

# JUCM™

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THE JOURNAL OF URGENT CARE MEDICINE®



Urgent Care  
Association  
of America



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# Patient Portals Part II: ‘Who’s That Practice Behind the Curtain?’



In my last column, I discussed the decision-making process around patient portals and proposed a systematic approach intended to mitigate risk, ensure security, and manage access. A portal, by definition, is an ‘entrance’—a virtual access point to a practice, its staff and patient medical records. The most common access point is a practice’s website and a well-designed one can enhance access, improve efficiency, and help sell your practice to new patients.

The two main purposes of a practice’s website are to introduce the practice and to help patients navigate through its resources. A website is often the first place prospective patients go to learn more about who you are, what you do, and why you are doing it. The key elements are as follows:

### ‘Who we are’

1. Clinician bios: A list of your practice’s clinical providers, their pictures and bios is as an important introduction to patients seeking care. Patients use practice websites to make early “relationship” decisions, much as they do with Facebook and LinkedIn. It is surprising how few practices take the time to introduce their clinicians to prospective patients online.
2. Practice leaders: The owners and management team should be listed separately from the providers.
3. Locations: Practice locations, maps, and contact information are critical components.
4. Facility: Pictures of the facility are an oft-overlooked way to tour a patient through your practice. If you have put the effort into creating a comfortable healing environment, then you should provide visuals that demonstrate that effort and attention to detail. Patients do care about it and the effort alone makes prospective patients feel that you take your practice seriously.
5. Facility Part II: With a little creativity and basic technical skill, you can provide a video tour of the facility. This not only gives you an opportunity to show people around the practice and introduce the staff and is an important chance to communicate your vision for the practice and views on patient care.
6. Social media links: Your webpage should connect with any social media presence you have.

### ‘What we do’

1. Services offered: This is, of course, the most obvious.
2. Forms, etc: Everything from sports physical forms to pre-registration forms can be included.
3. Online registration: With a little more technical know-how, you can include secure online registration that gets uploaded to your practice management software.
4. Billing and contact info, and even functionality for online payment can be added to your site.
5. A dedicated contact link that forwards to a specific e-mail address is important. Include a way for a patient to provide an email and phone number, to generate feedback.
6. Other instructional and interactive components can be added, depending on your patients’ or practice’s needs.

### ‘Why we do it’

1. Mission, Vision and Values: If you don’t have these, there are numerous free online resources that can help you get started. Mission, Vision, and Values are distinct entities and serve different purposes and no organization is too small to have them. Together, they serve as the guiding light for a practice and, more frequently than you might imagine, for patients. This is also a chance to differentiate your practice from the competition. A well-executed Mission, Vision, and Values statement can be a very effective internal and external marketing tool. It also keeps everyone in the organization accountable, both to each other and to patients.
2. Statement from the practice leader: This statement is an opportunity to connect the ‘Who,’ ‘What,’ and ‘Why’ in a more approachable and exciting form. It personalizes the experience and can be a real motivator. Patients want to feel a connection to the practice, and this is an excellent way to achieve that. ■

Lee A. Resnick, MD  
Editor-in-Chief  
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### CLINICAL

## 9 Acute Abdominal Pain in Children

This article will guide you through the differential diagnosis, management and disposition of pediatric patients presenting with acute abdominal pain.

Kayleene E. Paqán Correa, MD, FAAP

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## 23 Offering Patient Wi-Fi in the Urgent Care Center

The costs of and barriers to adding Wi-Fi to an urgent care center are low and the benefits include a better patient experience and improved perception of wait times.

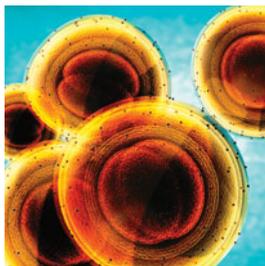
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### CASE REPORT

## 28 Methicillin-Resistant *Staphylococcus aureus*

Accurate, early diagnosis and appropriate antibiotic treatment of MRSA is essential to prevent subsequent morbidity and mortality.

Samina Yunus MD, MPH, and  
Donna Goetsch, MSN, CNP



### IN THE NEXT ISSUE OF JUCM

Nineteen percent of all hospital injuries are caused by adverse drug events, most of which involve common medications and many of which are drug-drug interactions. As use of multiple drug therapies becomes more frequent and patients' medication lists grow longer, the more likely they are to present for care with complaints related to drug-drug interactions. Next month's cover story reviews the risk factors for drug interactions with warfarin, antibiotics, oral contraceptives, statins, and selective serotonin reuptake inhibitors. It's not possible for an urgent care provider to remember all potential drug interactions. It is necessary, however, to maintain a high level of suspicion when making changes or additions to a patient's medications, and to thoroughly review existing medications when prescribing something new.

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[editor@jucm.com](mailto:editor@jucm.com)

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Judith Orvos, ELS  
[jorvos@jucm.com](mailto:jorvos@jucm.com)

## ASSOCIATE EDITOR, PRACTICE MANAGEMENT

Alan A. Ayers, MBA, MAcc

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John Shufeldt, MD, JD, MBA, FACEP  
David Stern, MD, CPC

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Brandon Napolitano  
[bnapolitano@jucm.com](mailto:bnapolitano@jucm.com)

## ART DIRECTOR

Tom DePrenda  
[tdeprenda@jucm.com](mailto:tdeprenda@jucm.com)

Braveheart  
Publishing

120 N. Central Avenue, Ste 1N  
Ramsey, NJ 07446

## PUBLISHERS

Peter Murphy  
[pmurphy@braveheart-group.com](mailto:pmurphy@braveheart-group.com)  
(201) 529-4020

Stuart Williams  
[swilliams@braveheart-group.com](mailto:swilliams@braveheart-group.com)  
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*JUCM The Journal of Urgent Care Medicine* 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 health-care marketplace. As the Official Publication of the Urgent Care Association of America and the Urgent Care College of Physicians, *JUCM* seeks to provide a forum for the exchange of ideas and to expand on the core competencies of urgent care medicine as they apply to physicians, physician assistants, and nurse practitioners.

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# JUCM CONTRIBUTORS

**A**cute abdominal pain in children is a common complaint and a diagnostic challenge. Self-limiting conditions usually are the cause, but a “tummy hurt” also may herald a serious medical or surgical emergency, such as appendicitis. In this month’s cover story, author Kayleene E. Pagán Correa, MD, FAAP, offers a guide to differential diagnosis, management, and disposition of pediatric patients who present with acute abdominal pain. Excellent history-taking skills and a careful, thorough physical exam are the keys to making the diagnosis or at least making a reasonable conclusion about a patient’s care.



Dr. Correa is a pediatric emergency medicine fellow at Rainbow Babies and Children’s Hospital, Cleveland, Ohio.



When you encounter patients with skin infections and presumed insect bites, a high degree of clinical suspicion must be maintained.

That is the key message of this month’s case report, by Samina Yunus MD, MPH, and Donna Goetsch, MSN, CNP. The patient was a 22-year-old white female who presented to an urgent care clinic with a complaint of an infected spider bite on her left upper thigh. She had noticed a pimple-like lesion a week before, which had since grown and developed a central, black area with surrounding warmth, redness, and pain. The diagnosis? Community-acquired methicillin-resistant *Staphylococcus aureus* (C-MRSA), which occurs in populations that have none of the typical risk factors seen in patients with hospital-acquired MRSA.

Dr. Yunus is Assistant Professor of Family Medicine at Cleveland Clinic Lerner College of Medicine in Cleveland, Ohio. Ms. Goetsch is a Family Nurse Practitioner at Cleveland Clinic Chagrin Falls Family Health Center and Urgent Care in Chagrin Falls, Ohio.

Wi-Fi is all but ubiquitous in businesses and retail establishments and many hospitals have introduced it as an amenity to help patients and visitors feel at ease in unfamiliar surroundings.



But many urgent care centers have yet to move beyond offering magazines and static health messages in their waiting rooms. As Alan A. Ayers, MBA, MAcc describes in this month’s practice management article, offering Wi-Fi in urgent care is a logical step and one that patients are coming to expect. The costs of and barriers to adding Wi-Fi are low and the benefits include a better patient experience and improved perception of wait times.

Mr. Ayers is Associate Editor, Practice Management, *JUCM*, Content Advisor, Urgent Care Association of America, and Vice President, Concentra Urgent Care.

### Also in this issue:

**John Shufeldt, MD, JD, MBA, FACEP**, discusses the complexities of decision-making when providing end-of-life care for patients who can’t give medical consent or direction. The key message here is that interpretation of a “do not resuscitate” order is not straightforward and documentation of the provider’s judgment, made following discussion with next of kin (if possible), is prudent.

**Nahum Kovalski, BSc, MDCM**, reviews new abstracts on literature germane to the urgent care clinician, including studies of an update on flu activity and fasting before lipid measurement.

In Coding Q&A, **David Stern, MD, CPC**, discusses use of CPT code S9083, E/M, and radiology codes.

Our Developing Data end piece this month looks at the marketing tactics that urgent care centers use to reach their target audience. ■

### To Submit an Article to JUCM

*JUCM*, *The Journal of Urgent Care Medicine* encourages you to submit articles in support of our goal to provide practical, up-to-date clinical and practice management information to our readers—the nation’s urgent care clinicians. Articles submitted for publication in *JUCM* should provide practical advice, dealing with clinical and practice management problems commonly encountered in day-to-day practice.

Manuscripts on clinical or practice management topics should be 2,600–3,200 words in length, plus tables, figures, pictures, and references. Articles that are longer than this will, in most cases, need to be cut during editing.

We prefer submissions by e-mail, sent as Word file attachments (with tables created in Word, in multicolumn format) to [editor@jucm.com](mailto:editor@jucm.com). The first page should include the title of the article, author names in the order they are to appear, and the name, address, and contact information (mailing address, phone, fax, e-mail) for each author.

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# Knowledge Abounds at UCAOA Annual Convention

■ P. JOANNE RAY

*“The great trouble with most men is that those who have been educated become uneducated just as soon as they stop inquiring and investigating life and its problems for themselves.”*

– Newton Diehl Baker

Whether you are a physician, nurse, physician assistant or office manager, both your urgent care center’s patients and your fellow staff members rely on you to keep learning and striving to improve your professional skills and knowledge. Fortunately, UCAOA provides urgent care-specific clinical and practice management continuing education opportunities for you. The 2013 UCAOA Spring Convention is right around the corner! It is being held at the Walt Disney World Dolphin Hotel in Orlando during what some recognize as spring break, so travel arrangements should be made early. PreConvention events are April 7-8 and the Main Convention runs April 9-11 with a kick-off reception in the exhibit hall the evening of April 8.

The UCAOA Spring Convention is the premier event devoted solely to those practicing urgent care medicine and managing urgent care centers. So, why should YOU attend?

- **Connections:** The UCAOA Spring Convention is a great place for networking. Urgent Care is a dynamic profession with outstanding practitioners, managers, and educators. Hear about all the great work being done, meet people with the same interests and make invaluable professional connections while you renew friendships and make new ones.
- **Education:** Get the latest clinical and evidence-based information. Bring your team to expand their knowledge about reimbursement strategies, clinical topics, ways to grow your center and improve patient satisfaction, strategies for compensation and staff performance, and dozens more urgent care-focused topics.



**P. Joanne Ray** is chief executive officer of the Urgent Care Association of America. She may be contacted at [jray@ucaoa.org](mailto:jray@ucaoa.org).

*The 2013 UCAOA Spring Convention is right around the corner!*

*PreConvention events are April 7-8*

*and the Main Convention runs*

*April 9-11 with a kick-off reception*

*in the exhibit hall the evening*

*of April 8.*

- **Leadership:** You will learn from the experts. Take the time to meet them, share a conversation, and discover how you might become a leader in UCAOA.
- **Fun:** Get recharged at the UCAOA Spring Convention and energize your passion.
- **Information:** Learn about best practices. Take home tangible, implementable ideas to grow your program and optimize outcomes for your patients. Meet industry vendors and learn about the latest tools and products to improve your center.
- **CME:** Up to 14 AMA PRA Category 1™ credits plus an additional 6 credits for attending a Pre-Convention course on Monday, April 8 and 11 credits if you attend Clinic Startup (April 7-8).
- **Keynote:** Molly Fletcher, the “female Jerry McGuire,” will be kicking off the Main Convention with an inspiring talk on **Unleashing Your Potential**.

Make plans now to participate in this “can’t miss” professional, educational and networking opportunity! Brochures were mailed out mid-January and you can find the full curriculum online at [www.ucaoa.org/spring](http://www.ucaoa.org/spring). Plan early so your center can arrange coverage. I look forward to seeing you in Orlando! ■



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## Acute Abdominal Pain in Children

**Urgent message:** This article will guide you through the differential diagnosis, management and disposition of pediatric patients presenting with acute abdominal pain.

KAYLEENE E. PAGÁN CORREA, MD, FAAP

### Introduction

"My tummy hurts." That is a simple statement that shows a common complaint from children who seek care in an urgent care or emergency department.<sup>1</sup> But the diagnosis in such patients can be challenging for a clinician because of the diverse etiologies. Acute abdominal pain is commonly caused by self-limiting conditions but also may herald serious medical or surgical emergencies, such as appendicitis. Making a timely diagnosis is important to reduce the rate of complications but it can be challenging, particularly in infants and young children. Excellent history-taking skills accompanied by a careful, thorough physical exam are key to making the diagnosis or at least making a reasonable conclusion about a patient's care.<sup>2</sup>

This article discusses the differential diagnosis for acute abdominal pain in children and offers guidance for initial evaluation and management of pediatric patients presenting with this complaint.

### Pathophysiology

Abdominal pain localization is confounded by the nature of the pain receptors involved and may be classified as visceral, somatoparietal, or referred pain. Visceral pain is not well localized because the afferent nerves have fewer endings in the gut, are not myelinated, and are bilateral, entering the spinal cord at several levels. Children perceive visceral pain generally over the epigastric, periumbilical or suprapubic region.

Kayleene E. Pagan Correa is a pediatric emergency medicine fellow at Rainbow Babies and Children's Hospital in Cleveland, Ohio.



© Getty Images

Contrary to visceral pain, somatoparietal pain is well localized, intense (sharp), and associated with one side or the other because the nerves associated are numerous, myelinated and transmit to a specific dorsal root ganglia. Somatoparietal pain receptors are principally located in the parietal peritoneum, muscle and skin and usually respond to stretching, tearing or inflammation. Referred pain is generally well localized but distant from the affected site. It arises when visceral pain fibers affect the somatic nerve fibers in the spinal cord.

### History, Symptoms and Laboratory Diagnosis

Often, history is the most important component in mak-

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- Sklice Lotion should be used in the context of an overall lice management program

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- The most common adverse reactions (incidence <1%) were conjunctivitis, ocular hyperemia, eye irritation, dandruff, dry skin, and skin burning sensation

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## INDICATION

Sklice Lotion is a pediculicide indicated for the topical treatment of head lice infestations in patients 6 months of age and older.

## ADJUNCTIVE MEASURES

Sklice Lotion should be used in the context of an overall lice management program:

- Wash (in hot water) or dry-clean all recently worn clothing, hats, used bedding and towels
- Wash personal care items such as combs, brushes and hair clips in hot water

A fine-tooth comb or special nit comb may be used to remove dead lice and nits.

## IMPORTANT SAFETY INFORMATION FOR SKLICE LOTION

In order to prevent accidental ingestion, Sklice Lotion should only be administered to pediatric patients under the direct supervision of an adult.

The most common adverse reactions (incidence <1%) were conjunctivitis, ocular hyperemia, eye irritation, dandruff, dry skin, and skin burning sensation.

Please see brief summary of full Prescribing Information on following page.

For more information, please visit [www.Sklice.com/HCP](http://www.Sklice.com/HCP).

<sup>a</sup> Two randomized, double-blind, vehicle-controlled trials in patients 6 months of age and older with head lice infestations. The primary endpoint was assessed as the proportion of patients who were free of live lice at day 2 and through day 8 to the final evaluation 14 (+2) days following a single application.<sup>2</sup>

Sklice Lotion is manufactured by DPT Laboratories Ltd. and distributed by Sanofi Pasteur Inc.

**References:** 1. US Food and Drug Administration. Sklice Lotion approval letter, February 7, 2012. [http://www.accessdata.fda.gov/drugsatfda\\_docs/appletter/2012/202736s000ltr.pdf](http://www.accessdata.fda.gov/drugsatfda_docs/appletter/2012/202736s000ltr.pdf). Accessed January 9, 2013. 2. Sklice Lotion [Prescribing Information]. Swiftwater, PA: Sanofi Pasteur Inc.; 2012.

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**Brief Summary of Prescribing Information**

**1 INDICATIONS AND USAGE**

**1.1 Indication**

SKLICE® Lotion is indicated for the topical treatment of head lice infestations in patients 6 months of age and older.

**1.2 Adjunctive Measures**

SKLICE Lotion should be used in the context of an overall lice management program:

- Wash (in hot water) or dry-clean all recently worn clothing, hats, used bedding and towels.
- Wash personal care items such as combs, brushes and hair clips in hot water.
- A fine-tooth comb or special nit comb may be used to remove dead lice and nits.

**2 DOSAGE AND ADMINISTRATION**

For topical use only. SKLICE Lotion is not for oral, ophthalmic, or intravaginal use.

Apply SKLICE Lotion to dry hair in an amount sufficient (up to 1 tube) to thoroughly coat the hair and scalp. Leave SKLICE Lotion on the hair and scalp for 10 minutes, and then rinse off with water.

The tube is intended for single use; discard any unused portion.

Avoid contact with eyes.

**4 CONTRAINDICATIONS**

None.

**5 WARNINGS AND PRECAUTIONS**

**5.1 Ingestion in Pediatric Patients**

In order to prevent ingestion, SKLICE Lotion should only be administered to pediatric patients under the direct supervision of an adult.

**6 ADVERSE REACTIONS**

**6.1 Clinical Trials Experience**

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice.

The data described below reflect exposure to a single 10 minute treatment of SKLICE Lotion in 379 patients, ages 6 months and older, in placebo-controlled trials. Of these subjects, 47 subjects were age 6 months to 4 years, 179 subjects were age 4 to 12 years, 56 subjects were age 12 to 16 years and 97 subjects were age 16 or older. Adverse reactions, reported in less than 1% of subjects treated with SKLICE Lotion, include conjunctivitis, ocular hyperemia, eye irritation, dandruff, dry skin, and skin burning sensation.

**8 USE IN SPECIFIC POPULATIONS**

**8.1 Pregnancy**

Pregnancy Category C

There are no adequate and well-controlled studies with SKLICE Lotion in pregnant women. SKLICE Lotion should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

No comparisons of animal exposure with human exposure are provided due to the low systemic exposure noted in the clinical pharmacokinetic study [see *Clinical Pharmacology (12.3) in the full prescribing information*].

**Human Data**

There are published reports of oral ivermectin use during human pregnancy. In an open label study, 397 women in their second trimester of pregnancy were treated with ivermectin tablets and albendazole at the labeled dose rate for soil-transmitted helminths and compared with a pregnant, non-treated population. No differences in pregnancy outcomes were observed between treated and untreated populations.

**Animal Data**

Systemic embryofetal development studies were conducted in mice, rats and rabbits. Oral doses of 0.1, 0.2, 0.4, 0.8, and 1.6 mg/kg/day ivermectin

were administered during the period of organogenesis (gestational days 6–15) to pregnant female mice. Maternal death occurred at 0.4 mg/kg/day and above. Cleft palate occurred in the fetuses from the 0.4, 0.8, and 1.6 mg/kg/day groups. Exencephaly was seen in the fetuses from the 0.8 mg/kg/day group. Oral doses of 2.5, 5, and 10 mg/kg/day ivermectin were administered during the period of organogenesis (gestational days 6–17) to pregnant female rats. Maternal death and pre-implantation loss occurred at 10 mg/kg/day. Cleft palate and wavy ribs were seen in fetuses from the 10 mg/kg/day group. Oral doses of 1.5, 3, and 6 mg/kg/day ivermectin were administered during the period of organogenesis (gestational days 6–18) to pregnant female rabbits. Maternal toxicity and abortion occurred at 6 mg/kg/day. Cleft palate and clubbed forepaws occurred in the fetuses from the 3 and 6 mg/kg groups. These teratogenic effects were found only at or near doses that were maternally toxic to the pregnant female. Therefore, ivermectin does not appear to be selectively fetotoxic to the developing fetus.

**8.3 Nursing Mothers**

Following oral administration, ivermectin is excreted in human milk in low concentrations. This has not been evaluated following topical administration. Caution should be exercised when SKLICE Lotion is administered to a nursing woman.

**8.4 Pediatric Use**

The safety and effectiveness of SKLICE Lotion have been established for pediatric patients 6 months of age and older [see *Clinical Pharmacology (12.3) in the full prescribing information and Clinical Studies (14) in the full prescribing information*].

The safety of SKLICE Lotion has not been established in pediatric patients below the age of 6 months. SKLICE Lotion is not recommended in pediatric patients under 6 months of age because of the potential increased systemic absorption due to a high ratio of skin surface area to body mass and the potential for an immature skin barrier and risk of ivermectin toxicity.

**8.5 Geriatric Use**

Clinical studies of SKLICE Lotion did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients.

**10 OVERDOSAGE**

In accidental or significant exposure to unknown quantities of veterinary formulations of ivermectin in humans, either by ingestion, inhalation, injection, or exposure to body surfaces, the following adverse effects have been reported most frequently: rash, edema, headache, dizziness, asthenia, nausea, vomiting, and diarrhea. Other adverse effects that have been reported include: seizure, ataxia, dyspnea, abdominal pain, paresthesia, urticaria, and contact dermatitis.

In case of accidental poisoning, supportive therapy, if indicated, should include parenteral fluids and electrolytes, respiratory support (oxygen and mechanical ventilation if necessary) and pressor agents if clinically significant hypotension is present. Induction of emesis and/or gastric lavage as soon as possible, followed by purgatives and other routine anti-poison measures, may be indicated if needed to prevent absorption of ingested material.

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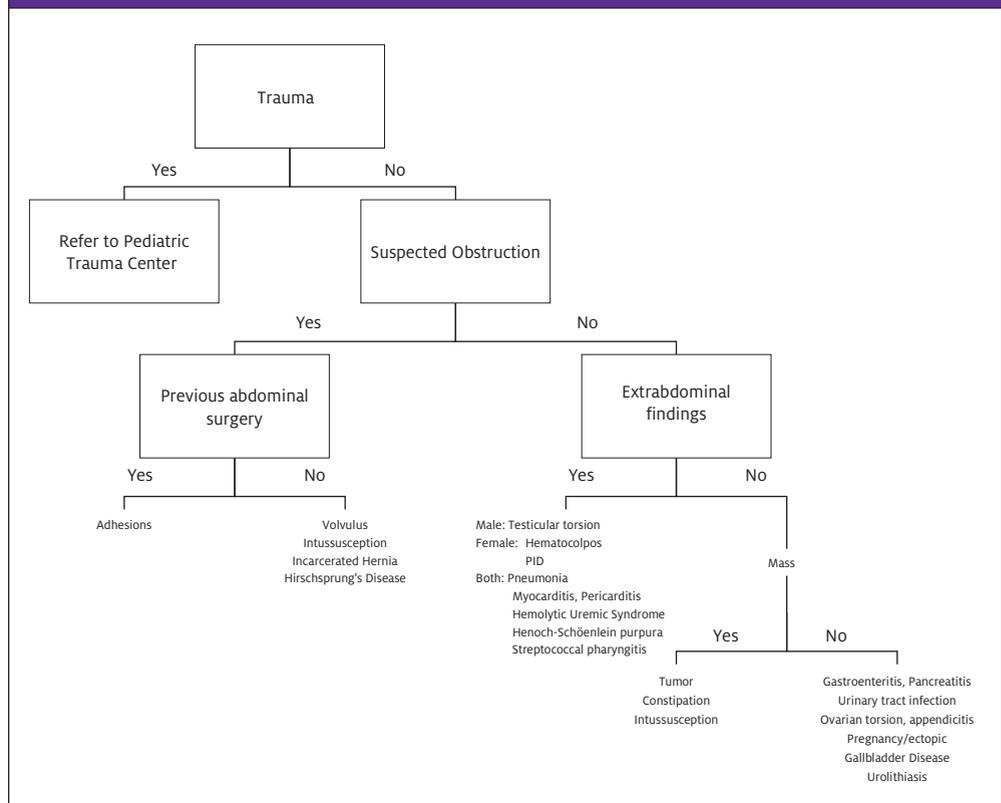
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ing the diagnosis. The age and sex of a patient, the order of onset of symptoms, progression and quality of pain, associated symptoms (fever, vomiting, diarrhea, constipation, anorexia, rash, altered mental status, dysuria, hematuria or vaginal secretions), gynecologic and surgical history and history of recent trauma are important to narrow the differential diagnosis in addition to the physical exam (**Figure 1**). Some of the indicators on the history and physical exam that should prompt surgical evaluation include: bilious vomiting, pain worsening with movement, involuntary guarding,

rebound tenderness and tenderness with percussion or history of abdominal trauma. Patients with findings concerning for obstruction, peritoneal irritation, incarcerated hernia, systemic life-threatening conditions (diabetic ketoacidosis and hemolytic uremic syndrome), tubo-ovarian abscess or ruptured ectopic pregnancy should be transferred for further management.<sup>3</sup>

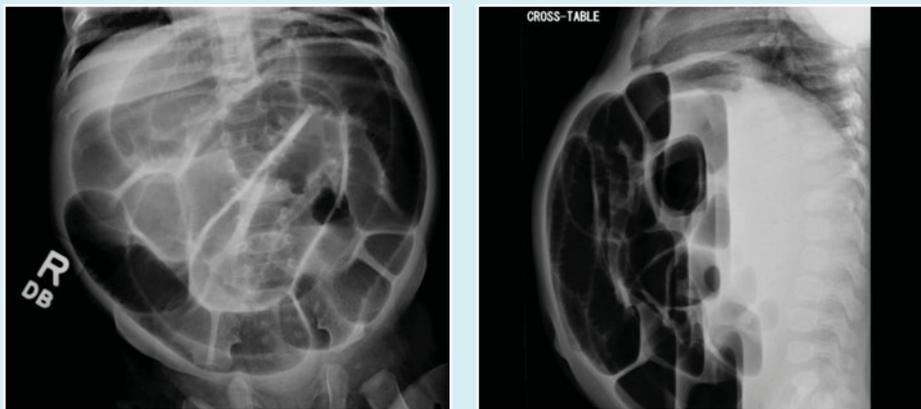
Children with abdominal pain who are well-appearing, otherwise healthy, have a normal physical exam and tolerate feedings may not require laboratory or imaging studies and can be discharged home with close follow up by primary physician within 24 hours unless intussusception is suspected. Ancillary studies should be performed when history or physical examination suggests a concerning diagnosis. The choice of test should be based on the diagnoses being considered and a patient's age. Initial work up may include a complete blood count (CBC), basic metabolic panel, sedimentation rate, c-reactive protein (CRP) level, and urinalysis, although other specific laboratory studies such as lipase, amylase, liver enzymes, testing for pregnancy, gonorrhea and chlamydia, and wet prep may be appropriate, depending upon the conditions being considered. Laboratory studies are usually not diagnostic but

**Figure 1. Algorithm for differential diagnosis of acute abdominal pain in children**



can be used to confirm a clinician's suspicion. Analgesia should be provided according to a patient's reported pain. Although in the past administration of morphine to children with acute abdominal pain for pain reduction was believed to affect the examination, several studies have concluded otherwise.<sup>4,5</sup> Imaging studies can be used to confirm the suspected diagnosis. If further imaging or repeated abdominal exams are necessary to clarify the diagnosis, a patient may have to be transferred to a hospital that has a pediatric surgery service. Abdominal films may demonstrate obstruction (air fluid levels, distended bowel, or sentinel bowel loops), perforation (free air), fecalith, or constipation.<sup>6</sup> Chest radiograph can be used if there is a concern for basilar pneumonia or signs of myocarditis. For children with suspected midgut volvulus, achalasia, or duodenal web, an upper gastrointestinal (GI) series with contrast is the best examination. Ultrasound is noninvasive, relatively inexpensive and does not use ionizing radiation, but accuracy varies depending on the ultrasonographer's technique. Imaging may show pyloric stenosis, intussusception (doughnut sign), appendicitis (noncompressible, aperistaltic tubular structure arising from the cecum with periappendiceal fluid and walls

**Figure 2. Small bowel obstruction**



Small bowel obstruction: Dilated small bowel loops with multiple air fluid levels and absence of small bowel gas in a patient with intussusception.

**Figure 3. Doughnut sign on ultrasound**



Abdominal ultrasound was performed in same patient as in Figure 1 and showed a doughnut sign in the right upper quadrant consistent with intussusception.

rectal contrast and requires an increased amount of radiation.

**Causes of Acute Abdominal Pain Related to Obstruction**

*Volvulus*

Improper rotation and fixation of duodenum and colon (malrotation) makes the midgut vulnerable to volvulus. The volvulus twists about the superior mesenteric artery axis, causing the midgut to lose its blood supply, leading to development of ischemic necrosis. Most patients with volvulus present during the first year of life, and particularly the first month of life. The condition manifests as bilious vomiting, abdominal distension, GI bleeding, and subsequent shock.<sup>7</sup> A patient with volvulus should be resuscitated (ABCs), receive nothing per os (NPO), have a nasogastric (NG) tube placed for decompression, be started on broad-spectrum antibiotics to cover the GI tract and should be transferred for further imaging and surgical evaluation.<sup>8</sup> Expeditious management may make the difference between a condition that is completely reversible and one that results in loss of a large segment of intestine. An

> 6 mm in diameter), ovarian torsion, ectopic pregnancy, cholelithiasis and urolithiasis. Computed tomography (CT) scan is helpful for identifying nephrolithiasis, appendicitis, pancreatitis, abdominal masses, inflammatory bowel lesions, and intra-abdominal abscesses but it can be invasive, may require intravenous (IV), oral, or

upper GI series is the study of choice, and laparotomy is required for definitive treatment.

*Intussusception*

Intussusception is the telescoping of one portion of the bowel into its distal segment; most commonly the ter-



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**Figure 4. Contrast enema study**

Water-soluble contrast enema was performed in the same patient, but reduction was unsuccessful after multiple attempts. The patient went to the operating room for an exploratory laparotomy.

Small intestine invaginates into the cecum. It is one of the most frequent causes of bowel obstruction in children aged 2 months to 5 years and is often the result of hypertrophy of the Peyer patches, most likely secondary to viral infections. In approximately 20% of cases, an underlying disorder such as lymphoma, polyps, Meckel's diverticulum or vascular malformations act as the lead point for intussusception. The classic triad is vomiting, colicky, severe abdominal pain and currant jelly stools but these signs are not always present. Abdominal pain can occur at 15- to 20-minute intervals and become more frequent and severe over time. Children may behave normally and be free of pain between episodes but fever is common and mental status changes can occur. On physical exam, a sausage-shaped mass is sometimes palpable and the rectum must be examined for a positive stool Hemoccult test.

Plain abdominal radiographs can be performed to rule out contraindications for contrast enema and to evaluate for soft-tissue mass. It can show distended bowel loops with absence of gas (**Figure 2**). A target sign—two con-

centric radiolucent circles superimposed on the right kidney—or a crescent sign—a soft-tissue density projecting into the gas of the large bowel—also may be seen on abdominal radiographs of patients with intussusception.<sup>9</sup> Ultrasound can show a bull's eye, coiled spring or doughnut sign (**Figure 3**). A patient with intussusception should be NPO and receive IV hydration, with placement of a NG tube and transfer for surgical consultation and an air or barium enema study. The efficacy of administration of antibiotics before such a study has not been established but they sometimes are given because of the risk of perforation. Surgery is indicated when contrast enema is unsuccessful (**Figure 4**). In such a case,

a patient should be admitted for observation because of the 2% to 5% risk of recurrence soon after reduction.

#### *Incarcerated Hernias*

Hernia is the protrusion of an organ or its fascia through the wall of the cavity that contains it. Umbilical hernia is most common, followed by inguinal and scrotal.<sup>10</sup> Incarceration risk is greater during the first 6 months of life. Patients present with irritability and vomiting. On exam, an erythematous bulge is seen, which becomes more prominent with increased abdominal pressure. Reduction can be attempted by applying pressure along the proximal inguinal canal with one hand while "milking" gas or the content of the incarcerated bowel with the other hand for up to 5 minutes.<sup>11</sup> If manual reduction is unsuccessful, a patient should be transferred for surgical evaluation. Ultrasonography can also be performed to confirm the diagnosis.

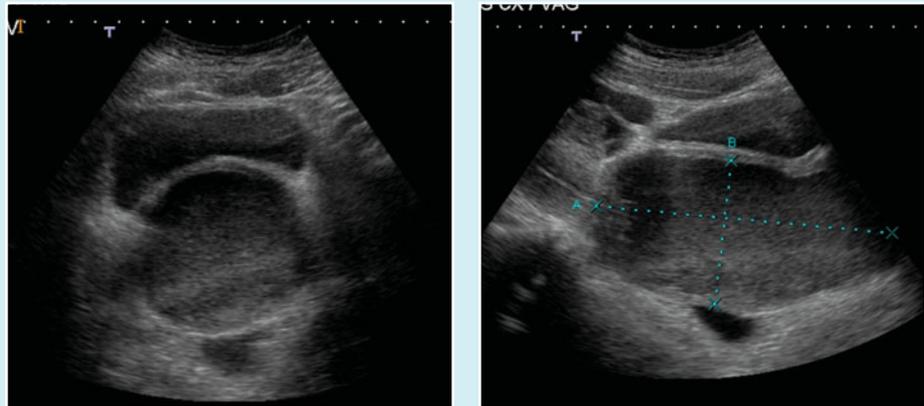
#### *Hirschsprung's Disease*

Hirschsprung's Disease is congenital absence of ganglion

cells in the mesenteric and submucosal plexuses of the bowel, resulting in abnormal peristalsis of the aganglionic segment. In approximately 80% of cases, the rectosigmoid area is involved. The presentation may vary from complete obstruction at birth, with vomiting, abdominal distension and failure to pass meconium, to delayed passage of meconium and repeated episodes of constipation. Approximately 24% to 34% of patients may present with enterocolitis, explosive foul-smelling diarrhea, fever, vomiting,

and abdominal pain and distension, which is the most severe and potentially lethal complication of Hirsch-

**Figure 5.**



Pelvic ultrasound showing a distended vaginal canal, in transverse (a) and sagittal views (b), with echogenic fluid (hemorrhagic product) extending to the uterus, suggestive of hematocolpos in a 12-year-old female with abdominal pain and amenorrhea.



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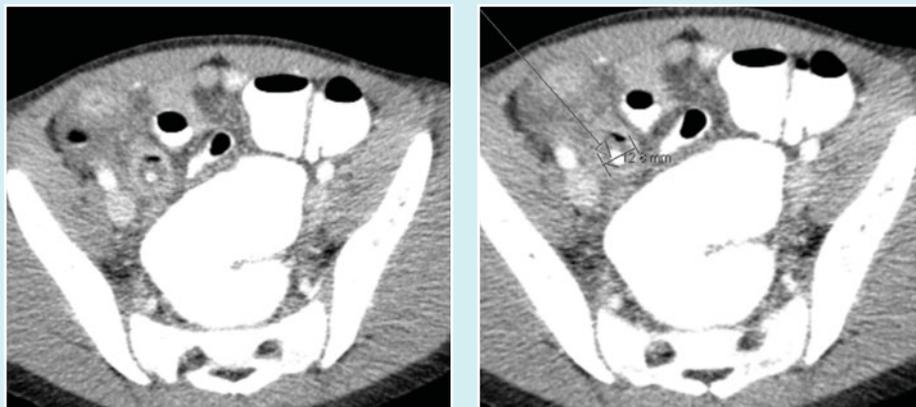
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Figure 6.



Abdominal-pelvic CT scan showing enlarged appendix with enhanced edematous walls and a calcified appendix in a patient with appendicitis.

prung's disease.<sup>12</sup> Such patients should be managed with volume resuscitation and broad-spectrum IV antibiotics to provide coverage against aerobic and anaerobic organisms. In children with a more classic presentation, a barium enema should demonstrate a transition zone, but the definitive diagnosis requires rectal biopsy.

#### Adhesions

Adhesive bowel obstruction can be seen in approximately 2% to 15% of patients who undergo laparotomy. Most cases occur within 3 months of the surgery and 80% within 2 years of the procedure. Patients present with emesis, abdominal distension, and irritability. Transfer should be performed for pediatric surgery consultation and nasogastric decompression.

### Extra-abdominal Causes of Acute Abdominal Pain

#### Testicular Torsion

Testicular torsion occurs when the spermatic cord twists, compromising the blood supply to the testicles and scrotum. It can result from trauma or strenuous exercise, or the cause may not be obvious. Patients often report sudden testicular pain that may radiate to the lower abdomen and inguinal area, nausea and vomiting. On physical exam, the testicle is tender with a transverse orientation and elevation in the scrotum. Doppler ultrasound can distinguish between other diagnoses with normal or increased blood flow (epididymitis) and torsion (no flow). Prompt transfer to a hospital with a urologic service that can provide surgical exploration—preferably within 6 hours of the onset of pain—is required.

#### Ovarian Cyst and Ovarian Torsion

Ovarian cysts are uncommon in premenarchal patients, but females of reproductive age have the highest incidence of ovarian torsion.<sup>13</sup> Pain from an ovarian cyst may result from bleeding into the cyst or rupture of a hemorrhagic cyst, causing peritoneal irritation. Rupture usually occurs preceding a menstrual period. Ultrasound should be performed to document the size of the cyst and rule out tumors. Analgesia and

proper follow up with gynecology is appropriate.

As with testicular torsion, patients with ovarian torsion present with sudden sharp pain that radiates to the ipsilateral groin and may be accompanied by nausea and vomiting. Doppler ultrasound is helpful in revealing the diagnosis, but definitive diagnosis is based upon surgical findings. Prompt gynecological consultation and surgery is required for definitive management. Complete blood count (CBC) may show anemia from hemorrhage, leukocytosis in ovarian necrosis, and electrolyte disturbances in patients who have severe vomiting.

#### Ectopic Pregnancy

Ectopic pregnancy is rare in the pediatric population but should be part of the differential diagnosis for all sexually active adolescents who present with acute abdominal pain. The classic symptoms include abdominal pain, vaginal bleeding and amenorrhea, but dizziness, vomiting, and symptoms of urinary tract infection (UTI) also may be present. Risk factors include previous ectopic pregnancy, pelvic inflammatory disease (PID), previous tubal ligation, use of an intrauterine device (IUD), infertility, and previous abortion. Ten to twenty percent of patients may present in shock. Pregnancy tests are very accurate and ultrasound usually shows an adnexal mass or blood in the cul-de-sac. ABCs should be the first step in management and a patient should be transferred for ob/gyn consultation and surgical management.

#### Pelvic Inflammatory Disease

Risk of PID is increased in patients who have recent

insertion of an IUD, have multiple sexual partners, and use vaginal douches among other factors. Patients with PID usually present with lower abdominal pain, vaginal discharge, urinary symptoms, and fever. On physical exam, vaginal/encervical discharge may be abnormal or purulent and cervical motion and adnexal tenderness may be present. Blood work may show leukocytosis, and an elevated sedimentation rate and c-reactive protein (CRP) level. According to the Centers for Disease Control and Prevention, PID is confirmed if pelvic tenderness is associated with one or more of the following: acute or chronic endometritis or salpingitis with histologic evaluation of biopsy, demonstration of *Neisseria gonorrhoea* or *Chlamydia trachomatis* in the genital tract, salpingitis visualized by laparoscopy or laparotomy, isolation of pathogenic bacteria in a clean specimen from the upper genital tract, or inflammatory/purulent pelvic peritoneal fluid without a source.<sup>14</sup> Evaluation should include cultures of cervix, urethra, rectum or urine for *N. gonorrhoea* or *C. trachomatis*. Sexually active patients presenting with pelvic or lower abdominal pain with no other cause should be empirically treated with antibiotics for PID. For mild-moderate PID, ceftriaxone 250 mg IM once plus doxycycline 100 mg orally twice daily with or without metronidazole 500 mg twice daily for 14 days, or cefoxitin 2 g IM single dose and Probenecid 1g orally administered concurrently in a single dose plus doxycycline 100 mg twice daily with or without metronidazole 500 mg twice daily for 14 days can be given. Patients who are pregnant, have tubo-ovarian abscess, have failed oral therapy or have severe illness should be admitted for IV antibiotic therapy with cefotetan 2g every 12 hours or cefoxitin 2g IV every 6 hours plus doxycycline 100 mg every 12 hours.

#### Urinary Tract Infection

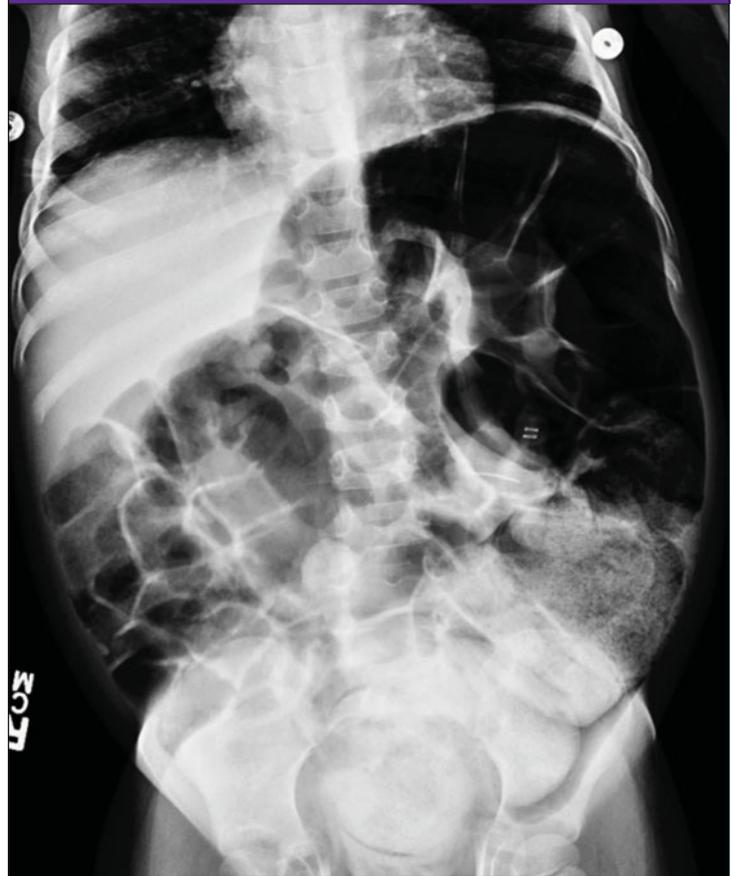
Fever may be the only manifestation of UTI in some children. Infants and young children may present with nonspecific symptoms such as vomiting, anorexia, diarrhea, lethargy, oliguria and failure to thrive. Older children may present with abdominal pain, flank or back pain, dysuria, or frequency. Urine culture is the gold standard for diagnosis, but urinalysis can be indicative of UTI.<sup>15</sup> Urinary tract catheterization should be used to obtain urine from febrile infants. Children can be

treated with oral antibiotic therapy such as a third-generation cephalosporin, trimethoprim-sulfamethoxazole or amoxicillin-clavulanate (higher resistance rate). Antibiotic duration—a short course of 3 to 7 days vs a long course of 7 to 14 days—is controversial, but patients with febrile illness should be treated for at least 10 days.<sup>16</sup> Infants younger than 2 months and patients with pyelonephritis, urinary tract obstruction or immunocompromise should be admitted for IV antibiotic therapy. Young children may require further follow up to evaluate for urinary tract abnormalities such as vesicoureteral reflux.

#### Hematocolpos

Hematocolpos is menstrual blood in the vagina. It is seen in adolescents who begin menstruation have retention of menstrual blood in the vagina because of an imperforate hymen. Patients usually complain of lower

Figure 7.



Patient with distension of the colon, a G-tube and moderate to large amount of stool present, consistent with constipation.

abdominal pain that sometimes is associated with nausea and vomiting. On physical exam, a bulging, blue-domed area can be seen in the vaginal area. Pelvic ultrasound can be performed to confirm the diagnosis and to rule out hematometra (menstrual blood in the uterus) (**Figure 5**). An adolescent with hematocolpos should be transferred for gynecological evaluation and surgical repair.

### Other Causes of Acute Abdominal Pain

#### *Appendicitis*

Appendicitis is most common in adolescents and relatively rare in patients younger than age 5 years, which leads to delayed diagnosis and higher rates of perforation.<sup>17</sup> Most common symptoms include vomiting (85%-90%), pain (35%-77%), diarrhea (18%-46%), fever (40%-60%), and anorexia. In fewer than 50% of cases, localized right-lower-quadrant pain is noted. Vomiting is usually the first symptom, but progression of symptoms is somewhat difficult to verify. On physical exam, guarding, rebound tenderness, and other peritoneal signs may be present. Laboratory studies such as white blood cell count and CRP may support the diagnosis. Ultrasound and CT scan can be used when diagnosis is not clear (**Figure 6**). Patients with suspected appendicitis should be NPO, receive IV antibiotics, and be transferred for surgical consultation or repeated abdominal examinations if the diagnosis is still unclear.

#### *Gallbladder Disease*

Gallbladder disease is more common in adolescent females than in younger children. Hemolytic disease (sickle cell disease, spherocytosis and thalassemia), obesity and pregnancy are risk factors. Patients often present with right-upper-quadrant and epigastric pain that frequently radiates to the right subscapular area. Vomiting, fever, and jaundice may also be present. Laboratory studies such as a CBC, liver enzymes, and bilirubin levels can be performed. Ultrasound is the study of choice to evaluate for gallbladder disease. Cholecystitis is an inflammation of the gallbladder caused by gallstones and should be treated with antibiotics, analgesia, a low-fat diet, and eventually cholecystectomy.

#### *Pancreatitis*

Pancreatitis is not common in the pediatric population, but can occur at any time during childhood. It is most

*Children perceive visceral pain generally over the epigastric, periumbilical or suprapubic region.*

frequently associated with trauma, but also can be associated with drugs (steroids, thiazides, estrogen and L-asparaginase), systemic diseases (cystic fibrosis, and systemic lupus erythematous), familial pancreatitis (autosomal dominant), infections (mumps) and anatomic abnormalities such as pancreas duplication, ductal atresia or stenosis, and common duct stones. Patients usually complaint of mid epigastric abdominal pain that may be associated with nausea and vomiting. On physical exam, the abdomen may be distended, bowel sounds may be decreased, and tenderness is found over the epigastric area. Elevated lipase and/or amylase levels (increase within 6 to 12 hours of onset and fairly rapid clearance from the blood) will help with the diagnosis.<sup>18</sup> Lipase is more specific and some studies suggest that lipase elevations occur earlier and last longer than amylase elevations. Abdominal radiograph may reveal an epigastric sentinel loop or pancreatic calcifications. An enlarged, hypoechoic pancreas or a pseudocyst can be seen on ultrasound, but CT scan is the most important imaging test for diagnosis of pancreatitis and its abdominal complications. Patients should be transferred for admission and diet progression with enteral feeds and, in very rare cases, for surgical management such as in the case of pancreatic necrosis.

#### *Gastroenteritis*

Gastroenteritis is more common in patients from low socioeconomic areas and with exposure to day care centers. Children younger than age 5 years may have 1 to 5 episodes per year but gastroenteritis can occur as often as 15 times per year in children in developing countries.<sup>19</sup> Most episodes are viral and bacterial, and less likely caused by parasites. Symptoms (vomiting, diarrhea and abdominal pain) are usually brief and self-limited, lasting 3 to 7 days, but they may be prolonged by antimotility agents that cause intestinal stasis and prevent the protection afforded by enteric pathogens that result from active motility of the small intestine. Most patients with mild-to-moderate dehydration will respond to appropriate oral rehydration therapy. Patients with severe dehydration may have electrolyte abnormalities and need IV hydration and admission. Patients with intractable vomiting will also need to receive IV hydration. Rehydration should be started with isotonic solution such as normal saline or Ringer's Lactate 20 mL/kg bolus. Further fluid management is beyond the scope of this article.

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### Constipation

Constipation is common in children and although there is not one simple definition, it can be considered as decreased stool frequency. A normal infant may pass stools 1 to 7 times a day.<sup>20</sup> Toddlers can have 2 stools per day and children older than age 4 years may have 1 to 2 stools per day. Constipation is not a disease; it is a symptom of a problem such as cystic fibrosis, malnutrition, and Hirschsprung's disease, among others.

On physical exam, fecal masses may be palpated on the left lower quadrant and a patient may have abdominal distension. On rectal exam, anal fissures may be seen and a distended rectum full of stool can be found (**Figure 7**). Treatment consists of disimpaction and evacuation of the stool remaining in the bowel, which can be accomplished by using hypertonic phosphate (Fleet) enemas. Oral laxatives such as lactulose, polyethylene glycol (Miralax), bisocodyl or senna can then be used. If a patient does not respond to such treatment, he or she should be referred for admission and disimpaction under physician supervision. Dietary changes should also be implemented to increase fiber consumption. In infants, sorbitol-containing juices such as prune or pear juice are an alternative.

### Abdominal Masses

The tumors that most commonly present as abdominal masses include neuroblastoma, extragonadal germ cell tumors, hepatoblastoma and Wilms' tumor.<sup>21</sup> Neuroblastomas and hepatoblastomas are more common in children younger than age 2 years, whereas Wilms' tumors, hepatocellular carcinoma, and ovarian germ cell tumors are more common in older children. Tumors are not a common cause of acute abdominal pain, but rather, present with progressing abdominal distension. Neuroblastomas initially manifest with watery diarrhea and sometimes opsoclonus-myoclonus. Hematuria can be seen in patients with Wilms' tumor. Patients with palpable abdominal masses should be transferred for further imaging and workup for definitive diagnosis. Specific workup and management is out of the scope of this article.

### Uncommon causes of abdominal pain

Acute abdominal pain can be a symptom associated with different disease processes that generally have other distinguishing clinical features.<sup>22</sup> Diseases will be mentioned as part of the differential diagnosis for abdominal pain but their management is out of the scope of this article. Some of the life-threatening diseases include diabetic ketoacidosis (usually also presenting

with polyuria, polyphagia, and polydipsia), hemolytic uremic syndrome (bloody diarrhea, hemolytic anemia, thrombocytopenia, and acute renal injury), primary bacterial peritonitis (caused most commonly by *Streptococcus pneumoniae* in patients with nephritic syndrome), Henoch-Schönlein purpura (purpuric rash in lower extremities and buttocks, arthralgia, and renal disease), myocarditis, pericarditis, and pneumonia. ■

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# Practice Management

## Offering Patient Wi-Fi in the Urgent Care Center

**Urgent message:** The costs of and barriers to adding Wi-Fi to an urgent care center are low and the benefits include a better patient experience and improved perception of wait times.

ALAN A. AYERS, MBA, MAcc

Wi-Fi is now ubiquitous. Step into most any coffee house, theme restaurant, library, shopping mall or other service establishment and you'll find that Internet access is readily available and usually free of charge. Many hospitals have also introduced Wi-Fi as an amenity for patients and their guests in an effort to help them feel at ease in unfamiliar surroundings. This means that at the touch of a button, consumers can access the latest news, email, and social events through their smart phones and tablets. But while the rest of the business world moves into the "information age," many urgent care centers remain "in the past" with their months-old magazines and static health messages. As patients come to expect the availability of Wi-Fi in health care facilities, offering Wi-Fi at your urgent care center is a logical next step.

### Public Wi-Fi Improves the Patient Experience

When restaurants began to introduce free Wi-Fi, they learned that customers would sit longer in their seats, order more drinks, or opt for dessert as they browsed their Facebook "walls," finished their online games, or responded to one more email. By offering a place to "relax," establishments with Wi-Fi attracted more customers, their customers spent more money, their loyal customers returned more frequently, and their businesses experienced higher profits than non-connected

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**Alan Ayers** is Content Advisor, Urgent Care Association of America, Associate Editor—Practice Management, *Journal of Urgent Care Medicine*, and Vice President, Concentra Urgent Care.



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competitors. Urgent care operators can learn from these observations.

The urgent care environment is inherently stressful. Patients are dealing with illness or injury, they're uncomfortable, they're away from work and personal activities, and friends and family members may be concerned. In today's "on-demand" world, people are also generally impatient with waiting. Access to Wi-Fi dra-

**Table 1. Key Considerations for Wi-Fi in the Urgent Care Center****Do we manage this in-house or through an outsourced provider?**

- √ What is the aptitude and skill of the center's current staff as it pertains to network architecture and Internet security?
- √ Can an installation be accomplished internally and is there someone who will be available to respond to connectivity issues as needed?
- √ What is the cost differential between managing Wi-Fi in-house versus utilizing a contractor?

**Will this be a paid or a free service?**

Urgent care centers have the capability to offer either a free or paid connection to Wi-Fi. Paid connections are often seen in upscale hotels and on airlines—places where individuals with expense accounts need immediate or interim Internet access. Service establishments including hospitals most often offer their Wi-Fi services for free. When considering Wi-Fi as an amenity and given what should be short durations of patient waits, Wi-Fi in urgent care really should be free.

**Will Wi-Fi access be over the center's local area network or a separate guest network?**

A separate guest network is the surest way to eliminate the risk of hacking into protected health information and to prevent the intrusion of malware and viruses into the local area networks hosting the center's practice management applications. In addition, separating business and guest traffic can prevent "slowing" business processes due to bandwidth constraints.

**How many people will have access to the network?**

As a center's volume grows, its Wi-Fi capabilities will need to expand with it. The Wi-Fi system should have sufficient bandwidth to accommodate everyone waiting in the office, whether that number is large or small. If the center is in a high-density area where patrons of other businesses may access the Wi-Fi system, the center may especially consider access controls via "password" or "registration."

**How will Wi-Fi access be controlled?**

Controlled connectivity requires users to connect using a password provided by the front office or by entering and validating (registering) their credentials on a splash page. Having controlled access provides for tighter security and also allows for further consumer insights on those patients, as the URLs visited can be easily accessed by the administrator of the network.

matically diminishes the stress of an urgent care encounter by allowing patients' attention to be consumed by their own devices. In fact, providing free Wi-Fi facilitates activities that are already taking place.

According to a Blue Chip Patient Recruitment (BCPR) mHealth study, 61% of patients are reading their email, 49% are texting, and 47% are surfing the Internet in medical waiting rooms.<sup>1</sup> When patients have something to focus their attention, they're less likely to disturb staff and to perceive wait times as being "long."

**Develop the Solution In-House or Use a Contractor?**

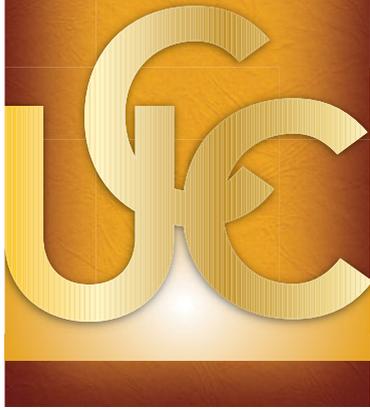
Many urgent care centers resist implementing patient Wi-Fi because they perceive it's too expensive. The reality is that most medical offices already have an internal computer network, meaning much of the technical infrastructure is already in place. Ultimately, all that's required is a router and an Internet Service Provider (ISP). A router is a small piece of equipment responsible for distributing (or routing) Wi-Fi connections through the office and an ISP is the company that provides connectivity to the Internet—typically a phone or cable company. A good wireless router—with some built-in security features—is available at any technology store for \$200 or less.

However, "do-it-yourself" solutions allowing open, non-controlled access—particularly if over the same network that supports the center's operations—can present a risk of hacking into the center's applications, tie up bandwidth thus slowing down business systems, and can present legal risks if there is no agreement or acceptance to terms of Internet use. At the very least, the center should use a separate network and Internet connection for "guest" versus "employee" access. The more protections for the user and the center, the more complex the set-up required, usually exceeding the technical expertise of the center's staff. To identify the best set-up for your center, start by answering the questions addressed in **Table 1**.

A good way to identify independent providers in your community is to ask for referrals from restaurants and other businesses you frequent. In addition, national service providers like [www.privatewifi.com](http://www.privatewifi.com) and AT&T can turn the center into a "hotspot"—a branded turnkey solution that includes installation, network management, reporting, and 24/7 customer and technical support.

**Information Security Issues in Implementing Public Wi-Fi**

Both patients and providers have natural concerns regarding information security. Providers need to remain compliant with Health Insurance Portability and Accountability Act (HIPAA) standards and patients need to know that their personal health information is secure. The most significant information security step



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Advocate Good Shepherd Immediate Care, Crystal Lake, IL	FastMed Urgent Care Winston-Salem Stratford Road, Winston-Salem, NC	Mount Sinai Urgent Care, New York, NY	Premier Care - Park Slope, Brooklyn, NY
Algiers Urgent Care, New Orleans, LA	Gardens Urgent Care Lake Worth, Lake Worth, FL	Omni Medical Care - Newburgh, Newburgh, NY	Reddy Urgent Care, Athens, GA
Bee Caves Urgent Care, Austin, TX	Gardens Urgent Care Palm Beach Gardens, Palm Beach Gardens, FL	Omni Medical Care - Poughkeepsie, Poughkeepsie, NY	Riverwoods Urgent Care, Glendale, WI
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Cathedral Square Urgent Care, Milwaukee, WI	Helix Medical Centers Tequesta, Tequesta, FL	Our Urgent Care Wentzville, Wentzville, MO	Suncoast Urgent Care, Spring Hill, FL
CityMD East 67th Street, New York, NY	Impact Urgent Care - FM 78 & Woodlake, San Antonio, TX	Pardee Urgent Care, Hendersonville, NC	Taos Urgent Care, Taos, NM
Covenant Clinics, LLC, Las Cruces, NM	Lake After Hours Central, Baton Rouge, LA	PeaceHealth Medical Group Urgent Care, Eugene, OR	Trinity Urgent Care, New Port Richey, FL
Doctors Express Downingtown, Downingtown, PA	Lake After Hours Denham Springs, Denham Springs, LA	PeaceHealth Medical Group Urgent Care RiverBend Pavilion, Springfield, OR	Urgent Care Center, McAlester, OK
East Coast Urgent Care Physicians, Nanuet, NY	Lake After Hours Drusilla, Baton Rouge, LA	Physicians Immediate Care - St. Lucie West, Port St Lucie, FL	Urgent Care of Connecticut - Glastonbury, Glastonbury, CT
EmergiCare - Austin Bluffs, Colorado Springs, CO	Lake After Hours Hammond, Hammond, LA	Physicians Immediate Care-Eastern, Port St. Lucie, FL	UrgiMed Family Medical Center, Randolph, NJ
EmergiCare - Garden of the Gods, Colorado Springs, CO	Lake After Hours Highland, Baton Rouge, LA	Physicians Immediate Care-Fort Pierce, Fort Pierce, FL	Valley Immediate Care, LLC - Grants Pass, Grants Pass, OR
ER QuickCare PL, Naples, FL	Lake After Hours O'Neal, Baton Rouge, LA	Physicians Immediate Care-Southwestern, Port St. Lucie, FL	Valley Immediate Care, LLC - North, Medford, OR
Family First Urgent Care, Oakhurst, NJ	Lake After Hours Perkins, Baton Rouge, LA	Premier Care - Great Neck, Great Neck, NY	Valley Immediate Care, LLC - South, Medford, OR
FastLane of Zachary, Zachary, LA			



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We would like to say "Thank You" to all of the Certified Urgent Care Centers that have been awarded this designation in our program since its inception in 2009. We are proud to say that the program has grown to over 500 centers nationwide. If your center is not yet certified, we encourage you to apply in 2013. For more information go to [www.ucaoa.org/certification](http://www.ucaoa.org/certification) and find out how you can get certified today!

that can be taken is to physically separate the public or guest network from the internal network. Although that requires two separate but parallel systems, the result is effectively two separate “houses” for data storage—with the guest network being a shell containing very little information and the internal network being a fortress that contains practice management data.

In regard to the network itself, WPA or WPA2 (Wi-Fi Protected Access) encryption protocols are standard on certified Wi-Fi equipment, minimizing the chance that information will be intercepted. Perhaps more important of a deterrent is controlling network access via password protection (i.e. individual passwords for each patient, changing of default passwords on routers and servers, and password protection on the servers or routers).

### Barriers to Offering Public Wi-Fi

Offering public Wi-Fi to patients presents very few technological challenges. Patients accessing the system must have adequate connection speed, as well as appropriate upload and download privileges. If patient Wi-Fi is through a separate guest network, requiring patients to agree to “Terms of Service”—which typically appear on a splash page upon accessing the Internet—and outlining expectations for use of the service can curtail most legal issues. Typical conditions of use include (but are not limited to):

- Internet is for personal use only while a patient or visitor to the center.
- Attempts to break security, tamper with the system or access secure information are strictly prohibited.
- Internet may not be used for any illegal activity including hacking into other systems, violating intellectual property rights (downloading of pirated or copyrighted materials), or distribution of spam, viruses or malware.
- User will not access or display any material that may be considered offensive, lewd, pornographic, violent, threatening, hateful, or otherwise objectionable.
- User consents to having all Internet activity monitored and recorded by the center, which may be used to ensure compliance with the Terms of Service, applicable law, and in protection of the center’s rights, property and interests.

In addition to the Terms of Service, users should also be presented with a Disclaimer, Limitation of Liability, and Indemnity Clause—which basically state use of the Internet is subject to availability, is at the user’s own risk,

that the center takes no responsibility for activities that occur while online (such as incomplete financial transactions or risks the user’s computer will be hacked or infected with a virus), and that the user will hold the center harmless from any claim arising from using the Wi-Fi. Samples of these agreements can be found on the websites of any public Wi-Fi provider.

Concerns that patients will access or display inappropriate materials—such as pornography—can be controlled by applying a Web filter that blocks access to sites deemed inappropriate. Outsourcing the public Wi-Fi to a third-party provider is the easiest way to ensure a technical infrastructure and terms of service that protect the center.

Other concerns with public Wi-Fi include a dearth of technological skills on the part of staff and lack of physical space for patients in which to feel comfortable with their Internet-related activities. In regard to physical space, the urgent care waiting room should be designed with sufficient power outlets and a variety of seating. Workstations and power strips can be purchased at any office supply store. From a customer service perspective, having Wi-Fi that doesn’t work is worse than having no Wi-Fi at all so staff must be adequately trained to answer patient questions and reset the router if necessary. An outsourced Wi-Fi network provider can provide more advanced technical capabilities, including assessment of patient’s connectivity issues over the telephone.

### Reasons to Not Offer Public Wi-Fi

There are very few downsides to offering public Wi-Fi in an urgent care center. Concerns over the potential for signal interference with existing calibrated equipment are typically unfounded, because there should be adequate shielding in place. Some clinicians may require that patients turn off their electronic devices (especially those that record audio or video) to protect patient privacy and to prevent distraction during the actual physician-patient encounter, thus limiting their use to the waiting room. But more common concerns have to do with whether patients will actually have sufficient time to use the Wi-Fi. Given the walk-in nature and variety of cases seen in urgent care, it’s inevitable that there will be individuals who will need to wait longer than others. While no wait or a short wait is ideal, patient Wi-Fi will make the waits that occur more tolerable.

### Raising Awareness of Wi-Fi in the Center

While some patients may “stumble upon” or be alerted to the availability of Internet connectivity by their

**Table 2. Marketing Free Wi-Fi at the Urgent Care Center**

- **Door Decal:** A decal placed on the center's door advertising that Wi-Fi is available or that the center is a commercial "hotspot."
- **Front Desk Sign:** Point-of-sale materials placed strategically at the front desk raise awareness of Wi-Fi and can prompt patients to ask the staff about how to access the Internet.
- **Patient Receipt:** Patients' individualized Wi-Fi passwords may be written or printed on a payment receipt. This not only raises awareness of the availability of Wi-Fi but also signals to patients that the practice is concerned about information security.
- **Internet Advertising:** In addition to including the presence of Wi-Fi on the center's own website, the center can register with one of multiple independent websites that list Wi-Fi-enabled locations around the country.
- **Center Marketing Materials:** Including the Wi-Fi symbol on printed marketing materials and advertisements for the center communicates to potential patients that the center offers the amenity and cares about the patient experience.

devices, most will not know Wi-Fi is present unless prompted. How will the medical practice get the message out that they have a Wi-Fi connection? **Table 2** provides several ideas for marketing the service.

The use of landing pages and splash pages on the Wi-Fi connection itself offers a distinct opportunity to raise patient awareness of the center's other service offerings, such as travel medicine and immigration physicals, or of seasonal promotions like flu shots and school physicals.

### Conclusion

Internet connectivity is an amenity that can easily be offered by an urgent care center. As the number of Wi-Fi-enabled establishments grows, patients will have greater expectations of Internet connectivity everywhere they go. For urgent care operators, the cost and barriers to adding Wi-Fi are relatively low and the benefits of improving the patient experience and reducing wait time perceptions can manifest incredible value through the repeat visits and positive word-of-mouth of satisfied patients. ■

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# Call for Articles

*JUCM*, the Official Publication of the Urgent Care Association of America, is looking for a few good authors.

Physicians, physician assistants, and nurse practitioners, whether practicing in an urgent care, primary care, hospital, or office environment, are invited to submit a review article or original research for publication in a forthcoming issue.

Submissions on clinical or practice management topics, ranging in length from 2,500 to 3,500 words are welcome. The key requirement is that the article address a topic relevant to the real-world practice of medicine in the urgent care setting.

**Please e-mail your idea to**  
*JUCM* Editor-in-Chief  
 Lee Resnick, MD at  
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He will be happy to discuss it with you.



# Case Report

## Methicillin-Resistant *Staphylococcus aureus*

**Urgent message:** Accurate, early diagnosis and appropriate antibiotic treatment of MRSA is essential to prevent subsequent morbidity and mortality.

SAMINA YUNUS MD, MPH, and DONNA GOETSCH, MSN, CNP

### Case Presentation

A 22-year-old white female presents to the urgent care clinic with a complaint of an infected spider bite on her left upper thigh. She first noted a pimple-like lesion approximately a week before presentation. The lesion has subsequently grown and developed a central, black area with surrounding warmth, redness, and pain. She denies any fever or chills or concurrent similar lesions elsewhere. She has been applying topical neosporin to the area, with no improvement.

The patient has not been in a health care facility over the past year.

### Observations and Findings

#### Physical Exam

On examination the woman is alert, oriented, and in no acute distress.

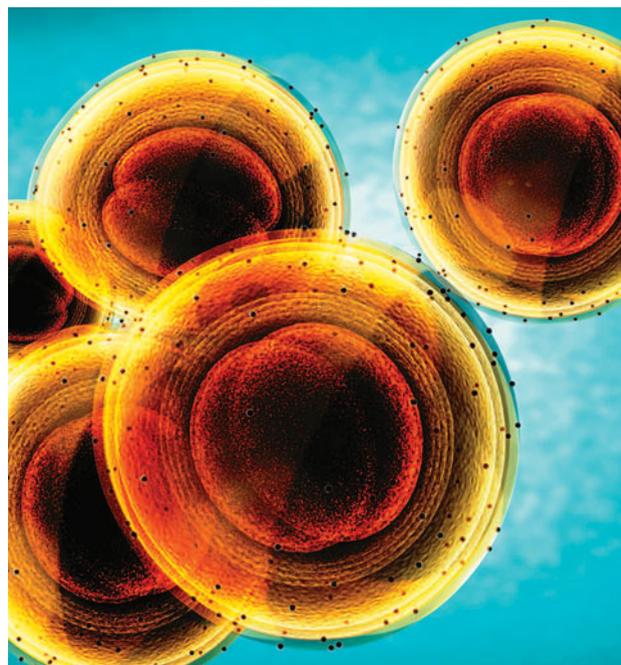
Temp: 98.0 °F

BP: 102/60 mmhg

Initial local exam revealed the following: Raised, erythematous, circular area approximately 3 cm in diameter with a necrotic center with a scab. It was tender to palpation. No fluctuation was noted.

A scalpel was used to derroof the central area and culture taken and sent for routine stain and culture. A

**Samina Yunus** is Assistant Professor of Family Medicine at Cleveland Clinic Lerner College of Medicine in Cleveland, Ohio. **Donna Goetsch** is a Family Nurse Practitioner at Cleveland Clinic Chagrin Falls Family Health Center and Urgent Care in Chagrin Falls, Ohio.



dressing was applied over the lesion.

### Disposition

The patient declined a tetanus vaccine. She was started on doxycycline pending culture results. Short-term pain medications were prescribed. Detailed discussion was held on the need to monitor her symptoms and to return in case of worsening.

### Laboratory Results

The culture and stain results revealed many gram-positive methicillin-resistant *Staphylococcus aureus* (MRSA) clusters with susceptibility to tetracycline and trimethoprim/sulfamethoxazole.

### Follow up

The patient called the office 2 days later stating she was not tolerating the oral doxycycline because of gastrointestinal upset. The antibiotic was changed to Bactrim DS. Culture results were still pending.

When the culture report was received, the patient was called and a message was left instructing her to continue the Bactrim DS, complete the course of treatment, and follow up as needed.

The patient called back after a few days, stating that she had developed a new lesion near the original site. She was seen the same day and admitted to not taking the doxycycline or getting the prescription for Bactrim DS filled. On exam she was noted to have a red, raised, 2-cm papule adjacent to the original lesion. She was advised to have her prescription for Bactrim DS filled, complete the entire course, and follow up if lesions did not resolve or worsened.

### Discussion

Since it was first reported in 1968, MRSA has emerged as one of the major etiologic agents in both nosocomial and community-acquired infections.

Recent data indicate that the incidence of life-threatening invasive hospital-acquired MRSA (H-MRSA) is declining, but similar trends have not been seen in the incidence of community-acquired MRSA (CA-MRSA).<sup>1</sup>

Occurring in a population with none of the traditional risk factors for MRSA, CA-MRSA has a higher incidence in certain populations and has increased exponentially since the 1990s. Children younger than age 2 years, African-American populations, Native Pacific islanders, and Alaska Natives appear to be at higher risk, as are athletes, individuals in correctional facilities, and military recruits. *Streptococcus* is the major etiologic agent for nonpurulent skin infections/cellulitis. The majority of purulent skin and soft-tissue infections (SSTIs), however, are caused by *Staphylococcus*, with MRSA overtaking MSSA as the major strain. A 2006 study published in *The New England Journal of Medicine* stated that MRSA was responsible for 59% of purulent SSTIs.<sup>2</sup>

More recent studies show an even higher incidence in certain populations. C-MRSA was responsible for up

to 75% of infections in children in certain regions and up to 61% in all patients presenting to a community primary care clinic system with SSTIs.<sup>3,4</sup>

Health care providers at urgent care centers and Emergency Departments are the initial and often only source of care for these patients. CA-MRSA infections usually target skin and soft tissues, presenting as pustules or boils. The initial presentation is a raised, red, painful area, with or without necrosis which is often misdiagnosed as a spider bite by the patient. Deeper infections such as osteomyelitis, pneumonia, and pyomyositis have also been reported.

As drug resistance becomes an increasing problem, it is very important that urgent care and primary care providers be familiar with not only the judicious use of antibiotics but also the appropriate antibiotics to treat these infections.

In 2011, The Infectious Disease Society of America (IDSA) released its first Evidence-Based Guidelines for the treatment of MRSA infections.<sup>5</sup> The guidelines have been endorsed by the Pediatric Infectious Disease Society, The American College of Emergency Physicians, and The American Academy of Pediatrics. The guidelines are listed along with Strength of Recommendation and a Summary of Evidence and provide clear direction about which antibiotics are preferred under different circumstances.

In Summary they state:

- For uncomplicated simple skin abscesses and boils, incision and drainage should be the primary management. This is often all that is necessary. **A11**
- Antibiotics should be considered in the presence of more complicated presentations like multiple sites of infection, associated systemic symptoms, immunosuppressed host, septic phlebitis, or failure of response to incision and drainage.
- Every effort should be made to obtain a culture and, in case of purulent cellulitis, associated abscess or presence of systemic symptoms, empirical therapy for CA-MRSA should be started pending culture results. **A11**
- In the case of outpatients with no purulent drainage or exudate and no associated abscess, empirical therapy for infection due to beta-hemolytic streptococci is recommended except in patients who do not respond to betalactam therapy or have systemic symptoms. **A11**

### Preferred antibiotics

For empirical coverage of CA-MRSA SSTIs in the outpa-



## Now Online in *JUCM*

# Social Media Primer for Urgent Care Providers

Use of social media is fast becoming one of the most vital tools in patient decision-making about providers. Urgent care providers without a social media presence may potentially be losing patients, but how do you launch an effective social media marketing campaign? This month's *JUCM* web-exclusive article—based on a popular session at the recent UCAOA conference—explores the evolving social media landscape and gives urgent care providers the information and tools they need to start their own effective social media campaigns. Learn the rules of the Internet road for blogs, Facebook, Twitter, and other social media outlets by visiting <http://jucm.com/read/casereport.php?casereport=31>, online only.

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## CASE REPORT: MRSA

tient setting, recommended antibiotics are:

- Clindamycin, trimethoprim–sulfamethoxazole (TMP–SMX), a tetracycline (doxycycline or minocycline), and linezolid. A11

For both beta-hemolytic streptococci and CA-MRSA coverage, options include clindamycin alone, or TMP–SMX or a tetracycline in combination with a beta-lactam (i.e., amoxicillin) or linezolid alone. A11 While use of Zynox or Linezolid is also an A11 recommendation by the IDSA, cost and reports of emerging resistance raise concerns about its use as first-line therapy.<sup>5</sup> The use of rifampin as a single agent or as adjunctive therapy for the treatment of SSTIs is not recommended. A111.

### Indications for hospitalization

Although most cases of CA-MRSA can be treated on an outpatient basis, hospitalization is required for certain patients. Indications include the presence of systemic symptoms, toxic appearance, unstable co-morbid conditions, necrotizing fasciitis and/or limb- or life-threatening infection.<sup>6</sup>

### Points to remember

A high degree of clinical suspicion must be maintained when seeing patients with skin infections and presumed insect bites. Cultures should be taken whenever possible and coverage for CA-MRSA provided in the presence of purulent infections. ■

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## Continue CPR! or How to Save the Patient and Screw the Pooch<sup>1</sup>

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

So there I was (all good stories start this way), having just participated in saving a 58-year-old guy who collapsed while playing golf with his buddies. It was a classic v-fib arrest—dropped after hitting a great drive right down the middle of the fairway. The man’s friends started CPR, paramedics arrived and shocked him out of VF into a sinus rhythm and intubated him.

While in the emergency department (ED), the man started waking up; he was reaching for the tube and seemed to be following commands. I had already arranged an ICU bed for him when a woman claiming to be his wife ran into the ED and screamed, “Take that tube out immediately; he has a DNR” at the top of her lungs.

Although the patient was waking up, it was still way too early to extubate him. In my very gentle, Marcus Welby-like voice I said, “Ma’am, your husband is alive and, considering what happened to him, doing great. We expect him to wake up and have minimal or no cognitive impairments. However, if we remove that tube now, we may completely wreck his chances for a complete recovery.”

Her response was less than encouraging: “If you don’t pull that tube immediately, I’ll have your a\*\* and your medical license.” How nice, she wants me for my mind too! I’ll spare you the details, but the story actually gets worse from here. We actually did extubate him about 10 hours later. His first words? “I want a cheeseburger!” His wife? An RN; this was her fifth marriage and her first four husbands all died. Can you say Black Widow? She filed a complaint with the medical board about me saving her husband.

The reason I did not simply yank the patient’s tube when she shoved the DNR papers into my face was my belief that

I could get sued if I killed him but no one would successfully sue me for saving him. Until recently, that belief held true. (More on that later.)

Why does this matter in to an urgent care provider? Every day, 7,000 people—yes, 7,000—enroll in Medicare. Odds are great that with all of us “baby-boomers” hitting retirement age, some of us will decide to spice up your day and die in your urgent care center. So, listen up, because unless you have a pediatric urgent care practice, this is relevant to you.

First, some background. A number of legal or quasi-legal documents fall under the term “advanced directive.” Generally speaking, advanced directives are written to provide some direction regarding end-of-life care for a patient who may not be able to give medical consent or direction. They fall into the following categories:

### DNR Order

Controversy exists surrounding the interpretation and execution of do not resuscitate (DNR) orders. For example, does “DNR” mean do not treat up to the point the patient requires resuscitation? Or does it mean once the patient codes, everything stops? Some newer forms are more specific, using check boxes to delineate the level of care acceptable to the patient. On the surface, that makes sense, but practically speaking, these forms are still challenging to use. If a person checks no intubation and suffers a short-term event (seizure) and needs to be intubated, do you let him/her die? If “no defibrillation” is checked, does that mean no AED in the case of sudden death? What if the patient is still conscious and can make decisions and wants “everything done”? Do you quit when he/she becomes unresponsive? Because of all these common potential pitfalls, many institutions now use a “limitation of treatment form.” Take-home point: When faced with one of these situations, misery loves company. Get the family involved at the outset and document the decision made together.



**John Shufeldt** is principal of Shufeldt Consulting and sits on the Editorial Board of *JUCM*. He may be contacted at [jshufeldt@shufeldtconsulting.com](mailto:jshufeldt@shufeldtconsulting.com).

*Urgent care physicians and emergency physicians are in no way restricted from performing lifesaving interventions on patients with living wills, inasmuch as we won't have the opportunity to confer, at least prospectively, with the attending physician.*

**Pre-hospital Directives**

Most states have instituted some form of an advanced directive upon which paramedical personnel can rely when erroneously called to treat a critically ill or injured patient. These can be physician-driven DNR-like documents or a patient- or surrogate-driven advanced directive. Their implication for urgent centers is negligible, save for a patient or family attempting to use one in the “pre-hospital” urgent care arena.

**Living Will**

A living will is a fairly standard form used in most states to direct health care workers to not perform or to perform certain medical interventions. Any competent person 18 years of age or older can author a living will by signing and dating a statement before two witnesses. The witnesses must be at least 18 years old, and should not be related to the person signing the declaration, a beneficiary of his or her estate or financially responsible for his or her medical care.

A living will only goes into effect once an individual lacks the capacity to make health care decisions and it lasts until he/she has the capacity for decision-making. Living wills vary in specificity but often include interventions such as:

- CPR
- Defibrillation
- Intubation
- Artificial nutrition
- Antibiotics
- IV fluid
- Analgesia

As mentioned, a living will can be very specific or very general. The following is an example of a statement sometimes found in a living will: “If I suffer an incurable, irreversible illness, disease, or condition and my attending physician determines that my condition is terminal, I direct

that life-sustaining measures that would serve only to prolong my dying be withheld or discontinued.”

The key to this statement is “my attending physician.” Thus, urgent care physicians and emergency physicians are in no way restricted from performing lifesaving interventions on patients with living wills, inasmuch as we won't have the opportunity to confer, at least prospectively, with the attending physician.

**Durable Power of Attorney**

Finally, individuals can make a prospective decision about who can act as a surrogate if they become incapacitated. This generally allows for more flexibility because the surrogate can make decisions on behalf of an incapacitate person that the patient would ordinarily make. Obviously, you have to trust the person you appoint. Case in point: A friend of mine from medical school called me not long ago and asked if I would act as his medical power of attorney. I replied, “Of course, but what about your wife Tracy?” He responded, “That b&^\* would cut off my testicles and only then take me off the ventilator!” Fearing that they had split up, I inquired as to Tracy's whereabouts. He responded, “She is right here, want to speak with her?”

What if no durable power of attorney exists? What is the chain of command regarding who can decide the fate of the patient? In Arizona, the decision-making hierarchy goes like this: Patient's spouse, unless legally separated > adult child of patient > domestic partner > siblings > close friend > attending physician with ethics committee.

**How making the wrong decision will get you sued**

You are working in an urgent care center when a patient presents with the complaint of constipation. You learn that the patient has gastric cancer and is on very large doses of opioids, which are the likely cause of the current issue. The patient is obviously terminally ill but is very uncomfortable secondary to his fecal impaction. You take a KUB to confirm your suspicion and check for free air. As you get your gloves on to disimpact the patient, he becomes very bradycardic and ultimately codes. The family member is unsure of the patient's code status but tells you, “He is very religious and probably wants everything done.” Using “substitute judgment” and because the family member hedges on the code status, you elect not to try to resuscitate this obviously terminally ill patient, telling the family member, “In good conscious, I simply cannot do this to him.”

The surviving family members decide to sue on the “loss of a chance” theory. Their suit alleges that you failed to promptly initiate appropriate care to treat the decedent's cardiac arrest and that this negligence deprived the decedent of the loss of a chance to survive. The Iowa Supreme Court

recently recognized an action for loss of chance in a terminally ill cancer patient whose resuscitation request was not honored by the physician.

### Getting back to the Black Widow

So what changed? There have been a number of suits alleging “wrongful life.” In Florida, a 92-year-old patient’s granddaughters filed suit against a nursing home and medical director, alleging that they committed battery against their grandmother when they failed to follow her DNR order after she coded. In addition, the lawsuit, which sought unspecified damages, alleged that the medical director decided to send the patient to the hospital rather than follow her DNR order because he was not at the nursing home at the time she collapsed. The paramedics performed CPR and intubation, and transported the patient to a hospital. There, she was on life support for 3 days and died 4 days after life support was discontinued.

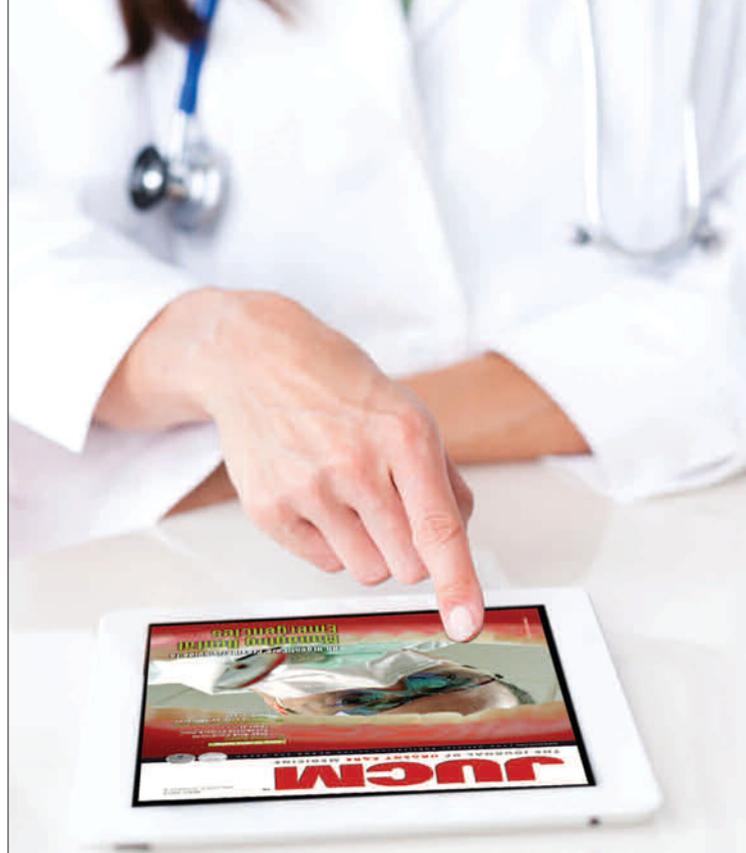
In another case, a patient was admitted to the hospital for chest pain. The attending physician, after a discussion with the patient, wrote that the patient was not to be resuscitated. At one point during his hospitalization, he went into v-fib and was cardioverted by the nurse. The patient survived the event and even thanked the nurse. Four days later he suffered a massive stroke; he ultimately died a few years later. The family sued, alleging that the nurse’s actions constituted battery and that the nurse was negligent in not following the physician’s orders.

### Epilogue

Eighty-five years ago, Justice Benjamin Cardozo wrote, “Any human being of adult years and sound mind has a right to determine what shall be done with his own body.” This right of self-determination is evidenced legally in the form of consent, before any diagnostic or therapeutic measure is instituted. For the consent of the patient to be legally valid, the consent must be given after the patient has been fully informed about the proposed treatment. In other words, the consent must be informed consent. Once the consent is obtained and it is valid, a provider, whether he or she agrees or not, is legally obligated to follow the patient’s wishes.

If faced with a life-or-death scenario, do your best to determine the wishes of the patient or surrogate, if one exists. Document your attempts to determine these wishes. If you cannot, use substitute judgment to determine the plan. Despite the “wrongful life” cases, if I had to do it again, and did not know the wishes of the patient, call me old fashioned, but I would err on the side of saving a patient’s life. ■

1. The phrase “screw the pooch,” meaning to mess up, commit a grievous error, was made famous in Tom Wolfe’s book *The Right Stuff*.



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## Flu Activity Picks Up Nationwide and Should We Fast Before We Measure Our Lipids?

■ NAHUM KOVALSKI, BSc, MDCM

Each month, Dr. Nahum Kovalski reviews a handful of abstracts from, or relevant to, urgent care practices and practitioners. For the full reports, go to the source cited under each title.

### Flu Activity Picks Up Nationwide

**Key point:** CDC recommends vaccination and antiviral treatment against influenza

**Citation:** <http://www.cdc.gov/flu/spotlights/flu-activity-picks-up.htm>. Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases (NCIRD).

Influenza activity was continuing to increase in the United States and most of the country was experiencing high levels of influenza-like-illness (ILI), according to CDC's January 4 FluView report. "Reports of influenza-like-illness (ILI) are nearing what have been peak levels during moderately severe seasons," according to Dr. Joe Bresee. CDC continues to recommend influenza vaccination and antiviral treatment when appropriate at this time.

"While we can't say for certain how severe this season will be, we can say that a lot of people are getting sick with influenza and we are getting reports of severe illness and hospitalizations," says Bresee, who is Chief of the Epidemiology and Prevention Branch in CDC's Influenza Division. "Anyone who has not already been vaccinated should do so now," Bresee says. "And it's important to remember that people who have severe influenza illness, or who are at high risk of serious influenza-related complications, should get treated with influenza antiviral medications if they get flu symptoms regardless of whether or not they got vaccinated. Also, you don't need to wait for a positive laboratory test to start taking antivirals."



Nahum Kovalski is an urgent care practitioner and Assistant Medical Director/CIO at Terem Emergency Medical Centers in Jerusalem, Israel. He also sits on the JUCM Editorial Board.

CDC tracks influenza activity year-round and publishes a report weekly on Fridays. According to this surveillance, the proportion of people seeing their health care provider for ILI in the United States had been elevated for four consecutive weeks prior to the January 4 report, climbing sharply from 2.8% to 5.6% during that time. Last season, which was relatively mild, ILI peaked at 2.2%. Comparatively, during 1998-1999 and 2003-2004, which were moderately severe seasons, ILI peaked at 7.6%. During 2007-2008, another moderately severe season, ILI peaked at 6.0%. During the 2009 H1N1 pandemic, ILI peaked at 7.7%. ■

### Should We Fast Before We Measure Our Lipids?

**Key point:** No Need to Fast Before Lipid Measurements.

**Citation:** Gaziano JM. Should we fast before we measure our lipids? *Arch Intern Med.* November 12, 2012. doi:10.1001/jamainternmed.2013.1771.

Researchers in Canada used laboratory data to measure variations in lipid measurements according to the time since a patient's last meal (range, 1-16 hours). Nearly 210,000 individuals were included.

Overall, mean total and HDL cholesterol levels varied little, by less than 2%, with differing fasting times. LDL and triglyceride levels varied more, by less than 10% and 20%, respectively.

An editorialist concludes: "The incremental gain in information of a fasting profile is exceedingly small for total and HDL cholesterol values and likely does not offset the logistic impositions placed on our patients, the laboratories, and our ability to provide timely counseling to our patients. This, in my opinion, tips the balance toward relying on nonfasting lipid profiles as the preferred practice." ■



## S9083, Radiology, and E/M Codes

■ DAVID STERN, MD, CPC

### **Q.** Can CPT code S9083 be billed with an E/M service code or would this be considered double dipping?

**A.** You would not typically add CPT code S9083 to an E/M service unless instructed to do so specifically by an insurance company. CPT code S9083, “Global fee urgent care centers,” would be used in instances where the insurance company has stated that the reimbursement is based on a flat rate (global fee or case-rate) per a contractual agreement. All services performed are bundled into this one code unless carve-outs have been negotiated.

If your urgent care center sees only patients with minor illnesses and injuries, a case-rate contract might be a good fit. However, if your offices are equipped to handle more serious situations, such as dehydration requiring intravenous fluids, fractures, complicated lacerations, etc., then it may be advisable to negotiate a contract based on procedures performed as opposed to a case rate. Unfortunately, however, most payors offer either case-rate or fee-for-service contracts, and are **not** flexible in allowing the urgent care to choose the type of contract. ■

### **Q.** Can x-ray and ultrasound codes be billed separately from global E/M fees? If so, which codes can be used?

**A.** Typically, the E/M codes 99201-99215 are not “global” E/M fees, but rather, describe the level of evaluation and management services performed during the encounter. However, urgent care contracts for certain payors may use unconventional reimbursement and coding methods. For example, the payor may:

- expect the provider to code the E/M appropriately but will reimburse the same case-rate amount no matter what E/M or procedures are performed;



**David E. Stern** is a certified professional coder. He is a partner in Physicians Immediate Care, operating 18 clinics in Illinois, Oklahoma, and Nebraska. Dr. Stern was a Director on the founding Board of UCAOA and has received the Lifetime Membership Award of UCAOA. He serves as CEO of Practice Velocity ([www.practicevelocity.com](http://www.practicevelocity.com)), providing software solutions to over 750 urgent care centers in 48 states. He welcomes your questions about urgent care in general and about coding issues in particular.

*Certain CPT codes include a combination of both a professional component and a technical component. If the physician or other qualified health care professional is performing only a portion of the service, modifiers are used to indicate which portion of the service was provided.*

- pay on a fee schedule with different rates per E/M but will not reimburse for any additional procedures;
- pay on a fee schedule with different rates per E/M but will not reimburse for some specific procedures, such as radiology procedures; or
- expect the provider to use a specific E/M code for every single visit (or one specific code for every new-patient visit and one specific E/M code for every established-patient visit). Payors may forbid you to add procedure codes; others may allow them.

Thus, you need to check your contracts.

Radiology and Imaging codes (70010-79999) are described in the Current Procedural Terminology (CPT) codebook. Under typical arrangements with Medicare and other fee-for service providers, you would bill for radiology and imaging services separately when they are performed by or under the supervision of a physician or other qualified health care professional.

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## CODING Q & A

portion of the service was provided.

- **Modifier -26 Professional Component:** When the professional component is reported separately, the service may be identified by adding modifier - 26 to the usual procedure number. Modifier -26 is used if the only service performed is the reading and report of radiology or imaging service.
- **Modifier -TC Technical Component:** Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances Modifier -TC is used to report that the center is billing for only the technical component of the radiology or imaging service.

As of January 1, 2012, Medicare required that the technical component of advanced diagnostic imaging (specifically, Magnetic Resonance Imaging [MRI], computed Tomography [CT], and Positron Emission Tomography [PET]) be billed only by providers who are accredited by one of the following organizations:

- The American College of Radiology;
- The Intersocietal Accreditation Commission; or
- The Joint Commission. ■

**Q. Would we bill CPT code S9083 global fee urgent care centers for Medicare patients?**

**A.** Medicare expects fee-for-service coding, which means billing for each service performed separately rather than coding a global flat-rate fee.

CMS specifically creates "S-codes" at the request of payors for services that Medicare does not reimburse. Thus, Medicare does not reimburse S9083 or any other "S-code." ■

## Had Any Interesting Cases Lately?

Case Reports are one of JUCM's most popular features. Case Reports are short, didactic case studies of 1,000-1,500 words. They are easy to write and JUCM readers love them. If you've had some interesting cases lately, please write one up for us. Send it to Judith Orvos, ELS, JUCM's editor, at [jorvos@jucm.com](mailto:jorvos@jucm.com).

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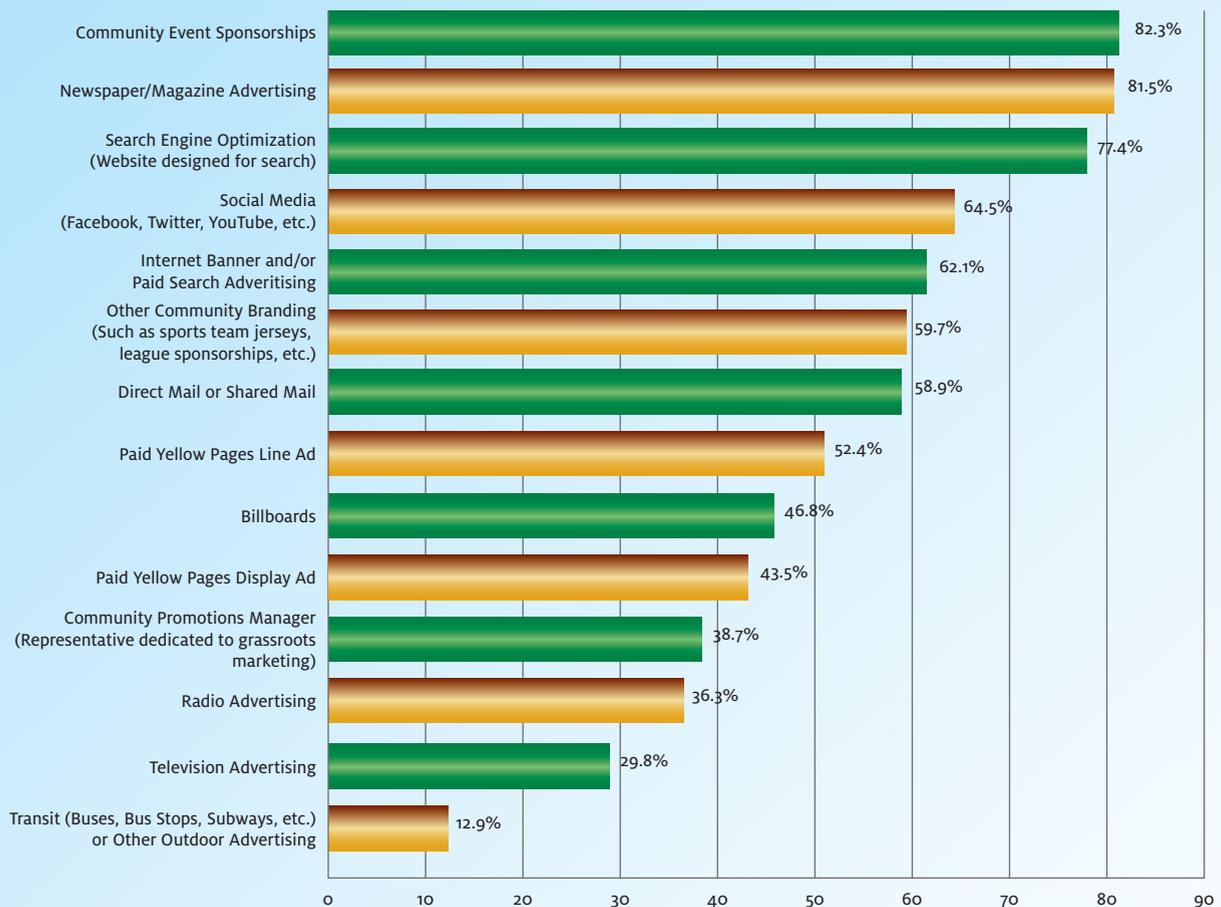
# DEVELOPING DATA

These data from the 2012 Urgent Care Industry Benchmarking Study are based on a sample of 1,732 urgent care centers; 95.2% of the respondents were UCAOA members. Among other criteria, the study was limited to centers that have a licensed provider onsite at all times; have two or more exam rooms; typically are open 7 days/week, 4 hours/day, at least 3,000 hours/year; and treat patients of all ages (unless specifically a pediatric urgent care).

In this issue: What Marketing Tactics is Your Center Using?

## USE OF MARKETING TACTICS

Centers use a variety of tactics to reach their target audiences. While use of more “traditional” outlets such as newspaper advertising remains high (in 2010 newspapers and community events also held the top two spots), there has been an increased emphasis, in recent years, on search engine optimization and other Internet-based activities as the Internet continues to extend itself into the daily lives of most potential patients (n=124).



Acknowledgement: The 2012 Urgent Care Industry Benchmarking Study was funded by the Urgent Care Association of America and administered by Anderson, Niebuhr and Associates, Inc. The full report can be purchased at [www.ucaoa.org/benchmarking](http://www.ucaoa.org/benchmarking).



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CEO, Practice Velocity**

\*“Urgent Care 2012: A Host of EMR Options,” March 2012. © 2012 KLAS Enterprises, LLC. All rights reserved. [www.KLASresearch.com](http://www.KLASresearch.com)

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