEMI
- Wolff-Parkinson-White syndrome
- Brugada syndrome

Diagnosis

This patient was diagnosed with inferior lateral STEMI.

The normal PR interval is 120 to 200 ms; this PR interval is 194, so it would not be first-degree AV block.

Supraventricular tachycardia is a narrow complex tachycardia with a heart rate over 100 bpm; the rate here is 76, so this is not SVT.

Wolff-Parkinson-White would have three findings including a widened QRS (>120ms), short PR (<120ms), and a Delta wave; none of these findings are present.

Brugada syndrome is diagnosed when leads V1 and V2 show ST elevation with an R R' phenomena. This is not present, either.

This ECG *does* show ST elevation in the interior leads, which are leads II, III, and aVF, as well as showing elevation in some of the lateral leads, namely V5 and V6. This is an acute inferior lateral STEMI.

Learnings/What to Look for:

- Symptoms predictive of myocardial infarction often include
 - Exertional chest pain

- Diaphoresis
- Dyspnea
- Pain similar to symptoms present during a past MI
- Atypical symptoms may include fatigue, confusion, or neck/arm/jaw pain
- Diabetic patients, the elderly, and women may present atypically
- This patient initially attributed his symptoms to heartburn, a common occurrence with inferior MI
- Inferior STEMIs are typically due to an occlusion in the right coronary artery (RCA)

Pearls for Urgent Care Management and Considerations for Transfer

- All patients with STEMI require emergent transfer to the emergency department via EMS
- Acute inferior lateral STEMIs are high risk, as the occluded vessel may also result in infarction of the right ventricle and resultant hypotension. Place two large-bore IVs while waiting for EMS to arrive
- Do not administer SL NTG to patients with an inferior STEMI, as this may result in severe hypotension
- Consider oxygen if hypoxemic and place on a cardiac monitor while awaiting transport
- Have patient chew an aspirin 81-325 mg while awaiting transport



A 51-Year-Old Woman with Multiple Dermatological Symptoms and Muscle Weakness



Case

The patient is a 51-year-old woman who presented to urgent care complaining of a rash, pruritus, myalgias, and muscle weakness. The rash was an erythematous blanching patch spread across her chest in a V shape. She had also noticed that her fingernail folds were red and swollen.

The patient can't recall when she first noticed her symptoms, but reports that they've started affecting her everyday life (such as having difficulty rising from a chair) within "the past couple of weeks."

View the image taken and consider what your diagnosis and next steps would be.

THE RESOLUTION

**Differential Diagnosis**

- Systemic lupus erythematosus
- Polymorphous light eruption
- Allergic contact dermatitis
- Dermatomyositis

Diagnosis

This patient was diagnosed with dermatomyositis, a multisystem autoimmune connective tissue disease characterized most often by a symmetrical proximal extensor inflammatory myopathy; a characteristic violaceous cutaneous eruption; and pathogenic circulating antibodies.

Diagnosis is made through blood tests showing elevated levels of muscle enzymes. Further testing includes lung x-rays; electromyography; MRI; and skin or muscle biopsy.

Learnings/What to Look for

- While the etiology is unclear, some evidence suggests that genetically susceptible individuals with certain HLA types mount aberrant cellular and humoral responses after exposure to infection, malignancy, or drug ingestion
- Clinical features of dermatomyositis can be categorized into cutaneous and systemic manifestations

- Typical findings include a heliotrope rash, atrophic dermal papules of dermatomyositis (ADPDM, also known previously as Gottron's papules), shawl sign, holster sign, photosensitivity, flagellate erythema, poikiloderma, calcinosis cutis and nail fold changes. Pruritus is also common
- Systemic manifestations of dermatomyositis include fatigue, malaise, and myalgias, as well as various musculoskeletal, gastrointestinal, pulmonary, and cardiological complaints
- Up to 40% of patients with adult dermatomyositis may have an occult malignancy

Pearls for Urgent Care Management and Considerations for Transfer

- Treatment of dermatomyositis includes corticosteroids for the muscular component and avoiding exposure to the sun
- Immunomodulatory medications such as methotrexate, mycophenolate mofetil, or intravenous immunoglobulin may be used
- Refer to a rheumatologist

Acknowledgment: Images and case courtesy of VisualDx (www.VisualDx.com/JUCM).



Updated IDSA Guidelines Stress Early, *Appropriate* Treatment for Community-Acquired Pneumonia + Influenza

Urgent message: Just as what is predicted to be a brutal flu season picks up steam, the Infectious Diseases Society of America has released new guidelines stressing the need for timely, dual treatment in adults with community-acquired pneumonia who also test positive for influenza.

■ CORNELIUS O'LEARY, JR., MD

After more than a decade, the Infectious Diseases Society of American has published new guidelines on community-acquired-pneumonia—noteworthy for both its switch from narratives to a Grading of Recommendations Assessment, Development, and Evaluation (GRADE) format and its fairly specific advice on the timing and mode of treatment for patients with CAP who also test positive for influenza.

The authors note that CAP is a condition with a high degree of variability, and that this recommendation does not cover the scope of prevention, diagnostic criteria, and treatment of all patients with comorbidities or who are immunocompromised. In addition, per the guidelines, antibiotic selection for the treatment of bacterial CAP involves coverage of the major players or usual suspects in CAP:

- *Streptococcus pneumoniae*
- *Staphylococcus aureus*
- *Mycoplasma pneumoniae*
- *Moraxella catarrhalis*
- *Haemophilus influenzae*
- *Legionella* species



Cornelius O'Leary, Jr., MD is an urgent care physician with Emergency Care Dynamics, San Diego, CA.

■ *Chlamydia pneumoniae*

This study mentions that the etiological landscape of CAP is changing due to the implementation of pneumococcal conjugate vaccine and involves several viral pathogens. Further, the authors note that adult patients with evidence of CAP who test positive for influenza should be given dual treatment with antibiotics *at the time of diagnosis*.

Please note that the diagnosis of CAP is outside of the scope of these guidelines.

Viral and bacterial pathogens often coexist in CAP, and there is no diagnostic test sensitive enough to differentiate between these pathogens. The authors discourage the use of serum procalcitonin as it is considered inaccurate in identifying viral pneumonia, warning providers not to use this test to determine initial need for antibiotic therapy.

Following are guideline recommendations we consider most relevant to the urgent care setting:

1. Sputum gram stain and culture are not recommended for patients being treated in the outpatient setting.
2. Blood cultures are not recommended in the outpatient setting at the time of diagnosis.
3. Routine urine antigen testing for *Legionella* is not recommended in adults with CAP unless there are epidemiological factors such as an outbreak or travel.
4. When influenza is circulating in the community, the committee recommends testing for influenza with a rapid

GUIDELINES UPDATE

influenza molecular assay (influenza nucleic acid amplification test), which is preferred over a rapid influenza diagnostic test (antigen test).

5. The committee recommends empiric antibiotic therapy should be started in adults with suspected or radiographically confirmed CAP regardless of the results of serum procalcitonin tests.
6. In addition to clinical judgment, IDSA believes physicians should use a validated clinical prediction tool for prognosis. The Pneumonia Severity Index is the preferred test to determine the need for hospitalization in adults diagnosed with CAP, not the CURB65 tool.
7. Antibiotic recommendations for initial therapy are as follows:
 - For healthy outpatient adults with no comorbidities, the committee recommends:
 - a. Amoxicillin 1 g po TID
 - b. Doxycycline 100 mg po BID
 - c. A macrolide (Azithromycin 500 mg day 1 then 250 for 4 days (Z-pak dose) or clarithromycin) *only* in areas with pneumococcal resistance to macrolides <25%

- For outpatient adults with comorbidities such as heart, lung, liver, renal disease, diabetes mellitus, alcoholism, asplenicism, or malignancy:
 - a. Combination therapy: Augmentin or a cephalosporin (cefepodoxime or cefuroxime) and a macrolide (strong recommendation) or doxycycline (conditional recommendation)
 - (Be prepared for calls from the pharmacy questioning combination therapy)
 - b. Monotherapy: Respiratory fluoroquinolone (levofloxacin, moxifloxacin, or gemifloxacin) ■

Note

Urgent care providers are strongly advised to review the full set of guidelines, entitled Diagnosis and Treatment of Adults with Community-Acquired Pneumonia. An Official Clinical Practice Guidelines of the American Thoracic Society and Infectious Disease Society of America. It's available online at <https://www.atsjournals.org/doi/10.1164/rccm.201908-1581ST>.



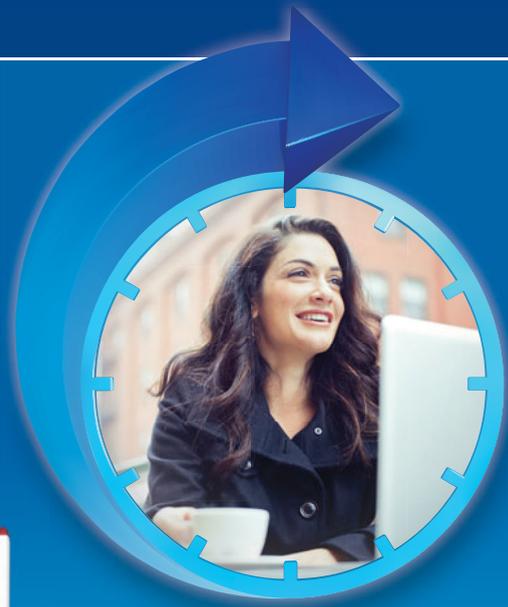
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†Cepacol® is the #1 Recommended product in the Sore Throat Lozenges category in the US among the Universe of Physicians (IQVIA ProVoice Survey). Period from June 1, 2018 to May 31, 2019.



Rural and Tertiary Markets: The Next Urgent Care Frontier

Urgent message: Given the oversaturation and resulting fierce competition among urgent care chains in the affluent suburbs of major cities, the underserved rural health-care market offers tremendous growth opportunity for the forward-thinking urgent care operator.

ALAN A. AYERS, MBA, MAcc

Urgent care began as a suburban phenomenon—and continues to be, as evidenced by the Urgent Care Association's *2018 Benchmarking Report* that asserts 78% of its recorded urgent care centers are in suburban areas, while those in rural areas represent only 4.1%.¹ While UCA's report speculates that "reimbursement does not support the costs to staff and operate urgent care in the most sparsely populated rural areas," understanding the history and evolution of urgent care perhaps provides greater context.

The first urgent care operators were largely entrepreneurial ED doctors, who opened the original practices in the affluent suburbs of sunbelt cities where they chose to work and live. Likewise, the new "urgent care" concept held great appeal for the affluent suburban consumer with disposable income, as they were more than willing to pay a copay differential for immediate, walk-in care as opposed to the long appointment waits generally associated with their primary care provider or the cost and hassle of ED visits.

Moreover, at the time, urgent care in general wasn't recognized by Medicaid (or Medicaid reimbursement was insufficient to cover urgent care's operating costs), so urgent care relied heavily on commercially insured patient populations for its financial model to work.

This confluence of opportune factors—high demand for fast injury/illness episodic care without needing an appointment, locations in affluent areas, the time and savings realized from avoiding the ED—converged to contribute to urgent care's meteoric rise. This fast growth attracted the attention of the private equity sector,



which began scaling urgent care while it simultaneously played a key role in its growth, development, and widespread acceptance.

While scaling its urgent care chains and platforms, private equity closely mimicked the model of the big-box retailers by clustering together in "retail zones" where urgent care centers would see ample disposable income amid a dense consumer population. Actively

Alan A. Ayers, MBA, MAcc is Chief Executive Officer of Velocity Urgent Care and is Practice Management Editor of *The Journal of Urgent Care Medicine*. The author has no relevant financial relationships with any commercial interests.

seeking out prime demographics this way inevitably led to fierce head-to-head competition in the most desirable markets.

The Consequences of Urgent Care Oversaturation

Today we see a large concentration of urgent care centers in markets such as Phoenix, Dallas/Fort Worth, Houston, Austin, Miami, Baltimore-Washington DC, Northern New Jersey, etc. In short, urgent care has become ubiquitous in just about every major U.S. market. This oversaturation has caused some chains to struggle to achieve profitability (or reach breakeven), to the point where private equity firms have begun selling off their urgent care platforms to combat these common pain points:

- Increased difficulty in finding and securing prime real estate in highly competitive trade zones
- Longer ramp-up periods for new centers to reach breakeven, requiring substantially greater amounts of working capital to launch a new urgent care or add new locations
- Higher overall operating costs—including rent, advertising, and labor—in saturated, highly coveted markets
- Insurance companies beginning to refuse “urgent care” contracts and/or “location adds” to existing contracts for urgent care centers in markets they deem to be saturated

The Healthcare Plight of Rural America

Meanwhile, the rural communities, in which 57 million Americans currently live, are experiencing the opposite set of circumstances; they’re underserved and struggling amid sparse and dwindling healthcare resources. A rural community, when defined by researchers for statistical purposes, is any community that is not part of a metropolitan area. “Rural” basically includes any population, territory, or housing that lies outside of an urban area.

According to research by National Public Radio (NPR) conducted with the Harvard T.H. Chan School of Public Health and the Robert Wood Johnson Foundation, 26% of Americans living in communities have not been able access healthcare when they needed it in recent years.²

Often situated in remote geographic locations, rural communities have sparse access to healthcare providers who are either few and far between, or long distances away. Further, these communities feature a number of key social determinants that make them far more likely to have residents in poor or declining health due to a litany of factors: large percentages of elderly residents,

low insurance levels, few primary care providers, and economic challenges brought on by limited financial resources. Further, residents in rural areas tend to have higher rates of complex health issues, including mental health struggles, depression, obesity and diabetes, drug and alcohol abuse, and COPD.

Add to these challenges the poor public transportation in many rural communities, and traveling to the nearest provider becomes a cost and time expense that comes with considerable tradeoffs (eg, *Do I take the day off from work to commute to the nearest healthcare provider for my health issue?*). And for rural residents earning low wages and few paid days off from their jobs, just getting to the doctor’s office represents an enormous burden.

Rural Hospitals Closing at an Alarming Rate

The earlier-cited NPR poll also surprisingly asserted that out of the 26% of rural Americans with limited access to healthcare, many have at least one form of health insurance.¹ So, what’s the primary cause for the rural healthcare access problem? Look no further than the ongoing closure of rural hospitals. According to the Cecil G. Sheps Center for Health Services Research, 107 rural hospitals have closed since 2010. Even more worrisome, 673 additional rural hospitals, according to data provided by iVantage Health Analytics, are currently “at risk” of closure.³ Rural hospitals face a number of challenges, including:

- Staffing shortages: Although 20% of the nation’s population, or 57 million Americans, live in a rural area, just 10% of the nation’s physicians’ practice there, according to reporting from the CMS 2016 Rural Health Summit.⁴
- Being in a state that elected not to implement a Medicaid expansion program, leaving a larger percentage of the patient population with inadequate insurance coverage, fewer private payer options, and higher uncompensated care costs.
- Challenging patient demographics: Rural hospitals treat a disproportionately large number of patients over 65, service veterans, and people managing lifestyle diseases such as obesity and diabetes. Treating some of the nation’s sickest patient populations naturally results in greater healthcare costs.
- Higher unemployment rates among the patient population in contrast with urban areas: The U.S. Department of Agriculture reported that through 2016, rural areas reached 5.4% unemployment compared with an average rate of 4.8% in urban areas.⁵ Greater unemployment means fewer

employer-sponsored health plans, and more uninsured patients who often can't afford healthcare.

The confluence of these and other challenges has resulted in a large number of rural hospitals that struggle financially to stay afloat. Healthcare analytics firm Charis Group and iVantage Health Analytics researchers, for example, reported in 2017 that 41% of 2,100 rural hospitals studied had negative operating margins.⁶ Some rural hospitals see so few patients due to geography and other factors that the staffing and infrastructure costs necessary to stay open create a financial burden that becomes unsustainable.

In short, the rural healthcare landscape is dotted with economically fragile hospitals, with many more teetering on the brink. And without remedy or intervention, closure is the unfortunate next step. This growing scarcity of rural healthcare access points has led to rural patients going without care completely, having to travel relatively vast distances to receive care, or experience lengthy waits to even get a doctor's appointment with healthcare providers closer to home.

Rural Markets: The Last "Urgent Care" Frontier—and a Massive Opportunity

Put simply, rural communities are struggling due to a lack of resources—a shortage of providers, dwindling access points, and inadequate insurance coverage among residents. This dire lack of healthcare resources to provide adequate care for an extremely vulnerable patient population affords the forward-thinking urgent care operator a massive opportunity to become the provider of choice in these rural markets. In fact, the potential to build significant market share and patient loyalty in rural and underserved communities far exceeds what's capable in today's oversaturated, highly competitive suburban markets where patients view urgent care as more or less a commodity; they see them all as "the same" or similar, with little to no brand differentiation. For urgent care operators, the rural market may indeed represent the "last frontier" where there is fertile territory to put down stakes and build out platforms amid fewer competitors.

Considering the footprint of a big box chain like Walmart (approximately 5,000 stores with a third of those located in tertiary, "rural-like" markets), it stands to reason that there's probably the potential for another 1,500 urgent care centers in rural/secondary markets. The typical rural town's population and patient volumes, though, will generally only support one urgent care. So, once an urgent care operator puts down stakes in a rural

town, the opportunity for another center is likely lost forever. At the most, there is probably just a 2- to 3-year expansion window until the rural markets are completely filled in.

Advantages for the Rural Urgent Care Operator

For the urgent care operator, establishing a center in an underserved rural community has several built-in advantages over its suburban counterpart, and offers a considerable return on investment. These include:

- Pent-up demand leading to fast ramp-up to profitability. Residents of rural towns are often faced with hour-long drives to the nearest hospital, clinic, or healthcare provider. For the rural patient living and working in a remote region, going to the doctor's office amounts to a daytrip out of town, which means extra expense and a full day away from work or school. This becomes an even greater burden for people with physical limitations or acute conditions who must make special arrangements as far as medical transportation to accommodate, say, wheelchairs, IV poles, and oxygen tanks. Imagine how eager and welcoming the community would be to the newly opened urgent care right there in town. Utilization will be high, allowing a newly opened center to reach breakeven in 3-4 months, as opposed to the 18- to 24-month window necessary for an urgent care in a saturated, urban/suburban market. Less working capital, therefore, is needed to sustain the operation at startup, relieving some of the initial financial burden for the urgent care operator.
- Much cheaper rent in rural markets. Consider the rental rates in front of a Walmart in, say, South Boston, VA (a town of approximately 8,000 residents) at about \$13.50/sq. ft compared with those found in the upscale Virginia Beach Town Center in Virginia Beach (a populous resort city of 430,000+ residents) where rental rates are over \$50/sq. ft. Additionally, ambulatory facilities in rural towns typically have smaller footprints than their suburban counterparts, making the operating expenses much more manageable overall.
- Cheaper advertising costs. Following the previous example, consider the advertising costs for a single urgent care in suburban Washington, DC. Radio and television advertising costs would be prohibitive for a small urgent care attempting to reach a media market of 6 million people. In a small-town rural market, however, advertising is significantly less expensive. Billboards, radio, and newspaper

advertising are all much cheaper and more cost-effective, accessible marketing modalities for the urgent care operator.

- More loyal and less expensive labor. Fewer local employers means less competition for workers and hence more loyal employees. Additionally, the decreased competition for labor in small towns and rural communities means labor will be less expensive overall.
- A grateful community. The statistics and studies clearly demonstrate that residents of rural markets have acutely felt the absence of desperately needed local healthcare access points. The iVantage study referenced earlier found that 22% of rural residents went without care not because they couldn't afford it, but because the nearest provider was too far away.³ A new urgent care center that removes the need for a road trip to a hospital in a neighboring city is welcomed with open arms by a community that wants to help it succeed.

Challenges for the Rural Urgent Care Operator

Although urgent care does indeed seem to be the perfect fit to provide a fast, convenient ambulatory access point to rural communities with struggling hospital or non-existent local healthcare access, the rural market is not without some inherent challenges:

- Provider shortage. The aforementioned CMS 2016 Rural Health Summit also reported that the physician shortage in rural areas—an extension and manifestation of the larger nationwide physician shortfall—accounted for 65% of the healthcare professional shortage.⁴ When surveyed, providers express hesitance to move to and ply their trade in sparsely populated regions. Medical residents have expressed similar reservations; they don't want to be isolated in a geographically remote area that lacks infrastructure such as health IT access and specialty support. Indeed, the overwhelming majority express a desire to work in communities of at least 10,000 individuals.
- Patient populations that want to utilize the urgent care as medical home or as their primary care. These urgent cares can offer an expanded range of services beyond what's typical of urgent care, such as occupational medicine, wellness exams, and vaccinations. The urgent care operator must caution against taking on time- and resource-intensive services such as managing COPD, diabetes, and/or hypertension if they don't have the infrastructure

to handle that kind of extra capacity, as it would negatively impact the flow and throughput vital to an efficient urgent care operation.

Notable Rural Urgent Care Examples

The UCA 2018 *Benchmarking Report* notes just 6.7% of urgent cares are located in rural markets. The report further speculates that, despite the need for urgent care services in these markets, current reimbursement models may not support the costs to operate and staff centers in sparsely populated rural communities, and act as a deterrent for urgent care providers.¹ Still, there are rural urgent care operators who are indeed finding ways to make the model work and provide services to these underserved areas. Following are several noteworthy examples:

Fast Pace Urgent Care – Tennessee, Kentucky, Louisiana, Mississippi

- A total of 95 clinics located throughout Tennessee, Kentucky, Louisiana, and Mississippi, in all rural areas. (Notable: There is not a single center in the more populous Tennessee cities such as Nashville, Memphis, Knoxville, or Chattanooga.)
- Began as one clinic in the small town of Collinwood, TN (population 949) in the fall of 2009 and has since expanded to 95 locations in four states.
- Vision/Mission Statement: “Change the delivery of healthcare in *rural areas* by integrating excellent patient care, education, accessibility, community service, in a way that puts the patient's needs first and improves the health status of our communities.”
- In addition to urgent care services, Fast Pace offers occupational medicine, health and wellness screenings, vaccines, and routine physicals. Fast Pace also offers some monitoring and patient education in managing lifestyle conditions like diabetes, asthma, and high blood pressure

RedMed – North Mississippi

- Founded in 2005
- Eight locations in North Mississippi (notable: the largest market RedMed serves is Oxford with a population of 23,000, with the smallest being Pontotoc at 6,000 residents).
- In addition to urgent care services, RedMed offers occupational medicine, flu shots and vaccinations, and school and sport physicals.

SouthStar Urgent Care (Hulin Health) – Louisiana

- Founded in 2011 by Hulin Health, a parent company based in Broussard, LA (population 6,000+).
- Company mission is to open clinics “in rural communities that don’t have access to large, non-emergency room care.”
- In addition to urgent care services, SouthStar Urgent Care offers physicals, diagnostics services, and vaccinations.
- Has clinics in New Iberia, Abbeville, Eunice, Marksville (the smallest market at 5,000 residents), Oakdale, Opelousas, and Ville Platte.

MainStreet Family Urgent Care – Rural Alabama

- Founded in 2015; 15 locations in Alabama.
- In addition to urgent care, Mainstreet Family also offers primary care services
- Featured in the local news in Fall of 08’ for the clinic’s efforts to address the health issues and expand and serve the rural communities of Alabama.
- Six clinics located in towns with 7,000 or fewer residents.

Urgent Care and Rural Challenges

Overall, urgent care operators continue to go after suburban and urban markets. Even though rural markets are chronically underserved and desperately need healthcare providers, urgent care has been slow to move into these areas for two primary reasons: reservations about being able to achieve the necessary patient volumes for profitability, and being able to attract, retain, and compensate high-level clinicians in remote geographic locations that are effectively “off the grid.”

Patient Volume Concerns

Urgent care conventional wisdom has long asserted that a center would need an average of 25 visits per day to achieve breakeven, depending on payer mix and negotiated contracts. Rural communities, many of them having far less than 10,000 residents despite typical catchment areas of up to 30 miles, may not provide the necessary patient volume and foot traffic to achieve those numbers, despite their need for more ambulatory healthcare access points.

One possible solution (which is still very much in its formative stages) is federal subsidies to support urgent care centers that serve vulnerable, underserved, and rural communities. The American Hospital Association (AHA), a well-known advocate of rural communities and their healthcare challenges, recently commissioned a

task force to investigate the ways that urgent care can help fill the gaps in rural communities where there are struggling hospitals or a dearth of healthcare access points. The AHA released a two-page report proposing several federally backed payment models to ensure that rural urgent cares that struggle with patient volumes have the “financing necessary to ensure they have adequate reimbursement to cover costs and the resources necessary to meet the needs of their community.”⁷ These initiatives are still in their incipient stages, though, and since they have yet to be hashed out by healthcare leaders and policymakers for widespread implementation, there are few hard data available on them. However, it appears to be a promising avenue that could help support urgent care operations that take the initiative to support undeserved communities outside of urban and suburban markets.

In the absence of promising new federally supported reimbursement models, though, there are still plenty of rural urgent care operators that are thriving regardless. While the 25 visits-per-day dictum remains a good benchmark given that, regardless of location, the majority of the expenses in urgent care are the fairly static staffing costs, the break-even number can be reduced somewhat in rural locations with the aforementioned lesser rent, lesser labor costs, and lesser marketing expenses. Further, if the question remains as to the population base present to drive 25 visits per day, rural urgent cares like the ones highlighted earlier are indeed expanding their business models toward offering more services to meet the profitability threshold. These additional revenue-generating clinical service additions and expansions have included primary care services and occupational medicine, for instance, where feasible.

“Primary care” in this context would have to be something like “primary care lite,” of course, insofar as performing services such as wellness exams and vaccinations for generally healthy people, and not full management of complex and acute health issues such as diabetes, COPD, or hypertension. Dedicating the time, resources, and manpower necessary to manage such conditions would likely interfere with flow and throughput necessary for a speedy and efficient urgent care operation.

Rural urgent care operations with lower patient volumes often have reduced weekend hours, as well, but are still open 7 days toward meeting the UCA “qualifier” of 7-day access.¹

Bottom line, the urgent care operators having success in the rural markets have figured out the model and adjusted their business plans to make it work. Never for-

get how one of the world's largest retailers, Walmart, had humble beginnings in rural Arkansas, defying conventional wisdom along with the naysayers. Launching an urgent care in a rural, underserved area will require a thorough examination of the relevant factors in the target community, and an in-depth evaluation of the operating model of current successful rural urgent care operators—followed by emulation and implementation of what they're doing to succeed in a similar way.

Potential Provider/Clinician Shortages

As mentioned, urgent care operators may struggle to recruit and hire qualified providers and clinicians for rural markets for a variety of reasons:

- The financial inability to offer providers' relocation expenses and other financial incentives to entice them to work in a remote geographic market.
- Medical residents staying "close to home," and starting their careers in urban regions where they either went to school or enjoy abundant healthcare resources (including resources for graduate medical training).
- Given the few clinicians in the rural community, a lack of shift coverage alongside concerns regarding their ability to achieve a work-life balance in resource- and labor-deficient towns.

One viable solution is to develop staffing models that feature nurse practitioners and physician assistants, with a single physician working onsite or remotely (nearby) to manage the operation, perform specific services and procedures outside of the clinician's scope of practice, and handle complex cases and high-priority tasks. Another option for rural urgent care operators is to target DOs to fill in their provider slots. DOs currently only represent about 10% of urgent care clinicians; however, many DO schools are in states with a large number of rural and underserved communities. And since medical students tend to practice where they went to school, DOs would in theory need fewer incentives to "stay home" and provide a much-needed service to struggling local community.

Lastly, the rural urgent care model should rely heavily on cross-training its support staff. Rather than have the typical number of full-time x-ray techs and medical assistants whose salaries aren't supported by patient volumes, clinicians and providers should be willing and able to perform those tasks. Cross-training and sharing of clinical tasks helps minimize operating costs while maximizing productivity, also saving expenses by relying less on higher-paid clinicians.

"The urgent care operator who takes the initiative to explore the opportunity in a struggling rural community will not only find a market with few competitors, but a loyal and grateful community that is invested in the urgent care's success."

Conclusion

Rural America is at risk of losing hundreds more financially struggling hospitals, exacerbating an already dire situation where rural populations are in desperate need of healthcare access points. This represents a golden opportunity for enterprising urgent care operators to shift their focus away from crowded and highly competitive suburban markets, and to underserved communities who will welcome them wholeheartedly. And even though there are valid concerns about sparsely populated rural areas providing the necessary foot traffic to keep the urgent care profitable, there are many urgent cares that have overcome those challenges and proven that the model can indeed work. Hence, the urgent care operator who takes the initiative to explore the opportunity and put down stakes in a struggling rural community will not only find a market with few competitors, but a loyal and grateful community that is invested in the urgent care's success. ■

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Can Urgent Care Patients be Treated Anonymously?

Urgent message: Due to the perceived “acute nature” of the urgent care setting, many patients falsely believe that they can be treated anonymously. On the contrary, legal implications, insurance practices, and the integration of technology with medical records mean that delivering anonymous care is nearly impossible.

■ ALAN A. AYERS, MBA, MAcc

Healthcare is intensely personal, and patients seek care with different motivations. For example, some patients may perceive urgent care as less intimidating and less embarrassing for evaluating symptoms associated with sexually transmitted infections (STIs) than the health department or Planned Parenthood. Other patients just may not want to deal with their primary care physician (PCP) for an episodic issue.

Regardless of the patient’s motivation, urgent care is available and ready to help with unbiased, nonjudgmental care—but typically providers can’t do so anonymously.

There are a few situations in which practitioners can provide care without knowing details about the patient’s identity or creating a medical record. However, these situations most often occur outside of the clinic, such as during a natural disaster or on-the-scene treatment at an accident. But these situations would most likely not occur within the course of regular operations in the urgent care center.

Legal Implications

When a patient and healthcare provider have an encounter in the urgent care center, a mountain of legal ramifications piles up at the same time. This primarily revolves around the fact that the patient must give legal consent to medical treatment. Touching a patient without their consent can be considered

“battery” or worse. Without identifying himself, the patient isn’t able to sign an informed consent document.

Ensuring that legal release before treatment gets documented is crucial in the event that a patient brings forth an allegation of malpractice against the provider. In such a case, there needs to be concrete evidence showing who both parties are. An individual only has standing in malpractice if they are the actual patient, and a provider can only defend herself with documentation showing the course of treatment was medically appropriate. By treating a patient anonymously, the urgent care clinic is unable to obtain this necessary precaution.

Meanwhile, as technology continues to become further integrated with medical record-keeping, a patient’s health record doesn’t always stay within the confines of an urgent care center like it did in days past. Today, a patient’s information resides in an “integrated system” made available to assure quality guidelines are being followed, including access by other healthcare providers when it is needed for treatment. This increases the importance of establishing a sound patient identity. By preventing omissions and/or keeping false or “contaminated” information out of the patient’s medical record, their care in the future will be better.

STD/STI Testing

One of the most common situations that patients want to receive anonymous care for is when they need to undergo STI testing. Many people feel embarrassed when they think they are suffering from a sexually transmitted infection. While that stigma must be addressed by healthcare as a whole, many patients seek out urgent care because they feel that it is the most “anonymous” option.



Alan A. Ayers, MBA, MAcc is Chief Executive Officer for Velocity Urgent Care and is Practice Management Editor of *The Journal of Urgent Care Medicine*.

However, the federal government (and many local governments) have laws that require healthcare providers to report certain conditions. Most of these regulations focus on diseases that are highly communicable. Of course, STIs fall directly into this category. Other conditions like HIV also require the provider to notify the client's partners so they can receive testing and treatment. As such, practitioners can't provide anonymous care in the event that they need to report one of the mandated conditions. (A comprehensive list of state reporting laws maintained by the Centers for Disease Control can be found at: <https://www.cdc.gov/std/program/final-std-statutesall-states-5june-2014.pdf>.)

Prescriptions

In many cases, a visit to urgent care will end in the provider prescribing medication to treat the patient's condition. Since patients will then go home to recover, this form of treatment is often one of the only choices. Unfortunately for patients seeking anonymous care, prescriptions can only be written for someone after confirming their identity.

In order for a physician to transmit a prescription order to the pharmacy, they must include the patient's name. Meanwhile, the patient will also need to present a valid ID card when they go to pick their medication up.

Since most urgent care visits ultimately end in a prescription, anonymous care would severely limit the treatment options a patient has available to them.

Proper Identification Methods

Much like they can't deliver treatment anonymously, urgent care providers must also ensure that they obtain proper patient identification. Patients presenting without an ID card make for a far more complicated process—one that can lead to messy legal situations, as well.

Here's a real-world example: A 53-year-old woman tried to pose as her 35-year-old daughter to receive treatment at urgent care for a nonemergent condition. She claimed that the DMV confiscated her out-of-state driver's license and she had no other way to prove her identity. Meaning no passport, no paystub, no Social Security card, etc.

Though it isn't clear why she tried to hide her identity, providers at the clinic turned her away because they couldn't positively identify her. Had they treated her anyway, the daughter's medical record and insurance claims could have been marred with conditions and treatments that she did not have. Even if the mother had paid cash, after using her daughter's identity she could have submitted a claim to her daughter's insurance.

Insurance Considerations

Insurance is another big reason why patients cannot be treated

anonymously. When a patient visits urgent care and wants to use insurance benefits to pay, it is obviously important to make sure that the correct account is charged. False insurance claims can exhaust lifetime medical benefits, result in future denials or complications based on "pre-existing conditions," or compromise future quality of care if incorrect medical information is stored on the patient.

An example of the presence of "pre-existing conditions" hurting the patient may be liability in a legal action. Presume the mother mentioned above came in for "low back pain" using her daughter's identity. If her daughter was later in a car accident resulting in chronic back pain, defense lawyers would certainly have a plausible way to deny responsibility on behalf of their client.

Obtaining patient identification is also crucial in helping prevent Medicare/Medicaid and other health insurance fraud. With that being said, not all clients will want to pay for their care with insurance. Some will walk in and want to pay in cash.

At most urgent care centers, this is a completely acceptable alternative. However, it still doesn't mean that patients can be treated anonymously. The receipt issued could still be submitted by the patient for reimbursement, which is a common practice when the patient's insurance is "out-of-network." Some patients might be angry that they still need to identify themselves even if they want to pay with cash. Unfortunately, while paying in cash can be a privacy alternative to some degree, patients still cannot be treated anonymously due to the other reasons discussed previously.

Special Circumstances

Although the vast majority of patients cannot be treated anonymously, there are a few exceptions. As noted, physicians are not only allowed but are obligated to help in the event of an emergency (for example, if they witness a vehicle crash and pull over to provide first aid). In this case, obtaining identification isn't necessary due to the urgent and nontraditional nature of the encounter. The same is true for providers helping in emergencies like an earthquake, hurricane, or flood. Meanwhile, some physicians also take part in special programs that provide treatment to the homeless population. This is done free of charge and may result in anonymous treatment.

Conclusion

While not all patients agree with the practice, declining to treat patients without identifying them is better for everyone in the long run. Doing so not only prevents insurance fraud, but also keeps electronic medical records more accurate, ultimately leading to better care in the future. In the urgent care setting, treating patients anonymously is a definite "no." ■



Three Tips to Optimizing Patient Collections

■ MONTE SANDLER

Over the last decade, perhaps the most staggering shift in consumer-based healthcare has been the increase in patient responsibility. Due to the rise in high-deductible health plans (HDHPs), providers are now faced with the challenge of collecting an average of 35% of their revenue from patients, without a downward swing in the insured population.

Consider the following:

- In 2018, 85% of covered workers had a deductible, up from 59% in 2008.
- The average deductible in 2018 was \$1,573, up 114% from \$735 in 2008.
- Since 2013, the burden on patients has increased by 212% due to HDHPs.

Since the cost and effort to collect from patients is greater than that from the large commercial or government insurance plans, urgent care centers and providers across the healthcare spectrum have grappled with how to best maintain low levels of bad debt due to unpaid patient balances, while also preserving their satisfied base of recurring patients. Those that have succeeded in walking this fine line have implemented all, or a combination of, the three strategies listed below.

Standardized Time-of-Service Collection Policy

Clinics that succeed in limiting bad debt on balances after insurance understand that probability of collecting from a patient drops by up to 50% after a patient leaves the office. Per a 2017 McKinsey & Company survey on consumer health, the likelihood of a patient paying when asked prior to seeing the provider (check-in) is 90%. That drops to 70% at check-out, and an alarming 40% after the patient leaves the clinic.

Organizations should adopt a time-of-service (TOS) collections

policy in line with their values and their patient base, but it should be strictly adhered to by all front desk staff and include amounts above and beyond the copayment, to the extent the patient has remaining amounts in their deductible. Considerations of how much to collect when the patient has a large amount remaining on their deductible should be made with the intent of optimizing the opportunity for on-site collections, but limiting downstream refunds, including, but not limited to:

- Average reimbursement per visit
- Visit type
- Primary insurance
- Whether the patient has secondary insurance coverage

Utilize your practice management system's capabilities to provide eligibility verification (ie, 271 responses) to discern the remaining deductible amount. Be careful not to make assumptions as to coverage, copayment amount, etc. with a quick glance, as many of these responses require a bit of scrolling to ensure the proper payer and financial information specific to urgent care.

Automated, Simple Payment Options

Even with the implementation of a solid time-of-service collections policy, it is certain that significant patient balances will be outstanding after insurance processes the claim. This is when clinics commence their standard patient billing protocol including, most commonly, the mailing of three paper statements, maybe a pre-collection letter, then a final review of the patient's account prior to sending the balance to a collection agency. This is an expensive process, not only due to postage and labor costs, but because the relative ineffectiveness and lack of response to paper statements, translating to bad debt.

Patients want easy, automated options to pay their bill. We're living in the world of Amazon and Netflix, and urgent care, as the on-demand niche of healthcare, fills that role in our industry. The automation option that best ensures timely adjudication of patient balances and most significantly eliminates bad debt risk is storing credit cards on file.



Monte Sandler is Executive Vice President, Revenue Cycle Management of Experity (formerly DocuTAP and Practice Velocity).

Functionality from practice management systems differs in this regard, with some requiring a bit more manual lift, while others automate the process. Either way, most offer a secure and compliant mechanism to pass credit card information to your merchant services vendor with the ability to process payments once they become patient responsibility. When a credit-card-on-file process works as intended, patient A/R, by definition, only exists from the time of assignment of the balance and the grace period given before processing the payment. Typically, there is a message delivered to the patient—text message or email is preferable—letting them know their card will be charged in X number of days, according to your policy.

To the extent patients refuse to store their card on file and the standard patient balance protocol applies, consider the following to allow for easier ability to pay:

- E-statements as opposed to paper are cheaper and more effective, typically including a link directly to your payment portal.
- Text message balance reminders.

- If patient statements are utilized, is there an ability for the patient to scan a QR code on the statement, linking them directly to your payment portal?
- Do you accept PayPal, Venmo, etc.?

Measure and Track Your Success

Finally, clinics cannot truly be successful in managing patient A/R, or anything else for that matter, without sophisticated tracking mechanisms. Specifically, it is essential to understand the following points in order to set a baseline, and then how they trend over time, in order to identify any red flags, requirements for additional training, and execution:

- Patient collections per visit, in relation to patient bad debt per visit. In other words, what percentage of patient A/R is being collected as opposed to being written off.
- Ratio of patient payments at TOS vs after the visit.
- Statement volume and costs.
- Conversion of patients and/or visits to the credit card on file process. ■



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Flu Season is Nearly Synonymous with Rapid Test Season—Are You Ready?

Patients come to urgent care because they know they can get excellent care without an appointment, and without languishing in the waiting area of the ED. So, it stands to reason that if they need lab tests they want to get them on site, at your facility, with the same degree of efficiency that drew them in to begin with.

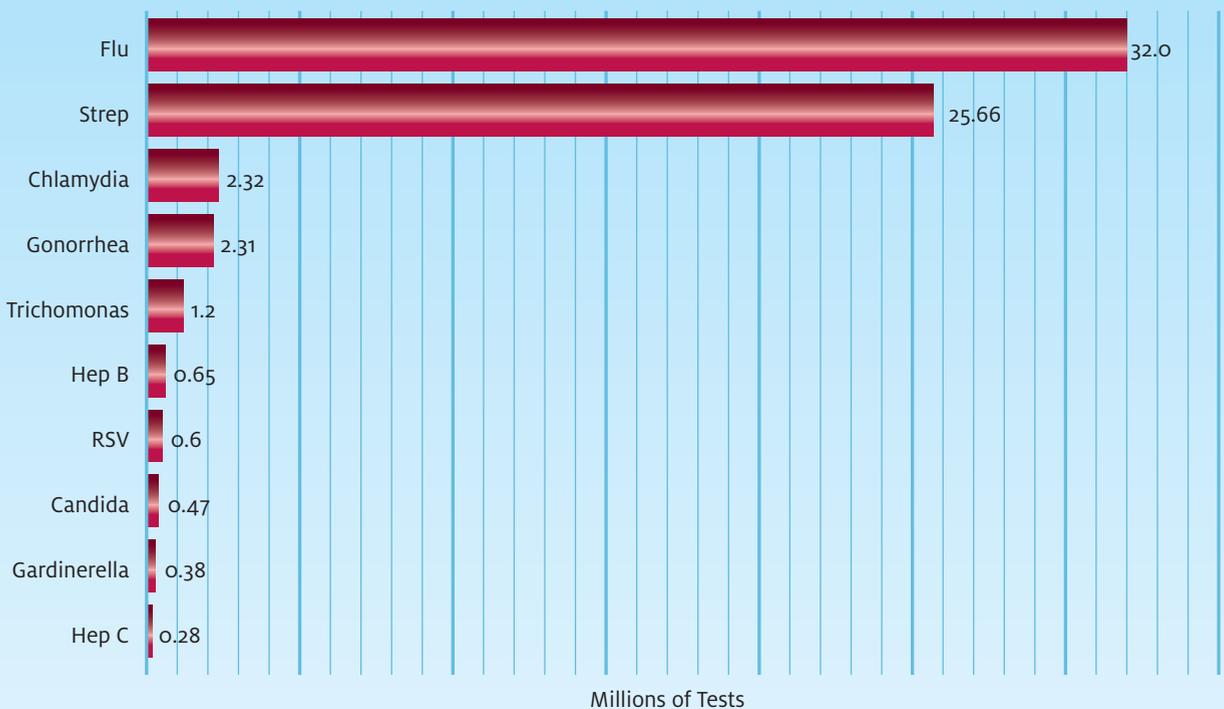
This is never truer than in the winter months. Influenza, of course, comes to mind first. In fact, it is the most preva-

lent rapid test administered in urgent care annually. But what other rapid tests are patients likely to need? And almost as important, are you able to supply it?

In the hope that this information will help you be prepared for any eventuality, in any season, below we share the top 10 rapid tests performed in urgent care, drawn from JUCM's own extensive chart research. ■

INSIGHTS INTO URGENT CARE RAPID TEST VOLUMES

The Top 10 Rapid Tests Performed in Urgent Care



Source: Urgent Care Chart Survey. *J Urgent Care Med.* 2018.

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