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Counterpoint: Readers React to *JUCM* Original Research

■ ANDREW GROCK, MD; MANUEL CELEDON, MD; and JONIE HSIAO, MD

It was with great interest that we read Most Clinicians Are Still Not Comfortable Sending Chest Pain Patients Home with a Very Low Risk of 30-day Major Adverse Cardiac Event (MACE) by Dr. Michael Weinstock, et al in the February 2021 issue of *JUCM*.¹

In this study, the authors surveyed attendants at an emergency medicine conference in 2018 as to their comfort level discharging patients after a negative acute coronary syndrome (ACS) work-up.¹ The survey cohort consisted mostly of United States and Canadian attending physicians, residents, or mid-level providers. Later that year, the American College of Emergency Physicians (ACEP) published national guidelines recommending an acceptable 30-day MACE rate of 1%–2%.² However, survey respondents reported much more conservative views, with almost 50% reporting an acceptable level of missed 30-day MACE of 0.1% or 0.01%. In fact, less than 1/3 of participants met ACEP's recommended 1%–2% miss rate.²

Though the authors address potential changes in responses due to these newer guidelines, we feel the need to address the possible root causes of these very conservative responses.

Firstly, the word “missed” implies an attribution of fault to the treating provider; and what provider would willingly admit to being comfortable “missing” a critical diagnosis? This wording, which brings to mind fear of litigation and a poor patient outcome, may begin to explain the conservative views of the study participants.

Secondly, comfort level does not necessarily correspond to actual provider practice. A provider's comfort level discharging a low-risk chest pain patient is multifactorial, including factors such as poor follow-up and coexisting conditions.³ In fact, the American Heart Association first recommended discharging low-risk patients after a negative ED ACS work-up 8 years prior

to the survey, which makes it difficult to believe that the surveyed providers continue to admit patients at a 0.1% rate of 30-day MACE.⁴

Most importantly, equating missed MACE and missed ACS is somewhat confounding. MACE often includes percutaneous coronary intervention and coronary artery bypass graft surgery, which may be appropriately offered to patients without ACS to treat (for example, stable angina).

Experts have argued that 30-day MACE is in fact a poor marker to determine ED disposition. Weinstock, et al proposed using clinically relevant adverse cardiac events (CRACE) such as rate of in-hospital life-threatening arrhythmia, ST-segment-elevation MI, cardiac or respiratory arrest, or death to describe a more clinically relevant outcome.⁵ The time after which the “missed” CRACE is attributed to the index provider may require adjustment to a more ED-centric endpoint such as the 15-day endpoint recently proposed by Green and Schriger.⁶

The next question posed by this research is: What to do with low-risk patients after a negative ACS work-up? Hospitalization carries known risks such as medical error and delirium.^{7,8} Yet, a benefit to admitting patients after a negative ACS work-up in the ED has yet to be demonstrated. Previously, admission afforded a chance to catch potential “missed” ACS, perform provocative testing, and optimize medical management.

Current data suggest a drastically different picture. With the implementation of the high-sensitivity troponin, the rate of unstable angina has decreased and may potentially be a disease of the past.^{9,11} In fact, 18% to 30% of patients previously classified as having unstable angina would now be defined as NSTEMIs.¹²

One large study on patients hospitalized for possible ACS after two negative troponins, two nonischemic electrocardio-



Andrew Grock, MD; Manuel Celedon, MD; and Jonie Hsiao, MD are all affiliated with the Greater Los Angeles VA Healthcare System and the David Geffen School of Medicine, UCLA.

“Currently, the best available evidence supports discharging low-risk patients after a negative ACS work-up and a 4-week risk of MACE at 1%-2%. In addition, multiple national and international organizations have recommended discharge of these patients, and there is no demonstrated benefit to admission.”

grams, and normal vital signs in the ED demonstrated a 0.06% (95% CI, 0.02%-0.14%) rate of inpatient complications (a STEMI, cardiac or respiratory arrest, or death).⁵ Of these four patients, two were noncardiac, and two were possibly iatrogenic.⁵ Additionally, provocative testing in low-risk populations results in no mortality benefit or decrease in ACS rates. Instead, it only serves to increase the rate of cardiac catheterizations, which carries its own rate of complications.^{2,13-16} Optimal medical management theoretically could improve 4-week rates of MACE, but does not require hospitalization to perform. As Weinstock, et al previously posited, “does an increased risk of MACE at 4–6 weeks justify immediate hospitalization or emergent intervention?”⁵

While we are all trying to do the best we can for our patients, it’s important to recognize the limitations and risks of hospitalization in weighing the appropriate disposition. In discussing these risks with patients, it does appear that they seem to be significantly less risk-averse than doctors when engaged with shared medical-decision making.¹⁷⁻¹⁹

The testing and data for diagnosing and positioning possible ACS patients has drastically changed in the past 10 years. Currently, the best available evidence supports discharging low-risk patients after a negative ACS work-up and a 4-week risk of MACE at 1%–2%.²⁰⁻²³ Additionally, multiple national and international organizations have recommended discharge of these patients, and there is no demonstrated benefit to admission.^{2,24}

All that’s left is to get our fellow physicians and providers comfortable with these new recommendations. ■

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JUCM encourages substantive feedback from readers on all the original research we publish, but also regarding clinical review articles, case reports, practice management content, and anything else you see in the journal. If you have a perspective on a topic relevant to the urgent care community, we'd like to know about that, too. If you would like to comment on something you read here (or would like to read here), or suggest a topic for an Urgent Perspectives editorial, send an email to editor@jucm.com.



HEALTH LAW & COMPLIANCE

11 Getting Served: The Do's and Don'ts of Litigation

Malpractice lawsuits, with or without merit, are common. That doesn't make them any less potentially devastating emotionally or professionally, of course. The first step is managing your internal reaction. You'll need help with the steps that follow.

Gita Pensa, MD, FAAEM

PEDIATRIC URGENT CARE



17 Return to Sports in the COVID-19 Era: A Clinical Review



Safe "return to play" is something we associate with concussions and orthopedic injuries. In the time of COVID-19, though, the implications of rushing to rejoin the team are even more dire.

Brian Harvey, DO and Natalie Stork, MD

PRACTICE MANAGEMENT

25 Addressing Fraternalization in the Urgent Care Workplace



We all want a convivial workplace, where colleagues get along and enjoy working together. Sometimes friendship can blossom into something more, however. What is the operator's role in deciding what is—and isn't—acceptable?

Alan A. Ayers, MBA, MAcc

ORIGINAL RESEARCH

33 Assessing the Rate at which Pacemaker and Defibrillator Patients Present to the Emergency Room with their Manufacturer ID Card: A Cross Sectional Study



Care can be delayed if an urgent care or emergency clinician attempts to interrogate the CIED of a patient who does not know their device manufacturer and does not carry their ID card. This scenario illustrates

the importance of patient education in care centers, such as the emergency department and urgent care.

Tinh M. Le; James F. Neuenschwander, MD, FACEP; Mary Jones, DNP; Ankur Parekh; Hana Le; Kaitlyn Cedoz; and Clark Daugherty

CASE REPORT

39 An Unresponsive Pupil in the Urgent Care: Can a Diagnosis Be Made from the Bedside History and Exam?



The short answer to the question raised in the title of this article is yes. The details are both interesting and enlightening, though—and can help you ask the right questions while avoiding the wrong ones.

Kayla Penny, BS; Joseph LaRochelle, PharmD, BCPPS, FCCP; Deirdre Hooper, MD; Haley Harrington, BS; and Kelsey Rooney, BS

CLINICAL

43 *N gonorrhoeae*: Dual Therapy Is Out. Monotherapy Is In.



The Centers for Disease Control and Prevention has updated its recommendations for treating uncomplicated gonococcal infections of the cervix, urethra, or rectum—and understanding the context for the change is essential.

NEXT MONTH IN JUCM

Ultrasound is the gold standard for diagnosis of deep vein thrombosis. The fact that they're not widely available in urgent care centers does not mean suspicion of DVT should be followed automatically by a referral or transfer to a higher-acuity setting. Far from it, in fact. By relying on the history, physical exam, and risk stratification with tools like the Wells score, the urgent care provider is more than capable of diagnosing DVT on site, shortening the time it takes for the patient to start treatment (and, therefore, reducing risk for a poor outcome). Read all about it in the November issue of *JUCM*.

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It's not uncommon for a healthcare provider to be hit with a malpractice suit. Sometimes, if you're aware someone's care really was less than optimal or that a patient or family member was upset over an outcome, you might expect it. Other times, it might come out of the blue and leave you completely bewildered.

Either way, it's not a pleasant experience. How you react at first (and even more important, the first steps you take) can certainly make your situation better or worse than it might otherwise be, however—and that's the subject of this month's cover article. In *Getting Served: The Do's and Don'ts of Litigation* (page 11), **Gita Pensa, MD, FAAEM** of the Department of Emergency Medicine at the Alpert Medical School of Brown University gives solid advice on how to manage your internal reaction and the best way to navigate through the process toward the best possible resolution.

The norm, of course, is that you provide excellent care. That's been a bit more challenging over the past couple of years, thanks to the COVID-19 pandemic. The rules have not only changed, but sometimes you have to make them up as you go along. Take youth sports, for example. When is it safe for young athletes to get back in the game—and how can you tell if they're really ready? *Return to Sports in the COVID-19 Era: A Clinical Review* (page 17) offers evidence-based solutions. We appreciate **Brian Harvey, DO**, and **Natalie Stork, MD**, of Children's Mercy Kansas City addressing this important topic.

In urgent care, there's an ongoing quest to see just how much can be done on site without the need to refer or transport patients. A perfect example is addressed in this month's case report, *An Unresponsive Pupil in the Urgent Care: Can A Diagnosis Be Made from the Bedside History and Exam?* by **Kayla Penny, BS**, of Louisiana State University Health Shreveport, School of Medicine; **Joseph LaRochelle, PharmD, BCPPS, FCCP**, from Xavier University of Louisiana, College of Pharmacy; **Deirdre Hooper, MD**, Louisiana State University Health New Orleans, Department of Dermatology; **Haley Harrington, BS**, Louisiana State University Health Shreveport, School of Medicine; and **Kelsey Rooney, BS**, Louisiana State University Health Shreveport, School of Medicine. You can read the article on page 39.

Occasionally things come up that really are beyond your control. When a patient who has a pacemaker or a defibrillator shows up without their CIED card, for example, there's simply nothing to interrogate. How often that does happen, however—and is there really nothing you can do? The answers might surprise you, but can be found in *Assessing the Rate at Which Pacemaker and Defibrillator Patients Present to the Emergency Room with Their Manufacturer ID Card: A Cross Sectional Study* on page 33. Thanks to authors **Tinh M. Le**, Case Western Reserve

School of Medicine; **James F. Neuenschwander, MD**, Genesis Healthcare System and The Ohio State University; **Mary Jones, DNP**, Genesis Healthcare System and Frontier Nursing University; **Ankur Parekh**, The Ohio State University; **Hana Le**, The Ohio State University; **Kaitlyn Cedoz**, Alabama College of Osteopathic Medicine; and **Clark Daugherty**, University of Toledo College of Medicine and Life Sciences.

Another thing that is beyond the control of urgent care operators is the bond that can form between coworkers. As much as we encourage camaraderie and a sense of "team," when romance blossoms or preferential relationships develop it can be a tricky time for the staff. Having guidelines in place—and ensuring they're communicated—is essential. *Addressing Fraternalization in the Urgent Care Workplace* (page 25) by **Alan Ayers, MBA, MAcc** provides tips on making sure you do it right. Mr. Ayers is president of Experity Networks and senior editor, practice management for *JUCM*.

One area in which guidance is always helpful is billing and coding—especially at this time of year, when the Centers for Medicare and Medicaid Services releases its annually updated ICD-10-CM guidelines. Fortunately, **Monte Sandler**, vice president, revenue cycle management for Experity has summed up the most urgent care-specific aspects. You can read *ICD-10 Changes for 2022* on page 53.

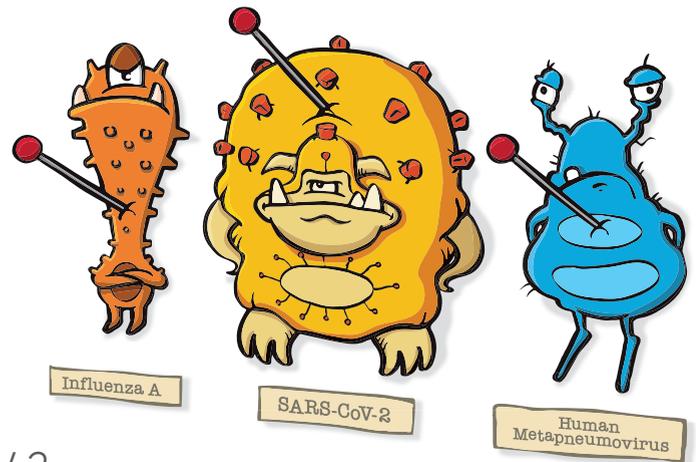
Finally, in *Abstracts in Urgent Care* (page 28), **Ivan Koay, MBChB, FRNZCUC, MD** reviews new articles on UTI treatment in men; acute respiratory illness in children; the use of isopropyl alcohol for acute nausea in adults; and the safety of a second COVID-19 vaccination dose in a patient who had a reaction to the first dose. Dr. Koay is an urgent care physician based in Dublin, Ireland, as well as an examiner and trainee supervisor for the Royal New Zealand College of Urgent Care Education Faculty for the Urgent Care Medicine Fellowship, Royal College of Surgeons Ireland.

We Want Your Feedback!

JUCM's mission is to provide you with relevant, accurate, and well-executed content that helps you do your job. If we publish something that stirs your thoughts or that provokes a reaction, let us know. **Andrew Grock, MD; Manuel Celedon, MD; and Jonie Hsiao, MD** did just that in their response to an original research article we published a few months ago. You can read their response in *Counterpoint: Readers React to JUCM Original Research* on page 1. (If you would like to follow suit and let us know how you feel about an article, or have a suggestion for a future article, email us at editor@jucm.com.) ■

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Hope

■ LOU ELLEN HORWITZ, MA

Hope is tough. It's defined as "a desire accompanied by confident expectation." And yet when you hear people talking about hope lately, their expectations don't sound all that confident.

Hope is tough because when we have it we have something to lose, which can make that hope precious to us. And when something is precious to us we tend to protect it, to shelter it, to keep it away from exposure so nothing happens to it.

The problem with that is that, often, nothing does happen. Nothing at all. We are so afraid of losing what we hope for that we don't let it grow strong and resilient and adaptive. Consequently, it gets smaller and harder the tighter we clutch it.

We've seen this in urgent care before, in the early 2000s when we held on so tightly to our model, defending it to all comers, that it came very close to stultifying itself. Then, blessedly, we remembered who we are and what we are made of and why we're here. We exposed our hopes for what urgent care could do and we tried and failed and succeeded and our hopes evolved, and continue to evolve and grow.

What urgent care has become is a different kind of model, and for a different audience than we anticipated. We created urgent care as a place for unplanned illness and injury to be treated outside of an emergency room or clogged appointment book. We created it for patients and our fellow providers. But just look at what it's become.

Urgent care has become *the* model of determinedly hopeful, ongoing reinvention that is the envy of most of the healthcare continuum and all of its stakeholders. They invest in us, they acquire us, they come to us, and then they look at us and say, "How are they doing this?"

The answer, I think, comes from a mindset that Jim Collins refers to in *Good to Great* as "The Stockdale Paradox." The Stockdale Paradox is named after Admiral Jim Stockdale, who was in a prisoner-of-war camp from 1965 to 1973. Conditions were

"Urgent care was forged in the school of hard knocks and our determination skills were refined long ago.... We have faced reality and retooled, and neither our faith nor hope that we will prevail will waiver."

brutal and rules were inconsistent, and there was no way to know if his ordeal would ever end. In his interview with Admiral Stockdale, Collins asked how he dealt with the experience. Stockdale told him he never lost faith that he and his fellow POWs would make it out, but *also* that he faced the facts of his current reality, whatever they might be. The optimists who only had "hope" were crushed over and over again when those hopes were dashed against reality.

If you look back (and forward) at urgent care centers throughout the pandemic, you can see the Stockdale Paradox at work. Yes, everyone has deeply hoped that COVID would be kind of like a bad flu; then it wasn't. After a year we thought it would go away; then it didn't. Then it kind of did, then it was back. If all we had were precious protected hopes, we'd have been in a lot of trouble—but we had more than that.

Urgent care was forged in the school of hard knocks and our determination skills were refined long ago. Brutal facts are our daily bread and adaptability is our middle name. But most assuredly we are also steeped in hope and faith in our vision, and a deep belief that we are right about what healthcare can be. That combination is extraordinarily powerful, and we are still only at the beginning of what we are capable of.

In closing, I do realize that you are likely reading this at about the time we were supposed to be coming together in New Orleans. Watching us have to cancel the Convention again was probably almost as painful for you as it was for us. You may be worried about how UCA is doing, but I want to tell you to worry not. We have faced reality and retooled, and neither our faith nor hope that *we will prevail* will waiver. We know we are going to prevail because *we are you* and *you are us*—and that, too, is an extraordinarily powerful combination. ■



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



CONTINUING MEDICAL EDUCATION

Release Date: October 1, 2021
Expiration Date: September 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

Accreditation Statement



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

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

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- **Michael B. Weinstock, MD**
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Return to Sports in the COVID-19 Era: A Clinical Review (page 17)

- 1. The rate of cardiac involvement in young-adult, collegiate, and professional athletes with COVID-19 has been found to be:**
 - a. 35% in adult hospitalized patients
 - b. 24% overall
 - c. Between 0.5% and 3%
 - d. Negligible
- 2. A child or adolescent who has had an ICU stay or intubation due to COVID-19 should be restricted from sports and physical activity for:**
 - a. 3 to 6 months
 - b. 3 to 6 weeks
 - c. 1 year
 - d. Typically 3 months, but it's at the provider's discretion
- 3. After being diagnosed with COVID-19, it is recommended that an athlete hold off on sports participation and exercise for:**
 - a. 10 days after the positive test
 - b. 10 days after symptom resolution without fever-reducing agents
 - c. Once they are able to complete activities of daily living
 - d. All of the above

Addressing Fraternization in the Urgent Care Workplace (page 25)

- 1. The legality of a fraternization policy depends on which of the following?**
 - a. The policy itself
 - b. The wording of the policy
 - c. The policy's application
 - d. All of the above
- 2. Most common antifraternization policies prohibit:**
 - a. Romantic or sexual relationships between supervisors and their direct subordinates
 - b. Romantic or sexual relationships between peers who work together directly (eg, in the same department)
 - c. Non-work-related relationships of any kind between supervisors and their direct subordinates

- d. All group activities not directly sanctioned by the company

3. A fraternization policy should be:

- a. Incorporated in the employee handbook and training
- b. Posted on the company's website
- c. Be explained to new employees but not set in writing so it can be enforced at management's discretion
- d. Just posted in a common area so workers see it often

An Unresponsive Pupil in the Urgent Care: Can A Diagnosis Be Made from the Bedside History and Exam? (page 39)

- 1. Which of the following could inform a diagnosis of pharmacological unilateral mydriasis?**
 - a. Lack of ocular pain and ptosis
 - b. Benign physical exam
 - c. Exposure to a topical, anticholinergic medication
 - d. All of the above
- 2. Which of the following may cause unilateral mydriasis?**
 - a. Adie's syndrome
 - b. Cocaine intoxication
 - c. Recent eye trauma
 - d. Acute angle closure glaucoma
 - e. All of the above
- 3. Which test should be done if a cerebral aneurysm is suspected?**
 - a. CBC and electrolytes
 - b. Skull films
 - c. MRI scan
 - d. Bedside neurologic exam; if normal, patient can be reassured there is no aneurysm



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Getting Served: The Do's and Don'ts of Litigation

Urgent message: Being sued for malpractice can have everything to do with the quality of the care you provided, or it could have practically nothing to do with the quality of the care you provided. Either way, you need to respond in a way that increases your chance of a positive outcome (and of maintaining your joy in practicing urgent care medicine).

GITA PENSA, MD, FAAEM

Upon returning home from a busy urgent care shift, you notice a certified letter with a law firm's return address. You open the letter and realize you are being sued in the case of a 26-year-old woman you saw almost a year ago. As your heart beats harder, you think about returning to the urgent care to pull up the chart. You wonder who you should call (the medical director, the insurance company...?) Should you put an addendum on the chart more completely detailing your memory of the case? While you remain frozen with fear racing through your mind, you hear your children's voices calling from the TV room. "Mommy's home!"

Many medical providers fear receiving notice of malpractice litigation.¹ Even in states with low relative risk of malpractice paid claims, high levels of worry among providers persist. Regardless of the ultimate outcome of a lawsuit, the personal impact of malpractice litigation itself on the individual provider is often significant.²

Malpractice litigation is exceedingly common. Research suggests that by the age of 65, over 75% of physicians in low-risk specialties, and 99% in high-risk specialties, had faced a malpractice claim at least once in their careers.³ The majority of claims do not result in any payment to the plaintiff, and only a small minority of cases proceed to trial. In one study, 68% of claims that closed in a single calendar year were dropped, dismissed, or withdrawn; out of the 7% of claims that were decided by a trial verdict, 88% resulted in the provider prevailing.⁴

In another recent study by Wong, et al, out of 6,779 closed medical professional liability claims originating from ED or urgent care centers over a 15-year period, 65.9%



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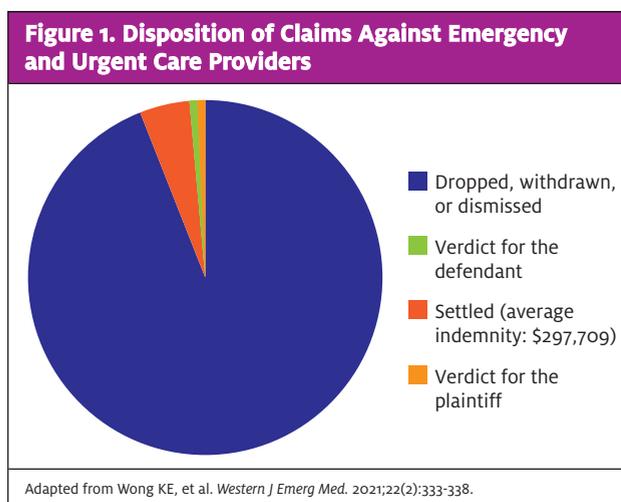
were dropped, withdrawn, or dismissed; 22.8% were settled for an average indemnity of \$297,709; and 7.6% went to trial. Of the cases that went to trial and jury verdict, defendants prevailed 92.6% of the time.⁵ (See **Figure 1**.)

Despite the frequency and fear of litigation, many providers are not well-versed in how litigation unfolds once a lawsuit is initiated. In this article, we focus on the details of what a provider might expect when they find the "letter in the mail," as well as some general principles the provider should adhere to during the early stages of litigation.

Background

"Getting served" or "receiving notice" are the informal terms used to describe how most providers are notified

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that a lawsuit is being filed against them. This “service of process,” as it is known legally, is part of the right to procedural due process as guaranteed in the fifth and 14th Amendments to the United States Constitution. This step in initiating a lawsuit is essential. If it is not executed properly and within the rules of that particular jurisdiction, the case cannot proceed.

Service of process gives the defendant provider a formal notice that the lawsuit is starting, and it is typically accompanied by the “complaint” (the stated grounds for the lawsuit). It also establishes that the court hearing the lawsuit has jurisdiction over the defendant.

A provider may be served by a certified letter in some places, but in others it may happen in person, delivered by a “process server” (an agent of the court who may deliver official documents) or even by a sheriff in uniform. There is generally no advance notice that someone is coming to serve papers, and the element of surprise unfortunately adds to the traumatic nature of the encounter.

Service of process may occur at home or work. One can imagine the impact of being served papers by a sheriff in uniform in front of colleagues or patients at work, or at home in front of family. Physicians have even described being served by a sheriff in uniform in front of extended family during Thanksgiving dinner.⁶

As you may surmise, this moment is sometimes leveraged by plaintiff’s attorneys as an opportunity to distress the defendant at the very start of the case. It is an opening move in a long, strategic process. Understanding that these methods are tactical, engineered to elicit an emotional response from the defendant, may be somewhat helpful in minimizing the intended effect.

The manner of service of process notwithstanding,

the accompanying written complaint itself is typically quite distressing to the provider. Written in formal, legal language, it usually describes the defendant’s alleged malpractice and negligence in a very forceful and emphatic manner, again crafted for impact. An emotional response is natural—and intended.

The traumatic impact of litigation on the provider starts at the very beginning, with receiving notice. The accusation of malpractice, whether or not substandard care was rendered, often creates a cascade of responses in the defendant that may have significant psychological, cognitive, spiritual, and physical effects, known collectively as *litigation stress*.⁷ Understanding the strategy behind service of process, as well as knowing what concrete steps to take and to avoid during this time, can help mitigate the litigation stress.

First Steps: Do’s

Contact your Malpractice Insurance Carrier

The first step after receiving notice of litigation is to contact your medical malpractice insurance carrier, as they will give you further instruction on how to proceed. They will typically assign you a representative who will oversee the claim and answer any questions. They will also often assist you in the next crucial step, which is obtaining a defense attorney.

It should be noted that, in some instances, the plaintiff’s attorney might first contact the provider or their employer directly (rather than go through the formal service process initially) in the hope of getting a quick settlement in order to spare the cost and trouble of litigation. Should a provider receive a letter or phone call like that, they should not correspond with the attorney at all, but rather contact their carrier immediately and go from there.

Obtain an attorney

Your insurer will be paying the attorney’s fees, and typically will determine which attorneys you may work with. If you have an attorney in mind, they may oblige you. They may assign you a particular attorney or provide you with a list of possible choices. Keep in mind that your attorney will be ushering you through a process that is foreign to you. You will be relying on them heavily, so it is helpful to have an attorney who is experienced with medical malpractice rather than personal injury law in general. Having a senior partner advising on your case is also helpful.

Your attorney will help with some crucial next steps, such as officially responding to the complaint in a

timely manner, which is required by the court. They will also assist you in answering “interrogatories,” introductory questions you will likely be sent by the plaintiff’s team. This begins what is known as the “discovery phase,” in which the attorneys on each side start building their cases, filing record requests, doing research, and obtaining external case reviews and deposition testimony. In due time, your attorney will prepare you for your own deposition.

In some states, the filing of the lawsuit will automatically trigger involvement of the state Department of Health and Licensure. Your attorney can help you with whatever is required in this case as well.

Seek support

Although providers are often admonished by their insurer and attorney to avoid talking to others about the case, this refers to the medical details and case events. It is absolutely fine to talk with trusted and discreet people in your life, such as your significant other or family, about the fact that you are being sued and how it impacts you. Talking about traumatizing events is a key element in processing and recovery.⁵ Seeking out peer supporters may be particularly helpful, as they have a baseline understanding of the stress of malpractice litigation that laypeople may not. It may also be helpful to speak confidentially with a mental health clinician during this time.

Learn More About the Process

Several books about medical malpractice litigation are available from online vendors and have information on both the practical aspects of litigation as well as managing its psychological impact. Professional societies, malpractice insurers and attorneys may have resources, as well. Online legal reference sources can also give you an overview of the civil litigation process. Knowledge about the process and your role in it may serve to mitigate your overall anxiety.

Practice Self-Care

Healthcare providers are notorious for neglecting self-care, and the culture of medicine does not inherently encourage us to prioritize our personal needs. However, malpractice litigation is an abnormal, longitudinal stressor, uniquely designed to erode provider well-being. Being sued adds on to the already significant daily challenges of practicing medicine; combating this extra stress requires a thoughtful and strategic intervention.

Though it may at times feel difficult, establishing a routine with attention to exercise, nutrition, sleep, and personal

relationships is helpful. Scheduling time for enjoyable activities and relaxation is also important, even if this means saying no to extra professional responsibilities.

Professional help from a well-trained mental health clinician can also help. As in the case of provider burnout,⁸ techniques exist that may help you reframe the litigation events in a more constructive way. Research-based resilience training, cognitive behavioral therapy techniques, and acceptance commitment therapy may all also arm you with valuable tools to help you cope. Litigation is unfortunately a high-risk time for burnout, anxiety, depression, substance use, post-traumatic stress disorder symptoms, and even suicide.⁷ Taking early, proactive steps to protect your physical and mental health is important. Give yourself permission to make your well-being a priority.

Things To Avoid During This Time: Don'ts

Do Not Alter the EMR

Do not alter the medical record in any way after receiving notice of litigation. The electronic medical record (EMR) keeps an audit trail with easily discoverable data indicating who entered the record, when they viewed it, and from what computer or terminal. It records if a chart was viewed or altered in any way, and all changes are discoverable. It is increasingly common for attorneys to hire digital forensics experts who will reveal any alteration attempts, and the optics of such attempts will spell devastation for your case. There have been many cases lost after an EMR audit in the last several years. If possible, avoid accessing the chart at all to avoid any hint of impropriety. You will have a chance to review the records once obtained by risk management, your insurer, or your attorney.

Do Not Attempt to Contact the Plaintiff or Their Family

Occasionally, the urge to personally communicate with the plaintiff or their family is very strong. You may wish to explain what happened, or apologize for their loss, or just connect to them on a human level. However, once litigation is initiated, this could easily be seen as intimidation and is *absolutely forbidden*. All communication from this point further is limited to the attorneys.

Do Not Keep Your Own Notes or Do Research

Do not write notes or do any research about the case without the knowledge of your attorney. It is important that all of this is kept within the protection of attorney-client privilege. Classifying any notes as attorney-client work product is protective to you. When you are deposed, you will be asked about any notes, research, or

records you have kept, and it is important that you can answer honestly under oath that you have only done this in conjunction with your attorney.

Do Not Despair

The initiation of a lawsuit is an intensely stressful time. Recognize that malpractice litigation is very common, and many of your peers and role models have weathered it. Being prepared for the challenges of litigation and taking care of your mental and physical health are of paramount importance. There are resources to help you better understand the practical aspects of litigation and its psychological impact. Understanding what steps to take, as well as the need for support and guidance during this time, will minimize the anxiety associated with the process.

Conclusion/Teaching Points

1. Most physicians will face a lawsuit at some point in their career. Less than half result in payments, and only a small number proceed to trial.
2. Of cases which do go to trial, roughly 90% result in

a defense verdict.

3. If you are involved in a malpractice action, do not alter the chart or take notes without the advice of an attorney, as there is an easily discovered audit trail in the EMR metadata.
4. Though you should not discuss the details of the case with anyone other than legal counsel, you can discuss your *feelings* about being involved in a malpractice action. ■

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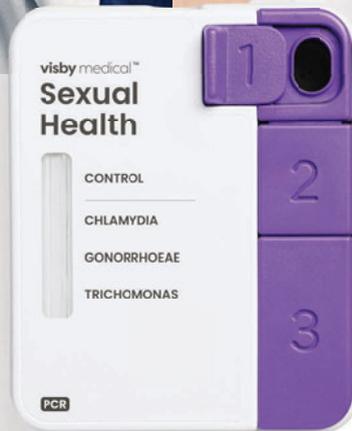
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Return to Sports in the COVID-19 Era: A Clinical Review

Urgent message: The COVID-19 worldwide pandemic has changed sports as we know it. Returning athletes back to sport safely continues to be widely debated among physicians in cardiology, primary care, infectious disease, and sports medicine. The return-to-play process after a COVID-19 infection will depend on the severity of their infection, duration of symptoms in the context of any concerning past medical history, and/or family history. Urgent care providers should be prepared to conduct "clearance" exams and provide guidance on safe return to the playing field.

BRIAN HARVEY, DO and NATALIE STORK, MD

Case Presentation

A 15-year-old male presented to the urgent care seeking clearance after his COVID-19 infection. His symptoms lasted for 5 days and included loss of taste, cough, sore throat, and fatigue. He reports he had 3 days of fever at the start of his symptoms. Currently, he is asymptomatic and has not had symptoms for the past 2 weeks. He is an avid football athlete and wants to return as quickly as possible.

Introduction

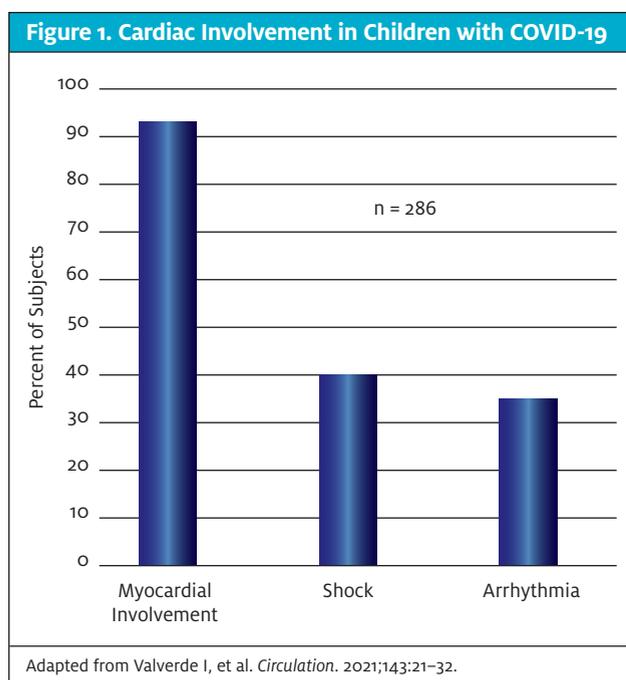
SARS-CoV-2 is a novel coronavirus that causes a multitude of symptoms known as COVID-19, which has continued to spread exponentially across the world, killing millions, including over 600,000 in the United States. When the United States economy "shut down" in March of 2020, sports participation, ranging from professional to recreational, followed suit. Within a few short months, mitigation strategies in sport led to the resumption of practice and competition, even as the pandemic continued to spread.

As cases continued to rise, more information was discovered about COVID-19, including its effects on the



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Author affiliations: Brian Harvey, DO, Children's Mercy Kansas City. Natalie Stork, MD, Children's Mercy Kansas City. The authors have no relevant financial relationships with any commercial interests.



athlete. SARS-CoV-2 can affect most major organs, including the cardiovascular system.

COVID-19 commonly affects the adult heart, with up to 78% of adult patients demonstrating changes on imaging or laboratory testing.¹ Concern regarding the impact this virus may have on the cardiovascular system of athletes, and specifically the potential for sudden cardiac death in the athlete, quickly arose. The possibility of arrhythmias, particularly ventricular arrhythmias associated with myocarditis, has been an area of focus in sports medicine.

In May of 2020, these alarming reports led to initial recommendations for the evaluation of all athletes with a history of COVID-19, prior to returning to sport. At the time, a conservative approach to the evaluation was recommended, with consideration to include screening electrocardiograms, laboratory evaluation, echocardiogram, and cardiac magnetic resonance imaging.²

As pediatric cases increased, multi-inflammatory syndrome in children (MIS-C) has been reported. While there is still ongoing research, cardiac involvement in MIS-C has been high. Cardiac arrhythmias were shown to be present in 35% of hospitalized patients and echocardiographic changes, including 24% having coronary artery abnormalities³ (See **Figure 1.**) However, cardiac involvement remains less defined currently in asymptomatic and mildly symptomatic pediatric patients.

In more recent studies, cardiac involvement in the

young-adult, collegiate, and professional athlete has been reported at a much lower rate, ranging from 0.5% to 3%.⁴ As more evidence has been published, recommendations on how adult and college athletes return to play have changed. The most recent recommendations on screening the pediatric athlete after a COVID-19 infection have come from the American Academy of Pediatrics, updated in August of 2021.⁵

Treatment/Return to Play Strategies

In the asymptomatic athlete, defined as no symptoms with a positive test, as well as mild symptoms (defined as fever $\leq 100.4^{\circ}$ for ≤ 4 days, < 1 week of chills, lethargy, myalgias), it is recommended to have at least a telehealth visit or a phone call with the primary care physician prior to returning to participation in sport. During the screening process, if there are any symptoms by history, it is recommended to have an in-office evaluation that consists of a full cardiac screen questionnaire, full physical exam, and consideration of an ECG. If there are any abnormalities or concerns, a referral to cardiology is warranted. If there are no concerning findings, a slow return to play process as described later in this article is recommended.

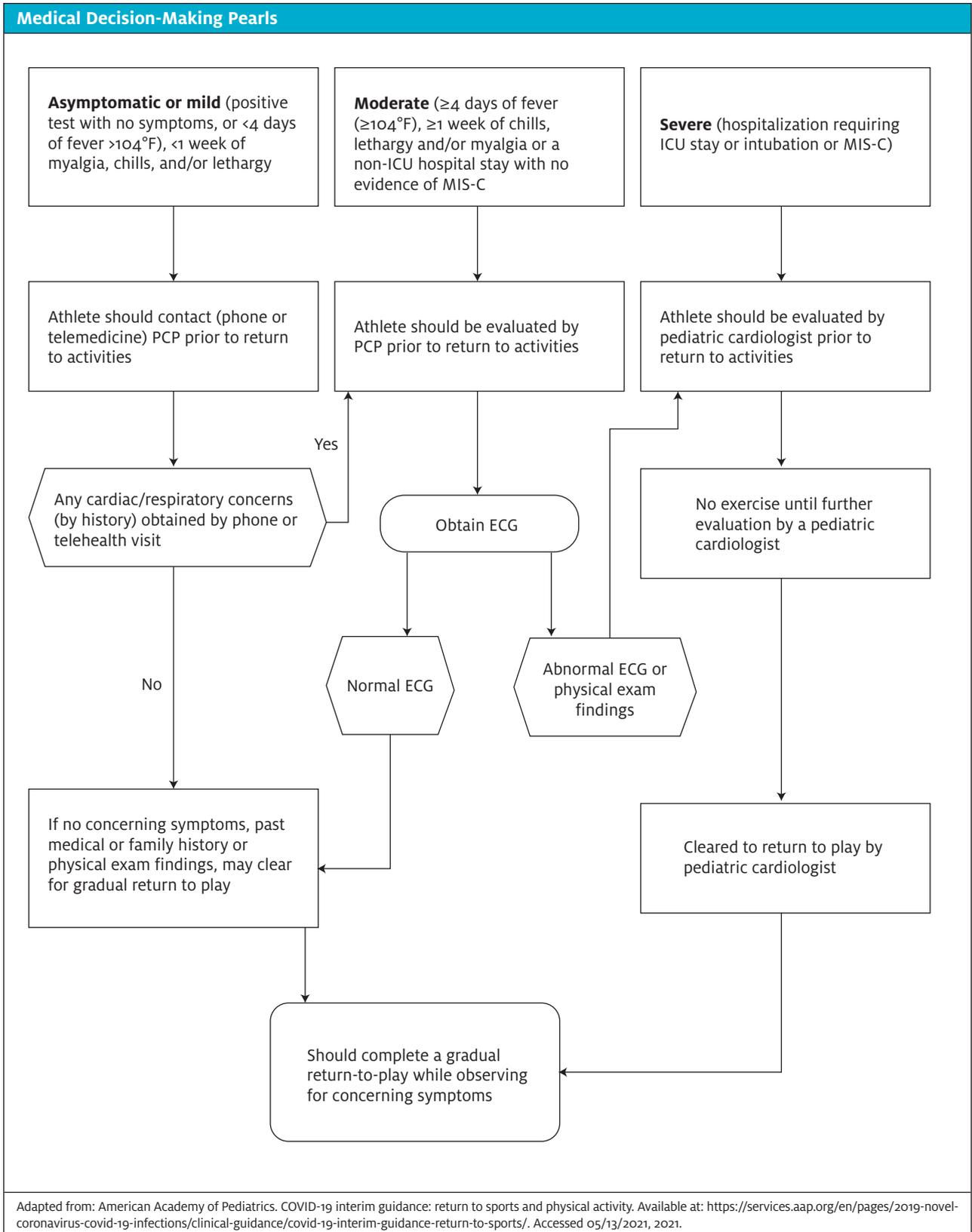
For a moderate illness in the athlete (as defined as symptoms ≥ 4 days of symptoms, ≥ 1 week of chills, lethargy, myalgias OR non-ICU hospitalization), it is recommended that an in-office evaluation be performed prior to the return to sport. Again, this would include a cardiac questionnaire, physical exam, and an ECG. If there are any concerns or abnormalities, a referral to cardiology should be made. If there are no concerns, following the return to play process is recommended.

For severe infections, defined as an ICU stay, intubation, or diagnosis of MIS-C, athletes should be followed clinically by pediatric cardiology. Athletes are asked to refrain from any exercises or exertion for a minimum of 3-6 months as directed by pediatric cardiology. A slow return to play process after clearance is recommended.

Keys to History and Physical Exam

The American Academy of Pediatrics (AAP) continues to recommend that all children and adolescents who test positive for COVID-19 notify the primary care physician, who knows the athlete, prior to return to sports or physical activity.⁵

Children who are asymptomatic or have mild symptoms (< 4 days of fever ($> 100.4^{\circ}\text{F}$), and/or < 1 week of myalgias, chills, and lethargy) are recommended to have at least a phone call or telemedicine visit with their pri-



primary care physician prior to return to sports or physical activity. This phone consultation or telemedicine visit should specifically address questions concerning for any associated cardiovascular symptoms, including but not limited to chest pain, shortness of breath out of proportion for upper respiratory illness, new-onset palpitations, or syncope. If any concerning symptoms are identified, the child/adolescent should be evaluated in person prior to clearance for sports or activities.⁵

Children or adolescents with moderate symptoms (>4 days of fever (>100.4°F), and/or >1 week of myalgias, chills, and lethargy and/or a *non*-intensive care unit hospital admission, and no evidence of MIS-C), should be evaluated in person by their primary care physician after symptom resolution and appropriate quarantine. The primary care physician should review cardiac symptoms described in the American Heart Association (AHA) 14-point screening evaluation, with emphasis on the cardiac symptoms below, including shortness of breath that is new or out of proportion to prior upper respiratory tract infections.⁵ Any child or adolescent who has had severe COVID-19 symptoms (ICU stay and/or intubation) or MIS-C should be restricted from sports and physical activity for a minimum of 3-6 months and should be evaluated by a cardiologist prior to return to sports or physical activity. This follow-up should be arranged prior to discharge from the hospital.⁵

MEDICAL HISTORY

Personal History

- Exertional chest pain/discomfort
- Palpitations or abnormal heartbeat
- Exertional syncope or near syncope
- Excessive exertional and unexplained fatigue/fatigue associated with exercise
- Prior recognition of a heart murmur
- Elevated systemic blood pressure
- Prior restriction from participation in sports
- Prior testing for the heart ordered by a physician

Family History

- Premature death – sudden and unexpected before the age of 35 due to heart disease in one or more relatives
- Disability from heart disease in a close relative
- Specific knowledge of certain cardiac conditions in family members, specifically: hypertrophic or dilated cardiomyopathy, long-QT syndrome, or other ion channelopathies, Marfan syndrome, or clinically important arrhythmias

Physical Exam

- Heart murmur – exam supine and standing with Valsalva, specifically to identify murmurs of dynamic left ventricular outflow tract obstruction
- Femoral pulses to exclude aortic stenosis
- Physical stigmata of Marfan syndrome
- Brachial artery blood pressure, sitting, preferable both arms

If there is any new shortness of breath with exercise or shortness of breath out of proportion to a typical upper respiratory tract infection, dyspnea on exertion, new chest pain, syncope, or palpitations, an ECG or referral to cardiology is recommended.

The physical exam should be comprehensive but focus specifically on the cardiac and pulmonary systems. The cardiac exam should be performed in the supine, standing, and squatting position, specifically listening for new murmurs, abnormal rhythms, or gallops. Any new murmur, gallop, or arrhythmia should be referred to cardiology for clearance.

Any athlete who is experiencing a new-onset exercise intolerance, chest pain with exercise, syncope, or near syncope as they return to sport should be evaluated.

If an athlete has a remote history of COVID-19 and has returned to exercises on their own without issues, a phone call to update the patient's primary care provider is recommended.

Diagnostics

As mentioned previously, diagnostic testing and imaging depend on severity of the infection, duration of symptoms, and past medical and family history. While primary care physicians may consider ordering an ECG depending on the clinical history and exam, further workup will occur at the discretion of a cardiologist.

The cardiologist will determine further workup and evaluation. This may include ECG, echocardiogram, laboratory evaluation, cardiac MRI, Holter monitor, or exercise stress test depending on the severity of the disease, symptoms, and/or abnormalities found on history, physical, and diagnostic workup. There is no standard workup approach currently for cardiologists in the asymptomatic, mild, or moderate categories; these should be symptoms-based.

ECG

T-wave inversion to T-wave abnormalities, flattening or other abnormalities in the T-wave, as well, have been seen in the hospitalized patient with MIS-C and reported in the asymptomatic/mild symptom patient population, as well. These abnormalities appear to resolve with time.

Special Considerations: Return-to-Play Steps

Once an athlete has been diagnosed with COVID-19, it is recommended that they hold off on sports participation and exercise for 10 days after the positive test or symptom onset, and 10 days after symptom resolution without fever-reducing agents. Athletes may begin Phase 1 of the following return-to-play progression once they are able to complete activities of daily living (ie, walking around the house, dressing, daily hygiene tasks, etc.) without worsening of symptoms and have been cleared by a healthcare provider for exercise or sports activities. Over a 7–10-day period, athletes can slowly return into activity adapted from Elliot, et al.⁶

- Phase 1: At least two sessions of light aerobic activity (up to 70% maximum heart rate) for up to 15 minutes. Sessions should be at least 24 hours apart. Activities may include brisk walking, light jogging, or using a stationary bike. No strength training.
- Phase 2: At least one session of aerobic exercise (up to 80% maximum heart rate) for up to 30 minutes. Simple movement activities such as running drills may be added to increase the level of difficulty. No strength training.
- Phase 3: At least one session of exercise (up to 80% maximum heart rate) for up to 45 minutes. May add some simple sport-specific activities and strength training to increase the level of difficulty.
- Phase 4: At least two sessions of sport-specific training (up to 80% maximum heart rate) for up to 60 minutes. Sessions must be at least 24 hours apart.
- Phase 5: Resume normal training activities and duration for at least one session.
- Phase 6: Return to competition with no restrictions

Prevention

Mitigation strategies should be used throughout practice and competition to decrease the spread of COVID-19 transmission. Appropriate handwashing hygiene, use of individual water bottles, and cleaning procedures should be followed. The AAP currently recommends that all athletes participating in indoor athletics wear a mask. This can reduce the transmission equal to that of outdoor sports. If an athlete is unvaccinated, masks should be worn while not participating actively in sport and while on the sideline if 3 feet of social distancing cannot be maintained.⁵

The best prevention is the COVID-19 vaccine. The vaccine has been shown to be safe and effective in reducing severe disease and hospitalizations.

The AAP continues to recommend an annual health evaluation performed in the medical home (ie, the primary care physician/provider office). In an ideal world this would incorporate components of the pre-participation evaluation. The frequency of the actual pre-participation evaluation, however, does fluctuate by state requirement with some states requiring an annual evaluation while other states have recently switched to every 2-year requirement for the PPE (preparticipation evaluation) component. The AAP recommends, however, physicians and healthcare providers should ask about any COVID-19 prior infection since their last pre-participation and/or annual exam and vaccine status in the pre-participation evaluation.⁵

Summary

For the 15-year-old male athlete who presented with moderate symptoms, it was recommended he be evaluated in person by his primary care physician once his symptoms resolved and that he finish the recommended quarantine. Upon evaluation by his primary care physician, a review of the 14-point AHA screening evaluation questions and a thorough physical exam were conducted and did not reveal any concerning symptoms. He was instructed to complete a 7-day gradual return-to-play protocol as outlined previously.⁶ He was able to return to football without symptoms.

A Caveat

It is important to note that presentation of this case reflects recommended best practices at the time of this publication. Recommendations will continue to evolve quickly, however, as we continue to learn and discover more. As such, recommendations included in this review may change with time. ■

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Addressing Fraternization in the Urgent Care Workplace

Urgent message: Whereas sexual harassment is defined as *unwanted and one-sided*, many times employees *choose* to become romantically involved, requiring that urgent care centers have a policy and a plan to address workplace fraternization.

ALAN A. AYERS, MBA, MACC

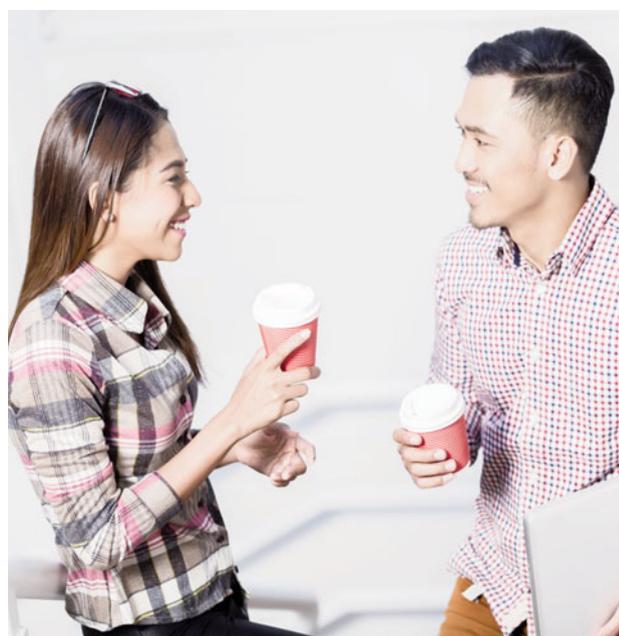
In 2019, McDonald's fired its Chief Executive Steve Eastbrook for engaging in a relationship that violated company policy. The fast-food giant's standards of business conduct prohibit employees with "a direct or indirect reporting relationship" from "dating or having a sexual relationship."¹ In 2020, Nine Entertainment Co-Chief Executive Hugh Marks admitted to a relationship with a former subordinate.² And earlier this year, Eli Lilly announced that its chief financial officer would be replaced after discovering a consensual but "inappropriate personal relationship" he had with an employee.³

This behavior is not exclusive to executives of major corporations. It occurs in small and medium-size businesses of every stripe around the country. Here, we examine fraternization in the workplace and how urgent care owners can address this behavior with a company policy.

How Is Fraternization Defined?

Merriam Webster defines fraternization as associating or mingling as brothers or on fraternal terms.⁴ Fraternization in the military is defined as prohibited personal relationships between military service members of different ranks and positions.⁵ In today's corporate settings, fraternization generally means improper relationships, from overly casual relationships to friendships to romantic relationships.⁵

Fraternization is different from sexual harassment, which is defined as unwanted and one-sided. This activity is consensual and two-sided. Even so, what often starts as a consensual relationship may evolve into allegations of sexual harassment if the relationship disinte-



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grates, particularly if there's a power disparity (subordinate/supervisor) between the two individuals.⁶ And even when the coworkers are on an equal footing, fraternization to the point of a romantic relationship can be a significant risk and detrimental to an urgent care operation.

Legal Issues Concerning Fraternization

Fraternization when the individuals are "just friends" may be innocuous enough. Friendships at work can cultivate loyalty and job satisfaction and create a better

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“An urgent care operation's fraternization policy should focus on how relationships, romantic or otherwise, impact the productivity and efficiency of the team.”

product or service. However, friendships can also alienate those who feel “left out” from out-of-work activities. These employees may hear about important information after the fact. This can fuel gossip and foster perceptions of favoritism, exclusion, or discrimination. In addition, a manager may undermine his or her leadership credibility and authority among other employees who view him or her as unethical if they believe he or she is romantically involved with someone on the team or in the company. Plus, a subordinate may later claim that he or she was coerced into the relationship by the manager.⁷

Non-fraternization policies are designed to protect the company from liability and other issues. For example, an employee may allege that they were wrongfully discharged from their position because they fraternized with another employee.⁸⁻¹³ An employee may also bring a claim of negligent hiring, negligent training, or negligent retention when a company fails to address fraternization that impacts work.¹⁴⁻¹⁶ An employee may also bring a claim for negligent monitoring or supervision.¹⁷

In addition, claims of sexual harassment and a hostile work environment may arise from an employer's lack of enforcement of a non-fraternization policy or from failing to address such issue with a policy in the employee handbook.

Fraternization in Urgent Care Centers

As far as urgent care centers—even those that are owned by larger companies—are concerned, the clinic workplace is typically small with no more than five to seven employees working at any given time. These employees have specific assignments, and if two (or more) employees are involved in a personal situation, the entire operation may come to a screeching halt, impacting revenues, company image, recruitment, and word-of-mouth.

Teamwork is critical for quality patient care. Anything that undermines the team—including toxic gossip, workplace bullying, and sexual harassment—must be addressed by management.

Creating a Fraternization Policy

In the case of Easterbrook, McDonald's said its board determined the CEO engaged in a relationship that violated company policy. The restaurant chain's standards of business conduct prohibit employees with “a direct or indirect reporting relationship” from “dating or having a sexual relationship.”¹

It's highly unlikely that you can legally create a “no dating” policy for your employees because a policy that restricts an employee's free choice to do legal and lawful things could be considered an infringement or violation of their rights. In addition, there are legal protections for privacy rights. For example, in California, the state constitution protects privacy rights at work *and outside of it*. Thus, a policy requiring employees to disclose romantic relationships with coworkers there would violate state law.¹⁸⁻²⁰ State privacy laws differ, however, so an urgent care owner or manager inquiring into rumors of fraternization that disrupts work may or may not be prohibited.

One court has said that while “privacy expectations may be significantly diminished in the workplace, they are not lacking altogether. An employer may have sound reasons for monitoring the workplace, but that does not mean an employer has carte blanche to monitor all the activities of every employee.”²¹

Company policies that prohibit employees from fraternizing with coworkers may not be legal, depending on the circumstances. Policies that ban all fraternizing without specifying romantic relationships can be in violation of labor protections under the National Labor Relations Act.²² That law protects the right of employees to meet and organize for mutual support. As a result, policies that ban romantic relationships specifically can violate worker's privacy rights in some states.¹⁸

For example, a security company, Guardsmark, enforced a non-fraternization policy that forbids employees to “fraternize on or off duty, date or become overly friendly with the client's employees or with co-employees.”²³ The U.S. Court of Appeals for the District of Columbia Circuit held that the NLRB erred in approving the rule prohibiting fraternization with clients on- or off-duty because the rule failed to distinguish between union fraternizing and social fraternizing. In effect, the company was defining fraternization too broadly.²⁴

A clear company policy is critical to enforcing fraternization in the workplace. The legality of a fraternization policy depends on three factors:

1. The policy itself
2. The wording of the policy

3. The policy's application²⁵

Most common antifraternalization policies prohibit romantic or sexual relationships between supervisors and their direct subordinates.²⁶ In addition, there are companies that prohibit consensual relationships between coworkers. This is aimed at shielding the company from potential problems caused by distraction or romantic conflict.²⁵ If two employees at an urgent care start dating, they may pay so much attention to each other that their work suffers and patients receive poor service and treatment. There may also be the issue of public displays of affection which can be disruptive to other employees. Employees who are romantically involved may spend a disproportionate amount of work time or work resources such as email and text messaging on a company phone in non-work-related conversations and activities. Moreover, if the relationship ends badly, it could create an even greater distraction.

Urgent care centers must not create a policy that is too broad, like Guardsmark. Moreover, the policy must not violate state or local law. The policy should focus on how relationships, romantic or otherwise, impact the productivity and efficiency of the team. The policy should not be exclusionary, but should apply to all employees regardless of gender or sexual orientation. It's vital to create a fraternization policy that will minimize the impact of the things that can go wrong in the workplace and maximize the positive aspects of employee relationships.²⁷

The Contents of Fraternization Policies

A fraternization policy needs to have multiple parts and must do the following:

- Identify the types of relationships that are forbidden because of their potential impact at work
- Define the romantic and friendly behavior that is acceptable and what is unacceptable
- Prohibit romantic relationships between a manager and a direct report
- In larger organizations, prohibit dating relationships between employees who are separated by two levels in the chain of command, no matter the reporting relationship or department
- State the potential consequences of violating the policy
- Provide courses of action that leave an employee with opportunities to understand and comply with the policy²⁸

This type of policy should not prohibit all relationships, but rather, define how the relationship exists in

the work environment at the urgent care. The fraternization policy should be included in the employee handbook and incorporated with other training.

Takeaway

Many companies run into trouble because they do not have a corporate policy on fraternization.²⁶ The safest course of action for an urgent care operation is to draft clear and specific policies and then enforce them fairly and consistently. ■

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ABSTRACTS IN URGENT CARE

- Duration of UTI Treatment in Men
- Acute Respiratory Illness in Children
- Isopropyl Alcohol for Acute Nausea in Adults
- Neurological Events and Metronidazole Prescribing
- Do the Modified Sgarbossa Criteria Offer Advantages Over the Original?
- Safety of a Second COVID-19 Vaccination Dose in Patients Who Had a Reaction to the First

■ IVAN KOAY, MBCHB, FRNZCUC, MD

How Long Should We Treat UTI in Men?

Take-Home Point: In afebrile men with UTI symptoms, a 7-day course of ciprofloxacin or trimethoprim/sulfamethoxazole was noninferior to a 14-day course.

Citation: Drekonja D, Trautner B, Amundson C, et al. Effect of 7 vs 14 days of antibiotic therapy on resolution of symptoms among afebrile men with urinary tract infection. *JAMA*. 2021;326(4):324-331.

Relevance: Given the significant risk of adverse events related to longer courses of antibiotics, prescribing the shortest effective course of antibiotics is important for patient safety.

Study summary: This was a double-blind, randomized, placebo-controlled trial conducted at two U.S. Veterans Affairs (VA) medical centers. Male patients with UTI symptoms such as dysuria, frequency of urination, urgency of urination, hematuria, costovertebral angle tenderness, or perineal, flank, or suprapubic pain were treated with either 7 or 14 days of ciprofloxacin or trimethoprim/sulfamethoxazole. All participants initially had an antibiotic prescribed by their treating clinician for 7 days then continued antibiotic therapy or placebo for days 8 through 14 of treatment, depending on their randomization group. These antibiotics were chosen because they accounted for 90% of the antimicrobials used in this situation for treatment within the VA system. A urine culture was not required for enrollment, although it was encouraged in institutional clinical guidance. From a study population of 272 participants, symptom resolution occurred in 91.9% of participants

in the 7-day group vs 90.4% in the 14-day group, meeting the noninferiority criterion. Recurrence of UTI symptoms was not significantly different between the 7-day group (9.9%) vs the 14-day group (12.9%).

Editor's note: There were several limitations to the study. The choice of antibiotics was limited to ciprofloxacin or trimethoprim/sulfamethoxazole. The homogeneous population of participants (ie, older men) within the VA system only and the potential that some participants may not have had a UTI were also limitations. These results cannot be applied to female patients because the sites within the urinary tract of infection are generally distinct (eg, prostatitis vs cystitis). ■

Antibiotic Prescribing in Children with Acute Respiratory Illness Presenting to the ED

Take-home point: The use of rapid respiratory pathogen (RRP) testing did not reduce the rate of antibiotic prescribing to children presenting with acute respiratory illness in this study.

Citation: Rao S, Lamb M, Moss A, et al. Effect of rapid respiratory virus testing on antibiotic prescribing among children presenting to the emergency department with acute respiratory illness: a randomized clinical trial. *JAMA Netw Open*. 2021;4(6): e2111836.

Relevance: Antimicrobial stewardship is a perennial challenge for UC/ED clinicians. It is unclear the value in affecting management.

Study summary: This was a single-center, randomized prospective trial based in a large pediatric ED. Participants included in the study were those triaged as category (ESI) 3 to 5 who were deemed stable and did not require clinician evaluation within 30 minutes of arrival. All participants underwent nasopharyngeal aspirate testing for RRP. Results of the test were



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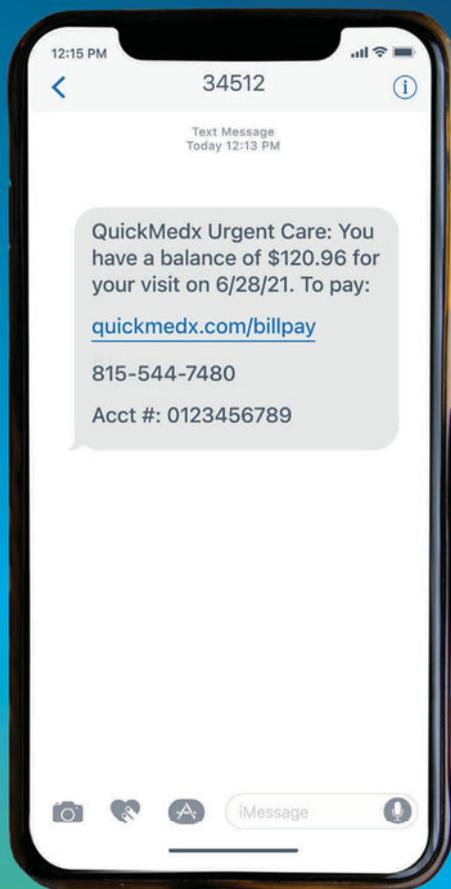
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made available to the treating clinicians for those in the intervention group and not to the clinicians for those in the control group. Pathogens evaluated for this study included adenovirus, coronaviruses HKU1, NL63, 229E, and OC43, human metapneumovirus, rhinovirus/enterovirus, respiratory syncytial virus, influenza A, A/H1-2009, A/H3, and B, parainfluenza virus 1, 2, 3, and 4, *Bordetella pertussis* and *B parapertussis*, *Chlamydophila pneumoniae*, and *Mycoplasma pneumoniae*.

The authors found that of the 908 children recruited, those in the intervention group were more likely to receive antibiotics than children in the control group (relative risk [RR], 1.31; 95%CI, 1.03-1.68) and to have a diagnosis for which antibiotics would be indicated (risk difference, 8.6; 95%CI, 3.2-13.8). Secondarily, there were no significant differences in antiviral use, ED length of stay, recurrent ED visits, or hospitalization. In the intention-to-treat analysis, children whose clinician knew the RRP test results were more likely to receive antivirals (RR, 2.6; 95%CI, 1.6-4.5), be admitted to the hospital from the ED (RR, 1.8; 95% CI, 1.4-2.5), and have longer ED length-of-stay (RR, 1.6; 95%CI, 1.5-1.7).

Editor's note: This was a single academic center study. The study was underpowered to detect a difference in per protocol analyses; this was corrected for statistical purposes by the authors with a modified intention to treat analysis. ■

Inhalation of Isopropyl Alcohol for Treatment of Acute Nausea in Adults

Take-home point: Inhaled isopropyl alcohol (IPA) was more effective than placebo in the treatment of nausea and vomiting in adults in this study.

Citation: Candemir H, Akoglu H, Sanri E, et. al. Isopropyl alcohol nasal inhalation for nausea in the triage of an adult emergency department. *Am J Emerg Med.* 2021;41:9-13.

Relevance: Being able to treat patients rapidly for severe nausea prior to clinician evaluation with a rapid-acting and safe agent would be of great utility in urgent care practice.

Study summary: This was a prospective, double-blinded, randomized controlled study conducted in a single academic center ED in Turkey. Patients presenting to triage with nausea and vomiting and that were eligible were randomized to receive pharmacy-prepared gauze soaked in IPA or saline (placebo) to inhale. A numerical rating scale (NRS) was taken at the initial point and then subsequently at 2-, 4- and 10-minutes post intervention, with physicians allowed to use rescue antiemetics after 10 minutes. The authors recruited 118 patients (62 IPA and 56 placebo groups). They found significantly decreased intensity of nausea on the NRS with IPA use compared with

placebo. There was a reduction in the mean NRS scores at 10 minutes in the IPA compared with placebo (2.7 v 0.9) with a higher percentage of patients in the placebo group requiring rescue antiemetic treatment (74.1% vs 44.3%), both statistically significant (p=0.008 and 0.004).

Editor's note: This was a single-center study conducted in Turkey. There was no longer-term follow-up after the initial 10 minutes, nor any comment regarding recurrence of the symptoms postdischarge from the study protocol. ■

Neurological Events Associated with Metronidazole Prescribing

Take-home point: Metronidazole is associated with an increased risk of adverse peripheral and central nervous system events.

Citation: Daneman N, Cheng Y, Gomes T, et al. Metronidazole-associated neurologic events: a nested case-control study. *Clin Infect Dis.* 2021;72(12):2095-2100.

Relevance: Metronidazole is one of the most common antibiotics prescribed in the urgent care setting; it is important for UC providers to be aware of potentially serious adverse reactions, even if they are relatively rare for commonly prescribed medications.

Study summary: This was a retrospective population-based nested case-control study involving older adults (>65 years) in Ontario, Canada. Cases were evaluated based on the receipt of metronidazole or clindamycin (control population) in the previous 100 days and who subsequently presented with peripheral or central neurological events. During the 14-year period of analysis, the authors found that a total of 1,212 out of 74,839 patients exhibited acute neurological events (encephalopathy, cerebellar dysfunction, or peripheral neuropathy) after exposure to metronidazole. These events were associated with an increased odds of metronidazole exposure compared with clindamycin (OR, 1.72 [95% CI, 1.53-1.94]). The incidence of neurological events following administration of metronidazole was 0.25%, which was on par with incidence of other serious antibiotic-adverse events that have prompted warnings from the Food and Drug Administration. The authors recommend reporting metronidazole-associated neurological events to the federal authorities.

Editor's note: This study was limited to older adults with no representation for younger patients. The indications for use of clindamycin, the comparative antibiotic, are different to metronidazole. ■

EKG Diagnosis of AMI in Ventricular Paced Rhythm

Take-home point: The modified Sgarbossa criteria (MSC) is more sensitive than the original Sgarbossa criteria (SC) for the diagnosis of ST-elevation myocardial infarction (STEMI).

Citation: Dodd K, Zvosec D, Hart M, et al. Electrocardiographic diagnosis of acute coronary occlusion myocardial infarction in ventricular paced rhythm using the modified Sgarbossa criteria. *Ann Emerg Med.* 2021;So196-0644(21)00249-3.

Relevance: Diagnosing AMI in patients with paced rhythms can be challenging. The Sgarbossa criteria can aid in identifying acute ischemia in this relatively common presentation; however, they were somewhat less sensitive than ideal.

Study summary: This was a multicenter, observational case control investigation based in 16 centers. Subjects were patients with ventricular pacemakers who presented with symptoms concerning for acute coronary syndrome (ACS). They were compared with other patients presenting to the ED with ACS symptoms. The patients were then subdivided based on angiography findings to an occlusive MI (OMI) group, non-occlusive MI group, and a no occlusion control group. The MSC proposed alterations are:

1. Concordant ST elevation ≥ 1 mm in ≥ 1 lead
2. Concordant ST depression ≥ 1 mm and applicable in leads V₁-V₆
3. Discordant STE in ≥ 1 lead anywhere with ≥ 1 mm STE, as defined by $\geq 25\%$ of the depth of the preceding S-wave

The authors found that of the 149 patients recruited, 59 met the OMI criteria. In the diagnosis of OMI in ventricular paced patients, sensitivity of MSC was 89% compared with 56% in SC. The specificity of the MSC was lower for patients in the nonocclusion myocardial infarction group compared with the no-occlusion myocardial infarction group

Editor's note: This study was limited by its retrospective design. The modified Sgarbossa criteria, like the initial Sgarbossa criteria, seem to primarily have value in their high specificity (ie, useful for ruling-in STEMI). While the modified Sgarbossa criteria have better sensitivity than the initial criteria, in this study they still lack sufficient sensitivity to rule out ACS definitively in the setting of LBBB/paced rhythms. ■



How Safe Is Receipt of a Second mRNA Vaccination After Reaction to First Vaccination?

Take-home point: Most patients who had an initial reaction to the first mRNA COVID-19 vaccine tolerated a second dose without any serious events.

“Recommending antihistamine premedication may provide some additional benefit as well as psychological comfort for both clinicians and patients after having an adverse reaction after initial vaccination.”

Citation: Krantz M, Kwah J, Stone C, et al. Safety evaluation of the second dose of messenger RNA COVID-19 vaccines in patients with immediate reactions to the first dose. *JAMA Intern Med.* 2021;e213779.

Relevance: Getting the entire eligible population vaccinated is crucial in the fight against COVID-19. Patient safety in this process is also essential to ensuring public confidence in vaccination efforts.

Study summary: This was a multicenter, retrospective study conducted by Massachusetts General Hospital, Brigham and Women's Hospital, Vanderbilt University Medical Center, Yale School of Medicine, and University of Texas Southwestern Medical Center. Subjects were patients who had an immediate allergic reaction to the Pfizer-BioNTech or Moderna vaccine, with symptom onset within 4 hours of the first dose, at least one allergic symptom, and referral for an allergy/immunology consultation with in-clinic or telehealth assessment. The authors found that of the 189 patients participating in the study, the most frequently reported first-dose reactions were flushing or erythema (28%), dizziness or light-headedness (26%), tingling (24%), throat tightness (22%), hives (21%), and wheezing or shortness of breath (21%), with 17% meeting the criteria for anaphylaxis. Eighty-four percent received a second dose, with antihistamine premedication given in 30% of patients. All 159 patients, including 19 individuals with first-dose anaphylaxis, tolerated the second dose. Twenty percent reported immediate and potentially allergic symptoms associated with the second dose that were self-limited, mild, and/or resolved with antihistamines alone.

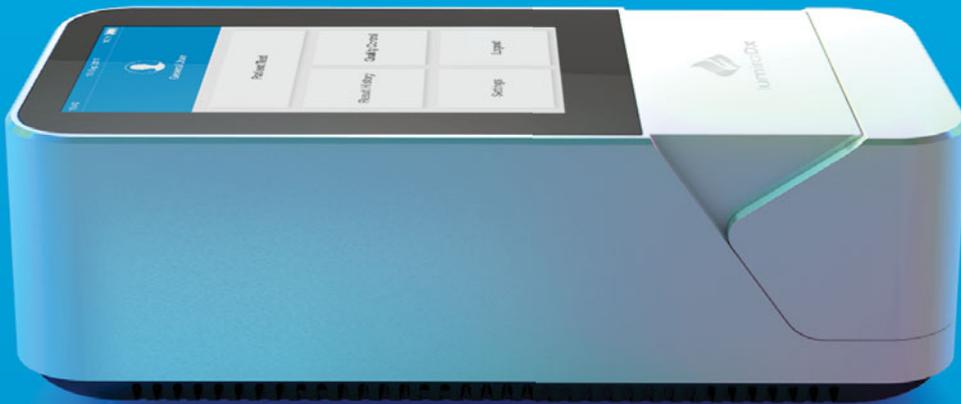
Editor's note: This was a small retrospective study, but the absence of serious adverse events is reassuring. Recommending antihistamine premedication may provide some additional benefit as well as psychological comfort for both clinicians and patients after having an adverse reaction after initial vaccination. This study also provides further evidence that serious adverse reactions to either dose of the mRNA vaccines is very rare. ■



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Assessing the Rate at which Pacemaker and Defibrillator Patients Present to the Emergency Room with their Manufacturer ID Card: A Cross-Sectional Study

Urgent message: Care can be delayed if an urgent care or emergency clinician attempts to interrogate the CIED of a patient who does not know their device manufacturer and does not carry their ID card. This scenario illustrates the importance of patient education in care centers, such as the emergency department and urgent care.

TINH M. LE; JAMES F. NEUENSCHWANDER, MD, FACEP; MARY JONES, DNP; ANKUR PAREKH; HANA LE; KAITLYN CEDOZ; and CLARK DAUGHERTY

Citation: Le TM, Neuenschwander JF, Jones M, Parekh A, Le H, Cedoz K, Daugherty C. Assessing the rate at which pacemaker and defibrillator patients present to the emergency room with their manufacturer ID card: a cross-sectional study. *J Urgent Care Med.* 2021;16(1):33-37.

Abstract

Background

Pacemakers and implanted cardioverter-defibrillators (also known as cardiac implanted electronic devices, or CIEDs) provide lifesaving functions and record critical clinical data. Clinicians cannot access these data or assess functionality without knowing the device's manufacturer. Every CIED patient is given an identification card indicating the manufacturer. Patients presenting to emergency departments/urgent care centers (ED/UC) without ID cards can cause delays, requiring time to be spent contacting manufacturers. To our knowledge, no studies have examined the rate at which patients present to ED/UCs with their



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“Inclusion criteria included: patients who had a CIED in place, who were able to answer whether or not they had their ID card, and who were over the age of 18. Prisoners, pregnant women, non-English speaking patients and those unable to respond to questions were excluded from the study.”

identification cards. This study's purpose was to determine the rate at which CIED patients presented to an ED/UC with their ID cards.

Methods

The study site was a community hospital with an annual ED/UC census of over 70,000 patients. After obtaining IRB approval, a convenience sample was used to find participants. Patients that met inclusion criteria were surveyed.

Results

One hundred and six patients met inclusion criteria and were enrolled from June 2013 to September 2014. Fifty-eight percent were male. Male mean age was 72 (SD = 13.70), with a range of 40-95. Women had a mean age of 74 (SD = 16.92), (95% CI, 69.79- 75.55), and had a broader age range of 24-91. Overall, 58 patients (55%) presented with their ID cards. Twelve patients (11%) presented with a potentially device-related complaint. Of those 12, eight presented with their ID cards. Statistical analyses were performed to determine whether the age of individuals, the sex of the individuals, and the reason for presenting to the ED/UC made a significant difference between the rates at which ID cards were presented.

Conclusion

Fifty-five percent of CIED patients presented to the ED/UC with their device ID cards. Even in the group of patients with potentially device related complaints, only 66% presented with their respective ID cards.

Introduction

Almost 2 million patients in the United States live with cardiac implanted electronic devices (CIEDs), a term used to describe pacemakers and implantable cardiac defibrillators.¹ CIEDs are indicated to treat a variety of cardiac arrhythmias. Pacemakers maintain a patient's

heart rate to ensure effective circulation, while implanted cardiac defibrillators provide voltage shocks to terminate life-threatening arrhythmias.²

As of 2016, roughly 200,000 pacemakers were implanted annually in bradycardic patients in the U.S.³ Worldwide, it is estimated that 1.25 million pacemakers are implanted annually.⁴

Because of their lifesaving functions and widespread use, it is essential for clinicians to be able to interrogate CIEDs. CIED interrogation reports include CIED data, such as recent arrhythmias or shocks, and allow providers to assess CIED functionality, such as device settings and battery life.

There are two classes of device used to interrogate CIEDs: device programmers, which can only be safely operated by International Board of Heart Rhythm Examiner (IBHRE)-trained technicians (often company representatives), and read-only device interrogators, which can be safely used by any healthcare provider.

Regardless of the chosen interrogation method, healthcare providers must first have knowledge of the device's manufacturer. This is because each of the three major CIED manufacturers (Abbott Laboratories., Boston Scientific Corporation, and Medtronic plc.) produce programmers and read-only interrogators that are only capable of interrogating CIEDs produced by that company. Consequently, each CIED patient is given an identification card (ID card) which indicates the device's manufacturer.

Care can be delayed if an urgent care or emergency clinician attempts to interrogate the CIED of a patient who does not know their device manufacturer and does not carry their ID card. Often, all three possible manufacturers must be contacted; this is a time-consuming process.⁵ Bayley, et al in 2005 reported that delays in patient care can cause overcrowding in the emergency department and urgent care centers and interfere with potential need for admitting a patient into an inpatient bed.^{5,6} Because of this, it is crucial for CIED patients to carry their ID cards at all times.

To our knowledge, no study has examined the rate at which CIED patients present to the ED/UC with their ID cards. The purpose of this study was to determine the rate at which CIED patients present to the emergency department/urgent care (ED/UC) with their ID cards, and to test for differences between those that presented with and without their cards.

Methods

An observational study was conducted to determine the rate at which CIED patients presented to the ED/UC

Table 1. Demographics	
Characteristics	Total (106)
Mean age (SD)	72.70 (15.12)
Male, n (%)	61, (58%)
Race, n (%)	
White	106 (100%)

Table 2. Sample Characteristics (n = 106)		
	Percent/ mean	Confidence interval/SD
Had ID card	54.7	44.8 - 64.4
Female	42.5	32.9 - 52.4
Had ICD Complaint	11.3	6.0 - 18.9
Age (mean; range 24-95)	72.7	15.1

with their device ID card. This study took place at a community hospital located in the Midwest with an annual ED/UC census of roughly 70,000 patients. The study was approved by the Institutional Review Board (IRB), was nonfunded and investigator-initiated, and was completed in accordance with STROBE (STrengthening the Reporting of OBServational studies in Epidemiology) guidelines.⁷

When trained research staff were available, all CIED patients presenting to the ED/UC were assessed for study inclusion. Inclusion criteria included: patients who had a CIED in place, who were able to answer whether or not they had their ID card, and who were over the age of 18. Prisoners, pregnant women, non-English speaking patients and those unable to respond to questions were excluded from the study. One hundred and six patients met the inclusion criteria and were enrolled from June 2013 to September 2014. Research staff determined whether or not patients had presented with their ID cards and recorded patient demographic information and chief complaints on a standardized data collection form (see Table 1).

Statistical analysis was performed using t-test for continuous variables and chi-squared test for categorical variables. We tested for significant differences between the ages of patients who presented with and without their ID cards, the rates at which males and females

presented with their ID cards, and the rate at which patients with and without cardiac-related chief complaints presented with their ID cards. Alpha was set to 0.05. No formal sample size analysis was performed.

Results

Of the 106 patients who participated in the study, 55% presented to the ED/UC with their ID cards. The cohort was 58%, with an average age of 73 years (SD = 15.1). See Table 2.

There was no significant difference between the rates with which male (62%) and female (44%) patients presented with their ID cards (p=0.068). See Table 3. Additionally, there was no significant difference between the rates at which patients with potentially device-related chief complaints, such as syncope or dyspnea, presented with their ID cards compared to patients without device-related chief complaints (66% and 53%, respectively; p=0.38). Finally, there was no significant age difference between patients who presented with and without their ID cards (72.2 vs 73.2 years, p=0.74).

Discussion

Emergency and urgent care clinicians frequently provide care to CIED patients with complaints such as chest pain, shortness of breath, fatigue, syncope, and

Table 3. Percent/Mean Differences in Having ID Card by Sample Characteristics (n = 106)			
	Had ID Card		p-value
	No	Yes	Chi-square/t-test
Sex			
Male (%)	37.7	62.3	0.068
Female (%)	55.6	44.4	
ICD Complaint			
No (%)	46.8	53.2	0.377
Yes (%)	33.3	66.7	
Age (mean (SD); t-test)	73.2 (15.8)	72.2 (14.7)	0.741
SD, standard deviation			

Table 4. Clinical Diagnoses			
Diagnosis	Frequency	Diagnosis	Frequency
Abdominal pain	5	Fracture of the thoracic vertebra	1
Abrasion	1	Fracture, shaft of femur	1
Acute blood loss anemia	2	GI bleed	1
Acute cervical strain	1	Hyponatremia	1
Acute CHF	1	Hypoxia	1
Acute coronary syndrome	1	ICD discharge	1
Acute exacerbation of chronic lower back pain	1	Intractable back pain	1
Acute on chronic respiratory failure	1	Irritation around percutaneous endoscopic gastrostomy (PEF) tube site	1
Acute psychosis	1	Left leg cellulitis	2
Alcohol intoxication with unspecified complication	1	Left leg weakness	1
Ataxia	1	Left, closed humeral fracture	1
Back strain	1	Leg swelling	1
Bronchitis	1	Lower GI bleed	1
Cellulitis	1	Lower UTI	1
Cellulitis of the right leg	1	Malfunction of gastrostomy tube	1
Chest pain	12	Mental status change	1
Chronic respiratory failure	1	Nosebleed	1
Closed head injury	1	Occluded PICC line	1
Congestive heart failure	2	Overdose of anticoagulant	2
Congestive heart failure, acute, systolic	1	Pneumonia	3
COPD	1	Restless leg syndrome	1
COPD exacerbation	4	Seizures	1
Diabetic ketoacidosis (DKA)	1	Shortness of breath	5
Dizziness	2	Shoulder strain	1
Dysemia	1	Slurred speech	1
Dyspnea	4	SOB	1
Elevated LFTs	1	Syncope	2
Encounter for medication refill	1	Syncope of the unspecified hypotensive type	1
Episodic lightheadedness	1	Unstable angina	1
Facial laceration	1	UTI	3
Fall	7	Ventricular tachycardia	1
Femoral neck fracture	1	Vomiting	1
Femur fracture	1		

dizziness, all of which could be caused by CIED malfunction (see **Table 4**). Although a variety of other conditions could also cause these symptoms, unidentified CIED malfunction can result in significant morbidity and mortality, making it important to rule out CIED malfunction as a potential cause. This is why

it is crucial to interrogate CIEDs early in a patient's stay.

Each CIED can only be interrogated by its specific manufacturer's interrogator. For the 45% of CIED patients in our study that presented without their ID cards, immediate interrogation would be impossible. Hence, it is crucial to be able to find this information

in other ways.

Anecdotally, we find that it is often, but not always, possible to determine this information in a patient's electronic medical record (ie, by reading provider notes from the patient's electrophysiology appointments). However, if an out-of-town patient presents without their ID card and cannot remember their manufacturer, you can find this information by calling each manufacturer's phone number and speaking with a representative:

- Abbott (formerly St. Jude): 1-800-722-3774
- Boston Scientific: 1-800-CARDIAC (227-3422)
- Medtronic: 1-800-929-4043

The traditional methods listed above are effective, but often time-consuming, meaning that patients who present without their ID card can face significant delays in care.⁸ Recent studies have suggested an alternative method—the use of read-only CIED interrogators. Read-only interrogators are incapable of altering CIED function, and can be safely used by any care provider, obviating the need to call company representatives.⁹ Like CIED programmers, each CIED manufacturer also produces a read-only interrogator. If an ED/UC owns each of the major manufacturers' read-only CIED interrogators, it is possible to determine an unknown CIED's manufacturer by simply attempting to interrogate the device with each company's interrogator. Only the correct interrogator will connect, bypassing the need for multiple phone calls and hold times.¹⁰

Patients presenting to ED/UCs may have complaints related to their CIEDs that require interrogation; therefore, the CIED manufacturer must be known. If patients carry their device ID cards, then their care may be expedited.

The results of this study are crucial to emergency and urgent care clinicians, as device ID card presentation can potentially allow for a more efficient interrogation process. Potential solutions to alleviate this issue include a phone app containing the necessary identification rather than a physical ID card. Additionally, the creation of a single call center for all three companies could expedite finding the device manufacturer and does not involve multiple attempts at contacting the manufacturer.

These results also demonstrate the importance of proper patient education. It is feasible that, with improved patient education both in the electrophysiology clinic and at ED/UC discharge, a given area's CIED patient population could grow to better understand the importance of always carrying their ID cards.

Limitations

This study had several limitations. Firstly, no a priori

“It is feasible that, with improved patient education both in the electrophysiology clinic and at ED/UC discharge, a given area's CIED patient population could grow to better understand the importance of always carrying their ID cards.”

power analysis was performed to determine ideal sample size. Secondly, because the study was conducted at a single community hospital system with a predominantly Caucasian patient population, the results of this study may be difficult to generalize. Similarly, the results may not be applicable to urgent care facilities that do not have the capacity to interrogate a CEID. Finally, patients were sampled using convenience sampling due to the nature of research staff schedules.

Conclusion

About half (55%) of CIED patients presented to the ED/UC with their device ID cards. Even in the group of patients with potential device-related complaints, only 66% of patients presented with their respective ID cards. No statistically significant difference was found relating to age, sex, or chief complaints. While several limitations impact the generalizability of our results, we identified a significant potential issue in the treatment of CIED patients. ■

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An Unresponsive Pupil in the Urgent Care: Can A Diagnosis Be Made from the Bedside History and Exam?

Urgent message: Ocular complaints for which there is no immediate, obvious explanation do not necessarily have to be referred to the emergency room or ophthalmology. Employing the process of elimination to narrow down a broad differential, using the available evidence, can expedite the correct diagnosis while allowing the patient to remain in the urgent care.

KAYLA PENNY, BS; JOSEPH LAROCHELLE, PHARMD, BCPPS, FCCP; DEIRDRE HOOPER, MD; HALEY HARRINGTON, BS; and KELSEY ROONEY, BS

Case Presentation

A male in his 40s presented with complaints of an enlarged pupil and blurry vision in his left eye. He reports that his symptoms started about 3 hours ago, following a morning of household chores. Since onset, his symptoms have remained constant and his right eye is not affected. The patient states that he woke up that morning feeling normal and did not notice any pupillary abnormalities.

Of note, he has a history of hyperhidrosis and reports applying a topical medicated wipe to his face just prior to engaging in his household chores. He reports thorough handwashing prior to and following medication application. He denies any atypical exposures while cleaning, including both new cleaning and gardening products. He also denies any trauma during this time. He reports full extraocular movements and denies eye pain, headache, stiff neck, nausea, vomiting, photophobia, seizure, use of blood-thinning medication, numbness, tingling, weakness, and dry mouth. He denies a history of prior similar episodes.



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Past Medical History

The patient has a medical history significant for severe

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hyperhidrosis, GERD, and allergic rhinitis. He denies any surgeries or relevant family history.

Medications

The patient takes fluticasone nasal inhalation (qd), omeprazole (qd), topical cloth glycopyrronium 2.4% applied to the forehead (PRN), and botulinum toxin injections to his axilla (quarterly for the last 8 years).

Review of Systems

- Constitutional: denies weight loss/gain, fever, chills, fatigue
- Ear, nose, throat: denies sore throat, rhinitis, tinnitus, and hearing loss
- Gastrointestinal: denies nausea, vomiting, and diarrhea
- Cardiovascular: denies chest pain, palpitations, and edema
- Pulmonary: denies shortness of breath, cough, and wheezing
- Musculoskeletal: denies myalgias, joint pain, and joint stiffness

- Genitourinary: denies hematuria, dysuria, and incontinence
- Psychiatric: denies depression, agitation, and anxiety
- Integumentary: denies rashes, pigmentation, and dryness

Physical Exam

On physical exam, he was hypertensive with a blood pressure of 185/105, but in no apparent distress. The patient was alert, oriented, interactive and well-appearing. The left pupil was enlarged and unreactive to light (**Figure 1**). Upon further inspection of the left eye, the globe was intact and the conjunctiva were not injected, and no hyphema was noted. Respiratory effort was normal with no apparent wheezing or shortness of breath. Patient had normal range of motion, tone, sensation, and strength in the upper and lower extremities with no rashes, lesions, swelling, or erythema noted.

Differential Diagnosis

- Medication side effect
- Cerebral aneurysm
- Stroke
- Botulism
- Adie's syndrome
- Cocaine intoxication
- Recent eye trauma
- Acute-angle closure glaucoma

Diagnosis

Upon detailed review of medications and the patient's activity on the day of presentation, it is most likely that the mydriatic pupil was a side effect of the glycopyrronium 2.4% cloth he used on his face approximately 2.5 hours prior to noticing blurry vision. Although he followed up application with thorough handwashing, he engaged in strenuous household work, which may have contributed to incidental spread of the medication to his eye. His pupil gradually returned to size over the next 5 days, with complete return of visual and constrictive function.

Discussion

The diagnosis of a pharmacological unilateral mydriasis can be inferred from the patient's lack of ocular pain and ptosis, benign physical exam, and viable alternative explanation—exposure to a topical, anticholinergic medication.

Although the patient's history of hypertension and unilateral mydriasis would be potentially concerning

for a cerebral aneurysm, an otherwise benign neurologic examination makes this less likely. The patient had full range of his extraocular eye movements and the globe was not positioned in an inferior and abducted configuration, indicating that a cranial nerve 3 palsy from a possible aneurysm or tumor is unlikely. Additionally, he denies meningeal signs, seizure-like activity, or use of blood-thinning medication, making a hemorrhagic or ischemic stroke unlikely.

If a stroke did occur in the right cerebral hemisphere, the patient would also likely have a left lower facial droop and loss of movement and sensation on the left unilateral face, arm, and leg.

Botulism is uncommon, and in addition to a benign neurological examination, there were no systemic symptoms such as bilateral descending paralysis, dilated pupils, and ptosis, as well as trouble swallowing and breathing which are typically seen with botulism.

Adie's syndrome is incongruent with this patient's demographics and would present with a pupil that is slowly reactive to light and constricts with accommodation.

Stimulant drug intoxication has been a known source to cause a dilated pupillary response. Cocaine has been shown to cause a unilateral mydriasis. However, the patient denies drug use and subsequently had a normal heart rate and was not euphoric, hypervigilant, anxious, or experiencing chest pains, making cocaine intoxication unlikely.

Recent eye trauma or surgery can lead to anisocoria. Conversely, the patient denies any recent eye trauma or surgery, and there were subsequently no indicators of obvious ocular trauma.

Acute-angle closure glaucoma is a common pathology in which to see a dilated and fixed pupil, but the patient's dilated eye was painless, no halos were observed in the patient's visual field, and the patient did not have a headache, ruling out acute angle closure glaucoma as the diagnosis.

Hyperhidrosis

Hyperhidrosis is a condition characterized by the excess production of sweat from eccrine sweat glands. Nearly 5% of the U.S. population is affected by hyperhidrosis, with most cases being primarily idiopathic in etiology. This condition impacts a patient's life in a variety of ways, including impairing daily functions and social and work interactions. In addition, patients are often embarrassed to discuss symptoms with a care provider. The most common area affected is the axilla, but craniofacial involvement occurs in up to 10% of patients.¹ There are a number of beneficial therapies approved

Table 1. Possible Side Effects with Glycopyrrolate

■ Dry mouth	■ Dizziness
■ Blurred vision	■ Upset stomach
■ Vision problems	■ Nausea
■ Loss of taste	■ Vomiting
■ Headache	■ Constipation
■ Nervousness	■ Bloating feeling
■ Confusion	■ Nasal congestion
■ Drowsiness	■ Difficulty falling asleep or staying asleep
■ Weakness	

Source: MedlinePlus. Available at: <https://medlineplus.gov/druginfo/meds/a602014.html#side-effects>. Accessed September 15, 2021.

“The confusion of unilateral mydriasis with a more serious condition has not only resulted in misdiagnoses, but also exposure to unnecessary neuroimaging and added medical costs.”

for the management of hyperhidrosis, including topical aluminum chloride, topical glycopyrrolate, iontophoresis, botulinum toxin injections, and oral anticholinergic drugs. Selection of treatment regimen depends on severity and site involvement.²

Pharmacologic Agents Which May Cause Unilateral Mydriasis

There are several other pharmacologic agents that can cause a unilateral dilated pupil, such as:

- Parasympatholytic drugs (atropine, homatropine, tropicamide, cyclopentolate)
- Sympathomimetics (phenylephrine, clonidine, apraclonidine, brimonidine)
- Scopolamine patch for motion sickness, aerosolized anticholinergic drugs (ipratropium)
- Certain plants (jimsonweed)⁸

Of importance to note, unilateral mydriasis caused by a pharmacological etiology is not associated with pain, a drooping eyelid, or double-vision, consistent with the presentation of this patient.⁸ Additionally, the pharmacologic agent causing the anisocoria can be narrowed down by assessing the amount of dilation of the abnormal pupil.⁸ For instance, an anticholinergic drug will cause ≥ 8 mm dilation and does not react to light, and a sympathomimetic drug will cause a 1-2 mm dilation.⁸

Glycopyrronium tosylate (Qbrexza) is a synthetic anticholinergic agent approved for the treatment of primary axillary hyperhidrosis. It is available in the

“This case emphasizes the importance of obtaining a thorough history and physical exam, in addition to a detailed medication review, including topical medication to help avoid such outcomes.”

form of a premoistened wipe to use on the underarm, once daily. Although the drug is only approved for primary axillary hyperhidrosis, it has been found to be safe and effective in reducing excessive facial perspiration as well.

Because the drug is rarely absorbed systemically and is unable to easily cross the blood-brain barrier, adverse reactions are often mild and the result of peripheral anticholinergic activity.³ While dry mouth is the most commonly reported adverse event, more worrisome side effects such as mydriasis, blurry vision, and dehydration have also been reported.⁴ (See **Table 1**.)

The time it takes for these adverse reactions to appear, as well as disappear, leads to a highly variable clinical picture once the drug is absorbed systemically. These findings explain the approximate 2-hour onset of action that was seen in our patient. In addition, the elimination pharmacokinetics likely account for why the mydriasis seen in our patient appeared to linger.

This notion is supported in that the mean terminal elimination half-life depends on the route of administration: 2.8 hours after oral administration, 6.2 hours after intravenous administration, and 33 to 53 hours after inhalation.⁵

Recommendations

Unilateral mydriasis is a particularly alarming side effect, as it is frequently associated with a more life-threatening condition such as cerebral aneurysm or intracranial hemorrhage. The diagnostic approach in a patient with an isolated cranial nerve palsy should start with considering the age and medical comorbidities of the patient. If an aneurysm is suspected, then an MRI is indicated.¹⁰ The confusion of this side effect with a more serious condition has not only resulted in misdiagnoses, but also exposure to unnecessary neuroimaging and added medical costs.^{6,7}

This case emphasizes the importance of obtaining a thorough history and physical exam, in addition to a detailed medication review, including topical medication

Summary

- In this patient, the diagnosis of a pharmacological unilateral mydriasis can be inferred from the patient’s lack of ocular pain and ptosis, benign physical exam, and viable alternative explanation—exposure to a topical, anticholinergic medication.
- Differential diagnosis for unilateral mydriasis includes acute-angle closure glaucoma, Adie’s syndrome, botulism, cocaine intoxication, cerebral aneurysm, medication side effect, recent eye trauma, and stroke.
- In light of the fact that unilateral mydriasis is an alarming side effect that could be a sign of cerebral aneurysm or intracranial hemorrhage, consider the age and medical comorbidities of the patient. If an aneurysm is suspected, an MRI is indicated.
- Pharmacologic agents which may cause unilateral mydriasis include the following:
 - Parasympatholytic drugs (eg, atropine, homatropine, tropicamide, cyclopentolate)
 - Sympathomimetics (eg, phenylephrine, clonidine, apraclonidine, brimonidine)
 - Scopolamine patch for motion sickness, aerosolized anticholinergic drugs (eg, ipratropium)
 - Certain plants (eg, jimsonweed)

to help avoid such outcomes. Patient counseling for this medication should stress the importance of proper hand washing after use and avoiding touching the area of application. Patient education pertaining to such side effects can allow for early identification that avoids added stress and costs for all parties involved. ■

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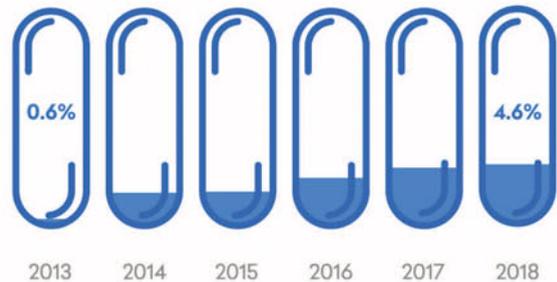
New Treatment

The CDC* now recommends monotherapy treatment for uncomplicated** gonococcal infections of the cervix, urethra, or rectum: **Ceftriaxone 500 mg IM** as a single dose for persons weighing <150 kg (300 lb)



Reason for Change

N. gonorrhoeae has become a superbug in the US, with a sevenfold increase in azithromycin resistance over 5 years (from 0.6% in 2013 to 4.6% in 2018)



Treatment Considerations



If chlamydial coinfection has not been excluded, add **Doxycycline 100 mg PO BID** for 7 days



For patients weighing ≥ 150 kg (300 lb), increase **Ceftriaxone** to 1 gram IM



For patients with a cephalosporin allergy, consider **Gentamicin 240 mg IM** as a single dose plus **Azithromycin 2 gram PO** as a single dose



During pregnancy, if chlamydial coinfection has not been excluded, add **Azithromycin 1 gram PO** as a single dose

*Update to CDC's Treatment Guidelines for Gonococcal Infection, 2020, <https://www.cdc.gov/mmwr/volumes/69/wr/mm6950a6.htm>

**Complications of gonorrhea, <https://www.cdc.gov/std/gonorrhea/stdfact-gonorrhea-detailed.htm>



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A 28-Year-Old with Foot Pain After a Fall



Case

The patient is a 28-year-old female who presents with pain in her left foot after a fall of roughly 10 feet while rock-climbing. She reports that she “landed hard” with the left foot taking the full force of the impact. On exam, she had left midfoot dorsal and plantar tenderness and bruising across top of foot.

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

THE RESOLUTION

**Differential Diagnosis**

- Acute compartment syndrome
- Cuboid fracture
- Cuneiform fracture
- Lisfranc fracture dislocation

Diagnosis

This patient was diagnosed with a Lisfranc fracture dislocation and a longitudinal cuboid fracture. *Lisfranc fracture dislocation* is a term that describes fractures and dislocations that occur at the junction between the tarsal bones of the midfoot and the metatarsals of the forefoot. The x-ray above shows a widening of the space between metatarsal 1 and metatarsal 2 and a widening of the space between cuneiform 1 and metatarsal 2. Named after Jacques Lisfranc, a field surgeon in the French army under Napoleon, the original context was as a new technique for amputation used to treat frostbite of the forefoot in soldiers on the Russian front.

Learnings/What to Look for

- Lisfranc fracture dislocations are most likely to occur while playing a sport, as the result of a motor vehicle accident, or during a fall from a height (such as while walking down steps or off a curb—or falling from a rock)
- Clinical findings include pain at the tarsal-metatarsal joints, swelling, ecchymosis, and potential joint instability

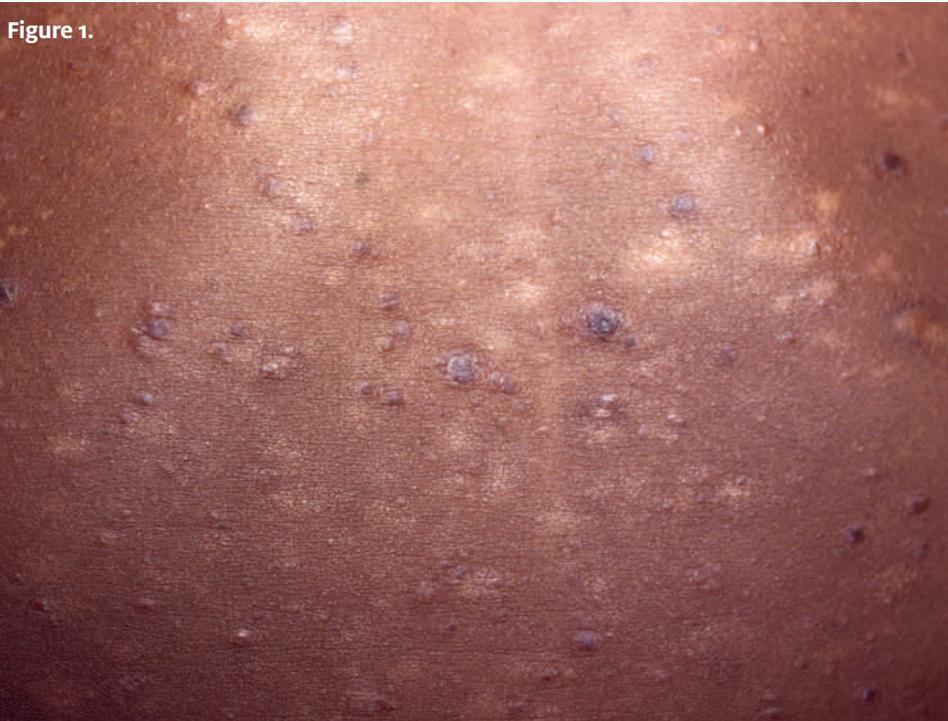
Pearls for Urgent Care Management

- Weightbearing x-rays should be considered to determine joint stability and presence of displacement
- Nondisplaced injuries may be treated conservatively (non-weightbearing with immobilization in a boot or short leg cast for 6 weeks, followed by progressive weightbearing)
- Displaced Lisfranc injuries are likely to require closed or open surgical reduction

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



A 7-Year-Old Boy with Scaly Red-Brown Papules on His Trunk

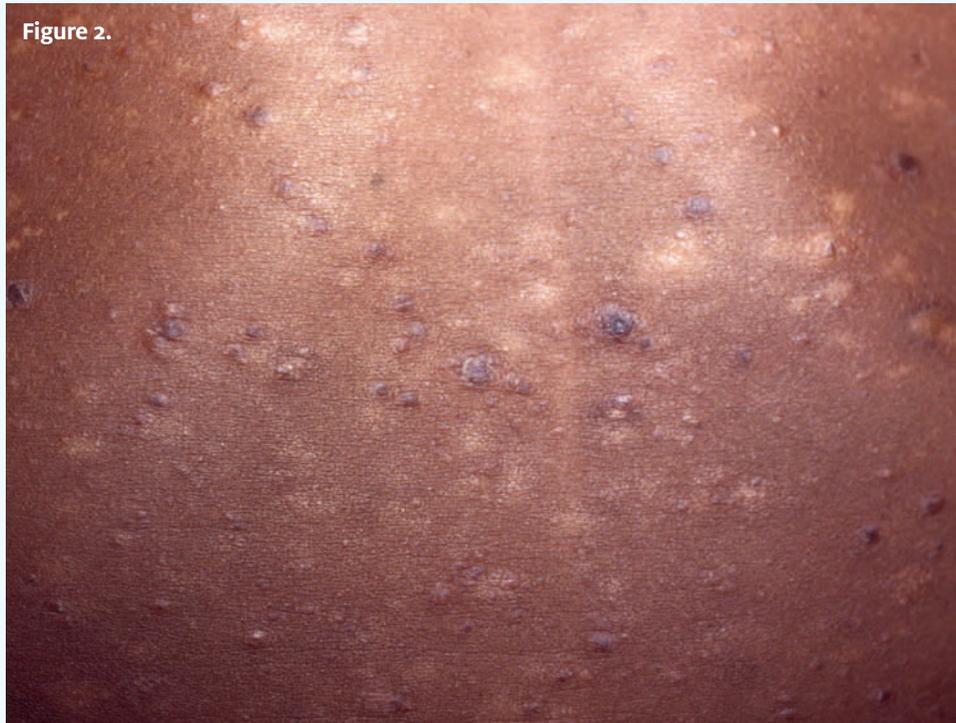


Case

A 7-year-old boy is brought to your urgent care center by his mother because she's concerned about a rash of scaly papules on his trunk, some of which had crusted or healed. A few of the lesions are hemorrhagic. She notes that they appeared a few days ago, accompanied by a mild fever. She dismissed the possibility that the source could be chickenpox because her son had been vaccinated. The boy reports that the papules are "really itchy." During the exam, you detect generalized lymphadenopathy.

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**

- Scabies
- Pityriasis lichenoides et varioliformis acuta (PLEVA)
- Pityriasis rosea
- Varicella

Diagnosis

This patient was diagnosed with pityriasis lichenoides et varioliformis acuta (PLEVA), or Mucha-Habermann disease. This is a T-cell lymphoproliferative disorder characterized by acute onset of asymptomatic to mildly pruritic crops of red or brown, 2- to 3-mm macules, and papules that rapidly develop vesiculation and necrosis, sometimes becoming hemorrhagic. Ulcerated and crusted lesions are common. The crops usually recur over weeks to months before spontaneously resolving, often leaving varioliform scars. Biopsy shows CD8 lymphocytes.

Learnings/What to Look for

- PLEVA most commonly occurs in male children and young adults, but can occur in both sexes, in all ages, and in all ethnicities
- Similar to pityriasis rosea, the rash is predominantly on the trunk, sometimes pruritic, and generally symmetric. However, PLEVA lesions are more red, brown, or hemorrhagic, which gives PLEVA its characteristic appearance. Generalized lymphadenopathy may be present

Pearls for Urgent Care Management

- PLEVA often resolves on its own within several weeks to several months
- Persistent cases may require treatment by a dermatologist, which could include oral antibiotics, topical or systemic steroids, immunomodulators, phototherapy, or sun exposure

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



A 61-Year-Old Woman with a 2-Day History of Chest Pain

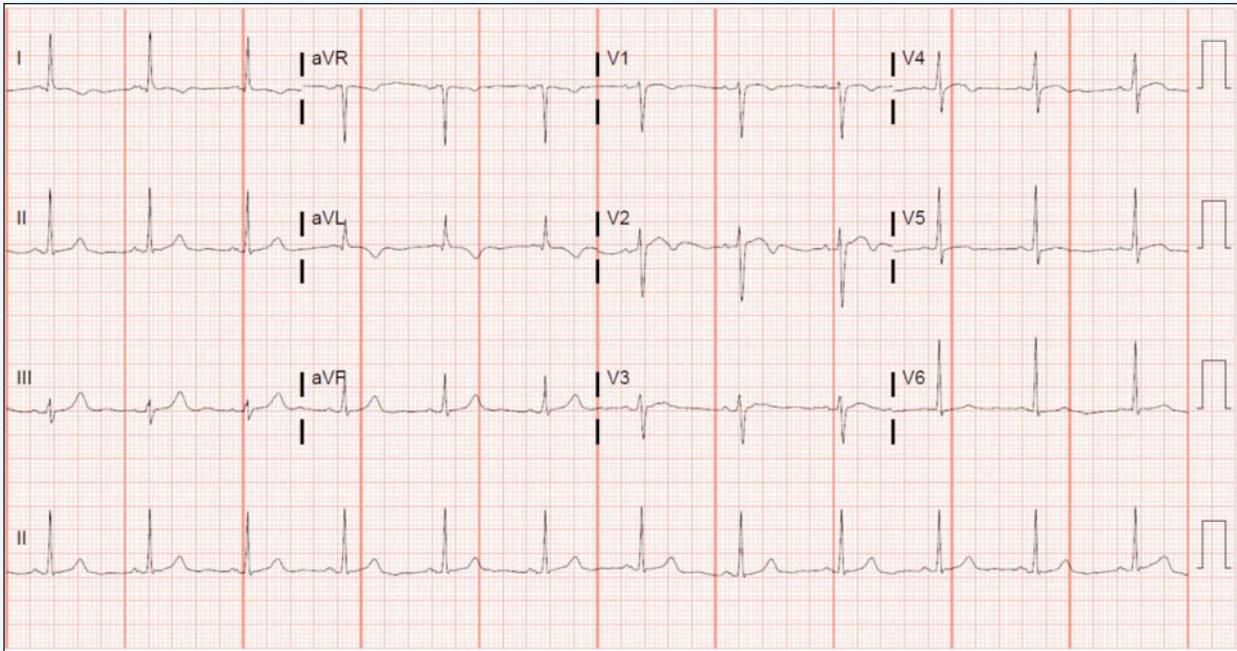


Figure 1.

A 61-year-old female presents to urgent care with chest pain for 2 days. She describes it as “mild right now” but says that it varies in intensity; it was so severe the previous night that it kept her from sleeping. Today the pain has been stuttering, lasting a couple of minutes at a time. Pain is substernal, nonradiating, and is associated with vomiting and diaphoresis. Vital signs are normal.

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 Benjamin Cooper, MD, McGovern Medical School, Department of Emergency Medicine, The University of Texas Health Science Center at Houston.)

THE RESOLUTION

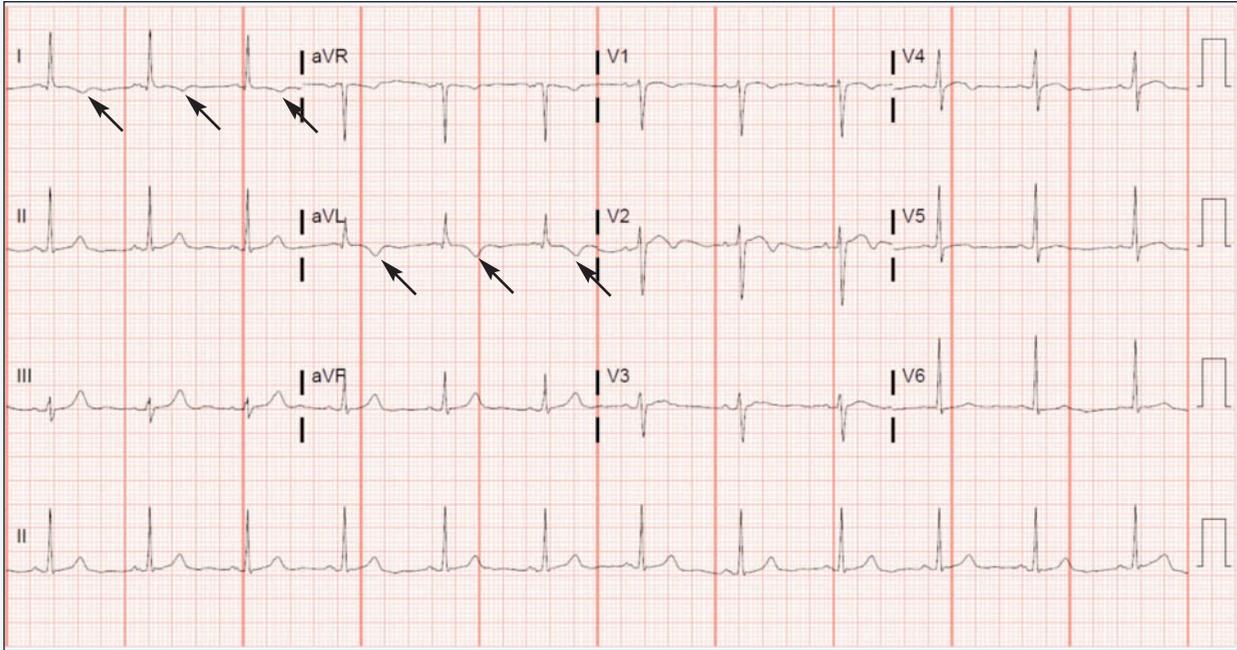


Figure 2. Symmetric T-wave inversions are seen on this ECG, illustrated in leads I and aVL with arrows.

ECG Differential Diagnosis

- ST-Elevation myocardial infarction (STEMI)
- Acute right heart strain
- Left ventricular hypertrophy (LVH)
- Ischemic T-wave inversions/myocardial ischemia
- Hypertrophic cardiomyopathy

Diagnosis

This patient was diagnosed with ischemic T-wave inversions/myocardial ischemia. The ECG reveals a sinus rhythm at a rate of 72 beats per minute. There is a normal axis and normal intervals. There are symmetric T-wave inversions in the high lateral leads (I, aVL), as well as a biphasic t-wave in V2. There are no ST elevations or depressions.

T-wave inversions in leads aVR and V1 are normal characteristics on the ECG, and an isolated T-wave inversion in lead III is a normal variant (“a flipped T is free in III”). Inverted T-waves can also be a normal finding in pediatric ECGs. New T-wave inversions when compared to old ECGs are always abnormal.

There are many causes of T-wave inversions, and ECG interpretation should occur within the clinical context of the patient’s presentation; our patient is presenting with symptoms consistent with acute coronary syndrome, and the finding of symmetric T-wave inversions in contiguous anatomical leads (lateral leads) is consistent with myocardial ischemia. Dynamic T-wave inversions on serial ECGs are typically seen with acute ischemia,

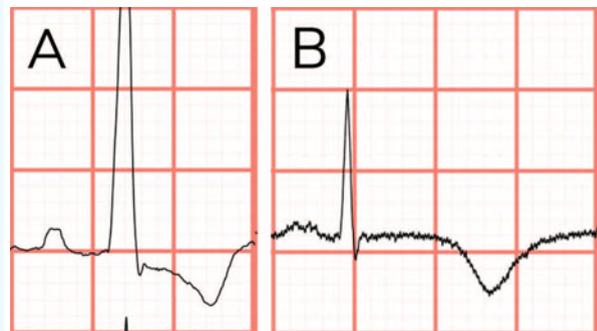


Figure 3. Comparison of “strain” T-wave inversion (panel A) and ischemic T-wave inversion (panel B) found in precordial lead V6. Note the tall QRS complex (extending 6 mm beyond the margin of the image) and an asymmetric T wave inversion characteristic of the “strain” pattern of left ventricular hypertrophy. The “strain” morphology in panel A is contrasted with the symmetric T-wave inversion in panel B, consistent with ischemia.

whereas fixed T-wave inversions are seen after infarction and are often associated with pathologic Q-waves.¹

Other causes of T-wave inversions include persistent juvenile T-wave pattern, normal repolarization changes after a bundle branch block, left ventricular hypertrophy, acute right heart strain as often seen in pulmonary embolism, hypertrophic cardiomyopathy, takotsubo cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy,² and cardiac memory,³ as well as elevated intracranial pressure.

Distinguishing between ischemic T-wave inversions and T-

THE RESOLUTION

wave inversions of ventricular hypertrophy is important for accurate diagnosis. Ischemic T-waves are found in contiguous leads and tend to be symmetric and deep, whereas T-wave inversions secondary to the “strain” of left ventricular hypertrophy are found in the lateral and high lateral leads (I, aVL, V5 and V6) and are asymmetric (**Figure 3**).⁴ ECGs consistent with the “strain” of left ventricular hypertrophy should also meet voltage criteria for the diagnosis.

Learnings/What to Look for

- The differential for T-wave inversions is broad and includes:
 - Juvenile T-wave pattern
 - Normal repolarization changes after a bundle branch block
 - Left ventricular hypertrophy
 - Acute right heart strain as often seen in pulmonary embolism
 - Hypertrophic cardiomyopathy
 - Takotsubo cardiomyopathy
 - Arrhythmogenic right ventricular cardiomyopathy
 - Cardiac memory
 - Elevated intracranial pressure
 - Normal in pediatric patients
- The correct interpretation of T-wave inversions relies on the clinical presentation
- Dynamic T-wave inversions on serial ECGs are consistent with

acute ischemia in the setting of acute coronary syndrome

- Differentiating between ischemic T-wave inversions and the strain pattern of ventricular hypertrophy is based on the morphology of the T-wave and voltage criteria of the QRS

Pearls for Urgent Care Management

- Utilize the clinical history in tandem with the ECG to identify the cause of T-wave inversion
- Serial ECGs, as well as comparison to prior ECGs, can help guide decision making
- In the setting of acute coronary syndrome, identification of acute ischemic T-wave inversions on ECG should prompt the provider to transfer the patient to a coronary intervention-capable facility

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ECG STAMPEDE



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ICD-10 Changes for 2022

■ MONTE SANDLER

Every year on October 1, the Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics release an updated ICD-10-CM Official Guidelines, as well as changes to the code set. This year there are 159 new codes, 32 deleted codes, and 20 revised codes, with a total of 72,748 codes to choose from. (Visit *ICD-10-CM Official Guidelines for Coding and Reporting FY 2022* at <https://www.cms.gov/files/document/fy-2022-icd-10-cm-coding-guidelines.pdf> to see the entire document.)

Three common diagnoses for urgent care are cough (R05), low back pain (M54.5), and polyuria (R35.8). Starting October 1, 2021, you will need to add a digit for increased specificity.

Cough:

- Acute cough (R05.1)
- Subacute cough (R05.2)
- Chronic cough (R05.3)
- Cough syncope (R05.4)
- Other specified cough (R05.8)
- Cough, unspecified (R05.9)

Low back pain:

- Low back pain, unspecified (M54.50)
- Vertebrogenic low back pain (M54.51)
- Other low back pain (M54.59)

Polyuria:

- Nocturnal polyuria (R35.81)
- Other polyuria (R35.89)

Social determinants of health may have an impact on the level of risk used to determine the appropriate evaluation and management (E/M) code since implementation of the 2021 E/M guidelines. The American Medical Association defines social determinants of health as “economic and social conditions that influence the health of people and communities.” The examples provided include food or housing insecurity, but they could also



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

“The only COVID-19 code added for this update is to be used for sequela of COVID-19 or associated symptoms/ conditions following a previous infection, and not for current infections.”

include situations like a patient being unable to afford their medication or not understanding the directions from the provider due to a lack of education. There are codes to report these circumstances in the range Z55-Z65 and more detail is being added for 2022:

- Less than a high school diploma (Z55.5)
- Inadequate drinking-water supply (Z58.6)
- Homelessness unspecified (Z59.00)
- Sheltered homelessness (Z59.01)
- Unsheltered homelessness (Z59.02)
- Food insecurity (Z59.41)
- Other specified lack of adequate food (Z59.48)
- Housing instability, housed, with risk of homelessness (Z59.811)
- Housing instability, housed, homelessness in past 12 months (Z59.812)
- Housing instability, housed unspecified (Z59.819)
- Other problems related to housing and economic circumstances (Z59.89)

These codes would be reported as secondary diagnoses.

Other new diagnoses include:

- Depression, unspecified (F32.A)
- Irritant contact dermatitis (L24.A0 – L24.B3)
- Nonsuicidal self-harm (R45.88)
- Personal history of self-harm (Z91.51)
- Personal history of nonsuicidal self-harm (Z91.52)
- Feeding difficulties, unspecified (R63.30)
- Pediatric feeding disorder, acute (R63.31)
- Pediatric feeding disorder, chronic (R63.32)
- Other feeding difficulties (R63.39)
- Abnormal findings of blood amino-acid level (R79.83)
- Encounter for immunization safety counseling (Z71.85)

Diagnosis	ICD-10-CM
Pneumonia	U07.1 – COVID-19 J12.82 – Pneumonia due to coronavirus disease
Acute bronchitis	U07.1 – COVID-19 J20.8 – Acute bronchitis due to other specified organisms
Bronchitis, not otherwise specified (NOS)	U07.1 – COVID-19 J40 – Bronchitis, not specified as acute or chronic
Lower respiratory infection, NOS or Acute respiratory infection, NOS	U07.1 – COVID-19 J22 – Unspecified acute lower respiratory infection
Respiratory infection, NOS	U07.1 – COVID-19 J98.8 – Other specified respiratory disorders
Acute respiratory distress syndrome (ARDS)	U07.1 – COVID-19 J80 – Acute respiratory distress syndrome
Multisystem inflammatory syndrome (MIS)	U07.1 – COVID-19 M35.81 – Multisystem inflammatory syndrome
Other involvement of connective tissue	U07.1 – COVID-19 M35.89 – Other specified systemic involvement of connective tissue

Finally, there is an entire section for conditions caused by use of cannabis or synthetic cannabinoids. The codes previously described as cannabis (derivatives) were deleted.

Poisoning:

- Cannabis (T40.711A–T40.714S)
- Synthetic cannabinoids (T40.721A–T40.724S)

Adverse effect:

- Cannabis (T40.715A–T40.715S)
- Synthetic cannabinoids (T40.725A–T40.725A)

Underdosing:

- Cannabis (T40.716A–T40.716S)
- Synthetic cannabinoids (T40.726A–T40.726S)

Code U09.9 (Post COVID-19 condition, unspecified)

This is the only COVID-19 code added for this update. It is to be used for sequela of COVID-19 or associated symptoms/conditions following a previous infection. It should not be used for current infections. First code the current symptoms/conditions, then add code U09.9 as a secondary diagnosis.

“Signs and symptoms of COVID-19 without a definitive diagnosis should be reported with the code for each presenting problem. Include ICD Z20.822 (Contact with and (suspected) exposure to COVID-19) in addition to the symptoms to identify the services as COVID-19 related.”

With the number of times the diagnosis coding rules have changed for COVID-19 since this all began; it may be a good time for a refresher.

Positive Diagnosis of COVID-19

Only confirmed cases as documented by the provider or confirmed by test results should be coded with ICD U07.1. This code should be the primary diagnosis on the claim. Additional diagnoses should be used to report manifestations.

If MIS develops as a result of a previous COVID-19 infection, report codes M35.81 and U09.9. If the provider does not document that the MIS is due to the previous COVID-19 infection, report codes M35.81 and Z86.16. If the patient has a known or suspected exposure to COVID-19, and no current COVID-19 infection or history of COVID-19, report codes M35.81 and Z20.822.

Additional codes should be assigned for any associated complications of MIS.

No Definitive Diagnosis of COVID-19

Symptomatic patients

Signs and symptoms without a definitive diagnosis should be reported with the code for each presenting problem. Some examples are:

- R05.1-R05.9 – Cough
- R06.02 – Shortness of breath
- R50.9 – Fever, unspecified
- R68.83 – Chills (without fever)
- R69.89 – Rigors
- M79.10 – Muscle pain
- R51 – Headache
- J02.9 – Sore throat
- R07.0 – Pain in throat
- R43.0 – Loss of smell
- R43.9 – Loss of taste
- R19.7 – Diarrhea
- R11.0 – Nausea without vomiting
- R11.11 – Vomiting without nausea
- R11.2 – Nausea and vomiting
- R07.9 – Chest pain (central)

“Patients who do not have symptoms but who have had actual (or even suspected) exposure to COVID-19 should be coded with ICD Z20.822. Per the official guidelines, during the pandemic, a screening code is generally not appropriate, as all of us may have been exposed.”

- R07.89 – Chest pain (anterior)
- R07.89 – Chest Pain (non-cardiac)
- R07.1 – Chest pain on breathing

This is not a comprehensive list. If the identified signs and symptoms are not on the list above, use the most appropriate ICD-10 available.

Include ICD Z20.822 (Contact with and (suspected) exposure to COVID-19) in addition to the symptoms to identify the services as COVID-19 related.

Asymptomatic patients

Asymptomatic patients with actual or suspected exposure should be coded with ICD Z20.822. Per the official guidelines, during the COVID-19 pandemic, a screening code is “generally not appropriate” as all of us may have been exposed. Even COVID-19 testing for preoperative testing should be coded as exposure, ICD Z20.822.

Other diagnoses for reporting COVID-19 related services include:

- History of COVID-19: Z86.16 (Personal history of COVID-19)
- Follow-up visits after COVID-19 has resolved without residual symptom(s) or condition(s): Z09 (Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm), and Z86.16
- Encounter for antibody testing: Z01.84 (Encounter for antibody response examination)
- Screening for COVID-19: Z11.52 (Encounter for screening for COVID-19)

Remember to always read the full description of the code to make sure you are using it correctly. ■



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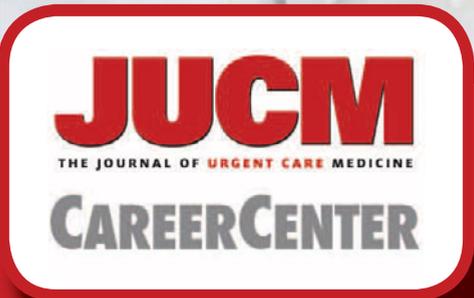


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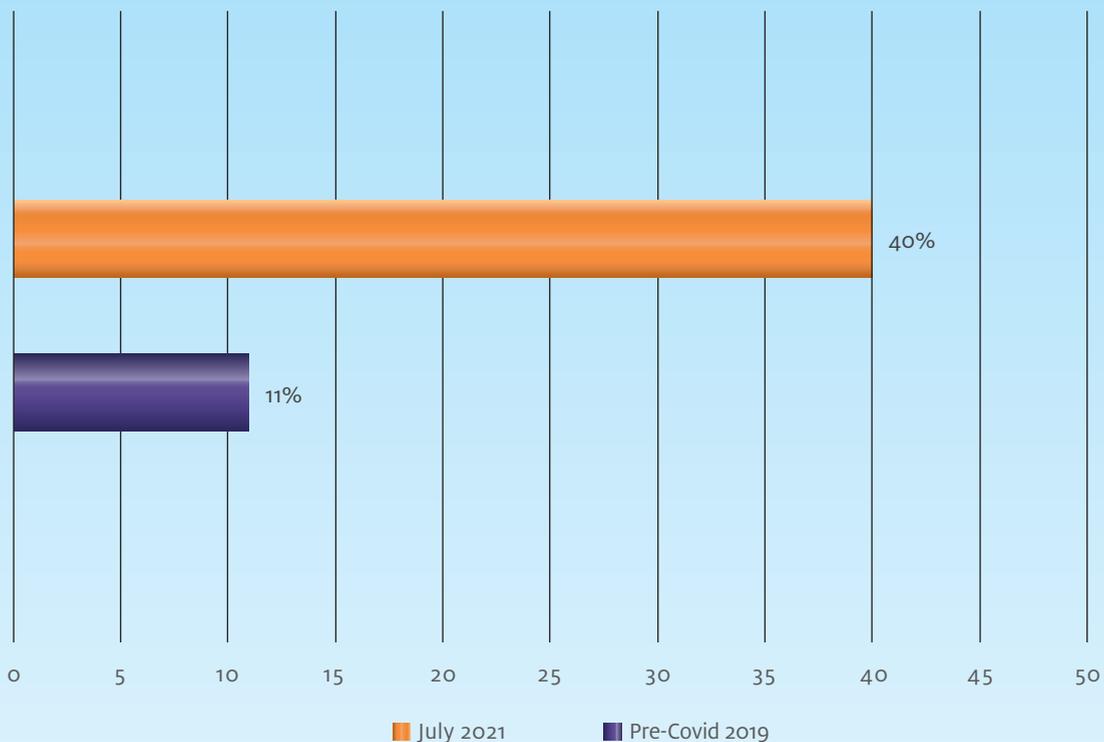
Telehealth Use Is Down from Its Peak—But the New Plateau Is Far Higher than Pre-Pandemic Levels

Patients were more willing to use telehealth than ever in the early days of the COVID-19 pandemic. According to data from a report published by McKinsey & Company, telehealth claims grew 7,800% between February 2020 and April 2020. They dropped precipitously just a couple of months later, but have since plateaued.

What could be of interest to urgent care operators who are

considering telehealth as a service option, especially as we're in the midst of a surge in the pandemic, is that the report notes the "new plateau" (which held steady between December 2020 and February 2021) is 38 times higher than pre-COVID-19 norms. Even more noteworthy, perhaps, is that from the looks of the graph below it appears a substantial percentage of healthcare consumers are likely to become more regular users. ■

HEALTHCARE CONSUMERS WHO PLAN TO USE TELEHEALTH IN THE FUTURE



Data source: Bestsenny O, Gilbert G, Harris A, Rost J. Telehealth—a quarter-trillion-dollar post COVID-19 reality? McKinsey & Company. July 9, 2021. Available at: <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality>. Accessed September 12, 2021.

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