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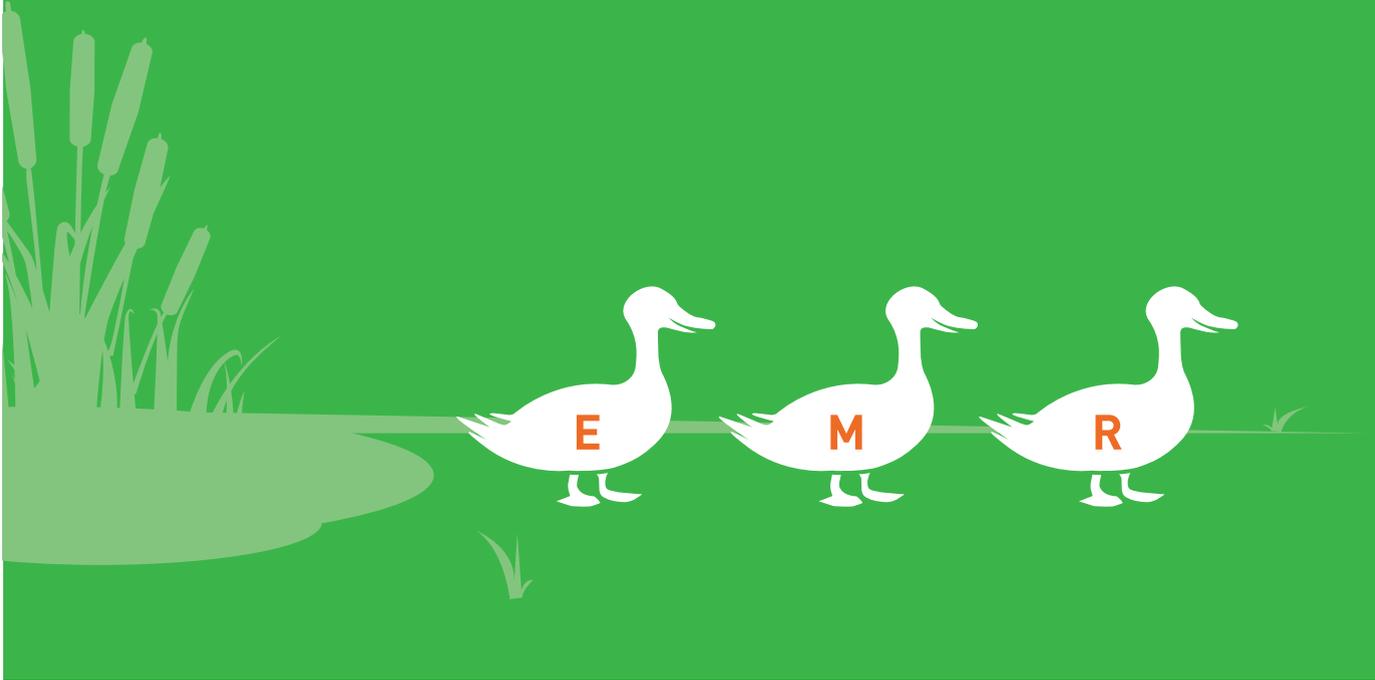
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Patient Satisfaction Surveys: Seeing Opportunities in Our Failures



It is well known, and exhaustively preached, that a satisfied customer will tell 2-3 people while a dissatisfied one will tell 8-10 (with some estimates as high as 20). Measuring and tracking patient satisfaction has become a focus of most every practice owner, much to the chagrin of their employees, who often view this as a way to publically embarrass and unfairly harass the staff. And yet, whether we are owners or employees, we all make pledges to our patients with regard to things like quality, quickness, and caring.

Conflict often arises in the debate over how to measure what exactly constitutes successful delivery on these promises. At one extreme is the case of the physician who has determined that patients will be inherently dissatisfied with their care because it is based on “quality” and “best practice,” which often conflict with patient desires. While there are certainly examples of encounters that fit neatly into this paradigm (drug seekers and unnecessary antibiotics come to mind), this all-or-nothing position vastly oversimplifies and completely misses the opportunities inherent in the process of eliciting patient feedback. We’ll call this physician an “absolute dismitter.” Another involves the physician, or practice owner for that matter, who focuses attention on the positive comments and high scores and dismisses the negative comments and lower scores as “outliers,” defending each one with excuses and blame. We’ll call this one the “selective denier.” And finally, consider: The employee who self-flagellates over every negative encounter or comment, throwing up his or her arms in defeat, seeing no point in trying so hard to please. We’ll name this person the “masochistic capitulator.”

Overcoming these dismissive and negative interpretations is not easy, but it *is* critical to the success of any practice in an increasingly competitive environment. MGMA recently released their benchmarking report, which found that 80% of “better performing” practices use patient satisfaction surveys. One might expect that the historically “consumer focused” urgent care industry would be even higher. Two significant business drivers are at play here:

1. **Volume:** Patient satisfaction drives “repeat visits” and “friends and family referrals,” two of the most important volume variables in the business.
2. **Reimbursement:** Irrespective of the final details and “rule-set” of the Affordable Care Act, reimbursement models are changing, and quality measures are undoubtedly a part of

the new paradigm.

So, given the strongly held and profoundly negative view of patient satisfaction surveys by providers and other employees, how do we “sell” the use of these tools in our practice?

1. **Adopt a “weakness orientation”:** Looking at our “warts” is the only way we will identify gaps in performance and opportunity for improvement. This principle can be adopted as a core value of your urgent care practice, and as such, be communicated and “pledged to” at hire. A low score or dissatisfied patient can be viewed as a “gift” to the practice and to the employee that offers insight into collective performance and into the “needs” of patients as consumers of health care.
2. **Be a “myth-buster”:** Identify the “selective deniers,” “absolute dismissers,” and “masochistic capitulators” in your practice and point-by-point, break down the myths they have built up to protect themselves from feeling vulnerable when presented with criticism. Expose the judgments, labels, and assumptions they are using and show them how these can create real obstacles to the quality patient care they so vehemently espouse. Identify the self-destructive and avoidant behaviors they are using. Reveal the opportunities they have to grow by listening more carefully to patients. And celebrate the long-term job satisfaction that comes with this approach.

All said, we are in a transformative time in health care, and “patient-centered” care has become a key benchmark for quality and business success. Developing a positive approach centered on a set of core values that everyone in the practice can agree to is the best way to take advantage of this incredibly valuable opportunity. This is our chance to turn “myths” into “gifts.” ■

Lee A. Resnick, MD
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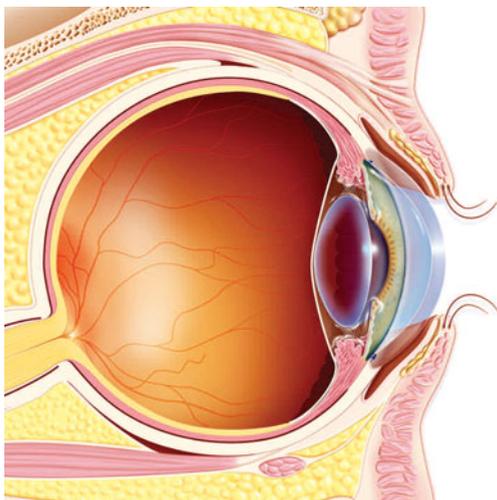
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Whether benign or vision-threatening, acute eye conditions seen in the urgent care setting require careful evaluation and triage, based on access to the right tools and knowledge of key clues to diagnosis.

Sarvotham Kini, MD

PRACTICE MANAGEMENT



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FSEDs have a role to play in our health care system but it's not to supplant urgent care centers.

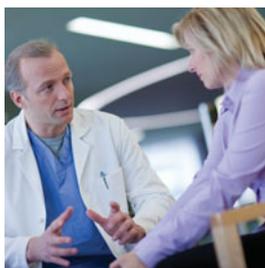
Alan A. Ayers, MBA, MAcc

CASE REPORT

26 Sacral Tumor

Each case—and patient presentation—in urgent care must be evaluated on its own merits. Rare diagnoses are possible and “benign” back pain complaints sometimes are not.

Heather Varley, PA-C, and
William Gluckman, DO, MBA, FACEP



IN THE NEXT ISSUE OF JUCM

The prevalence of asthma is increasing and acute presentations in urgent care are common, offering unique opportunities for short- and long-term management. Next month's cover story—the first of a two-part series—reviews the epidemiology and pathophysiology of asthma and provides guidance on key aspects of medical history-taking and examination of the patient who presents for urgent care with symptoms suggestive of asthma.

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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 healthcare 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

Our discussion of eye care in the urgent care setting concludes in this month's cover story with expert advice from Sarvotham Kini, MD, on management of subconjunctival hemorrhage, uveitis, iritis, keratitis, acute angle closure glaucoma, and eyelid conditions. As with Part 1 that ran in January, you'll find a wealth of photos to assist with differentiation of benign versus vision-threatening conditions in an article that underscores the importance of documenting visual acuity and knowing when to refer to a specialist to ensure that a patient's vision is preserved.



Dr. Kini is a Professor at the Georgia Regents University/UGA medical partnership, in the department of Emergency Medicine.



Back pain is a common presentation and at first blush, the cause seemed to be benign in the 30-year-old woman described in this month's case report, who had slipped in the shower 3 weeks before. Answers to "red flag" questions and findings on physical exam, however, pointed to a more serious cause, according to authors Heather Varley, PA-C, and William Gluckman, DC, MBA, FACEP. Their message to urgent care providers is to look at the whole picture with every patient and keep rare diagnoses in your differential for those who present with vague pain complaints.

Ms. Varley is a full-time Physician Assistant and Dr. Gluckman is President and CEO of FastER Urgent Care in Morris Plains, NJ.

The number of freestanding emergency departments (FSEDs) is growing and experts estimate that there are between 350

and 400 of these facilities operating today. FSEDs offer slightly more advanced services than urgent care centers and are staffed by board-certified Emergency Medicine physicians and ER-trained nurses. They may have a promising future in the US health care system—but only if they are located where there is truly a "need" and aren't used by unwary consumers with non-emergent conditions. That's the message of this month's practice management feature, by Alan A. Ayers, MBA, MAcc.



Mr. Ayers is on the Board of Directors, Urgent Care Association of America, Associate Editor, *Journal of Urgent Care Medicine*, and Vice President, Concentra Urgent Care.

Also in this issue:

In Health Law this month, **John Shufeldt, MD, JD, MBA, FACEP**, discusses the murky issues urgent care providers face when presented with a self-harming patient. A provider's obligation is to simply do the right thing—which may mean offering empathy rather than immediate referral to the emergency department.

The Urgent Care College of Physicians reviews new abstracts on literature germane to the urgent care clinician, including studies of pyuria and nephrolithiasis, PPIs and hospitalization for CAP, and antibiotics and NSAIDs for bronchitis.

In Coding Q&A, **David Stern, MD, CPC**, discusses coding for pulse oximetry, oral medication, and starting an IV.

Our Developing Data end piece this month looks at the percentage of patients who consider an urgent care center their "medical home." ■

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. The information you provide should be of practical use to our readers, who have come to practice in an urgent care setting from a variety of clinical backgrounds. Your article should take their perspective into account by considering several key issues, such as: What immediate management is indicated? What labs or diagnostics are required? What are the next steps; with whom should the patient follow up? Who should be admitted or referred to the emergency

room? Imagine yourself in the reader's shoes and ensure your article includes the answers to questions you'd be asking.

Please send tables, graphs, sidebars (boxes) and digital or film pictures whenever possible. Digital images should be a minimum of 300 dpi. Our readers appreciate well-chosen graphics that add practical value to an article. We prefer that you submit graphics that are original to you, such as x-rays taken as part of your practice. If you wish to use graphics that have previously appeared elsewhere—in print or on the Internet—you must let the editor know. She can write the previous publisher for permission to reuse the material in JUCM. There is no guarantee, however, that the permission will be granted and, if it is not, we cannot reprint the graphics.

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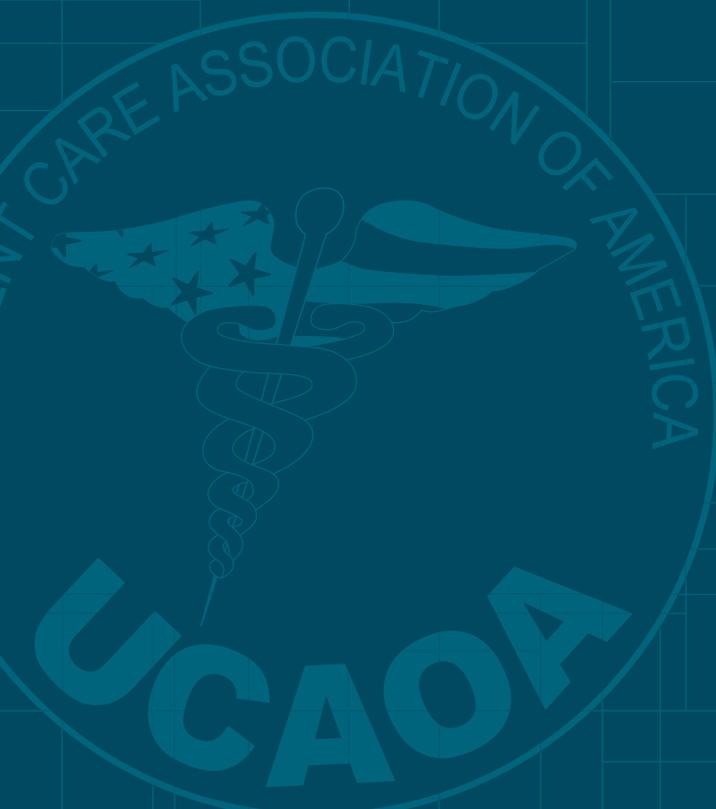
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UCAOA Professional Learning Program



Taking a 'seat at the table' in DC

■ NATHAN NEWMAN, MD, FAAFP

The new UCAOA Health & Public Policy Committee will guide an advocacy agenda with goals and objectives to include:

- Increasing recognition of urgent care centers as a high-quality, cost-efficient and convenient site of service;
- Defining and integrating the role of urgent care centers in a rapidly changing health care delivery environment;
- Ensuring reimbursement appropriately reflects the value and cost of care provided in the urgent care center setting;
- Encouraging the adoption by public and private payors of resource use and quality measures to appropriately reflect health care services provided in urgent care centers;
- Preserving the ability of urgent care centers to utilize ancillary services (e.g., imaging, laboratory, and durable medical equipment); and
- Influencing federal policies and initiatives to support and integrate the delivery of health care services by urgent care centers.

In December, I was accompanied on a trip to Washington, DC, by a team of members including Committee Chair and UCAOA Vice President Laurel Stoimenoff, Secretary Steve Sellars, Treasurer Dr. Rob Kimball, local committee member Dr. Bob Graw, Camille Bonta of Summit Health Consulting, and CEO Joanne Ray. We met with key leaders of the Centers for Medicare and Medicaid Services (**CMS**), Department of Health and Human Services, National Conference of State Legislatures (**NCSL**) Health Resources and Services Administration, and the Office of Carrier, Driver, and Vehicle Safety Standards of the Federal Motor Carrier Safety Administration in the U.S. Department of Transportation (**DOT**).

Each meeting resulted in recognition of the integral role that urgent care centers will play, well-defined action items, and planned follow-up meetings to engage urgent care centers in the health care delivery systems of our communities going forward. Notable highlights include:

- **CMS**: Educating consumers to support emergency room diversion programs and defining challenges that urgent care center physicians face in meeting requirements for CMS' quality programs such as the Physician Quality Reporting System (PQRS) and complying with policies for use of the Physician Value-based Payment Modifier, identifying types of measures appropriate for physicians practicing in the urgent care center setting so that urgent care center physicians are not unfairly penalized, (e.g., consider use of the place of service code for better risk/acuity adjustment and for peer group assignment under the VBP modifier) and working with CMS's Creative Services Department to incorporate urgent care centers in patient/beneficiary materials.
- **NCSL**: Identifying potential barriers that would prevent individuals who enroll in exchanges from using urgent care centers as a "regular" source of appropriate care, determining how states can make Medicaid attractive to more urgent care centers, and capitalizing on opportunities to educate state legislators about urgent care centers.
- **DOT**: Emphasizing the high percentage of urgent care centers that perform DOT examinations, seeking clarification on obstructive sleep apnea rules/guidance and improvements to the long form, and clarifying the role that UCAOA can play in adding DOT Medical Examiner Certification testing and training at our Spring Convention 2014.

Our Committee will focus on continuing efforts to be "at the proverbial table" where health care legislation and programs are being discussed. This year marks the full implementation of the Affordable Care Act and UCAOA will be the voice of the urgent care industry and the place to go for information.

Don't forget to make plans for the Annual Spring Convention, March 17-20 in Las Vegas, where more information on health care reform for urgent care will be discussed! ■



Nathan Newman is president of the Urgent Care Association of America. He may be contacted at info@ucaoa.org.

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Management of Ocular Complaints in Urgent Care: Part 2

Urgent message: Whether benign or vision-threatening, acute eye conditions seen in the urgent care setting require careful evaluation and triage, based on access to the right tools and knowledge of key clues to diagnosis.

SARVOTHAM KINI, MD

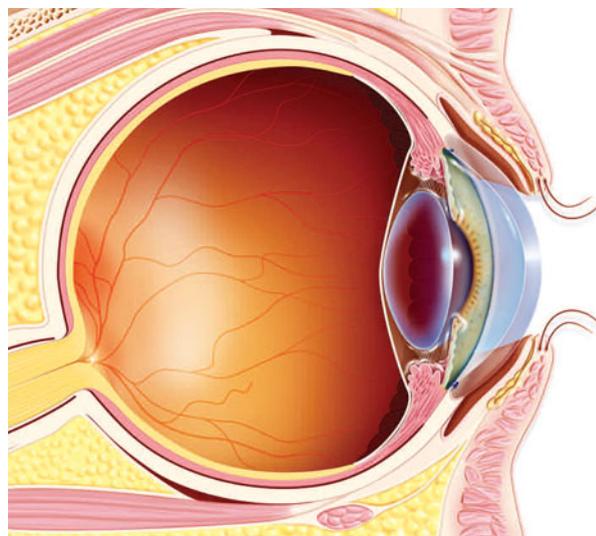
In Part 1 of this article in January, we discussed urgent care management of foreign bodies in the eye, corneal abrasion, red eye, scleritis, and conjunctivitis. In Part 2, we will review subconjunctival hemorrhage, uveitis, iritis, keratitis, acute angle closure glaucoma, and eyelid conditions.

Subconjunctival hemorrhage

Trivial events such as a cough, sneeze, Valsalva maneuver, or minor blunt trauma can cause bleeding under the conjunctiva. Patients with subconjunctival hemorrhage (**Figure 1**) may present with some degree of discomfort and anxiety secondary to the appearance of the bloody eye. The blood is usually bright red, appears flat, and is limited to the bulbar conjunctiva and stops abruptly at the limbus. It is important to differentiate the lesion from bloody chemosis, which can occur with globe rupture. Aside from appearance, this condition does not cause patients any pain or diminution in visual acuity.

Patients with subconjunctival hemorrhage should be warned about any excessive NSAID use and also reassured that complete resolution of their condition may take up to 3 weeks.

Sarvotham Kini is a Professor of Emergency Medicine, at the Georgia Regents University/UGA medical partnership in Athens, GA

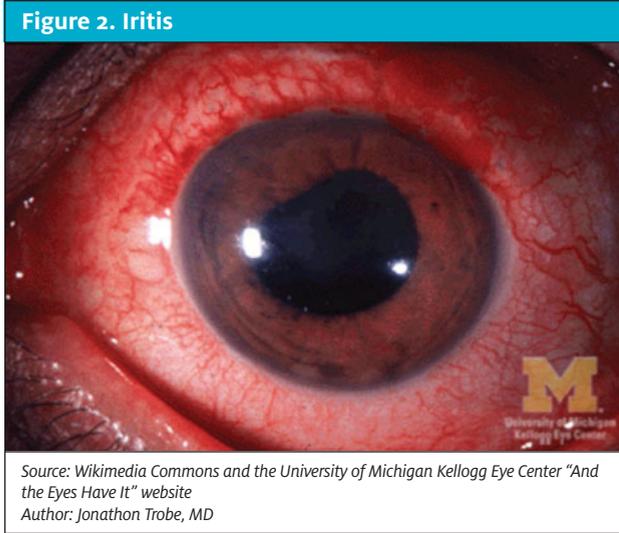
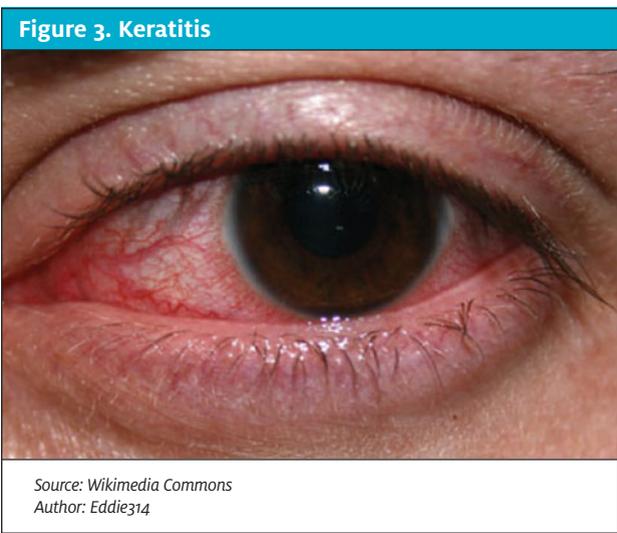


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Iritis

Uveitis is an inflammation of the uveal tract that includes iritis of unknown origin and can be secondary to trauma or other nontraumatic conditions such as rheumatoid arthritis and inflammatory bowel disease.¹⁻⁵ Iritis (**Figure 2**), arthritis, and urethritis are aspects of Reiter's syndrome.

Iritis can occur at any age but is most common in



patients aged 20 to 59 years.

Injection, photophobia, pain, and blurred vision are the common symptoms of iritis (anterior uveitis or iridocyclitis). The diagnosis is made with these clinical symptoms and a slit lamp examination. Leukocytes and fibrous debris in the anterior chamber along with intense ciliary flush are seen under the slit lamp.

Treatment with a topical corticosteroid and a cycloplegic agent is recommended to relieve the inflammation and prevent complications such as cataract and glaucoma. With a preliminary diagnosis of iritis, or any other significant, non-infectious, inflammatory condition, urgent care treatment with a corticosteroid is reasonable as long as ophthalmology follow-up can be assured. Extended treatment with topical corticosteroids

is discouraged without ophthalmology consultation. Ophthalmology referral for iritis is recommended.

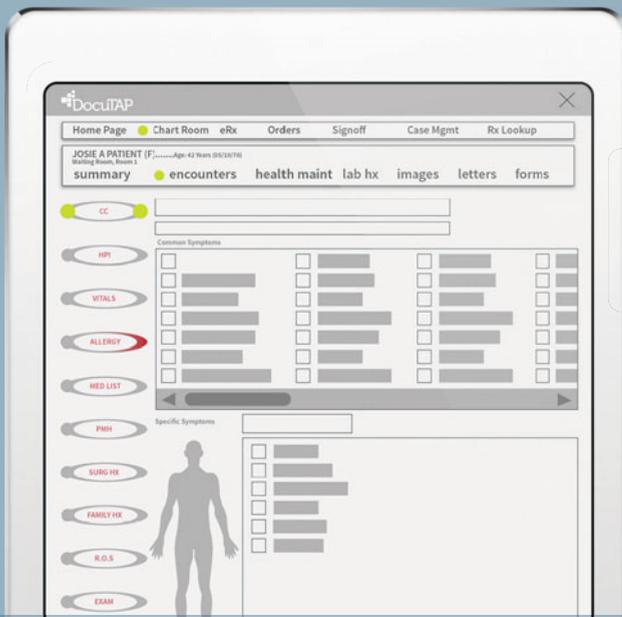
Keratitis (Figure 3) is inflammation of the cornea that can be due to infectious or non-infectious causes.⁶⁻⁹ Bacteria, viruses, fungi, and spirochetes can affect the cornea and destroy the corneal epithelium, leading to corneal ulcer in severe cases. Important causes of keratitis to remember are Herpes simplex virus (HSV), HSV-I and HSV- II, Herpes zoster and *pseudomonas*. HSV presents as typical dendritic ulcer on the surface of the cornea, which can be detected with fluorescein with or without slit lamp examination. Herpes zoster affects the ophthalmic branch of the trigeminal nerve and may produce a rash on the forehead and affect the cornea, both of which are painful and need to be treated aggressively.

Keratitis is a threat to vision because of the risk of corneal clouding, scarring, and perforation. Trachoma from chlamydial infection is a leading cause of blindness in the third world. In the United States, contact lenses play a major role in corneal infection and ulceration.

Patients with keratitis and corneal ulcer present with pain, eye discharge, photophobia and poor vision. A "white spot" on the cornea with these symptoms is due to a corneal ulcer until proved otherwise. Patients who wear "extended-wear" contact lenses and neglect to remove them at night have a 20-fold higher risk of developing corneal ulcer compared to those who are conscientious about the use of their lenses.⁶

Slit-lamp examination shows disruption of the corneal epithelium, an infiltrate in the corneal stroma, and even purulent collection (hypopyon) in the anterior chamber.

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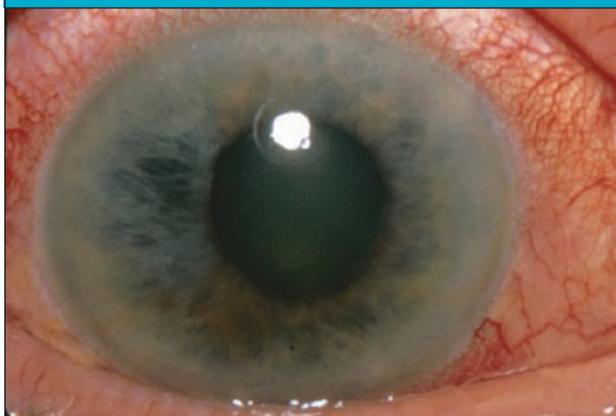


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Figure 4. Acute angle closure glaucoma

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Figure 5. Sty

Source: Wikimedia Commons
 Author: Andre Riemann

Although immediate empirical antibiotic therapy is recommended for keratitis, it is important to obtain corneal scrapings for Gram's stain, Giemsa stain, and cultures. Thus, treatment in direct consultation with an ophthalmologist is advised. Ciprofloxin ophthalmic drops are a recommended treatment for *pseudomonas* infection of the cornea.

Herpes simplex keratitis is treated with topical antiviral agents, cycloplegics, and oral acyclovir. Steroids are generally not recommended in treatment of Herpes Simplex I, because of the risk of corneal melting and perforation.¹⁰

Herpes zoster is easier to diagnose when the rash is in the typical dermatomal distribution over the eye. Hutchinson's sign is a rash over the tip of the nose, caused when the virus affects the nasociliary branch of the ophthalmic nerve, and a strong indication that the cornea is affected. Often the patient presents prior to the onset of rash, making diagnosis challenging. Given the significant risk associated with this condition, any patient with signs or symptoms of facial nerve pain and eye redness should be treated empirically for herpes keratitis until ophthalmology follow-up.

Herpes zoster ophthalmicus is treated with antiviral agents and cycloplegics. In severe cases, topical steroids can be added to prevent corneal scarring potentially leading to blindness.

Ultraviolet keratitis is an interesting clinical entity that you may be asked to see in an urgent care setting. Some patients develop ultraviolet keratitis after use of a sunlamp without eye protection, exposure to a welding arc, or exposure to the sun when skiing ("snow blindness"). Symptoms typically develop 8 to 12 hours post-

exposure and consist of severe bilateral eye pain with excessive watering and photophobia. The diagnosis can be made with use of fluorescein drops and examination under the slit lamp. Diffuse punctate staining of the cornea is confirmatory.

Ultraviolet keratitis is treated with instillation of 1 to 2 drops of Cyclogyl (to relieve ciliary spasm) and patching of both eyes. All patients recover within 24 to 48 hours without complications. Local anesthetics tend to delay corneal epithelial healing, hence prescribing local anesthetic drops for outpatient use must be discouraged.^{11,12}

Acute angle closure glaucoma

Acute angle closure glaucoma (**Figure 4**) is a rare and frequently misdiagnosed cause of a red, painful eye. When a patient presents with a painful red eye that is "rock hard" to digital palpation of the globe with or without corneal clouding, acute angle closure glaucoma should be considered and intraocular pressure should be measured in both eyes.¹³⁻¹⁶ A tonopen is a handy tool for measuring intraocular pressure that should be available to urgent care providers. Normal pressure is less than 20 mm of Hg.¹⁷

Headache, nausea and blurred vision are common associated symptoms in patients with high intraocular pressure. Urgent care physicians can use a simple yet reliable tool, tonopen to measure the intraocular pressure.¹⁷ Initial treatment of the condition includes topical beta-blockers, prostaglandin analogues, α_2 -adrenergic agonists, and pilocarpine to induce miosis. Induction of miosis opens up the angle and improves aqueous humor flow, thus reducing intraocular pressure. If the intraocular pressure is extremely high, the cornea will appear

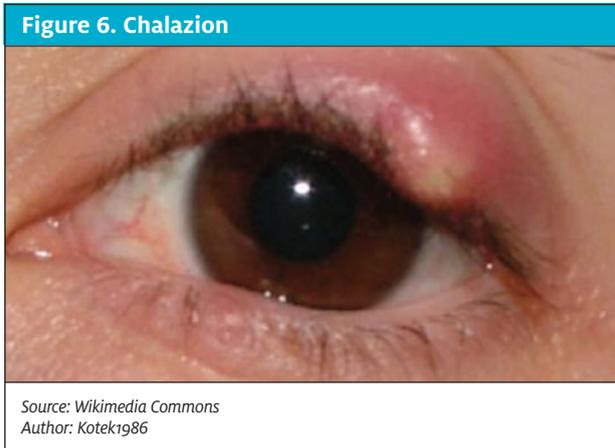


Figure 6. Chalazion

Source: Wikimedia Commons
 Author: Kotek1986

cloudy and the pupil will be mid-dilated and non-reactive to light. In that case, oral or intravenous acetazolamide may need to be used to improve the pressure, only after which will the topical drops begin to work.

Ophthalmology referral for acute angle closure glaucoma is crucial for definitive treatment (peripheral iridectomy) in a timely fashion to improve symptoms, lower the intraocular pressure, and save vision.

Lid conditions

Stye (**Figure 5**) or hordeolum is a common staphylococcal infection of the glands of Zeiss that can present as an abscess on the outside on the lid margin or inside on the palpebral conjunctiva.¹⁸ Characteristic features are localized redness, swelling, and an acutely tender area on the upper or lower lid. Warm compresses are helpful and may resolve the symptoms at an early stage. Antibiotic ointment (bacitracin or erythromycin) applied to the eyelid every 3 hours may be beneficial during the acute stage. Incision is rarely indicated if a small pinpoint pustule progresses to form an abscess.

A chalazion (**Figure 6**) is a common granulomatous inflammation of a meibomian gland of the eyelid.¹⁹ Patients with a chalazion present with a hard, nodular swelling on the upper or lower lid with or without redness and swelling of the adjacent conjunctiva. Chalazia can get infected. Treatment is usually with warm compresses, gentle massage and incision, and curettage²⁰ from the conjunctival surface of the lid, but corticosteroid injection may also be effective for chronic chalazia. At times, patients seek medical advice for chalazia, for cosmetic reasons.

Blepharitis

Blepharitis (**Figure 7**) is a common bilateral staphylo-

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References [1] Kaufman HE. Adenovirus advances: new diagnostic and therapeutic options. Curr Opin Ophthalmol. 2011;22:1-4 [2] FDA Section 510k number (K110722) for RPS Adeno Detector Plus™; March 15, 2011. *CPT stands for Current Procedure Terminology (CPT®) is copyrighted by the American Medical Association. QW modifier is added to CPT code to identify that the test is CLIA-waived.

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Figure 7. Blepharitis

Source: Wikimedia Commons
 Author: Sage Ross

coccal infection of the Meibomian, Zeis and Moll glands in the eyelid margins.²¹⁻²² Blepharitis can be associated with seborrhea of the scalp, eyebrows, and ears and its severity and time course may vary.

Patients with blepharitis complain of eyelid irritation, burning, and itching. The eyes are red over the lid margins and the immediate surrounding area of skin shows scales or granulation. Flakes can be seen clinging to the lashes.

Treatment involves warm wet compresses and lid hygiene consisting of washing with baby shampoo and removing the scales (lid margin debris). Associated seborrhea should be controlled as well.

Anti-staphylococcal antibiotic eye ointment such as bacitracin or erythromycin is rubbed daily on the lid margins, during acute exacerbations. At times blepharitis can exist along with a sty or chalazion.

Dacryocystitis

Acute or chronic dacryocystitis is infection of the lacrimal sac secondary to obstruction of the nasolacrimal system.²³ It occurs most often in infants and in individuals older than age 40 years. It is usually unilateral.²⁴

S. aureus and beta-hemolytic streptococci cause acute dacryocystitis. *Staphylococcus epidermidis*, anaerobic streptococci, and *Candida albicans* can cause chronic dacryocystitis.

Patients with dacryocystitis present with pain, swelling, tenderness, and redness over the tear sac area near the medial canthus of the eye. Purulent material may be expressed through the tear duct. Chronic dacryocystitis can present with tearing and mucous or puru-

lent discharge. Older patients may develop small stones in the lacrimal sac (dacryoliths), which may precipitate the infection.

Acute dacryocystitis responds well to systemic antibiotic therapy. Relieving the underlying obstruction is usually done electively but may be performed urgently in acute cases. Ophthalmic referral is necessary for this purpose.

Dacryocystitis is not uncommon in young infants who have congenital blockage of the lacrimal ducts, which often resolve spontaneously. If not, probing of the nasolacrimal system may be necessary.

Periorbital Cellulitis and Orbital Cellulitis

Periorbital (preseptal) cellulitis is a bacterial infection of the eyelids limited to the front of the orbital septum.^{25,26} The soft tissues around the eye are separated from the orbit by the septum, a tough membrane of protective connective tissue.

Common causes are eyelid trauma (abrasion, insect bite) contiguous infection extending from a sty or chalazion, or rarely from primary bacteremia in young infants. Common organisms are *S. aureus* and group A *Streptococcus*.

Presenting symptoms are circumferential erythema of the eyelids and periorbital skin, with swelling or puffiness of upper and or lower eyelids. Typically pain is minimal, and fever is low grade. There will be no proptosis or ophthalmoplegia. Vision is usually intact because the infection is limited to the preseptal tissues.

Orbital (postseptal) cellulitis (**Figure 8**) is a much more serious bacterial infection characterized by fever, painful purple-red eyelid swelling, and restriction of eye movement, proptosis, and variable decreased visual acuity. In general, the causative organisms are *S. pneumoniae*, *S. aureus*, *H. influenzae*, and *Moraxella catarrhalis*. Cellulitis usually arises as a complication of ethmoid or maxillary sinusitis. Untreated orbital cellulitis can lead to blindness, cavernous sinus thrombosis, meningitis, subdural empyema, or brain abscess.

At times, it will be difficult to distinguish periorbital infection from orbital cellulitis. Computed tomography scan should generally be obtained to delineate the extent of orbital involvement. Ophthalmology consultation is advised if orbital involvement is suspected.

Except for very early periorbital cellulitis, most patients with more advanced periorbital and all those with orbital infections should be treated in the hospital with appropriate intravenous antibiotics. Underlying sinus infections also should be addressed. ■

Figure 8. Orbital cellulitis



Source: Wikimedia Commons and the University of Michigan Kellogg Eye Center "And the Eyes Have It" website
 Author: Jonathon Trobe, MD

References

1. Mercieca K, Jones NP. Treatment of acute anterior uveitis in the community, as seen in an emergency eye centre. A lesson for the general practitioner? *Eur J Gen Pract.* 2012;18(1):26–9.
2. Guly CM, Forrester JV. Investigation and management of uveitis. *BMJ.* 2010;341:c4976.
3. Ishaq M, Muhammad JS, Mahmood K. Uveitis is not just an ophthalmologists' concern. *J Pak Med Assoc.* 2012;62(2):92–97.
4. Kruh J, Foster CS. The philosophy of treatment of uveitis: past, present and future. *Dev Ophthalmol.* 2012;51:1–6.
5. Khairallah M, Chee SP, Rathinam SR, et al. Novel infectious agents causing uveitis. *Int Ophthalmol.* 2010;30(5):465–483.
6. Goh PP, Shamala R, Chandamalar S, et al. Contact lens—related corneal ulcer: a two-year review. *Med J Malaysia.* 2010;65(Suppl A):120–123.
7. Dethorey G, Darvich A, Hay A, et al. Severe bacterial keratitis referred to ophthalmology emergency departments: a retrospective study of 268 cases. *J Fr Ophthalmol.* 2012 Sep 24. [Epub ahead of print]
8. Mascarenhas J, Srinivasan M, Chen M, et al. Differentiation of etiologic agents of bacterial keratitis from presentation characteristics. *Int Ophthalmol.* 2012;32(6):531–538.
9. Srinivasan M, Mascarenhas J, Rajaraman R, et al. Corticosteroids for bacterial keratitis: The Steroids for Corneal Ulcers Trial (SCUT). *Arch Ophthalmol.* 2012;130(2):143–150.
10. Wilhelmus KR. Antiviral treatment and other therapeutic interventions for herpes simplex virus epithelial keratitis. *Cochrane Database Syst Rev.* 2010;12:CD002898.
11. Davis H, Mont D, Scott C, et al. Relative impact of clinical evidence and over-the-counter prescribing on topical antibiotic use for acute conjunctivitis. *Br J Gen Pract.* 2009;59(569):897–900.
12. Yagci A, Bozkurt B, Egrilmez S, et al. Topical anesthetic abuse keratopathy: a commonly overlooked health care problem. *Cornea.* 2011;30(5):571–575.
13. Renton BJ, Bastawrous A. Acute angle closure glaucoma (AACG): an important differential diagnosis for acute severe headache. *Acute Med.* 2011;10(2):77–78.
14. See JL, Aquino MC, Aduan J, Chew PT. Management of angle closure glaucoma. *Indian J Ophthalmol.* 2011;59(Suppl):S82–S87.
15. Thomas R, Walland MJ. Management algorithms for primary angle closure disease. *Clin Experiment Ophthalmol.* 2013;41(3):282–292.
16. White J. Diagnosis and management of acute angle-closure glaucoma. *Emerg Nurse.* 2011;19(3):27.
17. Babineau MR, Sanchez LD. Ophthalmologic procedures in the emergency department. *Emerg Med Clin North Am.* 2008;26(1):17–34.
18. Panicharoen C, Hirunwiwatkul P. Current pattern treatment of hordeolum by ophthalmologists in Thailand. *J Med Assoc Thai.* 2011;94(6):721–724.
19. Arbabi EM, Kelly RJ, Carrim ZI. Chalazion. *BMJ.* 2010;341:c4044.
20. Ben Simon GJ, Rosen N, Rosner M, Spierer A. Intralesional triamcinolone acetonide injection versus incision and curettage for primary chalazia: a prospective, randomized study. *Am J Ophthalmol.* 2011;151(4):714–718.
21. Nemet AY, Vinker S, Kaiserman I. Associated morbidity of blepharitis. *Ophthalmology.* 2011;118(6):1062–1068.
22. Lindsley K, Matsumura S, Hatef E, Akpek EK. Interventions for chronic blepharitis. *Cochrane Database Syst Rev.* 2012;16(5)
23. Dantas RR. Lacrimal drainage system obstruction. *Semin Ophthalmol.* 2010;25(3): 98–103.
24. Pinar-Sueiro S, Sota M, Lerchundi TX, et al. Dacryocystitis: systematic approach to diagnosis and therapy. *Curr Infect Dis Rep.* 2012 Jan 29. [Epub ahead of print]
25. Baring DE Hilmi OJ. Management or mismanagement of periorbital cellulitis? A review of the literature and evidenced based guide. *Clin Otolaryngol.* 2011;36(1):57–64.
26. Pandian DG, Babu RK, Chaitra A, et al. Nine years' review on preseptal and orbital cellulitis and emergence of community-acquired methicillin-resistant Staphylococcus aureus in a tertiary hospital in India. *Indian J Ophthalmol.* 2011;59(6):431–435.



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Understanding the Freestanding Emergency Department Phenomenon

Urgent message: FSEDs have a role to play in our health care system but it's not to supplant urgent care centers.

ALAN A. AYERS, MBA, MACC

Introduction

Freestanding emergency departments (FSEDs) are walk-in medical facilities—structurally separate and distinct from a hospital—that hold themselves out to provide emergency care to the general public. While they claim many similarities to hospital EDs—capabilities to diagnose and stabilize cardiac arrest, stroke symptoms, breathing problems and trauma—there are also significant differences.

Unlike hospital EDs, many freestanding EDs:

- lack trauma level verification by the American College of Surgeons;
- do not receive patients via ambulance diversion or transfer;
- do not have overnight beds or intensive care capabilities;
- lack inpatient referral or admissions capabilities; and
- are unprepared to handle volume influxes from natural and man-made disasters.

Whereas the average hospital ED sees 150 to 200 patients per day, depending on the business model, many freestanding EDs often see as few as 35 to 40 patients per day and some private operators are profitable at less than 20.

In general, FSED patients are ambulatory and present themselves with what would triage as a lower priority

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level (urgent or semi-urgent) in a hospital ED. If a severely ill patient who presents at an FSED is determined to require a hospital admission, surgery or specialist care, they are stabilized and transferred by paramedic to a higher-acuity facility.

FSEDs differentiate themselves from their hospital-based counterparts in terms of the patient experience. Hospital EDs have a reputation for long wait times, busy staff, and crowded, uncomfortable waiting rooms. Whereas national studies reflect average 3-

hour wait times in the nation's ERs, FSEDs focus on getting patients out within 60 to 90 minutes. In addition, FSEDs are typically located in upscale retail developments and have fashionable décor that includes luxury furnishings and granite countertops, conveniences like Wi-Fi and exam room cable television, gourmet coffee and refreshment bars, children's play areas and pediatric-themed rooms. The atmosphere is more reminiscent of a boutique hotel lobby or day spa than the "sterile" or "clinical" environments associated with hospitals.

As illustrated in **Table 1**, FSEDs offer slightly more advanced services than urgent care centers. In addition to digital x-ray, they typically have computed tomography, ultrasound, full on-site lab capabilities, electrocardiography, as well as life-saving medical equipment. Personnel also differ at FSEDs, which are almost always staffed with board-certified Emergency Medicine physicians and ER-trained nurses. Urgent care centers, by contrast, are often staffed with family physicians and/or mid-level practitioners. And while urgent care centers

typically operate 12 to 14 hours a day, FSEDs operate 24 hours a day, 365 days a year.

Count and Growth of FSEDs

In 2009, the last year accurate, national statistics for freestanding emergency centers were published, the American Hospital Association counted 241 centers in 16 states.¹ That was up from 146 in 2005; applying the same growth rate, the current estimate is between 350 and 400 FSEDs in the United States today.

FSED growth is being driven in large part by hospitals and health systems expanding their footprints into growing suburban areas. This strategy is reflected in states like Delaware and Colorado, where a handful of FSEDs have taken a hybrid approach between a hospital ER and an outpatient clinic. For example, some of these centers offer outpatient surgery in addition to emergency care, or they have some overnight beds for emergency patients requiring observation and possible referral to a full-service hospital.

Texas is leading the nation in FSED growth, with



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Table 1. Differences between FSEDs and urgent care centers

	Urgent Care Center	Freestanding Emergency Center
Insurance Contracting	Typically as an urgent care facility, reimbursing either a flat fee per patient (with carve-outs for high-value procedures) or fee-for-service. May also be contracted as a primary care office.	As an emergency facility with physicians contracted as separate, independent providers.
Net Revenue per Patient	\$105 to \$150	\$350 to \$500 although some patients have reported fees of over \$1,000 for moderate- and low-acuity conditions.
Co-Pay Charged	Urgent care co-pay—typically \$35 to \$50.	Emergency room co-pay—typically \$75 to \$100.
Facility Fee Charged	Typically no facility fee is charged, except in certain instances in which the center is part of a hospital complex. Typically one invoice for all services on site.	A facility fee is charged in addition to a professional fee for the providers. Patient is often billed separately by the facility and physician group.
Cases Treated	Typically low- to-moderate acuity, with the bulk of patients presenting with minor infections, flu symptoms, allergies, rash, lacerations, sprains/strains, and fractures.	Typically non-emergent with greater emphasis on musculoskeletal injury and lacerations. Patients self-triage for acutely rising conditions including high fever, automobile accidents, and asthma attack.
Operating Hours	Typically 10-12 hours a day, seven days a week.	Most are open 24-hours a day, 365 days a year.
Square Footage	Typically 2,500 to 4,500 sq. ft.	5,000 to 20,000 sq. ft. depending on whether the center is independent or hospital-affiliated.
Trauma and Resuscitation	Providers typically certified in Basic Life Support although many have advanced life support certification. Center typically equipped with EKG, defibrillator and drug cart. Process is to stabilize patient, call 911, and then EMS transfers patient to hospital emergency room.	Providers certified in Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS). Capabilities to administer IV medications and perform cardiac enzyme and BNP labs. Process is to stabilize patient and admit to hospital (using contracted paramedic transport) under direct transfer agreement.
Provider Staffing	May be any combination of physicians, physician assistants, or nurse practitioners supported by medical assistants and technicians.	Emergency medicine physician on staff during all operating hours typically supported by an emergency medicine nurse. Ancillaries like lab and imaging supported by cross-trained technicians.
Provider Specialty	Typically family practice or emergency medicine with representation from internal medicine, pediatrics and other specialties. May or may not be certified by an ABMS-recognized board.	Typically board-certified in emergency medicine.
Laboratory	Varies by location. Typically CLIA-waived for point-of-care testing. Labs performed by medical assistants. Collection and send-out to reference laboratory for more advanced labs. Urine drug screening as a revenue center.	CLIA-certification for point-of-care testing plus automation for CBCs, D-Dimer, BNP, and cardiac enzyme testing. Laboratory technician on staff. Physician also utilizes microscope for diagnosis.
Imaging	Typically basic x-ray performed (depending on state law) by trained medical assistant or radiology technician. Consulting radiologist over-reads to validate diagnosis.	X-ray, low-resolution CT, and ultrasound performed by radiology technician, with consulting radiologist on-call to read images.

about 85 to 90 centers open and a dozen more under construction. The prevailing model in the state is the pure-play emergency center, targeting patients with moderately acute conditions, who have other options (hospital ERs and urgent care), but who are willing and able to pay a higher price for the shorter wait time and better patient experience at FSEDs.

Texas is unique in that FSED growth has been driven primarily more by entrepreneurial than hospital operators, but regardless, the growth and placement of the centers reflects the national trend—to serve affluent family demographics. Despite Texas’ size and number of medically under-

served counties, the vast majority of FSEDs have opened in relatively condensed areas—the highly competitive suburbs of Dallas, Houston, San Antonio, and Austin.

FSED Operating Models

Freestanding emergency departments are operated by hospitals, individual physicians and physician groups, and non-physician entrepreneurs. Just as there is variance in the capabilities and offerings of urgent care centers, the operating models of FSEDs vary depending on the ownership, location, size, competition, and target patient demographics of the facility.

Hospitals are turning to this model as a more cost-effective way to expand their footprint into new areas without the risky and exponentially costlier investment of building a full-service hospital. Foregoing the cumbersome Certificate of Need process required for a hospital, a health system can develop a medical campus that includes primary care and specialist offices, pharmacy, imaging, laboratory, physical therapy, occupational health—even a coffee and bake shop. FSEDs, like hospital EDs, are an excellent source of referrals for inpatient care. Health systems can expand their revenue base by “capturing” patients from suburban communities into their FSEDs and then “pushing” them to specialists at their urban hospital campus. As a competitive play, FSEDs expand the hospital’s brand presence. That’s why many FSEDs are opened to compete head-to-head against other hospitals or health systems. And where a hospital operates a local network of urgent care centers, its FSED can receive higher-acuity referrals from the urgent care—keeping the patient “in system.”

According to the Healthcare Financial Management Association (HFMA), five factors are driving hospital sys-

tems to utilize freestanding ERs in their strategies to increase market penetration and improve financial performance:

- Increased demand for hospital emergency services, including a steady increase in patients who commonly utilize hospital EDs for their primary health care needs.
- Dysfunction in legacy hospital EDs including inadequate number of beds and treatment areas, poor space configuration, and inefficient operations leading to ED wait times of up to 12 hours or longer in some cases—which cause hospitals to fall short of benchmark measures on ED length of stay.
- Ability to expand the hospitals’ brand and physical footprint without the capital costs and certificate of need requirements of building a new hospital or outpatient campus.
- Ability to expand incremental use of hospital-based services, capture referrals for the hospital and its affiliated providers, differentiate from competing hospitals, and mitigate competitive threats from urgent care centers, retail clinics and other on-

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Although HFMA lists “co-location with complimentary ambulatory services like imaging, laboratory and physician offices” as a critical success factor for freestanding ERs, many new freestanding ERs are stand-alone retail operations, completely separate from any other hospital-affiliated outpatient services.

For entrepreneurs, the FSED model is a way to turn a profit. An often-cited reason for Emergency Medicine physicians to open their own FSEDs is their desire to escape the bureaucratic challenges associated with large health systems and ER staffing groups, especially when their beliefs on how care should be delivered differ from management. The smaller, less hectic scale of FSEDs allows providers to spend more quality time interacting with patients, educating them and meeting their needs more fully. Working in or owning an FSED provides emergency physicians with much-desired autonomy.

FSED Demographics

A study of FSED locations reveals a clear bias towards affluent, densely populated—especially in terms of families with children—suburbs of large cities. Although an argument could be made that FSEDs expand access to emergency services, these areas are already hyper-competitive among existing health systems for ED patients. In general, FSEDs are not located to serve the Medicaid and indigent populations who rely on the “safety net” of urban hospital emergency rooms.

A study of the residential demographics surrounding each Texas FSED confirms these trends. In the Dallas/Ft. Worth and Houston markets, the 3-mile demographics of FSEDs reflect a median household income \$15k and \$20k higher (respectively) than the metropolitan averages. In addition, these centers are located in less diverse communities (smaller proportion of Hispanic and African-American residents) with a significantly larger proportion of married households with children (**Figure 1**). The same patterns have been noted in Seattle, Washington, where several FSED operators have opened in affluent urban and suburban neighborhoods already served by emergency rooms.²

So why are FSEDs targeting areas with potential competitors? Much of the reason lies in the investment to build and operate this type of center. Capital requirements range from \$3.5 million³ to \$20 million,⁴ plus the ongoing cost of permanently staffing a center 24/7 with Emergency Medicine nurses and physicians. To turn a profit, centers must be placed in areas where utilization and insurance coverage are high—where consumers are less sensitive to the cost differential of an emergency room co-pay—and that’s typically in suburban areas with high percentages of working professionals with families.

FSED Billing Issues

FSED bills can be up to 10 times the cost of a comparable visit to pri-

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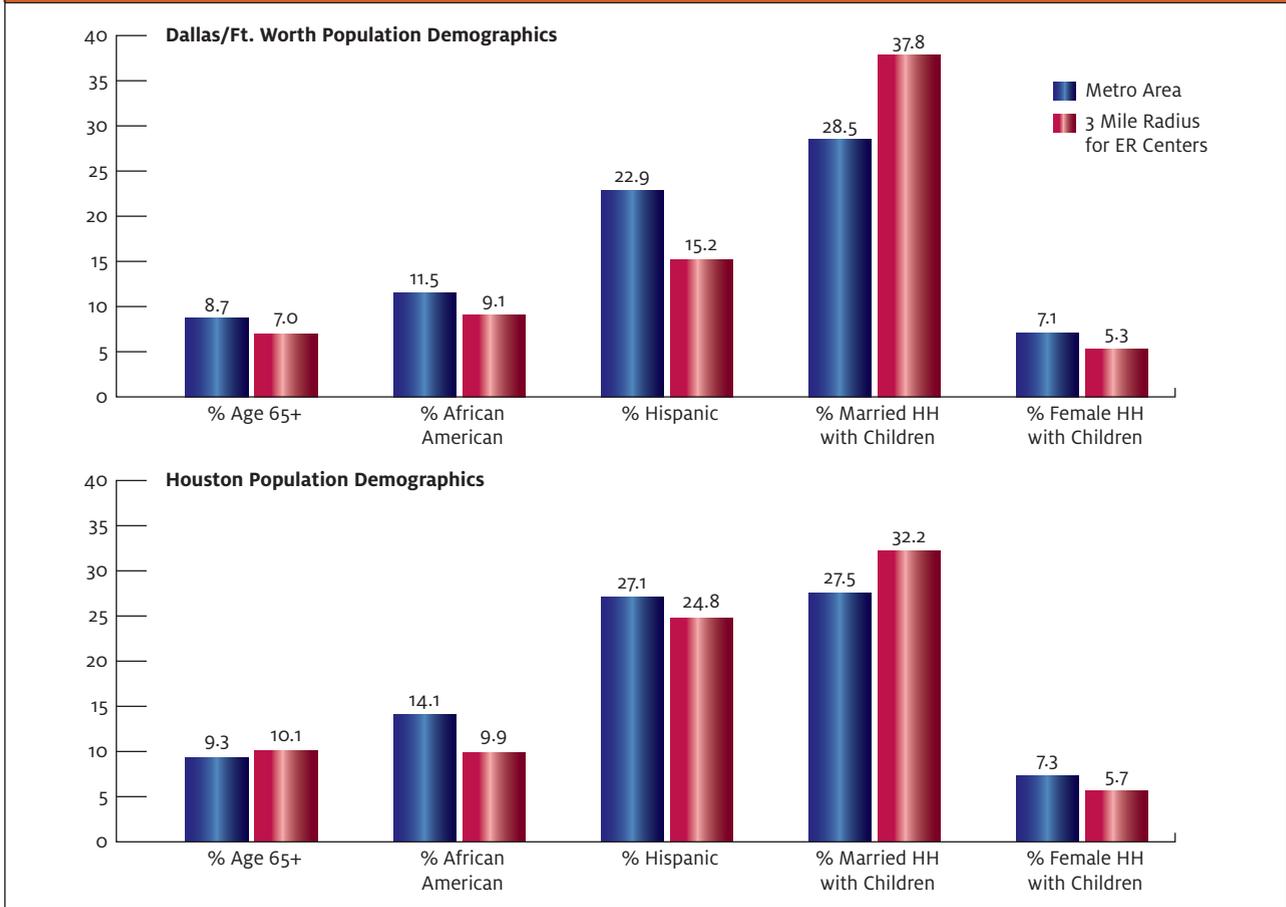
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Figure 1. Results of a study analyzing the average demographics around an FSED (3 mi radius) versus the average for the metropolitan area.
 (The communities in which FSEDs are located have higher incomes, more married families, and less racial/ethnic diversity.)



mary or urgent care. The primary culprit is the “facility fee”—a fee historically charged by hospitals to cover the high overhead of being prepared to handle any situation that presents while subsidizing charity and indigent care. While FSEDs argue facility fees are necessary and appropriate because FSED capabilities are similar to hospital EDs, patients and payors have questioned the legitimacy of facility fees because the centers—particularly storefront physician-owned FSEDs that resemble “doctor’s offices”—have a very different cost structure than full-service hospitals.

Although most hospital-affiliated FSEDs are contracted with insurance as in-network facilities, many independent FSEDs are not contracted despite advertising they “will bill your insurance.” They’re taking advantage of a “loophole” that requires payors to cover emergency services. What happens is the FSED bills the insurance company as an out-of-network provider and even if the insur-

ance company marks down its payment to “usual and customary charges” or “in-network rates”—because there is no contract with the payor—the FSED can then balance bill the patient. This leads to patient confusion and “fighting” with FSEDs (and their collection agencies) for weeks—especially for patients who go to a center under the impression that their insurance is “accepted by” (contracted with) the center.

Aetna has filed at least three lawsuits against FSEDs that charge facility fees. Their primary concern is that these centers charge a fee applicable to hospitals when they are not a comparable entity; hospitals have inpatient capabilities and offer a wide range of services, whereas the vast majority of FSEDs offer only emergency care.⁵ Another large insurance provider, Blue Cross Blue Shield of Texas, is warning members about the exorbitant fees charged by FSEDs. On its website, BCBS clearly states that these centers are out-of-network, are not comparable to hospital EDs in level

of care, and that treatment there may incur additional expenses to the patient.⁶

FSED Marketing Strategies

Given freestanding ED locations and facilities that appeal to upper-income consumers, a conclusion may be reached that time-starved professionals with employer-paid health insurance are undeterred by emergency room co-pays *if they believe* an FSED has shorter wait times, more sophisticated capabilities, and better qualified providers than other options, including urgent care centers—regardless of whether such capabilities are *needed* for their conditions or whether their *perceptions* are even reality.

To attract insured patients who can afford it, FSEDs market their ability to treat urgent as opposed to emergent conditions, their “cutting edge” technology, their sleek new facilities, and their providers’ board certifications. Additionally, FSEDs place a lot of emphasis on very short wait times. On average, the length of an ER visit in 2010 was just over 4 hours,⁷ so affluent patients who place a dollar-premium on their time can be seen in “10 minutes or less” at an FSED. Given their marketing messages, and similar marketing tactics to urgent care centers, it’s easy to understand why consumers become confused as to when to go to an FSED versus urgent care or the hospital.

Federal and State Regulation of FSEDs

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that hospitals participating in government health programs (Medicare, Medicaid, and/or Tricare) provide emergency medical treatment to any presenting patient, regardless of the patient’s ability to pay. Generally a hospital’s obligation under EMTALA is to provide an evaluation as to whether an emergent condition exists; if an emergent condition does exist, to provide treatment until that condition stabilizes; and last, to transfer patients to an appropriate specialized facility if care is required beyond the hospital’s capabilities. A freestanding ED that is affiliated with a hospital is generally subject to EMTALA while independently-owned facilities often forego the EMTALA requirements by opting out of federal health programs.

In Texas, legislation regulating the capabilities and operation of FSEDs was passed in 2009 to ensure facilities offering “emergency care” are comparable in capabilities to hospital EDs, both for patient safety and for payor understanding. Not only does the Texas law impose an “EMTALA-like” standard—requiring a screen-

ing exam and treatment of emergency conditions without charge—for centers not covered by the federal law, it requires a license from the state. “Minimum standards” are defined and include 24-hour operations, at least one licensed physician and nurse on staff at all times, and a stipulation that the Texas Department of State Health Services can inspect a facility at any time.

In addition, the Texas legislation requires insurance companies to cover any initial screening exam to determine if an emergent condition exists. And if an emergency is present, insurance must also cover the care given to treat it. Regardless of whether the center is contracted with insurance, care must be covered at the preferred level of benefits.

Prior to the Texas legislation, numerous entrepreneurial emergency centers operated evening and weekend hours but were not open 24 hours. The expectation was that many of these centers would close as the added costs and thin volume of overnight operations rendered the business model unprofitable. Although some centers did close, some relocated to areas more visible for 24/7 operations, others converted to “urgent care,” and most centers simply adapted to the regulation. The conclusion is that the margin on billing ER rates is sufficiently high enough to support 24-hour operations, even if nighttime volume is thin.

How FSEDs Add to Health Care Costs

Health care is most efficient when the acuity of the patient’s condition matches the capabilities of the facility and provider. For emergencies that require capabilities beyond that of an urgent care center, but not a full-service hospital, freestanding emergency rooms may be an appropriate “plank” in the health care delivery continuum. The problem, however, is when patients go to an emergency facility for non-emergent conditions. Through a combination of laws and the facility fee, the bill for the non-emergent condition could be many times greater than what the patient anticipated, and certainly higher than what was needed. This is the biggest criticism of FSEDs—that they will treat conditions that could be treated at an urgent care facility, but they’ll charge hundreds of dollars more.

Consumers are generally savvy in self-triage—they understand when a medical emergency warrants calling 9-1-1, going to a hospital emergency department, going to an urgent care center, or simply using over-the-counter products. For the small number of emergent cases that present at the freestanding ERs, it’s true there may be more advanced capabilities present, but the

same process exists as at an urgent care center to transfer those patients by paramedic to the nearest hospital.

More significant is the 95% to 97% of freestanding ER patients who are discharged to the street. Just as some studies indicate that up to 85% of all hospital ED patients can be treated in lower-acuity settings, many if not all of these low-acuity freestanding ER patients could be treated for lower cost in urgent care centers. This especially true because freestanding ERs—by virtue of their suburban retail locations—do not serve the same chronically ill patient base as their urban hospital counterparts.

FSEDs charge significantly higher prices for their care. Patients whose conditions are of mid to low level acuity should understand that the most cost-effective care option is an urgent care center or even their primary care physician, but NOT an ER. A barrier to patient understanding is that FSED marketing can be misleading and confusing, and even frustrating once the bill comes back. To help consumers understand the best choice for their condition, FSEDs should be clearer in their billing and level of acuity.

On the other hand, UC centers should aggressively advertise the conditions they are capable of treating in addition to their lower fees and co-pays. Because of their large reach to health care consumers, payors should seek to educate members in choosing the right tier of care for a condition—whether that be primary care, urgent care, or an emergency room.

FSEDs Contribute to Excessive ER Utilization

A recent report made for the U.S. Senate by the Center for Studying Health System Change found that only 4% of ED visits in 2008 were triaged as “immediate,” meaning the patient had to be seen immediately. Only 12% were deemed “emergent,” requiring a treatment in less than 15 minutes. Thirty-nine percent were triaged as “urgent,” meaning must be seen in 15 to 60 minutes, and 21% were “semi-urgent” and must be seen in 1 to 2 hours. Interestingly, only 8% of ED patients were triaged as “non-emergent.” These data indicate that most ED visits are not on the extreme ends of the care spectrum, they fall in a gray area between emergency and non-emergency.⁸

The takeaway from this study is that patient education on acuity and appropriate facility choices is key to minimizing unnecessary ER visits. The same study found that two-thirds of ED visits happened after normal business hours (8 am-5 pm), meaning patients may be going to the ED simply because they believe it is the only open option during non-business hours. As the population ages, millions of newly insured seek to estab-

lish primary care relationships, and that increased demand will spill over to emergency rooms especially with the PCP shortage exacerbating accessibility.

Although limited access to primary care is a contributor to ED visits, the report found that lack of access was not the main driver for unnecessary ED visits—utilization is attributed more to a lack of knowledge of alternatives and the acuity of the presenting conditions. This indicates that providers and payors should play a more active role in educating patients on evaluating their symptoms and identifying the appropriate treatment setting. Furthermore, not only will cost savings have an impact for the patients, but the greater impact is quality of care when shifting non-emergent ED visits to urgent care or primary care settings. Given the referral relationships that exist between urgent care centers and primary care providers, the transition from initial treatment to follow-up will be much smoother than if simply “treated and streeted” by the busy hospital ED.

Urgent Care’s Response to the FSED Phenomenon

Many of the reasons consumers choose freestanding emergency centers likewise apply to urgent care. Urgent care operators should educate the public through media advertising, grassroots activities, and public relations about their hours of operation, clinical capabilities, and the pleasant patient experience provided by their centers. To make an impact on consumers, urgent care operators should emphasize comparisons between:

- the total cost (and co-pay differentials) of an emergency room visit and an urgent care visit;
- urgent care length of stay of 1 hour or less versus 3 to 4 hours on average for hospital EDs;
- the more personalized experience in an urgent care center versus a cold, sterile ED; and
- comparable medical quality, physician expertise, and clinical outcomes.

In addition, because the Center for Studying Health System Change study cited primary care referrals as another reason for emergency room overutilization, urgent care providers should develop relationships with local physicians who will refer patients to urgent care for conditions requiring x-ray or lab, minor procedures, overflow due to seasonality, and during times the office is closed (vacations, evenings, weekends, and holidays). Association with an urgent care benefits primary care when the urgent care center forwards existing patient charts for follow-up and refers new patients for management of chronic or longitudinal conditions. The primary care physician can serve as a “front-line” in educating

patients as to the most appropriate treatment options.

Improvements to the FSED Model

FSEDs may have a future in our health care system, but they must find a way to limit overspending by unwary consumers looking for a quick fix for a non-emergent condition. Moreover, FSEDs are needed in rural areas where hospital EDs are not accessible, but where developing a full-scale hospital is not financially viable.⁹ Finally, FSEDs must ensure that patients presenting with a non-emergent condition understand the billing processes at the center. Before admitting a patient with a clearly non-emergent condition, the FSED should be obligated to explain its charges. Unfortunately, the efforts to expand ED capacity and volume through FSED construction suggest that many hospitals perceive few incentives or benefits to shift non-urgent care from their EDs to urgent and primary care settings.

Conclusion

FSEDs can certainly have a promising future in our health care system, but they must find a way to limit overspending by unwary consumers looking for a quick fix for a non-emergent condition. FSEDs are a great idea to alleviate overcrowding of hospital emergency rooms, but they should be located where there is truly a “need.” To bring cost savings, they should ensure patients presenting with a non-emergent condition understand the billing process at the center. Once FSEDs begin to refer non-emergent conditions to a more appropriate provider, then their potential for improvement in our health care system will be more easily realized. ■

References

1. Michelle Andrews. “Emergency Care, But Not At A Hospital.” *Kaiser Health News*, May 31, 2011. Accessed July 8, 2013. <http://www.kaiserhealthnews.org/Features/Insuring-Your-Health/Michelle-Andrews-on-Hospital-ER-Alternatives.aspx>
2. Carol M. Ostrom. “ER Building Boom is Wrong Prescription, Critics Say.” *The Seattle Times*, November 27, 2011. Accessed July 8, 2013. http://seattletimes.com/html/localnews/2016867292_hospitalbuildz7m.html
3. “Freestanding Emergency Departments – Attractive N L Investment.” Stan Johnson Company. Accessed July 8, 2013. <http://www.stanjohnsonco.com/?p=64>
4. Val Walton. “Stand-alone Emergency Room Could Come to Hoover.” *The Birmingham News*, December 29, 2010. Accessed July 8, 2013. http://blog.al.com/spotnews/2010/12/stand-alone_emergency_room_cou.html
5. Stephanie Armour. “Aetna Opposes Investor-Owned ERs as \$1500 Fees Charged.” *Bloomberg.com*, Mar 31, 2013. Accessed June 27, 2013. <http://www.bloomberg.com/news/2013-04-01/aetna-opposes-investor-owned-ers-as-1-500-fees-charged.html>
6. “Provider Finder Alert.” Blue Cross Blue Shield of Texas. Accessed June 27, 2013. <http://www.bcbstx.com/trs/alert.htm>
7. “Average U.S. ER wait time 4-plus hours.” *UPI Health News*, July 26, 2010. Accessed July 8, 2013. http://www.upi.com/Health_News/2010/07/26/Average-US-ER-wait-time-4-plus-hours/UPI-76891280122494/
8. Peter Cunningham, Ph.D. “Nonurgent Use of Hospital Emergency Departments.” *Center for Studying Health System Change*, May 11, 2011.
9. The Abaris Group. “Freestanding Emergency Departments: Do They Have a Role in California?” *California HealthCare Foundation*, July 2009. Accessed July 8, 2013. <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/F/PDF%20FreestandingEmergencyDepartmentsIB.pdf>

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Case Report

Sacral Tumor

Urgent message: Each case—and patient presentation—in urgent care must be evaluated on its own merits. Rare diagnoses are possible and “benign” back pain complaints sometimes are not.

HEATHER VARLEY, PA-C, and WILLIAM GLUCKMAN, DO, MBA, FACEP

Introduction

Each day in the urgent care setting, we are presented with a range of various pain complaints, from headaches, to back pain, to extremity pain. These complaints may be the result of injury, overuse, infection, arthropathy, or have no clear underlying cause. Although many of the cases we encounter in the outpatient clinic setting are benign and will respond to initial conservative management, it is important not to group all pain complaints together with a similar clinical work up and treatment approach. Each case must be addressed individually, with a careful history and thorough physical exam. Serious causes for pain must be ruled out, and other causes for pain appropriately identified and managed.

The following example is a case in which the patient had few risk factors but presented with complaints and a physical exam concerning for a more serious cause for back pain. This case highlights the importance of looking at the whole picture, and keeping rare and potentially dangerous diagnoses in your differential amongst the sea of vague pain complaints.

Case Presentation

A 30-year-old otherwise healthy female who was newly married and had no children presented to the urgent care center after a slip in the shower on a shampoo bottle that morning. She fell backward and landed on her lower back and buttocks, right elbow, and the back of her head. The patient presented complaining primarily of moderate to severe pain of the coccygeal region,

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8/10 in intensity, non-radiating. She denied loss of consciousness, current headache, nausea, vomiting, visual changes, numbness, tingling, lower extremity weakness, saddle anesthesia, bowel or bladder incontinence or retention. The elbow pain had resolved, and physical exam revealed no ecchymosis, swelling or limitation of movement. All other exams were unremarkable aside from localized tenderness over the sacrum and coccyx, without crepitus or deformity.

An x-ray was performed of the lumbosacral spine and coccyx, and read as normal. No apparent fracture was detected by the urgent care provider or the over-reading radiologist. The patient was discharged on non-steroidal anti-inflammatory drugs (NSAIDs), with oxycodone/acetaminophen for pain, and was instructed to apply ice to the affected area. She was feeling better

upon follow-up call a few days later.

The patient returned 3 weeks later complaining of 4 days of a return of the pain in her lower back and coccyx. She described the pain as a sharp ache that was 9/10 in intensity and increased at night, specifically when lying down. She noted numbness to her hips, perineum, and anterior proximal thighs. The patient also noted constipation, which she attributed to her use of pain medication over the past few days. She also reported mild urinary retention and a sensation that she had to urinate but was unable to intermittently over the past 4 days. She was able to walk and range her back without issue. She denied fever, chills, headache, dizziness, weakness, abdominal pain, nausea, vomiting, and dysuria. Her last menstrual period was 2 weeks prior and normal. After further questioning, patient did note that she had been experiencing intermittent lower back pain at night for the past year.

Observation/Findings

Evaluation of the patient showed the following:

- T: 97.2
- RR: 16
- P: 71
- BP: 121/77
- O2: 99% RA
- Weight: 110 lb Height: 5'3"

Physical exam revealed a well-appearing female in no acute distress. Positive exam findings included: *Right Anterior thigh (dermatome L1-S3)*—light touch sensation diminished, sharp/dull sensation diminished, 2-point discrimination intact, pain sensation intact, vibration sense intact.

Left anterior thigh (dermatome L1-S3)—light touch sensation diminished, sharp/dull sensation absent, 2-point discrimination intact, pain sensation diminished, vibration sense intact.

Right and left medial leg (dermatome L4)—light touch sensation diminished, sharp/dull sensation intact, 2-point discrimination intact, pain and vibration sense intact.

Lateral leg/medial foot (L5 dermatome)—sensation intact throughout to light touch, sharp/dull, 2-point discrimination, pain and vibration.

Lateral leg/dorsal foot (L5 dermatome)—sensation intact throughout to light touch, sharp/dull, 2-point discrimination, pain and vibration.

Lateral ventral foot (S1 dermatome)—sensation intact throughout to light touch, sharp/dull, 2-point discrim-

Figure 1. MRI of the sacrum and coccyx



ination, pain and vibration.
Proprioception was intact.

Overall it was noted that decreased sensation was greater in the left thigh and pelvic region compared to the right thigh and pelvic region.

Cranial nerves II-XII and all cerebellar tests were within normal limits. Strength was 5/5 and equal bilaterally in both the upper and lower extremities. Reflexes and pulses were 2+ throughout. Gait was normal. Musculoskeletal examination of the lower back was unremarkable, with no point tenderness and full range of motion. The abdomen was soft and non-tender with normal bowel sounds in all four quadrants.

Diagnostic Studies

Because of concern about nerve impingement/cauda equina syndrome, the patient was referred to a local imaging center for stat magnetic resonance imaging (MRI). MRI without contrast of the lumbosacral spine was obtained, with the presumed diagnosis of lumbar disc displacement with myelopathy vs. lumbar disc rupture with myelopathy. The patient was prescribed oxycontin, 10 mg Q12 with Nucynta, 75 mg 1-2 tabs q4-6 hrs PRN for breakthrough pain.

Diagnosis

Primary sacral bone tumor

MRI of the lumbar spine demonstrated no acute lumbar disc herniation/extrusion or acute osseous trauma to the lumbar spine. MRI of the sacrum and coccyx demonstrated a large multiloculated expansile cystic lesion centered on the mid sacrum with pathologic fracture (**Figure 1**). Findings were thought to represent a large aneurysmal bone cyst or giant cell tumor of the sacrum.

In order to further evaluate the mass and better define the osseous anatomy, an MRI with contrast and computed tomography (CT) without contrast of the sacrum and coccyx were ordered.

The patient was referred to Memorial Sloan-Kettering Cancer Center in New York City, where she was admitted for further work up and pain management, even though a tissue diagnosis had not yet been obtained.

The patient underwent CT scanning and a biopsy, which revealed chondroid chordoma of the sacrum.

Course and Treatment

The patient was placed on steroids in order to decrease inflammation and impingement on spinal nerves. She underwent a radical surgical resection of the tumor, with removal of her sacrum and coccyx beginning at the level of S2. Two lesions in the right and left pelvis were also removed through interventional radiology procedures. Chemotherapy and radiation had no benefit in the management of her chondroid chordoma, and were therefore not recommended as part of the treatment course. She remained in the hospital for 8 weeks for pain management, occupational therapy, physical therapy, and bowel and bladder training. She was left with residual bowel and bladder incontinence. She self-catheterizes her bladder 3 hours and is on a bowel regimen, taking Metamucil at night and a suppository in the morning in order to have bowel movements. She does not require a colostomy at this time. She remains in physical therapy three times per week for lower back and lower extremity strengthening and is now ambulating without assistance. She remains on methadone, 10 mg TID and Neurontin TID for pain management. The patient has frequent positron emission tomography and CT scans in order to monitor for recurrence and metastases, which to date, have remained clear.

Discussion

Chordomas are part of a family of cancers called sarcomas, which include cancers derived from the cells

of bones, cartilage, muscles and other connective tissue. Chordomas most closely resemble cartilage in their histologic tissue make up. Chordomas arise from cellular remnants of the notochord, the cells in the embryo that form the foundation for development of the spinal cord. The notochord regresses during fetal life as the spinal cord develops, however, some notochord cells do normally remain after birth embedded in the clivus of the skull and the sacrococcygeal regions of the spine. Rarely these remaining notochord cells go through a malignant transformation that leads to formation of a chordoma. Because of this local transformation, chordomas are most commonly found along the neuraxis, intracranially at the clivus, or in the sacrum at the base of the spine. Chordomas are rare slow-growing malignant bone tumors, accounting for 1% to 4% of primary bone tumors. However, of the primary bone tumors affecting the sacrum, more than half are chordomas. In the United States the annual incidence of chordoma is 1 in 1 million, with 300 new cases diagnosed each year. Because chordomas are typically located in close proximity to crucial structures such as the spinal cord, brain stem, and important nerves and arteries, they can be very difficult to treat, requiring highly specialized surgical and oncologic care, with close long-term follow-up.

Chordomas can occur at any age, but they are more common in adults, with a median age at diagnosis of 49 for skull base chordomas and 69 for sacral chordomas. The ratio of males to females affected by this rare tumor is approximately 1.6 to 1. There have been no definite identified causes for chordoma, however, some studies have indicated a possible genetic predisposition for development of the disease.

The symptoms of chordomas depend on their location. Patients with clival chordomas at the base of the skull typically present with headache, facial pain or paralysis, double vision, changes in hearing or tinnitus, difficulty swallowing, or hoarse voice. Sacral chordomas often do not cause symptoms until they are very large and patients with them may present with back pain, lower extremity pain, lower extremity weakness, numbness or tingling, rectal dysfunction, urinary retention or incontinence, erectile dysfunction, or in some cases, a palpable sacral mass.

Diagnosis of chordoma typical involves neurologic examination, imaging studies including MRI and/or CT of the affected area, followed by guided tissue biopsy. The three histologic types of chordoma are classical (“conventional”), chondroid, and dedifferentiated.

Chondroid chordomas tend to have a more indolent clinical course and be less aggressive overall than classical chordomas. Dedifferentiated chordomas are typically more aggressive and more likely to metastasize.

Surgical resection is the mainstay of treatment. Complete surgical removal of the tumor while preserving vital structures is essential in order to offer the best chance of survival and decrease the possibility of localized recurrence and metastases. Recent advances in surgical, imaging, and interventional radiology techniques have allowed surgeons to perform complete tumor excisions more commonly and successfully. High-dose radiation typically is required for successful treatment of chordomas. However, the proximity of vital neurologic structures to chordomas limits the dose of radiation that can be safely utilized. Therefore, radiation tends to be reserved for cases in which the entire tumor cannot be safely excised, or to shrink the tumor prior to resection in order to avoid damage to critical structures. Even with advanced techniques, complete resection of chordomas often comes at the expense of certain neurologic structures, impacting long-term function and quality of life in these patients. For example when resecting a sacral tumor, both S3 nerves must be preserved in order to maintain urinary and bowel function. If both S3 nerves are resected then patients will likely need to intermittently self-catheterize and use bowel medications. If both S2 nerves are resected, the result is complete urinary and bowel incontinence, requiring consistent urinary catheterization and a bowel regimen, as was the case with the patient in our case analysis. There are no chemotherapy drugs currently approved for treatment of chordoma, but recent trials have demonstrated a moderate response to the PDGFR inhibitor imatinib.

Prognosis for chordoma is different for each individual case. Factors such as patient age, tumor size and location, histological subtype, and extent of resection all affect clinical outcomes.

Take-Home Point

When dealing with a patient who presents with back pain, it is essential to identify possible risk factors for potentially serious spinal conditions and to ask all of the “red flag” questions to every single patient. A careful history including the patient’s age, cancer history, immunosuppression, drug use, changes in weight, fever, chills, prolonged steroid use, urinary symptoms, recurrent UTI, prolonged pain or pain not

improved with rest, may lead you to consider cancer or infection. A history of trauma or osteoporosis may raise suspicion for spinal fracture. Sudden onset of urinary retention or overflow incontinence, fecal incontinence or decreased rectal tone, constipation, saddle anesthesia, weakness in the lower extremities, or sexual dysfunction are concerning for cauda equina syndrome or severe neurologic compromise, and require an emergent work-up.

The patient in this case study came in believing her pain was associated with a fall 3 weeks prior and attributed some of her abnormal bowel and bladder function to the medication she was using to manage that pain. At first glance, you might agree with the patient and attribute her pain to the recent fall and the constipation to the opiates, but after questioning and physical exam, it was clear that she had serious neurologic clinical findings suggestive of spinal cord compression, and that she would require an immediate referral with an extensive work-up in order to offer the best prognosis. We had the luxury of being able to obtain an immediate MRI, although transfer to an emergency room would have been appropriate. ■

Bibliography

- Cheng EY, Ozerdemoglu RA, Transfeldt EE, Thompson RC. Lumbosacral chordoma: prognostic factors and treatment. *Spine*. 1999; 24(16): 1639.
- Chordoma. Mount Sinai Hospital website. Available at: <http://www.mountsinai.org/patient-care/health-library/diseases-and-conditions/chordoma>. Accessed May 1, 2013.
- Chordoma. Mayo Clinic website. Available at: <http://www.mayoclinic.org/chordoma/>. Accessed May 15, 2013.
- Gardner P, Snyderman C, Malyapa R. Understanding chordoma. Chordoma Foundation Website. Available at: <http://www.chordomafoundation.org/understanding-chordoma/>. Accessed May 15, 2013.
- Ishii K, Chiba K, Watanabe M, et. al. Local recurrence after S2-3 sacrectomy in sacral chordoma: report of four cases. *Journal of Neurosurgery: Spine*. 2002; 97(1): 98-101.
- Sciubba DM, Cheng JJ, Petteys RJ, et. al. Chordoma of the sacrum and vertebral bodies. *The Journal of the American Academy of Orthopaedic Surgeons*, 2009; 17(11) 708-717.
- Walcott BP, Nahed BV, Mohyeldin A, et. al. Chordoma: current concepts, management, and future directions. *The Lancet Oncology*, 2012; 13(2) 69-76.



Treating the Self-Harming Patient in the Urgent Care

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

He watched her walk through the door at the end of a long, busy day. She was an attractive, well dressed, athletic-looking young lady with a warm smile, the kind of girl he'd want his teenage son to date someday.

"Slam dunk," he thought. "This will be a quick visit and I'll still get out on time." The front office team registered her quickly. He suspected that they, too, wanted to get out on time. He followed behind her into the exam room, smiled as he introduced himself, shook her hand and sat down nimbly on the small metal stool which, unbeknownst to him, would become his chair for the next few hours.

Her eyes briefly met his when he shook her hand but then she immediately looked away. "Must be an STD or some other perceived embarrassing issue," he thought as he studied her body language. After a few pleasantries, he inquired about why she was at the urgent care center.

"I'm a cutter," she said in a matter-of-fact way as she pulled up her sleeve, exposing the numerous superficial lacerations on the volar aspect of her left arm. He studied her face for a brief moment and then turned his gaze to her outstretched arm. He noticed multiple old scars as well as some healing wounds and one deeper wound oozing blood. He believed he saw an exposed yet uncut tendon move up and down as she wiggled her fingers. "I think I need a stitch or two," she remarked in a detached, flat tone.

"I suspect you need more help than that," he replied as he continued to exam her hand and arm.

"Why do you do this to yourself? Are you trying to kill yourself?" he asked. "Of course not!" she replied in a tone changing from flat to indignant. "I do it because it helps me and because I want to do it. Now are you going to help me or not? I have a



date tonight and this needs to be fixed."

"I'm sorry to tell you that you are going to miss your date," he said, "I need to send you to the emergency department so that they can evaluate you for suicidal thoughts and get you the help you really need."

Hearing that, she immediately jumped off the examination table where she had been sitting and moved quickly toward the door. He jumped up and tried to bar her from leaving the room but was careful not to grab her or block her exit. He was on unfamiliar turf and he knew it.

"Wait, wait" he pleaded.

She spun around on her toes, and actually stepped toward him and said, "Look, I know I have a problem. I am not trying to kill myself. I just want you to fix this. How is this different from body piercing, or not being compliant with treatment, or taking drugs or even eating food that is not good for you?" Clearly, she had been through this discussion in the past and was well versed in the rhetoric and the logic others used and which apparently failed to persuade her.

"It just is," he said, "Cutting is something you are actually doing, the others are....." his voice trailed off as he searched for the syllogism.

"Exactly" she said. "It's the same thing. Now if you are not



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“There may be an increased risk of suicide in individuals who self-harm but generalizing self-harmers to be suicidal is typically inaccurate.”

going to suture me up, I'm out of here!”

Variations of this discussion and this issue happen daily in urgent care centers across the county. What obligation does a provider have when faced with these murky issues of deliberate self-harm? This article attempts to provide some guidance to clinicians who run into these issues.

On one end of the spectrum are patients who do not follow doctor's advice. These patients don't quit smoking, refuse to take antidepressant medications, take their antihypertensive medications only intermittently or eat food that is not good for them. At the other end are patients who are actively suicidal. Those patients take intentional overdoses, drive a car unrestrained at high speeds into a fixed object or attempt to use a gun or knife to fatally harm themselves.

Somewhere between these extremes are patients like the young lady above who are hurting themselves in a typically non-life-threatening way.

Self-harm (or self-mutilation in older literature) is defined as the intentional, direct injuring of body tissue (skin cutting is the most common form) most often done without suicidal intentions. There may be an increased risk of suicide in individuals who self-harm inasmuch as self-harm is found in 40% to 60% of suicides. However, generalizing self-harmers to be suicidal is typically inaccurate.

Self-harm is often associated with a history of emotional or physical abuse, and is most common in adolescence and young adulthood.

The behavior involves intentional tissue damage that is typically performed without suicidal intent. A common belief regarding self-harm is that it is an attention-seeking behavior. In most cases, however, self-harmers are very self-conscious of their wounds and scars and feel guilty about their behavior, which leads them to go to great lengths to conceal their behavior from others.

People who self-harm are generally not seeking to end their own life. Experts believe instead that they are using self-harm as a coping mechanism to relieve emotional pain or as an at-

tempt to communicate distress.

Thus self-harm is being used as a coping mechanism to provide temporary relief of intense feelings of anxiety, depression, stress, emotional numbness or a sense of failure or self-loathing.

It sounds trite, but a provider's obligation is to simply do the right thing. The right thing in medicine is to always put the patient's interest first. If you determine a patient is harming himself or herself, what obligation do you have as a provider? Initially, it is important to check the patient's competence. Does the patient realize the outcome of his or her actions? For example, if a patient takes a bottle of Tylenol and has no idea about the lethality of Tylenol, is this person competent to understand the potential outcome of his or her actions?

Once you determine that a patient is competent mentally, is he or she legally competent? Has the patient reached the age of majority? Check on your state's statutes; generally in most states, a person who is under the age of 18 or not emancipated is not legally competent.

If a patient is legally and mentally competent, was the intent to commit suicide? If someone shows up at a center of their own volition and denies trying to kill themselves – and you believe them—then you are arguably not obligated to force the patient into some sort of treatment or mandate that the individual be transferred to the ED.

If you do not believe that a patient is actively trying to kill himself or herself, then your next obligation is to treat the injury with which the individual presents. For the young lady above, the provider should repair the wound—after he repairs the lost trust. While repairing the wound, he should offer her some treatment options in a non-judgmental, non-threatening way.

At the end of the day, many people who engage in self-harming activities have been victims of some tragedy and need our empathy and support as opposed to judgment and threats.

If, after talking to a patient, you determine that the individual is, in fact, incompetent or is trying to commit suicide, you are legally and morally obligated to ensure that person's safety and facilitate transfer to the most appropriate place to receive care.

Epilogue: The patient missed her date and the provider and staff went home much later than anticipated. The provider spent about 90 minutes listening to the woman while repairing her wounds. The patient left with a number of options for support and treatment, which the staff found for her simply by searching the Internet. She felt she gained a confidant and possibly a future mentor for a future career in medicine; the provider left the center late that night, thankful that he was fortunate enough to take care of her and re-energized about his avocation. ■



Pulse Oximetry, Oral Medication.

DAVID STERN, MD, CPC

Q. I am reviewing documentation for a freestanding urgent care center that performs pulse oximetry on every patient they see, regardless of the reason. Is this typical? In some cases, they are billing the case rate code, S9083. Please let me know if this is standard operating procedure.

A. Medicare will allow payment for pulse oximetry under two conditions: 1) when it is linked to an appropriate diagnosis code; and 2) if it is considered as being “reasonable and necessary.” Examples of few instances in which you would bill are when a patient exhibits signs or symptoms of respiratory or cardiac dysfunction or when the diagnosis is a cardiopulmonary disease. You would bill CPT code 94760, “Noninvasive ear or pulse oximetry for oxygen saturation; single determination” for a single instance, or CPT code 94761 for multiple determinations when warranted.

If you are billing a case rate code, such as S9083, “Global fee urgent care centers,” you would not bill the code(s) for pulse oximetry unless this was a code that was negotiated for payment in addition to the case-rate payment. ■

Q. Can an urgent care center bill for oral medication such as Ibuprofen or Tylenol when given to a patient at the time of the visit? Also, we purchase emergency inhalers to give to patients seen when pharmacies are closed. Can we charge patients for the inhalers?

A. Typically, payors will not reimburse the expense for oral medication given to a patient even though there are HCPCS codes available for oral medication (e.g., S0119, Ondansetron, S5000, “Prescription generic drug,” S5001, “Prescription brand name drug,” or J8499, “Prescription drug, oral,

“On the subject of dispensing an inhaler, it would be no different than dispensing any other prescription medication. Dispensed prescription medications are generally not reimbursed by payors, unless you have set up an arrangement to essentially bill as a pharmacy to the patient’s prescription insurance plan.”

nonchemotherapeutic, NOS, etc.”). You can bill the patient for medication given in the office as long as the drugs were not samples provided to you by a pharmaceutical company. If you are unsure of a payor’s policy, you should check with the payor in question.

On the subject of dispensing an inhaler, it would be no different than dispensing any other prescription medication. Dispensed prescription medications are generally not reimbursed by payors, unless you have set up an arrangement to essentially bill as a pharmacy to the patient’s prescription insurance plan. There are a few pre-packaged dispensing companies that offer this service. However, reimbursement is minimal and often quite delayed. Thus, most clinics offer this service only on a cash basis.

In the case of an emergency, you would generally treat and bill for aerosolized inhalation treatment. The patient must be stable (i.e., not in need of immediate additional treatments) before discharge. Thus, unless you are in a rare community that does not have a pharmacy with extended hours, you should usually be able to send the patient to a pharmacy to pick up the inhaler. ■



David E. Stern, MD is a certified professional coder and board certified in Internal Medicine. He was a Director on the founding Board of UCAOA and has received the organization’s Lifetime Membership Award. He is CEO of Practice Velocity, LLC (www.practicevelocity.com), PV Billing and NMN Consulting, providers of software, billing and urgent care consulting services. Dr. Stern welcomes your questions about urgent care in general and about coding issues in particular.

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INSIGHTS IN IMAGES

CLINICAL CHALLENGE

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

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

FIGURE 1



The patient, a 47-year-old woman, twisted her left ankle while playing badminton 24 hours ago and was unable to bear weight on the left foot since then. Examination revealed moderate swelling of the lateral malleolus, no bruise, marked tenderness, slight ankle supination, inversion and adduction.

View the image taken (**Figure 1**) and consider what your diagnosis would be.

Resolution of the case is described on the next page.

THE RESOLUTION

FIGURE 2



Diagnosis: The x-ray reveals a horizontal relatively nondisplaced fracture (arrow) of the lateral malleolus below the level of the talar plafond representing a Weber type A fracture or Lauge-Hansen supination adduction Stage I injury. A splint and referral to orthopedics for further management is appropriate for this patient.

Acknowledgement:

Case presented by Xiangyang Jiao, MD, Ohiohealth Urgent Care, Columbus, Ohio.



ABSTRACTS IN URGENT CARE

- Pyuria and nephrolithiasis
- PPIs and CAP
- Antibiotics, NSAIDs for bronchitis
- AAP guidelines for pediatric antibiotics
- Tiotropium vs Salmeterol for asthma

■ SEAN M. McNEELEY, MD

Each Month the Urgent Care College of Physicians (UCCOP) provides a handful of abstracts from or related to urgent care practices or practitioners. Sean McNeeley, MD leads this effort.

Pyuria Poor Predictor of UTI in Nephrolithiasis

Key point: Classic symptoms and urine culture are the best indicators of infection in patients with acute nephrolithiasis. Pyuria proved a poor predictor.

Citation: Abrahamian FM, Krishnadasan A, Mower WR, Moran GJ, Talan DA. Association of pyuria and clinical characteristics with the presence of urinary tract infection among patients with acute nephrolithiasis. *Ann Emerg Med* 2013;62(5):526-533.

Infection can complicate the diagnosis of acute nephrolithiasis. Patients with both a stone and an infection are at much greater risk of complications including sepsis. Having a method to decide who needs antibiotics before a culture grows would both reduce unnecessary administration of antibiotics and delineate those who are at greater risk of complications.

To determine what factors can be used to decide which patients also have a urinary tract infection (UTI), Investigators in California looked at 360 patients with acute nephrolithiasis diagnosed by CT scan without contrast. Of these patients, 8% were found to have UTI by culture. A positive culture was defined as single-organism growth at greater than 10³ colony forming units/mL.

Unfortunately pyuria was a poor predictor of the likelihood of UTI. As with any screening test, the higher the white blood cell (WBC) count, the better the specificity, but sensitivity falls

precipitously. Pyuria defined as a level greater than 5 WBCs/hpf had a sensitivity of 79% and specificity of 81% for UTI, whereas using 20 WBCs/hpf had a sensitivity of 57% and specificity of 94% for UTI. As with all UTIs, a positive nitrate was specific, but not sensitive. Female gender, fever, dysuria and previous UTI all had relative risks approaching or greater than five. ■

PPIs and Risk of Hospitalization for CAP

Key point: Determining why a patient is on an acid suppression medication may help risk stratify those at increased risk of community-acquired pneumonia.

Citation: Filion KB, Chateau D, Targownik LE, et al. Proton pump inhibitors and the risk of hospitalisation for community-acquired pneumonia: Replicated cohort studies with meta-analysis. *Gut*. 2013 Jul 15; [e-pub ahead of print].

Determining if a patient is at increased risk of a disease such as pneumonia may change the tests a physician obtains to diagnose symptoms. Fear of increased risk of pneumonia may also cause a provider not to prescribe medication that may alleviate a patient's symptoms. Observational studies have shown that patients on acid suppression drugs may be at increased risk of community-acquired pneumonia (CAP).

Investigators in Canada tried to determine if acid suppression with a proton pump inhibitor (PPI) or diagnosis of gastroesophageal reflux (GERD) was the determining factor for increased CAP risk. To exclude GERD as the cause, investigators looked at patients placed on PPI for protection against new nonsteroidal use rather than those with GERD. This study was performed in a retrospective fashion on patients older than age 40 who used PPI for more than 28 days. The authors compared 47,000 exposed and 4.3 million unexposed patients over a period of 6 months.



Sean McNeeley is an urgent care practitioner and Network Medical Director at University Hospitals of Cleveland, home of the first fellowship in urgent care medicine. Dr. McNeeley is a founding board member of UCCOP and vice chair of the Board of Certification of Urgent Care Medicine. He also sits on the *JUCM* editorial board.

Neither PPI nor histamine type 2 blockers increased the risk of hospitalized CAP when statistical adjustments were made. Although the study used hospitalized pneumonia as its endpoint, it definitely calls into question whether PPI or the presence of GERD is the true risk factor for the increased risk of pneumonia. Obviously further study is needed, but for now it may help to determine why a patient is taking a PPI when considering risk of pneumonia. ■

Antibiotics, NSAIDs for Bronchitis

Key point: *Amoxicillin, clavulanic acid, and ibuprofen are no better than placebo for bronchitis with colored sputum and may lead to more problems due to greater side effects.*

Citation: Llor C, Moragas A, Bayona C, et al. Efficacy of anti-inflammatory or antibiotic treatment in patients with non-complicated acute bronchitis and discoloured sputum: Randomised placebo controlled trial. *BMJ*. 2013;347:f5762.

For some time, it has been known that most cases of bronchitis are viral and unlikely to respond to antibiotics, yet providers often still prescribe antibiotics on the basis of findings such as colored sputum. Ibuprofen is also a common suggestion for bronchitis. Investigators in Spain attempted to see if either of these prescriptions might hasten recovery from bronchitis.

In a single-blind, trial, 416 participants were randomized to into antibiotics, ibuprofen or placebo. No statistical difference among the groups was found in relation to days with significant cough. Duration was approximately 9 days for the patients in the ibuprofen group, versus 11 days for those on antibiotics or placebo. Of interest, side effects were more prevalent in the antibiotic and ibuprofen arms at 12% and 5%, respectively, compared with 3% for the placebo group. ■

AAP Guidelines for Antibiotics in Childhood Illness

Key point: *Antibiotics in common childhood illnesses should be reserved only for those with strict diagnoses, significant symptoms or prolonged duration according to the American Academy of Pediatrics.*

Citation: Hersh A, Jackson MA, Hicks LA, and the Committee on Infectious Diseases. Principles of Judicious Antibiotic Prescribing for Bacterial Upper Respiratory Tract Infections in Pediatrics. *Pediatrics*. Published online November 18, 2013.

Otitis media, sinusitis and pharyngitis are common complaints in children. According to the authors, antibiotics are given to as many as 1 in 5 patients for a total of 50 million prescriptions per year in the United States alone. This article focuses on up-

per respiratory infections and the diagnoses of otitis media, sinusitis, and pharyngitis. The authors suggest three principles to reduce antibiotic use:

1. Consider likelihood of bacterial cause;
2. Consider benefits versus harms of antibiotic use; and
3. Prescribe judiciously

These principles are then applied to each of the three diagnoses. Otitis media diagnosis requires both effusion and signs of inflammation. The number of patients needed to treat to produce benefit is still four. Amoxicillin is still first-line therapy and in children older than 2, watchful waiting should be considered for mild or unilateral disease.

Sinusitis may be bacterial with worsening, severe or prolonged symptoms (>10 days). Treatment with antibiotics is beneficial only for patients with strictly defined symptoms and once again, amoxicillin is recommended as first-line therapy.

Bacterial (strep) pharyngitis should only be treated when testing is positive. Testing should only be performed on patients with at least two symptoms (fever, tonsillar swelling/exudate, lymphadenopathy, or absence of cough). Benefits include shortened symptom duration and reduced risk of rheumatic disease. Amoxicillin with consideration of once-daily dosing is recommended. ■

Response to Tiotropium vs Salmeterol for Asthma

Key point: *More than one subgroup of asthma may exist and further testing is needed to help determine the best medication to add to inhaled steroids. This study attempts to define the subgroup best treated with tiotropium.*

Citation: Peters SP, Bleecker ER, Kunselman SJ, et al. Predictors of response to tiotropium versus salmeterol in asthmatic adults. *J Allergy Clin Immunol*. 2013; 132(5):1068-1074.e1.

Although inhaled corticosteroids are considered first line for asthma control, several options exist for second-line treatment. The investigators in this study attempted to find a subset of patient who would respond best to a long-acting muscarinic medicine such as tiotropium.

The study was performed in a double blind three-way cross-over manner. Increased inhaled steroids, tiotropium and salmeterol were each tried for 14 week. Morning peak flows were used to evaluate treatment success. The investigators found large numbers of patients who responded to either salmeterol or tiotropium, but not both. Response to albuterol appeared to predict which patients would respond better to tiotropium. The authors themselves stated that further testing to replicate their findings is needed before tiotropium is used prior to a trial of a long-acting beta agonist. ■



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For more information about this position and to be considered for this opportunity, please apply online at www.johnmuirhealth.com/for-physicians or contact Lindsey Stewart at P: (925) 952-2881, E: Lindsey.Stewart@JohnMuirHealth.com.

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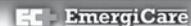
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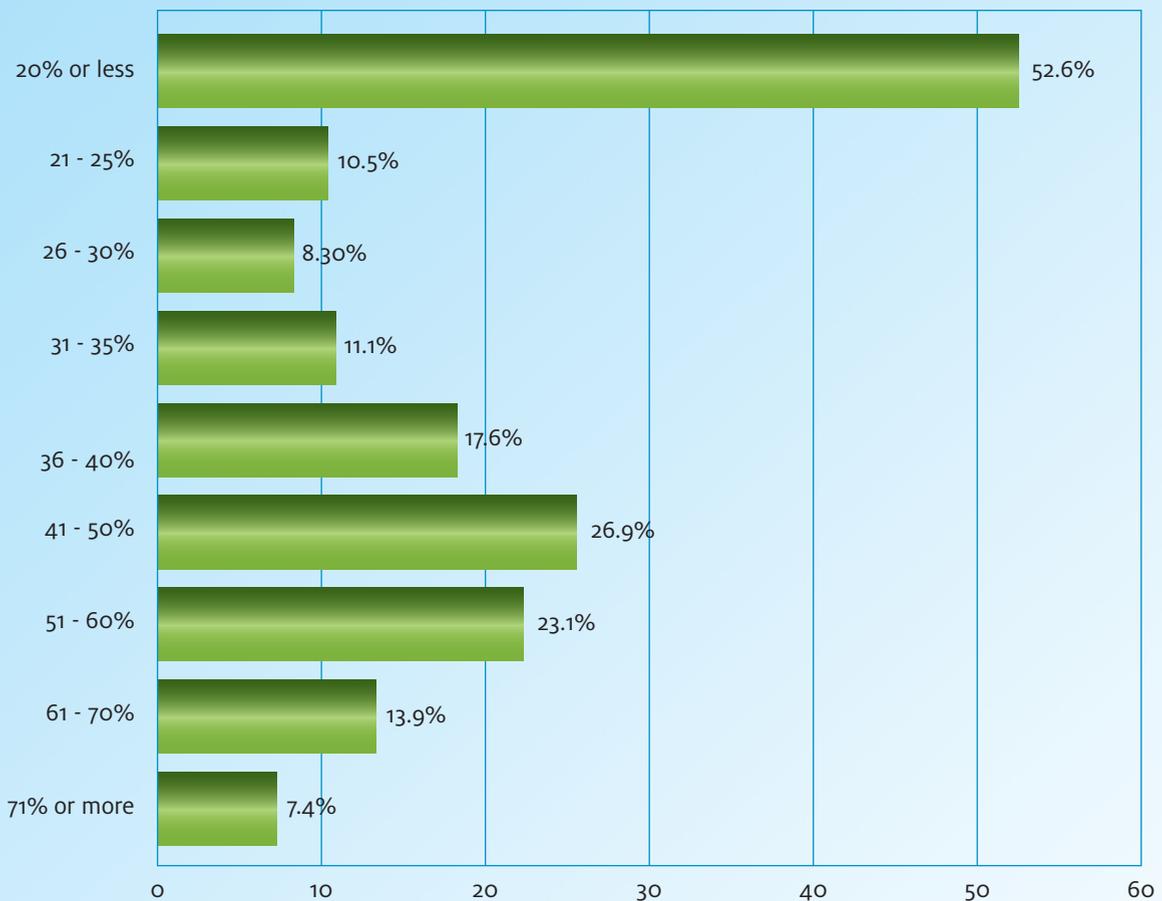


DEVELOPING DATA

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 Percentage of Patients Consider an Urgent Care Center Their “Medical Home”?

PERCENTAGE OF PATIENTS WHO CONSIDER CENTER THEIR "MEDICAL HOME"



On average, centers report that 25.1% of their patients consider that center their “medical home.” This correlates somewhat with the statistics published in the January issue, which indicate that a group of approximately 20% of urgent care patients use urgent care “in place of” having a primary care physician.

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.



The Urgent Care Association of America (UCAOA) will be recognizing its 10-year anniversary and celebrating urgent care throughout 2014. Help commemorate this special year by joining us at the National Urgent Care Convention!

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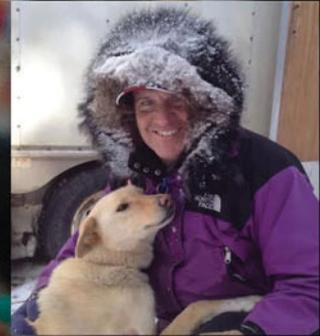
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