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Urgent Care
Association
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LETTER FROM THE EDITOR-IN-CHIEF

Risk Mitigation in Urgent Care: Part I

Editor's Note: This is the first of a two-part column that examines ways to reduce liability in the urgent care setting.



Our discipline is evolving rapidly and best practices are beginning to be defined. Staying abreast of practice standards for urgent care and implementing a disciplined risk mitigation plan will help your practice avoid the disruptive burdens of a medical malpractice lawsuit. The urgent care approach to risk management should be unique because our practice carries unique risks. I hope to provide some easy-to-integrate and “urgent care-centric” risk management tools for any urgent care practice, regardless of size.

Before creating a strategy for managing your liability risk, whether for your own personal protection or for the purpose of protecting the practice, it might be good to review the current state of medical liability in this country and its relevance to urgent care. Let's start with the incidence of lawsuits nationally. According to recent statistics (*NEJM*, Aug 8, 2011), the incidence of lawsuits for family practice physicians hovers around 5% annually. Of these defendants, only about 1% end up making payments to the plaintiffs. The incidence of lawsuits for emergency medicine physicians is approximately 7.5% annually, with only 1.5% resulting in payments. Although urgent care claims are not tracked nationally on a large scale, the consensus is that urgent care risk probably lies somewhere between emergency medicine and family medicine, although some argue that it may even be higher due to the lack of advanced diagnostics and variable training of urgent care clinicians. These numbers tell a very sad story that has led most physicians to practice in fear, despite the low incidence of actual payments to plaintiffs. The data demonstrate a huge disparity between number of lawsuits and number of payments, reflecting that too many lawsuits are filed. The need for reform is apparent.

At this point however, the best offense is defense, and we will therefore focus our discussion on strategies to lower your personal and practice risk.

The single most important caveat in risk management is to focus on what you CAN control. There are many variables that contribute to risk in health care. Only some of them are under our control, but identifying those that are, and creating risk mitigation strategies around them will make a significant impact. Kicking and scream-

ing about what you cannot control will not! And it should not be lost on anyone that each of these strategies also supports patient safety and care quality, the importance of which we can all appreciate.

Staying up to date: Before all else, each of us has a responsibility to make a commitment to keeping up with best practice and established guidelines as they pertain to urgent care. Several educational resources are available that define best practices in urgent care. The scope of competencies in urgent care is broad. Staying up to date requires a commitment to lifelong learning in your identified area of practice.

Identifying “at-risk encounters”: Establishing a short list of high-risk conditions and presentations is an exercise that every urgent care practice should go through. While beyond the scope of this column, a typical list would include things like chest pain, shortness of breath, confusion, altered level of consciousness, abnormal vitals, etc. For each, protocols for triage, physician evaluation, documentation, disposition and follow-up should be created. This sets the stage for ensuring risk mitigation at each stage of the encounter. A sample list can be found at www.jucm.com. Additional attention should be paid to the disruptive or conflict-oriented patient. An angry patient is more likely to sue when things go wrong, therefore, additional attention is required to the key areas of the encounter listed above.

Once you have defined “at-risk encounters,” you have a platform for your risk mitigation strategy. In next month's column, I will target areas of urgent care practice where risk flourishes, often unnoticed. These include charting/documentation, electronic medical record risks, supervision of the clinical team, policy and procedure gaps, and an all-too-common urgent care practice I call “pre-triage,” in which patients are told to go elsewhere for their care (most notably the emergency department) without having a physician evaluation. ■

Lee A. Resnick, MD
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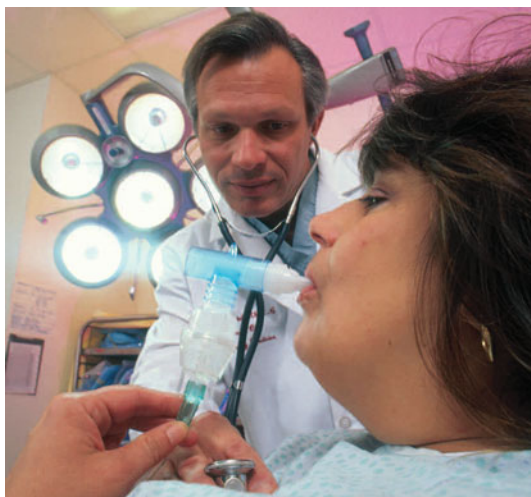
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CLINICAL

9 Assessment and Management of Asthma Exacerbation in Urgent Care: Part 2

The second part in a two-part series offers expert guidance on short and long-term management of the disease in the urgent care setting through the use of pharmacotherapy, protocols for treatment, and a written asthma action plan at discharge.

Bradley M. Turner MD, MPH, MHA, FCAP, FASCP and
Janet M. Williams, MD, FACEP

PRACTICE MANAGEMENT



16 Marketing Strategies: School, Sports, and Camp Physicals

Sports physicals offered by an urgent care center can be a "win" for both the center and the community. The community gets a flexible source for a time-critical service and the center gets another way to attract new and repeat business.

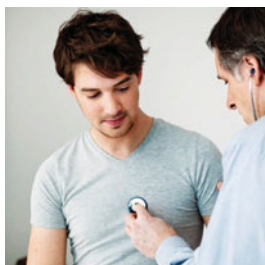
Alan A. Ayers, MBA, MAcc

CASE REPORT

22 Sarcoidosis

The key to this case was in the details of the presenting symptoms in the patient history: Alarm symptoms including extreme fatigue and weight loss, which warranted further diagnostic work up.

Abrar Khan, MD, MBA, Revathy Nair, MD, and
Mariann Melicharek, MD, FACEP



IN THE NEXT ISSUE OF JUCM

Differentiating between potentially life-threatening and more benign causes in a patient who presents to an urgent care center with a headache can be challenging. How to rapidly recognize subtle and nonspecific signs and symptoms that suggest a serious etiology for a headache is the subject of next month's cover story. The first of a two-part series, it focus on features associated with emergent headache syndromes that are likely to be presented in the urgent care setting, rather than the emergency department.

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JUCM The Journal of Urgent Care Medicine supports the evolution of urgent care medicine by creating content that addresses both the clinical practice of urgent care medicine and the practice management challenges of keeping pace with an ever-changing healthcare marketplace. As the Official Publication of the Urgent Care Association of America and the Urgent Care College of Physicians, *JUCM* seeks to provide a forum for the exchange of ideas and to expand on the core competencies of urgent care medicine as they apply to physicians, physician assistants, and nurse practitioners.

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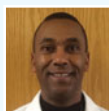
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With the increasing prevalence of asthma, more patients are likely to seek treatment for it at urgent care clinics. When asthma exacerbation is the suspected diagnosis, efficient short-term management is critical for a positive outcome. The urgent care provider's role in asthma care, however, doesn't stop there. Effective long-term management of the disease—the subject of this month's cover story, by Bradley M. Turner, MD, MPH, MHA, FCAP, FASCP and Janet M. Williams, MD, FACEP,—focuses on prevention of future exacerbations through pharmacotherapy and education at discharge.

Dr. Turner is an Assistant Professor of Pathology at the University of Rochester School of Medicine in Rochester, NY, and a staff physician with Team Health/Exigence Rochester Immediate Care in Rochester NY, and Team Health/Exigence Western New York Immediate Care in Buffalo, NY. Dr. Williams, previously Professor of Emergency Medicine at the University of Rochester School of Medicine, currently serves as the Medical Director of Team Health/Exigence Rochester Immediate Care in Rochester, NY.



Obtaining a detailed history from a patient who presents for urgent care is always good medicine, and that point is amply underscored in



this month's case report, by authors Abrar Khan, MD, MBA, Revathy Nair, MD, and Mariann Melicharek, MD, FACEP. In it, they recount the care of a 32-year-old Caucasian male with a history of fevers, sore throat, and back pain but a normal physical exam. The patient's "alarm" symptoms—fatigue and weight loss—are what drove further investigative studies that led to the diagnosis: sarcoidosis.

Abrar Khan is a physician at Premier Care, LLC, of Bellmore

in Long Island, NY. Revathy Nair is a recent graduate of American University of Antigua in Long Island, NY. Mariann Melicharek is the Medical Director at Premier Care, LLC, of Bellmore in Long Island, NY.

This month's practice management article is about a marketing strategy that can be a "win-win" for an urgent care center and the community: offering sports physicals. Because urgent care centers offer after-hours and walk-in convenience, they are well suited to potentially meet parents' and schools' need for the physicals often required before a student can participate in school, camp, inter-league, or club sports programs. According to author Alan A. Ayers, MBA, MACC, sports physicals also are a way for urgent care providers to attract new and repeat business. Parents and athletes who use a clinic for sports physicals will be more likely to return when future illness and injury arises.



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

Also in this issue:

In Health Law this month, **John Shufeldt, MD, JD, MBA, FACEP**, discusses the importance of reading the fine print when you are negotiating a malpractice insurance policy to avoid "gotchas."

Sean M. McNeeley, MD, and **The Urgent Care College of Physicians** review new abstracts on literature germane to the urgent care clinician, including studies of UTI and renal scarring, PAS scores for appendicitis, and WBC count and appendicitis.

In Coding Q&A, **David Stern, MD, CPC**, discusses codes for medical decision-making and the E/M code with intramuscular injection.

Our Developing Data end piece this month looks at the percentage of patients that urgent care centers send elsewhere for diagnostic tests. ■

To Submit an Article to JUCM

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

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

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

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UCAOA Unveils New Accreditation Program

■ P. JOANNE RAY

In March 20, the UCAOA announced the creation of a national accreditation and certification program for the urgent care industry. UCAOA Accreditation is the first of its kind to recognize not only the more traditional accreditation process of quality and safety but also the scope of the services provided by urgent care centers.

The UCAOA Accreditation Program demonstrates the urgent care industry's commitment to offering a systematic and consistent scope of care, quality and safety across all centers. UCAOA established its own program based on its objective to instill a greater focus on the nuances and uniqueness of the industry.

"The urgent care industry is experiencing explosive growth and strong demand from consumers who want convenient, affordable and quality healthcare," said Dr. Nate Newman, president of the UCAOA Board of Directors. "There is tremendous merit in evaluating the industry and striving for higher quality and standards of care. This accreditation process solidifies and builds upon our commitment to delivering the highest quality care whenever a patient visits one of our certified and accredited centers."

A confluence of macroeconomic trends including chronic emergency room overcrowding and limited access to primary care physicians has driven continued industry growth and demand. By 2020, there will be a shortage of approximately 45,000 primary care physicians, further underscoring the vital role urgent care centers play in the healthcare delivery landscape.

"The UCAOA mission states, in part, 'We exist to advance and distinguish the role of urgent care medicine as a healthcare destination.' The UCAOA Accreditation Program serves our

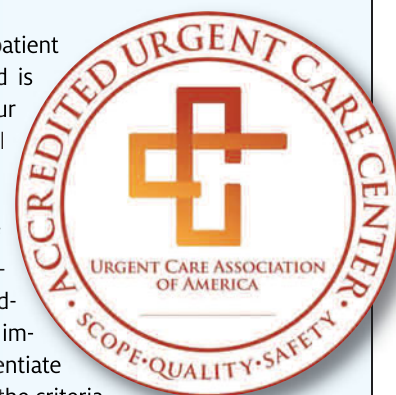
members as well as the patient population we serve and is perfectly aligned with our purpose," said Laurel Stoimenoff, vice president of the UCAOA Board of Directors and co-chair of the Accreditation and Certification Committee. "Additionally, accreditation is important to helping differentiate those centers who meet the criteria

from others in the marketplace, establishing a baseline definition for expected care and, in many cases, enabling them to qualify for in-network care for most providers. We encourage our members and all urgent care centers to pursue this unique recognition."

Under the new accreditation program, urgent care centers will be required to meet or ideally exceed UCAOA standards around key operational and clinical care matters including governance, human resources, patient care processes, quality improvement, physical environment, health record management, and patient privacy/rights/and responsibilities standards. These will be measured through comprehensive site tours administered by an independent third party with experience working in urgent care, interviews with patients and staff and other qualitative and quantitative assessments.

More details around the accreditation were announced at the UCAOA National Urgent Care Convention in Las Vegas, including recognizing the first UCAOA Accredited Centers, Advantage Care Physicians of Staten Island, NY, and DocNow Urgent Care of Rochester Hills, MI.

For more details about the program, to receive an informational packet, or to apply as an early adopter and get your center started toward this unique recognition, visit www.ucaoa.org or contact the UCAOA staff at 331-472-3739. ■



P. Joanne Ray is chief executive officer of the Urgent Care Association of America. She may be contacted at jray@ucaoa.org.

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Assessment and Management of Asthma Exacerbation in Urgent Care: Part 2

Urgent message: The second part in a two-part series offers expert guidance on short and long-term management of the disease in the urgent care setting through the use of pharmacotherapy, protocols for treatment, and a written asthma action plan at discharge.

BRADLEY M. TURNER MD, MPH, MHA, FCAP, FASCP and JANET M. WILLIAMS, MD, FACEP

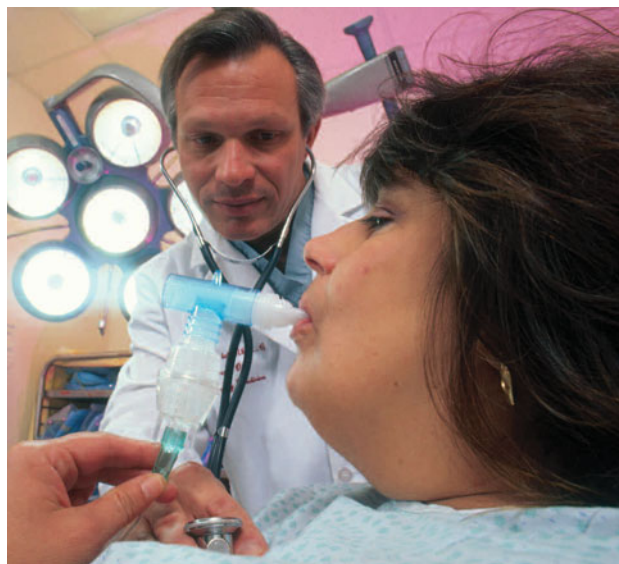
Introduction

Once the suspicion of an asthma exacerbation exists, short term management is focused on reducing the severity of the exacerbation, with the hopes of discharging the patient home for outpatient follow-up. This can be achieved through pharmacotherapy that reduces inflammation and relaxes the airway musculature, in hopes of reversing airflow obstruction. Long-term management is focused on prevention of future exacerbations through pharmacotherapy and education at discharge. Understanding the rationale behind short and long-term management of a suspected asthma exacerbation will lead to more efficient assessment and effective discharge of patients presenting to an urgent care center.

Pharmacotherapy

Pharmacotherapy for asthma generally can be divided

Bradley M. Turner is an Assistant Professor of Pathology at the University of Rochester School of Medicine in Rochester, NY and a staff physician with Team Health/Exigence Rochester Immediate Care in Rochester NY, and Team Health/Exigence Western New York Immediate Care in Buffalo, NY. **Janet M. Williams**, previously Professor of Emergency Medicine at the University of Rochester School of Medicine, currently serves as the Medical Director of Team Health/Exigence Rochester Immediate Care in Rochester, NY.



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into quick-relief short-term medications (short-acting beta₂ agonists [SABAs], anticholinergics, and oral/systemic corticosteroids), and long-term controller medications (inhaled corticosteroids, long-acting B₂ agonists [LABAs], leukotriene antagonists, and immunomodulators). Complementary and alternative medications (CAM) comprise another fast-growing subset of pharma-

Table 1. Dosages of Selected Drugs for Asthma Exacerbations in Urgent Care*

	Dosages	
Medication	Child Dose (≤12 years)	Adult dose
Albuterol (Inhaled SABA^a)		
Nebulizer solution (0.63 mg/3 mL, 1.25 mg/3 mL, 2.5 mg/3 mL, 5.0 mg/mL)	0.15 mg/kg (minimum dose 2.5 mg) every 20 minutes for 3 doses then 0.15–0.3 mg/kg up to 10 mg every 1–4 hours as needed, or 0.5 mg/kg/hour by continuous nebulization.	2.5–5 mg every 20 minutes for 3 doses, then 2.5–10 mg every 1–4 hours as needed, or 10–15 mg/hour continuously.
Metered Dose Inhaler (MDI) ^a (90 mcg/puff)	4–8 puffs every 20 minutes for 3 doses, then every 1–4 hours inhalation maneuver as needed. Use VHC ^b ; add mask in children <4 years.	4–8 puffs every 20 minutes up to 4 hours, then every 1–4 hours as needed.
Epinephrine (Systemic SABA) 1:1,000 (1 mg/mL)	0.01 mg/kg up to 0.3–0.5 mg every 20 minutes for 3 doses	0.3–0.5 mg every 20 minutes for 3 doses
Ipratropium Bromide	(Anticholinergic)^b	
Nebulizer solution (0.25 mg/mL)	0.25–0.5 mg every 20 minutes for 3 doses, then as needed	0.5 mg every 20 minutes for 3 doses then as needed
MDI ^a (18 mcg/puff)	4–8 puffs every 20 minutes as needed up to 3 hours	8 puffs every 20 minutes as needed up to 3 hours
Ipratropium With Albuterol^c		
Nebulizer solution (Each 3 mL vial contains 0.5 mg ipratropium bromide and 2.5 mg albuterol.)	1.5-3 mL every 20 minutes for 3 doses, then as needed	3 mL every 20 minutes for 3 doses, then as needed
MDI ^a (Each puff contains 18 mcg ipratropium bromide and 90 mcg of albuterol.)	4–8 puffs every 20 minutes as needed up to 3 hours	8 puffs every 20 minutes as needed up to 3 hours
Steroids	1-2 mg/kg in 2 divided doses (maximum = 60 mg/day) until PEF is 70% of predicted or personal best	40–80 mg/day in 1 or 2 divided doses until PEF reaches 70% of predicted or personal best
Prednisone		
Methylprednisolone		
Prednisolone		
<p>^a Adapted from the National Heart, Lung, and Blood Institute National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma Full Report [EPR-3].</p> <p>a. In mild-to-moderate exacerbations, MDI plus VHC is as effective as nebulized therapy with appropriate administration technique and coaching by trained personnel. MDI should be used with VHC and a facemask in children aged <4 years.</p> <p>b. Can mix in same nebulizer with albuterol (see below). Should not be used as first-line therapy; should be added to SABA therapy for severe exacerbations.</p> <p>c. Can be used for up to 3 hours in initial management of severe exacerbations.</p> <p>MDI = metered-dose inhaler; VHC = valved holding chamber; SABA = short-acting beta₂-agonist</p>		

cotherapy (acupuncture, chiropractic therapy, homeopathic and herbal medicine, breathing and relaxation techniques, and yoga). In the urgent care setting, quick-relief medications are the mainstay of treatment.

Although this review focuses on several forms of specific quick-relief, short-term pharmacotherapy (**Table 1**), urgent care providers should be familiar with the various other treatment options, their appropriate use, and possible misuse. For example, a patient whose history sug-

gests a severity classification of persistent asthma should be on an inhaled corticosteroid (unless contraindicated).¹ A second example is the misconception patients often have (personal experience) about the use of LABAs during acute exacerbations. LABAs *are not* recommended in acute asthma exacerbations.¹ Patients, however, may not be aware of that fact, and may attempt to use long-term controller medication for acute relief. Familiarity with these and other facts about the various long-term controller

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Table 2. Risk Factors for Death From Asthma*

Asthma history <ul style="list-style-type: none"> • Previous severe exacerbation requiring intubation or intensive care unit admission for asthma • Two or more hospitalizations for asthma in the past year • Three or more emergency department (ED) visits for asthma in the past year • Hospitalization or ED visit for asthma in the past month • Using >2 canisters of a short-acting beta₂-agonist per month • Sensitivity to Alternaria
Social history <ul style="list-style-type: none"> • Low socioeconomic status • Inner city residence • Illicit drug use • Major psychosocial problems
Comorbidities <ul style="list-style-type: none"> • Cardiovascular disease • Other chronic lung disease • Chronic psychiatric disease
Other <ul style="list-style-type: none"> • Lack of a written asthma plan
<small>* Adapted from the National Heart, Lung, and Blood Institute National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma Full Report [EPR-3].</small>

medications and CAM will facilitate more efficient assessment of the severity and control of a patient's asthma, and help to create a more effective discharge plan. A patient who is noncompliant with medications or not on appropriate therapy is at increased risk of recurrent exacerbations and increased morbidity. A nice overview of long-term controller and CAM options can be found in the EPR-3 report (pages 216-235;242).¹

SABAs are the most effective asthma therapy for rapid relief of symptoms and reversal of airflow obstruction.^{1,2} The EPR-3 recommends using SABAs only when necessary for symptom relief (i.e they *should not* be used on a continuous daily basis), or before anticipated exposure to known asthma triggers. SABAs should be used in all patients with asthma exacerbation (unless contraindicated). The dosage and delivery mechanism will be dependent on the severity of the presentation (**Table 1**). Anticholinergics are not recommended as monotherapy for quick relief of asthma symptoms.^{1,2} They can be used in combination with SABAs in severe presentations. The use of steroids should be oral rather than intravenous (IV) in the urgent care setting unless a patient is unable to take oral medications, or is approaching impending respiratory failure. Oral administration of prednisone has been shown to have effects equivalent to those of IV methylprednisolone, and in the opinion of the

EPR-3 expert panel, is usually preferred because it is less invasive. There is no known advantage for higher doses of corticosteroids in severe asthma exacerbations. The total course of systemic corticosteroids for an asthma exacerbation requiring an urgent care visit may last from 3 to 10 days. For corticosteroid courses of less than 1 week, there is no need to taper the dose. For slightly longer courses (e.g., up to 10 days), a taper can be considered; however, there probably is no need to taper, especially if patients are concurrently taking inhaled corticosteroids.

Management of asthma exacerbations in the ambulatory/urgent care setting

Establishing protocols for treatment based on current management guidelines can facilitate improved care of patients with asthma.^{1,3} A sample protocol is given in **Figure 1**. First-line treatment of suspected or diagnosed asthma exacerbations includes SABAs for all patients and oxygen, if necessary. Continuous administration of SABAs is the most effective means of reversing airflow obstruction.¹ The onset of action for SABAs is less than 5 minutes and repetitive administration produces incremental bronchodilation. Most patients will have a significant response after the first dose. It is recommended that patients who have a rapid response be observed for 30 to 60 minutes after the most recent dose of bronchodilator to ensure stability of the response before discharge to home.¹ After initial administration, the frequency of administration should be judged based on improvement in airflow obstruction, improvement of presenting signs and symptoms, and the occurrence of any side effects. Nebulizer therapy may be preferred for patients who are unable to cooperate effectively in using a metered-dose inhaler. Adding ipratropium bromide to a selective SABA produces additional bronchodilation, resulting in fewer hospital admissions, particularly in patients who have severe airflow obstruction.¹ Administer supplemental oxygen to maintain an SaO₂ >90%. Monitor SaO₂ until a clear response to bronchodilator therapy has occurred. In patients who have not responded completely to initial SABA, systemic corticosteroids are recommended. These medications speed the resolution of airflow obstruction and reduce the rate of relapse and may reduce hospitalizations.¹ A short course (5-10 days) of oral corticosteroids should be given at discharge. Theophylline is not recommended for treatment in the urgent care setting because it does not appear to provide additional benefit. Antibiotics are generally not recommended, except as needed for co-morbid conditions that would require antibiotics. Other therapies not generally recommended include aggressive hydration, chest physical ther-

apy, mucolytics, and sedation. In particular, anxiolytic and hypnotic drugs are contraindicated in severely ill asthma patients because of their respiratory depressant effect.

Discharge

The response to initial treatment is a better predictor of the need for hospitalization than the severity of an exacerbation on presentation.⁴⁻¹³ Therefore *repeat assessment should be the primary factor* in the decision to discharge the patient home, versus admit to the hospital. In general, discharge is appropriate if forced expiratory volume (FEV₁) or peak expiratory flow (PEF) has returned to 70% of predicted or personal best and symptoms are minimal or absent. Patients who have an incomplete response to therapy (FEV₁ or PEF 50% to 69% of predicted or personal best) and with mild symptoms should be assessed individually for their suitability for discharge home, with consideration given to factors listed in **Table 2** and **Figure 1**. Hospital admission is warranted if an incomplete or poor response persists. At discharge sufficient medications should be given for a patient to continue on the pre-

scribed treatment until follow-up. Follow-up should be to either to the patient's primary care provider or an asthma specialist. If an appointment can be scheduled prior to discharge, the likelihood that a patient will actually receive an appointment and follow up increases.^{14,15} A written discharge plan should be reviewed with a patient, including review of discharge medications and patient education on the correct use of an inhaler. Discharge is also an opportunity to inform or reinforce the signs of an asthma exacerbation, because studies show that some patients are unable to perceive signs of deterioration that would indicate a need to increase medication.^{16,17} This can be done through a written asthma action plan. Although the scientific evidence on written asthma treatment plans is inconclusive, studies do suggest that use of written plans may help patients improve control of their asthma, particularly with respect to prevention and management of asthma exacerbations, and they are recommended by the EPR-3.^{1,2} A written asthma action plan includes two important elements: daily management of medications and environmental triggers information on how to rec-

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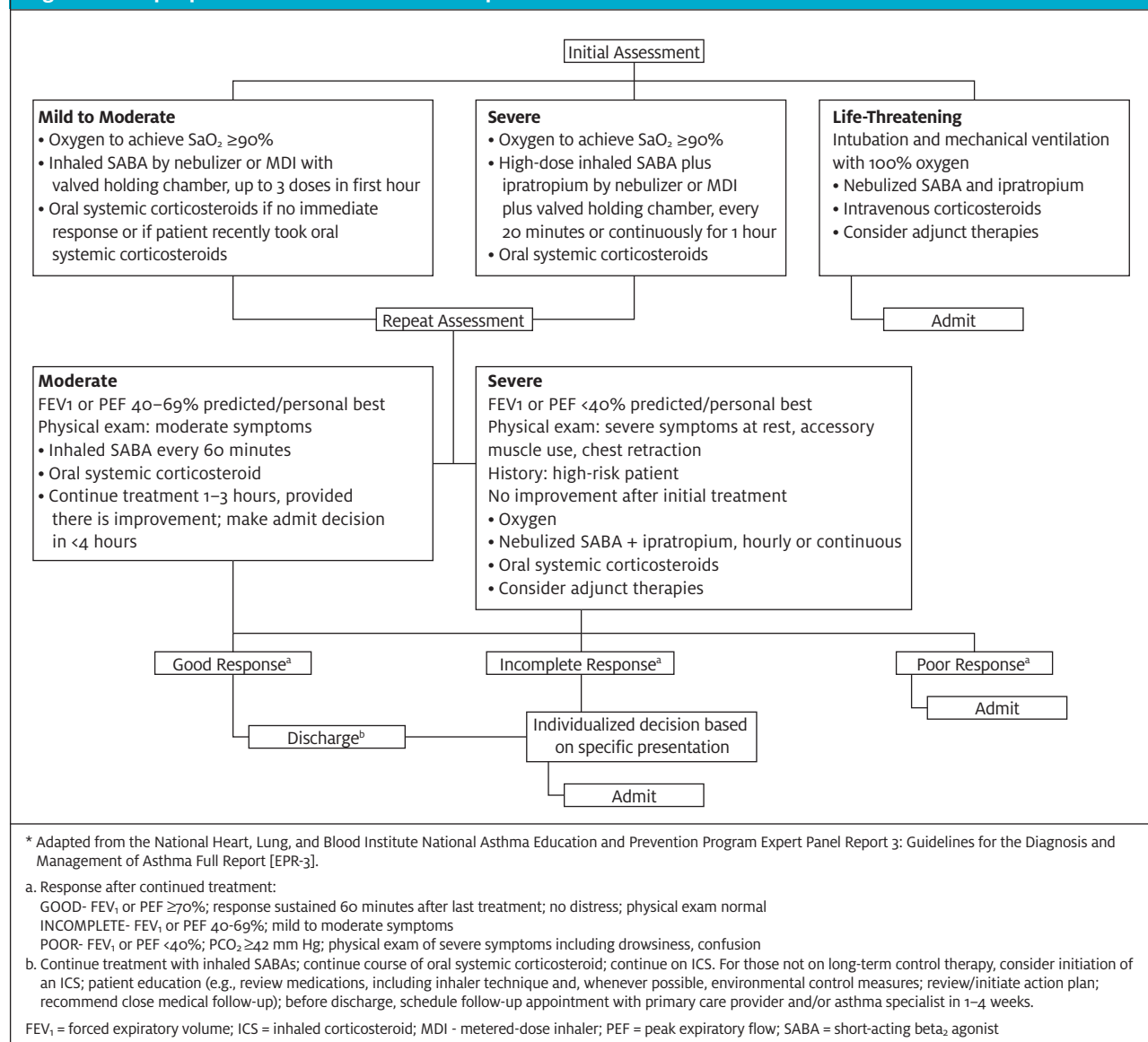
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Figure 1. Sample protocol for assessment of suspected or established asthma exacerbation*

ognize (i.e. signs and symptoms) and handle (i.e. medications, emergency contacts) worsening asthma.

A very nice example of a written asthma action plan for an adult and child can be found in the EPR-3 report (page 117-119).¹ A written asthma action plan is the most appropriate method to provide concise instructions on managing asthma symptoms in the ambulatory care setting.^{1,2}

Conclusion

In a previous issue (Part 1), we discussed the pathogene-

sis of airway inflammation in asthma, key indicators for a diagnosis of asthma on history and examination, and key risk factors suggesting worse outcomes in patients with asthma exacerbations. In Part 2, we reviewed the short and longer-term management of these patients through the use of pharmacotherapy, protocols for treatment, and a written asthma action plan at discharge.

As we enter an era of health care in which decisions about treatment are increasingly patient-driven, urgent care centers will become a first choice for many patients seeking health care advice. The prevalence of asthma is

increasing, and current trends suggest that an increasing number of patients with acute asthma exacerbations will present to urgent care centers for treatment. Understanding the underlying pathogenesis of asthma will help the urgent care provider in doing an adequate medical history and examination in order to elicit risk factors associated with worse outcomes. Understanding the various pharmacotherapy and treatment options, and the development of protocols for short-term management of asthma, will improve the efficiency and efficacy of treatment for asthma exacerbations in the urgent care setting. A written asthma action plan can contribute to improved long-term control of asthma through prevention and management of asthma exacerbations, leading to decreased health care costs and improved long-term outcomes. ■

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Practice Management

Marketing Strategies: School, Sports, and Camp Physicals

Urgent message: Sports physicals offered by an urgent care center can be a “win” for both the center and the community. The community gets a flexible source for a time-critical service and the center gets another way to attract new and repeat business.

ALAN A. AYERS, MBA, MACC

Schools, camps, inter-league and club sports programs typically require a pre-participation physical examination to evaluate a participant's general health, fitness level, risk of injury and physical well-being. A “sports physical” allows a physician to identify any conditions that might keep an athlete out of the game or affect performance. For parents and coaches, ensuring that all participants are “compliant”—meaning everyone’s “form” is “complete and eligible”—can be a daunting task. An urgent care’s after-hours, walk-in convenience, therefore, can potentially meet a need in the community while also raising awareness of the center, leading to increased utilization when participants have future injuries or illness.

What Sports Physicals Entail

Sports physicals differ from “well child” exams provided by a pediatrician in that their focus is to “clear” the participant for a specific activity. By contrast, a “well child” exam goes much deeper into developmental, behavioral, psychological, nutritional, social and other factors that affect a child’s lifetime health. Most state high school athletic associations have a standard template for the sports participation examination, which is adopted by most school districts; otherwise



schools and camps create forms specific to their programs. Parents will generally arrive at an urgent care center with the form to be completed, but an urgent care provider should be familiar with the general content of the forms prior to marketing the service.

Sports physicals generally consist of two parts—a medical history and physical examination—which occur in five steps:

- **Medical History:** Understanding past illnesses,

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injuries, surgeries or conditions like asthma or diabetes will help the provider diagnose problems and provide advice about preventing future complications.

- **Vitals:** Pulse, blood pressure, height and weight should be checked. Understanding rapid changes due to growth spurts enables the provider to address the stress of an activity on joints, muscles and bones.
- **Eye Exam:** This check is for proper vision and evaluation of whether a participant needs prescription lenses or the current vision prescription needs to be adjusted.
- **Fitness:** Provider examines the participant's heart, lungs, abdomen, ears, nose and throat, checking the cardiovascular system and recommending any limitations on physical activity.
- **Joints & Flexibility:** Testing the patient's strength, flexibility, posture and joints enables the provider to identify any areas that may be prone to

injury and to suggest exercises and offer tips to help build a healthier body.

In addition, given the prevalence of concussions in contact sports, some providers are adding a "baseline concussion test" to the sports physical. Prior to the occurrence of a concussion and when the athlete is feeling well, the baseline test assesses the athlete's normal brain processing characteristics. When a concussion occurs, swelling of the brain changes how quickly the brain solves problems and reacts to stimuli. Having a "baseline" understanding of how the brain functions enables the provider to determine when an athlete's brain has returned to "normal," and thus, the athlete can safely return to the sport or activity.

Last, if the sports physical reveals chronic or longitudinal illness that is not under treatment—or if the child does not already have a pediatrician for wellness and prevention—the urgent care provider should refer the patient to a pediatrician for follow-up care.



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Table 1: Sports Physical Practical Considerations**Promote sports physicals ahead of each season:**

- Determine whether students require a new physical for each sport or season. (Athletes usually play multiple sports or leagues, which could result in 2-3 physicals per year.)
- Visit schools prior to release for summer break.
- Get information into students' hands for fall or summer sports camps.
- Follow up with athletic director 6 weeks before school resumes.
- Visit schools 4 to 6 weeks prior to each season.
- Get information into coaches' hands during pre-season planning meetings.

Have the school's sports physical form on hand in the center:

- Get the form from each school or get school to approve your center's standard form. (There is typically a standard State High School Athletic Association form.)
- Familiarize providers with requirements for each school.
- Have forms on hand to help students who forget their forms.

The Marketing Value of Sports Physicals

For an urgent care operator, the marketing value of sports physicals is that they introduce parents and coaches to the center's providers, familiarize them with the facility and its processes, and create "top of mind awareness" should an injury or illness occur later in the school year. Although the physicals themselves can add incremental revenue, the focus is *not* selling sports physicals; it's capturing injury and illness visits later on. Thus, sports physicals are considered a *marketing tactic*.

As "marketing," sports physical promotions can be more targeted towards consumer segments with historic high urgent care utilization—families with children—and less expensive than mass media like billboards and radio. Sports physical promotions also lend themselves well to social media, public relations exposure, and word-of-mouth.

An investment in a sports physical promotion yields long-term returns for the urgent care center by cultivating patient loyalty:

- Student athletes return each year for their own physicals. A student participating in multiple activities, over 6 to 12 years, could result in 20 or more encounters between the student and the urgent care provider.

- In addition to individual students, there is loyalty within family households. Parents tend to follow with younger siblings the patterns they've established for their firstborn. Consider the recurring revenue from a family with four children, spaced 2 to 3 years apart, in middle/high school sports for 6 years each.
- Students continue to utilize urgent care centers into their 20s and 30s. Consider the "lifetime value" of a patient who is in the habit of going to the center whenever medical needs arise, including word-of-mouth within that patient's sphere of influence. College-aged students are often too old for their pediatrician but have not yet established a primary care relationship, making urgent care their default choice for health care.

The marketing of sports physicals differs from conventional advertising in that it requires a greater time commitment and relationship-building in the community. It also requires that the service be tailored to the specific needs of local sports programs.

Engaging Athletic Directors and Parents

When developing a sports physical promotion, start by reaching out to the athletic directors at local high schools and middle schools. They can provide insight as to participation requirements, forms, deadlines and the strengths and weaknesses of current providers. As the individuals typically responsible for participant "compliance," athletic directors also can be key allies in marketing the service because they control communications to coaches, trainers, teachers, volunteers, parents and athletes.

When meeting with an athletic director, it's important that an urgent care operator articulate the pricing and service advantages (i.e. after-hours accessibility, walk-in convenience, neighborhood location) over other providers. Be sure to provide flyers for coaches to distribute to students or to include in orientation packets.

Key messages for the athletic director include:

- The urgent care center can ensure that all participants are "compliant."
- The urgent care center is staffed with board-certified medical providers.
- The urgent care center can structure a sports physical promotion to meet the specific needs of the school or program.
- The urgent care center is available for sports-related injuries—including fractures, sprains/strains, and

cuts/abrasions.

- Urgent care centers are significantly cheaper than hospital emergency rooms (ERs), with co-pays typically \$25 to \$50 versus \$100 or more for an ER visit. Urgent care centers also have shorter wait times, with patients in/out in an hour versus 2 to 3 hours or longer at an ER.

Some urgent care centers, particularly those affiliated with hospital systems, partner with other provider groups interested in student athletics, such as Orthopedics and Sports Medicine, in promoting sports physicals. They position urgent care as the “entry point” to an integrated health system able to care for the “total athlete.”

In addition, in order to ensure that injury visits come to your urgent care center instead of the ER, consider extending the center’s operating hours to be open during major athletic contests. One network of urgent care centers extended its autumn operating hours to 11:00 pm on Friday nights to accept injuries from high school football games. It advertised its hours in the high school football program. This twist differentiated the center from competitors in the eyes of athletic directors and parents. Although few injury visits actually materialized, the promotion was still profitable because there was a steady stream of drive-by, non-injury urgent care patients taking advantage of the late-night hours.

Although athletic directors are highly effective at raising awareness of a sports physical program, an urgent care operator can also engage parents and athletes directly by way of:

- Flyers, posters or banners in the urgent care center aimed at raising awareness that physicals are available;
- Exterior signage at the center such as banners or yard signs to raise awareness among drive-by traffic;
- Advertising in local newspapers, parent-focused magazines, or via Internet search engines; and
- Press coverage in school newsletters or community newspapers.

Paid advertising that promotes sports physicals also promotes the center in general and can be considered a “seasonal marketing theme” in the center’s integrated advertising campaign.

Sports Physical Promotion Timing

Athletes should have a physical 6 weeks before the start of the sport season; however, that can vary due to changing sport seasons. This timing provides an oppor-

tunity to address an existing injury or improve conditioning prior to participation in the activity. How frequently an athlete must undergo a physical varies by program, with some schools requiring a physical for every seasonal sport or activity and others requiring one in advance of the school year.

Generally, the best time to contact an athletic director is in May prior to summer dismissal of the school year. It’s at this time that schools assemble and distribute materials for summer sports camps. After June, it’s likely that many of the coaches will be out on summer break and unavailable for contact. If a program can be devised in April or May, there is a time window to plan marketing and communication during June and July for a full launch coinciding with back-to-school in August. Ultimately, however, the timing will be unique to the needs of the specific school or program, so it’s critical to understand the deadlines they’ve established for participants. Table 1 outlines some practical considerations in sports physical promotion timing and execution.

Setting the Price

Urgent care centers are in the business of providing “episodic illness and injury care,” typically billed to a patient’s insurance. Student physicals are not intended to be a “core” product of the urgent care center—meaning the center is not in the “sports physical business.” A center does not have to turn a profit on the physicals themselves. If the center has capacity to perform the physicals—meaning no extra staff will be added—the incremental cost of performing a student physical is minimal. That means *any money collected* goes straight to the bottom line.

Unlike the well-child physical, which is performed by a primary care physician, covers a multitude of health issues, and is covered by insurance, a school, camp or sports physical is focused on meeting a specific requirement, less detailed in its scope, and typically not reimbursable under urgent care insurance contracts. Therefore, urgent care centers find that sports physicals are necessarily a cash-pay service.

As with any cash service, how much to charge is dictated by market conditions, so it’s important to understand what options are available to parents and how much they cost.

Some schools provide “mass” physicals at a specific date/time, typically by a volunteer physician who is a parent or athletic booster. If that occurs, an urgent care physician can inquire as to the volunteer physician’s interest in continuing the service. Often if his or her

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children have graduated, a provider is more than willing to “pass on” the responsibility. If not, then the only kids the urgent care center can expect to see are “stragglers” or “transfers,” so price the price point is less of a promotional issue.

If competitors are promoting sports physicals, then an urgent care center’s price should be on-par with other options. For example, if a competitor is advertising \$25, an urgent care center that charges \$50 will be seen as “unreasonable” by parents. But while an urgent care operator should be aware of competitors’ prices, he/she should never engage in a “price war.” Below a certain amount, time-starved parents are not particularly price-sensitive on an infrequent purchase. For example, if a competitor is advertising a “token price” of , say, \$12, the next price point is not \$11 or even \$5, but rather, is free or even free plus cutting a check to the school for the *privilege* of offering free physicals. If the physician does provide the service for free, he/she may be able to barter with the school for advertising in a printed program or a banner at the athletic venue.

Remember, the value proposition to schools and parents is convenience and compliance. If an urgent care center cannot viably compete due to well established options in a community, then it should abandon the opportunity and pursue other marketing tactics.

The Issue with “Free” Physicals

In order to provide a “service” to the community and raise awareness of an urgent care center’s offering, one urgent care provider partnered with a local children’s magazine and radio station to promote “free” sports physicals during the month of August. Although there was a tremendous response in terms of the number of physicals performed, analysis 6 and 12 months later revealed something quite troubling: Only a handful of those who had received physicals had anyone in their household return to the center for a paid illness or injury visit.

Now, one could assume that those households just didn’t have an urgent care need. But further mapping and demographic analysis of those who had received the physicals revealed a few trends:

- Households from low-income, inner-city areas outside the center’s suburban catchment.
- Households with a high likelihood of being on Medicaid, coverage that the urgent care center did not accept.
- Multiple households in the same public housing complex showing up at the same time.
- Households from rural and outlying communities outside the center’s catchment exhibiting the same behavior as the inner-city households.

Basically, the “free” sports physical promotion was effective in attracting people looking for something “free.” Families heard about the promotion, planned a special trek to the center, and brought along friends and teammates. Those patients never returned because had they actually needed urgent care after that visit, they

most likely would have used a provider much closer to their homes and schools.

Perhaps more revealing was the low volume of repeat business from households in the suburban catchment where the center is located. The psychology deterring those households is that if something is “free,” it must “have no value” or it must be “no good.” Parents—particularly those with three or four kids—were willing to take advantage of “free” to get a form filled out, but when it came to delivering medical care to a family member, their preference was for the “really good doctor”—meaning the one who “charges for his services.” The free sports physical promotion had branded the center as a low-quality “free clinic” in the eyes of these consumers.

Rebate Incentives and Other Promotions

Instead of offering sports physicals for free or at a highly discounted price, consider a price coincident to the value delivered—\$20 to \$35—and then “donating” a portion of the revenue to the school or athletic program. With constantly tightening budgets, schools are always looking for funding and the thought of receiving a seasonal check will co-opt athletic directors, coaches, and trainers in promoting an urgent care center as the “place to go” for physicals. It’s in the best interest of program leaders to increase the size of their donation.

The rebate promotion is driven by a flyer describing how the urgent care center will make a donation for every physical performed. Identify a charity for the donation—typically the school’s athletic boosters or general fund. For every paid physical, the center will donate a portion of its revenue—typically \$5 to \$10 on a \$20 to \$35 physical—to the charity. The center’s front office must establish a mechanism to track flyers redeemed and then issue a check to the school. In addition to working with each sports program, advertise the promotion in the community newspaper or school publication prior to the campaign. The check presentation should be planned to maximize public relations exposure—such as during a football game half-time—and be sure to submit a photo/press release of the check presentation to the community newspaper.

Conclusion

Conventionally the greatest utilization of urgent care centers is among family households with school-aged children. That’s because children are active and social, increasing the frequency of illness and injury. Although children should have a pediatrician for wellness and preventive care, time-starved parents often find themselves in a last-minute bind to ensure their children are compliant for their school, sports and camp activities. The walk-in, extended-hours convenience of getting a sports physical at an urgent care center thus can meet a real need in the community. And as parents and athletes become familiar with an urgent care facility, its processes and its providers, they are more likely to return to the center when future illness and injury arises. Therefore, sports physicals can be considered a “marketing tactic” and an investment in patient loyalty. ■

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Case Report

Sarcoidosis

Urgent message: The key to this case was in the details of the presenting symptoms in the patient history: Alarm symptoms including extreme fatigue and weight loss, which warranted further diagnostic work up.

ABRAR KHAN, MD, MBA, REVATHY NAIR, MD, and MARIANN MELICHAREK, MD, FACEP

Introduction

Sarcoidosis is a multisystem granulomatous disorder of unknown etiology. Most patients with sarcoidosis present to urgent care providers with symptoms such as cough, dyspnea, chest pain, eye pain and/or skin lesions. These symptoms should not go unnoticed because most cases of sarcoidosis are diagnosed through incidental radiologic findings. The case we present underscores the importance of obtaining a solid history from the patient. Further investigative studies are often warranted, despite routine complaints and a normal physical exam, especially if “alarm symptoms” are present, that is, weight loss, fatigue, loss of appetite, mental status changes, motor and sensory changes, or vision changes.

Case Presentation

A 32-year-old Caucasian male presented to the urgent care center with “fevers of up to 102°F” for about 2 days. In addition to the fever, he presented with a sore throat, which he describes as aching. The patient reports no cough, chills, or hemoptysis. Further diagnostic questioning reveals some back pain and fatigue with a 20-lb weight loss over the past “few months.” The patient was seen 8 months prior for a similar complaint, which he said got better with azithromycin, Proventil inhaler, and prednisone. A chest x-ray taken at the time was read as normal (**Figure 1**).

The man’s past medical history is significant for acid

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reflux and sciatica. At the time of evaluation the patient was taking rabeprazole. He reported no known malignancies in his family history and his social history was negative for smoking (quit in 2010). He admitted to being a social drinker and has never used illicit drugs.

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Figure 1.

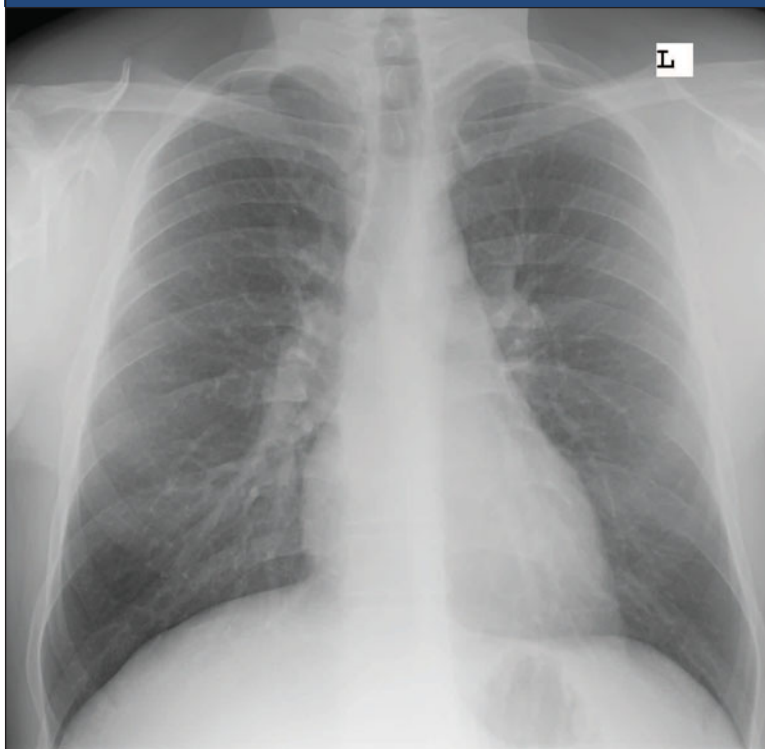


Figure 2.



Observation and Findings

Observation of the patient revealed the following vital signs:

- BP - 111/69 mmHg
- P - 94
- RR - 16
- T - 98.7° F
- SpO₂ - 98%
- Height - 5' 11"
- Weight - 170 (change from 8 months prior, 190 lb)
- BMI - 25.80 (change from 8 months prior, 26.5)

The patient's physical exam was within normal limits. However, he had several "alarm" symptoms, including weight loss and fatigue that warranted further investigation.

Labs/Imaging

- Rapid Strep A antigen
- Throat Culture
- Chest X-ray (frontal and lateral)
- CBC
- BMP
- TSH/Free T4
- Lyme Disease Serology

The initial encounter of pharyngitis warranted immediate testing with a Rapid Strep Test, which was negative. The culture was sent for laboratory analysis (later reported as negative) and a chest x-ray was performed with frontal and lateral views. The attending physician noticed that the right hilum appears abnormal and comparison with the patient's previous chest x-ray suggested that the right hilum was enlarged. The patient's current chest x-ray was sent to Radiology as a STAT read.

At that point, the patient was allowed to return home and discharged with specific instructions for follow up with his primary care provider. Chest x-ray impressions were read 8/21/2013 (**Figure 2**). Table 1 lists results of lab tests, which do not reveal any abnormalities.

The Radiology report on the chest x-ray confirmed bilateral hilar lymphadenopa-

Table 1. Lab test results

Lab value	Result
Glucose	104
Sodium	139
Potassium	4.2
Chloride	103
Carbon Dioxide	27
BUN	11
Creatine	0.95
Calcium	9.8
Protein	7.1
Albumin	4.4
Globulin	4.4
Alkaline Phosphatase	67
AST	15
ALT	18
TSH	1.56
WBC	4.4
RBC	4.56
Hemoglobin	13.6
Hematocrit	41.2
MCV	90.4
RDW	12.7
Lyme Disease Antibody Titre	0.8

thy and recommended a thoracic computed tomography (CT) scan to differentiate between sarcoidosis and lymphoma. The thoracic CT scan revealed enlarged hilar and mediastinal lymph nodes with small bilateral pulmonary nodules. The Radiology report also recommended further follow up for a differential diagnosis including sarcoidosis and lymphoma. The patient then was referred to a pulmonologist for follow up and diagnosis.

Diagnosis

Sarcoidosis

Discussion

In urgent care medicine, one must know that a single solitary diagnostic test should not deter a physician from paying attention to the history of present illness. The

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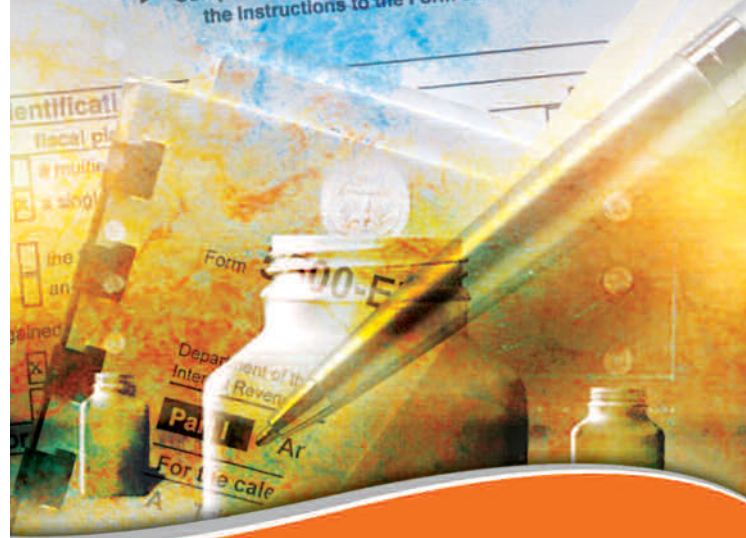
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patient described here does not fit the typical profile for sarcoidosis, but his presentation of fatigue, weight loss, and chronic symptomology should evoke suspicion even after the negative strep test.

Epidemiology

Sarcoidosis is a disease of inflammation of unknown etiology, characterized by the presence of non-necrotizing granulomas along the lymphatic tract of the lungs. The estimated prevalence is 10 to 20 per 100,000. The disease appears to vary in incidence amongst various ethnicities. It seems to be more prevalent in the black population, however, at a 2.4% lifetime risk versus 0.85% in the white community.¹ Sarcoidosis is predominately seen in African-American women. Seventy to 90% of cases of sarcoidosis are seen in patients aged 10 to 40 years.²

Clinical Presentation

Sarcoidosis can appear in practically any organ of the body, but it originates most often in the lungs and lymph nodes. Thus, the most common presenting symptoms include cough, dyspnea, and chest pain. Other features of sarcoidosis include fatigue, malaise, fever, and weight loss,² which were apparent in this case. On physical examination of the lungs, wheezing may also be present.²

Lung involvement occurs in over 90% of patients with sarcoidosis.³ Chest radiography at this time is both an accessible and cost-effective initial imaging diagnostic study for sarcoidosis. The classic chest x-ray finding is bilateral hilar adenopathy. However, that finding may be absent, or if present, may occur in combination with parenchymal opacities.⁴ The stage of pulmonary involvement is based on the chest x-ray findings. Although the x-ray can be useful in terms of anatomical findings, it is not a good predictor of disease activity or outcome.

In this case, x-ray exhibited right-sided hilar lymphadenopathy, which required follow up with CT to assess whether sarcoidosis or lymphoma was present. Although the results of the CT were inconclusive and no further diagnostic studies were required, CT and high-resolution

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CT radiography are superior to chest radiography in assessment of the degree of pulmonary parenchymal disease and lung fibrosis. CT and high-resolution CT may show parenchymal disease in patients with normal chest radiographs or in those patients who demonstrate only hilar lymphadenopathy on chest x-ray. CT can also serve as a guide for lung or lymph node biopsy, and may be also used to evaluate response to therapy.⁵

Treatment

Most patients with pulmonary sarcoidosis do not require treatment because their disease is asymptomatic, limited disease, spontaneously remits. For patients with asymptomatic pulmonary sarcoidosis and no substantial extrapulmonary involvement, initiating therapy with oral glucocorticoids is not compulsory. Symptoms, chest radiograph, and pulmonary function should be monitored at 3- to 6- month intervals. Oral glucocorticoids have been the most commonly used agents for the relief of symptoms and control of potentially disabling respiratory impairment from pulmonary sarcoidosis, even if they do not cure the disease.⁴⁻⁶

The standard dose of oral glucocorticoids is the equivalent of prednisone 0.3 to 0.6 mg/kg ideal body weight (usually 20 to 40 mg/day). The initial dose of prednisone is continued for 4 to 6 weeks.⁷ If a patient's symptoms, radiographic abnormalities, and pulmonary function tests are unimproved, oral prednisone should be continued for another 4 to 6 weeks at the dosage initially prescribed. In patients who are stable or whose symptoms are improving, the drug dosage can be tapered gradually.⁸

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Medical Malpractice Insurance: Read the Fine Print

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

Our emergency medicine group was informed that a new corporate mandate will force us to nearly double our malpractice coverage from \$1 million for each occurrence and \$3 million in yearly aggregate (\$1M/\$3M) to \$2M/\$4M. This mandate came despite our group's low malpractice claims history, a higher burden of proof for plaintiffs in the state where we practice, and a very "doctor-friendly" malpractice environment in our county. To my knowledge, there has never been an emergency medicine case in our jurisdiction that has exceeded the \$1M policy limits.

Logic notwithstanding, it was a mandate and thus, we were forced to comply. Some members of our group wanted to pursue joining our system's self-insured policy. On the surface, this makes some sense until one starts reading the fine print. This article will review a number of "gotchas" of which to be aware when negotiating malpractice insurance.

Joining Forces with a Health System

A large percentage of providers in the United States purchase medical malpractice insurance through companies that are admitted to write policies in their particular state. To be admitted, these carriers must comply with a number of strict financial and reporting requirements. In some states, if the carrier becomes insolvent, the state will guarantee at least some level of coverage.

Today, many providers are joining large health system-sponsored physician groups. These health systems often elect to self-insure in lieu of using a med mal carrier admitted to the state. One downside to this is that if the health plan becomes insolvent and declares bankruptcy, the state guaranty



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"A provider can negotiate with the system about certain terms in the employment and medical malpractice agreement and consider continuing his or her own coverage in the event that it's not possible to reach a reasonable compromise."

not step into guarantee coverage. In New York, when St. Vincent's Hospital declared bankruptcy in 2010, the physicians were left holding the bag. Before blindly signing on, make an effort to gauge to financial health of the fund and the sponsoring entity.

Another challenge that I have witnessed is that once providers sign on, they lose the ability to determine their own fate. The contracts I have reviewed all give the system a unilateral consent to settle the case on behalf of the physician. I have seen the following situation all too often. A frivolous medical malpractice case is filed. The self-insured determines that the cost of defense (discovery, experts and trial) would likely exceed \$75,000 and makes the purely economic decision to settle a defensible case, thereby throwing the physician under the bus. This triggers a report to the National Practitioners Data Bank and at least in my state, a medical board investigation. A veritable trifecta of abuse is heaped upon the provider solely based on economics. Once an amount is paid, it makes it that much harder for a provider to join other systems or med mal carriers, be admitted to additional states to practice medicine, or to join other organizations.

Even if the health system does agree to cover a provider in

the event of a malpractice action, the provider should stay vigilant for assessing what could become an inherent conflict of interest. An attorney representing a provider who is employed by or on retainer to the system has an inherent conflict, inasmuch as he or she is defending the provider yet being paid by the system. In such cases, the provider may want to retain counsel of his or her own who has been prospectively vetted by the plan.

In addition, many medical malpractice policies cover providers in peer review actions, medical board complaints, and other formal hearings. Providers who are terminated by the very system that provides coverage would be better served to find their own representation, but that likely will be very expensive.

The take-home point is to make sure you understand your rights under a health system's self-insured policy. Before signing the contract, a provider can negotiate with the system about certain terms in the employment and medical malpractice agreement and consider continuing his or her own coverage in the event that it's not possible to reach a reasonable compromise.

Hammer Clause

There are certainly times when settling a malpractice case is the smartest decision. With a consent-to-settle clause, the provider gets to make the final decision. Today, most carriers have a consent-to-settle clause but are tacking on "hammer" clause, which makes the consent clause nearly worthless. A hammer clause essentially compels a provider to settle against his or her will even with a consent-to-settle provision by making it financially hazardous to reject the insurance company's recommendations.

With a hammer clause, if a provider refuses a settlement offer recommended by the insurance carrier, the carrier's exposure is capped at the amount of the proposed settlement offer.

For example, let's say that an insurance company wants to settle a med mal case for \$50,000. The provider refuses because he or she knows that the case is easily winnable and that a settlement would mean significant additional exposure. If the case goes to court and is lost, the carrier will pay only \$50,000 regardless of the final decision. If the judgment is \$150,000,

"Even if the health system does agree to cover a provider in the event of a malpractice action, the provider should stay vigilant for assessing what could become an inherent conflict of interest."

"A provider can negotiate with the system about certain terms in the employment and medical malpractice agreement and consider continuing his or her own coverage in the event that it's not possible to reach a reasonable compromise."

the provider will end up being responsible the other \$100,000.

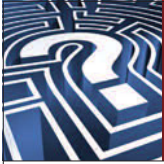
A modified hammer clause limits the carrier's liability to a percentage of the verdict in excess of the proposed settlement. For example, it may set a 50% limit. In the above case, the insurance company would pay the amount of the offered settlement (\$25,000) plus one half of the amount over that figure (\$50,000). The provider remains liable for the final \$75,000.

Here is a worrisome scenario under a policy (like ours) with higher limits. Our emergency medicine group's policy contains a limit of \$2 million per occurrence, meaning that there would likely be no uninsured exposure concerns for a typical claim with a maximum value of \$1 million. However, despite paying the significantly higher premiums, what if our insurer invoked the hammer clause after our refusal to consent to a settlement of \$250,000? We could face potential liability for all legal expenses incurred after the refusal, as well as potential liability for the amount of any judgment in excess of the recommended \$250,000. Essentially, the carrier has morphed our \$2 million policy into a \$250,000 policy.

You won't find the term "hammer clause" in your insurance contract. Typically, the clause is buried in the Defense and Settlement section, using somewhat ambiguous phraseology. For example:

If the Insured refuses to consent to a settlement recommended by the Insurer and elects to contest a Claim, the Insurer's liability shall not exceed the amount for which the Insured would have been liable for loss if the Claim had been so settled when and as recommended, and the Insurer shall have the right to withdraw from the further defense of the Claim by tendering control of the defense thereof to the Insured.

The bottom line is that if you are not sure, carefully read your policy. If you are still not completely sure, call your broker or agent or the carrier. This is not an area in which you can afford to assume anything. ■



INSIGHTS IN IMAGES

CLINICAL CHALLENGE

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

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

FIGURE 1



This patient presented with a painless mass in the leg.

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

Resolution of the case is described on the next page.

THE RESOLUTION

FIGURE 2



Diagnosis: The x-ray reveals an osteochondromatosis (arrows).

Osteochondromatosis is an inherited disorder in which multiple osteochondromas (black arrows) are seen throughout the skeleton.

Patients may have anywhere from 2 osteochondromas to hundreds of them. Most are incidentally found on adolescent x-rays. In the first or second decade of life, if not discovered incidentally, patients present with palpable bony masses and limb shortening.

Complications of osteochondromas include fractures, bony deformities, neurologic and vascular injuries, bursa formation, and malignant transformation.

Acknowledgement:

Case presented by Teleradiology Specialists
(<http://www.teleradiologyspecialists.com>)



ABSTRACTS IN URGENT CARE

- UTI and renal scarring
- PAS scores for appendicitis
- WBC count and appendicitis
- Physician attire and infection control
- Outpatient care of diverticulitis
- Screening for colonoscopy and diverticulitis
- Guidelines for treatment of acute otitis media
- Time to wound closure and infection

■ SEAN M. McNEELEY, MD

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

Prompt Treatment of Pediatric UTI Prevents Renal Scarring

Key point: To avoid renal scarring, don't wait for urine culture in pediatric patients. Treat within 3 days.

Citation: Coulthard MG, Lambert HJ, Vernon SJ, et al. Does prompt treatment of urinary tract infection in preschool children prevent renal scarring: Mixed retrospective and prospective audits. *Arch Dis Child*. 2013 Dec 18; [e-pub ahead of print].

Investigators in England looked at the relationship between time to treatment and renal scarring in two cohorts of patients in Newcastle. Comparison was made between a cohort in the 1990s and one in the 2000s, both composed of children younger than age 8. The two timeframes were chosen because of a change in the way children were triaged. Children in the more recent cohort were seen and treated sooner. The authors looked at time to treatment, time to referral, presence of scarring, and vesicoureteric reflux percentages. The 1990s cohort was retrospective and the 2000s cohort was prospective.

The results showed a reduction in scarring when treatment was initiated in less than 3 days. This study's design and complex statistics were probably less than ideal considering the strength of evidence. From an urgent care perspective, early treatment rather than wait and see what the culture grows should be considered when consistent symptoms or urinalysis are present. The negative from this perspective is the possibil-

ity of overuse of antibiotics. Further research, it is hoped, will better quantify the number needed to treat and number needed to harm when early antibiotics are provided. ■

PAS Scores for Appendicitis of Limited Use in Urgent Care

Key point: Thoughtful use of an appendicitis score and necessary transfer to a hospital with ultrasound capacity may reduce unnecessary radiation.

Citation: Saucier A, Huang EY, Emeremni CA, Pershad J.. Prospective evaluation of a clinical pathway for suspected appendicitis. *Pediatrics*. 2014;133(1):e88-e95.

Appendicitis is frequently a complex diagnosis and if missed, a common cause of litigation. Balancing the risk of missing the diagnosis with unnecessary radiation or transfer can be challenging. Investigators in this study attempted to supplement an appendicitis score with ultrasound to improve accuracy of diagnosis. The appendicitis score used was the Samuel score (PAS) reported in 2002. The following are each one point: anorexia, nausea/emesis, leukocytosis, left shift, and migration to right lower quadrant. The remainder worth two points are right lower quadrant (RLQ) tenderness to light palpation and tenderness at RLQ with cough, percussion, and heel tapping. Scores of 1 to 3 are considered negative and 8 to 10 are considered positive. The authors also used a neutrophil count >75% and a temperature of 38° C.

This study looked at patients aged 4 to 17 who presented to a tertiary care pediatric emergency room and were suspected of having appendicitis. They were then placed in three categories: negative (1-3), positive (8-10) or those with scores in the middle. As with this and the Alvarado score, the largest percentage of patients (61%) were left in the uncertain category. The remaining patients were screened by ul-



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trasound and defined as positive or negative. Positive patients were seen by Pediatric Surgery.

A total of 196 patients were correctly enrolled. Of those with a negative score, 0% were found to have appendicitis on follow up. PAS was found to be 81.5% sensitive and 71% specific. Adding ultrasound increased these values to 92% sensitivity and 95% specificity. From an urgent care perspective, the PAS overall may not be a very helpful method, considering that almost two-thirds of the patients fell into the indeterminate group. However, the performance of the score at the extremes may be helpful. Secondly, when transferring a patient, the ultrasound capacity of the receiving facility should be considered to help reduce the amount of unnecessary radiation. Approximately two-thirds of the group with intermediate PAS scores did not have appendicitis. ■

WBC Count Not Definitive for Appendicitis Diagnosis

Key point: *The best cut off for white blood cell count to rule out appendicitis is still debatable. Raising the number does decrease negative appendicitis surgery rate but it also decreases sensitivity.*

Citation: Bates MF, Khander A, Steigman SA, et al. Use of white blood cell count and negative appendectomy rate. *Pediatrics*. 2014;133(1):e39-e44

The investigators in this study attempted to find factors that may reduce negative appendectomy rates. The study was performed in a retrospective fashion and then confirmed in a prospective manner. After reviewing the patients with a negative appendectomy from previous surgeries, the researchers determined that the only consistent factor was the white blood cell (WBC) count elevation. They determined that raising the WBC count from 8,000 to 9,000 would reduce the normal appendix finding at time of surgery by more than half; however, it would also decrease sensitivity from 95% to 92%. The authors found this decreased sensitivity to be acceptable if patients between the two levels are observed, which is not usually possible in an urgent care setting. Considering that the negative appendectomy rate was already 2.6%, a loss of sensitivity of 3% in the screening function that urgent care centers provide for patients with possible appendicitis is a significant concern. ■

Consider Rolling Up Sleeves to Stem Infection

Key point: *Long sleeves and white coats, although commonly used in medical care, may be vectors of disease.*

Citation: Bearman G, Bryant K, Leekha S, et al. Healthcare per-

sonnel attire in non-operating-room settings. *Infect Control Hosp Epidemiol*. 2014;35(2):107-121.

As stated in the introduction of this article, attire of the physician is steeped in history and symbolism. Concern for the spread of hard-to-treat infections has led to discussion of physician attire. No definitive study about it has been done to date. This article attempts to look at the evidence for possible transmission of disease from health care workers' attire and consider it in light of the current traditions and patient expectations about how a physician should look. Unfortunately due to the lack of definite evidence, the GRADE or similar level of evidence system was not used. Although this document refers to hospital physicians, it is not hard to see how it could also apply to the physician's office or an urgent care center.

Suggestions included bare below the elbow (BBE) policies to avoid the possibility of disease transmission. BBE includes watches and rings. This recommendation was suggested on common-sense grounds alone. Considering white coats, the authors recommend house staff have at least two coats and a convenient method to launder them. They also suggested that a hook be placed for physicians to remove coats and other long-sleeved items before patient contact. Obviously not using white coats would be an alternative, but some facilities require them. Neckties also are frowned upon, but if necessary, should be secured so that patients do not come in contact with them. This article also reviews and comments on patient perception of physicians and their attire. The authors conclude that patients profess a preference for formal attire but when put to the test, attire does not seem to alter patient satisfaction or confidence in providers. ■

Support for Outpatient Care of Diverticulitis

Key point: *Outpatient therapy for selective diverticulitis patients is safe and effective. Unfortunately CT scan—which is not available to most urgent care clinicians—was used to define uncomplicated diverticulitis.*

Citation: Biondo S, Golda T, Kreisler E, et al. Outpatient versus hospitalization management for uncomplicated diverticulitis: A prospective, multicenter randomized clinical trial (DIVER Trial). *Ann Surg*. 2014;259(1):38-44.

Patients with diverticulitis occasionally present to urgent care centers. Although outpatient therapy for diverticulitis is offered by gastroenterologists and urgent care providers alike, it has not been well researched. The authors of this article attempted to find evidence for the safety and effectiveness of outpatient therapy in uncomplicated diverticulitis. The study was a parallel two-arm randomized, controlled trial. Patients who presented with abdominal pain and fever were diagnosed by

screening with plain films and then computed tomography (CT) scans. Those with uncomplicated diverticulitis (defined as pericolic phlegmon) were randomized to inpatient or outpatient therapy. Outpatient subjects were treated with 10 days of amoxicillin, clavulanic acid or ciprofloxacin/metronidazole, if penicillin allergic. Dietary instructions were given as 2 days of liquid diet advancing to low residue for the next few days as tolerated. Paracetamol was used for pain. Outpatients were called daily for 5 days by investigators.

Randomization included 132 patients. No difference in readmission or quality of life measures was noted between the groups. It is hoped that future studies without use of CT or that include patients with reoccurrence will help prove the safety of outpatient treatment for diverticulitis that is often provided in the urgent care setting. ■

Standard Colonoscopy May Apply for Uncomplicated Diverticulitis

Key point: *Patients with acute uncomplicated diverticulitis are no more likely to have cancer or precancerous lesions than a similar asymptomatic population and may be able to follow standard screening colonoscopy recommendations.*

Citation: Sharma PV, Eglinton T, Hider P, Frizelle F. Systematic review and meta-analysis of the role of routine colonic evaluation after radiologically confirmed acute diverticulitis. *Ann Surg.* 2014;259(2):263-272.

Once again, diverticulitis is the topic of an interesting article that may help to decrease medical costs without significant risks to patients. In the introduction, the authors note that diverticula may affect as many as 60% of patients living in industrialized countries. Diverticulitis may occur in as many as 25% of these individuals. In the past, colonoscopy was recommended because of concerns for malignancy and possible misdiagnosis. This meta-analysis reviewed studies from multiple industrialized nations of results of colonoscopy after an acute episode of diverticulitis. Once again, computed tomography (CT) scan was used to define patients with uncomplicated diverticulitis. The authors' definition was similar to the previous article as well, with colonic wall thickening and pericolic fat stranding only defining uncomplicated episodes.

The results of this complicated analysis were consistent with current expectations of colon cancer and precancerous lesions in an asymptomatic population. In other words their meta-analysis found no significant differences between the groups in risk of cancer. From the perspective of urgent care, where CT availability is infrequent, more study must be done to consider applying this to patients without the results of a CT scan. However, if a CT scan is available or performed elsewhere and the results are consistent with uncomplicated diverticuli-

tis, it appears that the risk of cancer or precancerous lesions is not increased. ■

New Guidelines Support Urgent Care Standard for Acute Otitis Media

Key point: *New guidelines will likely support the treatment typically used by urgent care providers for acute otitis media.*

Citation: Rosenfeld RM, Schwartz SR, Cannon CR, et al. Clinical practice guideline: acute otitis externa. *Otolaryngol Head Neck Surg.* 2014;150(1 Suppl):S1-S24.

New guidelines for the treatment of acute otitis externa in patients older than age 2 years were recently released by The American Academy of Otolaryngology – Head and Neck Surgery Foundation. This article is an update of the 2006 guidelines. The following are a few statements and recommendations:

- Hallmark sign is tenderness of tragus or pinna
- *Pseudomonas aeruginosa* and *Staphylococcus aureus* are the most common causes.
- Topical therapy should be first line if uncomplicated.
- Pain should be assessed and treated.
- Physician should ensure proper delivery with instruction or a wick if needed.
- If perforation is possible, medications prescribed should not be ototoxic.
- Failure to improve in 48 to 72 hours should trigger repeat evaluation.

Multiple Factors Impact Wound Infection Rates

Key point: *Time to closure may be less of a risk factor in wound closure than previously believed. Other factors appear to be more important and should be considered when determining need for prophylactic antibiotics.*

Citation: Quinn JV, Polevoi SK, Kohn MA. Traumatic lacerations: What are the risks for infection and has the 'golden period' of laceration care disappeared? *Emerg Med J.* 2014;31(2):96-100.

Methods to reduce wound infection continue to be debated. Most physicians are no longer treating patient with antibiotics if the risk is less than 5%. The importance of time to closure remains debatable. The investigators in this study looked at 27 variables and whether they had an effect on wound infection rates. The multicenter study was performed in prospectively. A total of 2663 patients completed follow up. Only 69 infections were diagnosed (2.5%). Time to wound closure of less than 12 hours was not superior to longer than 12 hours in this study. Other factors did seem to increase the risk of infection. Factors and relative risks (RR) include diabetes (2.7), lower extremity location (4.1) contaminated wounds (2.0) and size >5 cm. ■



MDM, E/M Code with Injection Codes

■ DAVID STERN, MD, CPC

Q. I was approached by a member of the hospital billing department who does urgent care (office based practice) and emergency department billing about a coding question. As the medical director, they asked for my thoughts and support. It's nice to work at a place that includes the docs! The question revolves around prescription drug management within the management options under the medical decision making (MDM) section pertaining to E/M calculation. We currently do not use this as a criterion to determine the billing level. If we were to use this option, I believe we would be able to raise many level 3 visits to level 4 visits.

For example, the patient presents with a sore throat and a rapid strep test is performed. That would most likely be billed as a level 3 by most providers in our group, based on the following information when calculating the MDM:

- Treatment Options: New problem to examiner with added workup = 4, Extensive
- Complexity: Order of clinical lab tests = 1, Minimal
- Risk: Undiagnosed new problem with uncertain prognosis = Moderate
- MDM = Moderate

Based on the information above, we should bill the sore throat/pharyngitis as a level 4, even without taking into account the prescription drug management.

Adding prescription drug management (Rx for Amoxicillin or other drug) would add more support to Treatment Options. I received a Medicare audit suggestion a few years ago about an influenza patient I treated with rapid flu testing and Tamiflu. I

"Most providers cautiously and consistently under-code the E/M so much that most providers cause the practice to lose ~\$50,000 to \$80,000 per year."

billed as a level 3, but the audit suggested level 4. What are your thoughts?

The next example is a patient who presents with an ankle sprain or fracture. An x-ray is ordered, and a prescription for Vicodin is given. We would calculate the MDM as follows:

- Treatment Options: New problem to examiner with added workup = 4, Extensive
- Complexity: Order of radiology test = 1, Minimal
- Risk: Prescription drug management = Moderate
- MDM = Moderate

What are your thoughts on billing level 4 visits in the scenarios presented?

A. It is nice to include the docs, as you say. Unfortunately, we have found that getting providers to consistently code E/M codes correctly is essentially impossible. I discovered years ago that most providers cautiously and consistently under-code the E/M so much that most providers cause the practice to lose ~\$50,000 to \$80,000 per year. Training doctors was almost impossible. Even after taking full-day coding trainings, they would revert to their old habits within a few days. That is why we actually created our EMR - to automate the coding and eliminate these coding errors.

E/M coding is quite complex, but the scenarios that you describe can be coded as a level four (as far as complexity). I just differ a little with the algorithm and results that you show, but the final MDM levels are the same. I have always taken a con-



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“We have found that getting providers to consistently code E/M codes correctly is impossible.”

servative stance and interpreted “work up planned” as referring to a work up that is “planned” to be completed after the actual visit.

Using Marshfield Clinic guidelines for MDM, you can code your scenarios as described below.

The patient presents with a sore throat and a rapid strep test is performed:

- Diagnoses: New problem (to examiner), no workup planned = 3, “Multiple”
- Data Reviewed: Order of clinical lab tests = 1, “Limited”
- Risk: Prescription drug management = 3, “Moderate”
- MDM = Moderate

The patient presents with an ankle sprain or fracture. An x-ray is ordered, and a prescription for Vicodin is given:

- Diagnoses: New problem (to examiner), no workup planned = 3, “Multiple”
- Data Reviewed: Order of clinical lab tests = 1, “Limited”
- Risk: Prescription drug management = 3, “Moderate”
- MDM = Moderate ■

Q. I would like information on coding an E/M code with an intramuscular (IM) injection procedure code for an urgent care EMR.

A. You can bill an E/M code with an IM injection code if a separate E/M service was performed. You would bill the appropriate E/M code with a modifier -25, “Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service.” Keep in mind that some payors may still bundle the E/M service into the injection code, so be sure to check payor agreements.

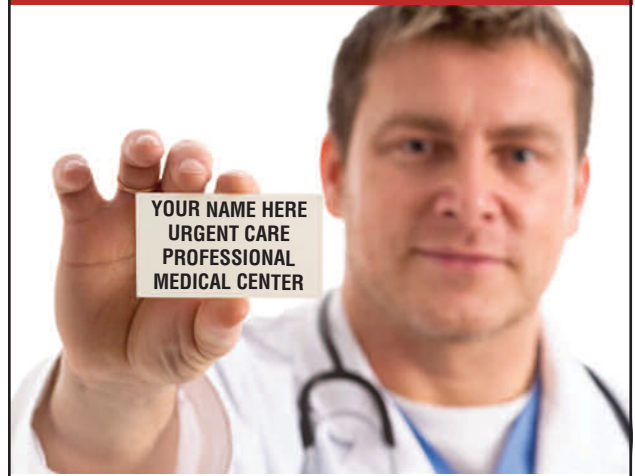
CPT also states, “Do not report 96372 for injections given without direct physician or other qualified health care professional supervision. To report, use 99211....” Therefore, if no physician is on the floor to supervise an injection given by a non-physician, then you can only bill 99211 for the injection service and 96372 is not billable.

You can often also bill the medication supply codes. You would find these codes in the HCPCS Level II manual. ■

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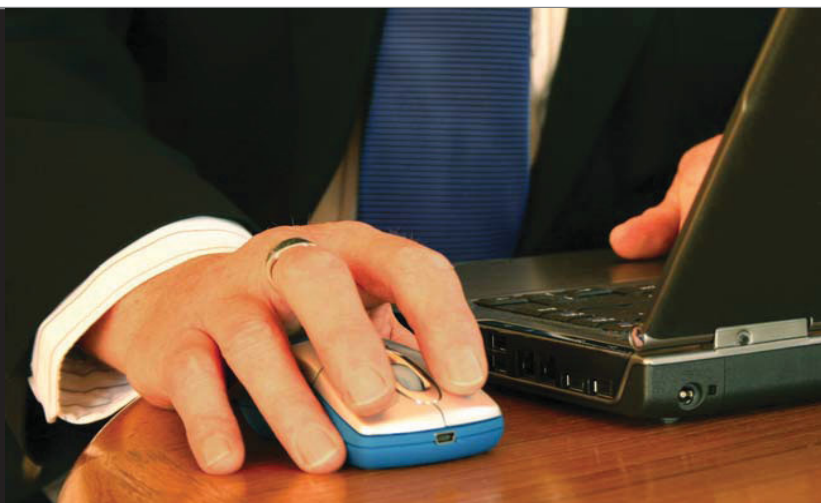
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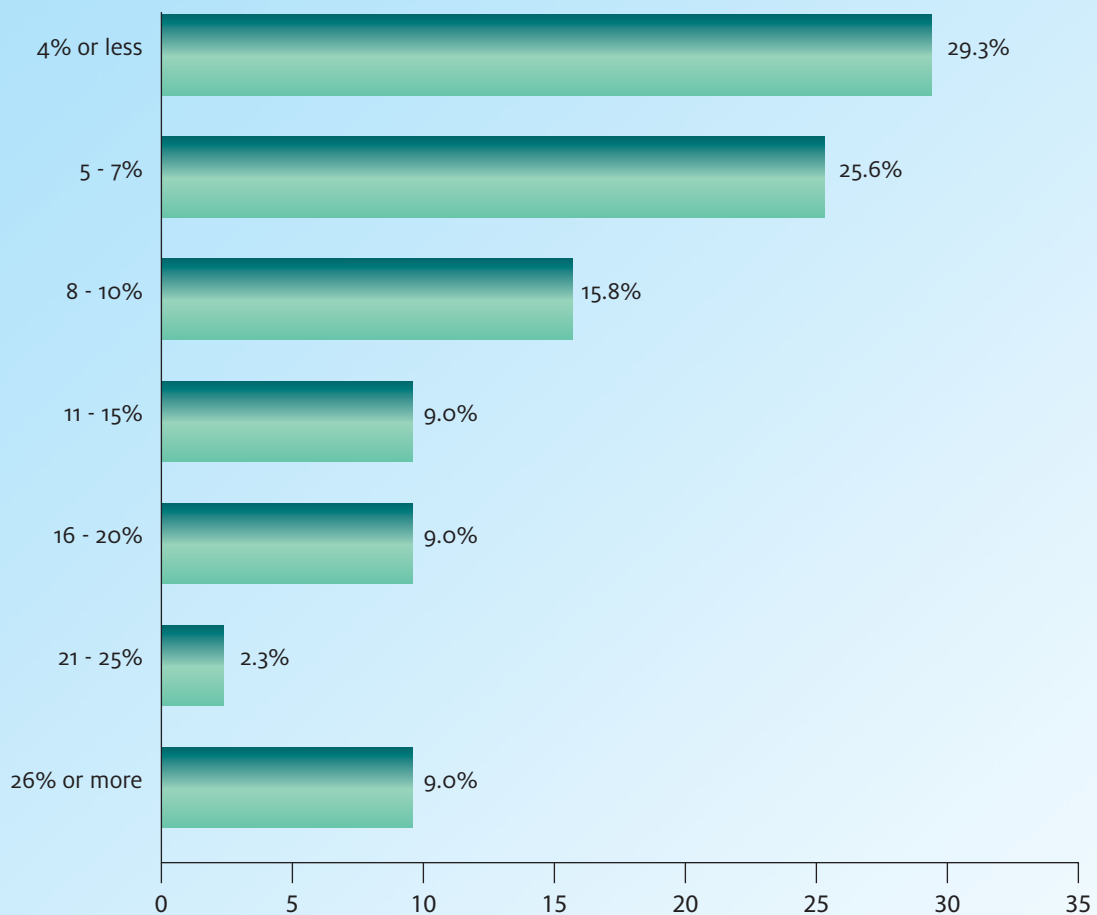


DEVELOPING DATA

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

In this issue: What Percentage of Patients Do Urgent Care Centers Send Elsewhere for Diagnostic Tests?

PERCENTAGE OF PATIENTS URGENT CARE CENTERS SEND ELSEWHERE FOR DIAGNOSTIC TESTS



Most urgent care centers continue to serve as a “one stop shop” for most of their patients, with only 13.1% of all patients being sent elsewhere for diagnostic testing not available onsite (n=133).

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



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