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HEALTH LAW AND COMPLIANCE

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Sexual Harassment Is an Ongoing Threat to Your Staff

■ ROMA B. PATEL

Picture a busy day in an urgent care center. The waiting room chairs are lined with a few frequent fliers, a child in need of a sports physical, and several new patients. As your staff focus on patient intake and managing clinical flow, a patient “playfully” grabs the nurse’s breast, grazes a PA’s groin, or “compliments” the medical assistant on her attractive figure.

Amidst the hustle of triage, diagnostics, abatement and treatment, this offensive behavior may go unseen by staff members and even unacknowledged by the recipient of the action. Whether he or she ever mentions it, the healthcare worker will certainly notice the dehumanizing act and may suffer as a result.

Sexual harassment in healthcare has always been a problem. The *New England Journal of Medicine* reported that 75% of female doctors had experienced sexual harassment in the workplace.¹ Separately, a *Medscape* poll reported that 71% of nurses have been the targets of sexually harassment specifically from patients.² The growth of the healthcare industry means this problem will only grow, unless serious leadership, organizational, and most importantly, significant cultural shifts take place in the minds of the individuals working within this system. While sexual harassment and abuse affects both men and women, we must recognize the historical role that violence against women plays in the context of modern workplace harassment—especially in healthcare settings.

Until recently, we have lived in a world where men have (or are expected to have) some sort of power or status over women. However, traditional notions that men are intellectually superior or more professionally competent are quickly being debunked now that women are gaining access to economic stability in their own right. The resulting increase in competition from women for jobs, along with more balanced autonomy and decision-making among genders, may threaten

some—causing retaliation in various forms.

This is a problem in urgent care, just as it is in the wider healthcare industry. The toll of sexual harassment or unwanted sexual attention in the workplace can be severely debilitating. Repeated and unaddressed sexual harassment can lead to feelings of anger, fear, embarrassment, and deep resentment. For workers who are already battling the variety of external stressors that are commonplace in the healthcare industry, the added pressure of having to numb or compartmentalize harassment on the job can compound into symptoms associated with post-traumatic stress disorder, which can severely inhibit a healthcare worker from feeling confident in performing their duties.

Tackling this problem in healthcare is especially difficult because professionals choosing a career in patient care often aim to put the needs of others before themselves, making them particularly vulnerable to abuse. In fact, Congress has recently recognized the need to address workplace violence against healthcare workers by introducing the Health Care Workplace Violence Prevention Act into the House of Representatives.³ This bill, if passed, will require certain healthcare employers to adopt a comprehensive plan for protecting healthcare workers and other personnel from workplace violence.

It is essential to have a zero-tolerance policy in your urgent care center, one that is both visible to staff and patients and consistently enforced. Creating and maintaining an environment where team members feel safe to report harassment because they know it will be addressed properly, regardless of who the perpetrator is, benefits every person, whether provider or patient, who walks through your center’s doors. ■

[Editor’s note: For an analysis of this topic from a legal perspective, read #MeToo in the Urgent Care Center: When the Perpetrator Is a Patient by Suzanne C. Jones and Roma B. Patel on page 29 of this issue.]

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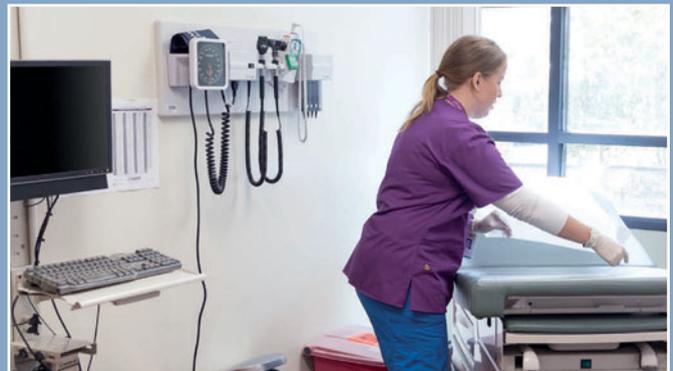
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HEALTH LAW AND COMPLIANCE

29 #MeToo in the Urgent Care Center: When the Perpetrator Is a Patient

Sexual harassment is an unfortunate reality in all professional settings—including the urgent care center. Often, policies reflect events between coworkers, or between supervisors and staff. The waters grow murkier when the person doing the harassing is a patient, and the victim is a clinician.

Suzanne C. Jones and Roma B. Patel

CLINICAL

11 An Updated Approach to Toddler's Fractures



When a child under 4 years of age presents with an unexplained limp or failure to bear weight, you're likely to think toddler's fracture. Management of this relatively common injury has been the subject of a fair amount of research, however—with the outcome being a wider variation in recommended treatment than you might have learned in med school.

Amy E. Pattishall, MD

PRACTICE MANAGEMENT

17 The Millennial Conundrum: Fostering an Engaged Multigenerational Urgent Care Workforce



There are many stereotypes associated with Millennials in the workplace. Some may be valid; many are not. The fact is, they'll make up the largest segment of the working population in the entire country soon—and their role in the urgent care center is being redefined every day.

Rachel Sossoman, MSHR, SPHR, SHRM-SCP

CASE REPORT

25 A 30-Year-Old Female with Headaches of Increasing Frequency



Cerebral venous sinus thrombosis is a relatively rare occurrence, but one whose signs and symptoms are likely to prompt a visit to an urgent care center. Quick identification and management are essential to prevention of stroke.

Asia Ferdous, DO and Jordan Miller, DO

IN THE NEXT ISSUE OF JUCM

Urgent care centers offer high-quality clinical care that's accessible beyond the traditional hours of a primary primary care office. The internet and social media are "open" even longer, of course, offering unparalleled marketing and outreach opportunities to operators with the right approach. We'll offer perspectives on how to do it in the October issue of *JUCM*.

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

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Anyone who has worked in the urgent care industry in the past few years has probably received a lot of information about their workplace policies on sexual harassment. Whether you're the owner or a manager, clinician, staff member, or office temp, you've been told that treating each other with respect at all times will foster a professional environment where everyone feels safe from unwanted advances, smarmy commentary, and dubious intentions based on gender or orientation.

However, sometimes predatory sexual behavior comes from individuals over whom management has relatively little control, and who are not bound by workplace policies. We're talking about patients. It might surprise you to learn that it happens frequently.



It might also surprise you to learn that urgent care employers are accountable for taking every reasonable measure to ensure an environment where workers are safe from sexual harassment even from those who are not under their employee—including patients, as is covered in this issue's Health Law and Compliance feature. In #MeToo in the Urgent Care Center: When the Perpetrator is a Patient (page 29), attorneys **Suzanne C. Jones** and **Roma B. Patel**, with support from research assistant **Grace Bandeen**, relay how to recognize, prevent, and help team members recover from sexual harassment committed by the people they've dedicated their working lives to helping. Ms. Jones is a shareholder at Buchalter, a law firm in Los Angeles where Ms. Patel is an associate.

Far more common, but also fraught with fear and anxiety for parents, are instances of toddler's fractures. Given the age of the patient, it's likely that such injuries are the first time a parent has had to bring their child to a healthcare facility for immediate care for an injury. Nerves are shot and emotions are running high. Being able to approach the situation with confidence, especially given that recommended management has grown less conservative in recent years, is an essential first step toward a positive outcome. Read **An Updated Approach to Toddler's Fracture** by **Amy E. Pattishall, MD** on page 11 and you'll be on your way. You can get CME credit for doing it, too.



Dr. Pattishall is associate professor of pediatrics in the Division of Pediatric Emergency Medicine at Emory University School of Medicine and practices at Children's Healthcare of Atlanta.

At least in those cases you'll have a good idea of the mechanism of injury, and exactly when the injury occurred. Relying on a patient's history of a headache that's gotten worse over "a few days" can be much more daunting. Does she have a history of migraine? Did she fail to mention a fall? You've got to be vig-

ilant for red flags, as demonstrated in **A 30-Year-Old Female with Headaches of Increasing Frequency** (page 25), a case report by **Aasia**



Ferdous, DO, PGY-4 and **Jordan Miller, DO, PGY-1**. Dr. Ferdous is a Fellow in geriatric medicine at Abington Memorial Hospital in Abington, PA; Dr. Miller practices emergency medicine at Adena Health System in Chillicothe, OH.



Headaches of a different sort are what some urgent care operators and clinicians expect from the growing number of Millennials working in urgent care centers. That's not necessarily a fair assumption, though. As **Rachel Sossoman, MSHR, SPHR, SHRM-SCP** explains in **The Millennial Conundrum: Fostering an Engaged Multigenerational Urgent Care Workforce** (page 17), there may in fact be subtle differences in how members of the Millennial generation communicate and view their role as employees, but that doesn't mean they don't bring unique assets to the table. Ms. Sossoman is director of human resources at Mercy Urgent Care in Asheville, NC

Also in This Issue

As always, we're indebted to **Joshua Russell, MD, MSc, FAAEM, FACEP** for surveying the landscape for new literature relevant to our urgent care readers, and distilling the key points from new articles into their most salient points. In this issue, he turns his keen eye on articles from other journals on why rude patients are ultimately doing themselves a disservice; a new take on immobilizing "boxer's fractures"; assessing and deciding on the best course of action for croup; and more. Abstracts in Urgent Care begins on page 21.

Finally, in **Revenue Cycle Management** (page 43), **David Stern, MD** examines whether utilizing credit card preauthorization can help optimize revenue in these days of escalating out-of-pocket costs and drawn-out collections processes. Turn to page 43 to learn more.

Thanks to Our Peer Reviewers

We appreciate the efforts of our peer reviewers to help us present original content that is high quality, relevant to the urgent care industry, and free from bias. This month, we thank:

- Sal A. D'Allura, DO, FAAFP
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Release Date: September 1, 2019
Expiration Date: August 31, 2020

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

Learning Objectives

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

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

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CONTINUING MEDICAL EDUCATION

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

An Updated Approach to Toddler's Fractures (p. 11)

1. When toddler's fracture is suspected, history should include all but which of the following?

- a. Potential mechanism or trauma
- b. Systemic symptoms, such as fever
- c. History of trauma
- d. Red flags for abuse
- e. All of the above

2. Differential diagnosis of new-onset limp in young children should include:

- a. Osteomyelitis
- b. Septic joint
- c. Soft tissue infection
- d. Neoplasm
- e. All of the above

3. What percentage of initial radiographs in children ultimately diagnosed with toddler's fracture are negative?

- a. 12%
- b. 41%
- c. Around 50%
- d. 66%

The Millennial Conundrum: Fostering an Engaged Multigenerational Urgent Care Workforce (p. 17)

1. As defined by Pew Research, "Millennial" employees are those:

- a. Under the age of 35
- b. Born between 1981 and 1996
- c. Born in the year 2000 or after
- d. Who turned 21 in the first decade of the current millennium

2. The notion that members of the Millennial generation tend to be lazy, disloyal, self-absorbed, and impatient has been found through research to be:

- a. Spot on
- b. Correct in general, though not universally true
- c. Based more on opinion than evidence
- d. The media's fault

3. According to global research by Gallup, what percentage of employees (of any age) are "actively disengaged" at work?

- a. 33%
- b. 16%
- c. 67%
- d. 79%

A 30-Year-Old Female with Headaches of Increasing Frequency (p. 25)

1. Risk factors for cerebral venous sinus thrombosis (CVST) include:

- a. Pregnancy
- b. Puerperium
- c. Oral contraceptive use
- d. Thrombophilia
- e. All of the above

2. The tests of choice for diagnosing CVST are:

- a. MRI/MRV
- b. Plain radiographs
- c. Noncontrast CT scan
- d. CBC
- e. Coagulation studies

3. Which of the following is first-line treatment for CVST?

- a. Decompressive craniotomy
- b. Mechanical thrombectomy
- c. Systemic anticoagulation
- d. Endovascular thrombolysis

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■ LAUREL STOIMENOFF, PT, CHC

The Urgent Care Association's Health & Public Policy (H&PP) Committee remains one of our most active volunteer groups. Chaired by Bob Graw, Jr., MD, FCUCM, and supported by Camille Bonta, UCA's lobbyist, the committee's tireless work deserves recognition. A sampling of their recent activities includes:

- **The Emergency Triage Treat and Transport (ET₃) model:** Announced by the Centers for Medicare & Medicaid Services (CMS) in February, this 5-year pilot will compensate select Emergency Medical Service providers to treat nonemergent patients with either the support of telehealth technology or transport to appropriate settings, including urgent care centers. UCA remains engaged in ongoing conversations with CMS and representatives of the emergency transport industry to prepare our members for a 2020 launch.
- **Urgent care in rural communities:** Rural healthcare access is a hot item legislatively at both the state and federal level. Urgent care centers are a viable solution for many of these communities, yet they may struggle financially due to lower volume and staffing challenges. A task force has been convened to frame our message and strategy. We are committed to pursuing the right incentives so urgent care operators can confidently enter rural markets.
- **Urgent care centers serving our nation's veterans:** Urgent care is now an option for eligible veterans enrolled through Veteran Affairs. UCA successfully advocated to ensure urgent care centers were included under the VA Mission Act and supported TriWest Health's efforts to build a nationwide network of contracted urgent care centers.
- **UCA Political Action Committee advances a state-level strategy:** In 2018, the UCA Board approved the formation of an independent political action committee (UCAPAC). State-level PACs were formed to correlate with escalating activity in key battleground areas. John Kulin,



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

"We encourage payers to eliminate arbitrary restrictions on scope of practice, including wellness care and services, and make the case that global payment rates stifle innovation and growth."

DO, FACEP, FCUCM awarded our first state-level donation in July. A major election year is imminent and UCAPAC will seek opportunities to fund select candidates supportive of the urgent care sector.

- **Fair reimbursement for urgent care access and services:** A position statement has been posted and distributed on fair payment for urgent care services. Despite the fact that urgent care centers provide a substantial amount of primary care, patient copays often not only exceed those of primary care providers, but also those for specialists—clearly, a disincentive to utilize urgent care. We are advocating for greater parity in patient financial responsibility for urgent care and primary care services. Additionally, we encourage payers to eliminate arbitrary restrictions on scope of practice, including wellness care and services, and make the case that global payment rates stifle innovation and growth. Urgent care owners and operators should establish their scope of care based on clinician skill sets and the needs of the community, as opposed to retrofitting their scope into contractual boundaries.
- **Urgent care and CMS's Merit-based Incentive Payment Program (MIPS):** Recognizing that the majority of urgent care centers provide episodic illness and injury care, the association has advocated for urgent care-appropriate MIPS activities. UCA has also submitted a request to CMS to recognize UCA accreditation as an improvement activity based on clinician onboarding, credentialing, and privileging standards.

We continue our quest to move from a defensive to an offensive strategy and are pleased to be reporting some wins. I want to express my most sincere gratitude to those who support UCA via membership, event attendance, and PAC contributions. We cannot do our work without you. ■

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An Updated Approach to Toddler's Fractures

Urgent message: Toddler's fractures are a common cause of limp and failure to bear weight in children under 4 years of age. Recent research shows wide variation in management of these stable fractures, favoring a less conservative approach.

AMY E. PATTISHALL, MD

***The case:** A 14-month-old male is brought to your urgent care by his parents immediately after an injury to his right leg at the park. The boy was riding down the slide on his father's lap when his foot got caught, twisting his right lower leg. He cried in pain, and now is refusing to bear weight. On examination with the child calm, both legs are well perfused with no swelling or obvious deformity. Examination of the right leg shows full range of motion at the hip, knee, and ankle. There is no thigh or foot tenderness. Warmth and tenderness are noted to the right lower leg. Radiographs of the right leg show no fracture.*

The "toddler's fracture" was first described in 1964 by Dunbar, et al, as an oblique, nondisplaced fracture of the distal tibial shaft in children between the ages of 9 months and 3 years, which can frequently go undiagnosed due to challenges with examination and subtle or lack of findings on initial radiographs.¹ The original definition has been expanded to include subtle or occult fractures in the lower limb of preschool-aged children following minor trauma.² Recent research has focused on management and follow-up.

History and Exam Pearls

Children with toddler's fractures typically present with limp or failure to bear weight on an extremity after minor trauma, such as tripping or falling a short distance. The mechanism usually suggests rotational force through the tibia with the foot and ankle fixed. Riding down slides on another person's lap has been shown to be a risk factor for injuries of the lower leg, including toddler's fractures.³ Occasionally, no history of trauma



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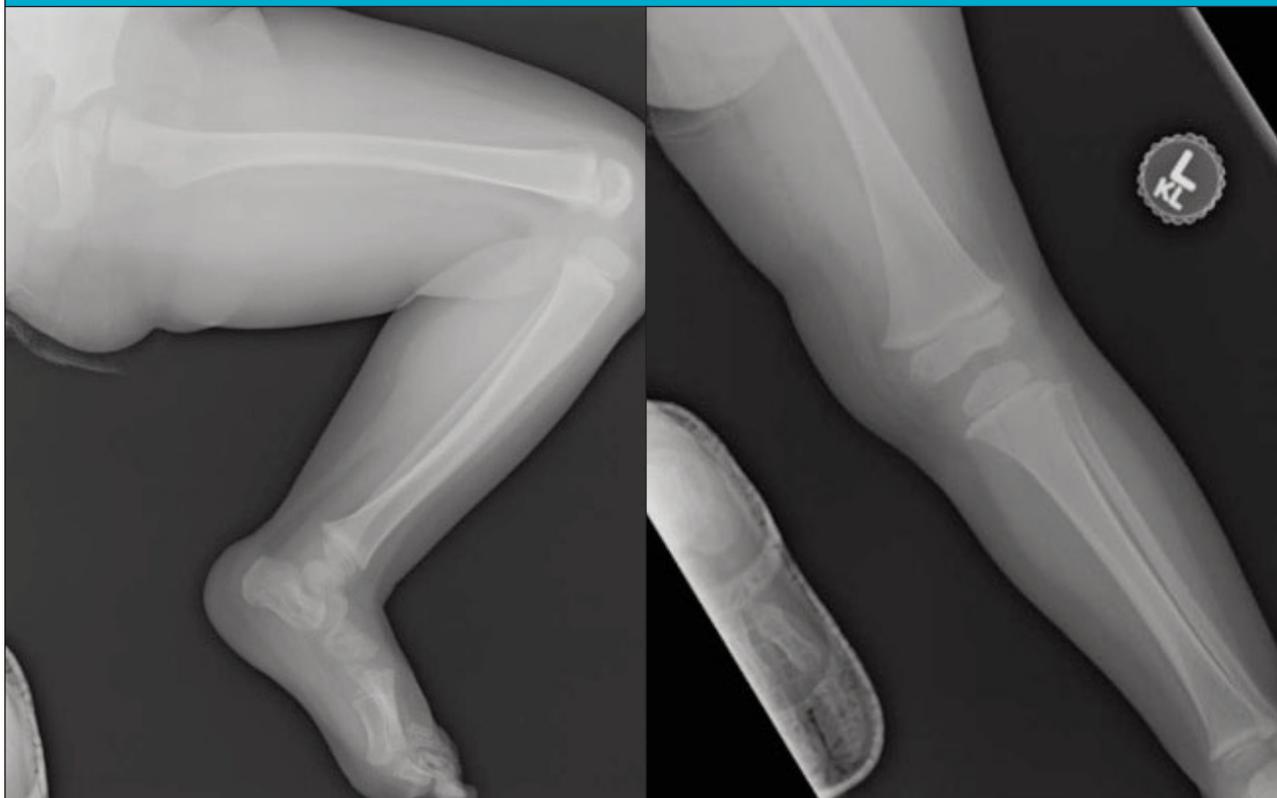
is elicited, but onset of symptoms should be acute. History of subacute or insidious onset of extremity pain or limp should broaden the differential to include inflammatory disorders or malignancy.

In addition to potential mechanism or trauma, the history should include inquiry into systemic symptoms (including fever) which are absent in the case of toddler's fracture. A patient with fever and limp or refusal to bear weight raises suspicion for infectious etiology; prompt recognition of conditions such as septic arthritis, osteomyelitis, and myositis is critical. A history of recent illness or antibiotic use may point toward a post infectious etiology, such as transient synovitis.

Examination may be challenging due to the distress of

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Figures 1a and 1b. Acute oblique fracture of lower tibial shaft in a 2-year-old.



Images courtesy of Teleradiology Specialists, www.teleradiologyspecialists.com.

“Patients will sometimes present without history of a specific mechanism of injury. However, a mechanism that is not consistent with exam findings or the developmental ability of the child should raise suspicion for nonaccidental trauma.”

the child and the relatively subtle physical findings. As with all patients with suspected trauma, the extremities should be inspected for deformity, erythema, or swelling. Neurovascular status should be evaluated by checking distal pulses and capillary refill, and assessing movement.

Patients may feel more comfortable positioned in their caregiver’s lap, and if the provider begins the exam

with the unaffected side. A longstanding recommended approach to the exam is to begin by testing the skin temperature of the lower legs.¹ Warmth over the anterior surface of the lower leg is a common finding with toddler’s fractures, thought to be due to subperiosteal hematoma formation at the fracture site.² If toddler’s fracture is suspected, exam of the affected extremity may begin with palpation of the hip, thigh, and knee, followed by the foot and ankle, and finally the lower leg.

Patients with toddler’s fracture may exhibit tenderness over the lower third of the tibial shaft, or may have pain with passive dorsiflexion of the foot or gentle twisting of the tibia by rotating the foot while holding the knee stable. Range of motion at the ankle, knee, and hip is typically normal.

A complete physical exam in patients with unclear cause of limp may reveal an etiology outside the musculoskeletal system, such as inguinal hernia, testicular torsion, or appendicitis. Providers should maintain vigilance for potential nonaccidental trauma by examining the patient for other suspicious or unexplained injuries.

Because toddler's fracture can result from minor trauma, patients will sometimes present without history of a specific mechanism of injury. However, a mechanism that is not consistent with exam findings or the developmental ability of the child should raise suspicion for nonaccidental trauma.

The consequences of a missed diagnosis of an infection, neoplasm, or nonaccidental trauma can be dire in children. Sequelae such as systemic sepsis, cartilage and growth plate damage, future growth disturbance, clinical worsening or metastasis of malignancy, and risk of future nonaccidental trauma highlight the importance of a careful history and physical exam in evaluating these patients.

Radiographic Diagnosis

On plain film, toddler's fractures are classically described as a spiral or oblique fracture through the distal third of the tibia. Initial radiographs are frequently negative, but a follow-up film 1-2 weeks after presentation will often confirm a fracture by revealing periosteal reaction and signs of fracture healing. In their 2001 study, Halsey, et al reported 66% of patients diagnosed with toddler's fracture had negative initial radiographs; and 41% of those presumed cases showed radiographic evidence of fracture at follow-up.⁴ In a larger, more recent study, 39% of patients had negative initial x-rays, with 93% of these showing evidence of fracture at follow-up.⁵ Though not routinely used, an internal oblique view may be obtained to better visualize subtle findings.⁶

Ultrasound has shown promise in identifying toddler's fractures through detection of the fracture hematoma, even in cases in which the initial radiographs are negative.² Increased use of ultrasound in the pediatric emergency room (PED) and urgent care setting may allow for earlier detection of these fractures while minimizing radiation exposure in pediatric patients.

While spiral fractures of long bones raise clinicians' suspicion for child abuse, evidence suggests that these fractures in the distal tibia commonly occur due to accidents and childhood injury.⁷ Spiral fractures of the midshaft tibia are more suspicious for nonaccidental trauma.⁸

Management

The textbook approach to managing both radiographically confirmed toddler's fractures and suspected toddler's fractures with negative plain films is with immobilization and referral to orthopedic specialist. Though a frequently cited 2001 retrospective study recommends long leg casting for all confirmed and sus-

Differential Diagnosis: New-Onset Limp in Young Children

What's common	<ul style="list-style-type: none"> • Fractures • Soft tissue injuries • Toxic synovitis/transient synovitis
What not to miss	<ul style="list-style-type: none"> • Osteomyelitis • Septic joint • Soft tissue infection (abscesses, myositis, cellulitis) • Neoplasm • Nonaccidental trauma
What to think about	<ul style="list-style-type: none"> • Osteonecrosis (sickle cell disease) • Inflammatory conditions (juvenile rheumatoid arthritis, systemic lupus erythematosus) • Developmental dysplasia of the hip • Coxa vara

“Physicians were more likely to manage confirmed fractures conservatively with above-the-knee circumferential casting, while below-knee splinting was most common in suspected cases.”

pected cases of toddler's fracture,⁴ there is wide variation in clinical practice. A 2016 retrospective cohort study at a tertiary care PED found that among patients 9 months to 3 years of age with radiographic evidence of toddler's fractures, 66.7% were placed in splints or casts, 24% were placed in CAM boots, and 9.3% were not immobilized.⁹

Seguin, et al surveyed physicians at 15 Canadian hospitals and found significant nationwide variation among immobilization with above-knee circumferential casting, below-knee circumferential casting, below-knee posterior splinting, other treatment, and no immobilization.¹⁰ The same study showed physicians were more likely to immobilize a radiographically confirmed fracture compared with a suspected case, and that when immobilization was utilized, physicians were more likely to manage confirmed fractures conservatively with above-the-knee circumferential casting, while below-knee splinting was most common in suspected cases.¹⁰ Similarly, a retrospective cohort study of patients 9-36

Figures 2a and 2b. Acute oblique/spiral fracture of the lower tibial shaft in a 13-month-old child.



Images courtesy of Teleradiology Specialists, www.teleradiologyspecialists.com.

“When faced with pediatric patients presenting with acute-onset limp or failure to bear weight, urgent care providers should consider the diagnosis of toddler’s fracture in those who demonstrate warmth or tenderness to the distal tibia, even if no evidence of fracture is seen on x-ray.”

months age in a Scottish PED found children with a confirmed toddler’s fracture were more likely to be casted (92%), compared with those with presumed toddler’s fractures (47%).¹¹

Prognosis

Prognosis of toddler’s fractures is good, regardless of management strategy. Recent studies have not noted any complications such as displacement, nonunion, or refracture.^{5,9,11,12} Skin breakdown as a result of splinting or casting has been noted as a potential complication, with as many as 17.3% of patients affected in one study.⁹ This finding, along with similar healing times regardless of management, has led experts to recommend the use of CAM boots, or no immobilization at all,⁹ or to base immobilization method on the patient’s comfort and parent preference.¹¹ Adamich and Camp recommend above-knee immobilization in younger toddlers to prevent slipping of below-knee immobilization that can occur on their short, conical legs, causing skin breakdown. They recommend below-knee immobilization such as CAM boots in older toddlers.¹² A 2017 study showed reliable healing of toddler’s fractures by 3-4 weeks, with significant earlier return to weightbearing if initial immobilization was with a CAM boot, rather than a short leg cast.⁵

When faced with pediatric patients presenting with acute-onset limp or failure to bear weight, urgent care providers should consider the diagnosis of toddler's fracture in those who demonstrate warmth or tenderness to the distal tibia, even if no evidence of fracture is seen on x-ray. As these are stable fractures with low likelihood of complications, immobilization strategy can be tailored to the patient and available materials; evidence suggests CAM boots may provide some protection from skin breakdown and faster return to weightbearing, especially in older toddlers. Follow-up with the primary care provider should be encouraged, with anticipation of immobilization for 3-4 weeks. Persistent pain or limp after this point may warrant further evaluation.

“Based on review of children in whom there was uncomplicated healing of toddler's fractures with <2 mm displacement, orthopedists developed a clinical pathway which guides definitive management at initial point of care [such as in the urgent care setting], and avoids repeat x-rays and orthopedic follow-up in patients with confirmed toddler's fractures.”

Follow-up

The need for routine orthopedic follow-up and repeat radiographs for patients with toddler's fractures has also been called into question. Studies have cited the need to minimize children's exposure to radiation, suggesting follow-up radiographs are unlikely to change clinical management, particularly in cases of radiographically confirmed toddler's fractures.^{5,11,12} In response to a retrospective review showing uncomplicated healing of all toddler's fractures with <2 mm displacement, orthopedists at The Hospital for Sick Children developed a clinical pathway which guides definitive management at initial point of care, and avoids repeat x-rays and orthopedic follow-up in patients with confirmed toddler's fractures. By instructing primary care providers on exclusion criteria and immobilization and educating parents

Diagnosis and Management Pearls

- When evaluating a child with a limp, red flags that may indicate a diagnosis other than toddler's fracture include fever or other systemic symptoms and insidious onset of symptoms.
- Even if the history suggests a toddler's fracture, consider the possibility of a fracture elsewhere on the lower extremity. Radiographs of the pelvis, femur and foot, in addition to the lower leg, may be warranted.
- A higher suspicion for child abuse should be maintained in patients with spiral fractures if the fracture is midshaft, if no specific mechanism of injury is given, if the mechanism of injury is not consistent with the exam or radiologic findings, or if the child is nonambulatory.
- A developmental history of the child's gross motor abilities is important in younger children to determine if the mechanism is consistent with the injury.
- Initial radiographs may be normal. If the provider has a high clinical suspicion for toddler's fracture, the patient should be managed assuming an occult fracture is present.

on splint removal, they aim to decrease cost to the family and the healthcare system.¹²

Case conclusion: *The patient is presumed to have a toddler's fracture and is placed in a posterior long leg splint; the parents are instructed to follow up with orthopedics in 1 week. A repeat radiograph obtained at follow-up demonstrates subperiosteal new bone formation of the distal tibia, providing evidence of a toddler's fracture. He is placed in a CAM boot to complete 4 weeks of immobilization. ■*

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§MUCINEX® Children's is the #1 Pediatrician Recommended non-antihistamine, multi-symptom brand in the Children's Cough/Cold category among the Universe of Pediatricians (IQVIA ProVoice Survey). MAT 52 weeks through February 2018.





The Millennial Conundrum: Fostering an Engaged Multigenerational Urgent Care Workforce

Urgent message: Are Millennial employees breathing fresh energy into the urgent care workplace or are they a new breed of workers who don't go along with established workplace norms? Your perspective may influence how you fair in their ascendance.

RACHEL SOSSOMAN, MSHR, SPHR, SHRM-SCP

Introduction

Millennials—Americans born between 1981 and 1996—became the largest demographic group in the U.S. workforce at 56 million strong in 2017; this year, they will overtake Baby Boomers as the largest segment of the entire U.S. population, according to Pew Research. Some urgent care operators may see this as a serious problem. Even the most flexible operators are likely to acknowledge this evolving multigenerational mashup presents a challenge. Fortunately, there is not only hope, but competitive advantage in the coming years for culturally savvy urgent care operators who adapt to the unique needs of the multigenerational workforce.

What Is the Problem (Assuming There Is a Problem)?

No problem can be solved without first understanding it. That said, one major challenge of identifying cultural problems in a multigenerational workforce is just that: identifying the problems.

Culture is defined as “the attitudes and behavior characteristics of a particular social group.”¹ In organizations (and urgent care is no exception), the social norms of that group, and thus, the organization's culture, are defined by people. Who gets to decide the cultural norms for the group? According to the *Stanford Encyclopedia of Philosophy*, social norms form when individuals interact.² Eventually, a collective mindset coalesces,



formed by a consensus of a majority, producing a social order of sorts. Once norms are established among a group, praise and blame are given to its members relative to conformity or nonconformity with the established norms.

Enter Millennials, also known as Generation Y. In

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2007, the Pew Research Center dubbed Millennials the Look at Me generation, alluding to the prevalence of social media use among Millennials, commonly associated with an inflated sense of self-importance.³ Culturally speaking, Millennials are often at the center of generational conflict in the workforce due to perceived attitudes and behaviors that conflict with workplace norms. Fairly or unfairly, workplace behaviors commonly attributed to Millennials often lead them to be assigned the culprit's role when cultural friction arises. This spotlight on Millennials isn't without some merit, as there *are* cultural norms unique to Millennials that make this group visible in workplaces when collective norms differ from theirs.

“Global research highlights the gap between culture and employee engagement in the United States, finding that a mere 33% of employees in the United States define themselves as ‘engaged’ at work. That leaves a whopping 67% who are actively disengaged.”

The characterization continues with egotism, one of several perceived behavioral characteristics that have catapulted this generation into the spotlight. Other perceptions of Millennials include, but are certainly not limited to, a general lack of communication skills outside of tech-savvy methods such as texting; disloyalty in the form of frequent job-hopping; and emotional instability that some say results from receiving too many “participation trophies” as children.

On the other hand...

An article from the *Journal of Business and Psychology* entitled Millennials in the Workplace: A Communication Perspective on Millennials' Organizational Relationships and Performance analyzed both empirical studies and popular literature on the group, and uncovered some suspect findings for anyone who believes Millennials are to blame for the multigenerational culture conundrum: most shockingly, that popular media have misclassified Millennials as lazy, disloyal, self-absorbed and impatient, and as a result, contributed to wide-

spread stereotypes based on information that was “more opinion than evidence-based.”⁴

The research-backed reality is less sensational and hardly reported in popular media, according to the authors. Assimilating into an organizational culture with established norms and cultural stereotypes against Millennials inhibits their ability to assimilate into the group.⁴ Is it possible that Millennials really *aren't* the culprit for our workplace woes? The article purports that Millennials are no different from any “outsider” attempting to assimilate into a culture that differs from that outsider. If that's the case, then any generation, culture, ethnicity, gender, group, person, etc.—not just Millennials—can become the outsider in a workplace culture.

By this measure, multigenerational conflict can be reframed as a result of the unwillingness to consider challenges to established norms instead of one generation's misconduct in the workforce.

There is one major advantage to defining the problem this way. Consider the Pew research on Millennials in the workforce and its implications for workplace norms. If norms are formed by the majority, then Millennials, the largest group in the workforce as of 2017, are in a prime position to define (or redefine) workplace norms. By eliminating one generation or the other as the suspected culprit of cultural problems and reframing differences as an opportunity for growth, urgent care centers can ensure that all cultures and generations have a voice in their respective groups.

Culture and Employee Engagement

Culture and *engagement* are two different concepts that are inextricably linked. According to Deloitte, *culture* can be summed up as “the way things get done around here,” while *engagement* can be described as “how people feel about the way things work around here.”⁵ The former describes norms; the latter describes individual/collective commitments to those norms. In a Culture and Engagement Perspective whitepaper, Deloitte describes both culture and engagement as “critical to business performance,” with “actively managed” cultures producing 147% higher earnings per share along with employees who are 87% less likely to leave.⁵

Global research by Gallup highlights the gap between culture and employee engagement in the United States, finding that a mere 33% of employees in the United States define themselves as “engaged” at work. That leaves a whopping 67% who are actively *disengaged*. Of that 67%, 16% are beyond disengaged, to the point of actively sabotaging the company.⁶

Why does engagement matter? According to the data, the short answer is: cost and risk. The same Gallup study purports that the costs of cultural dysfunction in the workplace can be “catastrophic.” A 2017 study conducted by the Engagement Institute—a collaborative effort among the Conference Board and Deloitte, among other organizations—revealed that disengaged employees cost upwards of \$550 billion per year.⁷ Urgent care is not exempt from the costly perils of dysfunctional cultures. What’s more, volatility stemming from shifting reimbursement models and payer mixes renders urgent care quite vulnerable if internal costs cannot be controlled. In a market with record low unemployment, turnover alone can be highly disruptive.

By comparison, the Gallup study revealed that organizations with engaged employees enjoy 37% lower absenteeism, 48% fewer safety incidents, 41% fewer quality issues, 10% higher customer satisfaction, 21% higher productivity, and 22% higher profitability. The benefits of an engaged workforce are as clear as the liabilities of a disengaged workforce.⁶

Employee engagement and workplace culture are directly linked and executives know it. However, according to Deloitte, while nearly nine out of 10 executives believe culture and engagement are very important, only 12% of companies believe they understand their culture.⁷

In other words, we know there are cultural issues stemming from our multigenerational workforces, we just aren’t sure what they are—and even if we do know (which we don’t), fewer than half of us are prepared to tackle the challenge of engagement.

How Can Urgent Care Engage a Multigenerational Workforce?

Build trust, influence change. How well do leaders and managers “walk the talk?” Culture and workforce engagement begins with urgent care leaders forming and communicating cultural expectations collectively *with* employees. The greater the employee involvement in decision-making, the greater the likelihood of employee trust in the leadership and engagement in the company. What better example of an essential cultural behavior in urgent care, for instance, than cross-functional teamwork among employees involved in patient throughput? Teamwork is also an essential behavior for cultivating functional multigenerational cultures. If they aren’t already, behaviors such as teamwork should be incorporated as clear performance expectations for employees, and employees should be held accountable

to them. Likewise, leaders must champion the value that different generations bring to the workforce, and set the expectation for an environment that’s generationally inclusive.

“Culturally savvy urgent care centers that invest time and resources in eliminating stereotypes, generational and otherwise, and fostering a culture of inclusion will be poised to thrive in the years to come.”

Define core values. If utilized properly, there is hardly a better avenue than core values—the intrinsic beliefs that organizations follow in all facets of work—to define cultural norms for an organization. Core values are the guiding principles that influence behavior when coworkers and supervisors aren’t there to direct it, and are a powerful tool to influence cultural norms. Core values are directly linked to pride in the organization, an emotion that strongly correlates with employee engagement. It isn’t enough to post core values on a website or letterhead, however. They must be regularly communicated and incorporated into all facets of work, from vacancy postings to training to job descriptions. Core values are helpful recruiting tools, as well, communicating to prospective employees a cultural message that candidates wouldn’t otherwise know.

Foster inclusive relationships with employees. A meta-analysis of workplace engagement studies published by groups such as Gallup, Towers Watson, and Hewitt Associates, among others, revealed that the direct relationship with one’s supervisor was the strongest of all drivers of employee engagement.⁶ The onus is on leaders to set the tone for inclusivity. Utilize multiple feedback channels to gauge employee attitudes toward their direct supervisors. Engagement surveys abound, and they offer benchmarkable questions that address the supervisor’s leadership skill, as well as recommendations for development.

Recognize and refrain from buying into stereotypes. Sure, some Millennials may prefer texting to other types of communication, but that doesn’t mean all Millennials do. Even if all Millennials *did* prefer texting, it doesn’t mean they should be marginalized for it. Insert cultur-

Why Employee Engagement Matters to Your Business⁶

Research by Gallup shows that organizations with engaged employees enjoy:

- 37% lower absenteeism
- 48% fewer safety incidents
- 41% fewer quality issues
- 10% higher customer satisfaction
- 21% higher productivity
- 22% higher profitability

ally savvy leadership. When work groups marginalize a coworker, leaders must quickly identify the underlying cause of the marginalization, and if it's cultural, correct behaviors accordingly. Some of the biggest drivers of employee engagement transcend generations. Take recognition, for instance. A LinkedIn survey revealed that 70% of employees, regardless of generation, would work harder in exchange for recognition.⁸ Their preferences for the specific type of recognition may vary, but their desire for recognition is the same. Inclusive cultures look for the commonalities and eliminate the stereotypes, and effective leaders influence that culture.

Listen. Communication goes both ways, and employee communication style preferences vary widely, but the desire among employees to have a voice is universal across generations. Upward communication is a catalyst of innovation, and can be a sign of a healthy work culture. Are employees thanked for feedback, or marginalized for speaking out in your urgent care operation?

Offer relevant incentives. Generational or otherwise, different employees value different incentives. Find out what incentives employees prefer by asking them. Then, offer incentives that cater to the diverse needs and desires of your workforce. There may be surprising cost savings, as not every employee is interested in climbing the corporate ladder. Some employees, for instance, may prefer schedule flexibility, training opportunities, or public recognition to promotions or large bonuses. Employees whose preferences are taken into consideration are more likely to be engaged.

According to Josh Bersin, founder at Bersin, Deloitte Consulting LLP, "Moving the 'diversity discussion' beyond gender and race to also discuss generational diversity and inclusion is a major theme for the next few years."⁵ In other words, an organization must reframe its definition of "diversity" to include generational diversity if it hopes to achieve a culture that values the con-

tributions of each member. Much in the same way that organizations have historically redefined norms to eliminate discriminatory behaviors against other groups, they must also redefine norms to eradicate the same stereotypes across generations—including, but not limited to, stereotypes against Millennials. Culturally savvy urgent care centers that invest time and resources in eliminating stereotypes, generational and otherwise, and fostering a culture of inclusion will be poised to thrive in the years to come. ■

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Summary

- Millennials have been maligned for being lazy, disloyal, self-absorbed, and impatient. However, recent research has shown these to be misperceptions based more on selective opinions rather than evidence.
- Urgent care operators can engage a multigenerational workforce better by:
 - Working to build trust and influence change
 - Defining core values
 - Fostering inclusive relationships with employees
 - Recognizing—and refraining from—buying into stereotypes
 - Listening
 - Offering incentives relevant to the individual
- Disengaged employees can increase both cost and risk in an urgent care center. A study from the Engagement Institute revealed that disengaged employees cost at least \$550 billion per year.
- Volatility stemming from shifting reimbursement models and payer mixes renders urgent care quite vulnerable if internal costs cannot be controlled. Further, in a market with record low unemployment, turnover alone can be highly disruptive.



ABSTRACTS IN URGENT CARE

- Rude Patients May Be in for a Fall
- Immobilizing ‘Boxer’s Fractures’
- Take Croup Without Stridor in Stride
- Tramadol: Safer for Acute Pain, or Not?
- Usefulness of ECGs in Detecting Hyperkalemia
- *V vulnificus* May Be Heading Your Way

■ JOSHUA RUSSELL, MD, MSC, FAAEM, FACEP

Practice of Urgent Care: Rude Patients May Do More than Ruin Your Mood

Key point: Individual and team performance of clinicians suffer in both quality of diagnostic approach and procedural skills when dealing with rude patients.

Citation: Riskin A, Erez A, Foulk TA, et al. The impact of rudeness on medical performance: a randomized trial. *Pediatrics*. 2015;136(3):487-495.

Patients in urgent care commonly have unrealistic demands and expectations. When they make disparaging remarks, it's easy to feel scrutinized and under pressure. I've often felt distracted in such situations myself, only to subsequently discover, upon further reflection, that I'd prescribed the wrong medication or failed to consider another possible diagnosis. Apparently, I'm not alone.

In this innovative study, Israeli researchers randomized teams of physicians and nurses to perform a simulated resuscitation of a very sick neonate under one of two scenarios: with a neutral family member present or with a rude family member present. Videos of the teams' performances were later reviewed by several judges blinded to whether the team was exposed to a rude family member or not.

Interestingly, but perhaps unsurprisingly, the teams who were faced with the challenging resuscitation under the duress of rude comments from a family member performed significantly worse in diagnosing the neonate's critical illness, performing necessary procedures to intervene, and functioning as a team. Overall, approximately half of the variance in performance

between teams could be explained by rudeness.

Prior psychological research has demonstrated that being exposed to incivility negatively impacts working memory, the RAM-type processing ability of our brains. This may mechanistically explain why clinicians perform worse when dealing with impolite or demanding patients.

Certainly, this knowledge does nothing to reduce the chances that we will deal with a rude patient on our next shift. However, it does arm us with the knowledge that we are entering into an especially error-prone mental state in such scenarios and, therefore, increased vigilance is advisable to avoid cognitive errors. So, while spending as little time interacting with uncivil patients may be tempting, it would be wiser to develop a habit of increasing the diligence of our clinical approach when we recognize we have a rude patient in front of us. ■

Do All Boxer's Fractures Need to Be Splinted?

Key point: Patients with uncomplicated fifth metacarpal fractures recover equally well whether the finger is splinted or buddy taped (and miss less work with taping).

Citation: Pellatt R, Fomin I, Pienaar C, et al. Is buddy taping as effective as plaster immobilization for adults with an uncomplicated neck of fifth metacarpal fracture? A randomized controlled trial. *Ann Emerg Med*. 2019;74(1):88-97.

Despite the name, boxer's fractures occur in many populations. In fact, most fifth metacarpal (MCP) fractures occur in nonfighters, with the fracture occurring because someone without training has punched a hard object with his bare hand. For this reason, it is almost always a dominant hand injury.

Immobilizing a young person's dominant hand for several months is a big decision. These Australian investigators performed a randomized controlled trial of 97 patients with uncomplicated fifth MCP fractures to determine if there is any benefit



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“Patients without stridor who are appropriately treated in urgent care with steroids and racemic epinephrine... are unlikely to have clinical decline after discharge if they appear stable at that time.”

in hand function from immobilization. Half were randomized to plaster splinting and half to “buddy taping” of the pinky to the ring finger. The primary outcome of interest was functional status at 3 months. Multiple secondary outcomes, including days of work missed, were investigated.

At the end of the study period, both groups showed similar (and essentially complete) recovery on average. Not surprisingly, though, patients in the buddy taping group missed significantly less work. Based on these results, buddy taping alone for uncomplicated boxer’s fractures seems like a reasonable, perhaps even preferable approach. This, however, was a small study and it is important to ensure that the hand specialist following up with the patient is also comfortable with this strategy, as splint immobilization remains the standard of care. ■

No Stridor, No Problem!

Key point: Pediatric patients with croup without stridor appear to be at very low risk of significant complications. Normal heart rate and absence of fever and chronic medical issues also portend lower risk in children with croup.

Citation: Elder AE, Rao A. Management and outcomes of patients presenting to the emergency department with croup: can we identify which patients can safely be discharged from the emergency department? *J Paediatr Child Health*. February 18, 2019. [Epub ahead of print]

Cases involving concern for pediatric airways can be anxiety-provoking, even for the experienced provider. Croup is a common urgent care presentation, and the characteristic findings of barking cough and stridor arise specifically from upper airway obstruction. Thankfully, most patients with croup will do well, but which patients are at risk for rapid clinical decline?

In this retrospective cohort study, the investigators reviewed the charts of over 5,000 pediatric patients between the ages of 6 months and 6 years presenting to an Australian ED over a 5-year period. They then subsequently examined 112 patients requiring at least two doses of nebulized racemic epinephrine. Among the patients that were admitted, only about one in five required further intervention. No discharged patient had any adverse events. Among admitted patients, those with stridor, sig-

nificant tachycardia, younger age, fever, and prior chronic medical conditions were most likely to require further intervention.

While this was an ED study, we can feel reassured that patients without stridor who are appropriately treated in urgent care with steroids and racemic epinephrine and who are without stridor are unlikely to have clinical decline after discharge if they appear stable at that time. It still seems prudent to observe children who had stridor which resolves with racemic epinephrine treatment for 1-2 hours in urgent care to ensure that they remain well-appearing and comfortable. Based on this study, we should be more cautious and give stricter return precautions for younger children; those with chronic medical conditions; and those with abnormal vital signs; and have a lower threshold for ED referral with these patients, as well. ■

Is Tramadol Really as Safe an Opioid as We’d Like to Believe?

Key point: Despite common beliefs to the contrary, tramadol does not carry a lower risk of dependence and chronic use than other oral opioids.

Citation: Thiels CA, Habermann EB, Hooten WM, Jeffery MM. Chronic use of tramadol after acute pain episode: cohort study. *BMJ*. 2019;365:l1849.

Tramadol is a weak μ -opioid receptor agonist with serotonin and norepinephrine reuptake effects. It was first approved by the FDA in the U.S. in 1995 and remained entirely unscheduled by the DEA until 2014, when it became a schedule IV medication. For these reasons, it has largely been thought of something like an “opioid lite” and prescribed for patients because it was believed to have a lower potential for dependence, abuse, and diversion.

More recent evidence, however, suggests that the perceived relative safety of tramadol is likely a misconception. This study adds to that body of research. Investigators reviewed over 400,000 Medicare patients undergoing elective surgical procedures from 2009 to 2018 and their subsequent duration of opioid use postoperatively. They adjusted for type of surgical procedures, as well as postoperative pain severity and duration. Hydrocodone and oxycodone were the most commonly prescribed opioids among these patients, comprising over 90% of prescriptions. Tramadol was a distant third.

“It is unclear how reliably the characteristic EKG manifestations of elevated potassium, including peaked T-waves and widened QRS complexes, can be used to identify hyperkalemia.”

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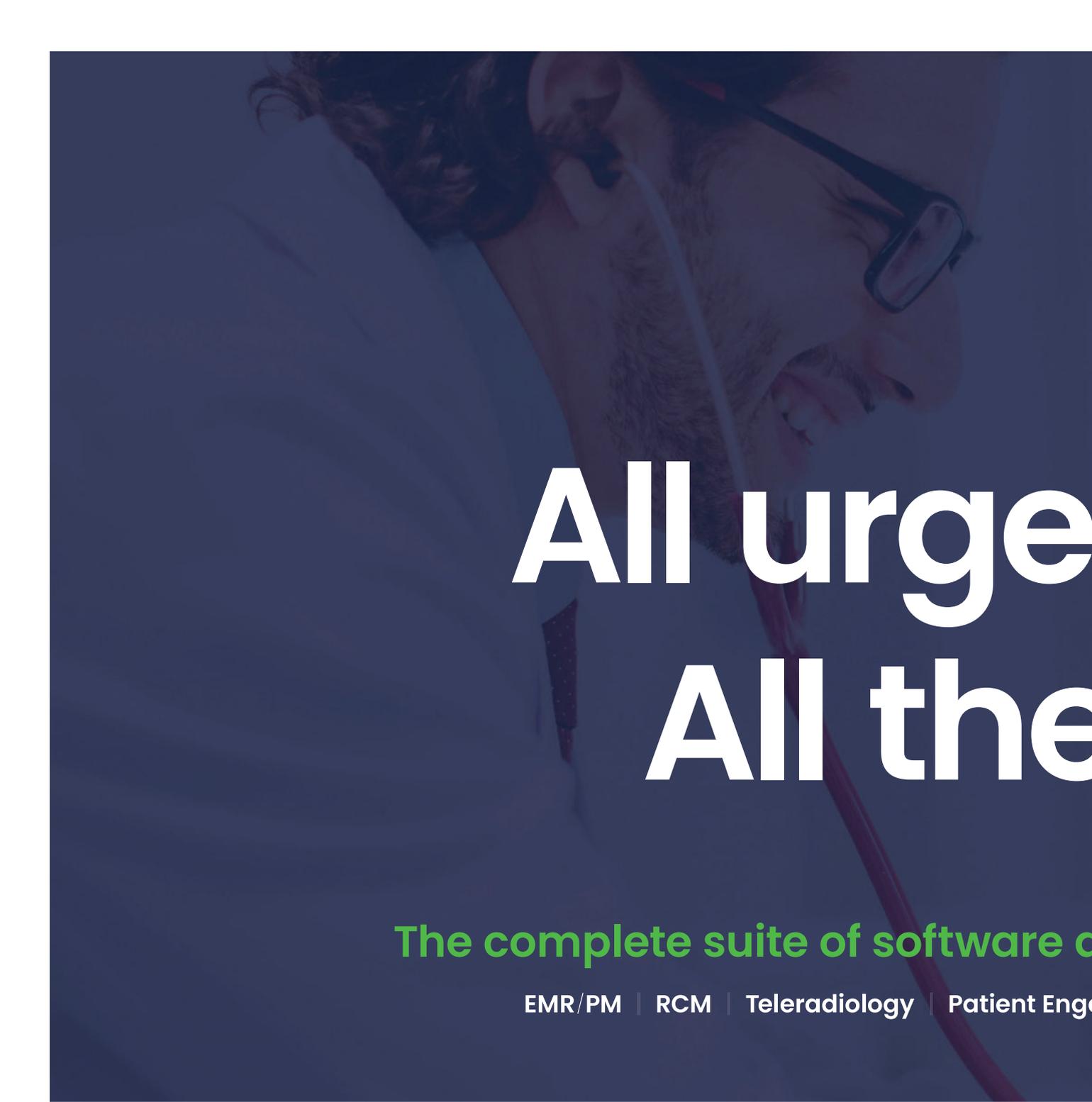
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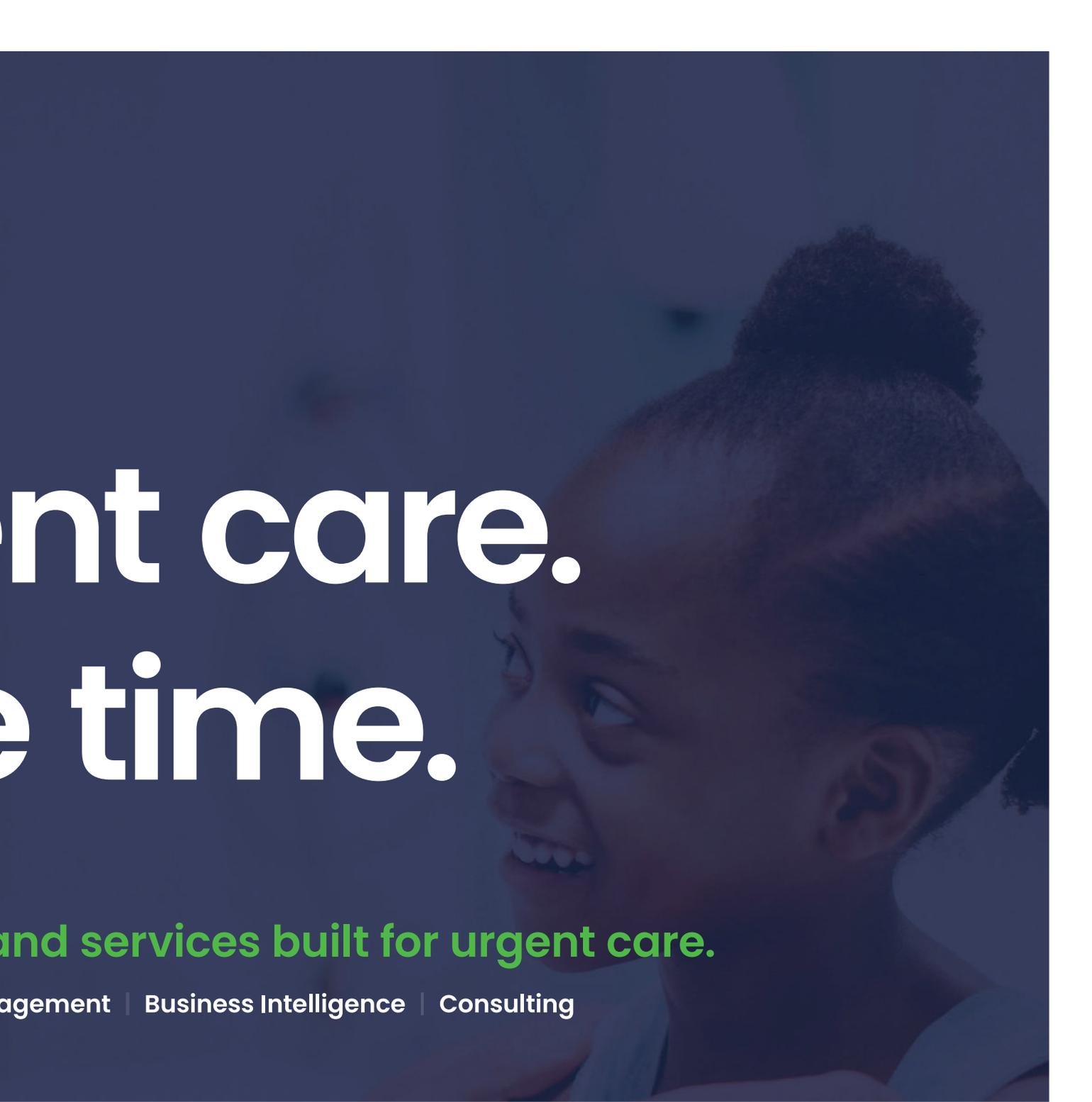
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Ideally, patients undergoing surgery would quickly be titrated off of opioid analgesics and not require them for a prolonged period of time (>90 days was the definition of “prolonged use” in this study). In both of these domains, tramadol performed significantly worse than other short-acting opioids. Patients prescribed tramadol were 6% more likely to still require prescription analgesia >3 months after surgery. More significantly, though, patients taking tramadol had a 47% greater relative risk of persistent use (>90 days of continuous use) compared with other short-acting opioids, paradoxically suggesting a much higher risk of dependence among patients prescribed tramadol compared with other short-acting opioids.

Based on the pharmacology of tramadol, the authors posit that one reason for this may be that while the tramadol parent compound shows weak μ -opioid receptor activity, the majority of patients rapidly metabolize it to O-desmethyltramadol, which has a 700x greater affinity for the receptor. This suggests that tramadol functionally acts like a much stronger opioid agonist. Regardless of mechanism, this study adds to mounting evidence that tramadol is simply not the safe opioid it has been touted to be. ■

The EKG: A Specific, but Insensitive, Test for Hyperkalemia

Key point: When present, EKG changes of hyperkalemia are highly suggestive of elevated serum potassium. Absence of EKG changes, however, does not rule out significant hyperkalemia.

Citation: Rafique Z, Aceves J, Espina I, et al. Can physicians detect hyperkalemia based on the electrocardiogram? *Am J Emerg Med.* April 22, 2019. [Epub ahead of print]

Hyperkalemia is the most immediately life-threatening electrolyte abnormality, and the symptoms of this are often vague and nonspecific. Unfortunately, most urgent care centers do not have access to rapid serum chemistry testing and, therefore, an alternative method of excluding significant hyperkalemia is desirable. In training, we are taught about the characteristic EKG manifestations of elevated potassium, including peaked T-waves and widened QRS complexes. However, it is unclear how reliably these findings can be used to identify hyperkalemia.

The authors of this study reviewed over 500 EKGs from end-stage renal disease (ESRD) patients receiving emergent hemodialysis at a Texas county hospital, then compared the EKG findings to the patient’s serum potassium value at the time the EKG was recorded. They found that EKG was poorly sensitive for detecting clinically significant hyperkalemia (sensitivity = 19% for K >6.0 mEq/L and 29% for K >6.5 mEq/L). However, the specificity of the EKG for significant hyperkalemia was much better (95%-97%).

These findings indicate that concerning EKG changes can

*“Cellulitis is a common urgent care diagnosis, and most patients go on to have a benign course. However, in patients with chronic diseases (especially chronic liver disease) and wounds from a marine environment, *V. vulnificus* should be strongly considered as a causative agent.”*

reliably rule in hyperkalemia; however, absence of changes on EKG cannot rule out elevated serum potassium levels. One caveat worth mentioning is that these patients all had ESRD and experienced elevated potassium more frequently than would patients without chronic kidney disease. The results may not be generalizable to a more typical urgent care population. Regardless, it seems that there is insufficient evidence to suggest that a normal EKG has a role in excluding the possibility of hyperkalemia. ■

Vibrio vulnificus Is on the Move!

*Key point: Cases of serious infection due to *Vibrio vulnificus* are occurring at increasingly northern climes in the eastern coastal U.S.*

Citation: King M, Rose L, Framow H, et al. *Vibrio vulnificus* infections from a previously nonendemic area. *Ann Intern Med.* June 18, 2019. [Epub ahead of print]

Vibrio vulnificus is a frightening pathogen. It lives in marine and brackish water environments and can cause life-threatening skin infections (ie, necrotizing fasciitis), as well as bacteremia after ingestion in susceptible patients. Historically, *V. vulnificus* was restricted to relatively southern bodies of water; however, with trends of warming surface waters, the bacterium appears to be migrating northwards.

This article outlines five cases of severe *V. vulnificus* infections resulting from exposures around Delaware Bay. All patients had history of handling seafood (eg, crabbing, abrasions from shellfish) and presented with classic symptoms of cellulitis. Three of the patients suffered from chronic hepatitis, one had diabetes, and one had Parkinson’s disease. All patients developed necrotizing fasciitis; one patient died.

Cellulitis is a common urgent care diagnosis, and most patients will go on to have a benign course. However, in patients with chronic diseases (especially cirrhosis or other chronic liver disease) and wounds from a marine environment, *V. vulnificus* as a causative agent should be strongly considered. It can be rapidly progressive and generally requires alternative antibiotics than those used for more common skin infections. ■



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A 30-Year-Old Female with Headaches of Increasing Frequency

Urgent message: Cerebral venous sinus thrombosis (CVST) occurs when a blood clot forms in the venous sinuses within the brain, preventing drainage of blood. It can cause blood cells to break down and leak into the brain tissues, forming a hemorrhage. This can result in stroke. CVST affects about 5 people in 1 million per year.

AASIA FERDOUS, DO and JORDAN MILLER, DO

Case Presentation

A 30-year-old female presented to urgent clinic with a headache that had been increasing in frequency over 4 days, often waking her from sleep. She also had retro bulbar pain, along with pulsatile tinnitus. It was associated with nausea but she denied any hemoptysis, weight changes, night sweats, or chills. She denied any past medical history or significant family history. Physical exam revealed a well-nourished, well-developed female who appeared to be in significant distress from occipital and neck pain. She had a benign physical exam, including normal muscle strength and gait. There were no significant cardiopulmonary or gastrointestinal findings. Cranial nerves 3-12 were intact and her gait was normal. Her only medication was a low-dose daily oral contraceptive pill.

Outcome

At the urgent care, this patient was diagnosed with atypical migraine and was sent home with instructions to follow up with her primary care provider, whom she saw a week later. Her primary care physician ordered magnetic resonance imaging because the patient's symptoms were new in nature, and severe with associated visual changes and nausea. The differential included primary malignancy, pituitary adenoma, pseudotumor cerebri, vertebral artery dissection, and thrombosis. MRI showed extensive thrombosis of the superior sagittal sinus, right transverse, and right sigmoid sinuses with extension into the right internal jugular vein. She was



admitted to the hospital for anticoagulation and further management.

The patient was transitioned from unfractionated heparin to enoxaparin (Lovenox) and then eventually bridged to warfarin. The patient's hypercoagulable workup was negative and a computed tomography scan of the chest, abdomen, and pelvis with intravenous and oral contrast done was unremarkable for any signs of malignancy. (CT would not typically be indicated in a

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case like this, but was done at the request of this very anxious patient as a courtesy.) The patient's venous sinus thrombosis was thus thought to be iatrogenically provoked secondary to oral contraceptive use.

Discussion

CVST is a very rare form of venous thromboembolism, representing approximately 0.5%-3% of all types of strokes.¹ Clinical presentation varies from one individual to another and possible clinical manifestations include headache, vision changes, and nausea with vomiting, seizures, stroke, coma, and even death.² These symptoms are not all-inclusive—patients may have only one, or may have multiple symptoms.^{2,3}

A minority of patients during presentation have no complaints of headache, which can make diagnosis extremely difficult. Moreover, patients with CVST presenting to an acute care setting are frequently misdiagnosed as having migraine or tension-type headache due to the rarity and possible variation of symptoms at presentation.⁴ Although a rare diagnosis, it should be considered in the differential.

“Patients with CVST will often present with headaches, yet the diagnosis can be easily missed due to the rarity of the case and complexity of its presentation. Thus, knowledge of its presentation, risk factors, and common findings are very important in order to avoid delays in diagnosis and avoid life-threatening outcomes.”

Risk factors for CVST include pregnancy and puerperium, oral contraceptive use, thrombophilia, malignancy, infections, dehydration, and head traumas. Overall, women are affected more frequently than men.^{4,5} Headache is the most common presenting symptom of CVST and is present in about 90% of cases.

Based on history, if the patient has signs of elevated intracranial pressure or signs of intracranial hypertension, this can strongly suggest the presence of CVST. Furthermore, the presence of papilledema on ocular exam can support the diagnosis as well.⁴ Certain clues to a patient's history should raise red flags that warrant further investigation. Examples include repeated visits to an acute care setting for new or worsening headaches, oral contraceptive use, pregnancy or postpartum state, and malignancy, among others.

If a CVST is suspected, transfer to a tertiary care center must be done immediately for further imaging, as MRI and magnetic resonance venography are the initial tests of choice for diagnosis. Most often, clots are found in multiple locations, but the superior sagittal sinus and the transverse/sigmoid sinuses are the most frequently involved areas.⁶

Treatment of cerebral venous thrombosis includes systemic anticoagulation as a first-line agent. The American Stroke Association recommends unfractionated or low molecular weight heparin with eventual bridging to warfarin.⁷ The novel anticoagulants have not been thoroughly studied in CVST and thus are currently not recommended in treatment guidelines. However, they are currently being studied outside the U.S. and may potentially replace warfarin in the near future. Mechanical thrombectomy is a potential treatment for severe venous sinus thrombosis or when anticoagulation is contraindicated. Failure to recognize and treat CVST not only delays the diagnosis, but worsens prognosis.

Most patients require treatment with anticoagulation alone. However, some patients require endovascular thrombolysis or more invasive procedures such as a decompressive craniotomy, which are done in clinical situations where patients quickly deteriorate despite anticoagulation.⁸ Current advances in technology are promising with regard to finding quicker ways to reach a diagnosis. For example, there is a published manuscript on using bedside ultrasound to differentiate between a common headache from headache due to increased intracranial pressure.⁹

Resolution

Our patient had a provoked thrombosis secondary to oral contraceptives. Low doses of oral contraceptive still have elevated risk for thrombosis, and there are case reports of CVST with use of vaginal ring contraceptives as well.¹⁰

A majority of patients will have recanalization of the vessels after thrombosis, but, as in this case, some

Table 1. Etiology in Men and Women

Etiology	Women (n=465)	Men (n=159)	P value
Gender-specific risk factors	65%	NA	NA
Oral contraceptives	46%	NA	NA
Pregnancy or puerperium	17%	NA	NA
Hormone-replacement therapy	3%	NA	NA
Complete etiological workup	79%	82%	0.5
No risk factor identified	8%	25%	<0.001
More than one risk factor identified	47%	33%	0.003
Genetic thrombophilia	22%	25%	0.4
Acquired prothrombotic condition	16%	15%	0.7
Any infection	10%	21%	<0.001
Ear, nose, and throat infection	7%	13%	0.03
Central nervous system infection	2%	4%	0.1
Malignancy	6%	11%	0.03
Mechanical precipitants	3%	8%	0.04

Mechanical precipitants includes cranial trauma, neurosurgical intervention, jugular catheter occlusion, and lumbar puncture; acquired prothrombotic condition includes nephrotic syndrome, antiphospholipid antibodies, and hyperhomocysteinemia.
Adapted from Coutinho JM, Ferro JM, Canhão P, et al. Cerebral venous and sinus thrombosis in women. *Stroke*. 2009;40(7):2356-2361.

patients will have chronic occlusion with formation of collateral circulation.⁴ This patient initially presented to urgent care for severe positional headaches but was diagnosed with atypical migraine and was sent home with instructions to follow up with her primary care provider. This scenario is very common, and patients with CVST will often present with headaches, yet the diagnosis can be easily missed due to the rarity of the case and complexity of its presentation. Thus, knowledge of its presentation, risk factors, and common findings is very important in order to avoid delays in diagnosis and avoid life-threatening outcomes.

After 3 months of warfarin use, the patient continued to have occasional episodes of headache without any visual changes or focal neurological deficits. Repeat magnetic resonance venography at 3 months showed chronic occlusion of the superior sagittal sinus and right transverse sinus. The sigmoid sinus had recanalized. ■

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Teaching Points

- Although rare, CVST is an important differential for a patient with risk factors for thromboembolism. The most important risk factors for CVST are pregnancy and puerperium, oral contraceptive use, thrombophilia, malignancy.
- If patient is showing signs of increased intracranial pressure, they should be sent to the emergency department for further workup.
- Remember the red flags: repeated visits to an acute care setting for new or worsening headaches, oral contraceptive use, pregnancy or postpartum state, and malignancy, among others.
- MRI/MRV are the tests of choice for diagnosing CVST and first-line therapy is with anticoagulation.



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#MeToo in the Urgent Care Center: When the Perpetrator is a Patient

Urgent message: Most urgent care operators are well aware of the need for strong, clear policies on sexual harassment among team members. Your responsibility to protect your employees doesn't end there, though. Situations in which the harasser is a patient present unique challenges—and consequences.

■ SUZANNE C. JONES and ROMA B. PATEL

Introduction

The #MeToo movement may have begun with high-profile actresses in Hollywood publicly acknowledging years of inappropriate behavior at the hands of powerful men like movie mogul Harvey Weinstein,¹ but it quickly evolved into something much broader. #MeToo has touched almost every industry across the country, from hospitality and technology to manufacturing and agriculture.

Unfortunately, urgent care, along with the healthcare industry in general, is no exception. Sexual harassment of healthcare providers has been a pervasive problem for decades. As a result, most urgent care employers are familiar with Title VII² and other laws that prohibit sexual harassment in the workplace. Most know to establish, post, and enforce policies prohibiting sexual harassment by coworkers and supervisors, to investigate harassment claims made by employees, and to impose disciplinary action on staff members if they violate the harassment policy.

The consequences of a business operator failing to do the right thing in regard to sexual harassment have never been greater—and that's in addition to the human cost. The U.S. Equal Employment Opportunity Commission (EEOC) launched



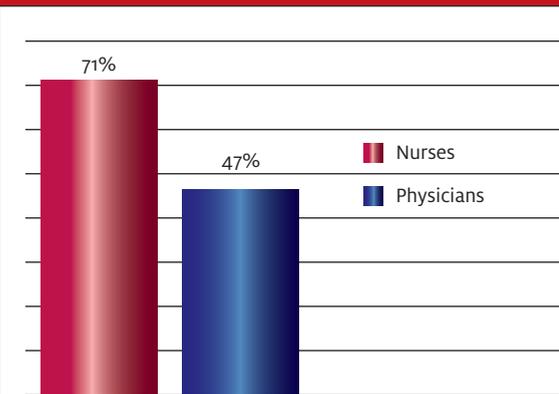
50% more sexual harassment lawsuits in the year following the start of #MeToo than in the previous year; further, the EEOC has seen a spike in the number of sexual harassment claims received.³ Gone is the era where companies can fail to take action after learning about sexual harassment or abuse occurring in the workplace without exposing themselves to serious, multiple risks to the business.

What urgent care center employers may not be aware of is that liability for sexual harassment of employees is not limited to acts by coworkers and supervisors, but also extends to third



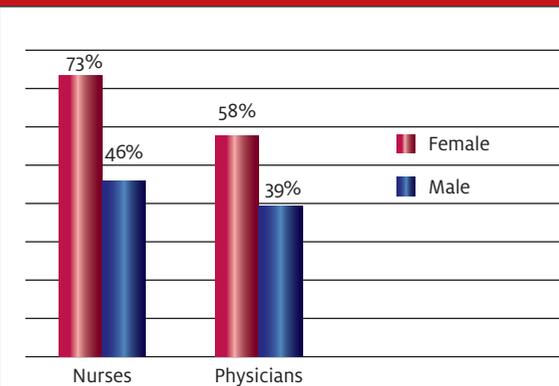
Suzanne C. Jones is a Shareholder at Buchalter, a law firm in Los Angeles. **Roma B. Patel** is an Associate at Buchalter. The authors thank research assistant **Grace Bandeen** for her invaluable assistance in producing this article.

Figure 1. Nurses and Physicians Who Answered Yes When Asked, "Have you Ever Been Sexually Harassed by a Patient?" (by Title)



Data source: Frellick M. Harassment from patients prevalent, poll shows. *Medscape*. February 1, 2018. Available at: <https://www.medscape.com/viewarticle/892006>. Accessed July 16, 2019.

Figure 2. Nurses and Physicians Who Answered Yes When Asked, "Have you Ever Been Sexually Harassed by a Patient?" (by Gender)



Data source: Frellick M. Harassment from patients prevalent, poll shows. *Medscape*. February 1, 2018. Available at: <https://www.medscape.com/viewarticle/892006>. Accessed July 16, 2019.

parties in the urgent care setting—including patients. Sexual harassment by patients may be particularly likely to occur in urgent care and hospital ED settings, where individuals may feel emboldened by the relative anonymity of seeing providers who don't know them. Risk is likely to be especially great when dealing with patients who are inebriated, on drugs (or seeking drugs), very ill, elderly, or disoriented.

Here, we examine why urgent care center operators should have zero tolerance for patients who sexually harass or abuse staff members. Failure to adequately protect employees from abusive patients can negatively impact the work environment

and employee health, and negatively affect the quality of patient care while increasing risk for medical errors.⁴

Tolerating abuse of staff by patients also can have a negative financial impact. Sexual harassment in the workplace generally results in lower staff morale, higher turnover, and diminished productivity. In addition, failure to protect healthcare employees from sexual harassment and abuse from patients (or other third parties present in the urgent care center) exposes urgent care centers to liability for sexual harassment of their employees.

We will also discuss practical steps that urgent care operators can take to protect their employees, the quality of care, and themselves from lawsuits based on sexual harassment of staff by patients and other third parties.

Sexual Harassment and Prohibited Retaliation Defined

Title VII prohibits both sexual harassment and retaliation.⁵ Under Title VII, "sexual harassment" encompasses any unwelcome conduct that is based on sex and is so frequent or severe that it creates a hostile or offensive work environment, or conduct that makes some aspect of one's employment conditional on submission to sexual advances or favors, inappropriate verbal communications, physical interactions, or pictures.⁶ Employees subjected to "materially adverse" actions by their employer because they have lodged complaints of sexual harassment can assert a separate Title VII claim for retaliation.

On its website, the EEOC defines sexual harassment in language similar to Title VII:

Harassment can include "sexual harassment" or unwelcome sexual advances, requests for sexual favors, and other verbal or physical harassment of a sexual nature. Harassment does not have to be of a sexual nature, however, and can include offensive remarks about a person's sex. For example, it is illegal to harass a woman by making offensive comments about women in general. Both victim and the harasser can be either a woman or a man, and the victim and harasser can be the same sex. Although the law doesn't prohibit simple teasing, offhand comments, or isolated incidents that are not very serious, harassment is illegal when it is so frequent or severe that it creates a hostile or offensive work environment or when it results in an adverse employment decision (such as the victim being fired or demoted). The harasser can be the victim's supervisor, a supervisor in another area, a coworker, or someone who is not an employee of the employer, such as a client or customer.⁷

Common examples of sexually harassing conduct by patients include making suggestive or lewd comments, as well as taking advantage of physical proximity by groping or other types of inappropriate or lewd behavior, sometimes involving patient nudity, disrobing, or touching private areas. Harassing behavior also can

come from a patient's companion or family member. For example, a patient's family member might repeatedly ask a nurse for a date, or make frequent comments that are uncomfortable or unwelcome about a provider's appearance. Such behavior undermines the professional competence of providers by making their gender and sexuality the focus of the interaction.

According to the United States Supreme Court, "retaliation" under Title VII means the employer's action following a complaint of sexual harassment is severe enough to "dissuade a reasonable worker from making or supporting" a sexual harassment claim, but "need not affect the terms and conditions of employment."⁸ Retaliation in healthcare settings can take a range of forms. For example, after reporting patient harassment an urgent care worker might be assigned to mostly unpleasant shifts or shifts that interfere with family responsibilities. Or, reporting abusive patient behavior may result in reduced hours, an increase of unpleasant tasks, undesirable pairing assignments, diminished opportunities to participate in special assignments that may lead to advancement, or other types of retaliation against "squeaky wheels"—which can have both a psychological and economic impact on workers who rely on meeting certain time or output requirements.

Why Is Sexual Harassment Pervasive In Healthcare?

There are many possible explanations and underlying causes for the pervasiveness of sexual harassment in healthcare. Factors that make healthcare unique and have contributed to the problem include the physical proximity that workers have to each other and their patients—many times in areas where there are few or no witnesses—as well as the intellectual and emotional intensity of caretaking and having such a large number of healthcare workers in nontraditional supervisory models.⁶

A 'patient-first' sensibility

Despite the growing number of women in provider roles and a greater understanding that this behavior is damaging, the historical reasons behind sexual harassment in healthcare remain. One is the unique dynamic between the patient and the treatment team—where quality of care and healing is the paramount goal, and physicians, nurses, and others are driven by ethical obligations to provide care for the patient notwithstanding patient abuses. The professional philosophy which guides many healthcare workers places a high value on tolerating unpleasant or distressful circumstances or "toughing it out" for the sake of patient care, even to the detriment of one's own self. The medical profession is especially rigorous, and signs of weakness or vulnerability in healthcare providers typically are not met with helpful hands.

Reliance on patients as customers

The competitive nature of healthcare as a business may also

lead employers to look the other way when patients harass providers. To the extent a patient has a choice with respect to which specific urgent care center, hospital, or other healthcare providers they visit, competing entities want to be the entity selected. Organizations may be inclined to have workers tolerate patient misbehavior as a function of client relations, along the lines of the adage "the customer is always right."

"Unaddressed sexual harassment may affect a provider's ability to communicate confidently with patients and colleagues, ultimately diminishing their ability to meet—and the facility's prospects for meeting—the standard of care."

Outdated stereotypes

Society's fetishization of the nursing profession also has contributed to a lack of respect for the bodily autonomy and dignity of nurses. Despite being highly trained, experienced, and capable, female nurses are still treated like accessories to the doctor, rather than providers in their own right, by some patients. This is especially common with elderly male patients, who may have significant difficulty taking instructions from a woman.

The longstanding prevalence of patient sexual harassment in urgent care and ED settings in particular probably results from a combination of many factors already discussed, including the type of patient mix involved (ie, patients inebriated, on drugs/or drug-seeking, elderly or disoriented), the typically "hands-on" nature of interaction when treating patients in such settings, and other common circumstances, such as the fact that care often is provided to patients who are only partially clothed or might be naked, behind a curtain or in a private room—which can allow some to feel emboldened to behave in ways they otherwise might not if fully clothed and not behind a curtain, alone with a provider.

Impact of Tolerating Patient Harassment And Abuse

Failing to properly address sexual harassment by patients can have multiple personal and organizational consequences on an urgent care center. Each incident of abuse that goes unaddressed contributes to the overall stress of the workplace and reinforces societal legitimacy of this destructive pattern of behavior.

People who are sexually harassed often have to "numb" themselves in order to carry on; over time, however, doing so eventually takes a toll. Sexual harassment is not only personally

degrading, but extremely stressful and exhausting—adding a heavy burden to the already high demands of working in a busy urgent care center.

In addition to complex emotional and psychological wounds, sexual harassment by patients can trigger unique internal conflict for healthcare providers, since many view their profession and their care for a patient as a calling. When the very core of that calling is the source of deep distress, a provider's inclination to suppress the feelings that result from such behavior is even stronger. The longer the historical tendency to ignore the problem continues, the more the psychological and physical impacts on workers in healthcare are likely to grow, reinforcing the societal legitimacy of this destructive behavior and negatively impacting both the healthcare workers and the care being provided.

Potential Consequences to a Provider's Career Due to Patient Sexual Harassment

Providers who suffer harassment at the hands of a patient may fear coming forward for a number of reasons. Most prevalent among them may be the perception that making a complaint could derail their career.

Society tends to think of medical providers as being almost superhuman. Patients trust them with life-affecting decisions and with the most intimate parts of themselves. Patients trust their doctors to know best, and to be "better" than they are. As such, providers must perform under pressure while maintaining a calm façade.

The terminology used in reporting harassment can be an obstacle in itself. No one wants to be labeled a *victim*, especially in a profession in which being perceived as weak can carry a professional toll. For doctors, especially, appearing to be mentally strong and in control is important for building the trust and respect of coworkers and patients alike. Physicians who are sexually harassed by patients report a loss of confidence, including in their professional abilities.⁹

Unaddressed sexual harassment may also affect a provider's ability to communicate confidently with patients and colleagues, ultimately diminishing their ability to meet—and the facility's prospects for meeting—the standard of care.

It also is likely to increase the possibility of medical errors. Studies have shown that this is due, in part, to disruptions in communication and breakdowns in teamwork, as workers "on guard" for sexual harassment may lose focus on important clinical tasks. It is not difficult to imagine a direct link between sexual harassment and other disruptive behaviors in an urgent care setting, as well as adverse patient outcomes and medication errors. These negative impacts also may ultimately lead to broader legal exposure.

Urgent care employers who turn a blind eye to patient sexual harassment of their workers are not only violating Title VII and inviting sexual harassment lawsuits; they also are likely to experience

a drop in the quality of care and possible increase in malpractice claims.

Consequences to the Business For Failing to Address Patient Sexual Harassment

Urgent care centers and other healthcare organizations that fail to adequately respond to patient sexual harassment of their workers are likely to experience negative financial impacts, including a loss of quality workers, a toxic workplace culture, lower productivity, and the potential of negative public relations exposure.

Specifically, employers should be mindful that ignoring sexual harassment (or any severe, potentially illegal problem) may lead to negative public scrutiny and damage to their brand. This is especially true given the prominence of social media today. Internet platforms offer employees an opportunity to connect and share their experience like never before. Accordingly, healthcare organizations that are unwilling or unable to adequately address harassment not only will have difficulty retaining talented workers, but may also have trouble recruiting quality workers—particularly in this era of provider shortages.

Effects of the Social Media Age

When workers are unhappy, it can be difficult for them to put on a "happy face" and devote the proper enthusiasm to their jobs. Patients pick up on this, and have many highly visible online platforms available to voice complaints about their experiences with urgent care centers. Patients who receive treatment in a negative workplace—for example, a workplace experiencing constant employee turnover, and populated with distracted workers and unhappy staff—may share their negative perceptions, experiences, and critical views online. Healthcare employers should not underestimate the role that social media and public reputation can play when sexual harassment goes unaddressed. The #MeToo movement's virality is the direct result of social media's ability to magnify voices. An organization that gains an online reputation for failing to protect workers is very likely to find it challenging to attract talented providers, and also will not present as an appealing choice when patients are choosing where to get treatment.

Ironically, operators who choose to tolerate patient misbehavior and sexual harassment of their staff as a misdirected "customer relations effort" in order to draw in business and be more competitive may find that the toxic atmosphere created by such an approach is much more damaging to their brand and reputation than taking the opposite approach of implementing and enforcing a zero-tolerance policy regarding patient harassment.

Potential for Civil Liability Over Sexual Harassment of Employees by Patients

As noted, the EEOC's regulations on sexual harassment specifically state that "employer[s] may also be responsible for the

acts of non-employees, *with respect to sexual harassment of employees in the workplace.*"¹⁰ Consistent with the EEOC regulations, most courts that have addressed the issue of an employer's liability for nonemployee sexual harassment in the workplace have determined that employers are liable for the harassment of an employee by a nonemployee when 1) the employer knows or should have known of the conduct and 2) fails to take immediate and appropriate corrective action.¹¹

Multiple cases filed by the EEOC and healthcare workers illustrate the very real liability exposure that exists for employers who fail to take employees' complaints of patient harassment seriously. Title VII requires urgent care centers (and all healthcare employers) to treat such complaints seriously, and to take reasonable steps to protect an employee once harassing patient behavior is known.

Purely verbal offensive conduct can be sufficient

Healthcare employers may mistakenly assume that employer liability for third-party sexual harassment conduct will only arise in situations that involve uniquely extreme and physically abusive patient conduct. They would be wrong. The EEOC and courts regularly find that employers were required to take seriously, and immediately and adequately address, employee complaints that involve purely verbal offensive conduct.

For example, the EEOC filed a Title VII sexual harassment lawsuit against Southwest Virginia Community Health System (SCVHS) for subjecting a female employee to a sexually hostile work environment after the female was repeatedly subjected to sexual harassment by a male patient.¹² The harassment involved unwelcome sexual comments by the patient in person at the clinic, and by telephone when he called the clinic. His comments included that he was "visualizing her naked" and suggestions that she have sex with him.

Although the receptionist complained to her supervisor, the supervisor did nothing to stop the harassment. SCVHS's settlement with the EEOC in 2013 required it to pay \$30,000 to the receptionist, and also to "conduct training for all employees on sexual harassment prevention; post a notice about the settlement; provide a copy of its sexual harassment policy to all employees; and report sexual harassment complaints to the EEOC."¹² The EEOC's press release announcing the settlement warned: "Employers have a responsibility to prevent sexual harassment not only by coworkers, but also by third parties, including patients and customers. Employers need to adopt measures to end sexual harassment that has been reported to the appropriate supervisor regardless of who is perpetrating the misconduct."

Employers can be deemed to have 'sufficient knowledge' without a report or direct knowledge

Other cases illustrate that healthcare employers can be found liable for sexual harassment even if the employee cannot show

that the employer *actually saw* patient harassment occur, and cannot show that the employer was directly notified about a specific incident of patient harassment. This is because an employer's *constructive* notice of patient harassment can be sufficient under the law. "Constructive" notice will be found if harassing behavior by a patient (or patients) is "so pervasive and open that a reasonable employer would have had to be aware of it."¹³

"If an urgent care center has 'constructive notice' that patient harassment is probably occurring based on past or other reported instances of harassment or abuse, the urgent care center may be deemed to have knowledge of the conduct and thus must take immediate and appropriate corrective action."

A recent example of a case involving constructive notice is *Poe-Smith v Epic Health Servs.*¹¹ There, a female home health worker sued her employer for Title VII sexual harassment, this time perpetuated by a third party in the home where the patient was staying. For several months, the male homeowner directed sexual innuendos and inappropriate comments toward her. Ultimately, he bought her a maid's costume and "told her she would have to model it," then followed her when she left the room, pushed her and "smacked her on her buttocks."¹¹ The worker reported the final incident to her employer, but had not previously complained about the homeowner. The employer's response was to immediately relieve her of the assignment and arrange a meeting between the worker and her managers to discuss the issue. The worker also was informed that the employer would meet with the homeowner. Based on these facts, the employer argued to the court (after the lawsuit was filed) that because it had taken immediate action, and its action had stopped the harassment, the worker could not prevail on her Title VII claim. The court disagreed and allowed the sexual harassment claim to proceed. The court reasoned that the employer still may be liable if the worker can prove that the employer was on earlier, *constructive* notice of the harassment.¹¹ If so, its corrective actions to remove the worker from the home when it did, while appropriate, were not immediate and were thus insufficient.

Similarly, if an urgent care center has constructive notice that patient harassment is probably occurring based on past or other reported instances of harassment or abuse, the urgent care center may be deemed to have knowledge of the conduct and thus must take immediate and appropriate corrective

Table 1. Protecting Your Operation from Sexual Harassment Lawsuits

Urgent care operators cannot control the actions of every patient (or employee, for that matter). However, there are steps every business can take to reduce risk for sexual harassment in the workplace and to protect itself from legal/financial risk if incidents of harassment do occur.

Step 1: As a critical first step, the urgent care center should maintain and enforce a policy that prohibits discrimination, harassment, and retaliation, and it should not only apply to employee conduct, but also to third parties (such as patients, families of patients, vendors, customers, and any other third party who may interact with employees). The policy should also include a detailed but user-friendly reporting mechanism, and an accompanying instruction that employees are expected to raise complaints.

Step 2: Policies are ineffective if employees are unaware they exist; thus, the policy must be communicated to employees in a regular and conspicuous way. (Typical ways are by requiring employees to acknowledge in writing their receipt and understanding of the policy, along with posting information about the policy in a breakroom or other employee area in the urgent care workplace.)

Step 3: Urgent care employers should provide training to both hourly staff and managers. *Hourly employees* should be trained with respect to a) what type(s) of behavior violates the policy; b) their obligation to report that behavior; and c) how to make such a report. *Members of management* should be trained with respect to a) how to identify harassment in the workplace; b) that patients (and other nonemployees) may be the cause of the harassment; and c) how to address issues concerning harassment when they arise.

Step 4: Once the urgent care workforce is educated on the policy, the urgent care employer must be prepared to handle an employee's complaint. Upon receipt of a complaint, the urgent care employer's first response should be to take the complaint seriously, and to refrain from mocking an employee who raises a complaint. (Failure to take all complaints seriously not only would violate the urgent care employer's Title VII responsibilities, but also would encourage the type of toxic workplace culture that led to the #MeToo movement.) Taking complaints seriously requires the urgent care employer to conduct an immediate and thorough investigation.

Step 5: Finally, there must be some sort of accountability. When the harassment or abuse is perpetrated by a patient or other third party in the workplace, the urgent care employer will have more limited options than with employee harassers. However, the urgent care employer can make it clear to patients who come to the facility, and to all other third parties, that there will be zero tolerance of sexual harassment in the urgent care center, and that serious consequences will result to patients and others who violate this policy—up to, and including, physical removal from the urgent care center and possibly being permanently barred from the premises.

action. If it fails to do so, it should be prepared to face a lawsuit from workers or the EEOC.

Protecting Yourself From Lawsuits Over Patient Harassment Of Staff

Consistent with the legal responsibility imposed upon urgent care employers by Title VII, and as made clear by the EEOC and the courts, urgent care employers must adopt measures targeted to end sexual harassment in the urgent care setting

regardless of who is perpetrating the misconduct.

Under the law, urgent care employers must take immediate and appropriate action in response to all sexual harassment that the urgent care employer directly witnesses, all sexual harassment reported to the urgent care employer, and also all sexual harassment the urgent care employer does not directly witness or receive a complaint about—but that it nonetheless *should know about* because the harassment is “so pervasive and open that a reasonable [urgent care] employer would have had to be aware of it.”¹⁴

In summary, federal law requires healthcare employers to have a policy prohibiting sexual discrimination, and to consistently enforce it by taking sexual discrimination complaints seriously, and taking prompt and appropriate remedial action.¹⁵

Notably, Title VII does not obligate employers to succeed in eliminating all sexual harassment from occurring in the workplace. Title VII instead requires urgent care employers just to be vigilant in seeking to protect their employees by responding immediately to complaints, and taking reasonable measures to abate all sexual harassment that they know (*or should know*) is occurring in the facility, regardless of who is doing the harassing.

There are several steps you can take to protect your operation from such sexual harassment lawsuits. The most basic are set forth in **Table 1**.

Real-Time Strategies to Address Patient Harassment

The urgent care center's policy on sexual harassment should be uniformly enforced and optimally should incorporate measures that can be used to address situations of provider complaints about patient sexual harassment in real time, as they are occurring.¹⁶ The following “real time” measures can assist in immediately mitigating any additional harm a provider may be facing when treating an abusive patient.

- First, the policy could provide that supervising providers must make a sincere effort whenever possible to reassign providers to different patients when a provider has complained of patient sexual harassment.
- Second, the policy could provide that supervising providers are authorized to ask a security guard, if available, to stand outside an exam room when a provider who has been harassed is inside the room, so that the patient is aware of a protective presence nearby.
- Third, the policy could provide that if the harassment or abuse is especially distressing to a worker, the supervising provider should make a sincere effort to allow the provider being harassed to take a break, in order to get relief. Similarly, the policy could provide that when a provider has complained about sexual harassment from a patient but is still providing care to the patient, supervising providers should make arrangements so that that patient will only receive care from the harassed provider

when accompanied by a companion provider. The harassed provider should not be required to be in a room alone with the harassing patient.

Use of medical records to document patient behavior and VIP patients

Providers should use objective language to thoroughly document sexually harassing and disruptive patient behavior in the medical record. (In other words, state the facts in direct, declarative terms.) The purpose of documenting patient misbehavior in the medical record is to flag the issue for other providers treating the patient and to protect the urgent care center and its workers in case the patient's behavior must be addressed in a more direct manner—such as by ejection from the facility and terminating care.

Documenting behavior in the medical record is especially important when treating VIP patients, as healthcare organizations often have different manners of providing care to them. Sometimes, VIP patients will be placed in more isolated parts of the unit and may even get to cherry-pick the providers who are assigned to their care—creating circumstances ripe for the type of abusive behavior that those in powerful positions may be accustomed to exhibiting. It is important for organizations to be mindful of the safety of providers when serving VIP patients.

Flexible reassignment rules and provider companion arrangements

Another strategy is to *encourage* medical staff and physicians who are being sexually harassed by a patient to make a request to be reassigned to a different patient rather than “tough it out.” Such a policy should provide that requests will be granted whenever possible under the circumstances. The policy can specify that when circumstances do not make such a transfer possible, the harassing patient going forward will only receive care from the harassed provider when he or she is accompanied by a companion provider.

Conclusion

Sexual harassment in healthcare has always been a problem, and continues to be a problem that needs to be better addressed. Medical providers face immense challenges and stress in their day-to-day jobs. Added to those challenges is a unique environment providing an opportunity for inappropriate behavior of the type discussed here to fester unseen and unaddressed.

The growth of the healthcare industry (and the urgent care marketplace in particular) means this problem will only grow unless serious leadership, organizational, and—most importantly—significant cultural shifts take place in the minds of the individuals working within this system. While the existence and enforcement of sexual harassment policies are important first steps, there is no employer sexual harassment policy that can

completely fix this problem. Society must develop the ability to have nuanced public and private discussions about gender dynamics, sex, and power.

The Association of Medical Colleges reported that 2017 was the first time the majority of entering medical students were female.¹⁷ An increase in females having access to higher education and thus entering spaces traditionally occupied almost exclusively by men, along with a resulting generational shift in culture, hopefully will also move society toward creating a healthcare system in which healthcare workers have better protection and are not subjected to such destructive behavior and societal ills with such continuing frequency.

The bottom line for the urgent care operator is, unchecked sexual harassment of urgent care center staff (and physicians) by patients poses clear risks to employee wellbeing, patient care, and organizational integrity. It also has very real legal consequences for any urgent care center employer that fails to adequately respond and take appropriate action to address such incidents when it knows (*or should know*) patient sexual harassment is occurring.

Consistent, strong organizational responses to patient harassment will offer legal protection for the urgent care operator while giving workers confidence and a path for reprieve when repeatedly confronted with the scarring and abhorrent behavior that healthcare workers are likely to continue to confront and have had to endure for generations. ■

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A 59-Year-Old Man with a Painful Elbow After a Fall



Figure 1.



Figure 2.

Case

The patient is a 59-year-old man who presents with pain in his elbow. He says he was experimenting with his son's hoverboard, hanging on to a pole to steady himself. He lost his balance and fell, with his right arm taking the brunt of the impact. His range of motion is limited by both pain and swelling.

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

THE RESOLUTION

Figure 1.



Figure 3.

Differential Diagnosis

- Acute avulsion fracture of the radial tuberosity
- Bicipitoradial tendinitis/bursitis
- Partial biceps tear
- Tear at the myotendinous junction

Diagnosis

The x-ray reveals multiple chip avulsion fractures anterior to the radial tuberosity and a flattened radial tuberosity. The patient experienced an acute biceps tendon tear at the insertion site on the radial tuberosity, with avulsion fracture of the radial tuberosity.

Learnings/What to Look for

- Radial tuberosity is a localized bony protrusion below the radial neck. It is a major elbow flexor and forearm supinator
- Biceps tendon avulsion tears occur when excessive tension/force is applied when the arm is extended from a flexed position to the extended position. Tears usually occur at the insertion site on the radial tuberosity
- Clinical history is that of a painful pop, localized pain on supination, and weakness

- Clinical findings are palpable defect in the biceps tendon region, retracted belly of biceps, and loss of flexion and supination strength
- Radiographic findings include avulsion fracture of the radial tuberosity. Diagnosis may be confirmed on MRI study, which reveals a completely torn and retracted biceps tendon from its insertion and attached bone fragment
- Contributory factors include male gender, smoking, use of anabolic steroids, and chronic impingement between the bones

Pearls for Urgent Care Management and Considerations for Transfer

- Treatment in older, sedentary, low-demand patients is usually conservative, with immobilization, analgesia, and later physical therapy. This results in diminished strength in sustained supination, flexion, and the grip strength
- In healthy young patients, surgical repair is indicated with re-implantation of the biceps tendon on the radial tuberosity

Acknowledgment: Images and case provided by Teleradiology Specialists, www.teleradiologyspecialists.com.



An 88-Year-Old Woman with Several Weeks of Dizziness

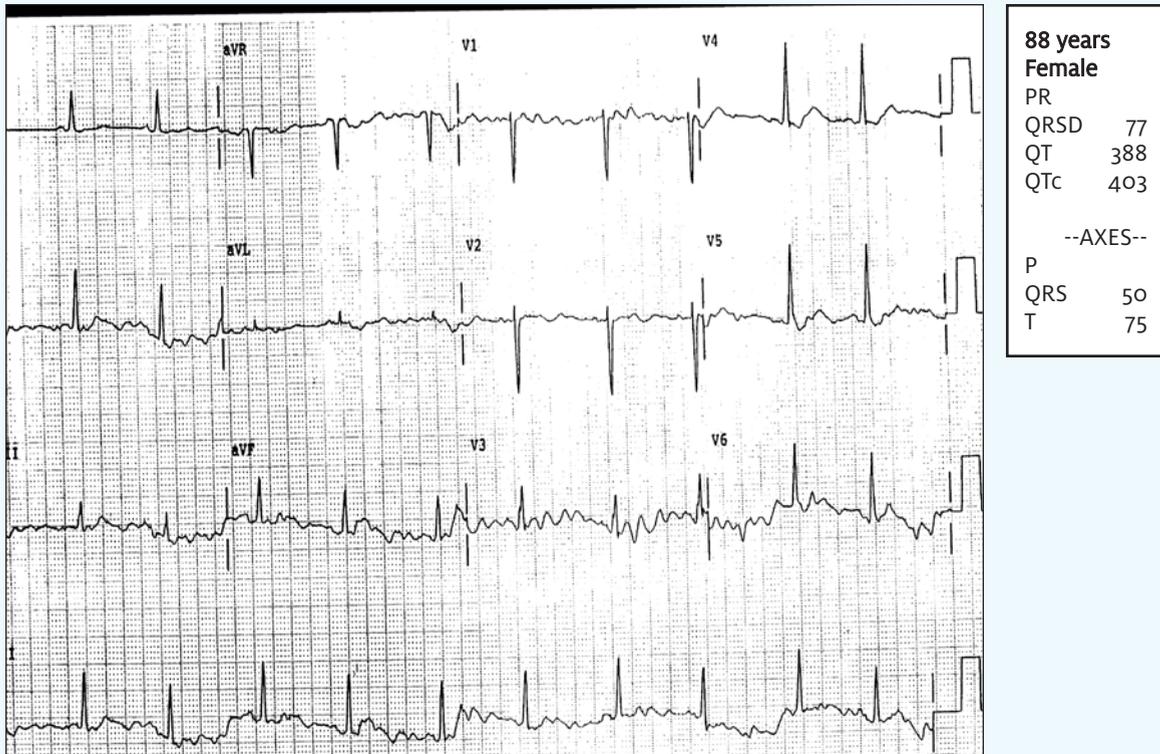


Figure 1.

Case

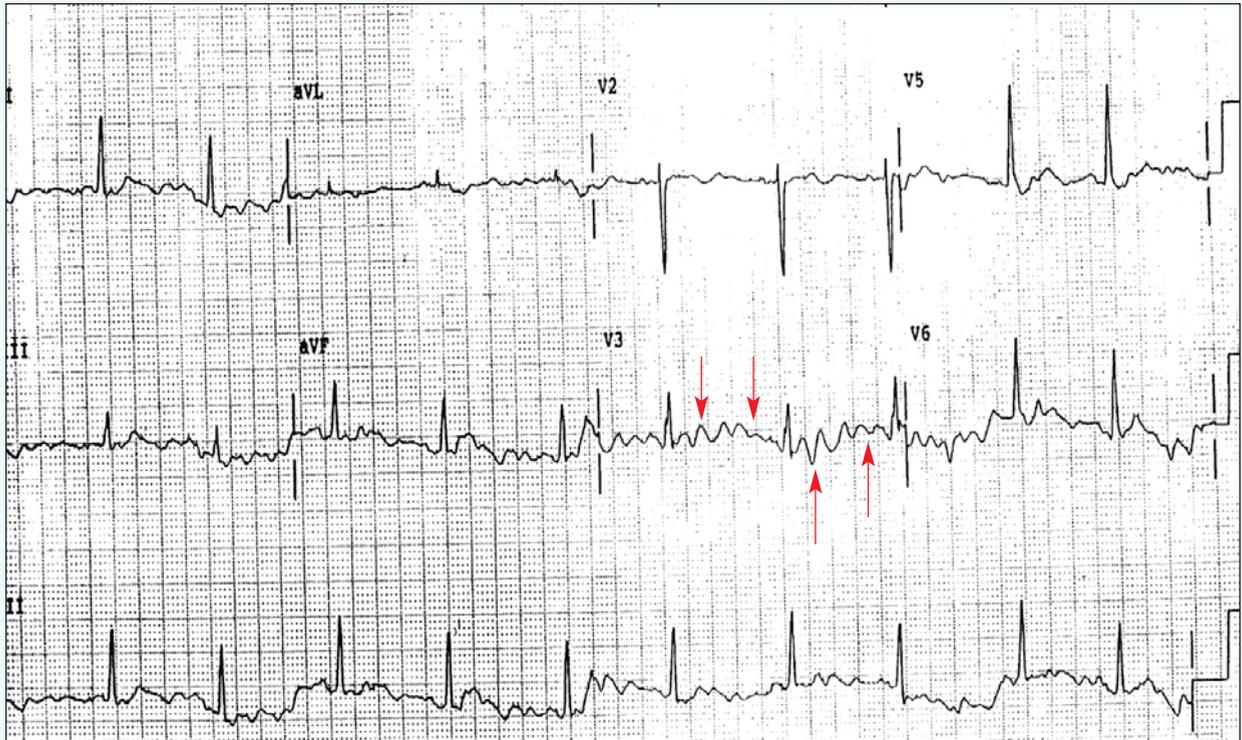
The patient is an 88-year-old woman with 3 weeks of dizziness but no complaints of chest pain/discomfort, shortness of breath, focal neurological signs, or diaphoresis. An ECG is performed by staff prior to clinician evaluation.

Upon exam, you find:

- **General:** Alert and oriented X 3, ambulatory
- **Lungs:** Clear to auscultation
- **Cardiovascular:** RRR without m/r/g
- **Abdomen:** Soft and NT without r/r/g
- **Ext:** Extremities: Normal

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

THE RESOLUTION

**Differential Diagnosis**

- Atrial fibrillation
- Atrial flutter
- First-degree AVB
- Second-degree AVB
- Baseline artifact

Diagnosis

This ECG shows a baseline artifact.

The ability to interpret an ECG is often dependent on the quality of the tracing. This ECG reveals a regular rhythm, so atrial fibrillation, characterized by an irregularly irregular rhythm, is not occurring.

Interestingly, atrial flutter can sometimes be tricky, as it is a regular rhythm often with a rate of 150 beats per minute, but the rate can be slower if there is a block; however, this can be a silver lining as it is then easier to see the “flutter waves,” best seen in lead V1. This is not occurring here.

AV block type 1 would be difficult to discern with this ECG, as there are no p waves seen; so, we cannot determine if the PR interval is >200 ms. We do, however, know that AV block type 2 is not occurring as there are no dropped beats.

Learnings/What to Look for

- The first two things to look for are rate and rhythm; if p waves are not able to be discerned, there should be consideration for atrial fibrillation, a junctional rhythm, a ventricular rhythm, or artifact
- Baseline artifact may occur from a patient who is moving, as well as a patient with a tremor (such as in Parkinson’s disease), spinal stimulator, or if the patient is not able to remain still (for example, because of respiratory distress)

Pearls for Urgent Care Management and Considerations for Transfer

- Do not be nice! Ask for the ECG to be repeated if you do not have reliable data on which to base your decision
- With a “wavy” baseline, first look for p waves and for the rate and rhythm. Atrial fibrillation is an irregularly irregular rhythm
- Correlate ECG findings with the patient’s clinical condition



A 47-Year-Old Female Cancer Patient with Red, Flaccid Bullae on Her Leg



Case

The patient is a 47-year-old woman undergoing chemotherapy for breast cancer with 1 day of several red, flaccid bullae on her leg as well as fever, cough, and shortness of breath.

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

THE RESOLUTION

Figure 2.

**Differential Diagnosis**

- Aspergillosis
- Atypical mycobacterial infection
- Mucormycosis
- Candida sepsis

Diagnosis

This patient was diagnosed with aspergillosis, a hyaline mold found worldwide in decaying vegetation, soil, water, food, and plants. Inhalation of *Aspergillus conidia* is the most common mode of acquisition. Dissemination can lead to skin involvement, as well as central nervous system, liver, spleen, heart, and bone involvement.

Learnings/What to Look for

- Cutaneous *aspergillosis* begins with red papules that form pustules. The pustules ulcerate and leave a central eschar evocative of the diagnosis

- This is an indolent process that develops over months or years (hence its alternate name, chronic necrotizing aspergillosis)
- Many infectious and noninfectious etiologies are possible in immunocompromised patients with pulmonary nodules. Organisms to consider include *Nocardia* species, mycobacterial species, *Legionella* species, cryptococcal infection, and endemic fungi
- Septic emboli are possible, especially in patients with indwelling central venous catheters

Pearls for Urgent Care Management and Considerations for Transfer

- First-line treatment for aspergillosis is voriconazole. Other prescription antifungal medications used as second-line treatment include lipid amphotericin formulations, posaconazole, isavuconazole, itraconazole, caspofungin, and micafungin

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



Utilizing Credit Card Preauthorization to Optimize Revenue

■ DAVID E. STERN, MD

With the continued rise of the cost of healthcare and higher out-of-pocket costs to the patient, urgent care centers are finding more patients struggling to pay their deductible. The process of billing patients for deductibles and other patient responsibility can be a long, drawn-out procedure resulting in significant costs, delays, write-offs, and slower collection time for the urgent care center. The traditional method of sending out patient statements and waiting and hoping for patients to pay is costly and inefficient. Contacting insurance companies prior to the patient visit to determine deductibles and copays does not work well in the urgent care center, as phone representatives are generally unavailable to take patient inquiry calls in a timely manner, causing your front desk staff to spend excess time on the phone rather than assisting patients. While utilizing online help may be quicker than a phone call, payer websites are often incomplete.

In the past, a few clinics have solved this problem by writing down patient credit card information along with a signed release to charge the card for the remaining balance when the Explanation of Benefits (EOB) is returned. The problem with this solution is that storing credit card information is noncompliant. Retaining copies of patient credit card information leaves the clinic exposed to a large risk for credit card fraud by a thief or dishonest employee.

There is, however, a compliant way to receive the same functionality. Some practice management systems give the clinic the ability to scan a credit card at the time of visit and then receive payment when the EOB is returned weeks or even months after the patient visit. The information is held electronically—and compliantly—by the vendor that provides merchant services to the clinic, mitigating the clinic's vulnerability to fraud from stored patient credit card information. Better yet, some practice man-

“Credit card preauthorization is a powerful tool to drive down healthcare collection costs and optimize clinic collections.”

agement software systems offer fully integrated functionality allowing all billing of patient credit cards to be automated in the system.

When the patient registers at the clinic, they complete preauthorization forms that permit the clinic to charge the credit card for the balance due from the patient after insurance processes the claim. The patient's credit card is then swiped and the credit card information is stored with a secure independent sales organization (ISO) for a set amount of time, typically 90 days. This generally allows enough time for the payer to return the EOB to the practice. Upon receipt of the EOB, the clinic can charge the amount that is the patient's responsibility, up to the maximum amount preauthorized by the patient. If the patient responsibility is greater than the preauthorized amount, then the patient should receive a statement for the remaining balance. In most cases in the urgent care setting, a preauthorized reserve of \$250 fully covers the patient responsibility.

Clinics that have implemented these systems have seen an increase in collections in the first month after receipt of the EOB. In addition, average savings on statements have been realized in the range of \$1 per patient visit.

When staff are properly trained on the process and how to effectively communicate the benefits to the patients, and as the use of credit card preauthorization becomes more commonplace in the urgent care center (and overall retail environment), our experience has been that patients will become as comfortable providing preauthorized payment information as they are when checking into a hotel room or renting a car. Thus, credit card preauthorization is a powerful tool to drive down healthcare collection costs and optimize clinic collections by providing timely and efficient collections of amounts deemed patient responsibility. Check with your software vendor to see if this functionality is available. ■



David E. Stern, MD, is board-certified in internal medicine. He was a director on the founding board of UCA and has received the organization's Lifetime Membership Award. He is CEO of Experity (formerly DocuTAP and Practice Velocity), which offers industry-leading SaaS EMR solutions, patient engagement technology, radiology over-read services, revenue cycle management services, and a robust analytics suite.

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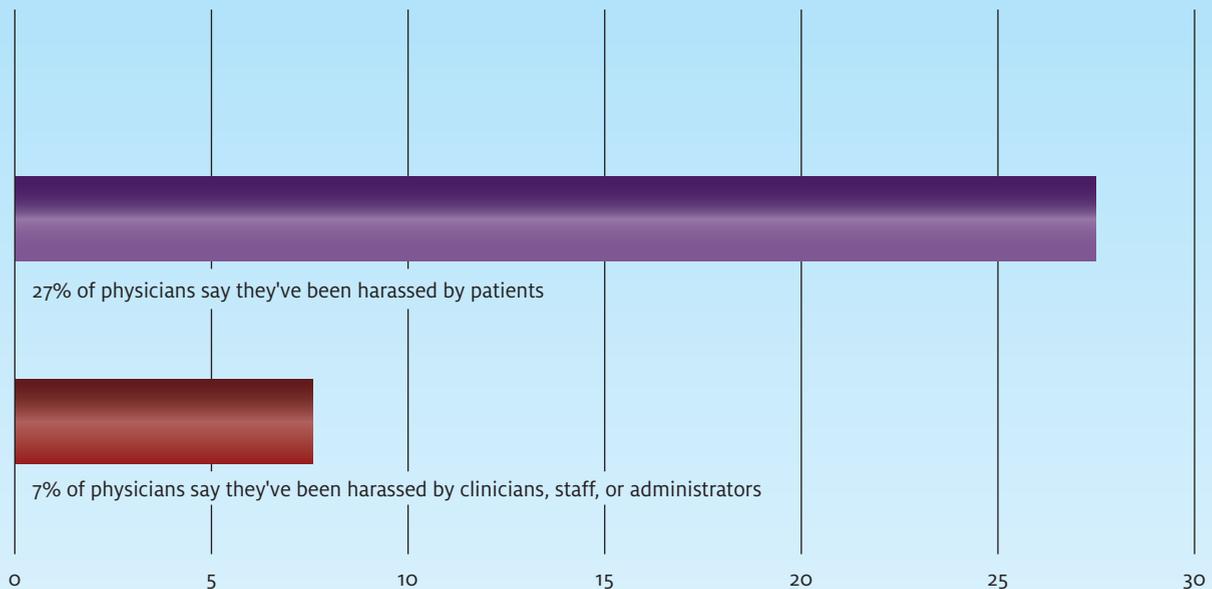
Sexual Harassment of Physicians by Patients: Far Too Common an Occurrence

When sexual harassment in a healthcare setting makes headlines, it tends to be because a healthcare provider touched or otherwise approached a patient in an inappropriate manner. (Remember Dr. Larry Nassar and the USA Gymnastics sex abuse scandal?) Then, of course there are the unfortunate incidents plaguing so many industries, in which someone in a position of power abuses their authority to force themselves on an underling, or dangles career benefits in exchange for sexual favors.

What you don't tend to read about is harassment of physicians at the hands of patients. The sad truth is that it happens far more than any of us would like to consider—nearly four times more frequently than harassment among co-workers, in fact. See the graphic below for more insights, and read #MeToo in the Urgent Care Center: When the Perpetrator is a Patient on page 29 to get a better understanding of the real and potential threats to not only your staff members' wellbeing, but the future of your entire operation. ■

SEXUAL HARASSMENT OF PHYSICIANS

Most often, the harasser is a patient



Adapted from Medscape Patients Sexually Harassing Physicians Report 2018. Available at: <https://www.medscape.com/slideshow/patients-sexually-harassing-physicians-6010036#1>. Accessed August 10, 2019.



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