JUCM™

THE JOURNAL OF URGENT CARE MEDICINE®

FEBRUARY 2015
VOLUME 9, NUMBER 5

Urgent Care Association of America

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Also in this issue

Medication Issues in Urgent Care

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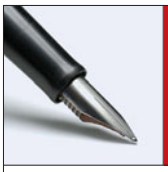


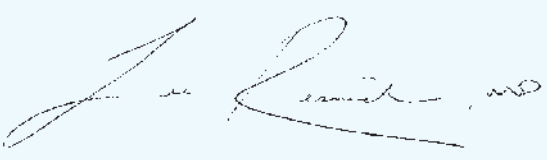
LETTER FROM THE EDITOR-IN-CHIEF

Evaluating Chest Pain in Urgent Care—"Catch 22 and the Three Bears": Part 1

What can Joseph Heller and Goldilocks teach us about managing no-win situations in urgent care? As it turns out, if you look under the covers of Baby Bear's bed, you might find something meaningful, perhaps even something that's "just right." Take the classic no-win situation when patients present to urgent care with chest pain. Without a definitive and reliable test to guide our decision making, we are stuck with the ultimate "damned if you do, damned if you don't" moment: Either send everyone with chest pain to the emergency department (ED) or roll the dice and send some of them home. Neither option is very good. One is "too hot" and one is "too cold." We cannot continue to ignore the problem; nor can we continue to complain about it.

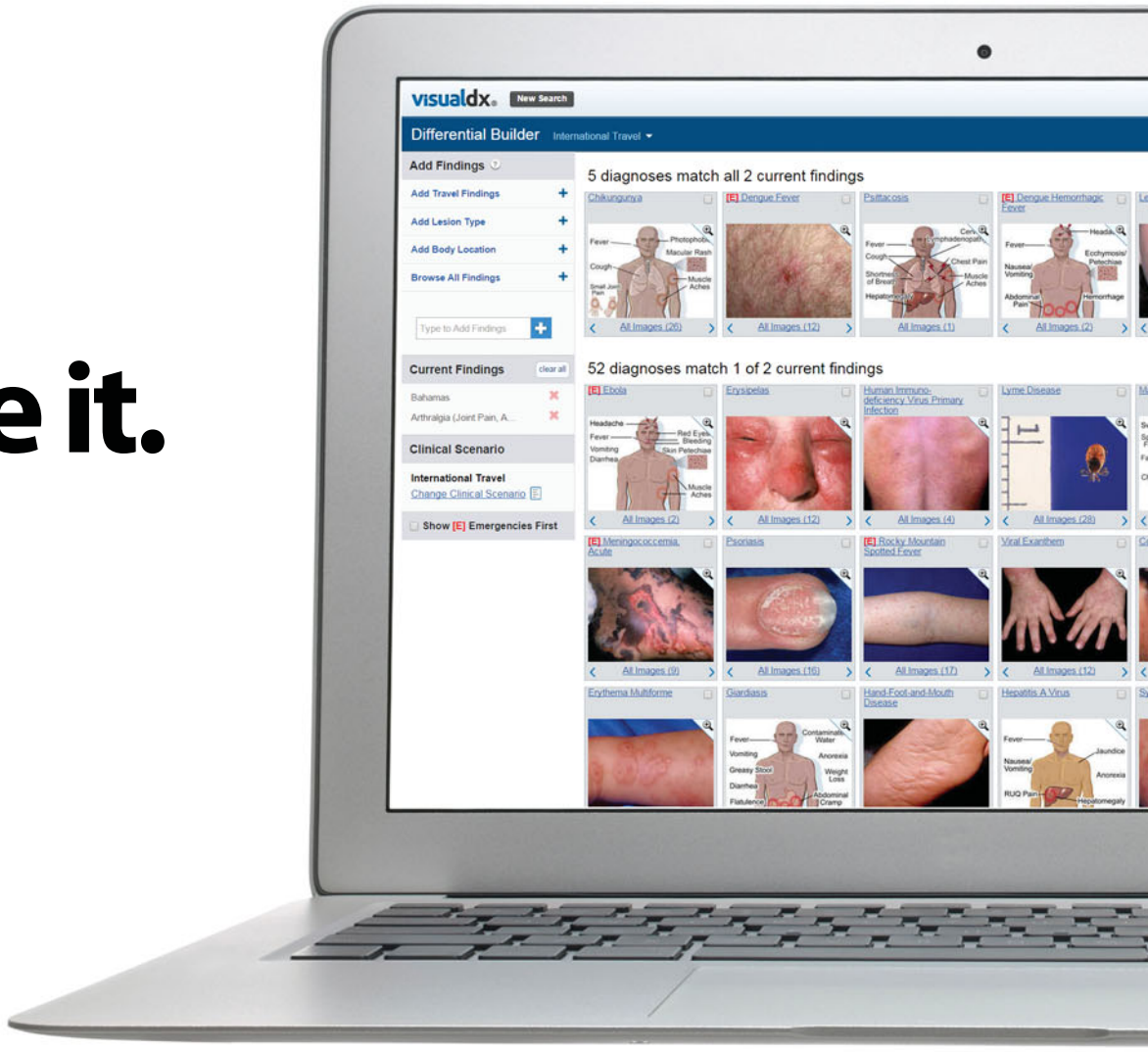
Alternatively, there may be an approach that's "just right," or at least "just right enough." The fact is that the behavior and decision making of most clinicians is driven by the desire to eliminate risk, an idyllic fantasy that simply does not exist. In the absence of risk elimination, we would all agree that risk reduction with a realistic eye toward minimizing false positives and false negatives is our ultimate goal. So what does the evidence tell us, and how can we apply the evidence to our daily routine in a way that reflects best practice? Although most rejectionists among us would say that there is no evidence that defends a balanced approach to managing chest pain in urgent care, the reality reflects otherwise. Several clinical decision tools, along with a few diagnostic tests, can minimize the risk of bad outcome and the risk associated with false alarms. Consider the following approach:

- **Step 1: The first step to evaluating patients with a complaint of chest pain in urgent care is to actually evaluate them.** As absurd as that may sound, the practice of "pre-triaging" patients with chest pain to the ED before completing an evaluation is commonplace in urgent care. Patients are told by front-desk personnel that "we don't see chest pain" and are then referred directly to the ED. In an unrealistic effort to eliminate risk, the urgent care has taken on immeasurable risk by not providing a clinical evaluation. If the patient collapses on the way to the ED or gets into an accident, what will be your defense then? All patients presenting to an urgent care should have an evaluation that is reasonable for their clinical condition.
- **Step 2: Determine whether the patient is stable or unstable.** A patient with chest pain who is clinically unstable (e.g., the patient has altered responsiveness, has significant bradycardia or hypoxia, has hypotension) should trigger the initiation of emergency protocols regardless of underlying cause. If, on the other hand, the patient is clinically stable, then a reasonable and systematic evaluation should follow without bias or emotion.
- **Step 3: Decide whether a transfer is necessary.** There should, of course, be several hard stops in the evaluation that will trigger urgent or emergency transfer. These will vary on the basis of the equipment and testing available but would include things like ST-segment elevation myocardial infarction and an elevated level of cardiac enzymes (e.g., troponin I). It should also be clear that all patients with "typical" chest pain and/or evidence of ischemic changes on electrocardiograms belong in the ED or catheterization laboratory.
- **Step 4: Decide whether the patient can go home.** This is perhaps the most challenging step of them all. Although it may be easy to identify patients who obviously belong in the ED (as described in step 3), it is, conversely, extremely challenging to determine which of the remaining chest-pain presentations can be managed more routinely on an outpatient basis. In next month's column, I will examine this step in detail, including an evidence-based paradigm for sending some chest-pain patients home safely and according to a reasonable standard of care. ■



Lee A. Resnick, MD, FAAFP
Editor-in-Chief, *JUCM, The Journal of Urgent Care Medicine*

I see it.



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February 2015

VOLUME 9, NUMBER 5

CLINICAL

8 Medication Issues in Urgent Care

Patients with multiple medical conditions likely take multiple long-term medications. In the face of polypharmacy, clinicians must be on guard against adverse drug reactions and drug allergies.

Jasmeet Singh Bhogal, MD

PRACTICE MANAGEMENT

22 A Process Approach to Differentiating Your Urgent Care Brand by Ensuring That Patients Leave Satisfied

If your urgent care center is to thrive, you have to differentiate it from other centers. How? Promise and deliver a good patient experience.

Alan A. Ayers, MBA, MAcc

CASE REPORT

28 Serious Pathology Masquerading as Chronic Back Pain

Chronic back pain, a common urgent care presentation, can mask major disease. Urgent care providers cannot assume previous diagnoses are correct.

Jessica Hoffmann, MS-4, and John Shufeldt, MD, JD, MBA, FACEP

IN THE NEXT ISSUE OF *JUCM*

A 50-year-old man who can't make it through the day without taking a nap... a 32-year-old new mother who is tired... an 82-year-old woman who has been exhausted for 2 weeks. Up to 7% of Americans experience fatigue, costing employers more than $130 billion each year. Next month's cover story helps the urgent care practitioner wade through an extensive differential diagnosis with a streamlined approach to diagnosis and management while staying alert for red flags for life-threatening problems.

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Mission Statement
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.

Affiliations
JUCM The Journal of Urgent Care Medicine (www.jucm.com) is published through a partnership between Braveheart Group, LLC (www.braveheart-group.com) and the Urgent Care Association of America (www.ucaoa.org).

Address Changes
JUCM (ISSN 1938-002X) printed edition is published monthly except for August for $50.00 by Braveheart Group LLC, 120 N. Central Avenue, Ste 1N, Ramsey NJ 07446. Periodical postage paid at Mahwah, NJ and at additional mailing offices. POSTMASTER: Send address changes to Braveheart Group LLC, 120 N. Central Avenue, Ste 1N, Ramsey, NJ 07446.

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When patients—especially the elderly—present to an urgent care center with an acute health issue on top of multiple chronic problems, the high likelihood that they already take multiple medications presents several dilemmas for practitioners. Author Jasmeet Singh Bhogal, MD, guides urgent care providers through the hazards of adverse drug events, drug–drug interactions, prescribing cascades, medication underutilization, drug allergies, and pseudoallergic reactions.

Bhogal is medical director of Virtua Express Urgent Care in Sewell, New Jersey.

This month's case report concerns a 37-year-old man with obesity who was sent from an urgent care center to an emergency department after reporting 3 days of severe-on-chronic, constant dull back pain. The patient had a long history of chronic back pain with multiple prior visits to urgent care centers and emergency departments. The diagnosis: Leriche syndrome, which had gone undiagnosed in previous examinations. Authors Jessica Hoffmann, MS-4, and John Shufeldt, MD, JD, MBA, FACEP, note that serious pathology can masquerade as chronic back pain.

Hoffmann is a fourth-year medical student at Creighton University—Phoenix Regional Campus in Phoenix, Arizona. Shufeldt is the principal of Shufeldt Consulting and is on the editorial board of the *Journal of Urgent Care Medicine*.

Health-care consumers may view all urgent care centers as being similar, but by taking specific steps to ensure that patients are completely satisfied when they leave, a center can stand out. Author Alan A. Ayers, MBA, MAcc, writes that if center leaders ensure that all practitioners and support-staff members are concerned with making a good first impression and providing positive experiences all the way from registration and booking through post-visit follow-up and communication, patients not only will become return clients but also will recommend the center to others.

Ayers is on the board of directors of the Urgent Care Association of America, is associate editor of the *Journal of Urgent Care Medicine*, and is vice president of Concentra Urgent Care.

Also in this issue:

In Health Law this month, **John Shufeldt, MD, JD, MBA, FACEP**, talks about what health-care providers should do if they end up in front of their medical board.

Sean M. McNeeley, MD, and the **Urgent Care College of Physicians** review new abstracts from the literature on research important to the urgent care practitioners, including troponin testing for acute coronary syndrome, tramadol and hypoglycemia, press releases versus original research articles, and the use of braces in single-level osteoporotic vertebral fractures.

In Coding Q&A, **David Stern, MD, CPC**, discusses billing in the absence of a payor contract, giving discounts to members of the military, and dealing with missing provider signatures in patients' charts.

Our Developing Data piece shows how the expansion of private insurance coverage in the United States is expected to affect the urgent care industry. ■

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—U.S. urgent care clinicians. Articles submitted for publication in ***JUCM*** should provide practical advice, dealing with clinical and practice management problems commonly encountered in day-to-day practice.

Manuscripts on clinical or practice management topics should be 2,600–3,200 words in length, plus tables, figures, pictures, and references. Articles that are longer than this will, in most cases, need to be cut during editing. The information you provide should be of practical use to our readers, who have come to practice in an urgent care setting from a variety of clinical backgrounds. Your article should take their perspective into account by considering several key issues, such as: What immediate management is indicated? What labs or diagnostics are required? What are the next steps; with whom should the patient follow up? Who should be admitted or referred to the emergency department? Imagine yourself in the reader's shoes and ensure your article includes the answers to questions you'd be asking.

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.

To Subscribe to *JUCM*

JUCM is distributed on a complimentary basis to medical practitioners—physicians, physician assistants, and nurse practitioners—working in urgent care practice settings in the United States. To subscribe, log on to *www.jucm.com* and click on "Subscription."

UCAOA Award Nominations

Celebrate the Urgent Care Industry

The Urgent Care Association of America (UCAOA) invites you to recognize achievements and contributions made to urgent care! Nominate yourself or a colleague for the UCAOA Awards to be presented at the Members' Breakfast during the **2015 Spring Convention, April 27-30**.

Awards Categories

- ***Outstanding Achievement Award:*** The highest honor given by UCAOA, this award recognizes significant achievements in the field of urgent care medicine.
- ***Lifetime Membership Award:*** Recognizes an individual member's significant contributions to the Urgent Care Association of America.
- ***Advocacy Award:*** Honors individuals, organizations or companies for impactful advocacy efforts benefitting patients or the industry on a state or national level.
- ***Community Service:*** Recognizes an individual or organization for significant volunteer initiatives that result in a positive impact on community health.
- ***Humanitarian:*** Recognizes an individual or organization for substantial medical-related volunteer outreach on a national or international level.

Submit your nominations at ucaoa.org/AwardNominations by 5pm Central on February 16, 2015.

If you have questions about the submission process please contact **Ross Reed**, Marketing Communications Specialist, at **rreed@ucaoa.org** or call **331-472-3746**.

Urgent Care Association of America

Stay in the know by following us on

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P. JOANNE RAY

Where do you turn to ensure that you and your team are on top of your clinical and practice management game, to share and network with peers on topics relevant to the challenges you face every day, and to find the strategies that will allow your urgent care center to plan, adapt, and succeed in these changing times?

Make plans today to ensure that you and your colleagues are in Chicago April 27–30, 2015, to participate, learn, and grow at the urgent care industry's largest dedicated gathering of urgent care business and clinical professionals and vendor and support services. Your spot is waiting for you. Year in and year out, the 3-plus conference days change attendees' entire perspectives, challenge their thought processes, and reward them with profound knowledge.

The Spring 2015 program has been completely revamped and expanded to offer you more diverse, relevant practice management and clinical sessions than ever before. As I write this, the education committee has just completed its faculty selections from more than 100 phenomenal submissions. We are planning new speakers, new exhibitors, and new topics, and we are very excited about what is in store for you. The 2015 UCAOA National Urgent Care Convention will provide thought-provoking panel discussions, enlightening keynotes, in-depth and interactive presentations, advanced and basic clinical skills sessions, boundless networking and career development opportunities, and an expansive exhibition hall showcasing more than 150 companies that provide the industry's most innovative products, technologies, and services. Look what you can do:

- **Select from three Practice Management Tracks and one all-new Urgent Care at the Crossroads Track.** Go beyond day-to-day operations and understand how to effectively strategize, plan, adapt, and connect to the future of urgent care. The educational content presented in these tracks is forward-looking, engaging, and thought-provoking and will be delivered by influential experts with proven business acumen both inside and outside of the urgent care industry.

- **Gain clinical skills and knowledge through Basic and Advanced Clinical Tracks geared specifically for healthcare practitioners treating the diverse urgent care patient population.** Presenting faculty members work in urgent care medicine, so you will get real-world advice and scenarios that apply to your daily clinical environment.
- **Take advantage of your time away from the urgent care center and register for one of the new Practice Management or Hands-On Clinical Boot Camp Pre-convention Courses to be held April 26 and 27!**
- **Bring your colleagues and your family.** Remember, there are discounts for 4 or more people registering together. Local urgent care representatives are planning organized activities for all interests to experience a bit of what Chicago has to offer.

Visit the official web site of the 2015 Spring Convention [http://www.eventscribe.com/2015/UCAOA/] to learn more about the education program, hotel and travel, exhibit hall, special events and networking, and more. You can't afford to miss the 2015 Spring Convention if you're an urgent care owner, physician, nurse practitioner, physician assistant, clinic manager, administrator, director, marketing representative, human resources manager, compliance manager, billing and collections specialist/manager, or coder or vendor.

Register today! Go to http://www.eventscribe.com/2015/UCAOA/ or call the UCAOA office at 800-698-2262. ■

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

Clinical

Medication Issues in Urgent Care

Urgent message: Polypharmacy—taking multiple medications to treat several chronic medical problems—puts patients at increased risk of developing additional health issues when they are prescribed even more medications for acute conditions in an urgent care center.

JASMEET SINGH BHOGAL, MD

Introduction

It is not uncommon for patients, especially elderly patients, presenting to an urgent care center to have multiple medical problems. This makes it more likely that they are taking multiple medications as well. In fact, according to a 2010 report by the Centers for Disease Control and Prevention (CDC), almost 40% of older Americans have taken five or more prescription medications in a month. Twenty percent of Medicare beneficiaries have five or more chronic conditions, and 50% take five or more medications.[1] The use of multiple medications presents a unique challenge to the urgent care provider: How do we balance the acute needs of the presenting condition with the potential for adverse reactions so commonly associated with polypharmacy?

This article focuses on the issues surrounding the use of multiple medications in an urgent care setting, with the goal of helping the urgent care provider make better care decisions while balancing the risk of adverse reactions with the benefit of treatment.

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Polypharmacy

Polypharmacy is the use of multiple medications by a patient, including over-the-counter medications and herbal remedies.[2] This is of particular concern in older patients, in whom there is already a greater risk of adverse events because of decreased medication clearance and other metabolic changes. The use of multiple medications is also independently associated with an increased risk for an adverse drug event (ADE), regardless of age.[3] Prescribing in the face of polypharmacy requires significant

Jasmeet Singh Bhogal, MD, is Medical Director of Virtua Express Urgent Care, Sewell City, New Jersey.

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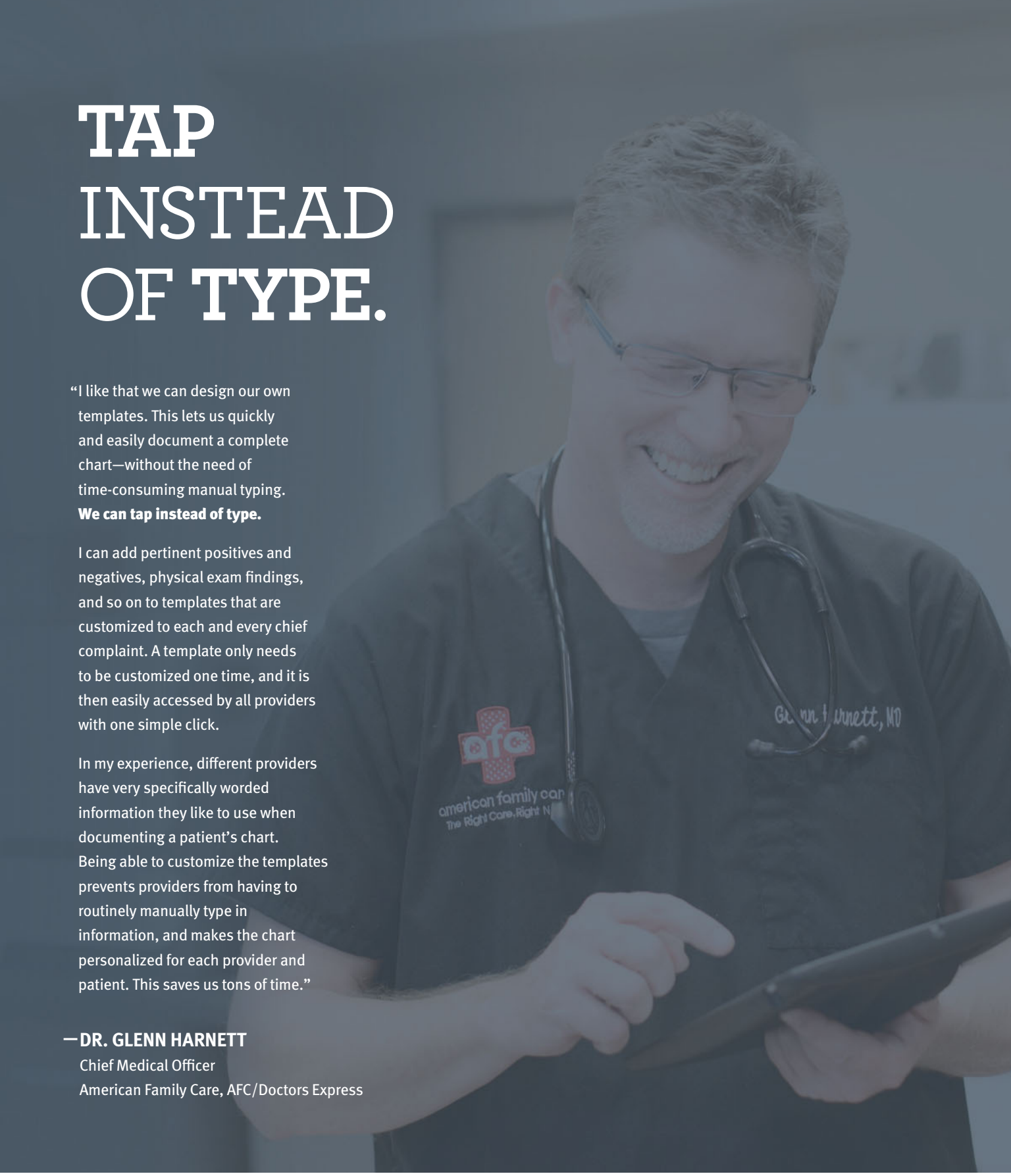

"I like that we can design our own templates. This lets us quickly and easily document a complete chart—without the need of time-consuming manual typing. **We can tap instead of type.**

I can add pertinent positives and negatives, physical exam findings, and so on to templates that are customized to each and every chief complaint. A template only needs to be customized one time, and it is then easily accessed by all providers with one simple click.

In my experience, different providers have very specifically worded information they like to use when documenting a patient's chart. Being able to customize the templates prevents providers from having to routinely manually type in information, and makes the chart personalized for each provider and patient. This saves us tons of time."

—DR. GLENN HARNETT
Chief Medical Officer
American Family Care, AFC/Doctors Express

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Table 1. Summary of 2012 American Geriatrics Society's Beers Criteria for Potentially Inappropriate Medication Use in Older Adults

Organ System, Therapeutic Category, Drug Type, and Disease or Syndrome	Rationale	Recommendation	Quality of Evidence	Strength of Recommendation
Anticholinergics (Excludes Tricyclic Antidepressants)				
First-generation antihistamines (as single agent or as part of combination products):	Highly anticholinergic; clearance reduced with advanced age, and tolerance develops when used as hypnotic; increased risk of confusion, dry mouth, constipation, and other anticholinergic effects/toxicity	Avoid	Hydroxyzine and promethazine: high; all others: moderate	Strong
Brompheniramine Chlorpheniramine Cyproheptadine Dexbrompheniramine Dexchlorpheniramine Diphenhydramine (oral) Hydroxyzine Promethazine	Use of diphenhydramine in special situations such as acute treatment of severe allergic reaction may be appropriate			
Antispasmodics: Belladonna alkaloids Clidinium-chlordiazepoxide Dicyclomine Hyoscyamine Scopolamine	Highly anticholinergic, uncertain effectiveness	Avoid except in short-term palliative care to decrease oral secretions	Moderate	Strong
Anti-infective				
Nitrofurantoin	Potential for pulmonary toxicity; safer alternative available; lack of efficacy in patients with creatinine clearance of <60 mL/min due to inadequate drug concentration in the urine	Avoid for long-term suppression; avoid in patients with creatinine clearance of <60 mL/min	Moderate	Strong
CNS				
Benzodiazepines, short- and intermediate-acting: Alprazolam Estazolam Lorazepam Oxazepam Temazepam Triazolam	Older adults have increased sensitivity to benzodiazepines and decreased metabolism of long-acting agents. In general, all benzodiazepines increase risk of cognitive impairment, delirium, falls, fractures, and motor vehicle accidents in older adults.	Avoid benzodiazepines (any type) for treatment of insomnia, agitation, or delirium	High	Strong
Nonbenzodiazepine hypnotics: Eszopiclone Zolpidem Zaleplon	Benzodiazepine-receptor agonists that have adverse events similar to those of benzodiazepines in older adults	Avoid chronic use (>90 days)	Moderate	Strong
GI				
Metoclopramide	Can cause extrapyramidal effects, including tardive dyskinesia; risk may be further increased in frail older adults	Avoid, unless for gastroparesis	Moderate	Strong
Pain Medications				
Meperidine	Not an effective oral analgesic in dosages commonly used; may cause neurotoxicity; safer alternatives available	Avoid	High	Strong

Table 1. Summary of 2012 American Geriatrics Society's Beers Criteria for Potentially Inappropriate Medication Use in Older Adults (Continued)

Organ System, Therapeutic Category, Drug Type, and Disease or Syndrome	Rationale	Recommendation	Quality of Evidence	Strength of Recommendation
Non-COX-selective NSAIDs, oral:	Increases risk of GI bleeding/peptic ulcer disease in high-risk groups Use of proton-pump inhibitor or misoprostol reduces but does not eliminate risk.	Avoid chronic use unless other alternatives are not effective and patient can take gastroprotective agent (proton-pump inhibitor or misoprostol)	Moderate	Strong
Aspirin >325 mg/d				
Diclofenac				
Diflunisal				
Etodolac				
Fenoprofen				
Ibuprofen				
Ketoprofen				
Meclofenamate				
Mefenamic acid				
Meloxicam				
Nabumetone				
Naproxen				
Oxaprozin				
Piroxicam				
Sulindac				
Tolmetin				
Indomethacin	Increases risk of GI bleeding/peptic ulcer disease in high-risk groups (see "Non-COX-selective NSAIDs, oral" in this table) Of all the NSAIDs, indomethacin has most adverse effects.	Avoid	Moderate High	Strong
Ketorolac, includes parenteral				
Skeletal muscle relaxants:	Most muscle relaxants are poorly tolerated by older adults because of anticholinergic adverse effects, sedation, increased risk of fractures; effectiveness at dosages tolerated by older adults is questionable	Avoid	Moderate	Strong
Carisoprodol				
Chlorzoxazone				
Cyclobenzaprine				
Metaxalone				
Methocarbamol				
Orphenadrine				
Aspirin for primary prevention of cardiac events	Lack of evidence of benefit versus risk in individuals ≥80 years old	Use with caution in adults ≥80 years old	Low	Weak
Beers Criteria for Potentially Inappropriate Medications That May Cause Drug–Disease or Drug–Syndrome Interactions That May Exacerbate the Disease or Syndrome				
Cardiovascular				
Disease or Syndrome	**Drug(s)**	**Recommendations and Rationale**	**Quality of Evidence**	**Strength of Recommendation**
Heart failure	NSAIDs and COX-2 inhibitors	Avoid	NSAIDs: moderate; CCBs: moderate; thiazolidinediones (glitazones): high; cilostazol: low; dronedarone: moderate	Strong
	Nondihydropyridine CCBs (avoid only for systolic heart failure)	Potential to promote fluid retention and/or exacerbate heart failure		
	Diltiazem			
	Verapamil			
	Pioglitazone, rosiglitazone			
	Cilostazol			
	Cilostazol			
CNS				
Chronic seizures or epilepsy	Bupropion	Avoid Lowers seizure threshold; may be acceptable in patients with well-controlled seizures in whom alternative agents have not been effective	Moderate	Strong
	Chlorpromazine			
	Clozapine			
	Maprotiline			
	Olanzapine			
	Thioridazine			
	Thiothixene			
	Tramadol			

Table 1. Summary of 2012 American Geriatrics Society's Beers Criteria for Potentially Inappropriate Medication Use in Older Adults (Continued)

Beers Criteria for Potentially Inappropriate Medications That May Cause Drug–Disease or Drug–Syndrome Interactions That May Exacerbate the Disease or Syndrome

Disease or Syndrome	Drug(s)	Recommendations and Rationale	Quality of Evidence	Strength of Recommendation
Delirium	All TCAs	Avoid	Moderate	Strong
	Anticholinergics	Avoid in older adults with or at high risk of delirium because of inducing or worsening delirium in older adults; if discontinuing drugs used chronically, taper to avoid withdrawal symptoms		
	Benzodiazepines			
	Chlorpromazine			
	Corticosteroids			
	H_2-receptor antagonist			
	Meperidine			
	Sedative hypnotics			
	Thioridazine			
Dementia and cognitive impairment	Anticholinergics	Avoid	High	Strong
	Benzodiazepines			
	H_2-receptor antagonists	Avoid because of adverse CNS effects.		
	Zolpidem			
	Antipsychotics, chronic and as-needed use	Avoid antipsychotics for behavioral problems of dementia unless nonpharmacologic options have failed and patient is a threat to themselves or others. Antipsychotics are associated increased risk of cerebrovascular accident (stroke) and mortality in persons with dementia.		
History of falls or fractures	Anticonvulsants	Avoid unless safer alternatives are not available; avoid anti-convulsants except for seizures. Ability to produce ataxia, impaired psychomotor function, syncope, and additional falls; shorter-acting benzodiazepines are not safer than long-acting ones.	High	Strong
	Antipsychotics			
	Benzodiazepines			
	Nonbenzodiazepine hypnotics:			
	Eszopiclone			
	Zaleplon			
	Zolpidem			
	TCAs and SSRIs			
Insomnia	Oral decongestants:	Avoid; CNS stimulant effects	Moderate	Strong
	Pseudoephedrine			
	Phenylephrine			
	Stimulants:			
	Amphetamine			
	Methylphenidate			
	Pemoline			
	Theobromines:			
	Theophylline			
	Caffeine			
Parkinson disease	All antipsychotics (except for quetiapine and clozapine)	Avoid; dopamine receptor antagonists with potential to worsen parkinsonian symptoms	Moderate	Strong
	Antiemetics:			
	Metoclopramide			
	Prochlorperazine			
	Promethazine			
GI				
Chronic constipation	First-generation antihistamines as single agent or part of combination products:	Avoid unless no other alternative Ability to worsen constipation; agents for urinary incontinence: antimuscarinics overall differ in incidence of constipation; response variable; consider alternative agent if constipation develops	For urinary incontinence: high; all others: moderate/low	Weak
	Brompheniramine (various)			
	Carbinoxamine			
	Chlorpheniramine			
	Clemastine (various)			
	Cyproheptadine			
	Dexbrompheniramine			
	Dexchlorpheniramine (various)			
	Diphenhydramine			
	Doxylamine			

Table 1. Summary of 2012 American Geriatrics Society's Beers Criteria for Potentially Inappropriate Medication Use in Older Adults (Continued)

Disease or Syndrome	Drug(s)	Recommendations and Rationale	Quality of Evidence	Strength of Recommendation
GI				
	Hydroxyzine			
	Promethazine			
	Triprolidine			
	Anticholinergics/antispasmodics			
	Antipsychotics			
	Belladonna alkaloids			
	Clidinium-chlordiazepoxide			
	Dicyclomine			
	Hyoscyamine			
	Propantheline			
	Scopolamine			
	Tertiary TCAs:			
	Amitriptyline			
	Clomipramine			
	Doxepin			
	Imipramine			
	Trimipramine			
History of gastric or duodenal ulcers	Aspirin (>325 mg/d)	Avoid unless other alternatives are not effective and patient can take gastroprotective agent (proton-pump inhibitor or misoprostol)	Moderate	Strong
	Non-COX-2 selective NSAIDs	May exacerbate existing ulcers or cause new/additional ulcers		
Kidney/Urinary Tract				
Chronic kidney disease stages IV and V	NSAIDs	Avoid; may increase risk of kidney injury	Moderate	Strong
Lower urinary tract symptoms, benign prostatic hyperplasia	Inhaled anticholinergic agents Strongly anticholinergic drugs, except antimuscarinics for urinary incontinence	Avoid in menMay decrease urinary flow and cause urinary retention	Moderate	Inhaled agents: strong; all others: weak

CCB, calcium-channel blocker; CNS, central nervous system; COX, cyclooxygenase; GI, gastrointestinal; NSAID, nonsteroidal anti-inflammatory drug; TCA, tricyclic antidepressant.

caution, and the urgent care provider must seriously consider the implications of prescribing medications to any patient who is already taking multiple medications.

Two of the most important concerns associated with polypharmacy include the prescription of and use of inappropriate medications and the increased incidence of ADEs. Additionally, and perhaps underappreciated, the avoidance of medically necessary medication out of fear of adverse reactions is also common in the setting of polypharmacy. Each concern will be discussed here.

Inappropriate Medications

The prescription of inappropriate medications can have devastating implications for the patient in any setting, not just in an urgent care setting. Several tools have been developed to minimize the risk of inappropriate prescribing, including the Beers criteria, Screening Tool of Older Person's Prescriptions (STOPP), and Fit fOR The Aged (FORTA). Of these, the Beers criteria are the most widely used.

The Beers Criteria

The Beers criteria are intended for use in ambulatory and institutional settings in patients aged 65 and older, with the goal of improving care by reducing patients' exposure to potentially inappropriate medications (PIMs) and thus avoid ADEs. Established in 1991, the Beers criteria have undergone three revisions, most recently in 2012. The criteria are to be used along with clinical judgment. They are not intended to forbid the necessary use of the listed medications. When any of the medications are required, their use should be individualized for the patient, preferably by a medical team, to take into account all risks and benefits. When alternative medications cannot be found or used, patients taking them must be monitored for ADEs. The criteria include 53 medications categorized into three classes:

1. Drugs that should be avoided
2. Medications that are potentially inappropriate for use in older adults because of drug–disease or drug–syndrome interactions that may exacerbate the disease or syndrome

3. PIMs to be used with caution in older adults

Table 1 highlights medications included in the 2012 American Geriatrics Society Beers criteria as PIMs for older adults. The table includes medication categories and individual medications that are commonly used in the urgent care setting and hence should be considered when treating older patients in that setting. The complete Beers lists are available on the following websites:

- http://www.americangeriatrics.org/health_care_ professionals/clinical_practice/clinical_guidelines_recommendations/2012
- http://www.americangeriatrics.org/files/documents/beers/PrintableBeersPocketCard.pdf

Of all the medications listed in the Beers criteria, anticholinergics deserve special attention because of their frequent use, and misuse, in the urgent care setting.

Anticholinergics

More than 1 in 5 elderly patients with dementia take drugs that have clinically significant anticholinergic activity.[4] The use of anticholinergics in the general population is likewise commonplace and includes several over-the-counter medications. Adverse effects of these medications include the following:

- Confusion
- Hallucinations
- Dry mouth
- Blurred vision
- Constipation
- Nausea
- Urinary retention (precipitation of acute retention in existing benign prostatic hypertrophy)
- Impaired sweating
- Tachycardia
- Precipitation of acute glaucoma episode in existing narrow-angle glaucoma

Although many medications have anticholinergic activity, some are routinely prescribed in the urgent care setting and therefore deserve special attention, including these:

- Antihistamines
  - Cimetidine
  - Cetirizine
  - Chlorpheniramine
  - Diphenhydramine
  - Hydroxyzine
  - Loratadine
  - Ranitidine
- Antispasmodics
  - Carisoprodol
  - Dicyclomine

- Baclofen
- Antinausea and antidiarrhea agents
  - Promethazine
  - Loperamide
  - Metoclopramide

The Anticholinergic Risk Scale has been developed to assess the risk of anticholinergic adverse effects.[5] According to this scale, the risk of anticholinergic adverse effects increases if the score is 3 or higher. This scale can be used as a tool to identify patients who are at a risk of developing anticholinergic adverse effects when prescribed such medications. There is some evidence to show that this score may be useful in acute settings to improve risk stratification.[6] In an urgent care setting, it can be helpful determining the pros and cons of prescribing these medications, especially in patients who are already taking medications that have anticholinergic effects. The cumulative effect of multiple medications on the list significantly adds to the risk of adverse events.

Adverse Drug Events

An ADE is defined as any injury that occurs from a drug, including noxious responses, drug administration errors, and any other circumstances that lead to an injury. Drug-related hospitalizations account for 2.4% to 6.5% of all medical admissions in the general population; the proportion is much higher for older patients.[7] According to the CDC, more than 700,000 individuals are seen in hospital EDs for ADEs each year in the United States. Nearly 120,000 of these patients need to be hospitalized for further treatment. Older adults (aged 65 years or older) are also twice as likely as others to go to US EDs for ADEs, representing more than 177,000 emergency visits each year.

Factors that increase the risk of ADEs include

- Coexisting and multiple medical conditions
- Old age
- Use of multiple medications

Although it may be hard to avoid an ADE when a medication is being prescribed for the first time, certain scenarios must be investigated when prescribing new medications:

- Dose-related ADEs
- Drug–drug interactions
- Prescribing cascades

Dose-Related Adverse Drug Events

Dose-related ADEs are seen more commonly in failure to adjust drug doses for renal insufficiency or impairment. A common error is the failure to obtain a medical history of existing renal problems, or worse yet, obtaining such a history but not accounting for it when prescribing medications. Given the pace of urgent care work, this vital information can easily be missed. It is also important to recognize impairment in elderly patients, because advancing age itself leads to

decreased renal function. Also, in the elderly population, the calculated creatinine clearance rate may not adequately reflect renal function.[8] The commonly used methods used for determining creatinine clearance include the following:

- Cockcroft-Gault equation
- Modification of Diet in Renal Disease (MDRD) Study equation[9]
- Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) equation[10]

The Cockcroft-Gault equation is used to calculate creatinine clearance in patients with a stable serum creatinine level. It uses the patient's sex, age, and lean body weight to calculate creatinine clearance. Although this equation was developed when obesity was less common, most drug-dosing guidelines have been developed using the Cockcroft-Gault equation. Given this, the most common drugs prescribed in the urgent care setting would require renal dose adjustments based on creatinine clearance, as derived from the Cockcroft-Gault equation. The equation, which does not use body surface area in calculating creatinine clearance, is as follows:

creatinine clearance = sex ×
[(140 – age)/(serum creatinine)] × (weight/72)

Dosing guidelines for patients who have decreased creatinine clearance are available via many resources, including medical software and websites such as Epocrates.com, Lexicomp Online (https://online.lexi.com), and Drugs.com (at http://www.drugs.com/dosage/). These are especially useful for safe dosing practices in elderly patients who require antibiotics to treat such conditions as pneumonia, urinary tract infections, and cellulitis.

Drug–Drug Interactions

Drug–drug interactions must be considered for every urgent care patient who is taking multiple medications. Risk of an ADE because of drug–drug interactions is substantially increased when multiple drugs are taken.[11] Older patients are more prone than other groups to drug–drug interactions because they take more medications, including cardiac and blood-thinning medications, which have serious interactions with various other medications. Common examples of medications causing drug–drug interactions include the following:

- **Nonsteroidal anti-inflammatory drugs (NSAIDs):** When patients are receiving warfarin therapy, they are at increased risk of bleeding if they are given NSAIDs.
- **Clarithromycin:** Patients taking digoxin are 12 times more likely to develop digoxin toxicity if they are given clarithromycin.
- **Azithromycin:** According to warnings from the U.S. Food and Drug Administration, azithromycin can cause abnormal changes in the electrical activity of the heart that may lead to a potentially fatal irregular heart rhythm. Patients at particular risk for developing this condition include those with known risk factors, such as the following:
  - Existing QT interval prolongation
  - Low blood levels of potassium or magnesium
  - Bradycardia

Table 2. Characteristics of the Main Types of Adverse Drug Reactions

Type A	Type B
85%–90% of all drug reactions	10%–15% of all drug reactions
Occur in healthy individuals when given a sufficient dose and duration of the medication	Occur in a subgroup of patients who are susceptible
Predictable, based on known pharmacologic properties of the drug	Mostly unpredictable, usually mediated by immunologic response
Includes:	Includes:
Overdose	Idiosyncratic (not attributable to known pharmacologic properties of the drug; not immune-mediated either)
Adverse effects	Intolerance (adverse effects at subtherapeutic doses)
Drug interactions	Immunologic reaction (allergy)
Secondary effects	

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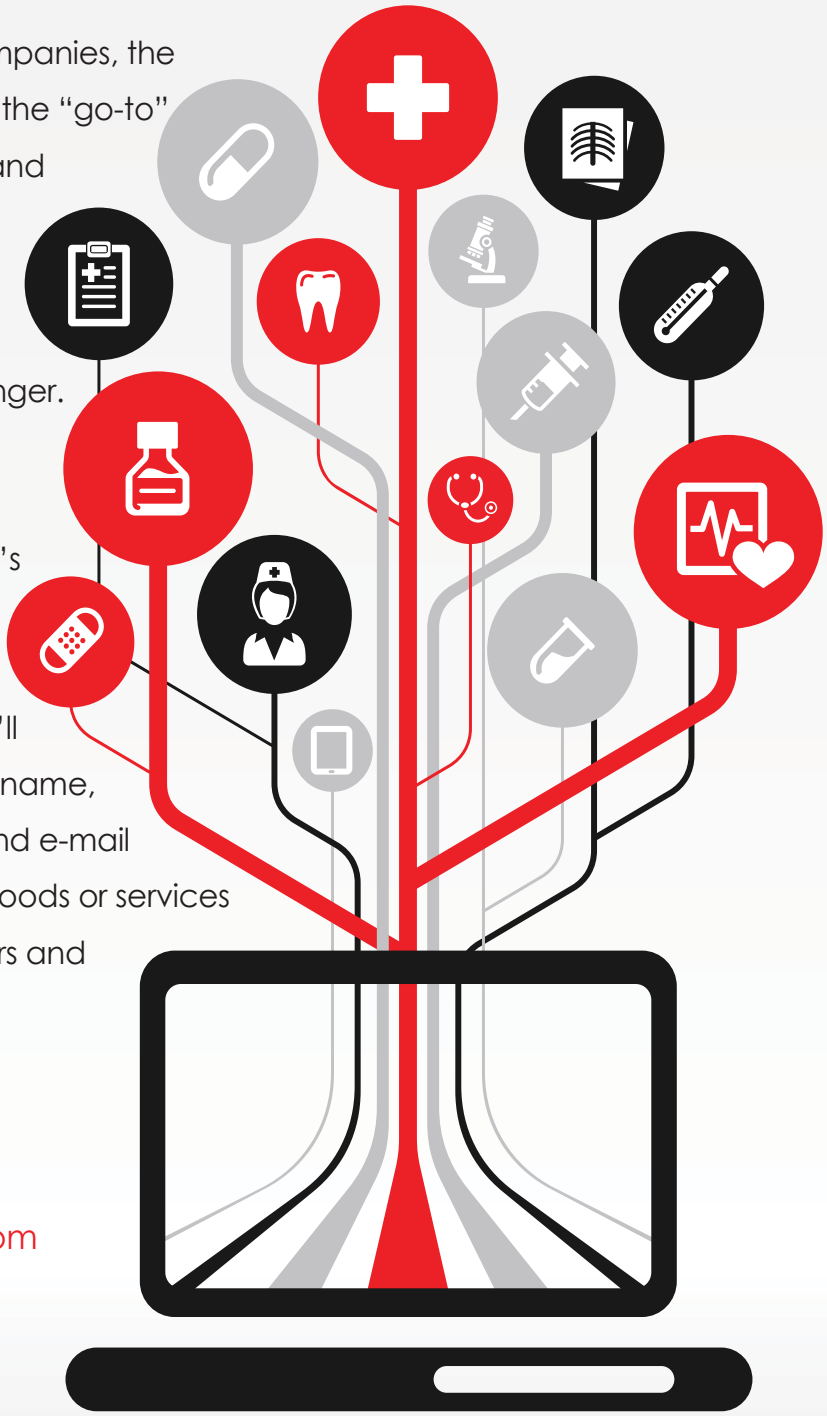

Whichever format you choose, you'll find complete contact information-name, address, phone number, website and e-mail addresses-for companies offering goods or services relevant to urgent care clinic owners and practitioners.

www.urgentcarebuyersguide.com

Table 3. Subtypes of Type B Drug Reactions

Type	Onset	Mechanism	Clinical Presentation	Agents
I	Immediate	IgE-mediated activation of mast cells and basophils	Urticarial rash; pruritus; flushing; angioedema of face, extremities, laryngeal tissues; wheezing; gastrointestinal symptoms; hypotension	Penicillin, cephalosporins, quinolones
II	Delayed: 5–8 days after exposure, sometimes even longer	IgG-mediated cell destruction	Hemolytic anemia, thrombocytopenia, neutropenia, agranulocytosis	Propylthiouracil, flecainide
III	Delayed: 1–2 weeks after exposure	IgG–drug complex deposition and complement activation	Serum sickness: fever, purpuric rash, arthralgias, acute glomerulonephritis Vasculitis: Purpuric/petechial rash, fever, arthralgias, lymphadenopathy, low complement levels Arthus reaction: localized swelling, erythema, and skin necrosis	Antitoxins (rabies, botulinum) Penicillin, cephalosporins, quinolones Tetanus, diphtheria, hepatitis B vaccines
IV	Delayed: At least 48–72 hours after exposure, sometimes days to weeks	T-cell-mediated	Contact dermatitis Maculopapular eruptions Drug fever Acute generalized exanthematous pustulosis Symmetrical drug-related intertriginous and flexural exanthema Stevens-Johnson syndrome Drug-induced hypersensitivity syndrome	Trimethoprim-sulfamethoxazole, minocycline, sulfasalazine, amoxicillin

IgE, Immunoglobulin E; IgG, Immunoglobulin G.

- Use of certain drugs used to treat arrhythmias
- Increased risk of QTc prolongation with use of azithromycin and citalopram, because both medications independently increase the risk of QTc prolongation

- Trimethoprim-sulfamethoxazole
  - Increased risk of hypoglycemia when used with sulfonylureas
  - Increased risk of hyperkalemia when used with
    - Angiotensin-converting-enzyme inhibitors
    - Angiotensin II receptor blockers
    - Spironolactone
- Increased risk of serotonin syndrome with a combination of any of the following drugs:
  - Amphetamines
  - Cocaine
  - Levodopa, carbidopa-levodopa
  - Tramadol
  - Selective serotonin reuptake inhibitors
  - Bupropion
  - Tricyclic antidepressants
  - Ondansetron
  - Valproate
  - Carbamazepine
  - Cyclobenzaprine
  - Buspirone
  - Triptans
  - Ergot derivatives
  - Lithium

Urgent care providers should be actively looking for these interactions before prescribing medications. A thorough and systematic review of the patient's medical history and the medications they are taking is very important to make sure that important drug–drug interactions are not missed when adding new medications at the urgent care visit. Also, if the medication has to be prescribed out of clinical necessity, a thor-

ough discussion of drug interactions with the patient should be part of the overall discussion. This helps the patient understand what signs and symptoms to look for if an ADE does occur because of drug–drug interactions. Documentation of the following is necessary when prescribing despite the possibility of drug–drug interactions:

- Clinical decision making related to why the benefit outweighs the risk (low likelihood or low risk of interaction, no alternative, risk of nontreatment outweighs risk of adverse reaction)
- The patient's understanding and acceptance of risk
- Anticipatory guidance for the patient

Various online resources Epocrates.com, Lexicomp Online (https://online.lexi.com), and Medscape's Drug Interaction Checker (http://reference.medscape.com/drug-interactionchecker) are available for checking these interactions.

Table 4. Description of Adverse Drug Reactions

Reaction	Examples
Overdose	Acetaminophen: hepatic failure Aspirin: metabolic acidosis
Adverse effects	Diphenhydramine: drowsiness
Secondary effects	Antibiotic: diarrhea Doxycycline: phototoxicity
Intolerance	Single dose of aspirin: tinnitus
Idiosyncratic	Nonsteroidal anti-inflammatory drugs: pseudoallergy

"A thorough and systematic review of the patient's medical history and the medications they are taking is very important to make sure that important drug–drug interactions are not missed when adding new medications at the urgent care visit."

Prescribing Cascades

Prescribing cascades occur when a new drug is prescribed to treat symptoms arising from an unrecognized ADE related to an existing therapy.[12] Again, this is of special concern in the elderly population. Given the fast-paced environment of the urgent care setting, these cascades can easily be overlooked without a dedicated effort to consider them. This is exacerbated when providers use more medications to treat the very symptoms created by existing medications. Sometimes, however, the initial treatment is unavoidable, and new medications have to be prescribed to control their adverse effects. Even when this is necessary, caution must be exercised to avoid further complications or adverse reactions. Examples of prescribing cascades include the following:

- Thiazide diuretic → gout → gout treatment
- NSAID → elevated blood pressure → antihypertension therapy
- Opioids → constipation → laxatives
- Antipsychotic medications → dystonia → diphenhydramine

Underutilization of Medications

In most circumstances, when clinically indicated medications are consciously avoided, the provider is attempting to do one of the following:

- Support compliance with essential medications
- Limit drug interactions
- Treat only active conditions
- Control the cost of treatment

An example of underutilization in the urgent care setting could include the avoidance of NSAIDs or oral steroids in patients presenting with an acute gout attack just because they have a history of diabetes or hypertension.

Drug Allergies

Drug allergies can be described as reactions that are produced as a result of an immune response to a medication. Adverse drug reactions can broadly be categorized into type A and type B (**Table 2**). Type A drug reactions include reactions secondary to drug overdose, adverse effects at therapeutic doses, drug interactions, and secondary effects of drugs. Type B reactions, on the other hand, are either immunologic reactions, adverse effects at sub-therapeutic levels, or reactions that are not attributable to the pharmacologic properties of the drug. Within Type B reactions, immunologic reactions can further be classified into the following types (**Table 3**):

- I: immediate reaction
- II: delayed reaction
- III: delayed reaction
- IV: delayed reaction

Table 5. Examples of Pseudoallergic Reactions	
Drug	**Clinical Reaction**
Aspirin, nonsteroidal anti-inflammatory drugs	Asthma, exacerbation of rhinitis, urticaria/angioedema
Opioids	Pruritus, urticaria
Ciprofloxacin	Urticaria
Local anesthetics	Vasovagal syncope, anxiety

A description of the types of reactions is provided in **Table 4**. Although these form the majority of the immunologic responses that lead to drug eruptions, there are others.

Drug-Induced Autoimmunity

The pathogenesis of drug-induced autoimmunity is poorly understood. However, some drugs can induce autoimmune diseases. Examples of this reaction include immunoglobulin A (IgA) bullous dermatosis associated with ciprofloxacin, ceftriaxone, and metronidazole.

Fixed Drug Eruption

Fixed drug eruptions are relatively more common, although as is the case with drug-induced autoimmunity, the pathogenesis is also not clearly understood. The reaction is characterized by an erythematous and edematous plaque with a grayish center or central bullae. It commonly occurs on the lips, tongue, face, genitalia, and acral areas. Typical offending agents include sulfonamides, tetracyclines, NSAIDs, acetaminophen, and anticoagulants. Drug withdrawal and avoidance are the main treatment. Symptomatic treatment is also advised.

Pseudoallergic Reactions

Although some drug reactions appear to be related to immunity, they are not mediated by the immune system. These are called pseudoallergic reactions. The clinical presentation of these reactions is similar to a true allergic reaction, but they do not worsen with repeated exposure. Because the clinical presentation is the same, these reactions should be taken as seriously as any other IgE-mediated reaction and should be treated in the same manner. Also, because these reactions are not immune-mediated, they are not diagnosed with skin testing or in vitro allergy testing. The mechanism behind these reactions is not completely understood. However, they could be secondary to the following:

- Inhibition of prostaglandin production and increased leukotriene production
- Direct stimulation of mast cells, resulting in the release of mediators
- Vasovagal reflex

Examples are provided in **Table 5**.

NSAIDs are of particular importance here, considering their widespread use, their over-the-counter accessibility, and the sheer number of different reactions possible with this class. There are six types of allergic reactions to NSAIDs.[13] Types 1 through 4 are recognized as pseudoallergic reactions, and types 5 and 6 are IgE-mediated allergic reactions. Type 5 and 6 reactions are usually caused by a single NSAID rather than multiple NSAIDs. Pseudoallergic reactions, on the other hand, can be caused by any NSAID that is a cyclooxygenase-1 inhibitor. Type 5 and 6 reactions usually result from prior exposure and sensitization to the same agent,[14] but that is not necessary for a pseudoallergic reaction to develop. The onset for type 5 and 6 reactions is usually minutes to a few hours after ingestion. For type 1, 2, 3, and 4 reactions, the onset is within 30 to 90 minutes. A description of the clinical features and associated comorbidities for each reaction type is provided in **Table 6**.

It is important to keep these reactions in mind when assessing patients with upper respiratory infections or cutaneous symptoms. Although these patients could have symptoms secondary to other etiologies, the use of NSAIDs could exaggerate existing problems.

Urgent care practitioners who are aware of the risk factors for drug allergies are much better able to avoid drug reactions in their patients.

Risk Factors for Drug Allergies

Important risk factors for developing drug allergies include the following:

- **Female sex:** For reasons not completely understood, women experience a higher frequency of both immediate and delayed drug reactions.
- **Recurrent drug exposure:** Repeated use of the same or related drugs is associated with higher rates of drug allergies.[15]
- **History of allergic reactions to drugs:** A history of allergic reactions to medications increases the risk that a patient will experience more drug reactions.
- **Human leukocyte antigen (HLA) type:** Patients' HLA type is related to their familial propensity to develop immunologic drug reactions.

Table 6. Features and Comorbidities of Allergic Reactions to NSAIDs

Type	Clinical Features	Comorbidities
1: NSAID-induced asthma and rhinosinusitis	Rhinitis	Asthma
	Nasal obstruction	Chronic rhinosinusitis with nasal polyposis
	Bronchospasm	
	Facial flushing	
	Conjunctival injection	
2: NSAID-induced urticarial/angioedema in patients with chronic urticaria	Urticaria and/or angioedema	Chronic urticaria
3: NSAID-induced urticarial/angioedema in asymptomatic patients	Urticaria and/or angioedema	None
4: Mixed respiratory and/or cutaneous reactions in asymptomatic patients	Respiratory and/or skin symptoms	Some patients may have asthma and chronic rhinosinusitis with nasal polyposis
5: Single NSAID-induced urticarial/angioedema (not aspirin)	Urticaria, pruritus, angioedema	None
6: NSAID-induced anaphylaxis (not aspirin)	More severe reaction than type 5	None

NSAID, nonsteroidal anti-inflammatory drug.

"Given the fast-paced environment of the urgent care setting, prescribing cascades can easily be overlooked without a dedicated effort to consider them."

- **Disease states:** Examples include
  - Atypical lymphocytes (e.g., Epstein-Barr virus, leukemia): reaction to aminopenicillins
  - Acquired immunodeficiency syndrome: reaction to sulfonamides

Conclusion

As the complexity of health states increases in patients seen at urgent care centers, especially the elderly, so does the necessity of guarding against polypharmacy and other medication-related perils. In the fast-paced environment of an urgent care clinic, polypharmacy can be easily overlooked and lead to drug cascading, which can result in serious health issues. If these complications do occur, then urgent care providers must be able to recognize them and act on them appropriately. Likewise, prescription, over-the-counter, and herbal medications can all contribute to the development of significant and sometimes fatal adverse drug reactions and allergic reactions. Taking time to obtain a thorough medical history and medication history, especially in the elderly, can go a long way toward minimizing the risk of medication-related maladies in the urgent care setting. ■

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A Process Approach to Differentiating Your Urgent Care Brand by Ensuring That Patients Leave Satisfied

Urgent message: Rapid growth of the urgent care industry has led to increased competition but little differentiation among urgent care providers, which consumers tend to view as "pretty much the same." The opportunity for urgent care is thus to foster patient loyalty by creating differentiated brands, which starts by taking a process approach to the patient experience.

ALAN A. AYERS, MBA, MAcc

Urgent care is maturing into a big business. In 2015, the industry's nearly 10,000 centers expect to see 160 million patients and generate $16 billion in gross revenue, according to the Urgent Care Association of America (UCAOA). Hospital systems, insurance companies, private equity, and venture capital firms have poured hundreds of millions of dollars into startups, mergers, and acquisitions in a market that has historically consisted of independent physician-entrepreneur practices. Yet despite boasting yearly revenue figures of the magnitude of the global coffee giant Starbucks—noteworthy for its enviable and powerful brand loyalty—the urgent care sector has yet to see any strong brands emerge, even among the larger regional operators.

To many Americans, however, "urgent care" is simply "urgent care," and utilization is driven not by brand

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loyalty but by factors like convenience of the location, operating hours, network insurance participation, or experience with a specific physician. Without a differentiated brand, the risk is that a center's patients will defect as soon as a more convenient/less expensive/more novel option becomes available. In markets where the growth of urgent care has resulted in more centers than the population can support, a lack of brand loyalty can prevent a center from ever reaching its volume potential.

This dearth of any firmly established brands within the urgent care space actually represents an enormous opportunity for the innovative urgent care operator. According to branding experts, building a brand that consumers will patronize repeatedly, even in the face of alternative choices, largely depends on that brand's ability to meaningfully differentiate itself.

Consider the draw of such trendy "power brands" like Starbucks, Apple, Tesla, Virgin America, and Whole Foods. How these brands are *experienced* by their loyal patrons is what sets them apart from the competition. So for urgent care operators, the question is a simple one: *How can the entirety of our brand experience be constructed to engender patient loyalty in the increasingly crowded immediate-care landscape?*

Consumer Touchpoints

From a consumer perspective, brands are experienced by way of what marketing gurus call *touchpoints*. A touchpoint is defined as "a single point of contact or interface through which a customer is exposed to a brand, in any way and at any time." Touchpoints can include, for example, overhearing a colleague discuss a particular product, walking an aisle in a store that carries that product, and hearing an advertisement of that product on the radio.

Touchpoints, as illustrated in **Table 1**, consist of both tangible and intangible assets, and can overlap experiential time frames. Thus, a consumer can potentially be exposed to a brand's marketing message before, during, and even after utilization. The sum total of a product and/or service's touchpoints—potentially quite numerous—are what ultimately forms its brand experience.

In short, a brand is a promise. Established brands declare their promise explicitly, and they reinforce that promise at every possible touchpoint. Whether it is a promise of the highest quality, lowest prices, greatest convenience, or most novel experience, a touchpoint is the vehicle that brands employ to capture market share. For urgent care operators seeking to build the kind of regional or national brand loyalty that helps them stand out from the pack, there must be a definitive and forward-thinking process approach undertaken to shape their brand's touchpoints.

The Patient Experience Pathway

In marketing, identifying the totality of a brand's touchpoints is called creating a *customer-journey map*. In health care, it has been described as chronicling the *patient experience pathway*. Because health-care consumers do not actually become patients until they decide to utilize an urgent

Table 1. Common Examples of Consumer Touchpoints

Prior to Utilization/Purchase	During Utilization/Purchase	After Utilization/Purchase
• Marketing channels • Community involvement • Word of mouth • Social media • Online reviews • Paid advertising	• Store or place of business • Website • Point of sale • Catalogue • Telephone • Sales or service staff members	• Follow-ups • Transaction emails • Online help • Billing • Thank-you cards • After-purchase marketing

care center, both terms apply equally here. But regardless of which phase consumers find themselves in, they are nonetheless experiencing the brand's touchpoints.

Starbucks, for example, goes out of its way to create a welcoming, community-like feel while serving up flavor-rich coffee drinks. The comfy, oversized couches, the free Wi-Fi and power outlets, the hip background music, and the baristas who greet you by name—all while quickly whipping up your favorite concoctions from memory—are just a few of the many evocative touchpoints that make Starbucks the brand giant it is today. They have cultivated such fierce brand loyalty that even when they periodically nudge up prices, they suffer no backlash; their customers still show up in droves. But the bottom line is that Starbucks' patrons come back—and keep coming back.

For urgent care, a great customer experience is even more crucial, because urgent care center utilization—except for select ancillary services—is episodic. That is, nobody actually plans to get sick. Therefore, it is of paramount importance that the successful urgent care experience consistently evoke feelings and emotions associated with the following core principles:

- Convenience
- Efficiency
- Friendliness
- Warmth
- Professionalism
- Affordability
- Wellness
- Satisfaction

Effectively promoting such values throughout an urgent care model's touchpoints—including, of course, the anticipated great clinical outcome—will help ensure that when the need arises, the brand is forefront in a prospective patient's mind. Thus, urgent care operators desiring to seize the opportunity—establishing a buzzworthy brand within the still-evolving urgent care landscape—must fully renounce any lingering "build it and they will come" stance that they may still harbor, and seriously commit to designing their practice from the patient's perspective, which is the only perspective that matters.

A Process Approach

Developing a differentiated brand takes planning, which entails designing processes, systems, and training that result in an exceptional patient experience. Back to touchpoints: As shown in Table 1, touchpoints can be many and varied. For most urgent care centers, pertinent touchpoints can be loosely grouped into the following categories:

- First impressions
- Registration and booking
- Waiting-room experience
- Front-desk interaction
- In-center service recovery
- After-utilization follow-up and communication

The role of the urgent care operator—thinking less like a clinician and more like a consumer or patient—is to view each separate aspect of the brand experience through the patient's eyes, then tailor its touchpoints so that they (1) sufficiently and meaningfully differentiate the brand and (2) effectively reinforce principles that lead to brand loyalty.

What follows is an examination of each of the bulleted touchpoint categories, accompanied by design strategies and implementation tips to be considered.

First Impressions: Prior to Arriving at the Center

To shape first impressions, the provider steps into the role of the consumer and begins the customer-journey map with advertising and first impressions. Although some urgent care operators are hesitant to invest heavily in advertising without understanding the return on investment, this kind of outlay can be made confidently when marketing is viewed as a revenue center that, when done right, *makes* money, and is critical in creating favorable first impressions.

Advertising: What advertising modalities (e.g., newspaper, radio, billboard, television) does the center employ, and what brand personality does that advertising present to consumers? Does the message align with the center's core principles? Repetition is key here, because a consumer must be exposed to a marketing message many times before the brand reaches top-of-mind status. So the ad campaigns must be regular, and spread across multiple channels. In addition, the adopted brand personality should shine through in all of the advertising.

Website: A professional, well-organized, and comprehensive website is an absolute must in this age of digital media. In addition, studies show that for the first time, people are now spending more time with digital media than they do watching television. Digital media is where consumers are, and your center must be there as well. To that end, an urgent care center should feature, at the minimum, a full-service website with patient login and registration functionality, a complete listing of services offered, and a detailed listing of hours of service. To take it a step further and really differentiate the center, examine the operating model of ZoomCare (www.zoomcare.com) centers in the Pacific Northwest. They enable patients to self-schedule from a smartphone, tablet, or computer with the provider of their choice, directly through the website. Self-scheduling is a novel concept in today's urgent care scene, but early adopters have thus far received rave reviews from patients.

Center location: Consumer anecdotes and focus groups confirm that drive-by signage visibility is the number-one driver of urgent care awareness. In concert with the crafting the advertising, choosing center locations should be strategic and opportunistic whenever possible. Busy intersections and shopping centers are ideal because they offer good curb appeal. Signage should also be prominent and well lit, so that it is unmistakable that the building does indeed house an urgent care center. If there is any doubt as to where to locate an urgent care center, just follow the retailers that appeal to the center's target patient base (e.g., Target, Kohl's, PetSmart).

Community visibility and grassroots activities: Community engagement through grassroots activities provides a brand with the repetition necessary to reach top-of-mind, and it establishes the center as fully entrenched within the fabric of the community. Some great examples of effective grassroots activities:

- **Interviews with local media** (television, newspaper, Internet) when health-related topics are dominating the news: Having a "health expert" chime in lends credibility to both the report and the center. You would be surprised at how often the center is remembered due to local media engagement.
- **Public appearances** with booth setups or tents, freebies, and family-friendly mascots on hand, especially on holidays: Of course, have your literature, brochures, and decals ready to disseminate.
- **Free, relatively inexpensive services offered at ribbon-cutting events** that announce the urgent care center's inclusion in the community: MedExpress (http://medexpress.com), for example, recently opened a clinic in Battle Creek, Michigan, and in an effort to generate foot traffic offered free flu shots to all visitors who stopped in during the first week.
- **School-related team or club sponsorships:** When your center's logo adorns the T-shirts and sweat shirts of schoolchildren all around town, your brand reaps the benefits of not only constant exposure but also of deep affiliation with the town or city.

These and many other grassroots activities are important touchpoints that will help shape and define the brand, often before a patient even sets foot in the center. Indeed, an implementation of this scale may result in a considerable upfront financial outlay, but recall that marketing is a proven revenue center when fully understood. Over time, the brand's growth will generate the foot traffic necessary to pay for these outlays, and then some.

Minimizing Patient Wait Times: Registration and Booking

When consumers decide to visit an urgent care center, that is the perfect time to show that your center will reward their patronage with uncommon efficiency, convenience, and satisfaction. This is a grand opportunity to differentiate the brand further, and to dramatically reduce the negative emotional impact of any wait, no matter how brief.

Online preregistration: Ensure that your website allows patients to preregister from their computer or tablet. Then, after ascertaining their driving distance from the center, call them when their time in the patient queue is approaching.

Allow patients to leave the center while waiting: If patients are not too sick or injured, the urgent care center can promise a phone call when it is their

time to be seen while they shop or run errands nearby.

Schedule appointment times online: Again, examine the aforementioned ZoomCare model for insight into how to go about patient self-scheduling, or discuss it with your information technology staff members. As ZoomCare centers have demonstrated, patients absolutely love this feature, and it gives them a sense of control over their own health-care choices.

Waiting-Room Experience

The center with the most modern and extensive waiting-room perks is the one that will leave an indelible mark on a patient's positive impression of the brand. Quality amenities include the following:

- **Digital entertainment:** Almost everybody, including kids, has a smartphone these days, so by providing complimentary Wi-Fi, you will spare many grateful patients from having to burn through their own data plan while waiting. Also, a couple of flat-screen televisions for viewing should be mounted in customer waiting areas.
- **Reading and activity materials:** Parents who have brought in a sick and cranky youngster will especially appreciate the momentary distraction that magazines and activity books or coloring books provide. These items can be purchased inexpensively at a discount store.
- **Beverages and snacks**: An urgent care lobby striving to help patients feel like welcomed guests should include items such as chips, pretzels, granola, bottled water, coffee, and cocoa. Gestures like these go a long way toward pleasing patients.
- **Blankets:** For sniffling, sneezing, and shivering patients, a warm blanket will provide a huge psychological boost and help them feel that staff members really care.
- **Waiting-room concierge:** Hire urgent care staffers dedicated to enhancing the waiting-room experience. They can apprise patients of how long it will be before they see a clinician, comfort and reassure little ones, refill and restock beverages and snacks, and hand out blankets. One urgent care center, for example, has its waiting-room concierge go to a store next door and return with fresh doughnuts if wait times began to creep up.

Recall the earlier Starbucks examples that outlined how the company's staff members go out of their way to make their customers feel welcomed and at home, much like an invited guest. For an urgent care center that offers these types of amenities, the effect would be similar. Remember that brands capture loyalists through the *experience*, and rolling out the proverbial red carpet in this way helps provide that coveted differentiation that stellar brands exhibit.

Front-Desk Interactions

Front-desk staff members have an opportunity to set clear expectations for the visit immediately, putting patients at ease with the knowledge that their visit will contain no unpleasant surprises. Staffers can accomplish this by outlining the entire patient experience in advance, which will include the following information:

- The total amount of time patients will be in the center, including how long before they see a clinician
- Exactly who patients will see, and what the clinician's medical experience and credentials (PA, MA, RN, NP, etc.) are
- All tests and procedures that will be done
- Financial obligation of the patient. Lack of price transparency has long been an annoyance to health-care consumers, so this level of full disclosure will be very welcomed.
- Answers to questions, in the form of bulleted handouts, that patients frequently ask, such as "Why am I waiting?" or "I have to pay how much?"

Showing this level of respect and transparency can serve to make patients loyal to the center because it eliminates much of the intimidation factor that people often face when trying to navigate the health-care system.

In-Center Service Recovery

A patient who leaves dissatisfied with the overall service delivery is said to have experienced a *service failure*, such as these:

- Rude and aloof frontline staff members
- Excessively long waits
- Payer issues (i.e., insurance not being accepted)
- Higher-than-anticipated co-payments
- Substandard clinical outcome
- Incorrect prescription medication
- Lack of comfort and convenience
- Domination of the consultation by a clinician who ignores or trivializes a patient's questions and concerns

Studies show that once patients who have experienced a service failure leave the center without remediation, the negative word-of-mouth that they will spread

can be very financially damaging to a practice. In addition to telling their friends and family about the awful service, they may take to an online review site like Yelp to bad-mouth the center to an audience of thousands, or contact their payor or other third party, leading to unwelcome scrutiny of the provider.

For a brand to flourish, there must be an in-center service recovery strategy designed to catch service failures as soon as possible. Waiting to attempt service recovery until after a patient has left the center is not ideal, as it may be too late by then. In-center service recovery strategies can include the following:

- **Actively engaging patients for feedback as they are leaving the center.** A simple query such as "How could we have improved your experience today?" is usually enough to get the ball rolling for a disgruntled patient. Surveys work as well, but many patients will not want to hang around to complete a lengthy survey—save for those who are aggrieved and welcome the opportunity to vent.
- **Giving frontline staff members the power to remediate and rectify issues on the spot.** Study after study has shown that empowering frontline workers to handle service failures is the single best predictor of a successful remediation. Examples include giving out gift cards and writing off the cost of the entire visit.

In sum, urgent care operators must embrace a simple truth when it comes to dissatisfied patients: No effort toward service recovery is too extreme. When service recovery is done correctly and enthusiastically, a *service recovery paradox* will often result. This paradox describes a situation in which patients are so happy that the center went out of its way to satisfy them in response to an initial service failure that their brand loyalty actually grows stronger than it was before. Hence, urgent care staffers should go out of their way to seek out and remediate service failures at every opportunity.

After-Utilization Follow-Up and Communication

Post-visit follow-ups and communication represent a valuable opportunity for the provider to reinforce its brand values many additional times. In fact, the touchpoints at this stage are just as important as the ones at prior stages, because they communicate the center's appreciation for the patient's business while making clear the center's intentions to court future business.

- **Follow-up calls within 24 to 48 hours:** Contacting patients a day or so after their visit helps to ensure that a great clinical outcome has occurred, and it also sends the message that your service delivery extends well beyond the in-center visit.
- **Solicit sign-ups for the center's opt-in e-newsletter:** An e-newsletter is a great way to keep patients abreast of the center's activities. The content should include trending health topics of interest to providers and patients, a calendar of events for both the center and the community as a whole, and photos of community and grassroots events that the center is involved in.
- **Social media engagement:** Social media studies show that Facebook users who "like" an organization's page are 60% more likely to recommend the organization's brand to others. Twitter, Google+, LinkedIn, YouTube, and Pinterest are other great tools to engage your patients online and help turn them into fans. Through these venues you can push out additional center-related advertising and announcements of seasonal offerings (e.g., flu shots, sports physicals, allergy evaluations). You can also post photos of grassroots events and community engagement.

Conclusion

Although urgent care has grown into a multi-billion-dollar industry, consumers still generally view all urgent care centers as the same because few operators have built brands differentiated enough to engender fierce patient loyalty. There is the opportunity, however, to use branding tools to gain a very large and loyal customer base. Chief among those are identifying and shaping touchpoints solely from the customer's perspective, and creating a differentiated brand *experience* that triggers a multitude of positive feelings and emotions. By focusing on the entirety of the experience, an urgent care center can create similar differentiation and begin to build a loyal patient base.

Forward-thinking providers must first identify and understand their service delivery through the eyes of patients, and then develop processes that ensure efficiency, convenience, professionalism, and satisfaction at every touchpoint. Hidden and neglected touchpoints are also shaping your brand, so aggressively finding and fixing them is critical.

It all comes down to how many resources—financial or otherwise—that an urgent care brand is willing to commit to the goal of true, meaningful differentiation. That is what all strong brands do, and the urgent care center that is successful in using its touchpoints to create that differentiation is the one that will rise to the head of the class. ■

Case Report

Serious Pathology Masquerading as Chronic Back Pain

Urgent message: Do not be fooled by the diagnosis made by clinicians before you. Many seemingly benign symptoms can be harbingers of more serious pathology.

JESSICA HOFFMANN, MS-4, and JOHN SHUFELDT, MD, JD, MBA, FACEP

Introduction

Chronic back pain is a common presentation in both the urgent care and emergency department (ED) settings. Care-on-demand providers often find themselves deciding how extensive a workup to do for a patient with acute-on-chronic back pain.

After a patient has had 4 to 6 weeks of conservative treatment (i.e., nonsteroidal anti-inflammatory drugs, muscle relaxants, patient education, and physical therapy) without a decrease in pain, imaging should be performed.[1] Conventional imaging for lower-back pain includes plain films, and if findings for plain films are nondiagnostic, then computed tomography (CT) or magnetic resonance imaging (MRI) should be performed. In addition, laboratory workups to assess for the presence of inflammation, such as erythrocyte sedimentation rate, C-reactive protein, and complete blood count with differential, may be performed to rule out infectious sources of low-back pain.

This approach, however, should not exclude evaluation of risk and red flags for more serious or threatening causes. Vascular, gastrointestinal, oncologic, and infectious etiologies are often overlooked without careful evaluation. Obtaining a detailed medical history and conducting a thorough physical examination are paramount for avoiding the "big miss" in the urgent care setting, as is an understanding of the red flags that may identify a more serious and even life-threatening etiology.

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Case Presentation

RC, a 37-year-old man with obesity, was sent from the urgent care center to the ED after reporting 3 days of severe-on-chronic, constant dull back pain. The patient had a long history of chronic back pain with multiple prior visits to urgent care centers and EDs. His chart at the urgent care center flagged him as a "frequent flyer" who might be seeking narcotics.

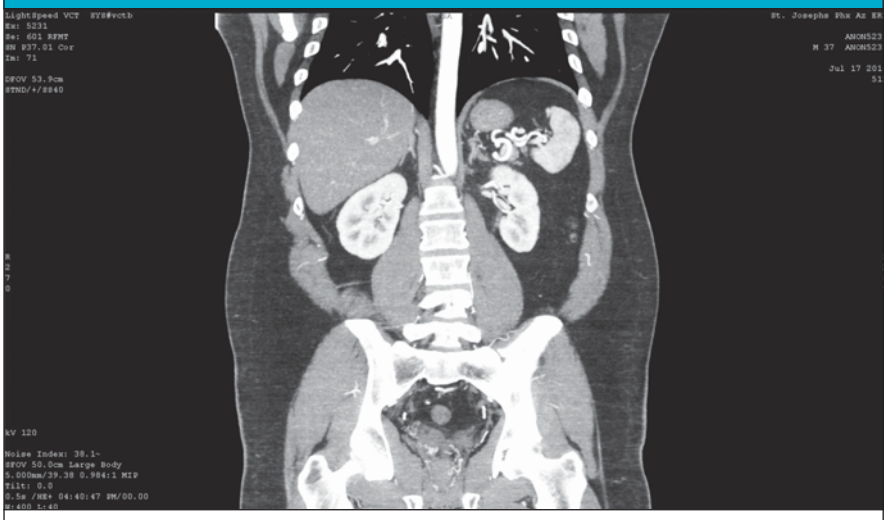
In addition, the patient's primary-care physician and an orthopedic spine specialist had previously evaluated him for similar problems, which the patient stated were long-standing. Prior workups included lumbosacral radiographs, CT of the thoracic and lumbar spine, and MRI, which revealed mild degenerative disc disease.

Earlier disease management had included physical and occupational therapy, and a referral to a pain-management program. The patient was sent from an urgent care center to the ED because he reported flank and low back pain, worse on the right side. Despite the flag on the patient's chart, the urgent care provider was concerned about ureterolithiasis and sent RC to the ED for further evaluation.

On ED presentation, RC also reported intermittent bilateral lower-extremity numbness and pain that was progressively worsening and became worse with exertion. On further questioning, the patient also reported difficulty developing an erection.

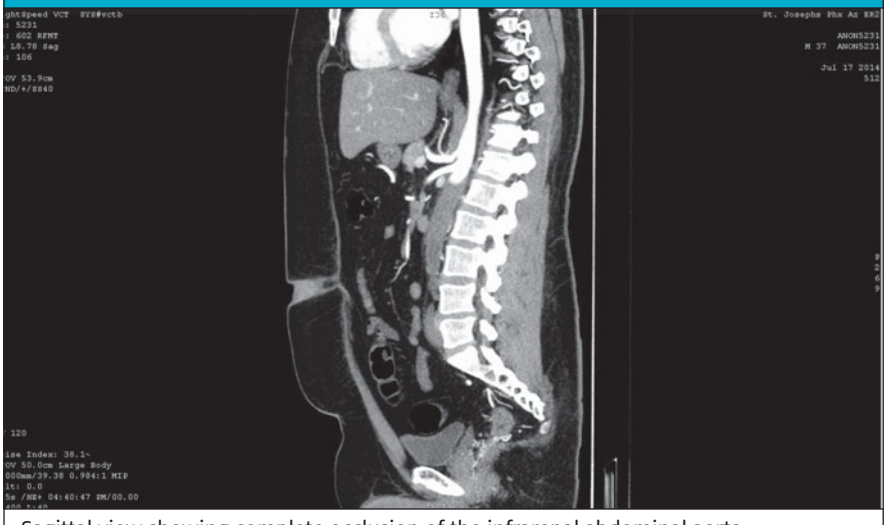
Medical and family histories revealed that RC was a current smoker with a medical history of hypertension without prior treatment and with significant family history of heart disease. The patient's parents both died of cardiac causes while in their fifties, his half-sister died of heart disease, and his half-brother had a myocardial infarction at an early age.

Figure 1.



Computed tomography angiogram from the case reported here, showing occlusion of the infrarenal abdominal aorta and occlusion of the ostium of the inferior mesenteric artery. Note the multiple renal infarcts.

Figure 2.



Sagittal view showing complete occlusion of the infrarenal abdominal aorta.

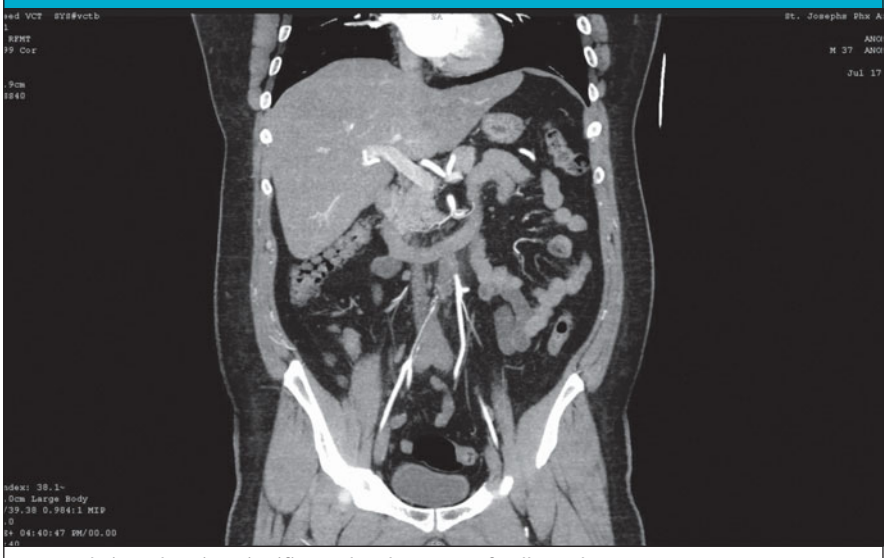
Observations and Findings

Evaluation of the patient showed the following:

T: 36.8°C
RR: 18
P: 117
BP: 176/124

Physical examination revealed an obese, alert male in mild distress secondary to back pain. Findings on his cardiovascular examination were significant for tachy-

Figure 3.



Coronal view showing significant development of collaterals.

cardia and diminished pulses in the bilateral lower extremities. His skin was warm to the touch; however, it had a dusky appearance while the patient was in a dependent position. The patient had bilateral flank tenderness to palpation. There were no other abnormal findings. Findings on the distal neurologic examination were unremarkable. The patient had a strength rating of 5+ (on a scale of 0 to 5) for his lower extremities on flexion and extension. He had good rectal tone and reported no saddle anesthesia. His bilateral deep tendon reflexes were rated 3+ (on a scale of 0 to 5).

Diagnostic Studies

Initially, a noncontrast CT scan of the abdomen and pelvis was ordered to rule out the presence of an obstructing stone. This revealed a 3-mm nonobstructing renal calculi of the left kidney as well as para-aortic stranding with small areas of calcification in the lumen of the aorta, which could represent aortic dissection or aortitis. Follow-up with a contrast-enhanced CT angiogram was recommended.

The angiogram revealed complete occlusion of the infrarenal abdominal aorta, extending into the common iliac arteries, with reconstitution of flow at the level of the bifurcation of the internal and external iliac arteries. Also present were occlusion of the ostium of the inferior mesenteric artery, reconstitution of flow distally, diffuse periaortic stranding, and multifocal left renal infarcts (**Figures 1, 2, and 3**).

Diagnosis

Leriche syndrome (aortoiliac occlusion).

Course and Treatment

The combination of findings on RC's medical history, physical examination, and CT angiogram revealed severe vascular disease consistent with Leriche syndrome. A vascular surgeon was consulted. The patient's blood pressure was controlled, and he underwent preoperative evaluation, including a pharmacologic stress scan using regadenoson (Lexiscan) for evaluation of his coronary arteries. On the third hospital day, he underwent aortobifemoral bypass surgery.

Discussion

Leriche syndrome, or aortoiliac occlusive disease, typically affects men in their fourth to fifth decade of life.[2] It is classically characterized by a triad of claudication, decreased femoral pulses, and impotence.[3] This constellation of symptoms is secondary to atherosclerotic obstruction of peripheral vessels.[4] Occlusion generally begins at the distal abdominal aorta and progresses both proximally and distally. Occlusion of the abdominal aorta at the bifurcation of the iliacs in Leriche syndrome typically develops slowly, which allows time for collateral vessel development and minimization of the risk of life-threatening ischemia. Risk factors for Leriche syndrome include cigarette smoking, hypertension, and hyperlipidemia.[5]

Several prior cases of Leriche syndrome presenting atypically have been described, including paraplegia,[6] sciatic neuropathy,[7] and treatment-resistant hypertension due to extension of occlusion to the bilateral renal arteries.[8] In the case described here, Leriche syndrome was disguised by a long history of chronic back pain and untreated hypertension. To our knowledge, this is the first case of Leriche syndrome presenting as worsening chronic back pain. In this case, the chronic and worsening nature of back pain likely correlated with the onset and degree of occlusion of the aorta.

The standard low back pain workup algorithm generally does not include specific vascular etiologies.[1] As in the case of RC, a generally healthy 37-year-old man

without obvious warning signs is presumed to have musculoskeletal back pain until there is a failure to improve with conservative treatment. According to traditional algorithms, RC received proper management of his lower-back pain before he presented to the urgent care center. The finding of mild degenerative disc disease on MRI likely led clinicians astray during previous assessments and contributed to the early missed diagnosis. The combination of hypertension, obesity, smoking history, and strong family history of cardiac disease placed RC at high risk for vascular pathology. If the numerous physicians who cared for RC prior to his ED visit had maintained broad differentials and performed thorough vascular examinations, RC might have received an accurate diagnosis and therefore more appropriate care much earlier in the course of his chronic back pain.

This case highlights the importance of obtaining a thorough medical history and performing a detailed physical examination even in patients with commonly benign chief symptoms. In addition, the case illustrates the value of maintaining broad differentials and ruling out serious pathology before attributing chronic back pain to musculoskeletal causes.

Take-Home Points

It is easy and convenient to work off the same diagnosis that health-care providers before you made. Patients with back pain are often ticking time bombs: Their back pain may be a symptom of significant disease such as epidural abscess, epidural hematoma, cauda equina secondary to canal stenosis, or aortic aneurysm. A high degree of vigilance is necessary to make the proper diagnosis in cases like this one.

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Medical Boards: Part 2

JOHN SHUFELDT, MD, JD, MBA, FACEP

The probability that you will receive a certified letter from your medical board informing you about an investigation is relatively low. But one day, you may be one of the unlucky souls who receives such a letter. What do you do?

Different boards have different rules about what gets reviewed or investigated and what does not. Some boards are mandated to investigate, at least to some degree, every complaint received. Others look at the veracity of the complaint and make a determination about whether to investigate. Because many complaints are dismissed early on, you might not ever know that a complaint was filed against you.

All boards derive their authority from a state legislature and are mandated by their charter to protect the public. Thus, when you receive a letter requesting medical records or a response, understand that the board represents the public, not you.

Do these things before you ever receive notice of any board investigation:

1. **Review your malpractice policy to ensure that it includes "cost of defense" coverage** and that it covers investigations and actions by medical boards and other contracting or credentialing entities.
2. **Review policies and procedures with your staff regarding how your practice is handling patient complaints and requests for records.** Many board complaints are initiated by patients who for one reason or another are upset. Thus, ensure that things like complaints about customer service, billing issues, and medical record requests are handled in a timely fashion and with the appropriate amount of sensitivity and kindness.

Do these things to prevent a board investigation:

1. **Be kind to patients and their families.** Patients complain when they are upset. Do not let the situation get to this point. Make sure your staff members are always pleasant to patients, no matter how difficult some patients may be. It is simply not worth drawing lines in the sand when it comes to interactions with patients. No matter how difficult the patient or the conversation, remember that you are a professional and must always come from a perspective of advocacy and caring.
2. **Document thoroughly and at the proper time.** Nothing protects you as well as a medical record that is documented meticulously and contemporaneously and not retrospectively.
3. **Get consults for and refer out as necessary any patients whose health issues are complex or are otherwise difficult to deal with.** Consulting the appropriate specialists is a good way to mitigate claims of negligence if the path you were on with the patient turns out to be incorrect.
4. **Avoid breaching patient confidentiality and avoid responding inappropriately to negative online reviews of your care provision.** Writing a response on such sites as Yelp like "This patient suffers from a mental illness" is a sure way to find yourself in front of your board.

"No matter how difficult the patient or the conversation, remember that you are a professional and must always come from a perspective of advocacy and caring."

Do these things when you receive a board complaint:

1. **Take the complaint seriously.** Your license is a privilege, not a right. Like any privilege, it can be taken away. You have worked very hard to achieve your license, so work just as hard to keep it. Respond to inquiries within the allotted time and be exceedingly professional. Do not ignore a request for a response, no matter how unjust or ridiculous you believe it to be.

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2. **Hire an experienced attorney.** Do not represent yourself. Boards have attorneys, so you should too. Most medical malpractice insurance has a provision that covers representation in front of a medical board. If yours does, take advantage of it. Also, it is likely that your carrier knows who the best attorneys are for handling board complaints. Too often providers start off representing themselves and then hire an attorney after the damage has been done.
3. **Avoid contacting the patient and the patient's family.** Once a complaint is filed, you must switch roles, from physician to litigant. Board members are your adversaries, and they are simply doing their job. Nothing good can come from contacting the patient. Any contact will be construed as trying to manipulate or cajole the patient into withdrawing the complaint. Even if the patient does withdraw the complaint, it is likely that the board will at least continue to investigate. So once the complaint is filed, do not contact the patient to plead your case or to correct what you believe is a misunderstanding. Likewise, do not attempt or threaten to sue the patient for libel or slander.
4. **Avoid turning over medical records to the board until you consult an attorney.** That said, you cannot delay responding or submitting records, so it is important to find representation immediately upon receipt of a complaint. Submit a timeline of events along with the records and be judicious about what records you send. Provide only relevant medical records after discussing them with your attorney.

"No matter how brutal the discussion, do not lose your cool before the board. If you do not know or do not remember particular information, then say so."

5. **Avoid meeting with the board or attending a formal or informal hearing without representation.** Having an attorney does not imply guilt; it implies intelligence. The attorney's job is to protect you from incriminating yourself. Even if you think the complaint is a simple misunderstanding that can be easily explained away, one mistake can cost you your license.

"Avoid talking indiscriminately to others about the case. Such conversations are discoverable and despite your good intentions can get you in deeper."

6. **Avoid altering your records.** In the age of digital records, alterations are very easy to discover. Even with handwritten notes, it is usually obvious what has been charted contemporaneously and what has been documented after the complaint was filed.
7. **Respond professionally.** I once witnessed a physician unload a verbal tirade at board members, ending with "And I do not recognize or submit to your authority!" Shortly afterward, his license was no longer his. No matter how brutal the discussion, do not lose your cool before the board. If you do not know or do not remember particular information, then say so. Do not make up anything or guess at the right answer. Answer the questions asked and nothing more. Do not do board members' job for them, however. Be direct, calm, and honest.
8. **Avoid talking indiscriminately to others about the case.** Such conversations are discoverable and despite your good intentions can get you in deeper. You can speak candidly to your spouse and attorney regarding your feelings about the case, but there is a caveat: I know of two cases in which the providers' former or soon-to-be-former spouses informed on them to the medical board.
9. **Be active in your defense—disclose everything to your attorney.** They can better assist you if they are provided all of the facts. I have had a couple of experiences where the facts were disclosed to me by the board during the hearing. When I asked the providers about these new revelations, the best they could do was give me a look like someone had "shot their puppy." One more thing: help your attorney identify experts who may be necessary to support your case.

Provided that you are direct, forthright, and forthcoming, most board complaints are survivable. The cases in which I have seen providers get into the most trouble and lose their licenses involved lying or record alteration by the providers. If you follow the advice here about preventing complaints and responding appropriately to them, you stand a good chance of retaining your license and providing care another day. ■

ABSTRACTS IN URGENT CARE

- Duration of Troponin Testing for ACS
- Tramadol Increases Risk of Hypoglycemia Requiring Hospitalization
- Base Medical Practices on Original Research, Not Press Releases
- No Brace Needed in Single-Level Osteoporotic Vertebral Fractures
- Pyuria Poor Predictor of UTI in Nephrolithiasis

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.

Duration of Troponin Testing for ACS

Key point: No definitive evidence for the 2-hour troponin rule-out for ACS.

Citation: Kelly A–M, Klim S. Prospective external validation of an accelerated (2-h) acute coronary syndrome rule-out process using a contemporary troponin assay. *Int J Emerg Med*. 2014 Oct 16. doi: 10.1136/emermed-2014-204442. [Epub ahed of print.]

As with other serious diseases, ruling out acute coronary syndrome (ACS) is a balance between not missing it and overtesting or treating patients without the condition. Much has been written about a 6- to 8- hour workup, including an electrocardiogram, troponin, and a cardiac score. This article looks to validate a similar pathway with a more sensitive troponin and a shorter duration of stay (2 hours).

This prospective cohort study was conducted in the emergency department of a community teaching facility. Eight hundred forty patients with nontraumatic chest pain met a complex exclusion criteria. Of them, 72 had a final diagnosis of ACS. One hundred seventy-seven patients had a thrombolysis in myocardial infarction (TIMI) score of zero. Troponin used was a TnI-Ultra. The authors noted no major adverse cardiac events in patients with a TIMI of zero and a troponin <99 percentile. The authors do note that because of the small size of this study, it was not powered to test their hypothesis.

From the acute care provider's perspective, this study is not directly applicable at this time, but it builds on a body of evidence regarding the ability to rule out ACS in a shorter time frame. ■

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

Tramadol Increases Risk of Hypoglycemia Requiring Hospitalization

Key point: The risk of hypoglycemia posed by tramadol is another reason to avoid the use of this analgesic if possible.

Citation: Fournier JP, Azoulay L, Yin H, et al. Tramadol use and the risk of hospitalization for hypoglycemia in patients with noncancer pain. *JAMA Intern Med*. 2014 Dec 8. doi: 10.1001/jamainternmed.2014.6512. [Epub ahead of print.]

As efforts to reduce the use of opiates continue, tramadol use has increased. Tramadol is known to cause hypoglycemia. The researchers in this case-controlled study compared the number of hypoglycemic events in patients treated with tramadol versus those treated with codeine. Hypoglycemia requiring hospitalization was the study end point. The risk with tramadol use was 52% higher than for codeine use (odds ratio, 1.51). The odds ratio was even higher (2.61) within 30 days of starting tramadol.

Considering that this study looked only at hypoglycemia significant enough to require hospitalization, the risk for severe

hypoglycemia, although small (7/10,000), is concerning. For the acute-care provider, the fact that no drug is without potential serious adverse effects is a good reminder to consider the risks as well as the benefits in prescribing any medication. ■

Base Medical Practices on Original Research, Not Press Releases

Key point: Be sure to read the original research article before considering the value of information in any press releases about a study.

Citation: Sumner P, Vivian-Griffiths S, Boivin J, et al. The association between exaggeration in health related science news and academic press releases: retrospective observational study. *BMJ*. 2014;349:g7015.

In this retrospective study, researchers attempted to describe the relationship between exaggeration in health science news and academic press releases. They compared a total of 462 press releases to the corresponding original research and news stories. Forty percent of the press releases contained exaggerated advice, 33% contained exaggerated causal claims, and 36% contained exaggerated inferences regarding humans from the findings of animal studies. As expected, news reports of studies in these three categories contained similar rates of exaggeration: 58%, 81%, and 86%, respectively. In comparison, the rates of exaggeration in news of advice, causal nature, and inferences regarding humans were 17%, 18%, and 10% respectively.

These data do go against the common belief that the news media rather than press releases are the source of exaggerations. The authors saw that as a positive finding, postulating that exaggerations might be more easily be prevented by researchers' institutions than by the news media.

From an urgent care perspective, this study highlights the importance of reviewing the original research before making changes in practice or providing advice. Another consideration is that patients are making changes to their treatment plans themselves on the basis of exaggerated benefits reported in the news media. Practitioners can use the findings of this study to explain to patients why health stories in the press must be validated by the original research before they are used as the basis for decision making. ■

No Brace Needed in Single-Level Osteoporotic Vertebral Fractures

Key point: Skip the brace (soft or rigid) in single-level osteoporotic vertebral fractures.

Citation: Kim HJ, Yi JM, Cho HG, et al. Comparative study of the treatment outcomes of osteoporotic compression fractures without neurologic injury using a rigid brace, a soft brace, and no brace: a prospective randomized controlled non-inferiority trial. *J Bone Joint Surg Am*. 2014;96:1959–1966.

Options for patients with acute osteoporotic vertebral fractures include the use of a rigid brace, soft brace, or no brace. Taking into consideration potential soft-tissue injury and discomfort from braces, researchers attempted to see if the use of no brace works as well the use of rigid or soft braces. In this small randomized study, 60 patients were assigned to either no brace, a soft brace, or a rigid brace. After 12 weeks, the patients were evaluated using Oswestry Disability Index scores. Findings for the no-brace group were not inferior to findings for the two brace groups.

For the urgent care physician, this study can be referenced when braces are requested for osteoporotic compression fractures. Although the study was small and the practices of local follow-up physicians should be considered, this study at least validates the decision to not prescribe a brace for patients seen at an urgent care center. ■

Pyuria Poor Predictor of UTI in Nephrolithiasis

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

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

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

To determine what factors can be used to decide which patients also have a urinary tract infection (UTI), Investigators in California looked at 360 patients with acute nephrolithiasis diagnosed by CT scan without contrast. Of these patients, 8% were found to have UTI by culture. A positive culture was defined as single-organism growth at greater the 10^3 colony forming units/mL.

Unfortunately pyuria was a poor predictor of the likelihood of UTI. As with any screening test, the higher the white blood cell (WBC) count, the better the specificity, but sensitivity falls precipitously. Pyuria defined as a level greater than 5 WBCs/hpf had a sensitivity of 79% and specificity of 81% for UTI, whereas using 20 WBCs/hpf had a sensitivity of 57% and specificity of 94% for UTI. As with all UTIs, a positive nitrate was specific, but not sensitive. Female gender, fever, dysuria and previous UTI all had relative risks approaching or greater than five. ■

Payor Contracts, Discounts, and Provider Signatures

DAVID STERN, MD, CPC

Q. We sometimes have patients come in to our urgent care center with an insurance payor that we do not have a contract with. We do not want to turn them away, but we do want to guarantee our payment. Do we have to submit a claim to the insurance company in such cases? Currently, we offer these patients a self-pay discount, and they pay us in full at the time of service.

A. Typically, contracts with payors forbid the practice of requiring payment from a patient except for copayments, deductibles, and noncovered services. However, if no contract exists, the practice has no contractual obligations. Thus, if a provider has no contract with a payor, then the provider is free to charge the patient directly for services provided. The provider does not have to submit a claim to the payor, but many practices will submit a claim as a courtesy to patients. ■

"TRICARE contracted rates are generally 90% of Medicare rates, so military folks already receive care at rates lower than those of Medicare."

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

"If no contract exists, the practice has no contractual obligations."

Q. How do we handle billing for a patient who has insurance with which we are contracted, but the patient does not want us to bill the payor?

A. This situation is a little complicated. It is likely that the contract with the payor states that the practice must bill all claims to the payor. If you know that the patient has insurance but the patient instructs you to not bill their insurance, you may have the patient sign a document that states that they had insurance and that you have offered to bill their insurance but that they do not want insurance billed for the visit. If you decide to implement this process, you should get formal legal advice from an experienced health-care attorney before implementing this policy. ■

Q. I would like to offer all patients who are active-duty or retired members of the military a 25% discount to make up for the fact that we do not accept TRICARE. I have read that Medicare will claim that it is entitled to the same discount. Is that true? How can I get around this if I do not want to have any government contracts?

A. If a 25% discount is still higher than Medicare rates, Medicare should not have any issues with this discount.

If the discount, however, results in rates below those of Medicare, theoretically Medicare might object. It is a commonly held view that if your practice participates in the Medicare program, then you can never offer anyone a rate lower than that of Medicare. Many billers hold this as a strict, no-exceptions rule. However, historically, the Centers for Medicare & Medicaid Services (CMS) has been more lenient in enforcement of this regulation. In any case, TRICARE contracted rates are generally 90% of Medicare rates, so military folks already receive care at rates lower than those of

"As a general rule, providers should not add signatures to the medical record beyond the short delay that occurs during the transcription process."

Medicare. In addition, many payors in some states (California, for example) have contracted rates that are less than those on Medicare fee schedules. ■

Q. We had a physician leave our practice before signing off on some of his charts. Can we still submit claims for these cases without the signature and just explain what happened? If not, what are our options?

A. I would not recommend sending the claims without a signature. Another physician within the group may sign on his behalf, but an explanation is required, such as this one: "Chart signed by John Jones, MD. David Smith, MD, relocated to California on 12/1/2014 and was unavailable to sign this medical record." ■

Q. One of our physicians was out of the office for a week and did not sign off on her charts. Is there a time limit for signing charts?

A. As a general rule, providers should not add signatures to the medical record beyond the short delay that occurs during the transcription process, which is generally 24 to 72 hours. Medicare guidelines (*Medicare Program Integrity Manual*, Publication 100-08, available from http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html) state:

"Late signatures may not be added to the record (beyond the short delay that occurs during the transcription process). Medicare does not accept retroactive orders. If the provider's signature is missing from the medical record, submit an attestation statement from the author of the medical record.

"If the order is unsigned, you may submit progress notes showing intent to order the tests. The progress notes must specify what tests you ordered. A note stating 'ordering lab' is not sufficient. If the orders and the progress notes are unsigned, your facility or practice will be assessed an error, which may involve recoupment of an overpayment." ■

Disclaimer: JUCM and the author provide this information for educational purposes only. The reader should not make any application of this information without consulting with the particular payors in question and/or obtaining appropriate legal advice.

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DEVELOPING DATA

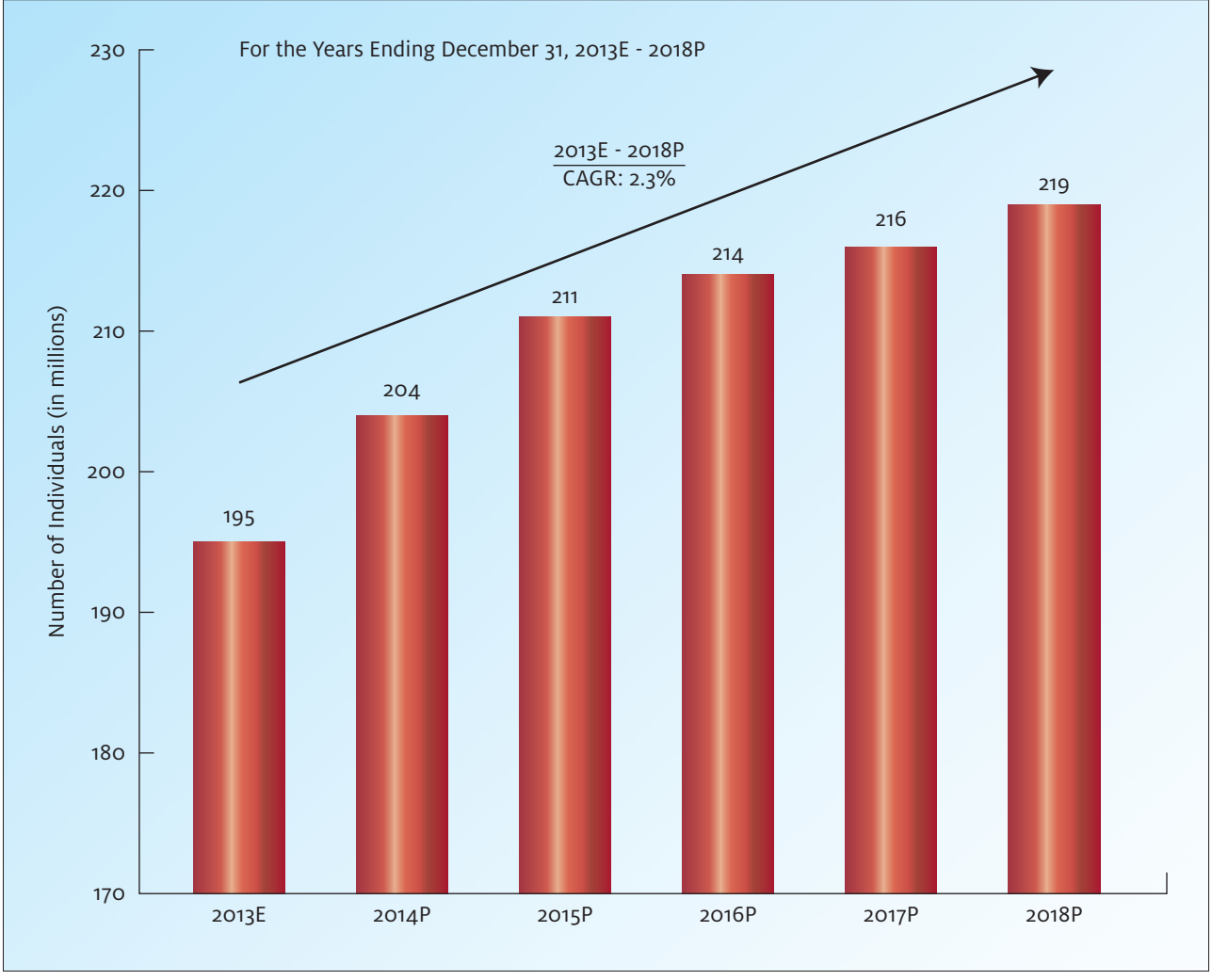
Data from IBISWorld show that the expansion of private insurance coverage in the United States presents a sustainable tail wind for growth in the urgent care industry.

- Approximately 55% of urgent care revenue is currently reimbursed by private insurance.
- Individuals with private insurance are more likely to seek medical treatment at an urgent care center than in a hospital setting.
- Private insurance companies are more likely to contract with urgent care providers to
  - Drive cost savings
  - Maintain high-quality medical care
- The Patient Protection and Affordable Care Act was expected to add 32 million individuals with private health insurance starting in 2014, which should drive demand for urgent care services.

The number of individuals with private insurance is expected to increase at a compounded annual growth rate of 2.3% through 2018.

Source: IBISWorld and Harris Williams & Co.

PRIVATE INSURANCE MARKET



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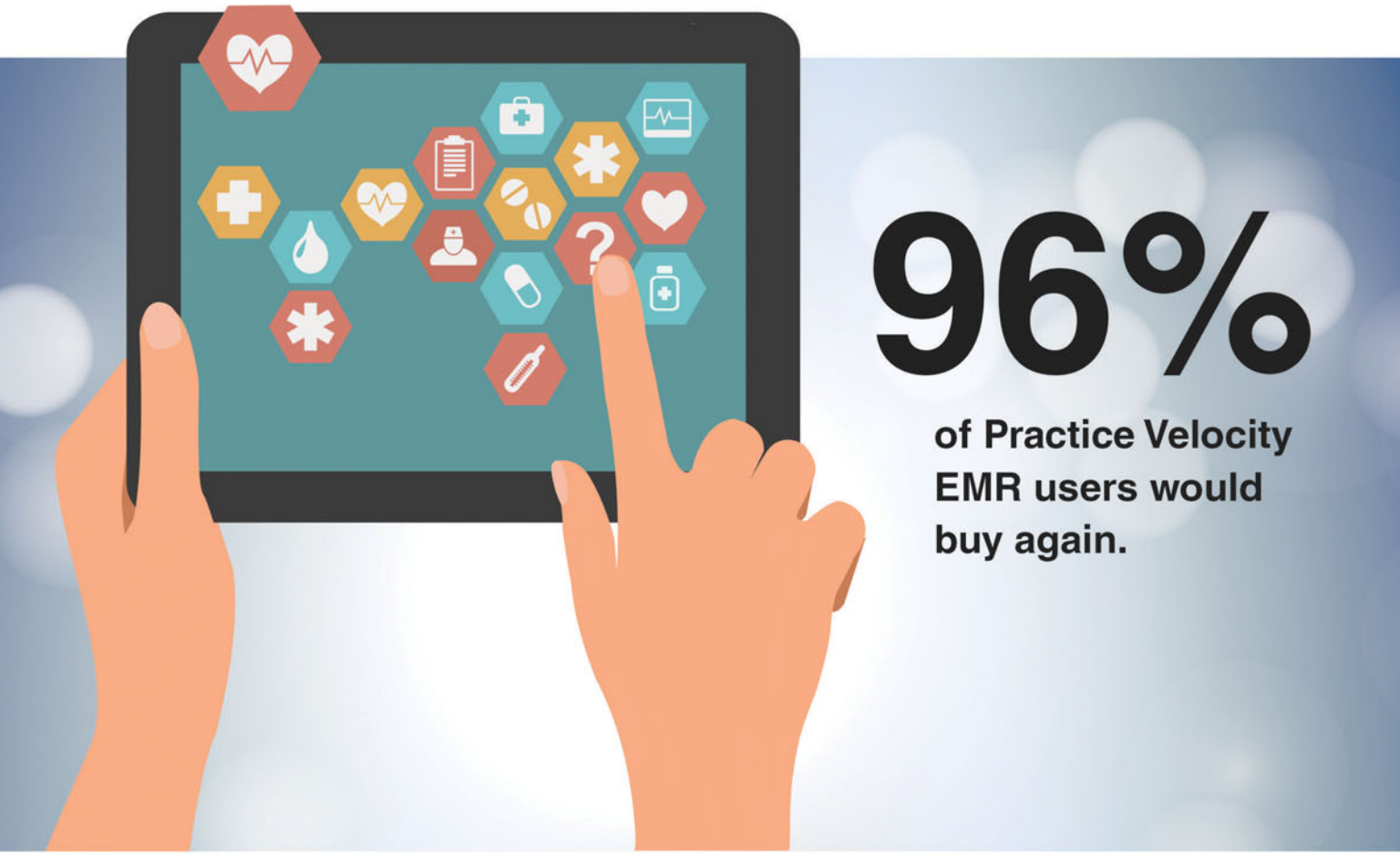

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