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Urgent Care Association of America

College of Urgent Care Medicine

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The Official Publication of the UCAOA and CUCM

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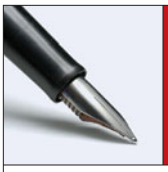
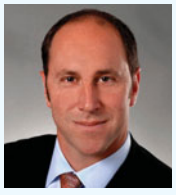


LETTER FROM THE EDITOR-IN-CHIEF

Expectations Disease



There are a few things from residency training that resonated so profoundly for me that they permeate everything I have done since. I will never forget my first delivery, not because I thought I would ever deliver babies in my practice, but because of the emotional and enduring collision of medicine and nature it represented for me. And who can forget the 36-hour shifts (now extinct) that I am quick to recount for young clinicians with the perfunctory "back in my day...."

There were, of course, specific patients whose stories stick with you or whose diseases you will only see once in a lifetime. But there is one experience, above all the rest, that changed the way I approach patient care, and that just might do the same for you: One of my clinical professors, a Birkenstock-clad hippie with a philosophical persona, developed a model for understanding common maladaptive patient behaviors that were previously unclassified or lumped into generic categories like "immature coping mechanisms." He described patterns of inappropriate behavior that are associated with a "loss of control," often triggered by stress, fear, pain, and vulnerability. He termed this new clinical entity, "Expectations Disease."

Here's what it means:

When expectations are negative or disabling, people feel a loss of control. But instead of choosing behaviors that might help them regain control, these patients have a tendency to choose destructive behaviors that they would not otherwise deliberately choose. Examples include substance abuse, anger, binge behaviors, panic, hysteria and somatization (patients with medical symptoms, often pain, but without an identifiable cause). These maladaptive behaviors allow these patients to temporarily shift their focus away from the real problem or stressor while providing them with a paradoxical sense of relief.

It's a fascinating construct when you think about it, and one that likely underpins a lot of presentations we see in the urgent care setting. This makes sense when you think about the spectrum of problems we see and the ease with which patients can access our care. These are often desperate cries for help, hidden behind distracting and unrelated behaviors. In order to ensure we deliver the right care for these patients, we have to get good at identifying Expectations Disease and responding appropriately.

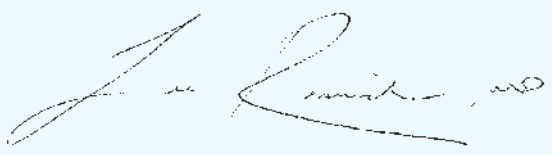
"Let's never forget that a cry for help is a gift, regardless of how misdirected or disruptive."

Needless to say, it can be quite challenging to hold our own emotions in check when someone is acting out in destructive or offensive ways (those of us with children at home have had to learn the hard way). So, here are a few practical tips:

The front office staff is usually to first to be impacted by these behaviors, so it can be helpful to be aware and prepared with a de-escalating response. First, always acknowledge the problem and demonstrate a genuine resolve to help. For example, you might say, "I can see that you are in pain, let's get you checked in so we can see what we can do to help." Substitute any of the following for *pain*: *angry*, *upset*, *concerned*, *sick*, etc. You get the idea. Remember, no one ever wants to be told to "calm down" or have their concerns dismissed. It's best to actively reassure these patients that we "have their back."

For physicians and advanced practice providers, these patients can feel exhausting and the task can seem daunting in our setting. My advice for you is simple: Don't feel like you have to "fix" everyone; just make a dent in the armor and get these patients better oriented for getting the care they need. If done with empathy, compassion, and advocacy, your patients will understand and appreciate it. And you can avoid unnecessary work-ups or medications.

For all of us, regardless of our position or role, let's never forget that a cry for help is a gift, regardless of how misdirected or disruptive. Being there for our patients when they are in distress is important. And helping them is what brings us joy. It's what we do. ■



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

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February 2018

VOLUME 12, NUMBER 5

11 Injuries to the Upper Extremity Due to Falls on Outstretched Hands (FOOSH)

Patients reflexively reach their arms out to try to cushion the blow when they slip on the ice or trip and fall—often resulting in injuries to an upper extremity and a trip to the urgent care center.

Michael Bartuseck, MSN, ARNP, FNP-C, EP-C

PRACTICE MANAGEMENT

17 Successful Site Selection in Urgent Care

Location, location, location isn't just the ruling maxim in real estate, but a key strategic decision when scouting the right address for a new urgent care center.

Alan A. Ayers, MBA, MAcc

HEALTH LAW AND COMPLIANCE

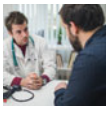
22 Law Enforcement and Healthcare: When Consent, Privacy, and Safety Collide

A police officer walks in and asks to see a patient who may be trying to evade capture, or seeking lab results of someone who's suspected of driving under the influence. What are your rights and responsibilities—both to your patient and the law?

Suzanne Cate Jones and Anne M. Brendel

CASE REPORT

27 Neck Rash on a 21-Year-Old Male



Key clues to a patient's persistent rash may lie in known or unknown comorbidities. Conducting a thorough history and ordering the right labs right now may be your only chance to get the diagnosis right.

Shailendra Saxena, MD, PhD and Bao Chau Nguyen, BS

OCCUPATIONAL MEDICINE

30 Foundation of Occupational Medicine in the Urgent Care Setting

Offering occupational medicine services can open new revenue streams and smooth out uneven patient flow—provided you understand the right way to get started, and where the best opportunities lie.

Max Lebow, MD, MPH, FACEP, FACPM

IN THE NEXT ISSUE OF *JUCM*

A 38-year-old man with chest pain poses challenges to the urgent care clinician. A fast—and accurate—history is just the first essential step in identifying the source of his trouble and making a sound decision as to whether he needs testing and treatment on site, or requires emergent care. Read one clinician's account of how this actual case evolved in the March issue of JUCM.

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

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When we talk about seasonal visits to urgent care at this time of year, most people probably think about cold, influenza, and various other infections brought on by keeping close quarters inside as illness sweeps through entire families or dormitories. If you read the *JUCM News* e-newsletter, you may also be aware that the holiday season is "popular" for food poisoning, carving accidents, and various effects of overindulging. What we don't necessarily consider is that when people slip and fall on the ice, their instinct is often to put their hand out to break their fall—also breaking bones in the process.

Our lead article this month seeks to right that oversight and ensure that you're ready to assess, diagnose, treat, and offer follow-up advice in the efficient manner for which urgent care is known. Injuries to the Upper Extremity Due to Falls on Outstretched Hands (FOOSH), by **Michael Bartuseck, MSN, ARNP, FNP-C, EP-C**, a nurse practitioner with Hometown Urgent Care and with Central Ohio Primary Care, as well as an instructor at Mount Carmel College of Nursing, begins on page 11.

Another sometimes-overlooked occurrence is the association between acanthosis nigricans and obesity and insulin resistance. It's actually a common one, according to authors **Shailendra K. Saxena, MD, PhD** and **Bao Chau Nguyen, BS.** Their case report, Neck Rash on a 21-year-old Male (page 27) illustrates how a thorough physical exam, complete with a full work-up for insulin resistance, will help you differentiate it from other dermatosis.

Dr. Saxena is a professor in the Department of Family Medicine at Creighton University Medical Center, as well as a member of the *JUCM* Editorial Board; Ms. Nguyen is a medical student at Creighton University School of Medicine, Class of 2018.

On the less acute side, though no less important (especially to your business), is the ever-growing phenomenon of urgent care centers that are reaping great rewards by offering occupational medicine. It's not a new idea, and yet there continue to be operators who are just taking the plunge for the first time.

As always, broadening the scope of your services in a new area can be a scary prospect. It's often helpful to get the advice of someone who has literally been there and done that (especially if they've *done that* especially well). That's why we're happy to introduce you to our latest contributor, **Max Lebow, MD, MPH, FACEP, FACPM**. Perhaps you don't need that introduction, having seen him speak at a UCAOA conference on the potential to increase your revenue by building an occ med practice. He'll be doing the same for *JUCM* in a series of articles, starting with this month's Foundation of Occupational Medicine in the Urgent Care Setting (page 30). Future issues will see him delve into the specifics of proper utilization of occupational medicine, how to document to assure you'll be paid fairly for your services, red flags in occupational medicine, and more.

Dr. Lebow is president and medical director of Reliant Immediate Care Medical Group, Inc.

One thing all business owners need to be aware of is the importance of location in actually getting people to come see you, whether you're opening a clothing store or a new urgent care center. (Bear in mind that urgent care is often described as being a retail delivery channel for healthcare.) **Alan A. Ayers, MBA, MAcc** is as well-versed in the intricacies of running a thriving urgent care center as anyone, so he's the ideal author to tackle this subject for *JUCM*. His article on Successful Site Selection in Urgent Care begins on page 17.

Mr. Ayers is chief executive officer of Velocity Urgent Care and is practice management editor of *JUCM*.

Regardless of where your urgent care center is located, however, it's likely that at some point your staff will interact with law enforcement. Maybe there was a theft on site or a break-in after hours. Or, an officer may demand something that your staff feels would violate their responsibility to the patient or even put their licensure in jeopardy. The latter actually happened in a highly publicized incident last summer, in which a Utah nurse was taken into custody for refusing to facilitate a blood draw at the request of a police officer in her workplace.

These scenarios raise serious, complicated questions so we turned to experts **Suzanne Cate Jones**, a shareholder with Buchalter, a law firm in Los Angeles, and **Anne M. Brendel**, an associate with Buchalter, to provide guidance that we expect will be useful to clinicians and front office workers in urgent care. Law Enforcement and Healthcare: When Consent, Privacy, and Safety Collide begins on page 22.

Also in this issue:

Glenn Harnett, MD reviews current literature relevant to urgent care practice. This month, he looks at new parameters for treating hypertension; maintaining good antibiotic stewardship; new infection guidelines from the American Academy of Pediatrics, and more. Get up to date by reading Abstracts in Urgent Care (page 33).

Finally, in Revenue Cycle Management (page 43), **David Stern, MD, CPC** offers insights into making sure you're properly compensated for conducting Medicare wellness exams. ■

CONTINUING MEDICAL EDUCATION

Release Date: February 1, 2018
Expiration Date: January 31, 2019

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

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

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Case Western Reserve University School of Medicine designates this journal-based CME activity for a maximum of 3 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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CONTINUING MEDICAL EDUCATION

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

Injuries to the Upper Extremity Due to Falls on Outstretched Hands (FOOSH) (p. 11)

1. **Which of the following are important historical factors to explore in patients with a FOOSH injury?**
   a. How injury occurred: Was it high impact, light impact, sporting event, or car accident?
   b. Any previous falls in the past?
   c. What is the location of pain?
   d. Are there any medications which may have contributed to a fall?
   e. All of the above

2. **Which of the following physical exam tests should be performed on all patients with a FOOSH injury?**
   a. Lachmann test
   b. Rovsing's sign
   c. Palpation of the anatomical snuff box
   d. Kernig's sign
   e. Brudzinski's sign

3. **Patients who suffer numbness and tingling after a FOOSH injury along the small and fourth digit should raise suspicion for fracture of the hook of hamate.**
   a. True
   b. False

Successful Site Selection in Urgent Care (p. 17)

1. **According to the article, when deciding on a specific location for an urgent care, what is the ideal community for a start-up?**
   a. A community that is highly populated with heavy traffic flow
   b. Major cities that have competition
   c. Communities that are underserved and have little competition

2. **What similarities does an urgent care share with a retail store when it comes to using algorithms to forecast potential sites?**
   a. Density
   b. Site
   c. Operations
   d. All of the above
   e. None of the above

3. **How can urgent care start-ups utilize occupational medicine to offset the low patient volume during the afternoon hours?**
   a. Strategically scheduling for services such as medicine physicals and therapy physicals
   b. Look for businesses that will use these services, such as trucking, warehouse, and construction industries
   c. Occupational medicine is not cost effective and should be used as a last resort
   d. Both a and b

Case Report: Neck Rash on a 21-Year-Old Male (p. 27)

1. **What is a typical appearance of acanthosis nigricans?**
   a. Vesicles in a dermatomal distribution
   b. Linear vesicles
   c. Velvety, hyperpigmented plaques
   d. Diffuse petechiae
   e. Generalized bullae

2. **Which of the following are possible underlying causes of acanthosis nigricans?**
   a. Diabetes mellitus
   b. Malignancy
   c. Drug induced
   d. Obesity
   e. All of the above

3. **All patients with acanthosis nigricans should receive what?**
   a. Insulin
   b. Weight loss
   c. Treatment of the underlying etiology
   d. Genetic testing
   e. Antibiotics

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Join us for this special black-tie event showcasing prominent members of the urgent care community! The Foundation Celebration is a major fundraising event benefiting research, community and public education programs supported by the Urgent Care Foundation. All proceeds raised during this event fund life-saving research, education and programs that directly support the mission of the Foundation.

ucaoa.org/2018Celebration

EVENT PROGRAM

6:30 pm
Cocktail Reception

7:00 pm
Ballroom Opens & Dinner Begins

8:00 pm
Live Auction & Paddleraise

9:00 pm
Awards Presentation & Dancing

Immediately Following

Urgent Care Foundation
Supporting Research & Education

Urgent Care at the Forefront in the 'New Normal' of Healthcare Delivery

LAUREL STOIMENOFF, PT, CHC

The CVS/Aetna proposed merger is a watershed moment that profoundly underscores the ongoing departure from old school healthcare delivery systems toward a customer-centric approach focused on access, convenience, and affordability.

While some may have been caught off-guard by this and other recent merger and acquisition announcements in the on-demand healthcare sector, those of us in urgent care already recognized this trend in consumer-driven care and have adopted delivery models catering to patient demands and accessibility.

Never Stop Innovating

As the healthcare delivery model continues to evolve, urgent care remains the industry leader providing urgent and primary care at a reasonable price point, often in a single stop for the consumer. Urgent care operators have been agile innovators at the forefront of the consumer healthcare revolution.

In November 2017, *Harvard Business Review* published an article entitled 3 Changes Retailers Need to Make to Survive that stated, *"The retailers left standing are those that figure out how to treat disruption as business-as-usual in an industry accustomed to slow, strategic planning*." It goes on to conclude, *"It's either adapt to the new environment or step aside and make room for a competitor who can."*

We have never been an industry to rest on our laurels (I had to say it); nor will we be in the future. Wise owners hire visionaries, have cultures that allow failure, and never look back. UCAOA's conference exhibit halls are replete with innovative technologies, services, and products, and it is exciting to see attendees engage with the vendors and embracing opportunities to ensure ongoing relevance and viability.

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

"Urgent care holds the reins to redefine on-demand care and its role in the healthcare mix."

Focused Innovation

I've always thought that monitoring new and established patients was one way of evaluating practice relevance. What technologies and campaigns were great at bringing a *new* patient into your office? What experience did they have in the office that brought them back as an *established* patient?

If one side of the new vs established patient ratio is weak or trending negatively without reasonable explanation, it's time to innovate. Where in the continuum of patient acquisition, administration, treatment, follow-up, and billing is your greatest opportunity?

Maintaining the Legacy of Leadership

We collect patient data—both quantitative and qualitative—to understand the best way to provide care and guide future planning. Vigilantly monitoring trends in patient demands and challenging the status quo will sustain our role as industry prognosticators. Consolidations, mergers and acquisitions, and other reshuffling of industry relationships will undoubtedly continue in response to the purchasing behavior of the consumer. We built the urgent care model on principles of customer-driven care, and we now hold the reins to redefine on-demand care and its role in the healthcare mix.

At the forefront of patient-centric transformations, our urgent care leaders educate consumers on their healthcare options, advocate the need for modernization to regulators, and forge stronger relationships with payers in an environment increasingly focused on value. Urgent care sets the tone for today's burgeoning delivery models, and remains laser-focused on the future to ensure growth and success tomorrow.

To read more of our thoughts on the future of urgent care, download the 2018 State of the Industry whitepaper at www.ucaoa.org/whitepaper. ■

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See **CME Quiz Questions** on page 7.

Injuries to the Upper Extremity Due to Falls on Outstretched Hands (FOOSH)

Urgent message: It is common for patients with injuries to the upper extremity due to falls on outstretched hands to present to urgent care. As such, evaluation, appropriate imaging, and initial treatment should all be within a clinic's capabilities.

MICHAEL BARTUSECK, MSN, ARNP, FNP-C, EP-C

Introduction

Urgent care centers play an integral role in treating patients with sustained injuries due to falls on outstretched hands (FOOSH). While complex anatomy of the wrist, hand, and elbow often lead to misdiagnosis of FOOSH injuries, their high prevalence makes it is imperative for urgent care providers to be proficient in diagnosis and management. Adequate treatment, follow-up, and patient education are essential to minimize risk for long-term complications, which may include avascular necrosis of scaphoid, scapholunate advance collapse (SLAC), and scaphoid non-advanced collapse (SNAC) wrist, as well as avascular necrosis and chronic pain. These can lead to significant morbidity and decreased quality of life.

In this article, we provide a simple and concise approach to evaluation, assessment, and treatment of common FOOSH injuries in the urgent care setting.

Anatomical Overview

While elbows and hands may be affected, FOOSH injuries typically impact the wrist, which is relatively complex and composed of eight carpal bones and the distal radius and ulna. Joining these are multiple ligaments and cartilaginous components. Our focus will be directed most at the proximal carpal row (scaphoid, lunate, triquetral), specifically the scaphoid (**Figure 1**).

Scaphoid

The scaphoid presents diagnostic challenges and can be difficult to treat, at least partly due to the fact that its vascular supply limits its ability to heal after injury. The main blood supply is retrograde, with the more proximal 70% to 80% supplied by the dorsal scaphoid branches entering along the dorsal ridge.[1,2] This slow flow of blood supply makes the scaphoid prone to osteonecrosis after injury, especially of the proximal pole, which has been reported to occur in 13% to 50% of such patients regardless of treatment.[2,3]

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Medical History

History taking is enhanced by attentive listening and

Michael Bartuseck, MSN, ARNP, FNP-C, EP-C is a nurse practitioner with Hometown Urgent Care and with Central Ohio Primary Care, and an instructor at Mount Carmel College of Nursing. The author has no relevant financial relationships with any commercial interests.

Table 1. FOOSH Injury Differentials

• Scaphoid fracture • Distal radius fracture • Distal radioulnar joint injuries – TFCC tear – Triquetral avulsion fracture	• Radioscaphocapitate tear • Hook of hamate fracture • Synovitis • Cellulitis • Radial head fracture • Scapholunate tear

focused questions. With FOOSH injury, history should focus on the following:

- How injury occurred: high impact, light impact, sporting event, car accident, replicating FOOSH, etc.
- Previous falls or any information regarding that extremity (osteoarthritis, surgery, previous fractures)
- Medications or illness which predispose patient to musculoskeletal injuries (eg, osteoporosis, dementia, autoimmune disorders, fluoroquinolones)
- Location: ulnar, radial, volar, dorsal, elbow, hand

Inspection should take place throughout the history and focus on key identifiers, including:

- Edema, ecchymosis, abrasions, lacerations, visible deformities, erythema, guarding, patient facial expressions, visible signs of distress or pain, and inspection of nonverbal cues from significant others in the room

After inspection, evaluate the patient's range of motion (ROM). There is conflicting research on performing motion on patients with injuries, as it can in some instances lead to adverse outcomes. Rather, simply asking the patient to demonstrate ROM can aid in assessing severity and guide next steps.

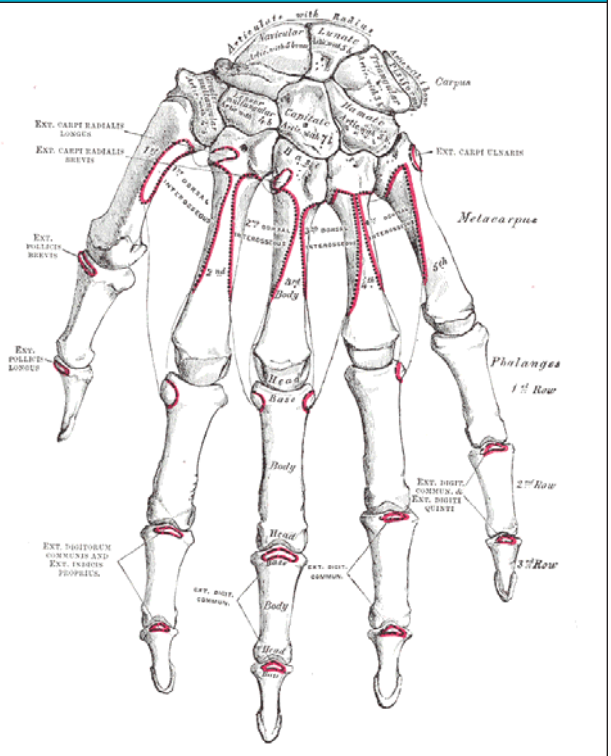
Examination, Diagnosis, and Management

When examining a FOOSH injury (or any orthopedic injury), palpate with a purpose. It is inherent in our role as urgent care clinicians to distinguish among injuries which need immediate stabilization, injuries which need immediate consultation, and injuries that need prompt, but not immediate follow-up. It is important to consider all differentials, as it is common for more than one injury to be present after a FOOSH (**Table 1; Table 2** shows examination techniques to consider).

Scaphoid Fracture

Scaphoid fractures are challenging to diagnose and treat. Patients who report radial-sided wrist pain that is either acute, subacute, or now chronic should be assessed as follows to help guide the clinician to diagnosis:

Figure 1.



Source: Wikimedia Commons contributors.

- Snuff box testing; compression of the anatomical snuff box is highly sensitive for scaphoid pathology. Should be performed on all FOOSH injuries. Pain is a positive finding[4-8]
- Pain on palpation of the scaphoid tubercle. The tubercle is located on the volar aspect of the wrist where the scaphoid is located radially[4-8]
- Thumb axial loading pressure[4-8]
- Thumb ROM causing pain at wrist[4-8]

Diagnostic imaging to assess for scaphoid pathology should consist of multiple views; there should be a lateral, PA, oblique, and ulnar deviation. The ulnar deviation view, also known as the scaphoid view, will open up the waist of the scaphoid for easier viewing for pathology. Despite best efforts with plain imaging, >20% of acute scaphoid fractures go undetected on initial imaging.[8]

Management for confirmed fracture via diagnostic imaging, or even suspicion with history and examination findings as listed above, should be treated as a fracture until proven otherwise. Acute scaphoid injuries are often occult on first radiologic imaging and require further investigation in a week with an orthopedic special-

Table 2. FOOSH Examination Techniques

Exam	Technique	Finding
Snuff box	Compression to anatomical snuff box	Positive for pain with palpation
Watson's	Deviate wrist ulnar with thumb compressed dorsally and index volar over IOSL	Clunk or clicking over the joint, pain, instability
Shuck/ballottement	Apply dorsal and palmar pressure to examining joint for instability	Clicking or movement of the joint/pain
Guyon's canal	Compress palmar aspect of wrist at hypothenar eminence	Pain, numbing tingling ulnar nerve distribution
Piano key	Ulna head compressed with examiner thumb	Ulnar head displaces down then back up
Table top	Press hands on table in pronation	Ulna subluxes volar
Distal radioulnar joint (DRUJ) grind	Stabilize DRUJ with one hand, rotate at carpus with other	Pain, grind, clicking

ist for repeat imaging. In the interim, the patient should be placed into a thumb spica splint (or short arm splint if no thumb spica is available).

It is imperative to explain the reasoning for splinting even without clear diagnosis to the patient. The explanation will help the patient understand the risk for detrimental outcomes if the scaphoid fracture is not treated properly. Those adverse effects include: avascular necrosis, osteoarthritis, chronic pain, decreased ROM, and need for surgery. Follow-up examination with either repeat x-ray or advanced imaging with MRI or CT scan will be required.

Red flag: The clinician *must* palpate the anatomical snuff box with suspicion of scaphoid fractures. Avascular necrosis commonly occurs with missed scaphoid fractures.

Distal Radius Fracture

Colles fractures are the most common type of distal radius fracture. They usually present with obvious deformity. Some, however, may be more subtle and require further investigation. Palpation over the dorsal aspect of the distal radius will elicit significant pain. There will be pain with range of motion of the wrist, and it is likely the patient will decline to perform motion. Diagnostic imaging will be required. Splinting with wrist control or Colles splint is effective with prompt follow-up to an orthopedic specialist. If displacement is present, closed reduction with splinting should be performed (presuming the provider is experienced with closed reduction technique). Postreduction imaging should be obtained.

Red flag: It is imperative to assess the neurovascular components distal to the fracture. If there is any compromise, ED evaluation should be initiated. Assess for motion of the thumb as the extensor tendon (extensor pollicis longus) can be ruptured due to fracture fragments.[2]

Radial Styloid Fracture

Fractures of the radial styloid will typically present in a fashion similar to a fracture of the scaphoid or distal radius. Management is similar to the distal radius fracture, with splinting and orthopedic referral.

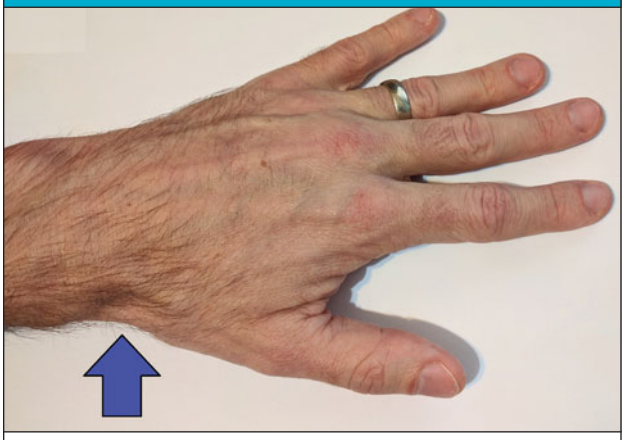
Red flag: With radial styloid fractures, also assess the scaphoid. Radial styloid fractures often present with obvious or occult scaphoid pathology. Palpation over the distal radius will elicit pain; thumb motion will also be very painful. Treat as a combination of scaphoid and radial styloid until proven otherwise.

Radial Head Fracture

Radial head fractures often occur with FOOSH injuries. Patients will complain of wrist pain and elbow pain, and be hesitant to perform ROM. However, pain with supination and pronation at the elbow is imperative for diagnosis. Palpation at the lateral aspect of the elbow elicits pain; you also may feel crepitus at the radial head with supination pronation. X-rays should be ordered, with at least AP and lateral views. Radial head fractures can be difficult to recognize on x-ray. Assess for a sail sign or effusion on the image. A positive fat pad sign aids in diagnosis, as well. If image is inconclusive, but exam is consistent, treat until proven otherwise.

Management should include intensive patient education. Compression wrapping for comfort and stability may be used along with a sling. Early light motion is imperative for these patients, as elbow contracture and stiffness are common after injury, possibly leading to

Figure 2.



Source: Wikimedia Commons contributors.

long-term complications. These patients need to be seen by an orthopedic specialist as soon as possible to begin management. Displacement or step off of the radial head may require surgical intervention, and motion could worsen alignment if not managed meticulously.

Red flags: Follow-up is imperative, as elbow stiffness from too little movement and displacement from too much movement/lifting are common and may lead to long-term complications. In addition, remember to assess the elbow, after a FOOSH.

Scapholunate Tear

Scapholunate (IOSL) injuries can occur solely or in combination with other injuries. They are often diagnosed as a simple sprain. They then continue to cause pain or discomfort in patients, causing them to seek further treatment later in life—at which point surgery to improve symptoms due to SLAC wrist or other irreversible damage will be a likely option. Tears to the scapholunate ligament alter the stability and kinematics of the wrist, causing excess stress and weakness to surrounding structures.[9] SLAC and SNAC wrist are possible complications which could lead to painful osteoarthritis. Surgery is often required to reduce pain and improve function of the wrist for these patients.[10]

Exam findings for scapholunate tears include snuff box tenderness, dorsal wrist tenderness, visible edema, and decreased extension of the wrist. Palpation to the dorsal aspect of the wrist at the location of the scapholunate ligament often yields great discomfort. Watson's test, which is used to assess ligament integrity, is helpful in diagnosis. Weakness of the injured wrist is often present in comparison to the contralateral wrist.[11]

Diagnostic imaging is helpful in determining severity of a confirmed or suspected IOSL tear. Obtain standard views with consideration of closed fist view, as this view will exacerbate an IOSL tear with a widening of the joint spacing in the AP view. Management for scapholunate injury should take into account the commonality of other wrist injuries being possible. Recommendation of a wrist control splint with avoidance of lifting or exacerbating activities and early referral to an orthopedic hand specialist is imperative to avoid long-term complications.

Red flag: It is important to assess contralateral extremity in all cases of FOOSH injuries, as there may be ligament laxity that is normal for that patient. Identifying "normal" ROM for them, as well as grip strength and other findings, such as obtaining imaging bilaterally, can be helpful. Avascular necrosis to the lunate can also occur after scapholunate injury known as Kienböck's disease.

Distal Radioulnar Joint

DRUJ consists of the articular between the distal radius and the ulna, which is boney in nature, and the triangular fibrocartilage complex (TFCC), which consists of cartilage, ligaments, and other soft tissue stabilizers. Patients with DRUJ injuries will typically complain of ulnar-sided wrist pain after a FOOSH. Often, the patient will complain of pain when lifting objects, along with clicking or a feeling of instability, and when pushing. Special examinations for ulnar-sided wrist pain include the piano key sign, grind test, and tabletop testing.[12] There will be pain when the patient supinates, as injury at the TFCC can cause abnormal ulnar head motion. The patient may also have clicking and subluxation of the overlying dorsal extensor carpi ulnar tendon (ECU) as the ulna displaces dorsally in some DRUJ injuries. The TFCC is the most commonly injured structure within the DRUJ, and responsible for most of its stability.

Imaging is needed to rule out fractures, and to assess the DRUJ joint spacing. Injuries to the triquetrum may be present, most notably as avulsion fractures. The triquetral avulsion fracture is best seen laterally in the x-ray. Patients with associated fractures and gross amount of instability and pain should be referred to orthopedic surgery. Most ulnar styloid and triquetral avulsion fractures can be managed with splinting/casting. Concomitant soft tissue TFCC injuries are likely. Patients with confirmed DRUJ pathology should be placed into a splint and referred to a specialist. Those without should have prompt follow-up with a primary care provider for reevaluation and possible advanced imaging and referral.

Red flag: DRUJ instability and ulnar-sided wrist pain

are complex even for seasoned hand surgeons. Obtaining radiographs, assuring no obvious fracture or instability, will get the ball rolling in diagnosis. This is the essential role for the urgent care provider in patients with ulnar-sided wrist pain. Most of these issues will need advanced imaging if the patient continues to have symptoms.

"Thorough history, as well as imaging, is helpful in assessing for acute injury, new or existing arthritis, and infection."

Hook of Hamate

Patients with numbing or tingling after a FOOSH injury along the small and fourth digit should raise suspicion for fracture of the hook of hamate. Body-of-hamate fractures are uncommon. This projection off of the hamate is in close relation to the ulnar nerve and is often fractured with FOOSH, or in sports that involve bats, sticks, or clubs. The patient will complain of ulnar-sided wrist or hand pain, weakened grip, and pain with flexion of the fifth and fourth digits in wrist ulnar deviation (hamate pull test).[13] Examination requires compression of Guyon's canal, eliciting pain and sometimes tingling. This area is volar on the ulnar aspect of the palm and represents the area of the hook of hamate. X-ray imaging must encompass a carpal view. This makes the hook of hamate visible and easier to diagnose. Patients should be splinted and sent for reevaluation for possible advanced imaging if still symptomatic.

Red flag: Provider must obtain carpal view for accurate assessment of the hook of hamate.

Synovitis

Synovitis is inflammation of the synovial lining of a joint or of the surrounding structure of a tendon or tendinous junction. A patient may present to urgent care with painful swelling of the wrist or hand, which limits motion. Synovitis can sometimes result from FOOSH episodes or from no trauma at all. It is important to investigate the numerous potential causes. Patients who display a synovitis may have underlying arthritic or autoimmune disorders. Obtaining thorough history, as well as imaging in these patients, is helpful, as you can assess for acute injury such as fracture and for new or existing arthritis and, in some instances, infection.

Extensor tenosynovitis has a hallmark "V" pattern as swelling occurs following anatomy of extensor wrist tendon sheath. Splinting with anti-inflammatory management is appropriate with no other pathological findings, with referral to PCP for continued management.

When present, flexor tenosynovitis occurs commonly with infection, affecting a hand or finger. Patient will present with swelling, erythema, and decreased ROM. The finger will be held in slight flexion, have a gross amount of swelling, and be painful along the flexor tendon. Passive extension also elicits severe pain.

Infective flexor tenosynovitis is an emergency. Prompt recognition and referral to the ED are paramount. Synovitis presentation should immediately raise red flags as to the underlying cause of the inflammation. Rule out infection immediately, then proceed with examination.

Red flag: Provider must recognize infection of flexor tendon sheath; treatment delay can lead to tendon rupture, skin/tendon necrosis, and loss of digit.

Cellulitis

Patients (especially the elderly, immunocompromised, or those who have a FOOSH in a possibly contaminated area) can develop skin infection. They should be examined to rule out combined musculoskeletal injury coexisting with infection. Imaging may be needed to rule out bony trauma, or any foreign body if wounds are present. Antibiotic treatment should be initiated as deemed necessary, assuming no other pathology is found.

Red flag: FOOSH injuries can accompany puncture wounds. Imaging may show foreign body. Thorough history can help decipher possible foreign body presentation. ■

References

1. Gelberman RH, Menon J. The vascularity of the scaphoid bone. *J Hand Surg Am.* 1980;5(5):508-513.
2. Meyer C, Chang J, Stern P, et al. Complications of distal radial and scaphoid fracture treatment. *Instr Course Lect.* 2014;63:113-122.
3. Steinmann SP, Adams JE. Scaphoid fractures and nonunions: diagnosis and treatment. *J Orthop Sci.* 2006;11(4):424-431.
4. Freeland P. Scaphoid tubercle tenderness: a better indicator of scaphoid fractures? *Arch Emerg Med.* 1989;6(1):46–50.
5. Grover R. Clinical assessment of scaphoid injuries and the detection of fractures. *J Hand Surg Br.* 1996;21(3):341–343.
6. Parvizi J, Wayman J, Kelly P, et al. Combining the clinical signs improves diagnosis of scaphoid fractures: a prospective study with follow-up. *J Hand Surg Br.* 1998;23:324-327.
7. Phillips TG, Reibach AM, Slomiany WP. Diagnosis and management of scaphoid fractures. *Am Fam Physician.* 2004;70(5):879–884.
8. Suh N, Grewal R. Controversies and best practices for acute scaphoid fracture management. *J Hand Surg Eur Vol.* Epub 2017 October 13.
9. Mugnai R, Della Rosa N, Tarallo L. Scapholunate interosseous ligament injury in professional volleyball players. *Hand Surg Rehabil.* 2016;35(5):341-347.
10. Andersson J. Treatment of scapholunate ligament injury: current concepts. *EFORT Open Rev.* 2017;2(9):382-393.
11. Chim HL, Moran S. Wrist essentials: the diagnosis and management of scapholunate ligament injuries. *Plast Reconstruct Surg.* 2014;134(2):312e-322e.
12. Thomas B, Sreekanth R. Distal radioulnar joint injuries. *Ind J Ortho.* 2012;46:493-504.
13. Kadar A, Bishop A, Suchyta M, Moran S. Diagnosis and management of hook of hamate fractures. *J Hand Surg Eur Vol.* 2017 Jan 1:1753193417729603.

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See **CME Quiz Questions** on page 7.

Successful Site Selection in Urgent Care

Urgent message: As a retail delivery channel for healthcare, success in urgent care depends on successfully executing the "retail" elements of the urgent care delivery model—the first of which is "location."

ALAN A. AYERS, MBA, MAcc

Urgent care differs from other types of medicine in that it adheres to a retail delivery model; successful urgent care practices are those that have mastered the traditional retail elements of convenience, accessibility, affordability, and customer service. When it comes to local market development and site selection, the mantra in retail is simple: location, location, location. High-traffic and high-visibility locations in areas that draw consumers for services are really the first keys to success in urgent care. If consumers—ie, patients—don't know your urgent care center exists, they can't find you, and you can't provide high-quality clinical outcomes to patients who aren't there. Therefore, your focus with local market development and site selection is to find the best location for your urgent care center.

Avoiding Saturated Markets

The urgent care landscape in the U.S. has grown tremendously over the years, with roughly 11,000 urgent care centers cropping up across the country. In Charleston, SC, for example, there are over 45 urgent care centers serving a population of 127,000. There are more than 120 urgent care centers serving the 1.6 million people of Phoenix, AZ. This begs the question: are markets too saturated? There are certainly areas of the country where an urgent care center has popped up on almost every intersection, but that doesn't mean there still isn't a lot of opportunity in the United States. You just have to find the right markets and the right locations—which means doing your research and looking for areas of opportunity.

A great place to start is to look at some of the innovative models that operators have figured out in order to avoid setting up shop in oversaturated communities. In Tennessee, for instance, Fast Pace has built more than 50 urgent care centers, none of which are located in major cities like Memphis, Nashville, Knoxville, or Chattanooga. That means all of their urgent care centers are located in rural, secondary markets. Initially, that might

Source: https://www.texasmedclinic.com/location/lh-35-n-eisenhauer/

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First-Mover Advantage?

A considerable conundrum in the urgent care industry is whether an entrepreneur should be the "first mover" into a market. As a retail business, urgent care thrives on cultivating a base of loyal and repeat customers. Consumers generally don't change their preferred routines, so once patients learn where an urgent care center is located and how to use its services, they typically keep returning to that location unless the center somehow fails to meet their expectations. But when you're the first mover in a market, the population density to support a new urgent care center may not be there at first, even if big box retail is already present. Big box retailers like Walmart can require 40 to 60 acres of land (or more) to accommodate parking lots and water run-off, so they tend to build first in growing areas while ample land is available. Fortunately, these chain retailers have thousands of other stores against which to offset the start-up losses on a de novo store, but an urgent care entrepreneur entering into an area too soon runs the risk of exhausting their working capital before the population is strong enough to support the center.

seem counter to urgent care's retail model seeking high incomes and a density of rooftops. But Fast Pace developed a business model much like Walmart's, which got its start in rural Arkansas.

Walmart founder Sam Walton identified a need in those rural southern towns, and people drove more than 30 miles to get to the nearest Walmart. Fast Pace identified a similar need for urgent care services in rural Tennessee, which was underserved and had very little competition. The urgent care centers Fast Pace opened in those rural areas are staffed primarily by nurse practitioners and offer a full range of urgent care services, as well as some primary care. They've done extraordinarily well because not only are they offering a service the community hasn't had before, but they're also making sure they're offering a good patient experience.

Forecasting Location Success

When a retailer like Kohl's or Target plans to open a new location, they utilize predictive forecasting using a mathematical algorithm that can tell them how successful a store is likely to be at a new potential site. Just as urgent care employs a retail model in its execution of healthcare, the algorithm to project the success of a new urgent care center at a potential location has some similarities to retail.

Patient volume is the key driver of revenue in urgent care, so the forecasting algorithm calculates the patient visits a site is projected to draw in. The key factors this algorithm takes into account are:

- Density
- Site
- Operations

Density

The number-one factor that drives volume in urgent care—or any retail business, for that matter—is density, or "rooftops." To draw patient volume, clearly you need people present in an area. However, depending on the market, there are different ways to define "density." If you're in an urban area like Los Angeles, the targeted density may be as close as a mile or may even be defined in terms of drive time (ie, no more than a 10-minute drive time) instead of distance; in rural areas, that catchment may extend out to 30 miles or more. The trade area factors that drive urgent care volume include a density of households and businesses; the demographics of households and businesses; and employees in industries who require occupational medicine services.

Demographics of households and businesses

Once you have selected a dense area of households and businesses, you must determine whether the demographics of those households and businesses match the profile of conventional urgent care users. The people within that area must also have a propensity to use urgent care services, along with the ability to pay for urgent care. Without those factors, you'll be surrounded by a population you can't serve.

The typical urgent care demographic in the United States is married couples with children. This tends to skew toward college graduates who are privately insured and are homeowners living in the growing suburbs of major metropolitan areas. They place a premium on their time, preferring to pay extra to avoid waiting 6 hours in the ED to get medical treatment.

Experience demonstrates that urgent care utilization is directly proportional to household income, meaning as household income increases, so does urgent care utilization. In general, urgent care has grown to match these demographics, gravitating toward the more affluent suburbs of larger cities. But keep in mind that things are rapidly changing, and demographics have started to change as payers change. Many states have started to increase Medicaid reimbursement for urgent care and decrease restrictions on urgent care utilization for managed Medicaid populations, opening up utilization to populations outside of urgent care's conventional demo-

graphics. However, when looking at market share, payer penetration is also a significant factor. If you have a population you are not able to serve due to payer mix, then you have to subtract those individuals when looking at that total population

Potential to offer occupational medicine services

Many urgent care providers get into occupational medicine because it is highly complementary to the urgent care model. Occupational medicine typically levels out the ebb and flow of a seasonal, walk-in business like urgent care because physicals and drug screens conducted on behalf of occ med customers are scheduled, allowing centers to fill in slower times. Occupational medicine can also boost an urgent care center's slower summer months because it tends to be busiest in the summer when companies are hiring; temporary labor is coming in; and construction season is underway. Collecting payment is also usually fairly simple; most urgent care centers are able to arrange Net 15 terms directly with the employers rather than billing a third-party insurance company.

Adding occ med services also helps you hire higher-quality staff. Contrary to popular belief, urgent care centers actually tend to be busiest first thing in the morning because people use urgent care like primary care. If a consumer isn't feeling well, they'll choose to get some sleep instead of heading out to the urgent care center late at night. If they're still not feeling well the next morning, they stop by the urgent care center on their way into work. That's why most urgent care centers are busiest at 8 AM, or whenever they open, and then level off around noon; my midafternoon, business is dead.

In the retail or service industry, you'd hire part-time employees to solve this problem, but in urgent care you can't get good people using that staffing model because most people in the medical field are looking for full-time jobs with benefits. So, scheduling occ med physicals, occupational therapy physicals, travel medicine appointments, and other occ med services helps flatten that daytime ebb and flow.

Areas dense with occ med opportunities might not be as obvious as you think. For example, north Dallas is full of high-rise office buildings and big corporate campuses that might appear rife with occ med opportunities. However, people who work for banks, IT consultancies, and law firms usually don't require work physicals or drug screens and tend to not get hurt at work; or, if they do, their workplace injuries are very minor. The employment base that's actually going to drive occupational medicine business for you will come from industries like trucking, warehousing, distribution, and construction. If you are in a suburban area, some big-box retailers are actually great for worker's compensation business. PetSmart, for example, entails animal bites as well as the typical lifting accidents found in big box stores. However, the one industry that presents occ med opportunities no matter where you are is municipal employment. Police, fire, parks and rec, sanitation, etc., exist in every community, so regardless of where you are, occupational medicine opportunities can be explored by reaching out to your municipality, potentially resulting in revenue that fuels your operations.

(*JUCM* is launching a series of occupational medicine-focused articles this month; read more in Foundation of Occupational Medicine in the Urgent Care Setting by Dr. Max Lebow on page 30.)

Table 1. Retailers with Demographics Similar to Urgent Care

- **PetSmart** – Families with kids use urgent care, and they also tend to have dogs.
- **Lowe's** – Appeals to men and women within the urgent care demographics age range.
- **Home Depot** – More of a business-to-business supplier, so there are occupational medicine opportunities.
- **Target** – Also appeals to women within the urgent care demographics age range.

Site

Having people—or density—is one thing, but you have to have the right location, as well. You can be in a rich, dense area like Times Square in New York, where there are a ton of people, but if you're on the 5th floor of an office building with no signage, you're not going to reach those people. In other words, there are real estate-specific factors that also determine the patient volume projection, including signage visibility, traffic counts, the aesthetics or the curb appeal, and the location of the building.

It's no coincidence when you see a retail zone with a cluster of stores; it's called retail draw. Retailers created that kind of business model because that's where the money is, and it has created a habit in consumers to go to that cluster when they need services. Because urgent care uses this retail model, you want to take advantage of this retail draw when choosing a location.

If you don't know where to pick a location, you can leverage the work that other retailers have already done.

Table 2. Summary of Real Estate Spaces

- Retail centers: Outlot buildings, in-line strips, endcaps
- Medical/dental professional buildings
- Former Hollywood Video buildings
- Former bank branches
- Urban storefronts
- Low-rise business parks and industrial flex spaces
- Second-floor spaces
- Former restaurants
- Lifestyle centers
- Office condominiums
- Empty big-box stores
- First mover in a new development

Kohl's, for instance, has incredible market research that tells them where they can be successful. If you look at who shops at Kohl's—most typically women ages 25 to 55 who are employed and have children—the demographics look a lot like the traditional urgent care demographics. So, if urgent care is serving the same consumer base as Kohl's, and you see a Kohl's store but there's no urgent care nearby, that could indicate there's probably an opportunity for an urgent care in that area. See **Table 1** for examples of other retailers that complement the urgent care demographic. If you're looking at an area where there's no retail, that's a big red flag for urgent care.

The location and design of the real estate space you select for your urgent care center will have a serious impact on your patient volume. If your patients encounter too many barriers when trying to visit your urgent care center—they can't see your center, they have trouble getting to it, or they have nowhere to park—they aren't going to come to you when they need medical care. Some key questions to ask when selecting a real estate space are:

- Is there high-visibility building signage?
- Are there parking limitations?
- Are there medical use exceptions?
- Is the building difficult to get to?
- Is the building highly visible?
- Will the build-out be too expensive?
- What are the ongoing maintenance costs?
- Is there good car and foot traffic during key times/days?
- Are there any accessibility issues for injured patients?
- Is there any risk of poor quality co-tenants in the future?

Types of real estate spaces

According to the Urgent Care Association of America's 2015 benchmarking study, the average square footage of an urgent care center is 3,700 square feet, about the size of an old Blockbuster or Hollywood Video. In fact, abandoned Hollywood Videos tend to be the ideal size and location for an urgent care center, so many have been remodeled into new urgent cares.

However, real estate spaces within retail centers, such as outlot buildings, in-line strips, and endcaps are also good options because they take advantage of retail draw, but they each have specific pros and cons to consider. Medical and dental professional buildings might seem like natural choices because of the patient traffic, but you need to research any service restrictions, parking issues, or signage limitations that could impact your center.

Urban storefronts have great visibility and car and foot traffic, but there are generally parking issues and a lack of night and weekend patient volume with these types of locations. Low-rise business parks have lower rent and an employment base for occupational medicine, but they typically lack the urgent care demographic. Lifestyle centers might be dense with the urgent care demographic but have high rent, parking issues, and really low signage visibility. A summary of the different types of real estate spaces can be found in **Table 2**.

Signage visibility

A critical factor for success is the visibility of your building and street signage. Your signage should have the same advertising impact as a billboard, and should prominently feature your center's name (which should include the words "urgent care" or otherwise clearly and concisely communicate the services you provide).

Good signage boosts the return for all other marketing investments. Texas MedClinic, which has urgent care centers in the San Antonio and Austin markets, combines high traffic counts, signage, and location to market their urgent care facilities. Texas has very high-traffic freeways that almost always have frontage roads lined with the rooftops of big-box retail and dense residential. Texas MedClinic's strategy has been to locate their centers along these frontage roads so drivers on these freeways, which have more than 100,000 cars a day, see their centers, turning their buildings into billboards. In other words, their physical facilities are key components of their marketing strategy. When the consumer drives by, they see that sign every day, and then they hear the radio ad and see the billboard, which starts to reinforce a message.

"Density and location don't matter if you're not able to meet consumers' needs from an operational standpoint."

As you can see, the facility is important. This may be cost-prohibitive for a startup urgent care, but traffic signage should be a key component of an urgent care marketing strategy for an established business.

Facility aesthetics

Center aesthetics are very important, as well. Healthcare is what we call a "blind product," or something the consumer really can't evaluate based on quality. A patient goes to the urgent care thinking she has pneumonia, and the doctor listens to her chest and tells her it's not pneumonia. The patient doesn't have the expertise to know whether the doctor is right or wrong; all she can judge is whether she feels better or not. So, because the consumer lacks the ability really to evaluate the clinical quality of care provided, they look for cues in their environment. That's why it's critical to have a facility that's clean, organized, modern—all attributes that connote quality. If the facility's a dump, the consumer is going to think, "A good doctor wouldn't work in this place. This isn't quality." Your facility could have the best doctor in the world, but your center aesthetics might communicate otherwise.

Operations

Now that you have people and a location, what is your operating model? Density and location don't matter if you're not able to meet consumers' needs from an operational standpoint, so you'll need to evaluate what the need is in your community. If your local community needs services at 10 PM, for example, but your center closes at 6 PM, your operating model isn't meeting your consumers' needs. The key components to consider include:

- Operating hours
- Medical providers/training
- Equipment/capabilities
- Customer service

Conclusion

As the urgent care industry continues to grow and change, look to creative urgent care models to avoid entering oversaturated markets. Use the algorithm to forecast projected patient volumes by looking at density, site, and operational factors. These factors will help you determine whether a potential site will have the patient volume to support a new urgent care center. If you're struggling with where to start, use the research retailers have already done when selecting sites for their stores; Kohl's or Target didn't choose the location of their stores haphazardly. A vast amount of market research went into the selection of those sites, and you can leverage that to your advantage. And as you start selecting potential sites, look to the future of your practice and consider whether you will have a multicenter footprint in the future. You will want to sell one day, and a multicenter footprint will generally command more value than a single center. ■

The Value of a Multicenter Footprint

When it comes time to sell an urgent care practice, the value per center of a local, multicenter network is generally greater than that of a single urgent care center. Urgent care centers are typically valued at a "multiple" of their earnings; whereas a single center may be worth four-times earnings, large multicenter networks have commanded premiums of 10- to 12-times earnings or higher. This is because when a center that has a multilocation presence, the following synergies are realized:

- **Marketing** – A multicenter footprint can better leverage mass media, improve internet marketing, and provide more service points for more people, more effectively building a local brand than a single location.
- **Staffing** – A multicenter footprint can create a bench of staff who can fill gaps caused by paid time off and maternity/paternity leave, or the ebb and flow in patient volumes across the center footprint, enabling greater staffing efficiency across the footprint.
- **Administration** – Centralized support functions like IT, human resources, accounting, and purchasing become more efficient when supporting a greater number of employees across a local business.
- **Operations** – Development of a multisite footprint enables scalable and repeatable systems and processes, including policies and procedures, which form the basis of consistency and quality across the sites.
- **Payers** – Payers want to offer a robust network of urgent care centers to their members, so a multilocation footprint that's out of network can lead to lost employer sales and member dissatisfaction for health plans.

Although some entrepreneurs are satisfied starting and running one center as a long-term business investment, many others proceed with the idea that if they are to one day sell their business, they can maximize the value and the appeal by covering a broader geography with multiple sites.

Law Enforcement and Healthcare: When Consent, Privacy, and Safety Collide

SUZANNE CATE JONES and ANNE M. BRENDEL

Urgent message: Urgent care providers are likely to encounter law enforcement officers in the workplace at some point—and to be asked to comply with requests that may or may not violate a patient's right to privacy, or compromise the urgent care center's compliance with federal or state law or medical ethics. Understanding your legal rights and responsibilities is essential to fulfilling your obligations to both the patient and the law.

Introduction

On the heels of the widely publicized incident involving the arrest of a Utah emergency room nurse for refusing a law enforcement officer's demand that she draw blood from an unconscious patient without the patient's consent, ED and urgent care providers may be left wondering how to appropriately respond when receiving requests from law enforcement. Such requests can trigger multiple compliance issues, including patient privacy and consent requirements, particularly when a provider's compliance with such requirements conflicts with law enforcement needs and goals, such as public safety, collection of evidence, and evidence integrity.

Providers working in emergency and urgent care settings face a unique set of challenges when dealing with law enforcement demands, due to the urgent "triage" approach (often involved when caring for patients in serious condition) and providers' access to potentially incriminating or identifying evidence that may be sought by law enforcement. As a result, courts have found that patients in the ED have a diminished expectation of privacy because of the nature of emergency care.[1-3] Nonetheless, even with a diminished expectation of privacy, compliance with a law enforcement officer's request is not always appropriate under the law. Thus, it is important for providers to know what the law is, in order to discern when a law enforcement request is in accord with the law and when it is not.

Complicating things further for providers, the "law" that governs such situations is not a single law but an entire network of rules and regulations, policies, and guidelines. For example, compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Fourth Amendment of the U.S. Constitution, among other laws, merely establishes a floor for what is required in connection with law enforcement requests that implicate patient privacy and consent requirements. State laws regarding privacy and consent, including criminal laws, introduce additional intricacies which vary widely across state lines.

In addition, there are facility policies and procedures, and state and national hospital associations that offer additional guidance for appropriately responding to law enforcement requests. The analysis here offers basic considerations related to appropriate provider responses to law enforcement requests when a patient has not given his or her consent or authorization with regard to a law enforcement request. Law enforcement requests to emergency providers typically include: 1) patient access; 2) fluid, body, or tissue samples; and/or 3) protected health information (PHI).

Accordingly, each of these types of requests will be discussed separately.

Requests for Patient Access

Providers who work in EDs (or urgent care settings) will be familiar with the fact that law enforcement officers are commonly present for one reason or another, because their duties often include responding to car accident scenes or other circum-

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"Generally, law enforcement is not permitted access to a patient without that patient's permission, unless the law enforcement officer has presented a warrant, restraining order, or other court order."

stances that involve injured people who need medical treatment (sometimes as a result of criminal activity). When not already present, law enforcement also may be specifically called by the hospital or urgent care facility in order to assist a provider in certain situations. In these and other types of circumstances, law enforcement officers may request access to an admitted patient in the ED or urgent care facility who has not consented to access.

There are several rules that govern whether or not law enforcement may appropriately have access to an admitted patient who has not given consent or authorization for such access.

Generally, law enforcement is not permitted access to a patient without that patient's permission, unless the law enforcement officer has presented a warrant, restraining order, or other court order—in spite of the aforementioned diminished expectation of privacy. Patients have a right of protection from unreasonable searches and seizures under the Fourth Amendment of the U.S. Constitution. Providers, however, should fully cooperate in seeking to obtain the patient's consent when a law enforcement officer requests access to a patient. On the other hand, if a provider believes that such access might impede the patient's care, access may be refused, unless a warrant, restraining order, or other court order is presented specifically permitting law enforcement access. Then, providers should allow the officer access consistent with the order.

Circumstances in which it is typically appropriate for a law enforcement officer to have access to an admitted patient without patient consent include instances where access to a patient is needed for safety purposes. For example, if access is requested for the safety of patients and/or security of facility staff because a patient has made threats or exhibited other behavior indicating that law enforcement protection is warranted, then law enforcement may be allowed access, as necessary. Access in such a case is dependent upon necessity (ie, whether it's necessary that law enforcement be present for safety reasons). In these types of situations, safety concerns will prevail over privacy protections—with limitation. For example, with regard to patients in police custody, it may not always be appropriate to have law enforcement inside a patient's room during an examination, when waiting outside is sufficient as determined by the HIPAA-covered provider/facility as long as it's consistent with the order or warrant.

It is also useful to note that, pursuant to various laws and state hospital association guidance, law enforcement is permitted to accompany a patient who is in law enforcement custody, in the ED or urgent care center, while the patient is being treated in connection with legitimate law enforcement activities.[4-6] In these cases, providers should take necessary precautions to limit disclosure of PHI to only what is necessary for the legitimate activity, and limit disclosure of other PHI belonging to the patient to the extent possible. In addition, if and when the scope of such request expands to include a body fluid or tissue sample in connection with a criminal investigation related to the patient, then state law regarding informed consent for medical services will apply, in addition to federal and state privacy laws.

Requests to Obtain Body, Fluid, or Tissue Samples from Patient

Generally, providers may not render medical services without the patient's consent, unless performance of emergency, lifesaving care is necessary. Taking samples from a patient is a type of medical service; thus, state consent laws apply. In addition, providers may not disclose PHI without patient authorization. State consent laws limit providers' responses to requests from law enforcement to obtain body, fluid, or tissue samples from a patient, and federal and state privacy laws limit disclosure of the sample results.

EMTALA considerations

It appears that the law continues to be unsettled regarding whether or not the Emergency Medical Treatment and Active Labor Act (EMTALA) requires an ED or urgent care center to perform a medical screening examination (MSE) on an individual who is accompanied by law enforcement. EMTALA requires an MSE if 1) an individual comes to the ED (which includes individuals brought to the ED by law enforcement), or, in some cases, an urgent care center,[7] and 2) there is a request for examination or treatment of a medical condition.[8] Additional legal and regulatory complexities arise when a patient is not personally requesting an MSE or experiencing an emergency condition.[9] In fact, CMS interpretive guidelines state that a hospital may not be required to provide an MSE to such individuals.[10] In such cases, EMTALA requires providers to take reasonable steps to obtain the patient's written informed consent to refuse or waive examination and treatment of a medical condition.[11]

"Federal and state privacy laws limit disclosure of the results of body, fluid, or tissue samples taken from a patient, when certain conditions are present."

State consent considerations

As a general rule, the patient must consent for law enforcement to obtain a patient sample, or the law enforcement officer must be in possession of a warrant or administrative request.[12,13] In most states, the law requires that licensed drivers consent to blood or urine testing following an arrest for driving under the influence when they obtain their driver license. These laws are considered "implied-consent laws."

Under implied-consent laws, blood draws may be performed on an unconscious patient in an ED or urgent care if the patient has been arrested for driving under the influence because the patient has already consented to such a blood draw when obtaining his or her license. However, if the patient who has been arrested for a DUI is conscious, then the patient cannot be forced to submit to a blood draw. Thus, a blood draw may be performed only with the patient's consent, unless the law enforcement officer has an applicable court order or warrant. Even though drivers have consented to blood or urine tests prior to obtaining their driver licenses, at the time of law enforcement's request for a blood draw, patients may still choose to withhold their consent and be subject to legal consequences for such withholding. Providers may be protected from civil liability for taking and/or being required to take a patient's blood sample from patients who are arrested or involved in a car accident pursuant to a law enforcement request.[14]

HIPAA considerations

There are some exceptions to the consent requirement under HIPAA in specified circumstances that implicate health and safety concerns. Specifically, blood draw results, or other PHI, may be disclosed without patient authorization *to avert a serious threat* to the individual's or the public's health or safety. Depending on the state, providers may even be required to notify law enforcement of any blood test result that indicates the patient's blood alcohol level is at or above the legal limit or of the presence of a controlled substance, but only if the provider is providing medical care immediately after the patient's involvement in a car accident.

As stated above, federal and state privacy laws limit disclosure of the results of body, fluid, or tissue samples taken from a patient, when certain conditions are present. This is because the result of the blood draw, or any other sample taken from a patient, *if accompanied by patient identifiable information*, constitutes PHI and thus triggers HIPAA and state privacy laws, as discussed below. Patient samples alone, however, are not PHI. As such, samples (or sample results) may be provided to law enforcement without patient authorization, but only if the sample is not accompanied by information identifying the patient, and the results have been de-identified. Such information does not constitute PHI under HIPAA because PHI must be individually identifiable.

Requests for PHI

HIPAA and state privacy laws generally prohibit the disclosure of PHI to law enforcement. However, a provider may disclose PHI to law enforcement without patient authorization, including individually identifiable samples or sample analyses, under certain circumstances. It is important to note that disclosures of an individual's identifiable DNA, dental records, body, fluid, or tissue samples or analysis cannot be disclosed without a court order, warrant, or written administrative request in the following situations:

1. When required by law

Providers may disclose PHI to law enforcement when disclosure is required by state law (eg, gunshot wounds). HIPAA permits disclosure of PHI as necessary to comply with state laws. A provider may also disclose PHI in response to 1) an administrative request (ie, an administrative subpoena), 2) a civil or authorized investigative demand, or 3) some other authorized legal process.

The conditions for disclosure are 1) that the information sought is relevant and material to a legitimate law enforcement inquiry, 2) that the request is specific and limited in scope (to the extent reasonably practicable), and 3) that de-identified information could not be reasonably used. Such disclosure should be limited to the PHI requested.

2. Law enforcement requests relating to identification and location

When requests are made by law enforcement for PHI without being accompanied by an administrative or court order, a provider's disclosure of PHI must be limited to disclosures for identifying and locating a suspect, fugitive, material witness, or missing person. Even then, providers are not given free-rein to respond to such requests. Such disclosure should be limited in accordance with the limitations described below.

3. Provider is a victim or crime occurs on hospital or urgent care facility premises

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In the event that a provider is the victim of a crime (for example, a patient assaults a provider), then the provider–victim may disclose PHI to law enforcement, provided that the PHI disclosed is 1) about the suspected perpetrator of the crime and 2) limited to information for identification and location purposes. If a crime occurs on the facility's premises, a provider may report PHI that he or she believes, in good faith, to be evidence. Such disclosure should be limited in accordance with the limitations described below.

4. To apprehend a perpetrator

A provider may disclose PHI to law enforcement when the provider reasonably believes a patient may have caused serious physical harm to a victim—provided that the admission was not made in the course of or based on the individual's request for therapy, counseling, or treatment related to the propensity to commit a violent act. Such disclosure should be limited in accordance with the limitations described below.

5. To avert a serious threat to health or safety

A provider may disclose information that he or she believes in good faith is 1) necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and 2) is to a person who can reasonably prevent or lessen the threat or is necessary for law enforcement authorities to apprehend an individual. Such disclosure should be consistent with ethical standards and limited in accordance with the limitations described below.

Limitations on certain disclosures of PHI

Where indicated above, disclosures are limited to the following information: name and address, date and place of birth, Social Security number, ABO blood type and rh factor, type of injury, date and time of treatment, date and time of death, and a description of distinguishing physical characteristics (ie, height, weight, gender, race, hair and eye color, facial hair, scars, and tattoos). State laws may further restrict provider disclosures.

Conclusion

Providers who work in ED and urgent care settings will be faced with law enforcement requests that trigger multiple compliance issues. As discussed above, a provider's response to a law enforcement request is limited by applicable federal and state law and facility policies and procedures. Unless law enforcement has presented a warrant, restraining order, or other court order requiring a different response, providers must obtain appropriate consent from patients prior to providing access to patients or obtaining samples from patients. In addition, providers must keep patient PHI safe and endeavor to balance patient and public safety and privacy protections when dealing with such requests. ■

"A provider may disclose information that he or she believes is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public."

References

1. *Wilson v State*. 99 S.W.3d 767 (Tex. App. 2003).
2. *Buchanan v State*. 432 So. 2d 147 (Fla. Dist. Ct. App. 1983).
3. *State v Rheaume*. 2005 VT 106.
4. Oregon Association of Hospitals and Health Systems. *HIPAA and Law Enforcement – Guidelines for Release of Protected Health Information (PHI) in Oregon* (2013). Available at: https://community.corporatecompliance.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=129e6da4-7a3d-4a20-a4d9-356a729356cd. Accessed January 8, 2018.
5. Washington State Hospital Association. *Hospital and Law Enforcement Guide to Health Care Related Disclosure, Eighth Edition* (2017). Available at: http://www.wsha.org/wp-content/uploads/HIPAA-Guide-2017-Update.pdf. Accessed January 8, 2018.
6. Florida Hospital Association, *HIPAA Requirements and Florida Law – Disclosure of Protected Health Information for Law Enforcement Purposes* (2016). Available at: http://www.fha.org/showDocument.aspx?f=HIPAA_Requirements_and_Law_Enforcement_Guide.pdf. Accessed January 8, 2018.
7. Medicare State Operations Manual. Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases § IV (Task 2 – Care Selection Methodology). Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_V_emerg.pdf. Accessed January 8, 2018.
8. Oregon Association of Hospitals and Health Systems, *Hospital & Law Enforcement Guidance for Conducting Forensic Blood Draws*. March 2016. Available at: https://www.oahhs.org/sites/default/files/forensic_blood_draw_guidance_FINAL_March2016.pdf. Accessed January 8, 2018.
9. Bitterman RA. Blood alcohols, labs, and minor treatments in the ED: is a medical screening exam required by EMTALA? *ACEP News*. July 1998. Available at: https://www.acep.org/Clinical—-Practice-Management/Blood-Alcohols,-Labs-and-Minor-Treatments-in-the-ED—Is-a-Medical-Screening-Exam-Required-by-EMTALA-/. Accessed January 8, 2018.
10. Centers for Medicare and Medicaid Services. State Operations Manual Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases. July 2010. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_V_emerg.pdf. Accessed January 8, 2018.
11. Examination and Treatment for Emergency Medical Conditions and Women in Labor (EMTALA). 45 U.S.C. § 1395dd(b)(2).
12. *Missouri v McNeely*. 569 U.S. 141. 2013.
13. American Hospital Association. Guidelines for Releasing Patient Information to Law Enforcement. Available at: http://www.aha.org/content/00-10/guidelinesreleasinginfo.pdf. Accessed January 8, 2018.
14. Pennsylvania Title 75 Pa.C.S.A. Vehicles § 1547(j).

*(**Authors' note:** Our intent here is to provide basic considerations for healthcare providers when faced with law enforcement requests in an ED or urgent care setting. However, the content of this article does not constitute legal advice. This article should not be used as a substitute for obtaining legal advice from an attorney licensed to practice in your jurisdiction. Providers should consult their facility policies, ask their facility's general counsel, and/or seek outside counsel advice whenever questions arise with regard to law enforcement requests related to patients.)*

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Reference: 1. https://www.federalregister.gov See "Microbiology Devices: Reclassification of Influenza Virus Antigen Detection Test Systems Intended for Use Directly with Clinical Specimens" (82 Fed. Reg. 3609) for the relevant performance specifications.

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See **CME Quiz Questions** on page 7.

Neck Rash on a 21-year-old Male

Urgent message: Acanthosis nigricans has a strong association with obesity and insulin resistance. Assessment involves a thorough physical exam to differentiate from other dermatosis, as well as full workup for insulin resistance. Early diagnosis in the urgent care setting, and treatment, will improve the appearance of acanthosis nigricans, but also the patient's overall morbidity.

SHAILENDRA SAXENA, MD, PhD and BAO CHAU NGUYEN, BS

Introduction

A 21-year-old Caucasian male presented for a circumferential hyperpigmented rash around the neck that began several months ago.

History

Past medical history was significant for morbid obesity and bipolar disorder. Previous medications included quetiapine fumarate (Seroquel) and bupropion (Wellbutrin). Family history was significant for diabetes in maternal grandmother and negative for gastrointestinal cancers.

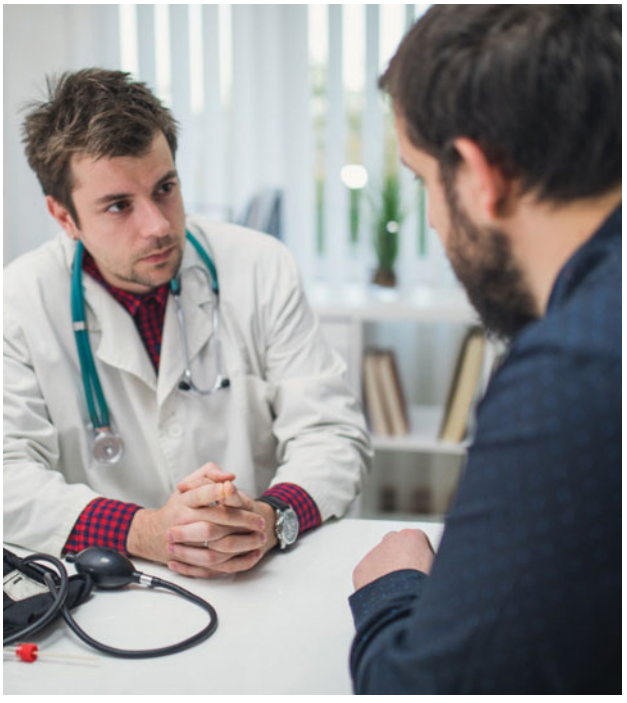
Physical Examination

Physical examination was negative for constitutional symptoms. Cardiac exam revealed regular rate and sinus rhythm with no extra heart sounds, murmurs, rubs, or gallops. Pulmonary exam showed clear auscultation bilaterally without rhonchi, rales, or wheezes.

Physical inspection of the neck area revealed circumferential velvety, papular, hyperpigmented rash and skin tags. Areas of rash did not blanch with pressure palpation and were not associated with pruritus or discomfort. The rest of physical inspection was within normal limits.

Differential Diagnosis

- Linear epidermal nevus – benign, linear hyperpigmented plaques that can become more prominent over time
- Confluent and reticulated papillomatosis – hyperpigmented and scaly plaques that occur on the neck, chest, and upper back, often seen in young adults
- Granular parakeratosis – pruritic brown-red plaques that often involve the axilla



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Workup

Physical exam suggested the neck rash being acanthosis nigricans due to its chronic nature, as well as the velvety,

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Table 1. Treatment options for acanthosis nigricans, as well as their potential side effects

Categories	Treatment Types	Outcomes and/or Side Effects
Treatment of underlying disorders (preferred method)	• **Obesity:** encourage weight loss • **Insulin resistance:** agents that improve insulin sensitivity, such as metformin • **Malignancy:** treatment of underlying malignancy	• Moderate improvement when associated with obesity and malignancy[1,2] • Uncertain improvement with insulin resistance[3,4]
Skin-directed treatments (for those who remained dissatisfied with improvement)	• Topical retinoids • Topical vitamin D analogs: reduce keratinocyte proliferation • Other topical agents: urea, salicylic acid, glycolic peels • Laser therapy	• Moderate success with 2-week course with few side effects[5] • Moderate success in some patients[6] • Moderate improvement after multiple sessions with few side effects[7] • Marked improvement after multiple sessions with few side effects[8]
Systemic treatments (reserved for very severe and refractory cases)	Systemic isotretinoin and acitretin	• Moderate success in patients with severe acanthosis nigricans[9] • Wide range of potential side effects, such as scaling of the skin and cheilitis[5]

unblanching characteristics with no pruritus. Patient was also worked up for insulin resistance with fasting serum glucose and hemoglobin A1C. No malignancy workup was done due to his young age, absence of family history, and no signs and symptoms aside from the neck rash.

Diagnosis

His neck rash was determined to be acanthosis nigricans secondary to insulin resistance.

Management

As acanthosis nigricans is associated with diabetes, it was not surprising the patient's lab results revealed insulin resistance, with fasting serum glucose of 110 mg/dL (normal 70-100 mg/dL) and HbA1C of 6.6% (normal <5.7%). He was started on oral metformin extended-release 750 mg once daily and counseled on lifestyle changes and exercise.

Treatment

Due to the benign and asymptomatic nature of acanthosis nigricans, cosmetic concerns are the focus of available treatments. Methods are divided into three categories: treatment of the underlying disorders, skin-directed treatments, and systemic treatments. These are detailed further in **Table 1**.

Discussion

Acanthosis nigricans is a benign, asymptomatic dermatosis characterized by velvety, hyperpigmented plaques most commonly found on surfaces of the neck and axilla. A thorough physical exam will differentiate acanthosis nigricans from its dermatosis counterparts, mainly through physical appearance and the absence of pruritis in acanthosis nigricans.

Acanthosis nigricans is closely associated with obesity and insulin resistance. This case study demonstrates the importance of a systemic approach to treating dermatosis in an acute setting. In patients with no history of insulin resistance but who are obese and have acanthosis nigricans, a full workup for diabetes mellitus should be performed. If a diagnosis of diabetes is reached, patients should be counseled on weight loss and started on agents that improve insulin sensitivity.

Rarely, acanthosis nigricans can also be linked with adenocarcinomas of the gastrointestinal (GI) tract.[10] A malignancy workup is warranted in patients with GI signs and symptoms. Treatment of underlying malignancy is the preferred therapy for those with malignancy-associated acanthosis nigricans.

In this case, this patient's presentation of a circumferential neck rash required more than just a topical hydrocortisone treatment; a full workup revealed diabetes mellitus-associated acanthosis nigricans. GI malignan-

Figure 1.

Velvety hyperpigmented rash and skin tags visualized around the neck.

Summary

- Acanthosis nigricans is characterized by velvety, hyperpigmented plaques most commonly found on surfaces of the neck and axilla.
- Differential diagnosis for acanthosis nigricans includes linear epidermal nevus, confluent and reticulated papillomatosis, and granular parakeratosis.
- A full workup for diabetes mellitus should be performed on patients with no history of insulin resistance but who are obese and have acanthosis nigricans.
- A malignancy workup is warranted in patients with both acanthosis nigricans and GI signs and symptoms.

cies were ruled out based on the absence of GI symptoms and a negative family history.

With the rising incidence of obesity and insulin resistance in the U.S. population, especially in younger age groups, it is vital for all acute care clinicians to diagnose and treat associated systemic diseases such as diabetes mellitus in cases of suspicious acanthosis nigricans. ■

References

1. Kuroki R, Sadamoto Y, Imamura M, et al. Acanthosis nigricans with severe obesity, insulin resistance and hypothyroidism: improvement by diet control. *Dermatology*. 1999;198(2):164–166.
2. Anderson SH, Hudson-Peacock M, Muller AF. Malignant acanthosis nigricans: potential role of chemotherapy. *Br J Dermatol*. 1999;141(4):714-716.
3. Bellot-Rojas P, Posadas-Sanchez R, Caracas-Portilla N, et al. Comparison of metformin versus rosiglitazone in patients with Acanthosis nigricans: a pilot study. *J Drugs Dermatol*. 2006;5(9):884-889.
4. Tankova T, Koev D, Dakovska L, Kirilov G. Therapeutic approach in insulin resistance with acanthosis nigricans. *Int J Clin Pract*. 2002;56(8):578-581.
5. Darmstadt GL, Yokel BK, Horn TD. Treatment of acanthosis nigricans with tretinoin. *Arch Dermatol*. 1991;127(8):1139-1140.
6. Gregoriou S, Anyfandakis V, Kontoleon P, et al. Acanthosis nigricans associated with primary hypogonadism: successful treatment with topical calcipotriol. *J Dermatolog Treat*. 2008;19(6):373-375.
7. Ichiyama S, Funasaka Y, Otsuka Y, et al. Effective treatment by glycolic acid peeling for cutaneous manifestation of familial generalized acanthosis nigricans caused by FGFR3 mutation. *J Eur Acad Dermatol Venereol*. 2016;30(3):442-445.
8. Rosenbach A, Ram R. Treatment of Acanthosis nigricans of the axillae using a long-pulsed (5-msec) alexandrite laser. *Dermatol Surg*. 2004;30(8):1158-1160.
9. Katz RA. Treatment of acanthosis nigricans with oral isotretinoin. *Arch Dermatol*. 1980; 116(1):110-111.
10. Lee SS, Jung NJ, Im M, et al. Acral-type Malignant Acanthosis Nigricans Associated with Gastric Adenocarcinoma. *Ann Dermatol*. 2011;23(Suppl 2):S208-S210.

Foundation of Occupational Medicine in the Urgent Care Setting

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Urgent message: Much has been written about the integration of occupational medicine into urgent care practice. However, doing so successfully requires consideration of many important factors. This is the first in a series of articles that will examine occupational medicine in the urgent care setting from the financial and practice management viewpoint, with the aim of guiding the urgent care decision-maker and practitioner in the best practices of business and clinical occupational medicine practice.

Introduction

Occupational medicine is a branch of preventive medicine. In practice, it is generally divided into workers compensation; the treatment of workplace illnesses and injuries; and occupational health, a broad field which includes workplace wellness and injury prevention, fit-for-duty and specialty physicals (eg, Department of Transportation), and drug and alcohol testing. While these disciplines are usually closely linked, they differ in actual practice and management and will be discussed separately.

Synergy of Urgent Care and Occupational Medicine

Urgent care and occupational medicine share many qualities of medical care and treatment. Most workplace injuries consist of minor trauma, similar to urgent care in both cause and treatment. However, it is the differences in handling that make occupational medicine a natural companion to urgent care.

Urgent care and occupational medicine can be synergistic. While urgent care is typically a morning and evening business, occ med physicals, re-checks and drug tests can be scheduled for the slower times of the afternoon to level patient ebb-and-flow and maximize productivity of a center's providers and staff. It is often a financial challenge to keep providers and staff productive during all daily hours of clinic operations. Occupational medicine provides a balance in that its busiest hours are during the day when urgent care is slowest, and vice versa. This allows even busier clinics to add occupational medicine to their menu of services without having to increase staff. Further, occupational medicine complements urgent care not only on a daily basis, but seasonally as well. And whereas urgent care is busiest in the winter months (eg, associated with flu and flu symptoms), occupational medicine is busiest during the summer months when companies are hiring and construction projects are in full swing.

Taken together, the combination of urgent care plus occupational medicine tends to smooth out the census graph throughout the day. This complementary dynamic is demonstrated on a regular basis at Reliant Immediate Care in Los Angeles, which, due to an airport location, is accessible to many large employers in the transportation industry who require compliance physicals and drug screenings. The airport location results in urgent care being busiest in the evening hours, with employers sending occ med cases in the morning.

As such, the occupational medicine patients can help equalize the patient census over the course of a day. [This is illustrated graphically in this month's Developing Data feature on page 48.]

The Value Proposition of Occupational Medicine

There are about 3 million workplace injuries and illnesses in the U.S. each year. Injury rates tend to be highest in the transportation, warehousing, construction, and manufacturing in-

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dustries, as well as with municipal employers like police, fire, sanitation, and parks/recreation. Depending on which industry is using your clinic, there could be between 3 and 7 injuries per 100 employees. And even in industries in which injury rates are low, client businesses still need basic occupational health services, such as preplacement physical examinations, fitness for duty exams, and drug screens.

The Cascade of Occupational Medicine: Compelling Economic Rationale

Once an urgent care patient has been registered, treated, and discharged, that's often the end of the encounter. In clear distinction from urgent care, discharge of the occupational medicine patient from their first work comp visit begins a cascade of follow-up care and case management, ancillary services (especially physical therapy), medication, and DME services. (See **Figure 1**.) Each episode of care, even follow-up for physical therapy, and medications/DME represent additional revenue opportunities for the clinic. And whereas workers comp and urgent care visits are reimbursed by third parties (either insurance or the government), occ med services like physicals and drug screens are paid by employers directly under NET/15 terms, enabling quick and ready cash flow for a center vs insurance accounts receivable which can take 45 to 60 days or longer to collect.

The Work Comp Cascade

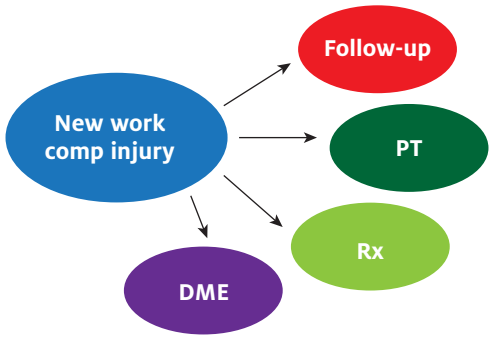
New injury/illness visit to the clinic

Initial medical management of occupational medicine patients differs little from urgent care treatment. Wound care, musculoskeletal injuries, basic fracture care, and contact dermatitis are treated similarly.

Perhaps the greatest difference goes to causation—workers comp expects a provider to opine on whether an injury was caused by employment, which means effective occ med providers get out and see their client's businesses. Workers compensation providers must also be mindful of OSHA regulations that make certain activities such as allowing time off work or prescribing certain drugs as "recordable," which can affect a client's workers compensation insurance premiums. Many workers compensation providers thus take a conservative approach to treatment—work hardening through light/modified duty and physical therapy in lieu of surgery or prescription drugs.

Over the long run, workplace new injuries will carry higher revenue in many cases for two reasons: First, workplace injuries and trauma are more likely to also have associated procedures such as sutures, or a diagnostic test such as an x-ray. Some states even allow acupuncture and chiropractic for workers comp, which can be integrated into the urgent care/occ med practice as well as specialty services like orthopedics, hand surgery, and physiatry (physical medicine). And some providers further provide impairment examinations that assess a patient's total disability from a workplace incident.

Figure 1. The Work Comp Cascade



By contrast in urgent care, in states where case rates and managed-care predominate, many urgent care visits carry a case- or flat-fee reimbursement rate, regardless of what is done during the visit. In work comp cases, the work comp fee schedule is more likely to reimburse fee-for-service for all procedures performed and documented. The combination of trauma-related visits and the work comp fee schedule tends to bring the reimbursement for initial work comp injury treatment to about 30% over the average urgent care visit reimbursement in most clinics, in our experience. Fee schedules can differ significantly by state, as they're typically set not by carriers, but by state industrial commissions.

In urgent care, the patient is referred back to their primary care physician at the end of a typical visit. For work-related injuries, patients are referred back to the urgent care/occupational medicine clinic for follow-up until the patient is deemed able to return to work.

Workplace Injury Follow-Up Care

In our experience, workplace injuries require about 3.2 follow-up visits for each new injury treated, on average in our clinic. Some new injuries may be so minor that they do not require any follow-up, while others will require weeks of recovery and treatment. For purposes of forecasting, these work-related injury follow-up cases can be estimated to about 80% reimbursement of the new patient average urgent care visit.

Physical therapy

Our recommendation is for urgent care/occupational medicine clinics to bring physical therapy in-house as soon as possible, for several reasons.

- First, having PT in-house improves the quality of care for the injured patient. Many patients can be improved by "work hardening" as opposed to surgery or drugs, which

Figure 2.

Each new work comp injury/illness				Each new urgent care visit		
	Charges	Visits/injury	Total		Charges	Total
New injury	$265		$265	New	$140	$140
Follow-up	$100	3.2	$320			
PT	$92	2.8	$258			
Medication	$85	$85				
DME	$75	$75				
Charges/new injury			$1,003	Collections		$140

Estimated revenue from a hypothetical worker comp patient vs a typical urgent care patient

enables them to heal faster and return to work more quickly. Communication between the physical therapist and the treating physician is key to identifying patients whose recovery may be delayed. Time off of work, not medical, is typically the employer's greatest expense of workplace injuries. Involvement of a physical therapist can result in earlier changes in treatment course, earlier diagnostic testing, or referral to a specialist.

- The second reason to bring physical therapy in-house is for convenience and employer/employee satisfaction. Businesses are looking for a one-stop solution to their workplace injury issues. Additionally, physical therapy can be used for occ med testing, such as demonstrating lift techniques, which is an additional cash service.
- Finally, physical therapy, if done correctly, can generate revenue for the clinic. In an active occupational medicine clinic like ours, there are usually about 2.8 physical therapy visits per new injury. Properly billed, and depending on the state work comp fee schedule, physical therapy should reimburse at about 65% of a typical urgent care new visit.

Medication and durable medical equipment

This is a rapidly evolving area of occupational medicine. Regardless of any changes the marketplace may undergo, there will always be a need for injured workers to get their medication and DMEs dispensed at the time of service. Negotiation with pharmacy benefit plans is a must to retain the ability to get patients what they need, when they need it. State workers comp legislation plays a role, as well.

Putting It All Together

All told, worker comp patients are likely to become more frequent and more lucrative than a "typical," straightforward urgent care patient. The sheer complexity of the process makes for a more formal and long-lasting relationship between patient and provider. **Figure 2** illustrates the projected revenue in a hypothetical case.

"Adding occupational medicine to an urgent care practice can help improve efficiency and help meet fixed costs by keeping staff busy across all hours of operation."

As described previously, adding occupational medicine to an existing urgent care practice can help improve efficiency and help meet the fixed costs of the practice by keeping staff busy across all hours of operation. This is important given that labor, and especially provider labor, is the greatest expense in urgent care.

What is learned from the occupational medicine cascade is that for each new workplace injury treated in the clinic, in terms of income, revenue can be expected to equal or surpass the revenue generated from up to seven urgent care visits, factoring follow-up visits, physical therapy, and medication and DME into the reimbursement mix. This means that even a modest program (say, 50 new injuries per month, less than 2 new injuries per day), can generate enough revenue to convert a struggling practice into one that is solidly in the black.

Next Steps

So, let's get started, right? Not so fast. To have a successful and long-term occupational medicine program, the clinic will need basic marketing; providers who understand the active management of occupational medicine illness and injuries and proper documentation; and a commitment to quality of care and occupational medicine that is defined by its own parameters of success. In our next articles, we will discuss the elements of a successful occupational medicine program, so providers and clinic operators alike can make the transition to offering occupational medicine as smoothly and efficiently as possible. ■

ABSTRACTS IN URGENT CARE

- Lower Parameters for Treating Hypertension
- Maintaining Good Antibiotic Stewardship
- New Infection Guidelines from AAP
- Faster CLIA-Waived CBC Test
- New Data on Migraine Medications
- Acetaminophen and Ibuprofen for Extremity Pain
- Resistant *Neisseria Gonorrhoeae*
- From AHA: New CPR Guidelines

GLENN HARNETT, MD

Each month the College of Urgent Care Medicine (CUCM) provides a handful of abstracts from or related to urgent care practices or practitioners. Glenn Harnett, MD leads this effort.

Revisiting Parameters for Treating Hypertension

Key point: New guidelines have lower thresholds for diagnosis and treatment of hypertension.

Citation: Whelton PK, Carey RM, Aronow WS, et al. 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *Hypertension*. [Epub ahead of print November 13, 2017]

The 2017 American College of Cardiology/American Heart Association (ACC/AHA) guidelines provide guidance for the prevention, detection, evaluation, and management of hypertension in adults. Recommendations include a lower threshold for the diagnosis of hypertension based on office blood pressure readings. Hypertension is now defined as a blood pressure ≥130 mmHg systolic or ≥80 mmHg diastolic; the treated blood pressure goal should be <130/<80 mmHg. The guidelines recommend pharmacologic therapy for all diagnosed hypertensive patients who have higher cardiovascular risk, and also for lower-risk patients who have a blood pressure ≥140 mmHg systolic or ≥90 mmHg diastolic. ■

Glenn Harnett, MD is principal of the No Resistance Consulting Group in Mountain Brook, AL; a board member of the College of Urgent Care Medicine and the Urgent Care Foundation; and sits on the *JUCM* editorial board.

Follow-Up: Curbing Inappropriate Antibiotic Use Long-Term

Key Point: Interventions to reduce inappropriate antibiotic prescribing likely need to be applied long-term to maintain effect.

Citation: Linder JA, Meeker D, Fox CR, et al. Effects of behavioral interventions on inappropriate antibiotic prescribing in primary care 12 months after stopping interventions. *JAMA*. 2017;318(14):1391-1392.

This study, published in *JAMA*, showed that stopping prescriber behavioral interventions aimed at reducing inappropriate antibiotic prescribing may cause a rebound in prescribing rates. This was a follow-up study to a prior randomized trial where two behavioral interventions, "accountable justification" and "peer comparison," were associated with reductions in inappropriate antibiotic prescribing in adults with acute respiratory infections. The accountable justification intervention required clinicians to write a justification for prescribing antibiotics when prompted by their electronic health record. In the peer comparison intervention, clinicians received emails that ranked their inappropriate prescribing rate against their peers' rates. In this follow-up study, the researchers measured the inappropriate prescribing rates in the 12 months after the interventions were stopped. The inappropriate prescribing rate increased from 6.1% to 10.2% in the accountable justification group, which was comparable to a control group who did not receive any behavioral interventions. The inappropriate prescribing rate increased from 4.8% to 6.3% in the peer-comparison group over the same 12-month period. The peer-comparison group still had better prescribing rates than the control group. This research suggests that these interventions may need to be applied long term to maintain their effectiveness. ■

New AAP Recommendations on Pediatric Infection Control

Key point: New guidelines on infection control in outpatient pediatric settings published by the American Academy of Pediatrics.

Citation: Sadoughi S, Sofair A. New guidance posted on infection control in pediatric ambulatory settings. *NEJM J Watch*. Available at: https://www.jwatch.org/fw113456/2017/10/23/ new-guidance-posted-infection-control-pediatric. Accessed January 11, 2018.

The American Academy of Pediatrics has updated its recommendations on infection control and prevention for pediatric ambulatory medical settings. This update provides new guidelines on infection control in pediatric ambulatory settings. Changes to the previous guidelines include a strong recommendation that all healthcare providers should receive an influenza vaccination annually. Specific recommendations for patients with cystic fibrosis include providing a mask for these patients when in common areas, as well as making sure they do not share common waiting areas with other patients. These patients may remove their masks when in a treatment room, although clinicians should follow contact precautions. Whenever transferring patients to the emergency department or hospital, information about the patient's diagnosis and isolation should be communicated. Other infection control measures include placing signs that promote cough etiquette in patient areas and waiting rooms. In addition, it is wise to avoid having plush animals in the waiting area, since these toys may harbor infectious bacteria or viruses. ■

Faster Results for CLIA-Waived CBC Tests

Key point: FDA approves the first CLIA-waived complete blood count (CBC) device for use in outpatient settings.

Citation: Brooks M. FDA approves new CLIA-waived CBC test for faster results. *Medscape*. Available at: https://www.medscape.com/viewarticle/888165. Accessed January 11, 2018.

Traditionally, outpatient medical offices had to be certified as a moderately complex laboratory to perform CBC testing onsite or send CBC blood samples to off-site laboratories, often requiring a delay of ≥24 hours to receive results. A new device reduces the number of hematology parameters to 12 (still including a complete blood count and differential). This new CLIA-waived, point-of-care device may provide more facilities, such as urgent care centers, the ability to perform this testing at the bedside. This device may give more urgent care clinicians the ability to access CBC results in real time and make more timely and informed medical decisions. ■

Prochlorperazine + Diphenhydramine vs IV Hydromorphone for Migraine

Key point: A new study reveals that prochlorperazine is superior to hydromorphone for pain relief in patients with migraine headaches.

Citation: Friedman BW, Irizarry E, Solorzano C, et al. Randomized study of IV prochlorperazine plus diphenhydramine vs IV hydromorphone for migraine. *Neurology*. 2017;14(89):2075-2082.

This randomized control trial published in *Neurology* compared 1 mg of IV hydromorphone with 10 mg IV prochlorperazine + 25 mg of diphenhydramine (to prevent akathisia) in patients with acute migraine headaches. Results revealed that the prochlorperazine/diphenhydramine combination was effective in pain relief for 60% of patients, compared with only 31% of patients who had pain relief with hydromorphone. The results were so profound that the data monitoring committee halted the trial early after only enrolling 127 patients. Researchers concluded that IV hydromorphone is substantially less effective than IV prochlorperazine for the treatment of acute migraine in the ED and should not be used as first-line therapy. ■

Nonopioids Over Opioids in Acute Extremity Pain

Key point: Acetaminophen and ibuprofen are superior to opioids for acute extremity pain.

Citation: Chang AK, Bijur PE, Esses D, et al. Effect of a single dose of oral opioid and nonopioid analgesics on acute extremity pain in the emergency department: a randomized clinical trial. *JAMA*. 2017;318(17):1661-1667.

This randomized, controlled trial published in the *New England Journal of Medicine* compared the analgesic effect of ibuprofen plus acetaminophen vs oxycodone or codeine plus acetaminophen. It enrolled 411 patients, randomized to four different regimens:

- ibuprofen 400 mg plus acetaminophen 1 g
- oxycodone 5 mg plus acetaminophen 325 mg
- hydrocodone 5 mg plus acetaminophen 300 mg
- codeine 30 mg plus acetaminophen 300 mg

The mean pain score before treatment was 8.7 (on an 11-point scale). There were no statistical differences among treatment groups 2 hours after treatment. These results suggest that urgent care providers may be able to avoid prescribing opioids for acute extremity pain by recommending acetaminophen and ibuprofen. ■

Resistant *Neisseria gonorrhoeae* in North America

Key point: Ceftriaxone-resistant Neisseria gonorrhoeae *has arrived in North America.*

Citation: Lefebvre B, Martin I, Demczuk W, et al. Ceftriaxone-resistant *Neisseria gonorrhoeae*, Canada 2017. *Emerg Infect Dis*. 2018;24(2). [Epub ahead of print]

Multidrug–resistant *Neisseria gonorrhoeae* has become more

prevalent throughout the world, but has not been identified in North America—until now, in Canada. Clinicians there isolated this pathogen via culture in a 23-year-old female with genital gonorrhea. The patient reported that she had a sexual partner who had unprotected sex during a trip to China and Thailand. Sensitivity results revealed the pathogen to be resistant to ceftriaxone, ciprofloxacin, and tetracycline but susceptible to azithromycin. Urgent care clinicians should consider performing a culture in cases where a gonorrhea infection may have been acquired in Asia or, like in this case, when the patient had a sexual contact with someone who had unprotected intercourse in Asia. ■

AHA: Compressions Over Respirations with CPR

Key point: New American Heart Association (AHA) guidelines for CPR focus on compressions more than respirations.

Citation: Kleinman ME, Goldberger ZD, Rea T, et al. An update to the American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. *Circulation*. 2018;137(1):e7-e13.

The AHA has updated its CPR recommendations in order to improve outcomes during out-of-hospital cardiac arrest. The new guidelines place renewed emphasis on the importance of effective compressions and when to give ventilations during CPR. In bystander-witnessed cardiac arrest, instructions are to apply compression-only CPR. All bystanders should provide chest compressions. Bystanders who are trained, willing, and able should give two rescue breaths after each cycle of 30 compressions. EMS providers should perform CPR with rescue breaths (30:2) or continuous chest compressions with positive pressure ventilations until a supraglottic device or endotracheal tube is established. When a tracheal tube is in place, positive pressure ventilations should be provided without pausing compressions. Of special note, ventilation is always recommended for children, though compressions should not be withheld if bystanders are unable or unwilling to perform rescue breaths. ■

UC+BG URGENT CARE Buyer's Guide™

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With listings from more than 340 companies, the JUCM Urgent Care Buyer's Guide is the "go-to" resource for information on goods and services in urgent care. The simple, easy-to-use, standalone website lets decision-makers connect with vendor experts with the click of a finger. Browse urgent care suppliers by category, search for suppliers by keyword or category, or view Buyer's Guide listings for featured suppliers.

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

INSIGHTS IN IMAGES

CLINICAL CHALLENGE: CASE 1

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

If you would like to submit a case for consideration, please log on to http://jucm.scholasticahq.com and follow the instructions to upload your text and image(s).

A 20-Year-Old Woman with Acute Chest Pain

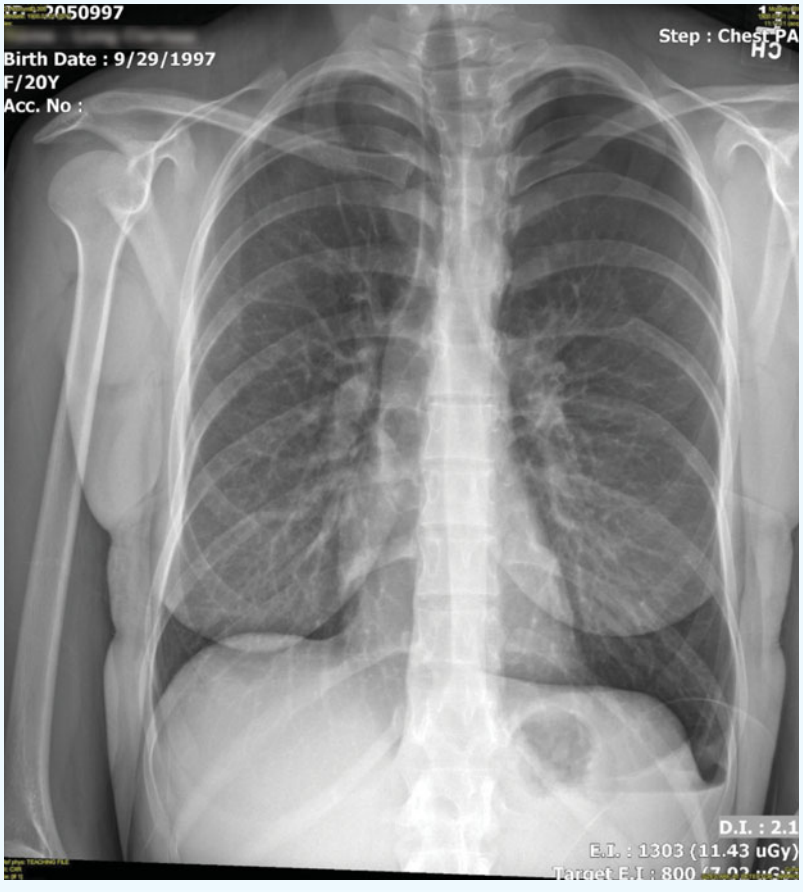


Figure 1.

Case

The patient is a 20-year-old female who presents with sudden onset of left sided chest pain. A collegiate cross-country runner, she reports that she also felt lightheaded when lacing up her running shoes earlier in the day.

View the image taken (**Figure 1**) and consider what your diagnosis and next steps would be. Resolution of the case is described on the next page.

THE RESOLUTION

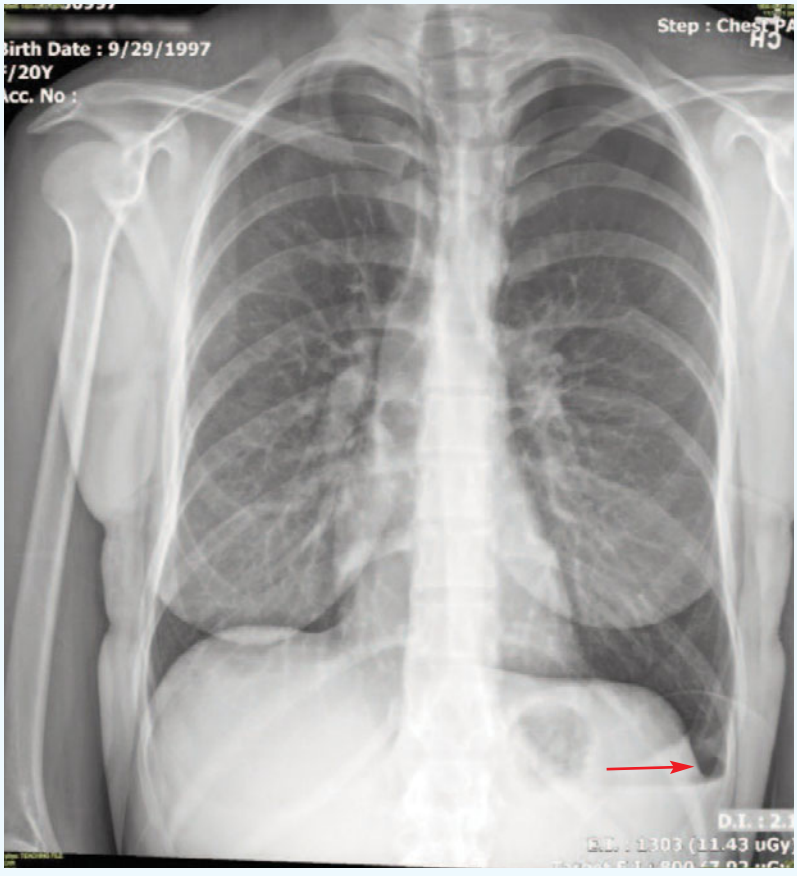


Figure 2.

Differential Diagnosis

- Acute aortic dissection
- Acute pericarditis
- Pediatric acute respiratory distress syndrome
- Primary spontaneous pneumothorax
- Pulmonary embolism

Diagnosis

The patient has primary spontaneous pneumothorax, which occurs most often in patients <35 years of age who have no underlying lung disease. Note the lack of lung markings in the left lower lobe at the site of the costophrenic angle.

Learnings

- People with a tall, thin build are more likely to develop a primary spontaneous pneumothorax
- Symptoms can include chest pain, dyspnea, tachycardia, and hypotension
- More concerning symptoms of tension pneumothorax include tachycardia, tachypnea, hypotension, lack of breath sounds on the affected side, increased jugular venous distension, and tracheal deviation

Pearls for Urgent Care Management and Consideration for Transfer

- For patients with a relatively small pneumothorax, administering oxygen with follow-up in the urgent care clinic or with the patient's primary care physician is appropriate
- Larger pneumothoraces or repeat episodes may warrant chest tube drainage. Surgery may also be considered in some patients
- A tension pneumothorax with hemodynamic instability or mental status change should undergo immediate needle decompression

CLINICAL CHALLENGE: CASE 2

A 51-Year-Old Man with Shortness of Breath and 'Burning' in His Chest

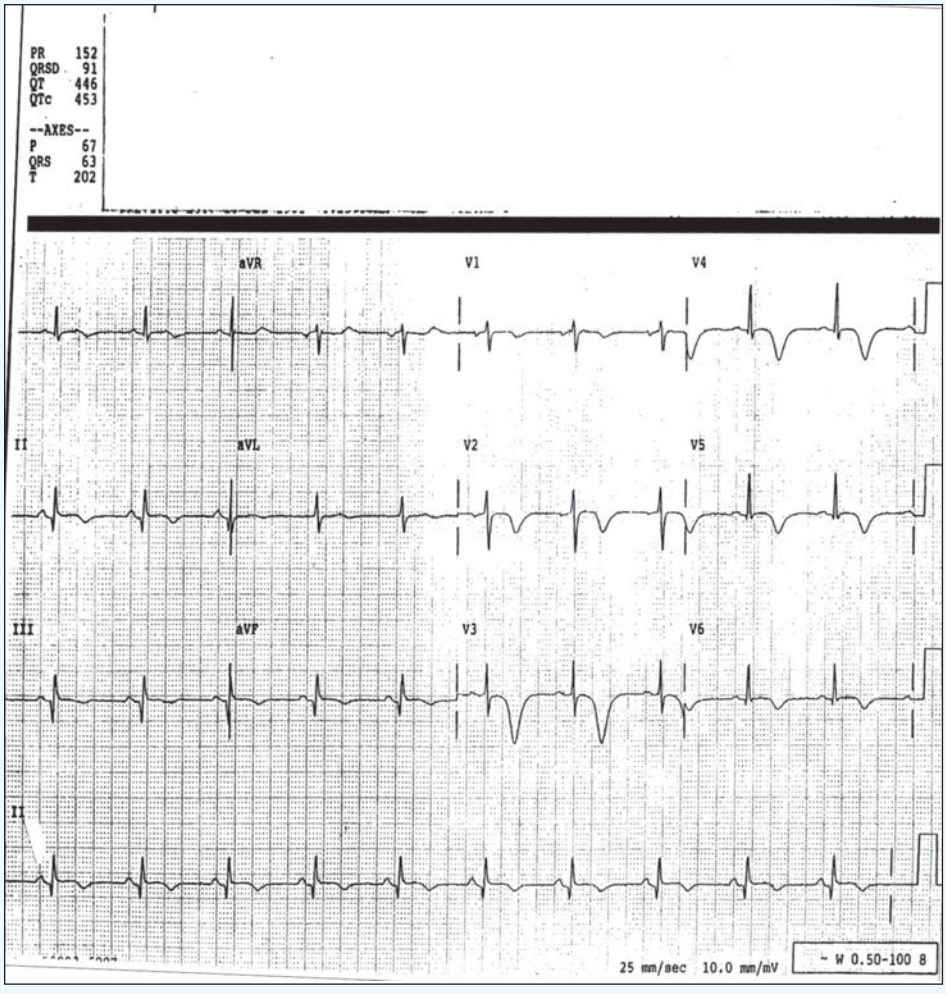


Figure 1.

Case

The patient is a 51-year-old man with shortness of breath and an intermittent burning sensation in his chest. His symptoms began 2 days ago.

Upon exam, you find:

General: Alert and oriented

Lungs: CTAB

Cardiovascular: RRR without murmur, rub, or gallop

Abdomen: Soft and NT without r/r/g

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

THE RESOLUTION

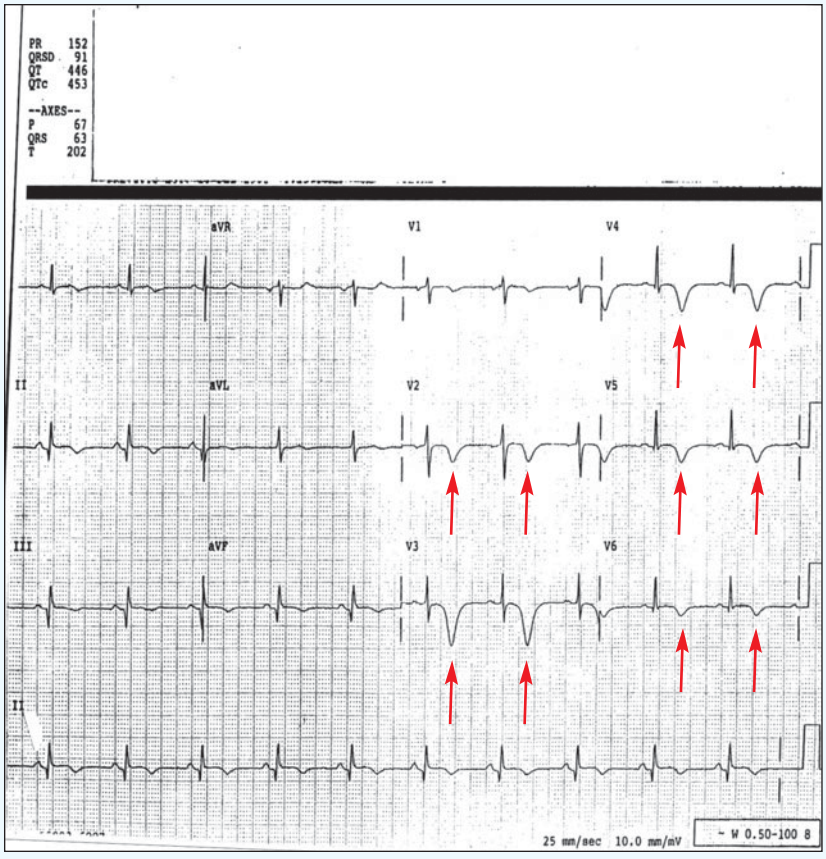


Figure 2.

Differential Diagnosis

- First-degree AV block
- Wolff-Parkinson-White
- Anterolateral ischemia
- Right bundle branch block
- Hyperkalemia

Diagnosis

The patient has anterolateral ischemia. The ECG reveals T wave inversion, likely from ischemia, in the anterior and lateral distribution

Learnings/What to Look for:

- Leads V3 and V4 reflect blood supply to the anterior part of the heart, whereas leads I, aVL, V5 and V6 reflect blood supply to the lateral part of the heart
- The anterior part of the heart usually gets its blood supply from the left anterior descending artery (LAD), also called the "widow maker"
- The inferior part of the heart usually gets its blood supply from the right coronary artery (RCA). It is reflected on the ECG in leads II, III, and aVF
- Note that an isolated T wave inversion or Q wave in lead III only is a normal finding. (A Q is 'free' in III. A flipped T is 'free' in III)

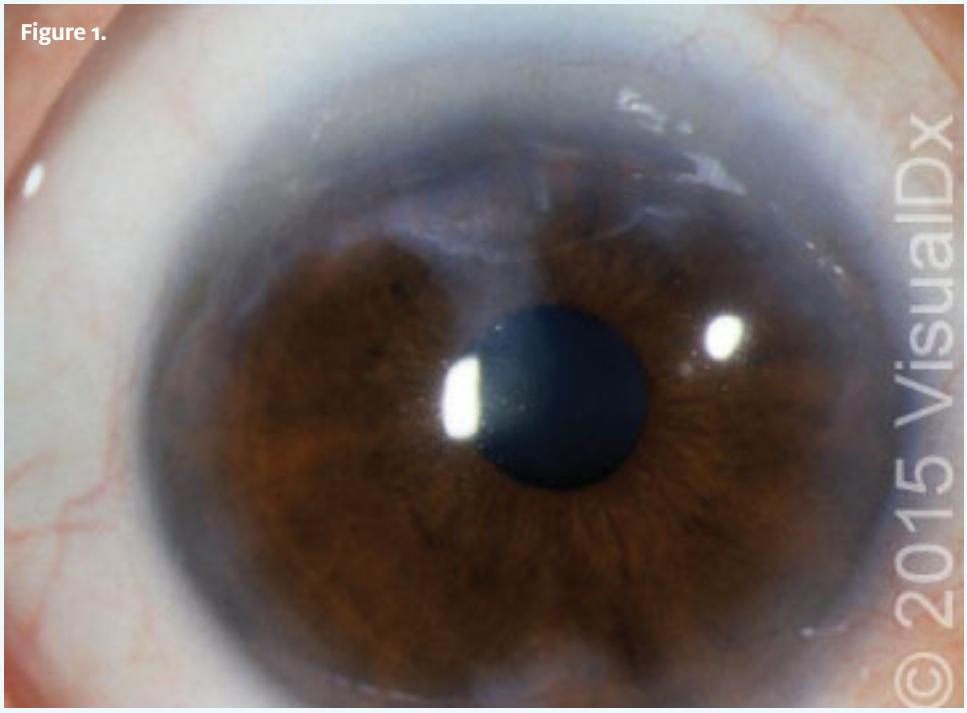
Pearls for Urgent Care Management and Considerations for Transfer

- Compare to a previous ECG, if available, as anterior T wave inversions may also occur from intracranial processes, including bleeding
- Patients with chest discomfort and/or dyspnea with an ECG concerning for anterolateral ischemia should have emergent transfer to the ED. While awaiting transport, the patient should be monitored, have IV access obtained if possible, and receive 81-160 mg aspirin
- EMS should be notified that the patient has an ECG concerning for ischemia

CLINICAL CHALLENGE: CASE 3

A 45-Year-Old Male with Sudden Eye Pain

Figure 1.



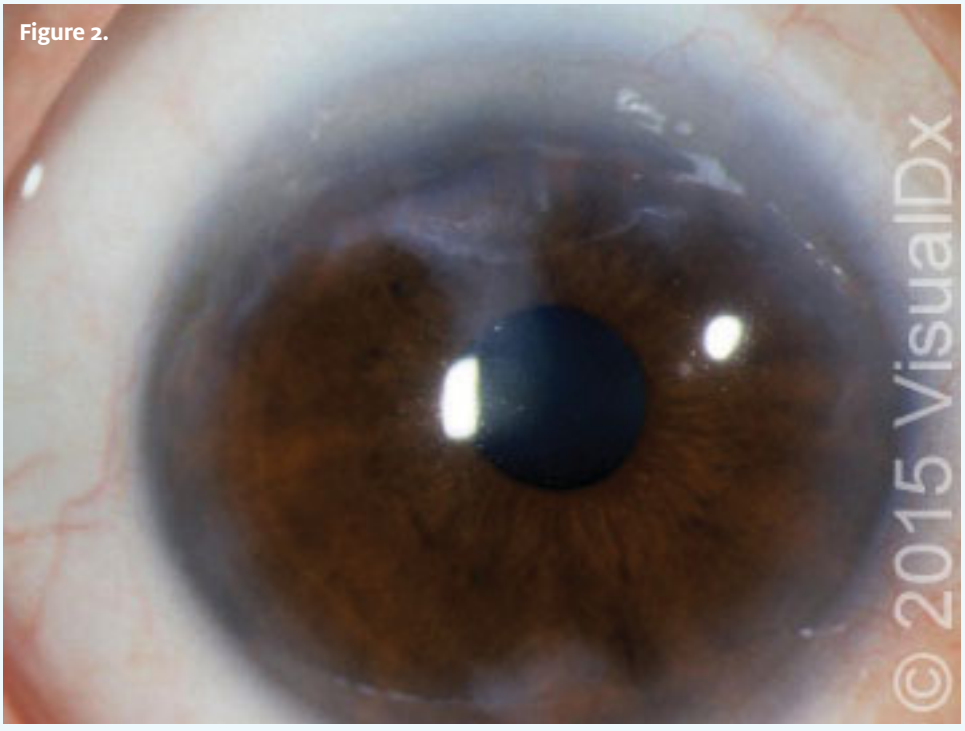
Case

A 45-year-old man presents with bilateral ocular pain, excessive tearing, and bloodshot eyes. He reports that his symptoms began 2 days ago with the sensation of a foreign body lodged in his eye, and that his eyes have been unusually sensitive to light. He has not worn his contacts since the onset of symptoms.

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

THE RESOLUTION

Figure 2.



Differential Diagnosis

- Blepharitis
- Contact lens solution toxicity
- Corneal foreign body
- Herpes simplex virus keratitis

Diagnosis

This patient is experiencing contact lens solution toxicity—a diagnosis that could be missed if he wasn't questioned as to contact lens use.

Learnings

- This toxicity is often associated with improper contact lens wear or poor contact lens hygiene
- There are two types of contact lens toxicity:
  - The more common form is caused by contact lens overwear (often sleeping in contact lenses), leading to corneal hypoxia. This will lead to rapid decline in vision associated with ocular pain, redness, and light sensitivity. Chronic hypoxia may cause corneal scarring and vascularization
  - The second type has been classically associated with the preservative thimerosal, but can be seen with any contact lens solution. Patients will complain of ocular discomfort and foreign body sensation

Pearls for Urgent Care Management and Consideration for Transfer

- The patient should be advised to wear his glasses instead of contact lenses pending ophthalmology follow-up
- Supportive care includes cold compresses for itching and swelling; warm compresses for aching, pain, or discharge; rinsing the eye(s) very gently with cool water; and avoidance of rubbing the eyes

Get the Most Out of Providing Medicare Wellness Exams

DAVID E. STERN, MD, CPC

Q. Are there specific requirements for Medicare wellness exams and who can perform them?

A. Medicare offers an initial preventive physical examination (IPPE), which is also known as the "Welcome to Medicare" preventive visit or the annual wellness visit (AWV). Either a physician (a doctor of medicine or osteopathy) or a qualified nonphysician practitioner (a physician assistant, nurse practitioner, or certified clinical nurse specialist) can provide the services.

The IPPE is a one-time initial examination that is covered within the first 12-month period after a participant is enrolled in Part B Medicare *only*. You would bill Healthcare Common Procedure Coding System (HCPCS) Level II code G0402, "Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment" for the service, which has an average reimbursement of $168.68. However, you can check the Medicare physician fee schedule for your jurisdiction for exact pricing (https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx).

Medicare has not designated a specific International Classification of Diseases Tenth Revision, Clinical Modification (ICD-10 CM) code to use. A couple of options are: Z00.00, "Encounter for general adult medical examination without abnormal findings" and Z00.01, "Encounter for general adult medical examination with abnormal findings," or another appropriate ICD-10 code based on any findings.

The goals of the IPPE are health promotion, disease prevention, and detection. All services listed in the IPPE must be provided in order to submit the claim for payment. Providers need to perform a physical exam and a review of:

- Medical and social history
- Potential risk factors for depression and other mood disorders
- Functional ability and level of safety

There also needs to be documentation of discussion with the patient regarding:

- End-of-life planning
- Results of the findings from the review
- Any other preventive services the patient might need
- Screening electrocardiogram (EKG/ECG)
- Other appropriate screenings and other preventive services

"The initial annual wellness visit is for patients who are no longer within the initial 12 months of their Medicare Part B coverage period and have not received an IPPE or AWV within the past 12 months."

The initial AWV is for those patients who are no longer within the initial 12 months of their Medicare Part B coverage period and have not received an IPPE or AWV within the past 12 months. The HCPCS code to bill for this service is G0438, "Annual wellness visit; includes a personalized prevention plan of service (PPPS), initial visit," reimbursed at an average rate of $173.70. A health risk assessment (HRA) must be completed with the visit. The following are just a few elements of the AWV:

- Administer the HRA
- Establish list of current providers
- Establish medical and family history
- Perform depression screening
- Perform functional and safety screening
- Document height, weight, body mass index (BMI), and blood pressure
- Perform cognitive function assessment

David E. Stern, MD, CPC, is a certified professional coder and is 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), NMN Consultants (www.urgentcareconsultants.com), and PV Billing (www.practicevelocity.com/urgent-care-billing/), 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.

"Medicare waives both the coinsurance and the Medicare Part B deductible once per year for ACP when certain conditions are met."

- Document a screening schedule
- Document any risk factors
- Offer appropriate referrals for education and counseling
- Discuss advance care planning (optional)

This information will need to be reviewed and updated at each subsequent AWV. Use HCPCS code G0439, "Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit," reimbursed at an average of $117.71 to bill each subsequent visit.

As mentioned, advance care planning (ACP) is an optional element of the AWV that involves a face-to-face conversation with the patient, involving the patient's wishes and preferences for medical treatment were he or she to be unable to speak or make decisions in the future. The discussion is documented in the medical record, and any forms completed are kept in the record, as well. Current procedural code (CPT) code 99497 can be billed for the first 30 minutes of the service, and CPT code 99498 is billed for each additional 30 minutes. These can be billed along with the HCPCS codes for the AWV visit. Average reimbursement for these services are $82.90 and $72.50, respectively. Medicare waives both the coinsurance and the Medicare Part B deductible once per year for ACP when the following is met:

- Provided on the same day as the covered AWV
- Furnished by the same provider as the covered AWV
- Billed with modifier -33 (preventive service)
- Billed on the same claim as the AWV

The AWV is not a routine physical exam, and Medicare does not cover routine physical exams.

More details about AWVs and the *Welcome to Medicare* visit are available on the CMS website (www.cms.gov; go to the Search box at the top of the home page and type in *awv* to learn more about AWVs or *welcome to Medicare* for more on the Welcome to Medicare visit). ■

PHYSICIANS WANTED

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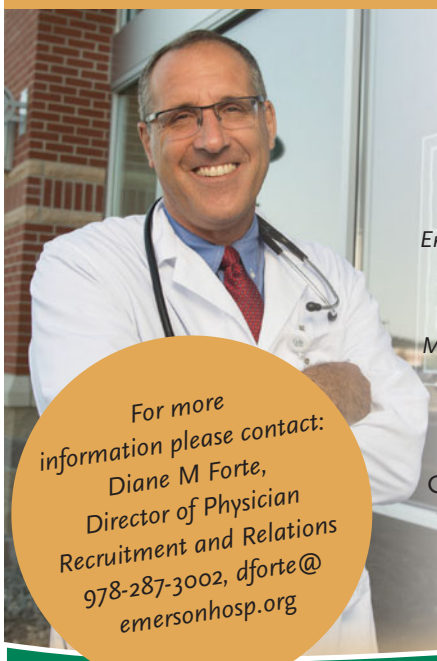
FAMILY PRACTICE **EMERGENCY MEDICINE** **INTERNAL MEDICINE /PEDIATRICS**



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Emerson Hospital serves over 25 communities and towns and over 300,000 individuals

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Great New England locations makes these opportunities an ideal choice for physicians looking for suburb living with close proximity to the city, some of the best public and private schools in the state, many area colleges and close to many recreational activities.

For more information please contact: Diane M Forte, Director of Physician Recruitment and Relations 978-287-3002, dforte@emersonhosp.org

Emerson Urgent Care

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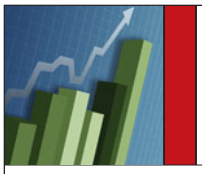
For immediate confidential consideration or to learn more please contact:
Tammie Chute - Physician Recruiter **tchute@summithealth.org** **717-267-7780**

MEDICAL EQUIPMENT/SUPPLIES

PRACTICE FOR SALE

MEDICAL EQUIPMENT/SUPPLIES



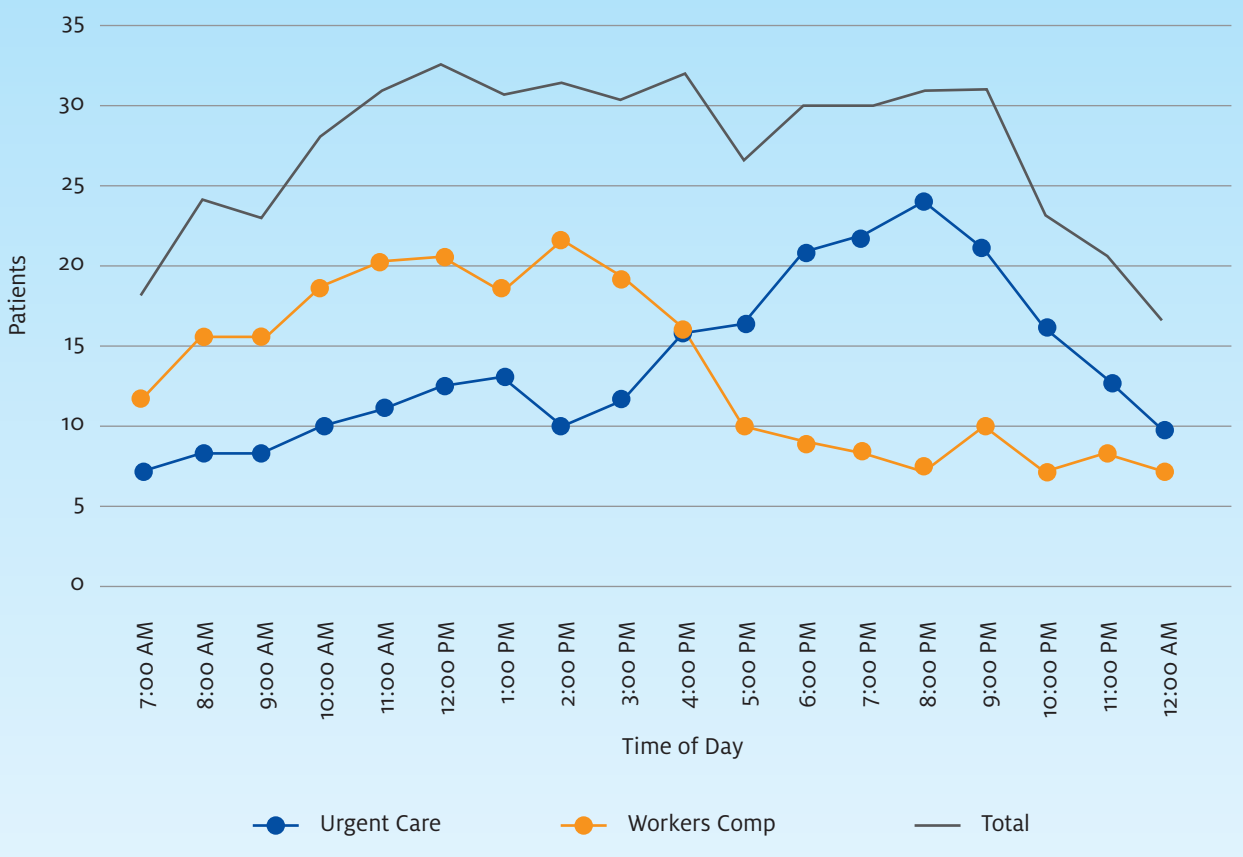
DEVELOPING DATA

The Complementary Nature of Occupational Medicine and Urgent Care

As detailed in the first entry of our new occupational medicine series (Foundation of Occupational Medicine in the Urgent Care Setting, page 30), urgent care centers that offer occupational medicine services have reported the dual offerings are complementary in a way that helps balance the patient census and increase revenue.

The data here, supplied by Dr. Max Lebow and reflecting Reliant Immediate Care in Los Angeles, illustrate that occ med visits tend to pick up when urgent care visits are lagging, and vice versa. In this way, operators can encourage greater consistency in traffic throughout the day (as well as the increased revenue that comes along with it). ■

CLINIC CENSUS



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College of Urgent Care Medicine

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