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MEDICINE

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PEDIATRIC URGENT CARE

You Could Be a Transgender Adolescent's Best Hope for Excellent Care—if You're Prepared



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Stepping Outside Yourself



Until recently, I've had the rare luxury of working in busy urgent care centers where I was virtually always working side-by-side with another provider. However, with changes in my career and UC staffing models in the wake of the pandemic, I find myself working in single coverage situations the majority of the time nowadays. While I do miss the camaraderie of multi-coverage practice, I miss the unfettered access to a second clinician's brain the most.

Have you ever found yourself caring for a patient and uncertain about what the best thing to do was? As clinicians we find ourselves facing such dilemmas every shift. The landscape of medical decision-making in urgent care is endlessly treacherous in its complexity and is studded with the various landmines of hidden bias and cognitive traps. There are, however, simple strategies we can use to protect ourselves from these pitfalls.

Asking for advice and input from other clinicians is often the default response to situations where we are unsure of how to proceed. We have a patient with an issue germane to a specialty outside our own, we call a consultant. We need a second opinion on a patient within our specialty, we curbside a colleague. They can often give us dispassionate, objective advice about what we should do given the situation.

How are they able to be so objective? The answer is simple: distance. They don't know the patient and weren't affected by the interpersonal dynamics of the interaction. They simply know the salient facts of the case. This distance limits many sources of bias that can arise from being the person who greeted, interviewed, and examined the patient. Conversely, we are at greater risk of many types of cognitive errors the closer we are to the patient. And when you're caring for the patient directly, you're about as close as you can get.

So, why not just present every case to another doctor or clinician like a resident or trainee might? This is an excellent option when the circumstances allow for it. In fact, this method has been studied specifically with compelling results. A group of French researchers found that emergency physicians who presented their cases to colleagues made a remarkable 40% fewer errors than those who went it alone.¹ So, yes, by all means, present patients to your colleagues as often as is prac-

tical. Take advantage of the insights which can only manifest among those with the luxury of distance from the case when they are willing to share their time and thoughts.

However, on most shifts, this is simply not practical or even possible. Many of us work in single coverage situations or are physically isolated from our colleagues. Even if you have other physicians working around you, the pace of patient care rarely allows for two clinicians to both stop what they are doing and take 5–10 minutes to discuss a patient's presentation.

But what if we could achieve this distance (and consequently improved objectivity) without having to rope a coworker into listening to us? Turns out we can through the use of a technique psychologists call *self-distancing*. Self-distancing refers to the process of creating psychological distance from your own subjective experiences. Numerous studies have shown that rational decision-making improves with greater self-distancing.^{2,3}

Achieving self-distancing can be done through a variety of simple mechanisms, but most center around the use of language. For example, a 2012 article in *Psychological Science* references a series of studies demonstrating that multilingual people can make better decisions when they hear the same problem stated in multiple languages.⁴ And if you do happen to speak more than one language, there's no reason this technique couldn't be used to create psychological distance when you're stuck on a case. This creation of distance is predicted by Construal Theory, which suggests that distance in one domain (eg, language) creates distance in other domains (eg, more holistic perspective).

When considering linguistics, a more universally practical strategy, however, involves simply changing the point of view when telling the patient's story. A number of social psychology studies have demonstrated that the perspective of self-talk matters. Self-distancing can be effectively achieved, therefore, by simply switching from the first person (ie, I and me) to the second (ie, you) or third person (ie, she, he etc.).⁵ So rather than presenting the patient to a colleague, you simply change the pronouns and present the patient to yourself.

I know this might seem a bit odd at first, but it's actually elegant in its simplicity and power. Rather than thinking to yourself, "I don't know what to do with this dizzy 64-year-old woman," say to yourself, "You're seeing a 64-year-old woman who presented with dizziness that resolved. Her vital signs are

normal. You've checked her neuro exam and an EKG. What does that still leave on your differential?"

By self-distancing, you will be able to get a more objective assessment of how high-risk the patient is. But if you're a bit too self-conscious to actually talk to yourself in front of your staff, there's another powerful tool for creating psychological distance we can use. In fact, we all spend at least 1/3 of our time using it on any given shift already; I'm speaking of our documentation. Many of us understandably look at our charting obligation as a nuisance; however, this attitude causes us to miss the opportunity the EMR provides in forcing us to consider the patient's presentation from a different perspective. By converting our thoughts from nebulous internal chatter rattling around our noggin into an organized written narrative, we give the patient's story form. In charting, we are compelled to observe our thoughts from an outside vantage point as they are splayed out on the virtual page. Psychological distance has been created.

Imagine you are caring for a young, otherwise healthy woman with a fever. You collect her history and sit down to quickly start her chart while you have her story fresh in your mind: "3 days of subjective fevers, body aches, intermittent headache, abdominal cramps." As you type and reread her

HPI, you realize you forgot to ask about associated diarrhea, travel, and vaccination history. She was well-appearing, but her answers to some of these questions might significantly alter your risk assessment. As these questions arise, you realize you need to collect more history and that you may need to order more than just the urinalysis and COVID swab you were initially planning.

So, whether it be through more intentional use of the medical record, presenting patients to yourself, or both, consider self-distancing on your next shift. You may find that much of the insights arising from objectivity that you've been seeking were within you all along. ■

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PEDIATRIC URGENT CARE

27 Approach to the Transgender Adolescent and Specific Health Considerations

It's common for transgender patients to have a history of bad experiences with healthcare providers. This may be especially true of adolescents. Urgent care could offer a chance to turn that phenomenon around, though—if you're aware of the challenges specific to this patient population.

Timothy McGinnis and Emily Montgomery, MD

CLINICAL

13 Urgent Care Management of Lacerations in the Elderly Patient



Elderly skin is fragile, and repairing it requires a different approach compared with how you would manage lacerations in younger patients.

Oscar D. Almeida, Jr., MD, FACOG, FACS and Amy Hunter, DNP, FNP-BC, MSN-RN

CASE REPORT

17 Atypical Skin Abscess Caused by Nontuberculous *Mycobacterium*



Cutaneous abscesses are common presentations in urgent care. Most can be attributed to *Staphylococcus aureus*—but you need to be equally prepared for the minority stemming from atypical organisms such as nontuberculous *Mycobacteria*.

Rachel Hughes, MD and Erik Butler, DO

PRACTICE MANAGEMENT

21 Thinking About Buying or Selling an Urgent Care Center?



Urgent care is a hot commodity in the healthcare business world these days. If this strikes you as the right time to enter or exit the market as an owner, you'll need to be keenly aware of how the COVID-19 pandemic has led to changes in how deals are evaluated and structured.

Alan A. Ayers, MBA, MAcc

CASE REPORT

33 Reoccurring Metatarsophalangeal Joint Pain



Several diagnoses—each with its own indicated course of action—can have similar presentation on history and exam. Foot pain is a key example.

Sergio P. Ramoa, MD, MS

ORIGINAL RESEARCH

39 COVID-19 Testing Pattern in a Suburban Pediatric Urgent Care Center



Children have suffered significant disruptions to educational and personal activities thanks to COVID-19. Recognizing urgent care's role in testing for the virus could show benefit for families and urgent care centers alike moving forward.

Rita P. Nunag, MD; Francesca M. Darquea, MD; Claire Loiseau; and Magdy W. Attia, MD

NEXT MONTH IN JUCM

One of the many things we've learned during the COVID-19 pandemic is that inequities in delivery of healthcare persist in the United States. How much of an issue is this likely to be in urgent care, specifically, though? Read Use of a Quality Improvement Tool for the Evaluation of Healthcare Disparities in Urgent Care: A Case Example for Bacterial Pneumonia, an original research paper, in our January issue to find out.

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Adolescence can be notoriously difficult to navigate. With social structures, scholastic settings, and bodies (and voices) changing over the course of several years, kids can have a hard time figuring out where they fit in.

Now replace the “typical” adolescent you had in your mind’s eye with one who is transgender. Things just got more complicated, didn’t they?

This month’s cover article, Approach to the Transgender Adolescent and Specific Health Considerations (page 27), by **Timothy McGinnis** and **Emily J. Montgomery, MD, MHPE, FAAP** from the University of Kansas School of Medicine, uses the case of a 15-year-old transgender male who presents with abdominal pain as the starting point of a discussion on the particular challenges for adolescent patients who are transgender, and for the healthcare providers they encounter. This is particularly germane to the urgent care setting because such patients may be less likely to have an ongoing clinical relationship with a provider they trust than other kids their age would.

In addition to her affiliation with the University of Kansas, where she is clinical assistant professor of pediatrics, Dr. Montgomery is clinical assistant professor of pediatrics at the University of Missouri-Kansas City School of Medicine. She practices at Children’s Mercy Kansas City.

At the other end of the spectrum, age-wise, the care of elderly patients who present to urgent care can also be vexing, especially when it comes to repairing their fragile skin.

As explained in Urgent Care Management of Lacerations in the Elderly Patient (page 13), an older patient’s skin lacerations require a different approach than you might use in younger patients. We appreciate **Oscar D. Almeida, Jr., MD, FACOG, FACS**, Urgent Medicare Center, in Huntsville, AL and **Amy Hunter, DNP, FNP-BC, MSN-RN**, University of Alabama in Huntsville and Urgent Medicare in Huntsville, AL for addressing this topic.

Of course, the fact that skin repair is a challenge in older patients doesn’t mean younger adult patients can’t present with dermatologically challenging cases. One is addressed in this month’s case report, Atypical Skin Abscess Caused by Nontuberculous *Mycobacterium* (page 17), by **Rachel Hughes, MD** and **Erik Butler, DO**, both from the University of North Carolina School of Medicine Department of Family Medicine. As with any atypical presentation, you’ll see that the typical approach just won’t do sometimes.

The same goes for disease prevention, as well. Children have generally been considered to be at lower risk for severe disease with COVID-19. There are exceptions, however, and even children who really won’t suffer tremendously even if

they’re infected can pass along the virus with deadly consequences. As such, testing is just as important as it is on non-pediatric patients. So, we’re happy to publish COVID-19 Testing Pattern in a Suburban Pediatric Urgent Care Center (page 39), which recognizes the vital role urgent care plays in testing. The authors, **Rita P. Nunag, MD, Francesca M. Darquea, MD, Claire Loiselle, and Magdy W. Attia, MD** are colleagues at Nemours Children’s Hospital in Wilmington, DE. Dr. Nunag also practices at PM Pediatrics in Wayne, PA and Dr. Darquea at Tricounty Pediatrics in Abington, PA. Dr. Attia is also affiliated with Sidney Kimmel Medical College at Thomas Jefferson University in Philadelphia.

Just as many segments of the general public continue to realize the value of urgent care at such chaotic times, various entities are discovering the value of urgent care operations as business propositions. So, we’re grateful to **Alan A. Ayers, MBA, MAcc** for penning an article called Thinking About Buying or Selling an Urgent Care Center? (page 21), which looks at how variability in urgent care volume attributable to COVID-19 may be changing how mergers and acquisitions are evaluated and structured. Mr. Ayers is president of Experity Networks and senior editor, practice management of *The Journal of Urgent Care Medicine*.

Another change in conditions that have a direct impact on the viability of your operation—specifically, the Medicare Physician Fee Schedule (MPFS) Final Rule issued by the Centers for Medicare & Medicaid Services on November 2—is addressed in **Monte Sandler’s** latest Revenue Cycle Management column starting on page 54. Mr. Sandler is executive vice president of Experity.

Finally, in this issue, **Nathan M. Finnerty, MD FACEP** and **Brett C. Ebeling, MD** help us keep up to date on articles published elsewhere, covering the question of whether high blood pressure readings in an acute care setting really need to be addressed; whether it’s appropriate to employ sucralfate in pediatric oral ulcers; the question of whether it’s safe to use oral corticosteroid bursts in children; and other topics. Dr. Finnerty practices in the Department of Emergency Medicine at Intermountain Medical Center in Salt Lake City, UT; is assistant professor of emergency medicine, adjunct in the Department of Emergency Medicine at Wexner Medical Center at The Ohio State University; and is contributing medical editor, Urgent Care Reviews and Perspectives, Hippo Education. Dr. Ebeling practices in the Department of Emergency Medicine at Genesis Healthcare System in Zanesville, OH and is contributing medical editor, Urgent Care Reviews and Perspectives, Hippo Education. Abstracts in Urgent Care begins on page 44.

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In every issue of *JUCM*, there are select articles on which we ask members of our peer review panel to comment. It's one step we take in trying to ensure that all the content we publish is relevant, clearly communicated, and free of bias. For their contributions in reviewing content for the September, October, November, and December issues, we thank:

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teering to serve as a peer reviewer, too. Just send an email, including your CV, to editor@jucm.com.

Notice of Retraction

It has been brought to our attention that the publication titled "An Urgent Care Approach to Fishhook Removal" originally published in the June 2021 print edition of *The Journal of Urgent Care Medicine* on June 1, 2021 ("Publication"), contains several changes made during the editing process performed by *JUCM* which the authors took issue with and subsequently demanded the Publication be retracted. Accordingly, at the request of the authors, Anthony G. Stanley, MD and Jorge Murillo, MD, we have fully retracted the Publication. ■

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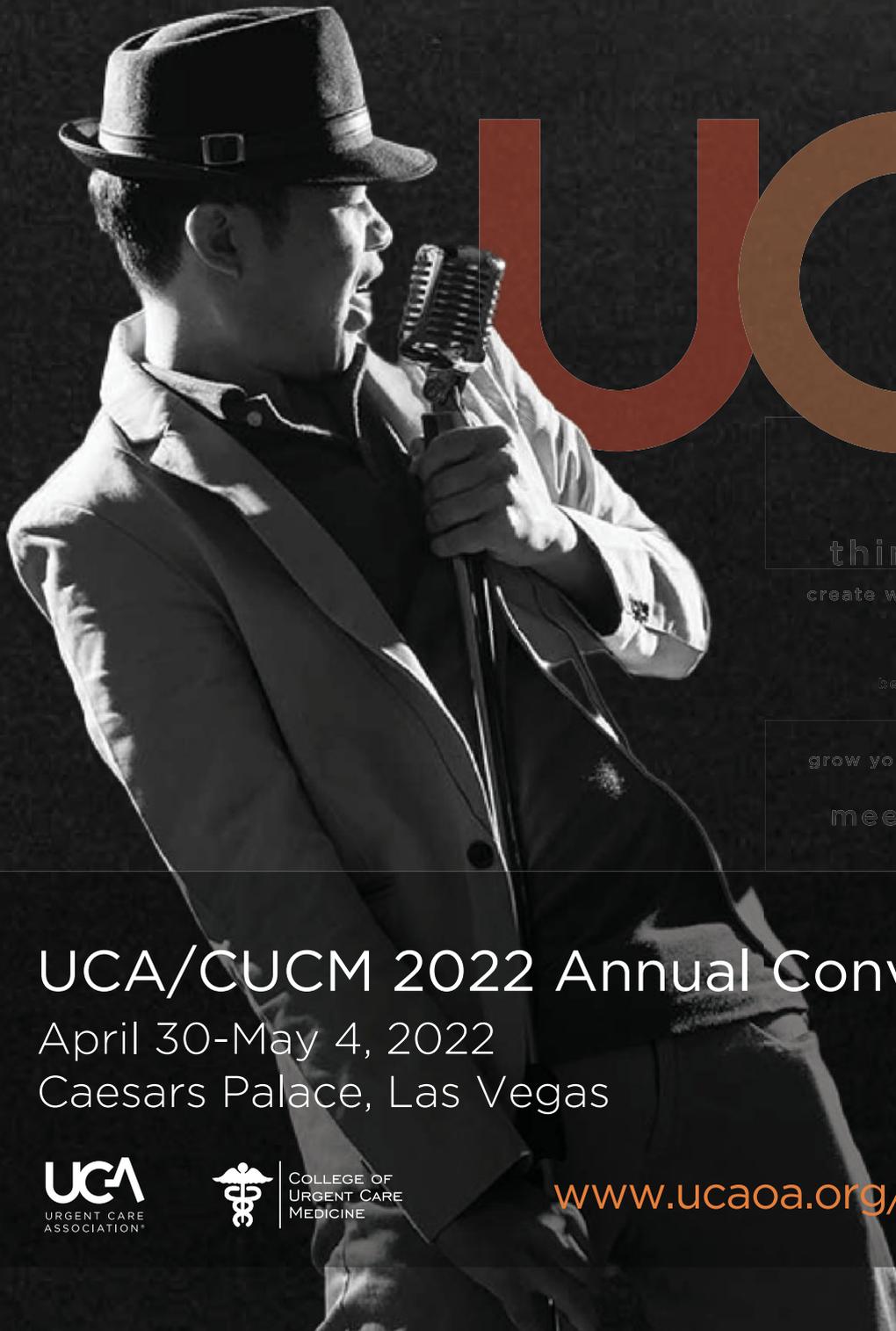
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Let's Get this Party Started

■ LOU ELLEN HORWITZ, MA

This time last year all we could talk about was the “twindemic” and whether it was coming or not. The ache for normalcy was pervasive, and though a twindemic did not materialize in 2020, the Delta variant was headed our way and we didn't even know it. We were so focused on driving volume for so long, and it seems so laughable today. Normalcy has a new definition.

What people tell me they are worrying about today is staffing shortages and burnout, patient anger to the point of violence, and the big glowing eye of the payer community swiveling towards urgent care. When we said we wanted to stand up and be recognized for our extraordinary contributions to healthcare, *more* downward pressure is not what we hoped for.

Trends we are hearing about include a move away from global rates (which were great for the payers when we did high acuity for moderate payment but lately we've done a lot of low acuity for moderate payment...so much for letting things “balance out over time”), and tiered payment structures that cut lower acuity by huge percentages (visit the North East Regional Urgent Care Association chapter's website at www.ne-ruca.org to learn more). Though we certainly don't and can't support collusion, we hope you are individually finding the strength in your negotiations to own the tremendous role you have played, are playing, and should play in your communities—and standing up for the critical importance of the scope of care that you provide.

And where will the patients go if not to us? We (and they) know the answer, and it doesn't seem to be telemedicine. Nothing against telemedicine—it's fantastic for the right things and urgent care has done a wonderful job integrating digital front doors, but there's a reason people talk about “healing hands”—it's the same reason patients want face-to-face when they are really sick or injured.

We are also not high cost. One study paid for by an emer-

gency medicine foundation using highly selective data does not prove that we are—no matter where the researchers went to school or how esteemed the publication is. Payers know this because they have their own data! We are also not sites of tremendous inefficiencies and waste. We are rightfully known for our efficiencies and ingenuity (hello...pandemic response), so they may as well stop squeezing us and look elsewhere. Let's all be sure we remind them of that at every opportunity.

Now About that Party

I know from the title of this column that there's a party in here somewhere, and I'll tell you where it is—it's in Las Vegas. Take a moment and close your eyes and remember what it feels like to be in a huge ballroom room filled with hundreds and hundreds of people who understand you. People who have been you. People who truly want to help you. People willing to share without agenda. People who have the answers you need—or at the very least can sympathize with your struggle or commiserate with your frustration.

Remember what it feels like to sit in a classroom and hear from people more knowledgeable than you. Remember what it feels like to share your own successes and receive the heartfelt thankfulness of a colleague who needed to know their dream was possible. Remember what likemindedness and affirmation feels like. Remember how it feels to have validation that your ideas are correct, your hunches are dead on, your suspicions are not crazy, your hopes are possible.

Remember what it's like to walk into an exhibit hall with hundreds of vendors who understand urgent care and might have the perfect solution for you. Remember that out of those hundreds of vendors, some have become friends and can't wait to show you their new thing. Remember how fun it is to round a corner in the middle of that huge hall and run into that very person you were hoping to meet. Remember the serendipity of getting some true face time with the right group. There's absolutely nothing like the UCA Annual Convention.

Let's do it again, shall we? (We'll have some supremely cool new things to share with you, too!) Registration opened December 1. I truly, truly cannot wait to see you all. ■



Lou Ellen Horwitz, MA is the chief executive officer of the Urgent Care Association.



CONTINUING MEDICAL EDUCATION

Release Date: December 1, 2021
Expiration Date: November 30, 2022

Target Audience

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

Learning Objectives

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

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

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

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CONTINUING MEDICAL EDUCATION

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Urgent Care Management of Lacerations in the Elderly Patient (page 13)

- 1. Why should x-rays be considered in patients with lacerations?**
 - a. To look for an incidental finding of a bone tumor
 - b. Even with minor trauma and no pain with palpation, an elderly patient may have a comminuted long bone fracture
 - c. To increase billing
 - d. Elderly patients may have osteoporosis, which makes them more vulnerable to fractures
- 2. The normal aging process by which the junction where the papillae bond the epidermis and dermis thins out results in:**
 - a. Increased susceptibility to injury from friction and shear
 - b. Decreased susceptibility to infection
 - c. Increased susceptibility to infection
 - d. Ease of suturing
- 3. Which of the following is important for repairing skin tears in elderly patients?**
 - a. Cleansing and suturing technique
 - b. Tissue adhesive technique
 - c. Ensuring the last tetanus injection has been given within 10 years
 - d. All of the above

Atypical Skin Abscess Caused by Nontuberculous *Mycobacterium chelonae* (page 17)

- 1. *Mycobacterium chelonae* is which of the following?**
 - a. Motile spore forming
 - b. Gram-negative
 - c. Fungal
 - d. Non-motile, non-spore-forming, gram-positive, acid-fast bacillus
- 2. Which group of patients may be colonized with *M chelonae*?**
 - a. Athletes
 - b. Healthy 20-year-olds
 - c. Patients with cystic fibrosis
 - d. Infants
- 3. The American Thoracic Society and Infectious Diseases Society of America recommend an oral macrolide combined with which of the following in patients with cutaneous infection with *M chelonae* and NTM?**
 - a. Amikacin
 - b. Cefoxitin
 - c. Imipenem-cilastatin
 - d. All of the above

Thinking About Buying or Selling an Urgent Care Center? (page 21)

- 1. Valuation of an urgent care operation can be based on which of the following?**
 - a. Assets
 - b. Earnings
 - c. Assets or earnings
 - d. Prospective growth in revenue
- 2. An “earn-out” stipulates that the seller will be paid out over a period of time, subject to:**
 - a. Compliance with noncompete and nondisclosure agreements
 - b. Achieving a certain level of performance
 - c. Reassessment of the value of the business at a predetermined date
 - d. All of the above
- 3. High revenue growth from which of the following factors is helping to drive merger and acquisition activity in urgent care?**
 - a. Healthcare reforms
 - b. Growing acceptance of urgent care by payers
 - c. Rising consumer demand
 - d. All of the above

Reoccurring Metatarsophalangeal Joint Pain (page 33)

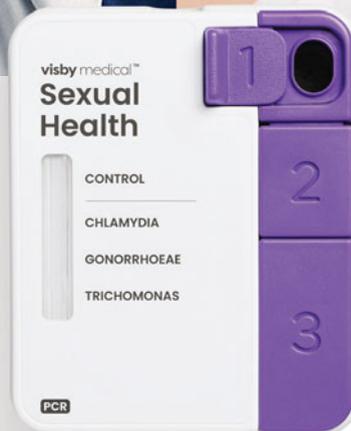
- 1. Due to numerous pathologies of the hallux, possible diagnoses are not always straightforward, even with an appropriate history gathered. In such cases, it is important to gather information on:**
 - a. Other daily activities
 - b. Footwear
 - c. Previously attempted treatments
 - d. All of the above
- 2. With normal walking, the ligament complex can bear up to 60% of the body weight, but increase:**
 - a. Up to 3 times for athletic activity, and up to 8 times for running jumps
 - b. Up to 8 times for athletic activity, and up to 3 times for running jumps
 - c. Sixfold
 - d. Insignificantly
- 3. Management of Class 2 turf toe entails:**
 - a. Symptomatic treatment and return to play as tolerated
 - b. 4-6 weeks of healing
 - c. 4-8 weeks of immobilization in a walking cast or CAM boot
 - d. Surgical intervention

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Urgent Care Management of Lacerations in the Elderly Patient

Urgent message: Fragile skin lacerations in geriatric patients require a different repair strategy compared with those in younger patients. Despite the increased complexity of their wounds, however, most elderly patients with lacerations can be appropriately managed in the urgent care center.

OSCAR D. ALMEIDA, JR., MD, FACOG, FACS and AMY HUNTER, DNP, FNP-BC, MSN-RN

Citation: Almeida OD, Hunter A. Urgent care management of lacerations in the elderly patient. *J Urgent Care Med.* 2021;16(3):13-16.

Introduction

Skin tears form a subcategory of traumatic lacerations frequently affecting older adults. A study that searched Medline and Cochrane Reviews found that patients over 65 years accounted for 88.2% of skin tears, with 41.3% reported in the 75- to 84-year-old group.¹ Falls in this patient demographic account for a significant number of lacerations: 60% occur in the home, 30% outside the home, and 10% in an assisted health-care center such as a hospital, clinic, or nursing/rehabilitation facility. Although falling is not considered a normal part of the aging process, there are age-related changes that may place older adults at a greater risk.² Interestingly, individuals 65 years of age or older were found to have a 27% annual probability of falling.³ This age group represents 15.2% of the population, approximately one in every seven Americans.⁴

In the geriatric population, even a minor injury may cause a skin tear. These traumatic lesions usually result from friction or blunt trauma on fragile skin. Additional risk factors include problems with mobility and balance, alterations in cognitive status, and visual impairment. Patients on anticoagulant therapy and those with comorbidities such as diabetes and peripheral vascular disease may suffer delayed wound healing and secondary infections.



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As we age, collagen and hyaluronic acid production decrease, progressively making our skin thinner. The loss of dermal thickness and subcutaneous fat, in a setting with sufficient force against fragile skin, may produce skin-tearing injuries. Although a skin tear can occur on any anatomical location, they are often sustained on the extremities. The pretibial and forearm/dorsal aspect of the hands are common sites for these injuries.

Unfortunately, due to skin fragility, some skin tears

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Table 1. STAR (Skin Tear Audit Research) System ⁴	
Category 1a	The edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap color is not pale, dusky, or darkened
Category 1b	The edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap color is pale, dusky, or darkened
Category 2a	The edges cannot be realigned to the normal anatomical position and the skin or flap color is not pale, dusky, or darkened
Category 2b	The edges cannot be realigned to the normal anatomical position and the skin or flap color is pale, dusky, or darkened
Category 3	The skin flap is completely absent

are not amenable to repair using standard suture or tissue adhesive techniques. Clinically, skin tears may be classified according to the STAR (Skin Tear Audit Research) system (Table 1).⁵ The usefulness of this instrument is twofold: first, to describe and document the degree of epidermal loss and state of the remaining epidermal tissue of a particular wound; second, to assist the healthcare provider with the treatment plan depending on the extent of the acute lesion. For example, a Category 1a skin tear, although having a fragile thin skin flap, can often be repaired by employing a Steri-Strips-and-suture or skin adhesive techniques, whereas a Category 3 skin tear where the skin flap is completely absent will heal by secondary intention.

Strategies For Skin Tear Repair

Due to aging, the junction where the papillae bond the epidermis and dermis thins out, resulting in less cohesiveness of the two layers of the skin. This normal physiologic process leads to increased susceptibility to injury from friction and shear. Elderly patients with skin tears, especially the critically or chronically ill, may develop secondary wound infections. Any strategy that minimizes the possibility of infection and delayed wound healing is paramount for a successful outcome. Therefore, management of these lesions should include the use of aseptic technique.⁶

Prophylactic antibiotic therapy may be considered, and a tetanus toxoid vaccine administered if the patient has not received one in the past 10 years.

Since elderly patients have a degree of osteoporosis which places them at an increased risk of fractures, x-rays should be obtained as the patient may have simultaneously sustained a fracture.

Finally, these injuries may be the result of an underlying condition such as loss of equilibrium, visual impairment, or cognitive changes and must be investigated.

Cleansing-and-Suture Technique

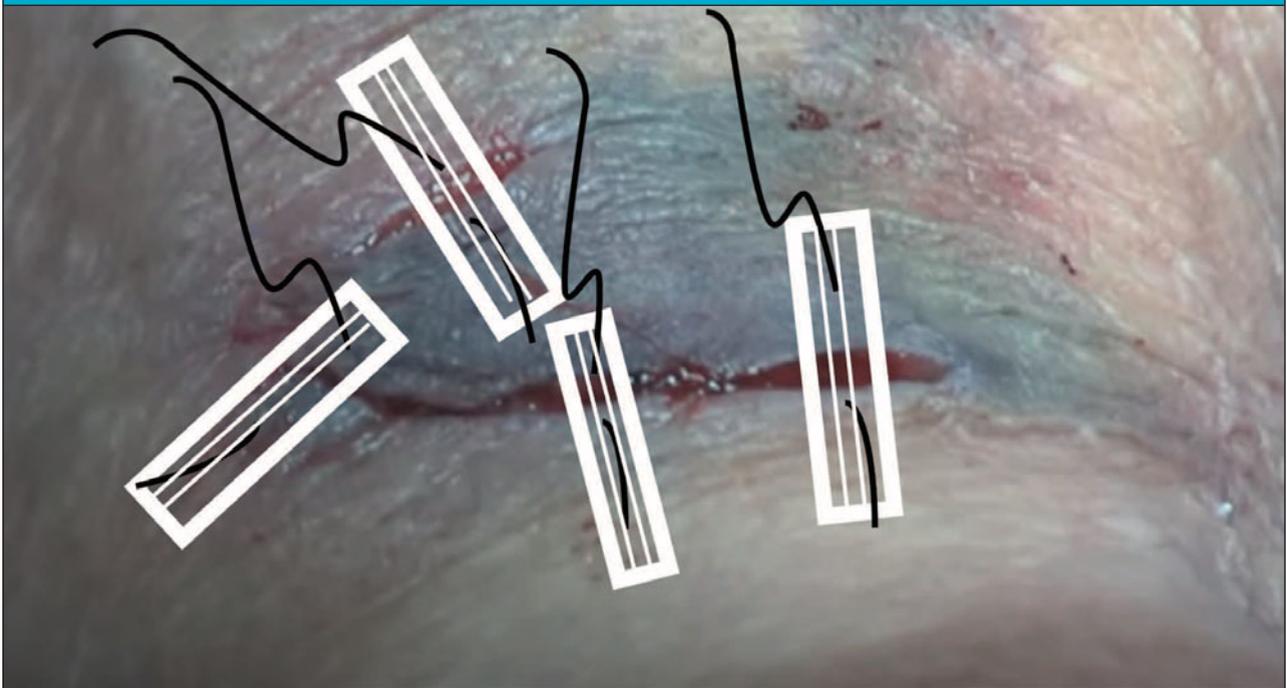
The first step in repairing a skin tear is to gently cleanse the wound with soap and water in order to achieve dilution of the microbial load. Although sterile water or isotonic saline may be used, tap water has been evaluated and found to be safe for wound cleansing. Since many elderly patients are on anticoagulant therapy, applying pressure alone over the wound may not stop the bleeding. Topical LET gel (lidocaine 4%, epinephrine 1:2000, tetracaine 0.5%) provides a safe and cost-effective adjunct for hemostasis and analgesia in these circumstances.⁷

After an initial wound assessment, including classification of the skin tear, appropriate debridement is undertaken. If hemostasis cannot be achieved by pressure alone, apply 1–3 mL of LET gel directly on the wound and cover the lesion with waterproof dressing (eg, Tegaderm) for 15–30 minutes. Although several hemostatic agents are available to stop/slow down bleeding, they are more expensive and not as readily available in the urgent care clinics. When hemostasis is achieved, carefully remove the dressing.

Unlike a younger patient's skin whose thicker dermis can tolerate the increased tensile strength of sutures, fragile skin in geriatric patients usually cannot withstand a typical laceration repair. Placing sutures in the friable skin of an elderly patient may create a "suture drag" or "cheese-wire" effect as the suture under tension will often tear through the skin. This iatrogenic skin damage will increase morbidity and delay wound healing.

Applying Steri-Strips over the skin tear in an elderly patient functions as an added layer of skin, allowing suturing and withstand increased tension. Figure 1 illustrates how a skin tear flap can be properly repaired following the strategic placement of Steri-Strips and suture. Additionally, using 4-0 nylon suture in a single interrupted fashion provides optimal tensile strength for the repair.

Figure 1.



STAR Category 1b skin tear flap with edges realigned to the normal anatomical position. Note the drawing of Steri-Strips and suture placement.

“Utilization of the STAR system provides the clinician with an evidenced-based tool that supports decision-making on wound repair and/or closure as well as providing a documentation system that can be useful when tracking wound healing progress over an extended period of time.”

Skin tears that cannot be realigned to the normal anatomical position due to partial absence of the skin flap (Category 2a, 2b) may be partially repaired with Steri-Strips and suture or tissue adhesives and depend on the remainder of healing by secondary intention.

Complete skin tears (Category 3) must rely entirely on healing by secondary intention. Skin tears usually follow a 7- to 14-day course for healing. Once the wound is healed and sutures removed, gently take off the Steri-Strips. Examine the healed wound carefully for any signs of infection that may have been obscured.

Tissue Adhesives Technique

Tissue adhesives provide another treatment option for repairing fragile skin tears in small superficial lacerations. When the “surgical glue” is applied to an epidermal flap, it forms a strong bond across apposed wound edges, allowing normal healing to occur. The tissue adhesive forms a “scab” when applied and falls off after 5 to 10 days. Irregular-shaped skin tears do well with tissue adhesives as they can be approximated to the underlying dermis and surrounding epidermis. This is especially useful in shredded thinner-width skin tears when suturing is not feasible due to a smaller horizontal width section of the epidermal flap.

In order for the tissue adhesive to adhere properly, the epidermal tissue must be dry and without bleeding. Generally, at least three applications of the tissue adhesive are necessary for an optimum repair.

Advantages of tissue adhesives include decreased procedure time because of its quick spread over the tissues, lack of sutures/subsequent suture removal, pain-free application, and providing a water-resistant protective coating. Contraindications for using tissue adhesives include repair of tissues requiring sutures to

achieve increased tensile strength, deep and crush wounds, and infected lacerations.

Unna Boot Technique

Skin tears in the lower extremity of geriatric patients, if neglected or improperly treated, can progress to a venous leg ulcer (VLU). The Unna boot was developed by the German dermatologist Paul Gerson Unna using a zinc paste to treat dermatitis associated with VLUs by producing high counter-pressure during ambulating and a low resting pressure.

The Unna boot is a prepackaged gauze bandage soaked with zinc oxide. Zinc oxide keeps the wound moist and expedites the healing process. Once the Unna boot is applied by wrapping the foot, ankle, and lower leg to just below the knee, it is covered with an outer wrap (Ace wrap or Coban) and must be changed every 3–7 days.

Although not intended for exercise, you can walk with the Unna boot.

Contraindications for using the Unna boot include acute pulmonary edema, cellulitis, deep vein thrombosis, arterial insufficiency, infected venous ulcers, and phlebitis.

Prophylactic Measure to Enhance Skin Thickness in the At-Risk Elderly Patient

As stated earlier, thinner skin places elderly patients at higher risk for a more cumbersome healing process in the event of traumatic lacerations. Regular skin application of 12% ammonium lactate lotion⁸ in at-risk areas such as the pretibial, forearm, and dorsal aspects of the hand increases the thickness of the epidermis and dermis. This effect enhances tensile strength, allowing for suture placement in these delicate skin areas.

Pearls

- Achieve hemostasis prior to closing the skin tear.
- Practice aseptic technique in order to minimize the risk of secondary infections.
- Document the STAR system category to communicate the degree of skin tear with the healthcare providers involved in the patient's care.
- Consider using the Unna boot technique when continued lower extremity pressure over a wound ulcer may be beneficial.
- Application of 12% ammonium lactate solution in at-risk skin areas will increase the thickness of the epidermis and dermis.
- Investigate and address the underlying condition that led to the injury in the elderly patient.

Conclusion

Older adults are considered one of the most vulnerable populations to care for in an urgent care setting. The increased prevalence of chronic wounds due to loss of skin elasticity as well as episodic acute injuries resulting in wounds can greatly affect the quality of life in the elderly. Normal changes that occur during the aging process in combination with multiple comorbidities, chronic medical conditions, multiple medications, and slowed wound healing make early recognition and proper knowledge and treatment of laceration and wounds imperative. Delayed, inadequate, or incorrect wound treatment and repair can lead to negative outcomes for older adults, such as secondary infection, skin ulceration, and in extreme cases amputation.

Utilization of the STAR system provides the clinician with an evidenced-based tool that supports decision-making on wound repair and/or closure as well as providing a documentation system that can be useful when tracking wound healing progress over an extended period of time. Once a wound-closure method is chosen, achieving hemostasis and practicing proper aseptic technique are standards of clinical practice. Knowledge and empathy of older adults combined with pathophysiology and psychology of aging are also essential skills in wound and laceration care.

By utilizing the strategies discussed here for skin assessment, wound repair, and documentation, urgent care clinicians can feel confident in their knowledge and skill to achieve optimal outcomes for older adults in the event of acute or chronic skin injury. The clinical pearls are of great value in an urgent care environment when caring for older adults with wounds and lacerations and can help guide the decision-making process for evidenced-based treatment plans and improved outcomes in the geriatric population. ■

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Atypical Skin Abscess Caused by Nontuberculous *Mycobacterium*

Urgent message: Cutaneous abscesses are common presentations in urgent care. While either methicillin-sensitive or methicillin-resistant *Staphylococcus aureus* accounts for up to 75% of skin abscesses, atypical organisms such as nontuberculous mycobacteria (NTMB) can also lead to abscess formation. Urgent care providers should be aware that the clinical presentation may be atypical and require specialized treatment.

RACHEL HUGHES, MD and ERIK BUTLER, DO

Case Presentation

A 26-year-old female with no known past medical history other than depression presented to urgent care with a complaint of a nonhealing sore on her thigh for 2 months. She was most concerned for a possible spider bite. A red sore had been present on her right thigh for 2 months, but in the preceding 2 days had become bigger and more tender. She denied systemic symptoms or drainage from the lesion. She denied a history of recurrent abscesses, methicillin-resistant *Staphylococcus aureus* (MRSA), IV drug use, new tattoos or piercings, recent travel, or known insect bites. She worked as an administrator in a tattoo parlor but did not handle tattoo equipment.

On exam, patient was afebrile and well-appearing with normal blood pressure and pulse rate. She had multiple, well-healed facial piercings and body tattoos. On her right thigh was a 2x2 cm oval purplish macule in raised indurated edges. There was spongy fluctuance in the center of the lesion with a small area of central erosion. (Figure 1.)

An incision-and-drainage (I&D) procedure performed with a 3 mm punch blade revealed a minimal amount of sanguine-purulent fluid from an empty wound cavity.



Differential diagnosis at the time included simple cutaneous abscess, folliculitis, insect bite/sting with necrosis, infected abrasion or skin trauma, or infected epidermal inclusion cyst. The most likely pathogen was thought to be *Staphylococcus* or *Streptococcus* species, given the typical

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Figure 1.

The satellite erythematous papules on the right thigh appeared after adhesive bandaging. The patient reported this was a typical reaction to adhesive.

prevalence of these organisms in skin infections. However, a gram stain and culture were obtained given the indolent course and atypical appearance of the lesion. Patient was given local wound care instructions and prescribed doxycycline 100 mg daily twice daily for 7 days to cover for methicillin-sensitive *S aureus* and MRSA.

Gram stain initially resulted with 2+ WBCs and no organisms seen. However, preliminary culture results on the same day revealed rapidly growing *Mycobacterium*. Fourteen days after the preliminary culture, *Mycobacterium chelonae* was reported along with sensitivity results. (Table 1.)

The patient was referred to Infectious Disease for consult, given the atypical organism identified and case reports of complicated antibiotic regimens required to effectively treat mycobacterial skin infections.

Further history revealed the patient did have a history of IV drug use with recent relapse (though this occurred after the abscess appearance), as well as chronic untreated hepatitis C. She also revealed that she was shaving her legs in an outdoor hot tub prior to developing the skin lesion. She continued to deny systemic symptoms including fever, chills, fatigue, respiratory symptoms, or weight loss that would indicate progression or dissemination of *M chelonae* infection. On exam, the infection

“The American Thoracic Society and Infectious Diseases Society of America recommend an oral macrolide initially (for example, clarithromycin monotherapy) combined with cefoxitin, amikacin, or imipenem-cilastatin for the treatment of cutaneous infections.”

remained localized to the soft tissue of her right thigh though without significant progression of healing.

Treatment, Outcome, and Follow-Up

Given the localized nature of infection, the patient was treated with linezolid 600 mg daily and clarithromycin 500 mg twice per day for 4-6 months, pending clinical improvement. Baseline CBC and CMP were checked for linezolid monitoring.

Discussion

M chelonae is a non-motile, non-spore-forming, gram-positive, acid-fast bacillus. It is classified as a rapidly growing NTMB, class IV in the Runyon classification. Cases of infection have been reported globally with no seasonal trend or association with a specific sex, race, or age group. Pertinent to our case, *M chelonae* has been shown to be resistant to chlorine and identified in water systems, though typically grows at lower temperatures (30°-32°C).¹

M chelonae infections present most often as a pustule, hemorrhagic crust, or abscess in areas of puncture wounds or skin trauma, often on the extremities. It has been reported after tattoos, acupuncture, sclerotherapy, injectable medication, and other injection procedures. The eye is the second most frequent site of infection. Disseminated skin involvement and invasive infections (such as infection of bone, joint, or muscle) can occur in immunocompromised patients. Pulmonary infection is rare but patients with cystic fibrosis can be colonized with *M chelonae*.^{1,2}

Treatment of *M chelonae* and NTM can be challenging. Expert consultation and sensitivities should be pursued given the potential for resistance patterns, multidrug regimens, and need for prolonged antibiotic treatment durations. The American Thoracic Society and Infectious Diseases Society of America recommend an oral macrolide initially (for example, clarithromycin monotherapy) combined with cefoxitin, amikacin, or imipenem-cilastatin for the treatment of cutaneous infections.³ Com-

Table 1. Susceptibility Testing Results	
	<i>Mycobacterium chelonae</i> MIC susceptibility result
Amikacin	16; susceptible
Cefoxitin	>128; resistant
Ciprofloxacin	4; resistant
Clarithromycin	0.25; susceptible
Doxycycline	>16; resistant
Imipenem	32; resistant*
Linezolid	8; susceptible
Minocycline	>8; resistant
Moxifloxacin	8; resistant
Tigecycline	0.25; no interpretation
Tobramycin	1; susceptible
Trimethoprim + sulfamethoxazole	4; resistant

*Imipenem breakpoints are considered tentative. Activity against rapidly growing mycobacteria is greater for imipenem than for meropenem or ertapenem.

combination therapy with at least two agents is recommended due to potential development of resistance during prolonged therapy.³ For treatment of disseminated or invasive disease, 4-6 months of systemic therapy is recommended. Other treatment modalities include local antiseptic and antibacterial therapy, repetitive surgical debridement, and I&D of abscesses.³

As with our patient, abscesses that do not respond to initial I&D may require further surgical excision or debridement.

The prevalence of *M chelonae* and rapidly growing NTM infections is increasing but they remain a rare cause of skin and soft-tissue infections.

NTM skin infections should be considered in the differential for abscesses with an atypical appearance, in infections that do not respond to initial standard treatment, or if patient presents with skin infection after an invasive procedure. Current IDSA guidelines recommend gram stain and culture of pus from carbuncles and abscesses, but treatment is also reasonable without culture in typical cases. In addition, I&D is the recommended treatment for abscesses (as opposed to antibiotics alone). Antibiotics against *S aureus* can be used as an adjunct to I&D, especially if the patient has features concerning for systemic inflammatory response syndrome (SIRS). An antibiotic against MRSA is recommended in patients who have failed initial antibiotic treatment, are immunocompromised, or in patients with SIRS and hypotension.⁴

This case highlights the importance of considering gram stain and culture during abscess I&D or before treatment of purulent cellulitis. If initial culture is unrevealing or infection is not responding to typical coverage for gram-positive organisms, then biopsy or acid-fast staining should be considered.

Take-Home Points

- Consider gram stain and culture during abscess I&D or before treatment of purulent cellulitis.
- Consider NTM skin infections with abscesses with atypical appearance, indolent course, or not responsive to typical therapy.
- Obtaining sensitivities is important for appropriate treatment of NTM skin and soft tissue infections given resistance patterns. ■

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Thinking About Buying or Selling an Urgent Care Center?

Urgent message: While market conditions for mergers and acquisitions are currently “hot,” variability in urgent care volume attributable to COVID-19 has led to changes in how deals are evaluated and structured.

ALAN A. AYERS, MBA, MAcc

ationally, merger-and-acquisition activity has set a record pace across all industries since the start of the pandemic. Corporations, private equity funds, and buyout firms have built up cash reserves to levels never seen before. Low interest rates provide few options for investors in search of steady cash flow. Prospective changes to capital gains taxes provide an immediacy for sellers. The result is a lot of money is currently chasing after increasingly fewer “quality” deals.

In healthcare, hospitals and health systems continue to consolidate providers in their local markets to create the integrated delivery networks required for patient coordination in value-based care. We also see themes of “population health” changing the delivery of primary care, particularly for dual-eligible Medicare Advantage populations. “Tech-enabled” providers promise to increase the operational efficiency of primary care while improving health outcomes for patients and payers.

Urgent Care Deal-Making Is ‘Hot’

Urgent care, which now numbers 10,000 to 14,000 centers depending on which data source you consult, fits well into multiple investment themes. Local operators provide a “retail storefront” and a loyal patient following that generates quantifiable downstream referrals for hospitals and health systems. Urgent care is also the easiest way for multispecialty providers to enter the acute care space.

The brick-and-mortar and established patient base of urgent care can be “marked” as expanded services from allergy to behavioral health, as well as telemedicine, to become more relevant to their patient base. Increasingly, Gen X and Millennial populations utilize urgent care in



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lieu of a traditional primary care provider or as the access point for all their health needs. And urgent care operators that have scaled to multiple locations generate reliable, steady cash flow in the form of EBITDA margins.

An added boost is that for the past 18 months, urgent care has performed over a third of COVID-19 tests, introducing providers to millions of new patients and generating the free cash flow to accelerate profitable growth while other retail storefronts have struggled.

In this environment, many urgent care centers are being cold-called for deals, if not exploring options on their own through a formal sale process. As a result, urgent care assets are trading at all-time highs in terms of valuation.

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

“We are seeing multiples all over the place. We’ve sold smaller businesses for 10 times reported (earnings) because they were a strategic asset, and we’ve sold them for four times because they were top decile performers and highly profitable.”

– Marc Anderson, Managing Director, The Belay Group

According to Luis de la Prida, managing partner of The NYBB Group based in New York City, six factors are driving M&A activity in urgent care:

- **Fragmentation.** Hospitals, large consolidators, and insurance companies have been actively buying up urgent care centers for years. As a result, their share of the market has grown. Even so, no one urgent care provider dominates the market nationally. That means that the market remains fragmented, with smaller operators (so-called “one-sies,” “two-sies”) making up a meaningful part of the market. Buyers like fragmented markets because they give them the opportunity to acquire smaller practices at lower multiples. Often, these acquisitions are accretive to the buyer because larger entities are valued at higher multiples.
- A favorable macroeconomic environment, especially low interest rates resulting in investment dollars seeking reliable monthly income.
- High revenue growth from:
 - **Healthcare reforms** during the past few years, leading to an increase in the number of insured individuals including expansion and privatization of state Medicaid programs.
 - **Growing acceptance of urgent care from payers**, many of whom incentivize their members to seek care in lower-cost settings, for example, as opposed to the emergency room.
 - **Rising consumer demand** for urgent care. This was partly driven by the high costs and overcrowding in emergency rooms, as well as primary care physician shortages.
 - **COVID-19:** Urgent care saw drops in volume in the early stages of the pandemic. However, they’ve seen an explosion in volume over the past year, as patients have flocked to urgent care for rapid testing, antibody testing, and monitoring. Many centers have also played a major role in (and benefited from) the mass rollout of

COVID vaccines.

- **Note:** Revenue has grown over the past 5 years, but profits are down slightly as a result of rising operating costs (especially during the pandemic).
- **Industry expansion.** According to *IBISWorld*,¹ the number of urgent care enterprises is expected to grow at an annualized rate of 6.9% over the next 5 years. This expansion will be seen in rural, urban, and suburban settings.
- Low capital requirements.
- Barriers to entry.

According to de la Prida, there are five major buyer types in urgent care: large consolidators, hospitals, private equity groups, insurance companies, and other, often-smaller physicians. Each buyer type shares common characteristics. For example, a large consolidator may be looking to rapidly build market share with the expectation of selling to a larger group. Alternatively, a hospital system may be buying urgent care centers to build service line expertise or to defend their market territory.

But the common characteristic that urgent care buyers have is that they have decided that it is in their best interest to grow through mergers and acquisitions. “Acquisitions often provide a cheaper and faster path to growth than growing organically alone,” de la Prida said. “They also allow for greater economies of scale, easier access to capital, and the ability to acquire expertise.”

“In general, buyers are looking for well-run centers in well-situated locations. In addition, they are interested in practices with steady-to-rising revenues and net cash flow. Practices with multiple locations, as well as those in rural areas are seeing meaningful buyer interest,” he added.

Marc Anderson, managing director of the Charleston, SC-based The Belay Group, specializes in urgent care transactions. He says that an acquiring entity’s goals in urgent care are generally to increase expansion into new geographies or capture pockets where they don’t have coverage in their current market.

“The decision between de novo vs acquisition generally revolves around the best return they perceive to have from their invested capital. In densely populated areas experiencing above-average population and community growth, like a South Florida or Dallas/Ft. Worth, where there is ample supply of urgent care, we see operators preferring to buy revenue vs build it. In more rural areas or where there isn’t full saturation of urgent care, we see existing operators leaning more towards de novo,” Anderson said.

He added that “much of the acquisition decision revolves around ‘available stock’ in (an) area and whether

it fits the acquiring entity's real estate profiles and/or can be easily retrofitted to a new brand without significant capital investment, along with a decent purchase price. As it relates to joint-ventured operators, I think they are much more inclined, especially more recently, to consider acquisitions due to the considerable revenue and cost synergies they are usually able to achieve."

How Urgent Care Transactions Are Structured

Urgent care operations are valued based on either their *assets* or *earnings*. When an acquirer "purchases" a physical presence, assuming leasehold improvements, furnishings, fixtures, equipment and supplies, valuation may be on the assets. This is uncommon and typically occurs when the underlying business is unprofitable. The buyer sees inherent value to the "brick-and-mortar" as a practice they can either improve or build upon. It may be more efficient to purchase something that's "turnkey" than to build something from scratch.

According to de la Prida, smaller practices are often asset sales. "These transactions will be codified in an asset purchase agreement. They will also typically have an employment or consulting agreement for the selling physician. Traditionally, we haven't seen a whole bunch of deferred payouts in these transactions," he explained.

Valuation Based on Earnings

In most instances, valuation is based on a "multiple of earnings" because the buyer sees value in the established patient base, providers and staff, payer contracts, and "intangibles" such as brand and culture they wish to continue into the future. Anderson explains the factors that drive a range of multiples:

"We tend to see people use a combination of discounted cash flow analysis and market multiples to price smaller deals with a heavy bit of negotiation. Since there isn't much publicly available data on market comps, it's mostly hearsay or the general rule of thumb of approximately 4- to 5 times earnings," Anderson said.

"The reality is that a larger, scaled organization should provide cost-synergies to an acquiring entity which makes their effective multiple lower, in addition to the implied arbitrage they get from earnings applied to the acquirors perceived multiple. We've seen small assets trade at eight- to 10 times their adjusted earnings on a synergized basis—although not knowing the acquiror's financial model, it can usually be guesstimated to be in the five times' range (lower RCM costs, better supply costs, scaled administrative costs, etc.). In the case of a health system, the synergies can be pretty dramatic on

the revenue side. We've seen scenarios where the acquiror has 50%+ better contracted rates, which goes straight to the bottom line," Anderson added.

When considering what to pay for an acquisition, at some point a buyer will have to weigh whether they'd get a better return on invested capital by the acquisition or building outright. Their thought process, according to Anderson is, "We can either buy two sites for \$10 or put up five sites for \$10. What's the best ROIC?"

Adjustments to EBITDA Valuation

When calculating the EBITDA figure to use, certain revenue or expenses may be "backed out" from the financial statements to get a more accurate financial picture of the business.

According to Anderson, typical EBITDA adjustments for closely held businesses revolve around nonoperational or owner-exclusive expenses. Other adjustments relate to truly one-time items—like operational consultants, large marketing plans, and expensed capital projects (since many are cash basis accounting, they tend to try to "write-off" all expenses vs capitalize).

"From a technical perspective, reported EBITDA is what a company reports, but we would really consider EBITDA exclusive of one-time and nonoperational items. Other reasonable adjustments to us are for pro-forma items that have occurred more recently and change the future performance of a business—such as a new, improved payer contract, or a lower price from a vendor; these should be adjusted into the historical periods as pro-forma adjustments. In rapidly growing, multisite operations with a proven growth profile, we believe it's also reasonable to adjust for run-rate performance for newly opened sites," Anderson explained.

"The key to us is that the current performance is going to be different than the performance that the acquiring entity gets at close or in a few months or more time. The purchase price should be based on what's

"A decent advisor should be able to give you an opinion on the value of your business as-is and advise on appropriate strategies to help maximize value—this should include identifying the strengths, weaknesses, and all valid adjustments for your particular business."

— Marc Anderson, Managing Director, The Belay Group

An earn-out is a contingent payout, which essentially involves shifting some of the purchase price to be paid in the future on the realization of future earnings or some other benchmarks of success.

expected in the future, and that's why acquiring entities often rely on multiple valuation approaches—discounted cash flow, market multiples, leveraged buy-out analysis—to triangulate a purchase price.”

Impact of COVID-19 on Valuation

COVID-19 has made underwriting very difficult for buyers. The volatility in performance experienced by many operators over the past couple of years has been dramatic. And in many primary or secondary metropolitan areas the growth has been highly positive. According to Anderson, this has resulted in larger multiples for selling companies but “from a current or trailing 12 months’ perspective, the multiple may seem muted.”

Anderson said most buyers are underwriting based on an expected heightened future volume from COVID-19 but more in-line with volume trends from previous “super flu seasons,” maybe just more consistent during the year. “My opinion is that we’ve seen the height of COVID-19 volumes and maybe will see one more peak this winter, but after that, vaccine mandates will start to take effect and testing accessibility, and costs (and margins) continuing to come down,” he said.

“I still think the long-term tailwinds of urgent care are better than they’ve ever been, but I also see that large operators are on a massive expansion and roll-up phase. So, while urgent care volumes in general will go up, we expect competition will also increase, probably reverting existing operators’ performance more back to historical means,” Anderson added.

The Increasing Role of Earn-Outs in Urgent Care Deals

An “earn-out” stipulates that the seller will be paid over a period of time, subject to achieving or exceeding a certain level of performance. This means that the seller is not only contractually obligated to stay with the company through a transition period, but that the seller will continue to have a demonstrable effect on the company’s financial performance.

For example, a buyer might agree to pay 90% of the total purchase price you desire upfront with the remaining 10% paid in stock or cash after a year of earn-out

time. Alternately, the buyer might split the sale price 50/50 over 5 years, during which the owner must agree to stay with the company and optimize its performance.

When there is a gap between an owner and a potential acquirer in the perceived value of a business, it is usually caused by the expected future growth of the company. For buyers, the earn-out smooths the ownership transition and offers protection against overpaying for a company that doesn’t end up thriving or growing the way they intended.

Earnouts were not common to urgent care transactions prior to the pandemic, but given the outsized performance of urgent care centers that embraced COVID-19 testing over the last 2 years, buyers now have concern over what future volumes will do because the COVID-19 volume spikes were so dramatic.

Earnouts can come in any flavor but are typically based on visit volume, not revenue or EBITDA, to avoid Stark issues. Typically, the buyer will lay out a pro-forma and if performance is within, say, 90% of budget, then the seller would get the full payout due at the milestone. If performance is less than projections, say 85%, 80% or lower, then the payout would be ratcheted down.

An issue for sellers occurs if the buyer substantially changes operations, including the services offered, cost structure, or operations management. A seller may be held accountable for results in a business very different than the one they sold, managed by entirely different people, with decisions made beyond the seller’s control. The longer the term of the earn-out, the greater the risk the seller will not realize the full value of the sale.

Sellers should thus be skeptical of “too good to resist” offers with payment contingent on a long earn-out period, particularly if significant changes to the brand, services, staffing, contracts, and technology will occur.

Buyer Expectations of Sellers

According to de la Prida, since the COVID-19 pandemic began, buyers are increasingly resorting to earn-outs and other deferred payments to bridge the valuation gap between buyer and seller. “We expect to see more deferred purchase price arrangements, requiring the sellers to prove out their projections on revenue, earnings, and EBITDA,” he said. “Also, in larger transactions, buyers continue to ask sellers to roll over a portion of their equity in the practice. Holdbacks for regulatory risks and other contingencies are also common,” de la Prida added.

Anderson further explains that from a transition perspective, many of the acquirers now have learned their lesson about managing the embedded culture of an

existing facility. “Due to the challenge in recruiting and retaining personnel, we’ve seen considerable effort in acquirers trying to be better stewards of a business than the previous owners; usually they have better benefit packages and they often won’t work the staff as hard and/or can supplement over-worked staff more easily,” Anderson explained. “The hardest transition usually is the older generation employed physician who still has many job options if they decide to leave. But this cohort is fading quickly as most places are now predominately staffed by APCs who more just want a stable job.”

Most sellers should expect to have a non-compete agreement for 3 to 5 years in a defined geographical area (lining up with acquirer’s footprint) for owning or operating a new similar business, Anderson added. “This doesn’t mean they can’t leave and go work for another operator. They just can’t own/invest in/operate a competing business. In the case of an urgent care business, that’s less than a handful of sites. Unless the owner is a practicing physician, we typically see the acquiring entity take over full operations and leadership.”

Thinking About Selling Your Urgent Care Center?

Business owners decide to sell their companies for myriad reasons, not the least of which are to capitalize on high valuations, retirement, and burnout. Many physician-entrepreneurial sellers love the *practice* of medicine but not the *business* of medicine, which has only become more complicated with COVID-19 variability in volumes, staffing, and supply chain challenges.

“The number-one characteristic shared by many of the sellers I’ve reached out to recently is exhaustion,” de la Prida said. “Small business owners have always had to wear many hats. The pandemic has taken a significant personal and business toll on urgent care sellers.”

Another common characteristic of sellers is they’re seeking to capitalize on still-high valuations in the sector, which continues to garner interest from buyers. Lastly, competition in the sector continues to increase. As a result, many sellers are seeking to exit to limit the impact posed by increased competition.

Predicting the Next 2-3 Years

de la Prida expects transaction activity to pick up over the next 2–3 years because the urgent care industry is still in the midst of a growth cycle. While some of this growth is from de novo buildouts, there’s still room for growth via mergers and acquisitions. He explained that the industry remains fragmented, with no one player accounting for more than 10% of centers. This means that there are plenty of smaller centers available for

“Volume is through the roof in many centers. Expenses are rising. Staff is burned out. And finding replacement staff is becoming harder and harder. This has led operators to work longer hours and take on more responsibility for the clinical, operational, and financial aspects of their practice. Not surprisingly, many sellers have reached the conclusion that perhaps the time to sell or exit their practice has arrived.”

– Luis de la Prida, Managing Partner, The NYBB Group

those seeking to increase market share.

Additionally, the pandemic slowed deal-making across all industries. “In 2020, many urgent care centers that were on the verge of engaging us pressed the pause button so that they could focus on dealing with the operational and financial issues presented by the pandemic,” de la Prida said.

But de la Prida added that the tide is turning quickly. “In the last month alone, five different urgent care centers across the country have reached out to us to help them sell their practice. Most have been seeking to take advantage of still-high valuations in the sector. Mostly, however, they have been looking to exit or partner with someone to obtain some relief from the issues posed by the pandemic.”

de la Prida said he’s also seen an increase in buyer interest as private equity groups have started to aggressively reach out to discuss the deal pipeline.

Conclusion

For those who are considering either buying or selling an urgent care, there will be continued uncertainty over the next 12 months regarding the direction of visit counts under COVID-19. While the investment market is “hot,” investors also require certainty and continuity. That means we’ll be more likely to see deals with deferred payouts contingent on meeting future goals. It’s a “seller’s market,” but sellers need to be diligent and fully understand the contingencies, expectations, and risks of any proposed deal structure. ■

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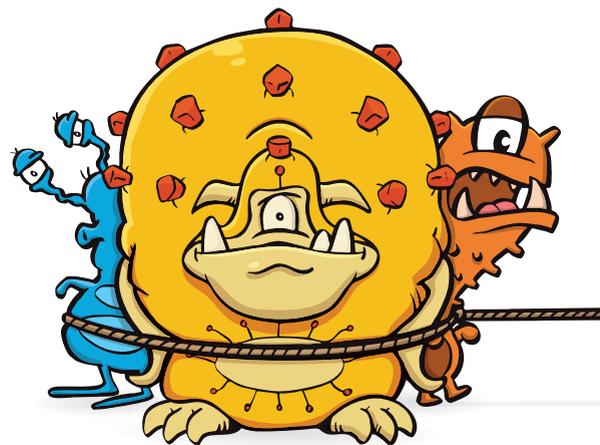
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Approach to the Transgender Adolescent and Specific Health Considerations

Urgent message: It is common for transgender patients to have a history of poor experiences with healthcare providers. As such, they may be less likely to have an ongoing clinical relationship with a primary care provider, making urgent care a likely destination when a need arises. Familiarity with issues facing adolescent transgender patients, in particular, can benefit both the provider and the patient.

TIMOTHY MCGINNIS and EMILY MONTGOMERY, MD

The Case

A 15-year-old transgender male (pronouns he/him/his) reports to urgent care with left lower quadrant abdominal pain. The pain was initially intermittent but has been constant for the past hour. He has associated nausea and vomiting. He denies fever, chills, vaginal bleeding, vaginal discharge, diarrhea, constipation, and urinary symptoms. He has no past medical history, and states that he has not had any gender-affirming surgeries. His only medication is intramuscular testosterone. He is not sexually active. Vitals show a BP of 125/76, HR of 112, RR 16, and temp 98.6°F. Chest exam shows a chest binder in place. Lungs are clear to auscultation. He is tachycardic with a regular rhythm and no murmurs. Abdominal exam demonstrates LLQ tenderness with guarding. He consents to a pelvic exam, which reveals a left adnexal mass and tenderness, but no bleeding or discharge.

Introduction

An estimated 150,000 adolescents (age 13-17) in the United States are transgender or gender nonconforming.¹ Multiple health disparities exist between transgender and cisgender adolescents.² For example, transgender



youth are more likely to attempt suicide, less likely to have health insurance, and are more likely to be homeless.^{2,3} Additionally, transgender patients often report poor experiences with healthcare professionals, including harassment and denial of care.^{3,4} Given these health disparities, urgent care and emergency clinicians

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Glossary of Relevant Terms	
Term	Definition
Cisgender	A person whose gender identity corresponds with the sex the person had or was assigned
at birth Transgender male/transman/FTM	A transgender person whose sex assigned at birth is female but whose gender identity is male
Transgender female/ transwoman/MTF	A transgender person whose sex assigned at birth is male but whose gender identity is female
Gender nonbinary/genderqueer	Gender identities that are neither male nor female
Gender-affirming surgery	Surgery undergone by a transgender person to alter their physical sexual characteristics to match their gender identity
Gender-affirming hormone therapy	Administration of hormones that allow for transgender individuals to have the secondary sexual characteristics of their gender identity
Gender-neutral pronouns	Used in individuals who do not identify as either male or female. Examples are they/theirs and zie/zirs

are often the de facto primary care providers for the transgender population. Therefore, it is important for all urgent care providers to understand the specific clinical considerations of this population and to know and employ methods to make the healthcare experience more comfortable.

History and Exam Pearls

Developing trust between a patient and provider is one of the most important aspects of healthcare. Given the likelihood that a transgender patient has had poor interactions with healthcare providers, creating a comfortable environment can be an essential step in developing that trust.⁵ For example, displaying trans-friendly symbols in patient rooms or on ID badges, and providing documents/brochures for LGBTQ health concerns is a good first impression that can provide patients with some assurance that they’re in a welcoming space.^{2,5,6}

Next, recognize that it is essential to take the medical history of a transgender patient in a gender-affirming way.⁴ As with cisgender patients, the use of open-ended and nonjudgmental questions is paramount.² The use of the patient’s correct pronouns is also essential.^{2,5} Intake forms that include questions about gender identity and pronouns can ensure providers and other staff address and refer to the patient in the manner they prefer.² If the provider is unsure of the patient’s pronouns, asking “What is your gender identity?” or “What pronouns do you use?” can be simple and effective.⁷ This will also show that you respect and value their gender identity.

A special consideration of the medical and surgical history in transgender patients is taking an anatomic/organ inventory.^{2,7} While it is less likely that

pediatric patients will have undergone gender-affirming surgery, this knowledge is important as it may influence the differential diagnosis. However, it is important to know that some transgender patients may feel uncomfortable disclosing this information due to fear of judgement or discrimination.⁴ If this happens, providers can explain that this information is necessary to make medical decisions and will remain confidential.⁷ A simple question to elicit this information is “Have you undergone any gender-affirming surgeries?” If they answer yes, a more in-depth history can be taken.⁷

Another unique consideration in the transgender population is asking about gender-affirming hormone therapy. Hormone therapy and puberty-blocking medications are more common than gender-affirming surgery in the pediatric population. Gonadotropin-releasing hormone (GnRH) analogs (leuprolide and histrelin) are often used in transgender and gender-diverse adolescents.⁸ These medications delay the onset of puberty, allowing adolescents more time to determine gender identity and research medical transition therapy, like hormones.^{2,8} This effect is reversible. Common side effects to be aware of in this medication class are hot flashes, gynecomastia (which may or may not be desired), weight gain, and fluid retention.⁹ There is an increased risk of osteoporosis with long-term use of these medications.⁹

Estrogen, progestogen preparations, and anti-androgens (spironolactone, cyproterone acetate, or 5-reductase inhibitors) are the mainstay of feminizing gender-affirming hormone therapy.^{7,10} The main concern in patients on estrogen therapy is the increased risk of venous thromboembolism.¹⁰ This is an important

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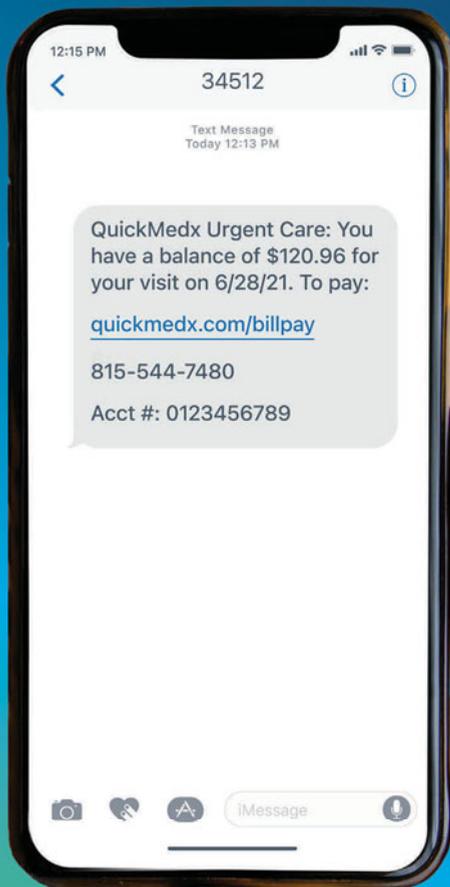
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Table 1. Genital Exam Advice
<ul style="list-style-type: none"> • Discuss steps of procedure before starting and then explain each step clearly as you perform the exam. • Allow the patient to listen to music with headphones during the exam. • Ask if the patient would like a support person in the room. • Ask the patient what their preferred terms for pertinent anatomy, like the vagina or anus. • Allow patients to use a mirror during the exam so they can observe what is happening. • If the patient has severe anxiety, oral benzodiazepines can be used in the correct clinical context.

Table 2. Causes of Abnormal Uterine Bleeding	
Structural Causes	Nonstructural Causes
Polyps	Coagulopathy
Adenomyosis	Ovulatory Dysfunction
Leiomyoma	Endometrial causes
Malignancy	Iatrogenic
	Not yet classified

consideration in transgender female patients who present with signs and symptoms concerning for deep vein thrombosis and pulmonary embolism. It is also necessary to assess for any contraindications to the use of estrogen, such as migraine headaches or history of hypercoagulable disease.¹¹

Testosterone preparations are the mainstay of masculinizing gender-affirming hormone therapy.¹⁰ Testosterone use can cause erythrocytosis and elevated liver transaminases.² Although erythrocytosis can cause an elevation in blood pressure, the risk of hypertension in transgender males on testosterone therapy is equal to that of cisgender males.² It is also important to keep in mind that testosterone can induce amenorrhea.¹²

Providers should obtain a menstrual history in all adolescent transgender males. Additionally, sexual history should be elicited when deemed clinically necessary. Transgender males with an intact uterus can still become pregnant, so a thorough sexual history will help with clinical decision-making. Keep in mind that these may be sensitive topics for some patients, so the use of open-ended, nonjudgmental questions will be beneficial.

Lastly, providers should screen for mental health issues such as anxiety and depression. The transgender population has high rates of depression, anxiety, eating disorders, and suicide ideation/attempts.² One study found that 30% of transgender patients had attempted suicide and 42% reported self-injurious behaviors.¹³

It is necessary to do a physical exam of all transgender patients, just as you would in a cisgender patient. However, there are a few considerations the provider should be aware of. One, is that many transgender individuals are survivors of sexual and physical assault.⁴ Therefore, the physical exam may be a triggering event for some individuals. Explaining the importance and reasoning behind a physical exam to the patient can be beneficial. Clinicians should perform the physical

exam in a gender-affirming manner. For example, use general terms for anatomy and ask patients if they have preferred terms for certain body parts.¹⁰ Perform a focused physical exam when possible.

Examination of genitalia can be highly distressing to some transgender individuals, as they may have anatomy that does not align with their current gender identity. If the patient has significant anxiety about the exam or denies the exam, it can be deferred.¹⁰ Some methods to make the procedure less distressing for patients are detailed in Table 1.¹⁰

Special Considerations

Pelvic and abdominal pain

The workup and differential for abdominal and pelvic pain in pediatric transgender patients is going to be like that of cisgender patients. However, there are some special considerations in the transgender population.

In transgender males with a uterus and ovaries, it is necessary to remember to include uterine/ovarian/vaginal causes of pain in the differential (PID, uterine fibroids, ovarian torsion, etc.). The use of testosterone in transgender males can induce atrophy of the vaginal mucosa, similar to a postmenopausal cisgender female.^{10,15} This can lead to dyspareunia and atrophic vaginitis as causes of abdominal pain.¹⁰ Additionally, atrophy of the vaginal mucosa increases the risk for bacterial vaginosis, cervicitis, and urinary tract infections.¹⁶ Abdominal pain in transgender males on testosterone may also be associated with cyclic testosterone dosing.¹⁰ This pain is often described as cramping.

In transgender females with a penis and testes, conditions such as testicular torsion, epididymitis, and torsion of the appendicular testes should remain in the differential. A rare condition to keep in mind in transgender females is estrogen-induced hypertriglyceridemia. Exogenous estrogen use can lead to hyperlipidemia, and there are some case reports of transgender females and cisgender females who have developed pancreatitis secondary to hypertriglyceridemia while on estrogen therapy.^{11, 17-19}

Heavy or persistent vaginal bleeding

Heavy or persistent vaginal bleeding in transgender males can be a distressing complaint.²⁰ The differential for abnormal uterine bleeding (AUB) is the same as it is in cisgender females. The American College of Gynecology recommends the mnemonic PALM-COEIN to create a differential for AUB (Table 2).²¹

Initial workup should consist of complete blood count, pregnancy test, and possibly pelvic ultrasound based on clinician judgement.²¹ Additional workup can include PT, PTT, TSH, and LFTs to assess for other causes of bleeding.²¹ The treatment of acute heavy vaginal bleeding in transgender males is different from that of cisgender females. Treatment options such as IV estrogen or high-dose oral contraceptives should be avoided due to the feminizing effects. If the patient is not already on testosterone, this can be started in order to induce amenorrhea.²² There are multiple testosterone formulations, but the majority use biweekly intramuscular or weekly subcutaneous forms.²² In patients already on testosterone therapy, increasing the dose may be beneficial as there is a dose-dependent response to inducing amenorrhea.²² Tranexamic acid should be used with caution in patients on testosterone, as there is a possible increased risk of thrombogenesis.^{23,24}

Additional medical management of persistent or heavy vaginal bleeding in transgender males can include aromatase inhibitors, selective estrogen receptor modulators (SERMs), progestogens, and GnRH-agonists.²² Referral to endocrinology is also an option.

Skin breakdown and soft tissue infections

Some transgender males may use chest binders to help diminish body dysphoria. Although chest binders are relatively safe, they can cause skin breakdown or other skin issues, like infection secondary to skin breakdown.¹⁴ Therefore, if a provider has clinical suspicion for a soft tissue infection or a fever of unknown origin, remember to check for skin issues beneath chest binders. Some patients may feel uncomfortable removing binders, so providing an explanation can be beneficial.²

Providers should also be aware of tucking, a technique that allows individuals to hide any outward evidence of the penis and testes. One method involves pulling the penis backwards between the legs and then raising the testes into the inguinal canal. Another technique is employing the use of binding tape to hold the penis and testes against the perineum. Tucking is relatively safe, but there is a risk of penile pain, inguinal hernias, and skin breakdown.²

Case Conclusion

CBC showed Hgb of 12.5, WBC of 7.6, and platelet count of 225. BUN was mildly elevated at 25 and Cr was 1.12. Ultrasound demonstrated a large left ovarian cyst and absence of blood flow to the left ovary on color Doppler, consistent with ovarian torsion. OB/GYN was consulted and the patient was transferred for detorsion and ovarian cystectomy. He recovered without incident. ■

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Reoccurring Metatarso-phalangeal Joint Pain

Urgent message: Acute or chronic hallux pain is a common complaint in urgent care. Due to the structure, several diagnoses can have similar presentation on history and exam. With this discussion, we examine a sesamoid stress injury.

SERGIO P. RAMOA, MD, MS

Introduction

The tibial (medial) and fibular (lateral) sesamoids are contained within the flexor hallucis brevis tendons along the metatarsal head.¹ They have several roles such as absorbing weight, helping glide and reducing friction of the tendons, and improving flexion strength. X-rays of injuries can sometimes be nonconclusive. Approximately 13.5% of the population have bipartite sesamoids—a sesamoid bone that has not fused together, leaving two separate components.² For those that have bipartite sesamoids, 90% of them involve the medial sesamoid.¹ Most of the weight transmitted to the first metatarsal is borne by the tibial sesamoid; therefore, most sesamoid pathologies are involved with the tibial sesamoid.¹

Case Presentation

A 39-year-old male runner presented with a 2-month history of intermittent right foot pain, worse at the right great toe. He stated that he has had similar issues in the past that would typically resolve with rest, but return when he resumed running. The most recent exacerbation started when the pain woke him up in the middle of the night. Patient denied any history of trauma, family history of joint pathologies, or recent dietary changes. He was a social drinker with 1-2 drinks per month. There were no known dietary restrictions, but he followed a low-fat diet while avoiding sugary snacks and frequent red meat consumption.

Physical exam

- Temperature: 97.2°, pulse 63, BP 100/62, O2 saturation: 98%, weight 180 lbs, height: 6'1", BMI 23.7



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- Worse with off-phase of walking
- Swelling and redness on plantar side only of the metatarsophalangeal joint (MTP). Tenderness with palpation. Skin is intact
- Full range of motion and sensation
- Strength 5/5

Differential and Decision-Making

With pain starting suddenly at night and without a distinct traumatic history, gout is a concern. On exam, he lacked uniform swelling and tenderness of the joint. He also denied family history and had no recent dietary changes. His pain was only on the plantar side of the

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MTP joint, with worse pain during the step-off phase of walking, which would increase concern for sesamoiditis. Due to the amount of redness and swelling, an x-ray was ordered. It showed a medial sesamoid with two components. This could represent a sesamoid variant like a bipartite sesamoid, stress injury, or a fracture.

Radiologic Results/Diagnosis

Chronic fragmentation of the sesamoid (Figure 1).

Treatment

Imaging for this patient is undiagnostic. In cases in which the exam, history, and radiology are not straightforward, MRI or isotope bone scan can better distinguish pathologies.¹ Both can also determine if a sesamoid may be a bipartite vs a fracture, as a bipartite sesamoid may still present with pain due to sesamoiditis. An MRI can also differentiate between an acute and chronic stress fracture, or if diminished flow caused avascular necrosis.

Due to the patient's history, an empiric approach was taken for stress fracture, but further imaging is still essential for determination of his pathogenesis. The first approach to an acute nondisplaced and chronic stress fracture can be conservative, nonoperative treatment. Given that the sesamoid bones' function is to absorb weight, reduced weightbearing is an important goal. In chronic stress fractures, this can be done with orthotics displacing the weight towards the heel.³ In acute nondisplaced injuries, immobilization and weightbearing need to be altered, such as with a cast and crutches. Activity should be modified from high- to low-impact exercises to prevent repetitive loading to the area, while maintaining physical conditioning. The stress fractures will typically heal in approximately 6 weeks, and a patient can return to normal activity only after complete healing to avoid a full fracture.⁴ Depending on practice type and the ability for the patient to follow up, an orthopedic referral may be reasonable at the beginning of management. With failed treatment or displaced fractures, referral to orthopedics is essential for surgical intervention. Preventive methods can also be implemented for runners (ie, decreasing total mileage, changes in terrain, avoiding hills, and replacing shoes every 6 months to maintain adequate shock absorption).⁴

Discussion

It is important to gather information on other daily activities, new and previous shoe wear, and attempted treatments. Due to numerous pathologies of the hallux, diagnosis is not always straightforward even with an appropriate history gathered.

In this patient, the sudden pain onset did increase concern for gout, but location was solely on the base of the toe. He also tried to avoid red meats (relative risk (RR) 1.41) and fructose "sugary" snacks (RR 2.02) and drinks (RR 1.82), which would increase the risk of gout. Increased BMI can increase risk of gout, although his was within normal range.⁵ With these considerations from the history and exam, his risk of gout was low. Though not obtained from the patient during history, dairy and vitamin C consumption can decrease risk of gout (RR 0.56 and 0.55, respectively).⁵

The incidence of turf toe, or plantar capsular ligament sprain or tear, has increased with the introduction of lighter foot wears into athletic activity.² With normal walking, the ligament complex can bear up to 60% of the body weight, increasing up to 3 times for athletic activity, and up to 8 times for running jumps.⁶ Hyperextension is the main cause of injury, and future arthritic changes are a greater likelihood in patients who

Table 1. Turf Toe Classes and Management ^{6,7}			
	Classification	Findings	Management
Class 1	Acute sprain of the ligaments with micro-tears and without instability	<ul style="list-style-type: none"> • Swelling • Mild ecchymosis • Full range of motion • Able to bear weight 	<ul style="list-style-type: none"> • Heal in 1 to 2 weeks • Symptomatic treatment and return to play as tolerated
Class 2	Partial tear of the capsular ligament	<ul style="list-style-type: none"> • Moderate swelling • Ecchymosis • Restricted range of motion • Painful movement • Painful weight bearing 	<ul style="list-style-type: none"> • Heal in 4-6 weeks • May need protected weightbearing, such as a walking boot • Days 3-5, gentle range-of-motion exercises with passive plantar flexion to prevent adhesions
Class 3	Complete tear of the capsule and instability	<ul style="list-style-type: none"> • Moderate to severe swelling • Ecchymosis • Decreased range of motion • Difficulty bearing weight • Significant tenderness with palpation 	<ul style="list-style-type: none"> • Heal in 6-12 months • 4-8 weeks of immobilization in a walking cast or CAM boot • Progressive range-of-motion exercises after immobilization • Protected ambulation with foot plate inserts or modified footwear • If failed treatment, surgical intervention may be necessary

have reduced dorsiflexion.⁶ Turf toe has different classifications; **Table 1** presents common exam findings. Along with treatment-specific management noted in the table, initial treatment should include rest, ice, compression, and elevation.

Sesamoiditis could be a very likely cause of the patient's symptoms, but should be a diagnosis of exclusion once other etiologies have been ruled out. He did not have a high risk of infection as his history lacked any trauma to the skin that would inoculate the sesamoids with bacteria. He also lacked a past medical history like diabetes which would increase the risk through immune suppression, poor vascularity, and peripheral neuropathy. Along the same line, no foreign body was suspected at this time due to lack of trauma, but further imaging with MRI may be able to better differentiate compared with x-ray. Due to frequent running, he could have increased risk of arthritis but x-ray did not suggest signs that would lead to an arthritic flare.

In cases in which the exam, history, and radiology are not straightforward, MRI or isotope bone scan can better distinguish pathologies.¹ Compared with other etiologies for the hallux and sesamoid, which affect both sesamoids, stress fracture typically involves only one sesamoid.⁴ Few (0.4%) running injuries are due to sesamoid stress fractures.⁴

Sesamoids fractures fall into a high-risk category that can have increased complications such as: complete fracture, nonunion, delayed union, and higher likeli-

hood of surgical intervention compared with other locations of the foot such as the 1st through 4th metatarsal and calcaneus.⁴ Therefore, it is important to have continued monitoring for full healing of the stress injury, as well as reinforcing to the patient to not return to previous repetitive impact activities prematurely.

Take-Home Points

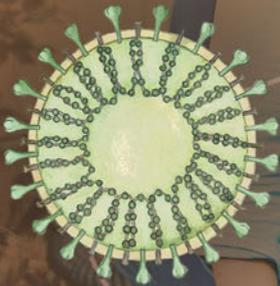
- First MTP pain is often not straightforward and can have several etiologies.
- MRI or isotopic bone can help differentiate among several pathogenesis of injury, as well as normal variants.
- First-step approach with fracture, stress injury, sesamoiditis, capsular injury, or arthritis is a conservative approach.

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Originally published online August 10, 2021.

With easing restrictions expect increasing respiratory infections.



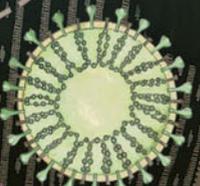
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COVID-19 Testing Pattern in a Suburban Pediatric Urgent Care Center

Urgent message: Though not considered as at “at risk” for severe disease with COVID-19, children have suffered significant disruptions to educational and personal activities throughout the pandemic. Recognizing urgent care’s role in testing for the virus could show benefit for families and urgent care centers alike.

RITA P. NUNAG, MD; FRANCESCA M. DARQUEA, MD; CLAIRE LOISELLE; and MAGDY W. ATTIA, MD

Citation: Nunag RP, Darquea FM, Loiseau C, Attia MW. COVID-19 testing pattern in a suburban pediatric urgent care center. *J Urgent Care Med.* 2021;16(3): 39-43.

Abstract

Background and Objectives

The COVID-19 pandemic disrupted educational, social, and recreational activities for children. Widespread testing became a primary strategy to limit spread. Pediatric urgent care centers (PUCCs) were at the forefront of performing these tests. We aimed to describe the pattern of testing in the PUCC population and summarize differences between symptomatic and asymptomatic in exposed and nonexposed patients who tested positive and negative for COVID-19.

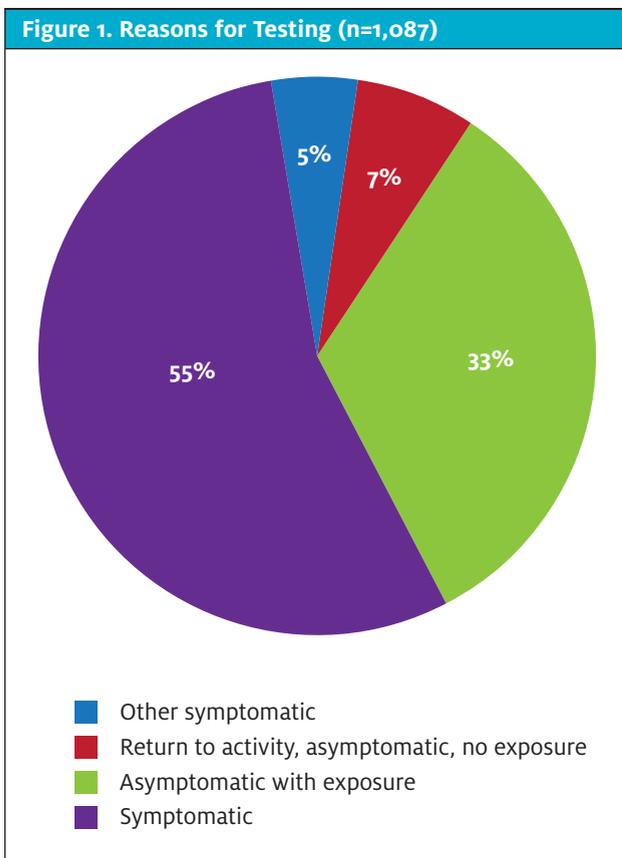
Methods

This was an IRB-exempt retrospective study of patients who underwent PCR COVID-19 testing between March 28, 2020 and January 31, 2021 at a suburban PUCC. All patients presenting to the PUCC underwent a “COVID screen” using a CDC screening tool for symptoms. All patients were able to obtain a COVID-19 molecular RT-PCR test regardless of the COVID-screen designation. Demographics, reason(s) for testing, exposure source, type and duration of symptoms, and test results



were obtained. Patients were stratified as symptomatic or asymptomatic, with or without exposure, and compared based on their COVID-19 test results. Data were analyzed using descriptive statistics and appropriate test for statistical significance.

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Results

During the study period, 1,087 COVID-19 tests were obtained. The study population was 48.9% male, 81.8% Caucasian, 7.6% Black, and 3.4% Asian; 4.9% were Hispanic or Latinx. The mean age was 8.8 (SD±5.8) years. Of the 1,087 patients tested for COVID-19 during the study, 10.5% were positive. The demographics of the positive group did not differ significantly from the study population except for age (mean 11.3; SD±5.8 years; P<.0001). Of 55.1% symptomatic patients, 12.8% tested positive compared with the asymptomatic group (44.9%), where only 7.6% tested positive; P<.005. Of the study sample, 48.9% reported exposure and were more likely to test positive: 16.9% compared with non-exposed, 4.3%; P<.0001. Exposures within the household accounted for 27.4%, of whom 35.6% tested positive, 44.6% were symptomatic, and 28.4% were asymptomatic. Of those reporting exposures but who were asymptomatic, only 9.9% were positive; P<.0001. Of asymptomatic patients with no known exposure, only 0.8% were positive. Although there was a significantly higher rate of positive tests in symptomatic patients, only loss of taste/smell was significant (18 pa-

tients with 12 positive; P<.0001). The remainder of known COVID-19 symptoms were not singularly associated with a positive test.

Conclusions

In our cohort, most COVID-19–positive patients had a known exposure. Symptomatic patients with a known exposure were more likely to be positive than symptomatic patients without an exposure. Symptomatic household contacts were the most common and associated with the highest rate of positive test. The lowest positivity rate was in asymptomatic patients without exposure. Loss of taste or smell was not a common symptom but was highly associated with testing positive. All other remaining COVID-19 symptoms alone were not significantly associated with a positive test. This data may guide testing and isolation recommendations in low-resourced areas.

Introduction

In March 11, 2020, the World Health Organization declared the COVID-19 outbreak a global pandemic, recognizing that the rapid spread of the virus and severity of illness associated with the SARS-CoV-2 infection had created a public health crisis. Educational, social, and recreational activities for children were disrupted due to pandemic regulations imposed by various public health officials. Widespread testing became a primary strategy in identifying COVID-positive patients for isolation and contact tracing to contain the spread of the disease as well as to assess community burden of the infection.

Pediatric urgent care centers (PUCCs) were at the forefront of performing these tests in children. Patients and their families were advised by healthcare providers to follow recommendations for quarantine and isolation from the Centers for Disease Control and Prevention, which often extended beyond reporting of test results. Understanding the patterns of test results in symptomatic and asymptomatic patients in those with and without an exposure to an index case, as well as clinical features of those who tested positive vs those who tested negative, may prove valuable in establishing more efficient testing, quarantine, and isolation recommendations to providers in similar or, more likely, lower-resourced clinical settings.

The aim of this report is to describe patterns of COVID-19 testing in a suburban PUCC and to summarize test results in symptomatic and asymptomatic patients with or without exposure to index cases for the purpose of risk stratifying potentially positive patients.

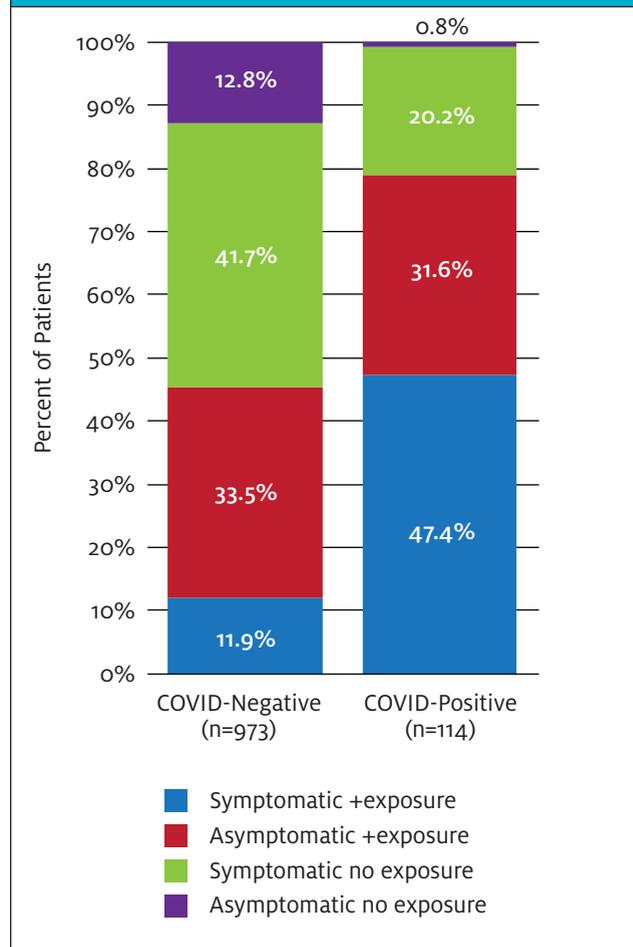
Methods

This is an IRB-exempt retrospective cohort study of pediatric patients who underwent PCR COVID-19 testing between March 28, 2020 and January 31, 2021 at a suburban PUC in Pennsylvania. All patients presenting to the PUC underwent a “COVID screen,” incorporating CDC screening question guidelines: fever >100.4°F (38°C) in the past 72 hours; cough; shortness of breath; rhinorrhea; sore throat; gastrointestinal symptoms including nausea, vomiting, diarrhea, or abdominal pain; or exposure to a suspected or confirmed COVID-19 case within the last 14 days. Any single positive reply was viewed as a positive screen. Exposure was based on a patient/parent report and may not have met the CDC standard of within 6 feet for at least 15 minutes. All patients were able to obtain a COVID-19 test if clinically indicated or upon request, regardless of the COVID-screen result.

Initially, patients were stratified as symptomatic or asymptomatic. Symptomatic patients were evaluated in the traditional patient-room manner. Asymptomatic (absence of fever, cough, rhinorrhea, sore throat, gastrointestinal symptoms) patients, with or without known COVID-19 exposure, were given the option of mobile evaluation and testing. The initial database of patients tested for COVID-19 contained unique identifiers, test dates, and test results. All COVID-19 samples were obtained by nasopharyngeal swab and performed as molecular RT-PCR at commercial labs. Results were usually obtained 48 to 72 hours after the PUC visit. All patients were advised to quarantine pending results of the COVID-19 test, and to follow CDC quarantine guidelines postexposure, if applicable. A retrospective chart review was performed to describe this population and included demographics, reason(s) for testing, whether there was a known or presumed exposure, and nature of that exposure.

Data were stored electronically on a password-secured drive. All patient identifiers were removed and study subjects were given identification numbers. After compiling a complete data set, we performed statistical analyses. The dependent variable was the PCR COVID-19 test result. Subset analyses included comparison of demographics and clinical features associated with positive tests in those who were symptomatic vs asymptomatic, with and without known exposure. We summarized data as ratios and means/standard deviations (SD), and used appropriate statistical analyses based on the nature of variables: Chi square for dichotomous variables and comparison of means for continuous variables.

Figure 2. COVID-19 Test Results of 1,087 Patients



Results

Study Population

During the study period, 1,087 COVID-19 PCR tests were obtained during 1,087 unique patient visits to our PUC. The study population was 48.9% male. Of patients, 81.8% identified as Caucasian, 7.6% Black, and 3.4% Asian. Of these, 4.9% were Hispanic or Latinx. The mean age was 8.8 (SD±5.8) years. Of all patients, 60.7% were evaluated in the traditional patient-room setting; 39.3% of patients presented for the sole purpose of receiving a COVID-19 test and chose the mobile-testing model where history, vital signs, and a limited physical examination were performed while the child was in the family vehicle. Reasons for testing are shown in Figure 1.

Of the 1,087 patients tested for COVID-19 during the study period, 114 (10.5%) were positive. The demographics of the positive group did not differ significantly from the study population except for older age (mean 11.3 years; SD±5.8 years; P<.0001).

Table 1. COVID Positive Rates, Symptomatic vs Asymptomatic, Exposed vs Not Exposed

	Symptomatic	Asymptomatic
Exposed	54	36
Not exposed	23	1

Test Results in Symptomatic and Exposed Patients

A total of 599 (55.1%) patients presented with symptoms that could be attributed to COVID-19 based on the evolving CDC criteria, while 488 (44.9%) were asymptomatic. Of all patients tested, 532 (48.9%) reported a COVID-19 exposure; of those, 170 (32.0%) were symptomatic. Of the symptomatic patients who were tested, 77 (12.9%) tested positive, compared with 37 (7.6%) from the asymptomatic group; $P < .005$. These 77 symptomatic patients accounted for 67.5% of all positive cases. Ninety (16.9%) patients who reported exposure tested positive, vs 24 (4.3%) patients without exposure; $P < .0001$. These 90 patients accounted for 78.9% of all positive cases (Figure 2).

Of asymptomatic patients with exposure (n=362) at the time of testing, 36 (9.9%) were positive; $P < .0001$. Fifty-four of 170 (31.8%) patients who reported symptoms and an exposure were positive; $P < .0001$. (See Table 1.) Only one asymptomatic patient of 126 (0.8%) with no known exposure was positive (Figure 2).

Of exposures, 146 (27.4%) were within the household and 52 (35.6%) tested COVID-19 positive; 65 (44.6%) were symptomatic. More specifically, 29 (44.6%) symptomatic patients with known household exposure tested positive for COVID-19, and 23 (28.4%) asymptomatic patients with household exposure tested positive; $P = .042$.

Fifteen of 87 (17.2%) patients who reported an exposure in a social setting were positive, six of 76 (7.9%) who reported a school/work/daycare exposure were positive, seven of 37 (18.9%) who reported a sports exposure were positive, and 10 of 186 (5.4%) who reported an unspecified exposure were positive.

Symptom data

Although there was a significantly higher rate of positive tests in symptomatic patients, only loss of taste or smell was a symptom significantly associated with COVID-19 infection. Twelve of the 18 (66.7%) patients who reported loss of taste or smell were COVID-positive; $P < .0001$. Of these 18 patients, only two reported a known COVID exposure, and both tested positive. Of note, the mean age of patients complaining of loss of taste or smell was 15 years (SD±3.7 years).

Symptomatic patients included in this cohort had at least one or more of these symptoms reported but none was singularly associated with a positive COVID-19 test: fever prior to arrival at the PUC, $P = .318$; fever present during visit, $P = .365$; cough or shortness of breath, $P = .594$; congestion or rhinorrhea, $P = .628$; sore throat, $P = .564$; or gastrointestinal symptoms, $P = .056$.

Discussion

Our report describes a population of children presenting to a PUC and who were symptomatic or asymptomatic, with and without exposure to a COVID-19 index case. Testing availability was limited at the onset of the pandemic and in the early weeks of our study, similar to other PUCs surveyed at the time.¹ Once the supply chain was established, testing protocols were no longer restricted, and our data were reviewed periodically to quantify community demand for COVID-19 testing, test supply availability, and to identify patterns of infection.

As a PUC, our families were subject to the terms of their insurance regarding urgent care payment, although there was no charge for the test itself. Only PCR testing was performed in our PUC; therefore, families seeking “rapid antigen testing” or those with financial barriers were not part of our study population. While age restrictions may have posed a barrier for testing at other testing facilities during the peak of our study, we found that our positivity rate was similar to the overall prevalence of positive tests in the community at the time.²

Of our COVID-19-positive cohort, 78.9% reported an exposure. Transmission rates have been reported as highest in household settings,^{3,4} and our study concurs with those reports. A study in Spain suggested overall household transmission rates of 31% to 37%, and 10% to 14% for social exposures,³ which closely matches our data of 35.6% positive among household exposures and 17.2% among social exposures. However, another meta-analysis found the household transmission rate to be 16.9%, with transmission to children lower than to adults (17% vs 28%, respectively).⁴

These findings should be interpreted with the understanding that lockdown measures may have limited exposure beyond the household during the timeframe of our study. Additionally, our asymptomatic patients were encouraged but not required to defer testing for at least 48 hours after a known exposure. Our study may have been impacted by a shorter incubation period prior to testing, as well as ample access to testing in the community.

A study published early in the pandemic using a mathematical model based on global data determined

symptomatic COVID-19 infection in children to be approximately 20%.⁵ A separate pediatric urgent care study reported symptomatic rates of 52% in their COVID-positive patients,⁶ closer to our findings of a 67.5% symptomatic COVID-positive rate. This disparity of symptom frequency in pediatric COVID patients may be unique to utilization of urgent care and accessibility of testing in our geographical area. However, transmission via asymptomatic cases poses an ongoing concern,^{7,8} and PUCCs can be a valuable resource for accurate COVID testing where available.

One study suggested mobile testing sites were frequently utilized for testing of young adult employees for return to work,⁹ but did not note reasons for pediatric testing, beyond referral by primary care offices. Our study indicates 7% of our tests were done solely for clearance to participate in an activity, whether school, sport, or work, without symptoms or exposure. We suggest this represents a significant cost and emotional burden to families and children attempting to maintain activities for healthy, low-risk children amid the pandemic restrictions. Overall, slightly less than 1% of asymptomatic patients without exposure tested positive for COVID-19.

Conclusion

In our PUCC cohort of 1,087 patients, 55.1% were symptomatic, 48.9% reported a COVID-19 exposure, and 10.5% were COVID-19 PCR positive. Of COVID-positive patients, 78.9% had a known exposure and 67.5% were symptomatic. Of tests requested, 6.8% were by patients without symptoms or known exposure for the purpose of returning to or to participate in an ac-

tivity, work, school, daycare, or sports. Patients who were symptomatic with a known exposure were more likely to be positive than symptomatic patients without an exposure. Household contact was the most frequently reported exposure and was associated with the highest rate of positive tests, more so if the patient was symptomatic. The lowest positivity rate was in asymptomatic patients without exposure. Loss of taste or smell was not a common symptom but was highly associated with testing positive for COVID-19. All remaining COVID-19 symptoms alone were not significantly associated with a positive test.

These data may help to risk-stratify patients' pretest probability from birth to 20 years old regarding likelihood of positive COVID-19 status and guide testing indications and isolation recommendations pending test results, especially in low-resourced areas. ■

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ABSTRACTS IN URGENT CARE

- The Importance (or Not) of High BP Readings
- Considering Sucralfate in Pediatric Oral Ulcers
- Osteopathic Manipulation for Low Back Pain
- Safety of Oral Corticosteroid Bursts in Children

■ NATHAN M. FINNERTY, MD FACEP and BRETT C. EBELING, MD

Do High Blood Pressure Readings Matter?

Take-home Point: Elevated blood pressure readings in the emergency room were not associated with an increased risk of poor cardiovascular outcomes in 2 years.

Citation: McAlister F, Youngson E, Rowe BH. Elevated blood pressures are common in the emergency department but are they important? A retrospective cohort study of 30,278 adults. *Ann Emerg Med.* 2021;77(4):425-432.

Relevance: This study aims to determine the clinical significance of a high blood pressure reading in the acute care setting with regard to medium-term cardiovascular outcomes.

Methods: This was a retrospective cohort study in which the authors studied all adult ED visits in a large-volume facility in 2016, involving patients with 2 years of records before and after their visit. The authors used the electronic medical record to examine the patients' health history over the subsequent 2 years for a primary outcome of a composite acute coronary syndrome (ACS), new-onset congestive heart failure (CHF), transient ischemic attack (TIA), or cerebral vascular accident (CVA).

Results: The study included 30,000 patients seen in the ED and revealed that >50% had blood pressures >160/100 at some point during their visit. Approximately 75% of patients had not previously been diagnosed with hypertension. Around 50% of patients were diagnosed with chronic hypertension and/or started on at least one antihypertensive medication in the subsequent 2 years. Among patients without a prior diagnosis of hypertension with an elevated BP reading in the ED, there was

an increase in the composite outcome of cardiovascular or cerebrovascular disease (3.3% vs 2.5%) compared with normotensive patients. At 2 years, the difference was 5.9% vs 3.8%. However, when adjusted for other cardiovascular disease risk factors, the risk between the two BP groups was no different.

Editor's comments: This study is limited by retrospective design and its non-UC setting; there are limited conclusions to be drawn for patients with elevated BP in the urgent care center. Despite these limitations, this study's results are consistent with other recent studies suggesting that patients with asymptomatic elevated BP readings in acute care settings do not benefit from aggressive BP management in the short- or medium-term. ■

Sucralfate Fails to Show Benefit for Oral Ulcers

Take-home point: Sucralfate as an adjunct to oral analgesics was not superior to placebo in improving oral intake in children with acute oral ulcers.

Citation: Singh NV, Gabriele GA, Wilkinson MH. Sucralfate as an adjunct to analgesia to improve oral intake in children with infectious oral ulcers: a randomized, double-blind, placebo-controlled trial. *Ann Emerg Med.* 2021;78(3):331-339.

Relevance: Oral ulcers are common with many pediatric infectious conditions. This study sought to determine if sucralfate added to standard acetaminophen/ibuprofen improves pain relief for children with oral ulcerative conditions.



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Methods: This was a randomized, double-blind, placebo-controlled trial of sucralfate vs placebo in children between 6 months and 5 years of age with acute infectious oral ulcers and poor oral intake. Subjects received either acetaminophen or ibuprofen and were then randomized to receive either sucralfate at 20 mg/kg per dose or a placebo solution. The primary outcome was oral fluid intake within 60 minutes of medication administration. The secondary outcomes were repeat emergency department visits, ED length of stay, need for intravenous hydration, hospital admission, adverse events, and the emergency clinician's determination of the adequacy of oral intake.

Results: One hundred children with mild dehydration (median age 1.5 years) were included. Oral intake 1 hour after drug administration was similar in both groups. According to the emergency physician's report, the secondary outcomes were significant only for adequate oral intake (71% in the sucralfate group vs 88% in the placebo group).

Editor's comments: This was a small, single-site study. Quantifying oral intake in small children is challenging; however, sucralfate seems to have no effect on a child's willingness to eat and drink in the setting of infectious oral ulcerative conditions.

Osteopathic Manipulation for Low Back Pain

Take-home point: Osteopathic manipulative treatment had a small, nonclinically significant effect on low back pain-specific activity limitations vs sham treatment.

Citation: Nguyen C, Boutron I, Zegarra-Parodi R, et al. Effect of osteopathic manipulative treatment vs sham treatment on activity limitations in patients with nonspecific subacute and chronic low back pain: a randomized clinical trial. *JAMA Intern Med.* 2021;181(5):620-630.

Relevance: Osteopathic manipulative treatment (OMT) is commonly utilized for mechanical low back pain. This study compares OMT with sham treatment for nonspecific low back pain (LBP).

Methods: This was a French prospective parallel group, single-blind, single-center, sham-controlled randomized clinical trial evaluating patients with subacute-chronic mechanical, low back pain. Patients were randomized to six sessions of standard OMT or sham OMT administered biweekly. The primary endpoint was the mean reduction in low back pain-specific activity limited at 3 months as measured by the self-administered Quebec Back Pain Disability Index. Secondary outcomes included mean reduction in LBP specific limitations, mean changes in pain and health-related quality of life, sick leave, and the number of low back pain episodes.

Results: Two hundred participants were randomly allocated to each group. The mean Quebec Back Pain Disability Index scores for the standard OMT group were 31.5 at baseline and 25.3 at 3 months. In the sham OMT group, index scores were 27.2 at baseline and 26.1 at 3 months. The mean reduction in low back pain-specific activity and limitations at 3 months was -4.7 and -1.3, respectively, which is not clinically significant. There were no significant differences in any secondary outcomes.

Editor's comments: This study corroborates the findings of most prior studies on the topic. Its robust design supports that there is limited-to-no role for OMT for the management of low back pain. ■

Safety of Oral Corticosteroid Bursts in Children

Take-home point: Steroid bursts were associated with a significant increase in adverse events within 31-90 days of exposure.

Citation: Yao TC, Huan Y-W, Chang S-M, et al. Association of oral corticosteroid bursts with severe adverse events in children. *JAMA Pediatr.* 2021;175(7):723-729-330. [Correction published July 6, 2021, to fix errors in the Abstract, Key Points, and text.]

Relevance: Steroids are commonly prescribed in many pediatric conditions. This study aims to determine the frequency of severe adverse events in children after receiving a burst of oral steroids.

Methods: This was a self-controlled, case series, cohort study of Taiwanese children who were prescribed oral steroids for <14 days. The National Health Insurance Database was also used to determine incidence of GI hemorrhage, sepsis, pneumonia, and glaucoma in patients receiving steroids vs those who did not.

Results: Out of 4.5 million children whose cases were reviewed, 23% received a steroid burst during the 7-month study period. The most common indications for steroid prescriptions were viral respiratory infections and allergic reactions. Patients receiving steroids had a higher risk of GI bleed (incidence rate ratio, (IRR) = 1.41), sepsis (IRR=2.0), and pneumonia (IRR=2.2).

Editor's comments: This study was limited by retrospective design and a homogenous study population. Steroid prescriptions included were up to 14 days, which is longer than usual practice in the U.S. Despite the study limitations, the large number of prescriptions reviewed suggests it is worth avoiding overly liberal steroid prescribing in children. ■



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A 47-Year-Old with Pain After Twisting His Ankle

Figure 1.



Figure 2.



Case

The patient is a 47-year-old male who presents with a primary complaint of right ankle pain after a pick-up game of basketball. He reports he twisted his ankle when he landed on another player's foot.

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

THE RESOLUTION

Figure 1.



Figure 2.



Differential Diagnosis

- Tuberos sclerosi
- Osteoblastic bone metastasi
- Osteopathia striata
- Osteopoikilosi
- Tuberos sclerosi

Diagnosis

The images reveal well-circumscribed sclerotic foci in the appendicular skeleton consistent with multiple bone islands. This patient was diagnosed with osteopoikilosis, also known as spotted bone disease, a sclerosing bony dysplasia characterized by multiple benign bone islands (enostoses) which are focal deposits of dense lamellar bone. This is an incidental finding.

Learnings/What to Look for

- Osteopoikilosis is a rare inherited benign condition found incidentally on skeletal rays
- Bone lesions are randomly distributed in a symmetric fashion
- Osteopoikilosis is seen in the appendicular skeleton (hands, feet, long bones, pelvis) with sparing of the axial skeleton (ribs, skull, vertebrae)

Pearls for Urgent Care Management

- Osteopoikilosis does not affect bone strength
- Treatment is limited to pain management with nonsteroidal anti-inflammatory drugs and analgesics

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



A 43-Year-Old Man with a Painful, Purulent Finger



Case

The patient is a 43-year-old male who presents with a painful collection of pus near his fingernail. He reported that it had developed over the past day. On examination, a large, yellow-green superficial pus collection was seen at the proximal nail fold with surrounding erythema and edema. The patient mentioned that he had a home renovation business and that it was common for him to experience mild injuries such as splinters on his hands. The patient was immunocompetent and was not currently on any medications.

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

THE RESOLUTION

**Differential Diagnosis**

- Nail candidiasis
- Felon
- Bacterial paronychia
- Nail bed injury

Diagnosis

This patient was diagnosed with bacterial paronychia. Acute paronychia is defined as inflammation of the proximal or lateral nail folds for fewer than 6 weeks. Pain, swelling, and redness are the cardinal symptoms, sometimes accompanied by abscess formation.

Acute paronychia frequently arises from trauma to one of the nail folds, resulting in compromise of the physiologic barrier to entry of microorganisms. Inflammation may proceed to bacterial infection, resulting in pus.

Learnings/What to Look for

- In some cases, the abscess tracks under the nail plate; if not treated quickly, it can result in permanent damage to the nail matrix

- Examples of inciting trauma include foreign bodies, such as splinters; manipulations, such as manicures or pedicures; ingrown nails; fingernail biting; finger sucking in children; or "hangnail" removal
- Occasionally, acute paronychia arises as a painful exacerbation of chronic paronychia, which is now understood to be a localized form of chronic irritant or allergic dermatitis
- Certain drugs, including retinoids (isotretinoin, acitretin), methotrexate, antiretroviral protease inhibitors (indinavir, lamivudine), and epidermal growth factor receptor inhibitors (cetuximab, gefitinib, lapatinib) can cause drug-induced paronychia, in some cases with associated periungual lobular capillary hemangioma (pyogenic granuloma)

Pearls for Urgent Care Management

- Mild paronychia calls for conservative treatment (warm water soaking, topical antibiotics with or without topical steroids)
- Abscesses call for drainage
- Specific bacteria predominate in trauma-related acute paronychia; indicated antibiotic treatment for infection with *Staphylococcus aureus*, *Streptococcus pyogenes*, and anaerobic bacteria derived from the oral flora is warranted

Acknowledgment: Images and case presented by VisualDx (www.VisualDx.com/JUCM).



A 36-Year-Old Male with Sudden-Onset Substernal Chest Pain

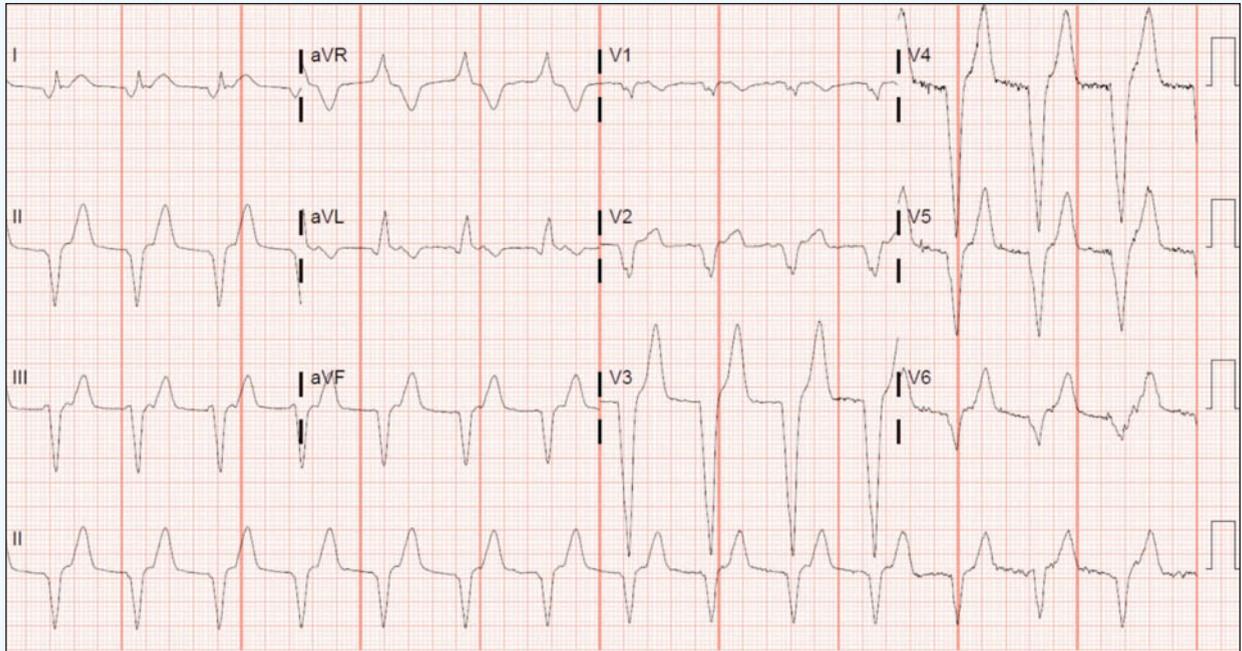


Figure 1. Initial ECG

The patient is a 36-year-old male with a history of tobacco and alcohol use who presents to urgent care with sudden-onset substernal chest pain and shortness of breath that began 1 hour prior to arrival.

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

(Case presented by Joshua Fan, MD, The University of Texas Health Science Center at Houston McGovern Medical School.)

THE RESOLUTION

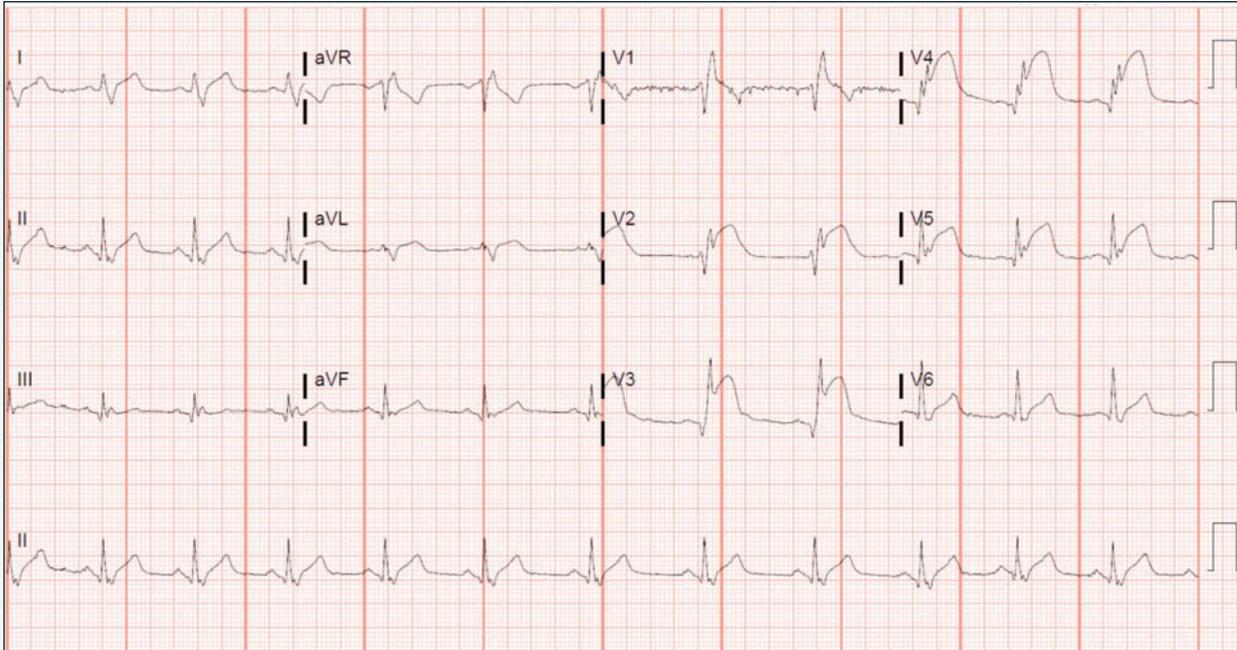


Figure 2. Anterolateral ST-elevation myocardial infarction

Differential Diagnosis:

- Ventricular tachycardia
- Left bundle branch block
- Accelerated idioventricular rhythm
- Supraventricular tachycardia with aberrancy
- Hyperkalemia

Diagnosis

This patient was diagnosed with accelerated idioventricular rhythm. The ECG shows a wide QRS complex (>120 ms) with a regular rhythm at a rate of 90 beats/min. There are no P waves preceding the QRS complexes, suggesting an ectopic impulse-generating focus. This ECG is consistent with an accelerated idioventricular rhythm (AIVR).

AIVR is a rhythm that occurs under conditions of enhanced automaticity. An enhanced ectopic ventricular pacemaker outpaces more superior pacemakers (eg, sinus node) and, thus, becomes the dominant pacemaker. It occurs at a rate faster than ventricular escape, but slower than ventricular tachycardia (ie, between 50 and 110 beats/min). AIVR can occur for many reasons, including electrolyte abnormalities and drug toxicity (eg, digoxin); however, it occurs most commonly in the setting of reperfusion—that is, after myocardial infarction or cardiac arrest. The prognosis is not adversely affected because the ventricular rate is in the normal range.^{1,2}

AIVR is frequently mistaken for ventricular tachycardia since

both have wide, regular complexes and can have signs of atrioventricular dissociation (eg, fusion and/or capture beats), especially when only viewed from the telemetry monitor. The feature that distinguishes the two rhythms is the rate:

- AIVR occurs at a rate between 50 and 110 beats/min; rates less than 50 beats/min are consistent with ventricular escape
- Ventricular tachycardia most commonly has a rate greater than 110 beats/min

Fusion and capture beats occur when a sinus-generated beat either fuses with a ventricular complex or gets conducted through the normal pathway, respectively. They suggest atrioventricular dissociation and can be seen in both AIVR and ventricular tachycardia. The distinction between AIVR and ventricular tachycardia is of paramount importance since the management differs significantly.

AIVR is a self-terminating and well-tolerated rhythm that does not require intervention, unlike ventricular tachycardia.³ However, the underlying etiology should be explored. Antiarrhythmics should be avoided due to possible hemodynamic collapse.⁴

In a patient presenting with AIVR and signs or symptoms consistent with acute coronary syndrome, as with our patient, spontaneous reperfusion of an unstable coronary plaque should be assumed, and the patient should immediately be transferred to a percutaneous coronary intervention-capable (PCI-capable) facility.

The patient here was found to have an anterolateral ST-elevation myocardial infarction on a subsequent ECG (Figure 2), and he was immediately transferred for PCI.

THE RESOLUTION

Learnings/What to Look for

- AIVR is a wide, regular rhythm with a rate between 50 and 110 beats/minute
- Capture or fusion beats suggest atrioventricular dissociation and can be seen with AIVR or ventricular tachycardia

Pearls for Urgent Care Management

- In most cases, AIVR represents reperfusion, often after thrombolysis
- Patients with AIVR should be transferred to a PCI-capable center
- Antiarrhythmics traditionally given in ventricular tachycardia should be avoided due to possible hemodynamic collapse
- Evaluate for other underlying causes, such as electrolyte abnormalities, severe cardiomyopathies, or drug toxicities

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What's in the Physician Final Rule for 2022?

■ MONTE SANDLER

The Medicare Physician Fee Schedule (MPFS) Final Rule was issued on November 2, 2021 by the Centers for Medicare & Medicaid Services (CMS). This rule is issued annually to announce policy changes for Medicare payments; this latest iteration will take effect on or after January 1, 2022.

Below I'll highlight some of the changes.

Fee Schedule

Medicare payment rates are impacted by a number of factors, including adjustment to the conversion factor, relative value units (RVUs) assigned, and geographic adjustments (ie, the geographic practice cost index (GPCI)). While these fees are for Medicare products, they have an impact on the industry when practice contracts are based on a percentage of the Medicare allowables.

This year, updates were made to the Practice Expense RVU's to account for increasing clinical labor pricing. However, the conversion factor was reduced to \$33.59. This is a \$1.30 reduction from 2021. Reasons for the reduction are budget neutrality adjustments to account for changes in RVUs as required by law and the expiration of the 3.75% temporary increase from the Consolidated Appropriations Act, 2021 (CAA).

Last year, Medicare implemented a significant increase in RVUs for office visit E/M codes due to their determination that providers were being undervalued for the work they perform. Unfortunately, to keep the budget neutral this caused a decrease to the conversion factor. This is something that will continue for several years unless Congress acts.

Based on the RVUs, the national allowables will be as follows (See **Table 1**).

Final payments will also be impacted by the 2% Medicare se-

"A longer virtual check-in service (for telehealth) will be made permanent in 2022. HCPCS G2252 is for 11-20 minutes of medical discussion with the patient when the acuity of the patient's problem may not warrant a visit but does require more assessment time from the practitioner."

questration which will go back into effect on 01/01/2022 without Congressional intervention. The sequestration is not a factor in determining Medicare allowables. Rather when a claim is adjudicated, Medicare's 80% portion of the payment is automatically reduced by 2%. The allowable is not reduced so there is no impact to the patient's cost-sharing amount. The patient cannot be billed for this 2% reduction in payment.

The Urgent Care Association encourages practices to email their member of Congress. U.S. Representatives Ami Bera, MD (D-CA) and Larry Bucshon, MD (R-IN) have sent a bipartisan letter to Speaker of the House Nancy Pelosi (D-CA) and Minority Leader Kevin McCarthy (R-CA) requesting immediate action to address payment cuts before the end of 2021. More than half of Congress has signed this letter. The full text can be found at https://www.ucaoa.org/Portals/80/pdfs/Physician%20Pay%202021.10.14.pdf?ver=_N3hN2Zi4NF5_DzBogKVUw%3d%3d&utm_source=Informz&utm_medium=Email&utm_campaign=Informz%20Click-throughs&_zs=5tOdi1&_zl=Wj9x7.

Not all services are part of the physician fee schedule (eg, labs), so these rates will not be impacted.

Vaccine Administrations

CMS has increased the allowable to administer influenza, pneumococcal, and hepatitis B virus vaccines to \$30 from an average rate of \$17.63 in 2021. This is for codes G0008 (influenza), G0009 (pneumococcal), and G0010 (hepatitis B). The amount is subject to a geographic adjustment.



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

Table 1.

Code	2021		2022		Difference in dollars	Percent Difference
	Total RVUs	National allowable	Estimated total RVUs	Estimated national allowable		
99202	2.12	\$73.97	2.14	\$71.88	\$-2.08	-3%
99203	3.26	\$113.75	3.29	\$110.51	\$-3.23	-3%
99204	4.87	\$169.93	4.90	\$164.59	\$-5.32	-3%
99205	6.43	\$224.36	6.48	\$217.66	\$-6.68	-3%
99212	1.63	\$56.88	1.66	\$55.76	\$-1.12	-2%
99213	2.65	\$92.47	2.66	\$89.35	\$-3.12	-3%
99214	3.76	\$131.20	3.75	\$125.96	\$-5.24	-4%
99215	5.25	\$183.19	5.29	\$177.69	\$-5.50	-3%

“The impact to the industry may be from commercial insurance plans that don’t currently require full credentialing of PAs. Practices should monitor their notices from payers for any policy changes.”

COVID-19 vaccine administration and monoclonal antibody infusion services will remain at the current rates until January 1 of the year following the end of the Public Health Emergency (PHE). The PHE remains in place through January 16, 2022 unless or until it is extended again.

Split/Shared Services

Split (or shared) evaluation and management (E/M) services are when the level of service is determined by documentation from both the physician and a nonphysician practitioner (NPP) for a date of service. The physician and NPP each personally perform a portion of the visit. The encounter could then be billed under the physician.

In the office setting, the incident-to guidelines must be met. For a service to be incidental, it must be a part of a physician’s treatment plan. This eliminates new patients, patients with new conditions, or patients with worsening conditions. In an urgent care setting, incident-to scenarios are extremely rare. In 2022, CMS will further limit this option to an institutional setting only.

However, practices may consider leveling the visit based on time to capture the services of both providers in the office setting. In the official 2021 E/M guidelines, the American Medical Association provides these instructions: “When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care profes-

sional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).”

For more information about leveling visits based on time, go to <https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf>.

Telehealth Services

CMS will cover telehealth services added during the COVID-19 PHE until the end of 2023 while they continue to consider a permanent policy change.

A longer virtual check-in service will be made permanent in 2022. HCPCS G2252 is for 11-20 minutes of medical discussion with the patient when the acuity of the patient’s problem may not warrant a visit but does require more assessment time from the practitioner.

The originating site fee, Q3014, for practices that use load sharing will have a small increase in 2022 to \$27.59 from \$27.02.

Physician Assistants

In recognition of current clinical practice and the evolving role of NPPs, CMS will be allowed to make direct payment to physician assistants (PAs). Currently, payments are only allowed to the employer of the PA. Effective January 1, 2022, PAs have additional options to bill Medicare directly for their professional services or even incorporate with other PAs and bill Medicare for PA services.

The impact to the industry may be from commercial insurance plans that don’t currently require full credentialing of PAs. Practices should monitor their notices from payers for any policy changes.

For the full rule go to, <https://public-inspection.federalregister.gov/2021-23972.pdf>. ■

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More People Really Are Trying Telehealth These Days—but That Doesn't Mean They Prefer It

There's been a lot of discussion (including in *JUCM* and *JUCM News*) as to whether the COVID-19 pandemic would usher in a Golden Age of telehealth, either within urgent care or in possible competition with urgent care. Now that we're approaching 2 years in, actual data on the subject are starting to emerge.

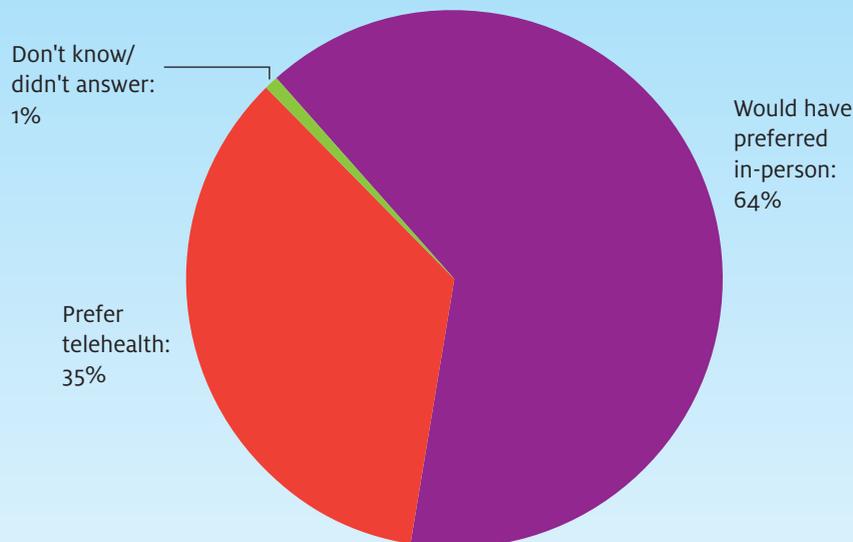
First, some background: Household Experiences in America During the Delta Variant Outbreak, a survey conducted this year for NPR, the Robert Wood Johnson Foundation, and the Harvard T.H. Chan School of Public Health, asked 3,616 U.S. adults (18 years of age and older) to share any "serious problems facing both themselves and others living in their households" between August 2 and September 7, 2021. Many of the questions were not directly related to healthcare, though it's likely there's overlap

between complaints that family incomes were adversely affected and concerns that medical needs went unmet.

One section of the survey focused on healthcare issues. The fact is that a lot of people—42% of respondents' households—really did utilize telehealth as the Delta variant became more pervasive in this country instead of chancing a trip to a brick-and-mortar practice. And 82% of them said they were either completely or somewhat satisfied, compared with 17% who were completely or somewhat dissatisfied.

This is far from a game-changer, however. As you'll see in the graph below, even being highly satisfied hasn't convinced the majority that they're eager to repeat the experience. ■

THINKING ABOUT THE MOST RECENT TIME RECEIVING ADVICE OR TREATMENT FROM A HEALTHCARE PROFESSIONAL VIA TELEHEALTH, WOULD YOU HAVE PREFERRED AN IN-PERSON VISIT, OR TELEHEALTH?



Data source: Household experiences in America during the Delta variant breakout. NPR, Robert Wood Johnson Foundation, and Harvard T.H. Chan School of Public Health. Available at: [chrome-extension://efaidnbmnnnibpcjpcglclefindmkaj/viewer.html?pdfurl=https%3A%2F%2Fmedia.npr.org%2Fassets%2Fimg%2F2021%2F10%2F20%2FNational%2520Report_Oct2021-FINAL.pdf&clen=728029&chunk=true](https://efaidnbmnnnibpcjpcglclefindmkaj/viewer.html?pdfurl=https%3A%2F%2Fmedia.npr.org%2Fassets%2Fimg%2F2021%2F10%2F20%2FNational%2520Report_Oct2021-FINAL.pdf&clen=728029&chunk=true). Accessed November 10, 2021.



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