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DEPARTMENTS

Assessment, Intervention, and Disposition of Patients with Psychiatric Symptoms

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LETTER FROM THE EDITOR-IN-CHIEF

In Support of a Pledge

If you are reading this, you should be a member of UCAOA. No cheating...keep reading.

The Urgent Care Association of America (UCAOA) is your representative organization. Whether you are a practice administrator, biller, owner, physician, physician assistant, or nurse practitioner, UCAOA is doing the heavy lifting on your behalf to build the foundation of this industry and discipline.

Consider the following:

- UCAOA was founded six years ago with the vision to be the catalyst for the recognition of urgent care as an essential part of the healthcare system.

  With a singular focus—and despite a mountain of obstacles—UCAOA has supported initiatives which have literally defined this discipline and established the industry as a major player in the delivery of acute care and occupational services to over 100 million patients annually.
- UCAOA was the first body to define the core competencies of the discipline of urgent care medicine. These competencies were used to design the first and only clinical fellowships, the first and only peer-reviewed journal, and hours of continuing education opportunities.
- UCAOA is the organization that funded the first and only national sampling frame in urgent care, identifying over 8,000 urgent cares nationwide. This was quickly followed by the first and only benchmarking study in the industry, identifying key services and practice parameters.

  Combined, these two studies created an urgent care framework which has given voice and definition to our role in healthcare.
- UCAOA quickly followed with the formation of an Urgent Care Certification process that allows your center to uniquely identify your urgent care services. UCAOA's partnership with the Joint Commission brought representation to the development of accreditation standards for urgent care centers and national recognition of our unique services.
- UCAOA's committees are hard at work creating new opportunities for urgent care. Legislative, public awareness, academic, quality, and benchmarking initiatives are ongoing to support the growth and evolution of our discipline and the entire urgent care industry.
- UCAOA is over 3,200 members strong as of this writing. Membership stretches across the country and around the globe, including Ireland, Australia, New Zealand, Israel, Canada, Mexico, and Hungary.

  UCAOA's commitment to its mission and vision is a commitment to its members, and a commitment to the industry at large. The mission and vision represent a promise to you. A promise of representation, a promise of growth and development, a promise of academic achievement and quality improvement.

Without your support, however, it will be impossible to deliver on those promises, and, on behalf of all of us practicing in urgent care, we cannot let that happen. To fulfill our commitment to our mission and vision, we must continually grow and evolve.

Membership in UCAOA is the single most important ingredient in support of this end.

If you are reading this journal, which is published by virtue of a partnership between UCAOA and Braveheart Publishing, you are benefiting from the work of UCAOA, so please support the organization that is working hard in support of all of us.

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Lee A. Resnick, MD
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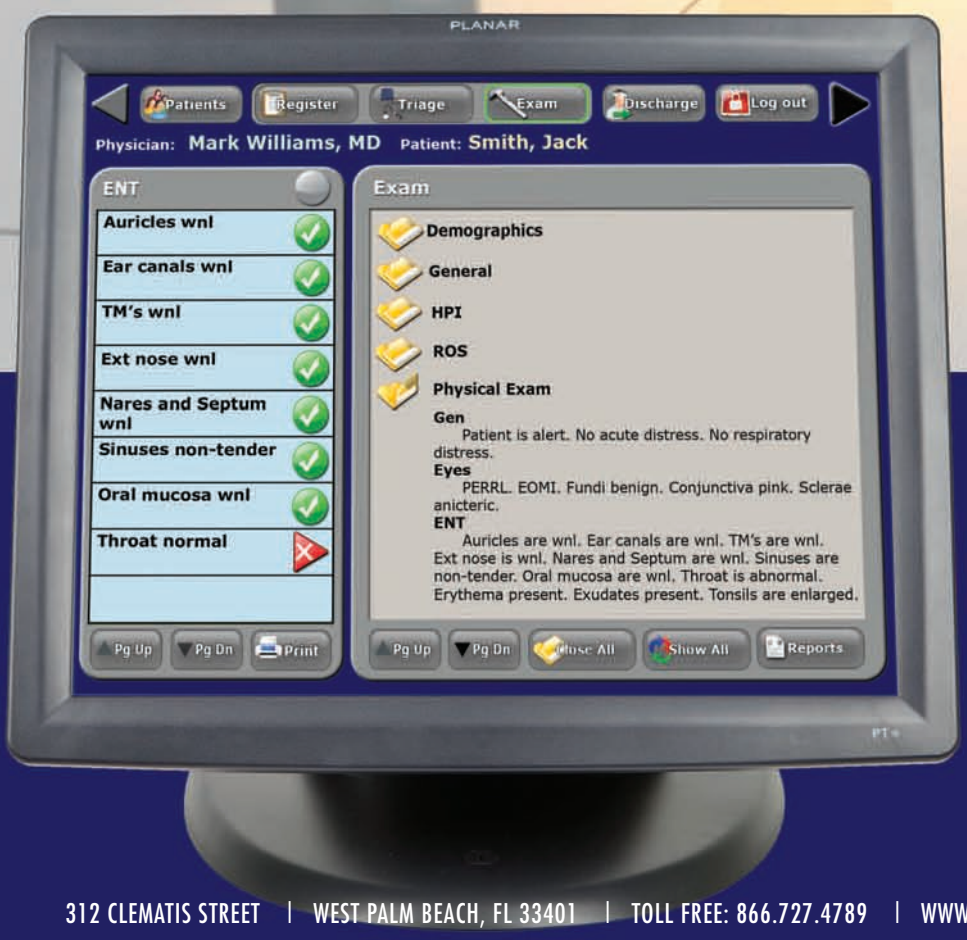

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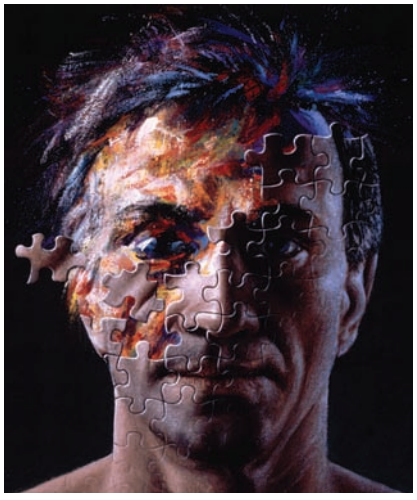

CLINICAL

PRACTICE MANAGEMENT

Community healthcare may be a competitive marketplace, but that doesn't mean perceived rivals for patient visits cannot be a rich resource for referrals. The first of two parts.

By Alan A. Ayers, MBA, MAcc

IN THE NEXT ISSUE OF *JUCM*

As winter and spring breaks approach, are you prepared to provide traveling patients with the proper vaccinations and to help them ward off water- and insect-borne disease?

WEB EXCLUSIVE

A Case Study of an Infected Thyroglossal Duct Cyst

A 3-year-old girl presents with a seemingly spontaneous one-day history of swelling in her neck, with associated erythema. Would you be prepared to diagnose it as secondary infection of a thyroglossal duct cyst and commence appropriate treatment? Available only at *www.jucm.com*.

By Marcia Taylor, MD, MSCR and Carlos Soto, MD

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

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Most urgent care clinicians are well versed in conducting a physical history and examination on a patient who complains of a lingering sore throat. Such patients are often communicative, specific, and fully able to participate in the work-up.

Suppose you had to suspect the veracity of everything a patient was telling you, though, or could not be sure whether her off-hand remark about being immortal was an attempt at humor or the mark of a distant relationship with reality? Is his racing pulse being caused by cardio distress, or a sign that he is having a panic attack?

Getting to the root of possible psychiatric problems can be difficult in any arena, but in a community setting where assessing mental health is probably not the clinician's forté, the challenges and possible consequences can be extreme.

In Assessment, Intervention, and Disposition of Patients with Psychiatric Symptoms (page 9), **Gregory P. Brown, MD**, provides an overview of assessing a few of the more common psychiatric conditions, shares his expertise on appropriate pharmacologic and non-pharmacologic treatment that can be administered on site, and offers advice on assessing the degree of risk a patient might pose to himself or others.

Dr. Brown came to our attention when he gave a compelling presentation on this very subject at the 2009 UCAOA Urgent Care Convention in Las Vegas last April. He is associate professor, chair, and residency program director of the Las Vegas Department of Psychiatry at the University of Nevada School of Medicine. His clinical interests include forensic psychiatry, transpersonal psychiatry, Jungian themes, and mind-body issues focusing on concepts of consciousness.

Obviously, patients with serious mental or emotional issues will need referral to a psychiatrist or other mental

JUCM CONTRIBUTORS

health professional. The referral gate swings both ways, though. Some urgent care operators are learning that it can be very beneficial for the patient and good for the business to establish referral relationships with other healthcare professionals such as pharmacists (or even the staff at a retail clinic).

In Building Urgent Care Referral Relationships: Pharmacies and Retail Host Clinics (page 29), **Alan A. Ayers, MBA, MAcc** walks us through the process of identifying and gaining the trust of viable referral candidates in the pharmacy and retail worlds.

Mr. Ayers is assistant vice president, product development for Concentra Urgent Care and content advisor for the Urgent Care Association of America.

Often, of course, no referral is necessary even if a patient presents with a less than run-of-the-mill problem. Take the case of a 3-year-old girl who presented with a one-day history of swelling in her neck that turned out to be caused by secondary infection of a thyroglossal duct cyst. In A Case Study of an Infected Thyroglossal Duct Cyst, available only at *www.jucm.com*, authors **Marcia Taylor, MD, MSCR** and **Carlos Soto, MD** recount the diagnostic process and how the patient was treated successfully.

Drs. Taylor and Soto are colleagues at Lexington (SC) Urgent Care; Dr. Taylor also practices at Lexington Medical Center.

Also in this issue:

Emory Petrack, MD, FAAP, FACEP examines how medical legal risk is affected by the age of the patient—and how to minimize your risk when treating children.

Nahum Kovalski, BSc, MDCM reviews new abstracts on community-acquired pneumonia, bronchiolitis in children, a possible link between antibiotics and birth defects, whether the serum D-dimer is used effectively, and a government accounting of the toll of the H1N1 virus to date.

John Shufeldt, MD, JD, MBA, FACEP borrows a page (or perhaps a tablet) from Moses and deconstructs the 10 commandments for staying litigation-free in 2010.

As the calendar turns from one year to another, **Frank Leone, MBA, MPH** discusses the virtue of embracing change in your tactics for marketing urgent care occupational medicine services.

David Stern, MD, CPC answers questions regarding reimbursement for time spent, and coding for time spent and care administered by midlevel providers.

JUCM is always looking for a few good authors. If you'd like to be one of them, share your idea for an article via e-mail to **Lee A. Resnick, MD**, *JUCM*'s editor-in-chief, at *editor@jucm.com*. ■

Leadership—Is It Really Lonely at the Top?

LOU ELLEN HORWITZ, MA

It's been said that "it's lonely at the top," and I think all of you have felt that at one time or another, perhaps even on a regular basis. When things aren't going as they should be at your clinic(s), generally you are the one who is suffering in silence, trying to figure things out—or at least ride out the storm without having to alarm the rest of the organization. When you walk through the hallways wishing your staff good morning, behind the smile your head is full of issues that must be considered and dealt with in the coming day, week, month, year.

It's true in the good times, as well. When critical decisions have to be made about the future, all the faces turn in your direction. You collaborate with others, but most of the time the buck eventually stops with you. Even in celebrating your successes, there is probably a little voice in your head pushing you on to the next challenge that you alone know about.

Family and friends are important supporters that try to help lighten your leadership burden, but they can't know all that you know or understand why that certain something has kept you awake for a week. Sometimes, it's easier not to bring it up at all, because it's just too complicated to explain and not likely to get you any new ideas anyway (or at least you tell yourself that).

Makes you wonder just a little bit why you do it, huh?

As you face down 2010, it's a good time to think about these things, whether you are in the midst of a success or a challenge.

I'm sure you've noticed the change in "tone" of commercials for all manner of products since the economy went south last year. In past years, we were exhorted to buy things because we were worth it or we deserved it or to keep up with the neighbors, etc. Now the marketing messages are all about getting back to the basics, remembering what's most important to us, and giving appreciation instead of things. I think that applies to the discussion at hand, as well.

Why do we become leaders? I don't think it's just a power trip. It's way too hard to stay in that leadership role for such a shallow gain. Everyone will have a different reason, but it's probably a pretty deep one that's ingrained in who you are. You are likely a leader because you can't help but be one. Very few start at the top, but almost everyone who gets there is there for a pretty good reason—especially in urgent care.

The position of "urgent care owner" is not one featured at career fairs. There aren't graduate programs or internships or even job postings. Becoming an owner comes 100% from within. You wanted to make something, build something, create something that was your own. Thrilling, but terrifying at the same time.

From talking to most of the owners I know, those feelings never really go away, no matter how successful you become.

The amazing thing about our group of owners, however (and the primary reason for me singling you out this month), is the "viral" effect each and every one of them has had on the industry as a whole. In very few cases has an industry been built so quickly by so many working so disparately.

I encourage you to get back to the basics of why you started down this road, and realize that any challenges are merely the result of your success thus far. You are still in business to be able to have challenges! This is a good thing!

We may not all be bright-eyed optimists, but it seems that we, over time, are all becoming partners. You may feel alone, but you are not. When your desk lamp is on late into the night, know that there are probably hundreds if not thousands of little points of light just like yours across the country. And slowly, slowly, we are taking urgent care to great places, together.

Happy New Year.

Lou Ellen Horwitz is executive director of the Urgent Care Association of America. She may be contacted at *lhorwitz@ucaoa.org*.

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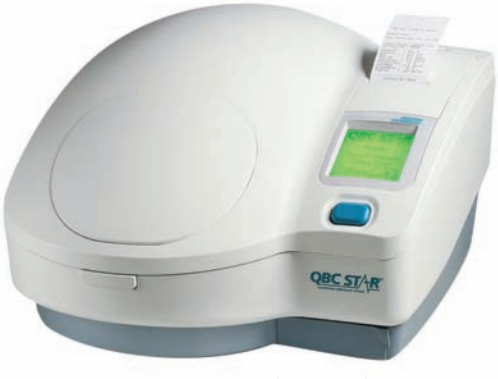

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Assessment, Intervention, and Disposition of Patients with Psychiatric Symptoms

Urgent message: Assessment of patients presenting with psychiatric conditions requires a modified set of skills compared with traditional medical assessment. Urgent care clinicians must be prepared to determine appropriate interventions—treatment, referral, or both.

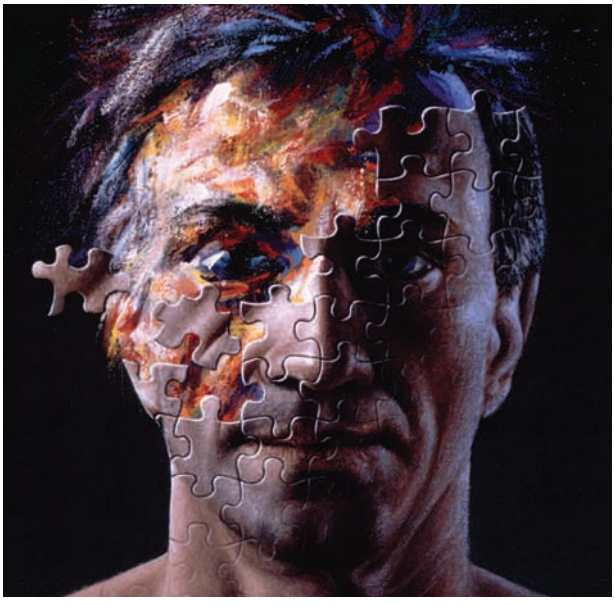
Gregory P. Brown, MD

Introduction

Typically, the interaction between clinicians and patients presenting with psychiatric conditions is guided by information obtained from the interview, history, and physical examination rather than emphasizing laboratory or radiological testing. Therapeutic options may be challenged by a lack of community resources in many regions of the country.

The general model, however, for the evaluation of a psychiatric patient in urgent care settings remains similar in overall format to that of a traditional medical patient:

- assessment of the condition
- appropriate intervention for the presenting complaint
- disposition to an alternative level of care when appropriate.



The importance of skill in assessment, intervention, and disposition of the patient with psychiatric complaints cannot be overstated, as it is estimated that at least 40% of patients presenting in an urgent care or primacy care setting have some symptoms which can be appropriately categorized as "mental health-related."

While not exhaustive, this article will provide reasonable, general concepts for this type of evaluation.

Assessment

The assessment of a psychiatric patient requires a thorough description of current and past symptoms of the nature that brought the patient to the urgent care setting, as well as an assessment of the patient's acuity.

The history-taking is followed by a general mental status and physical examination, with a focus on acute med-

Table 1. Symptoms

- Psychosis—reality based?
- Anxiety—autonomic hyper-arousal?
- Mood—dysphoria or elation?
- Cognitive—delirium or dementia?

ical conditions and the possible effects of substance use.

Isolating a condition that has been medically induced, such as a mood disorder secondary to hypothyroidism, or one that stems from substances of abuse, such as a cocaine intoxication-induced psychosis, may dramatically alter the intervention and disposition of a patient whose presentation initially suggested a primary psychiatric illness.

The urgent care clinician does not need to memorize the entirety of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), but rather can focus inquiry on the degree of symptomatology and its acuity. A specific DSM-IV diagnosis may in many cases be beyond the scope of the average urgent care clinician with little or no formal psychiatric training.

The main categories of symptoms likely to present within the urgent care setting include psychosis, anxiety, mood alterations, or cognitive impairment. Each carries with it a set of symptoms (**Table 1**), physical findings, and secondary evaluations that will help inform intervention.

Psychosis symptoms are characterized by hallucinations or delusions—both substantial departures from consensual reality. Depending on the content of the psychotic features, agitation or paranoia may also be prominent; this could require more urgent intervention.

Psychosis can also present as marked confusion with disorganized thinking leading to substantial inability to provide even basic self-care.

Anxiety symptoms may be related to hyper-responsiveness of the sympathetic nervous system. The most intense version of anxiety symptoms is a panic attack, which often includes a sense of doom, shortness of breath, chest tightness, diaphoresis, and palpitations. These symptoms may be confused by both the patient and the physician with a myocardial infarction or pulmonary embolism. In turn, an MI or PE often presents with acute anxiety. The differentiation can be challenging and may require a level of care beyond that available in the urgent care setting.

Panic attacks may be a symptom of several different anxiety disorders. In the urgent care setting, the primary goal is to alleviate symptoms of the actual panic attack and assure appropriate follow-up.

Mood symptoms are likely to be those of depression or of mania, opposite ends of the spectrum. Specific focus on assessment of *any* suicidal thoughts and plans are especially important when mood symptoms are the primary presenting issue.

Currently, the diagnostic criteria of bipolar disorder have come to be too often loosely applied; some caution should be used in accepting this history in the absence of a careful psychiatric review of systems.

Cognitive impairments in the urgent care setting typically involve changes in mental status consistent with either acute delirium or acute deterioration of a chronic dementing condition. Should the patient present with new cognitive symptoms or a clouding of consciousness suggestive of either dementia or delirium, respectively, these conditions must be properly evaluated and stabilized medically prior to transfer to a psychiatric facility.

Acute delirium should be considered a medical emergency even if confusion or apparent psychiatric symptoms are present. The medical cause of acute delirium must be sought and stabilized prior to a complete psychiatric evaluation.

Briefly, delirium is an acute confusional state characterized by a decreased ability to focus, sustain, or shift attention. Symptoms usually wax and wane. Dementia, on the other hand, is more of a steadily progressive disorder without rapid fluctuations in the absence of a new stressor such as medications or infections.

It is essential to obtain the medical–psychiatric history of an individual presenting with apparent psychiatric diagnoses or complaints. Obtaining the previous psychiatric diagnosis can be useful, especially a review of the interventions which were successful in the past.

It is also important to assess whether the presenting condition is chronic or acute. A chronic condition may be managed quite effectively at a lower level of care, especially with supportive family members or community. Always be vigilant for a new, reversible problem that may be worsening a chronic condition.

Substance-induced mood disorders or substance-induced psychoses require observation for a period of time adequate for the specific substance to clear prior to making a diagnosis of an independent psychiatric condition.

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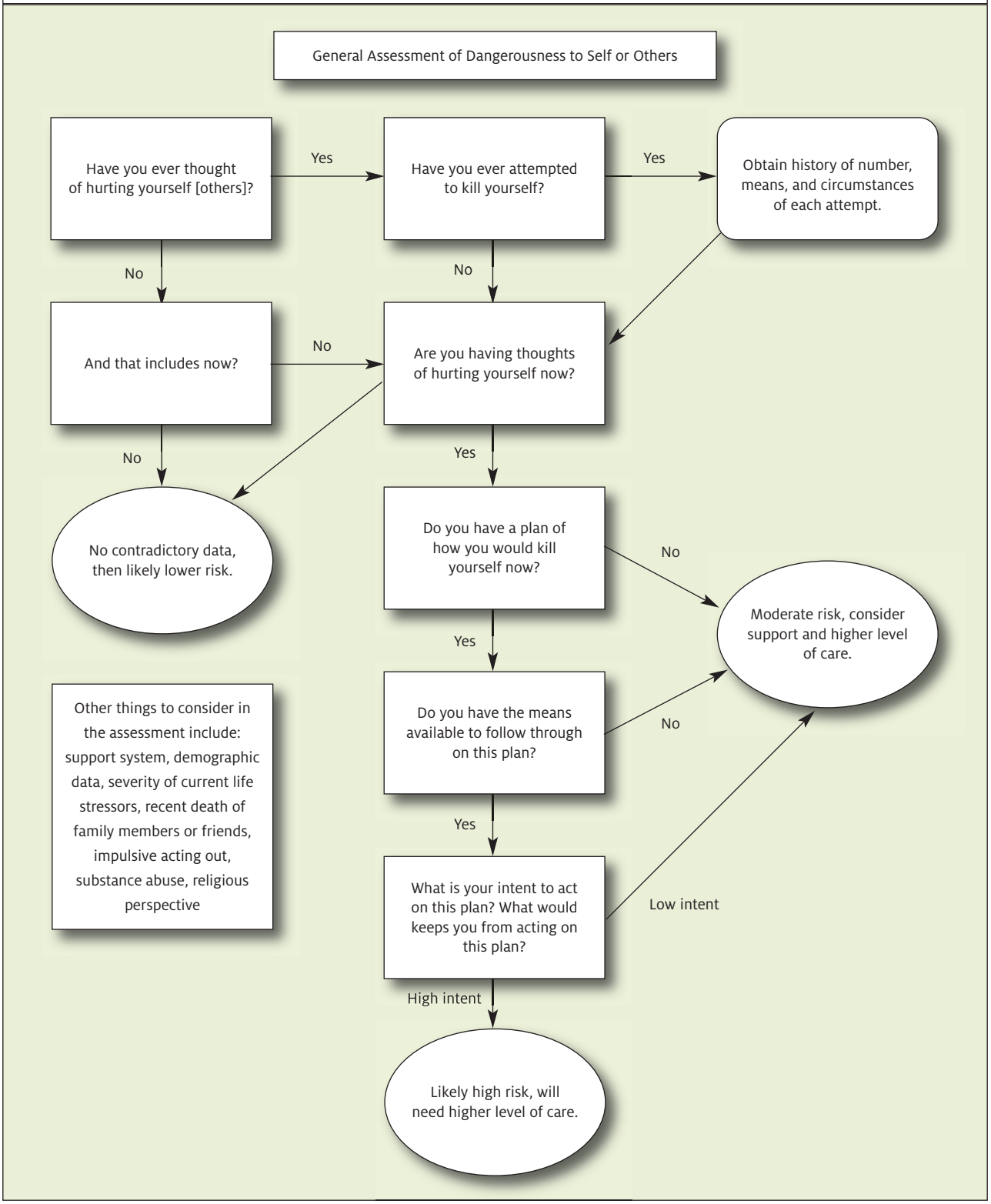
Figure 1. Assessing risk of danger to self or others.



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References:
1. Lichtenstein SJ, Dorfman M, Kennedy R, Stroman D. Controlling contagious bacterial conjunctivitis. *J Pediatr Ophthalmol Strabismus.* 2006;43:19-26.
2. Data on file. Alcon Laboratories, Inc.

Intervention

The interventions for patients presenting with psychiatric complaints tend to be pharmacological, psychological, social, and/or medical.

For the patient who presents with an acute psychosis—either hallucinations or delusions combined with severe agitation—a combination of medications can be given. Typically, this would include a combination of 5 mg of haloperidol (Haldol), 2 mg of lorazepam (Ativan), and 50 mg of diphenhydramine HCl (Benadryl), either PO or IM. The expectation is that this combination, known colloquially as "B52," will cause sedation, not resolve the underlying psychosis.

Note that it is essential to give the haloperidol in combination with the lorazepam and diphenhydramine; this combination acts to prevent acute dystonic reactions that increase agitation and can be confused with worsening of psychosis.

If agitation is the primary difficulty, this combination can be repeated once or twice at 30- to 60-minute intervals until agitation is resolved or until the patient can be appropriately transferred to a higher acuity type facility.

Table 2 offers an overview of options based on the conditions described here.

Panic attack or severe anxiety

For the patient who presents with a panic attack or severe anxiety, a high-potency benzodiazepine such as clonazepam (Klonopin), alprazolam (Xanax) or lorazepam may be used in an acute setting, in concert with a referral for psychiatric services to assess whether or not a more appropriate long-term medication and therapy would be preferred.

Depressive disorder

For the patient presenting with symptoms of a depressive disorder, either a selective serotonin reuptake inhibitor (SSRI) or a selective serotonin plus norepinephrine reuptake inhibitor may be the treatment of choice. Whether this is started from the urgent care setting depends on the timing and availability of follow-up with a primary care or psychiatric provider.

Bipolar mania

The patient who presents with a manic syndrome from an established bipolar condition may be treated with divalproex sodium (Depakote) at 50

Table 2. Pharmacological Interventions

Type of condition	Options
Acute psychosis, severe agitation	Haloperidol + lorazepam + diphenhydramine (B52)
Panic attack or severe anxiety	Lorazepam, clonazepam, or alprazolam
Depression	SSRI or SSNRI
Bipolar mania	Divalproex sodium and/or atypical antipsychotic
Substance induced	Substance specific
Chronic conditions	Condition-specific; restart that which worked best before

mg/kg per day and/or a newer atypical antipsychotic medication. Examples of the latter include aripiprazole (Abilify), risperidone (Risperdal), olanzapine (Zyprexa), and others. Contemporaneous consultation with a treating psychiatrist would be ideal in choosing an acute treatment plan, especially when the patient is already on other psychiatric medications.

If this condition is new and not well characterized, or is leading to increased agitation, higher levels of care may be necessary.

Chronic conditions

When there is a history of chronic psychiatric conditions, the most reasonable intervention may be simply to restart the medication(s) which worked best in the past.

Non-pharmacologic interventions

Non-pharmacologic interventions for the patient presenting with psychiatric complaints include providing a quiet area and time for the individual to decompress and calm down. In addition, building rapport in a non-confrontational manner and providing the patient an opportunity to express feelings and thoughts as fully as possible may allow him/her to resolve the condition to the point where a higher level of care might be unnecessary.

Social services interventions may as simple as helping the person find a shelter or place to live.

If the individual presents with what may be an acute medical condition that is leading to the psychiatric symptoms, then characterizing and stabilizing the medical condition must be the primary focus of care.

Disposition

The typical disposition choices in most communities include inpatient or outpatient care for medical conditions, psychiatric conditions, or substance detoxification and rehabilitation. Inpatient medical care would be a primary disposition for delirium (e.g., elderly patients who have new-onset medical problems resulting in changes of mental status; brain injury cases; or post-trauma cases or new-onset medical conditions that have psychiatric symptoms in affiliation).

Inpatient psychiatric care may be appropriate for patients presenting with

acute psychosis, suicidal thoughts, or suicidal behaviors and acute manic conditions with psychotic features, especially when self-care is impaired or the diagnosis and effective treatment plan are not well established. In addition, if the person presents in a catatonic state, inpatient psychiatric care may be necessary to provide for basic self-care needs.

Inpatient substance abuse treatment programs would be appropriate if use has been escalating or there is potential for medical instability related to the detoxification process, or unstable vital signs. A substance-induced psychosis that is not rapidly clearing may require inpatient substance treatment.

Outpatient medical treatment of this patient population would include chronic conditions, the management of hormonal imbalances (though perhaps not in the urgent care setting), or follow-up for an acute condition or medication side effect when adequate support is available.

Note that akathisia can present as a side effect of dopamine blocker medications and of phenothiazines often used for gastrointestinal complaints. Its presence is of considerable concern, as it raises suicide risk.

Outpatient psychiatric treatment would be reasonable for many of the patients assessed in terms of continuing or modifying the medications prescribed from the urgent care setting or reassessing the psychiatric condition, and is ideal for non-psychotic, non-acutely dangerous patients. Outpatient psychotherapy may be most appropriate for mood disorders, personality disorders, or those who have an identified acute life stressor.

Outpatient substance abuse programs are now quite common for detoxification and sobriety maintenance for those substances of abuse with non-life threatening withdrawal symptoms, and are ideal for the well-motivated patient.

Challenges

The repeat patient presents a specific challenge in the urgent care setting. Typically, these populations include patients who have been noncompliant with outpatient treatment, have comorbid substance abuse combined with chronic mental illness, and/or comorbid medical illness.

Involuntary commitment statutes are different for each state, but there are some general commonalities. It is important for the urgent care physician to be aware of the legal processes within the state where he/she practices to allow for the involuntary evaluation and retention of a mentally ill individual. Most states require that an individual be both mentally ill *and* dangerous to either self or others in order to be held for involuntary assessment. A general assessment tool for establishing level of danger to self or others is offered in **Figure 1**.

Some states allow for the combination of mental illness and grave disability for this process. "Grave disability" is usually defined as such poor ability to care for self that serious bodily harm would result if the patient were not hospitalized. Initially, the decision to hospitalize a patient against his/her expressed wishes is a clinical judgment, but state laws define who can make that initial assessment. After the required judicial review, the final decision becomes a legal finding.

Summary

In summary, the evaluation of the psychiatric patient in the urgent care setting requires that the clinician assess the symptom complex of the patient and rule out or treat acute contributing medical conditions. At times, the resolution of an acute medical condition will also resolve the psychiatric symptoms, classic examples being hypothyroidism masquerading as a major depressive disorder, encephalitis presenting with delirium, or a cocaine intoxication mimicking the symptoms of schizophrenia or mania.

In the urgent care setting, the physician should provide symptomatic relief of the chief complaint in an appropriate manner, which may include pharmacological, psychological, or social intervention. This is followed by a reasonable disposition plan, as indicated by either the seriousness of the symptom complex or the presence of ongoing acute dangerousness towards self or others. ■

Share your experience

If you have treated a patient with any of the presentations described in this article, let us know. We will publish relevant case studies in an upcoming issue of *JUCM*. Send an e-mail to *editor@jucm.com* for more information.

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Reducing Pediatric Medical Legal Risk in Your Urgent Care Center

Emory Petrack, MD, FAAP, FACEP

When it comes to medical legal liability, we all know the system is broken. Risk in the emergency and urgent care setting, of concern both to practicing physicians and administration, is no exception. Add emergency or urgent care services for children into the mix, and the level of concern increases even more.

The good news is that the vast majority of children present without life-threatening illnesses or injuries. However, when care doesn't go well, when adverse outcomes happen, parents' anxieties and tensions rise significantly and quickly. So does the risk of legal action.

Is there anything you can do to minimize your risk surrounding urgent care for children? The answer is a definite "yes!" While you cannot dodge all the bullets, you can significantly reduce the likelihood that you will need to have a discussion with your lawyer by taking proactive measures today.

Follow the four guidelines outlined here to dramatically decrease legal risk:

1. **Provide excellent pediatric emergency care.**
   While this may seem obvious, providing excellent care is not necessarily easy. The first question that arises when reviewing care is whether the "standard of care" was met. Unfortunately, this concept is not absolute.

   For example, a children's hospital serving as a level I pediatric trauma center is expected to provide a higher level of definitive care to a seriously injured 3-year-old than is a small community hospital or urgent care center. However, *all* healthcare facilities are expected to meet a certain minimum level of trauma support and to provide a certain minimum level of stabilization for that child.

   Many urgent care centers do not see a high volume of children. And overall, children tend not to become as seriously ill or injured as do adults. As a result, most urgent care centers have significantly less experience with significantly sick children. It is therefore essential that community providers of urgent care for children commit to ongoing pediatric clinical education.

   Journals like *Pediatric Emergency Care* or *Clinical Pediatric Emergency Medicine* provide case-based studies of common problems that arise in the emergency care of children.

   Conferences, through a variety of regional and national medical organizations, offer opportunities to learn about and discuss challenging cases. Local courses may be arranged for both physicians and nurses, with a focus on the practical aspects of pediatric urgent care.

   The American Academy of Pediatrics offers an excellent online, case-based monthly learning module, titled PREP-EM. While geared toward practitioners of pediatric emergency medicine, it is relevant for any provider wishing to focus on improving pediatric urgent care skills.

   Whichever medium is most appealing or practical, the key is to establish a commitment to continuing education in pediatric urgent care.

2. **Communicate well with children and families.**
   "People don't sue doctors they like..." (April 8, 2004 episode of *ER*.). While excellent communication has long been recognized as an important factor in reducing medical legal risk, communication with families is particularly critical.

   Parents are often anxious as they enter your urgent care center. Their perception, right or wrong, is that their child is sick or hurt enough to require immediate

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"It is essential to explore how various methods help capture—or impede capturing—clinical information."

care. Parents will sense your level of concern and caring seconds after they arrive. In fact, their opinion and bias towards the anticipated level of care was formed in triage and registration.

Does your center send out welcoming "we're here to help you" vibes when families arrive? It is essential that everyone providing clinical care take time to listen to the child's and/or parents' concerns, and reflect those concerns back in a way that makes it clear they are heard—and understood.

Most encounters are fairly straightforward. But when unexpected problems or delays arise, take time to explain to parents (and the child, when appropriate) what is happening. The reality is that these encounters often can be quite brief, so time is not usually an issue. The simple goal is to establish a truly human connection with the family. Communicating and demonstrating that you care is a great step forward in that direction and goes a long way in reducing potential medical legal problems that may arise much later.

3. Document with care, and care about your documentation.

"If it isn't written down, it never happened." This is well-documented advice related to medical charting. Every physician who has had the unfortunate experience of facing a legal action knows how absolutely essential chart documentation is to defending patient care.

And yet, in reviewing many pediatric charts, both for quality improvement and medical legal reasons, I am dismayed by how frequently I come across sloppy or inadequate documentation. Illegible handwriting, missing key elements, and inadequate descriptions of physical findings are just a few of the common problems I encounter regularly. These discrepancies are likely to come back to haunt a physician if subsequent problems arise.

Since children are an especially vulnerable population, the care surrounding pediatric emergencies faces particularly close scrutiny. The best way to ensure proper documentation is to document care as if the case *is* going to have unexpected, adverse clinical outcomes that will require your attendance at trial two years down the road. You may, or may not, even remember the case two years later, so it is vitally important to document, in black and white, *everything* you would want a lawyer or jury to know.

Essential elements include:

- Times the patient is seen, as well as times that labs, procedures, and reassessments are accomplished. This is essential, but often missing.
- Vital signs (and repeat vital signs, as needed), including how and when abnormal vital signs are addressed.
- A brief description of the patient's general appearance. Noting "normal" is not adequate. Use terms like "well-appearing," "interactive," and "smiling" to paint an image of a child who is not ill-appearing. The word "lethargic" is over-used, and suggests a seriously ill child requiring critical care.
- Specific areas of concern expressed by the parent, including relevant discussions (e.g., if a parent is concerned about appendicitis in a child with a benign abdomen, briefly document this concern and how it was addressed).
- Timely and appropriate follow-up for all patients.

4. Establish a culture that supports medical legal risk reduction.

Excellent chart documentation does not take place in a vacuum. Administration must support the effort and colleagues must recognize that documentation is important for everyone.

Many methods exist to help you document care, ranging from handwritten charts and dictation to template and electronic systems. While a review of these systems is beyond the scope of this article, it is essential to explore how various methods help capture—or impede capturing—clinical information for medical legal documentation.

In addition, chart reviews, as part of a quality improvement program, are very helpful in identifying and addressing documentation issues.

Stepping back from documentation, it is important to create an environment which supports excellence in urgent care for children.

Establishing a practice environment that truly expects the best for the children it serves means ensuring that all providers are "up to speed" on best practices for children. It means everyone is aware of how critically important communications are when it comes to children and families—not just for reducing medical legal risk, but for providing great care and service. ■

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 dermatologic conditions that real urgent care patients have presented with.

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

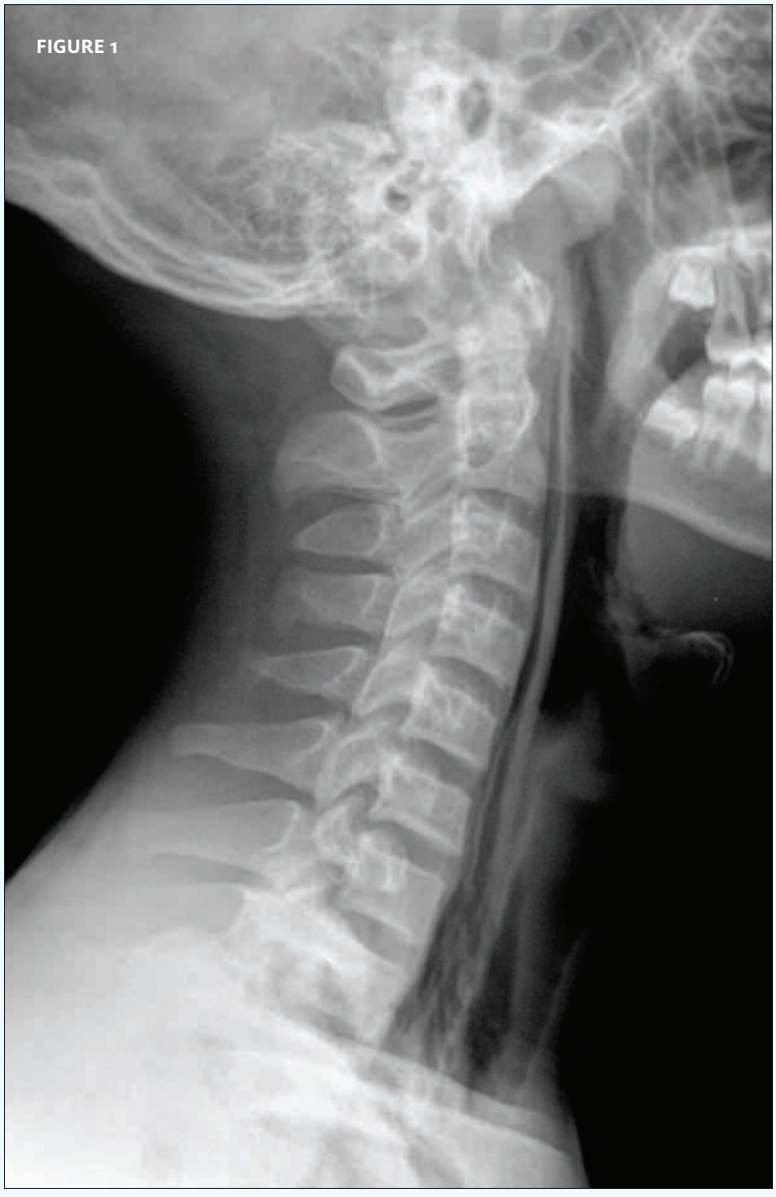


FIGURE 1

The patient is a 16-year-old male who presents with difficulty breathing and pain in his throat, along with difficulty swallowing and pleuritic chest pain.

All the symptoms began "a couple of hours" prior to presentation. There is no history of trauma or choking, nor of a recent dental procedure.

On exam, the patient looks well, and is quiet and not toxic; there are no sign of distress. Pulse is 75, O2sat 94 and there is no fever. His chest is normal, with bilateral air entry, no wheeze or crackles. Assessment is hindered by the patient's inability to take deep breaths, however. His tongue, pharynx, and tonsils all appear normal.

View the x-ray 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

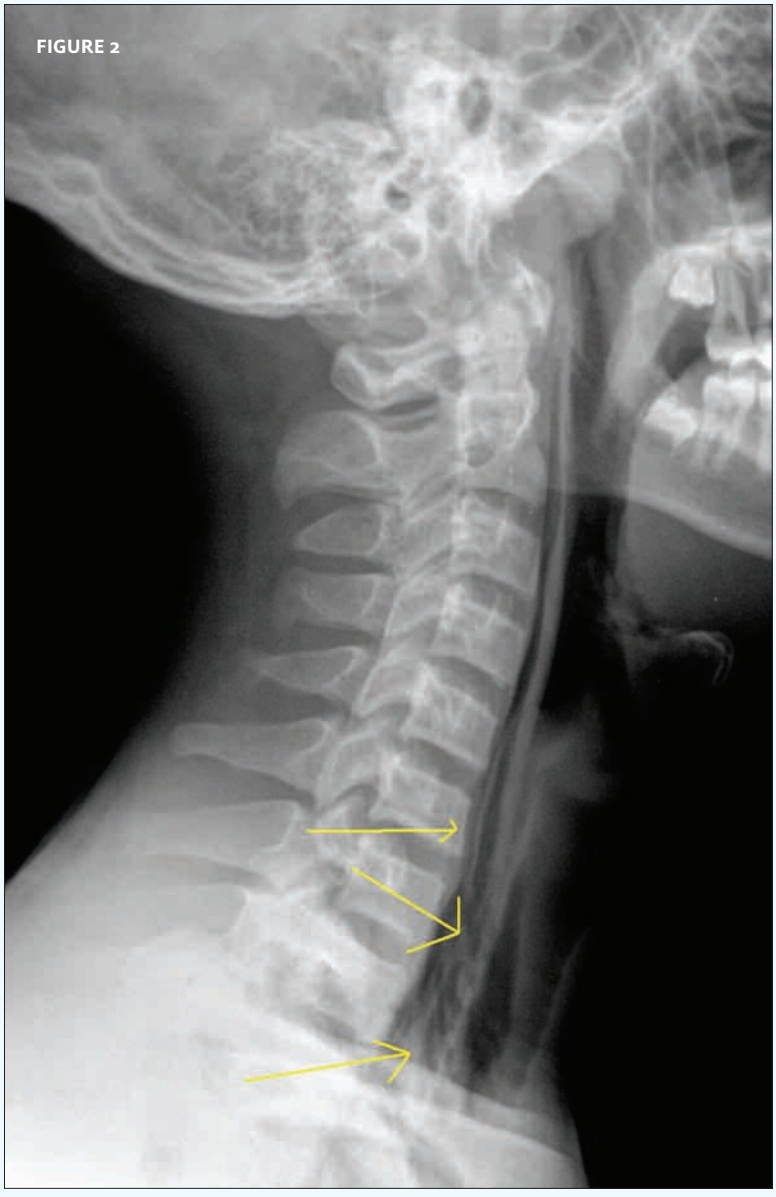


FIGURE 2

The multiple radiolucent streaks are consistent with air in the subcutaneous tissues.

This patient was referred to hospital, where he underwent CT that did *not* reveal a possible cause.

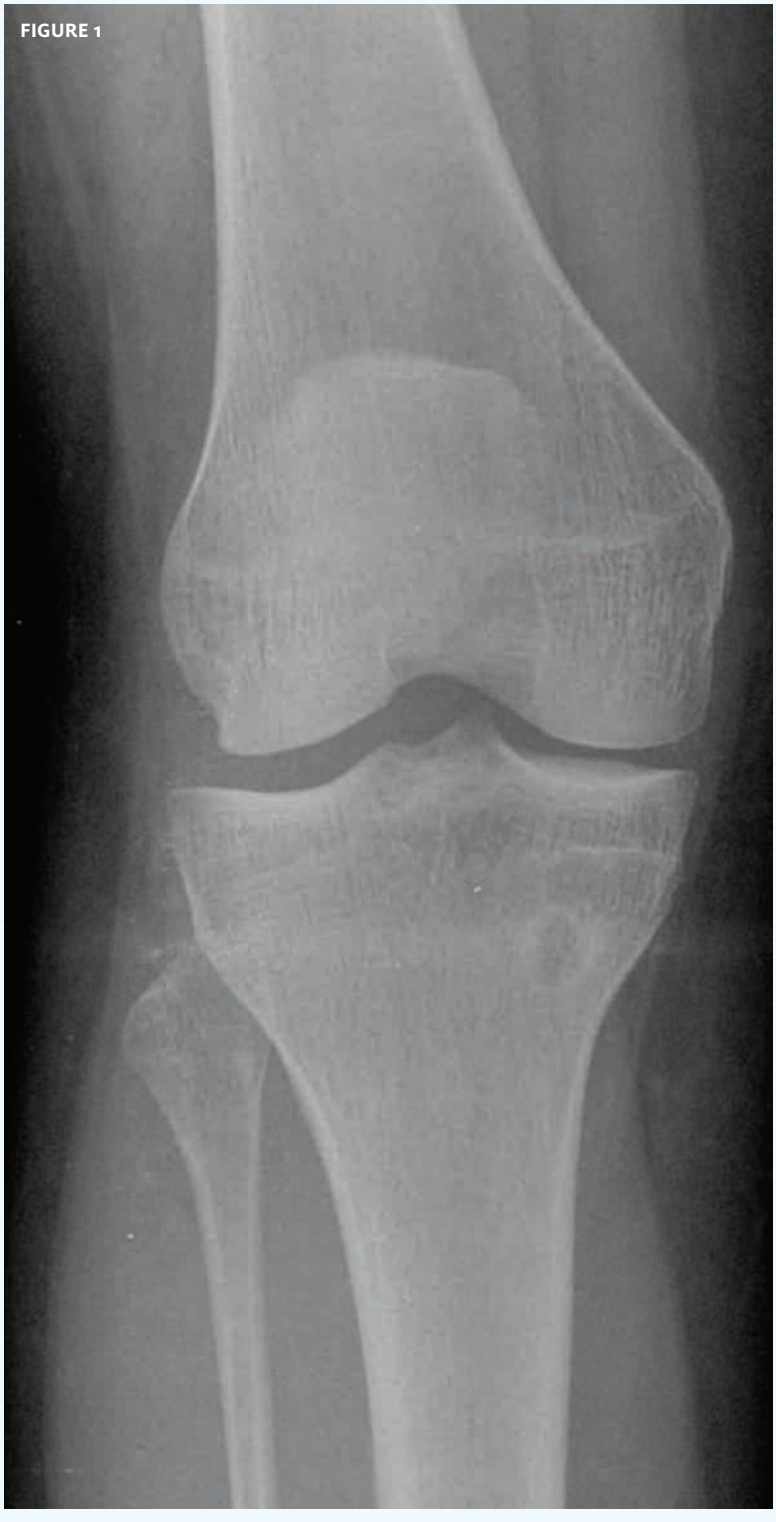
At last follow-up, ENT staff planned to scope him to assess for esophageal and/or tracheal pathology.

Acknowledgment: Case presented by Nahum Kovalski, BSc, MDCM, Terem Emergency Medical Centers, Jerusalem, Israel. The patient was treated by Dr. Gavriel Tibber, who saw the film and identified the findings.

INSIGHTS IN IMAGES

CLINICAL CHALLENGE: CASE 2

FIGURE 1



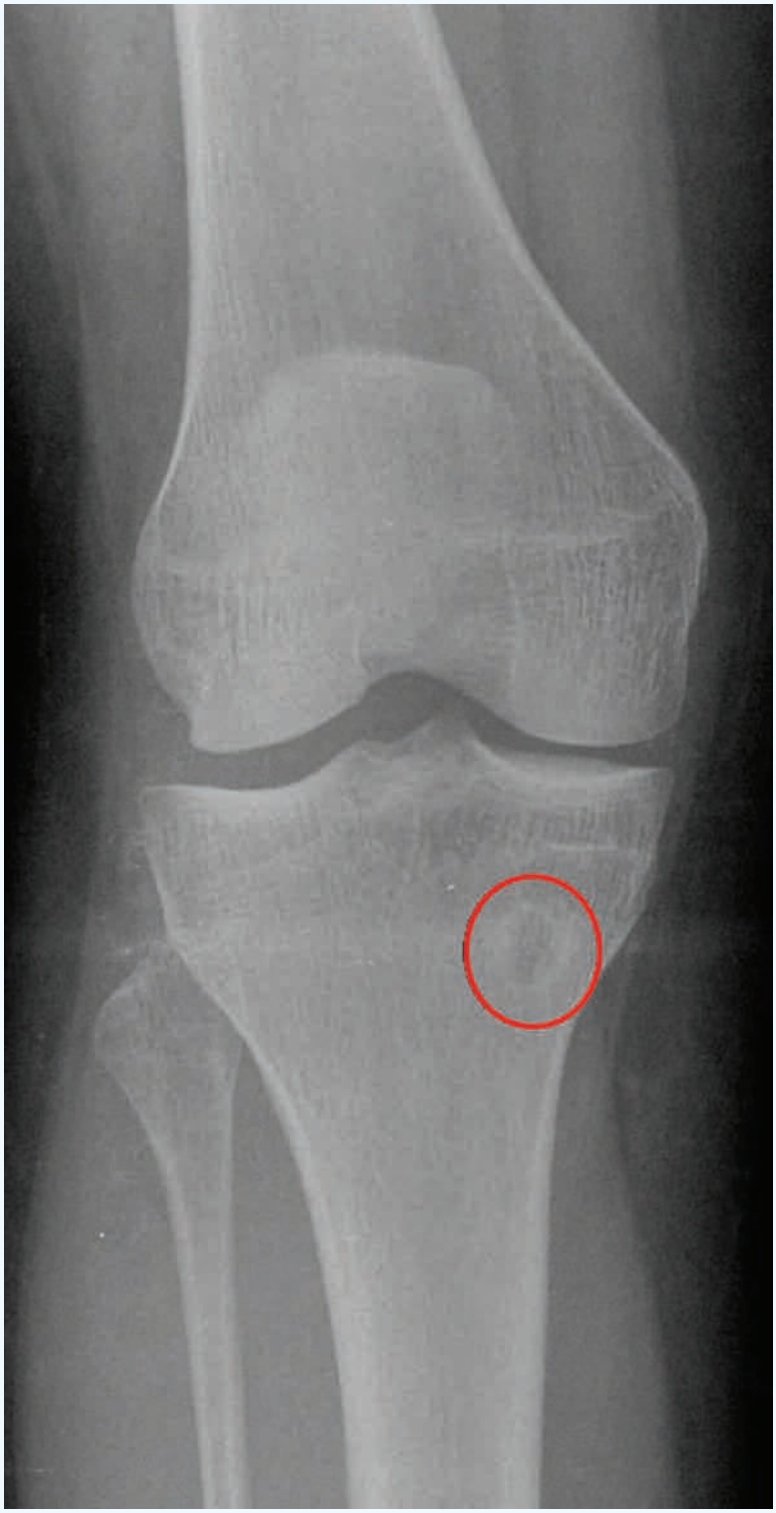
The patient is a 20-year-old female who presents with pain one day after experiencing a blow to the knee during a fall.

On exam, you reveal no significant findings beyond mild local tenderness. She is able to bear weight fully on both legs.

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



While there is no injury associated with the presenting complaint, there *is* a lytic lesion in the proximal tibia.

On review by the orthopedist, the patient was advised to get a bone scan.

This was incidental to the injury, but the differential diagnosis warrants further work-up, as described.

Acknowledgment: Case presented by Nahum Kovalski, BSc, MDCM, Terem Emergency Medical Centers, Jerusalem, Israel.

On CA Pneumonia, Bronchiolitis, Birth Defects and Antibiotics, Effective Use of D-dimer, and H1N1's Toll

NAHUM KOVALSKI, BSc, MDCM

Each month, Dr. Nahum Kovalski reviews a handful of abstracts from, or relevant to, urgent care practices and practitioners. For the full reports, go to the source cited under each title.

CAP Treatment Recommendations: Guided in the Right Direction

Key point: Results of two large cohort studies indicate that adherence to guidelines for treating community-acquired pneumonia is a good thing.

Citations: Arnold FW, LaJoie S, Brock GN, et al. Improving outcomes in elderly patients with community-acquired pneumonia by adhering to national guidelines: Community-Acquired Pneumonia Organization International Cohort Study results. *Arch Intern Med*. 2009;169:1515-1524.

McCabe C, Kirchner C, Zhang H, et al. Guideline-concordant therapy and reduced mortality and length of stay in adults with community-acquired pneumonia: Playing by the rules. *Arch Intern Med*. 2009;169:1525-1531.

Sharpe BA. Guideline-recommended antibiotics in community-acquired pneumonia: Not perfect, but good. *Arch Intern Med*. 2009;169:1462-1464.

Although guidelines for treating community-acquired pneumonia (CAP) have existed for years, controversy persists regarding guideline-recommended antibiotic regimens, and compliance remains lower than desired.

Now, two research groups have examined the outcomes associated with adherence to the 2007 Infectious Diseases Society of America/American Thoracic Society (IDSA/ATS) clinical practice guidelines for CAP management.

In a secondary analysis of data from an observational, retrospective, multinational cohort study, Arnold and colleagues examined outcomes of hospitalized CAP patients aged ≥65. Outcomes were better among the 975 patients whose initial antimicrobial therapies were regimen adherent than among the 660 patients whose initial therapies were non-adherent. Guideline adherence was associated with a higher proportion of patients reaching clinical stability within seven days (71% vs. 57%), a shorter median length of stay (LOS; eight days vs. 10 days), and a lower all-cause, in-hospital mortality rate (8% vs. 17%).

Using data from 113 community and teaching facilities in the U.S., the authors examined outcomes among 54,619 adults hospitalized with CAP. Guideline-adherent initial therapy was associated with decreased in-hospital mortality (odds ratio, 0.70), reduced LOS (mean reduction, 0.66 days), and reduced duration of parenteral therapy (mean reduction, 0.57 days).

As listed in an accompanying editorial, several tools are available to improve adherence to practice guidelines. It is time to use our electronic ordering capabilities, for one, to standardize CAP treatment in accordance with the 2007 IDSA/ATS recommendations.

[Published in *J Watch Infect Dis*, October 7, 2009—Larry M. Baddour, MD.] ■

Nahum Kovalski is an urgent care practitioner and assistant medical director/CIO at Terem Emergency Medical Centers in Jerusalem, Israel.

3% Hypertonic Saline for Bronchiolitis

Key point: Infants treated with hypertonic saline had outcomes similar to those treated with normal saline.

Citation: Grewal S, Ali S, McConnell DW, et al. A randomized trial of nebulized 3% hypertonic saline with epinephrine in the treatment of acute bronchiolitis in the emergency department. *Arch Pediatr Adolesc Med*. 2009;163:1007-1002

A recent Cochrane review suggested that 3% hypertonic saline might reduce length of stay in hospitalized infants with bronchiolitis. In a randomized, double-blind clinical trial conducted at a single pediatric emergency department in Canada, 46 infants with bronchiolitis received nebulized racemic epinephrine with either 3% hypertonic saline or normal saline.

Two hours after treatment, no differences were noted between the groups in the two primary outcome measures—change in a reliable and valid measure of respiratory distress and change in oxygen saturation. Fewer infants in the hypertonic saline group than in the control group were admitted to the hospital, but this difference was not statistically significant (35% vs. 57%).

Bronchiolitis is one of the few pediatric conditions for which hospitalization rates have increased during the past two decades. These results will likely prolong the debate about the use of 3% hypertonic saline to treat bronchiolitis. However, in view of recent findings that the combination of nebulized epinephrine and corticosteroids reduces admission rates, we might be on our way to developing effective treatments for bronchiolitis.

[Published in *J Watch Ped Adolesc Med*, November 25, 2009—Howard Bauchner, MD.] ■

Birth Defects Associated with Use of Antibiotics During Pregnancy

Key point: Sulfonamides and nitrofurantoins (Macrodantin) were associated with birth defects.

Citation: Crider KS, Cleves MA, Reefhuis J, et al. Antibacterial medication use during pregnancy and risk of birth defects: National Birth Defects Prevention Study. *Arch Pediatr Adolesc Med*. 2009;163:978-985.

Antibacterial drugs are among the medications most commonly used during pregnancy. Investigators analyzed data from a national birth defects study to compare antibiotic use in 13,155 mothers of infants with at least one major birth defect and 4,941 randomly selected mothers of infants without birth defects from the same geographic region and born during the same period (1997–2003).

Antibiotic use was determined by telephone interview six weeks to two years after the pregnancy. Exposure to antibiotics was defined as reported use during the month before the estimated date of conception through the end of the first trimester; 14% of cases and 13% of controls used antibiotics during this interval.

Sulfonamides were associated with six major birth defects, including anencephaly (odds ratio, 3.4) and hypoplastic left heart syndrome (OR, 3.2). Nitrofurantoins were associated with four birth defects, and erythromycins were associated with two defects. Penicillins, cephalosporins, and quinolones each were associated with one defect.

Hence, penicillins, erythromycins, and cephalosporins appear to be safe. Sulfonamides and nitrofurantoins appear to be associated with several birth defects and should be avoided if possible. Quinolones, used infrequently by women in this study, are not recommended for use during pregnancy.

[Published in *J Watch Ped Adolesc Med*, November 18, 2009—Howard Bauchner, MD.] ■

Do Emergency Physicians Use Serum D-dimer Effectively to Determine the Need for CT when Evaluating Patients for Pulmonary Embolism? Review of 5,344 Consecutive Patients

Key point: D-dimer screening was not used effectively to determine the need for MDCT in diagnosing acute PE in emergency patients.

Citation: Corwin MT, Donohoo JH, Partridge R, et al. Do emergency physicians use serum D-dimer effectively to determine the need for CT when evaluating patients for pulmonary embolism? Review of 5,344 consecutive patients. *Am J Roentgenol*. 2009;192:1319-1323.

The purpose of this study was to investigate whether D-dimer screening is being used effectively to determine the need for multidetector CT (MDCT) in diagnosing acute pulmonary embolism (PE) in emergency department patients.

The authors performed a retrospective review of all patients who underwent D-dimer testing or MDCT in the emergency department from January 1, 2003 through October 31, 2005. A D-dimer value of >0.43 mcg/mL was considered positive. Diagnosis of PE was made on the basis of the MDCT.

Clinical algorithms for diagnosing PE mandate that patients with a low clinical suspicion for PE undergo D-dimer testing, then MDCT if positive. For patients with a high clinical suspicion for PE, MDCT should be performed without D-dimer testing.

Of 3,716 D-dimer tests, 1,431 (39%) were positive and 2,285 (61%) were negative. MDCT was performed in 166 (7%) patients with negative D-dimer results and in 826 (58%) patients with positive D-dimer results.

The authors concluded that D-dimer screening was not used effectively to determine the need for MDCT in diagnosing acute PE in emergency patients. This is because 42% of pa-

tients with a positive D-dimer who should have undergone CT did not receive this examination, and 7% of patients with a negative D-dimer who should not have undergone CT according to protocol actually did undergo CT.

The authors estimated that the diagnosis of acute PE was missed in 12 patients.

H1N1 Update: Estimates of Flu's Toll; Seasonal Vaccine Not Effective Against 2009 H1N1

Key point: Government data tally number of cases, hospitalizations, and deaths.

Citations: CDC Estimates of 2009 H1N1 Influenza Cases, Hospitalizations and Deaths in the United States, April – October 17, 2009. Available at: *www.cdc.gov/h1n1flu/estimates_2009_h1n1.htm*.

MMWR. Update: Influenza activity—United States, August 30–October 31, 2009. 2009;58(44);1236-1241. Available at: *www.cdc.gov/mmwr/preview/mmwrhtml/mm5844a4.htm*.

Reports on 2009 H1N1 influenza in the U.S. will now use estimates from the CDC's Emerging Infection Program, rather than counting only laboratory-confirmed cases, according to a CDC news briefing.

The new estimates for the first six months of the pandemic (from mid-April to mid-October) find that:

- roughly 22 million people in the U.S. became ill from the virus
- nearly 100,000 were hospitalized
- some 3,900 died, including an estimated 540 children <18; some 2,900 adults between 18 and 64; and 440 elderly.

The CDC also concludes that the seasonal trivalent vaccine offers no protection from, or increased risk for, 2009 H1N1 disease.

An additional surveillance article on the pandemic notes that "severe outcomes among children ... continue to be prominent" and provides support for the recommendation that those aged 6 months to 24 years be targeted for vaccination. ■

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Building Urgent Care Referral Relationships: Pharmacies and Retail Host Clinics

Urgent message: Viewing other community healthcare providers (e.g., pharmacists) or even possible competitors (e.g., retail clinics) as referral sources can increase revenues and bolster the urgent care center's place in the healthcare system. The first of two parts.

Alan A. Ayers, MBA, MAcc

Urgent care has evolved to the point that it is a vital part of a community's healthcare infrastructure, offering access when primary care appointments are unavailable and relief when emergency rooms are at capacity.

As a first point of triage for many patients, urgent care also serves as a hub from which patients are directed to diagnostic facilities, medical specialists, and therapy services. The greater ties urgent care has to the tertiary healthcare system, the more effectively it works to assure affordable, accessible care in a community.

Before the benefits of urgent care can be realized, however, community providers must understand how urgent care complements their practices and adds value for their patients. This requires urgent care operators to educate the healthcare community on its delivery model and scope of services, identify mutually beneficial referral relationships, and develop processes to coordinate best patient care.

Urgent Care is Not a Threat

Before an urgent care center can build any referral relationship, it must overcome the perception that urgent care is a competitor. Some primary care physicians fear that urgent care's focus on episodic treatment leads patients to neglect preventive care and chronic disease management. Likewise, some emergency room administrators fear urgent care siphons away privately insured patients, increasing the financial burden of Medicare, Medicaid, and charity care on the ED.

Ideally, a well-organized healthcare delivery system matches a patient's needs to the most appropriate provider skill set and facility capabilities. For example,

Table 1: Urgent Care Referral Sources and Downstream Providers

Referral sources	Downstream providers
• Primary care physician offices • Medical specialist offices • Retail health clinics • Hospital emergency departments • Employer on-site medical clinics • Student health services • Ambulance/emergency medical services • Public health departments • Pharmacies	• Diagnostic imaging • Laboratory • Primary care offices – Family practice – Internal medicine – Pediatrics • Medical specialists: – OB/GYN – Dermatology – Podiatry – Physiatry • General and specialized surgery • Hospital emergency departments • Physical therapy/rehabilitation • Pharmacies • Durable medical equipment

emergency rooms are designed for trauma, resuscitation, and hospital admissions. Although an ED with excess capacity can profitably treat a patient with a minor sprain, urinary tract infection, or seasonal allergies, the ED's capabilities (and by extension, operating costs) are far beyond what's required for low-acuity cases. When an ED becomes congested due to staffing shortages, hospital patients boarding in ED beds, a surge in ambulance traffic, etc., shifting non-emergent cases to urgent care improves flow and reduces wait times in the ED. And because an urgent care visit costs approximately one-sixth of an ED visit, the availability of urgent care can reduce hospital write-offs, as many patients who cannot afford a $600 to $800 ED visit can easily pay $100 to $200 for urgent care.

Urgent care is not intended to replace established providers, but, rather, to support them in assuring patients get care in the most efficient and effective manner possible. Integrating urgent care starts with identifying what sources of care are available, understanding how patients access and navigate medical providers, and by creating win-win scenarios in which referral providers build up urgent care and in turn, urgent care builds up referral providers. **Table 1** lists common referral sources and downstream providers for urgent care patients.

Pharmacy Referrals

One of the most visible (yet often overlooked) referral sources is the retail pharmacy. According to the National Association of Chain Drug Stores (2009), there are more than 56,000 pharmacies in the United States, including 39,000 operated by food, drug, and mass-retail chains and 17,000 independents.

Most patients who visit a doctor will go to a pharmacy immediately after, making the pharmacist the first person to hear about the patient's experience. Pharmacists gain unique insight as to providers' reputations, practice methods, and patient base. And by managing all of a patient's prescriptions, a pharmacist can see a patient's entire health history. Pharmacists not only identify potential treatment interactions, but understand the complexities of chronic disease states like diabetes and hypertension.

Because pharmacists are tied in to patients and their providers, are trained in patient counseling, and are generally trusted advisors, consumers who have questions about their health will often ask their pharmacist what steps to take. Pharmacists routinely assist patients in selecting over-the-counter remedies, but when a more serious illness is suspected—such as a cough that could be pneumonia or swelling that could be a fracture—the pharmacist can recommend that the patient go to urgent care. Likewise, pharmacists may refer patients who need refills on expired prescriptions and do not have a local doctor.

Building a referral relationship starts with introducing the pharmacist to the urgent care center's range of services, operating hours, insurance participation, and pricing for cash pay patients. Providing the pharmacist with marketing collateral—magnets and maps to the center—will facilitate referrals when opportunities occur.

Pharmacy customers are healthcare consumers, so if the pharmacist is willing, display urgent care collateral at the pharmacy counter to raise awareness among all customers. Whenever collateral is placed, be sure to set a follow-up schedule to assess continued interest and replenish those materials.

Because the pharmacist is interested in building his own business, he may ask for your support in directing prescriptions to the pharmacy in return for promoting the urgent care center. Urgent care centers sometimes receive promotional benefits from pharmacies, such as free magazines for the waiting room placed in pharmacy-branded vinyl covers. Or, a pharmacy may pro-

vide coupons for the urgent care to display or give to patients at discharge. These perquisites add value to a patient's urgent care visit.

In addition, co-promotions such as health fairs or immunization clinics held at the pharmacy and staffed by urgent care personnel can also drive traffic into the pharmacy (while increasing awareness of urgent care), especially if the event is advertised.

There is nothing inherently wrong with an urgent care center recommending a particular pharmacy, provided the conditions in **Table 2** are met. Having data on hand—such as the number of patients seen at the urgent care or number of scripts written—can strengthen an urgent care center's presentation to the pharmacist.

Table 2: Conditions for Referring a Pharmacy

Generally, an urgent care center may recommend a particular pharmacy to patients when the:

- patient makes the ultimate decision whether to use the pharmacy
- recommendation is in compliance with all regulations and contractual agreements
- pharmacy is convenient to patients
- pharmacy accepts common insurance plans
- pharmacy is reputable, charges competitive prices, and provides good service.

Table 3: Conditions Subject to Referral From Retail Host Model Clinics to Urgent Care Centers:

- Automobile accidents and on-the-job injuries requiring a physician examination.
- Procedures requiring special lights, table and supplies such as:
  - incision and drainage
  - removing foreign objects
  - suturing cuts
  - casting fractures
- Conditions requiring an x-ray for diagnosis—from pneumonia to sprains/strains.
- Other conditions requiring equipment beyond the retail health clinic's capabilities—such as a pulmonary function test or nebulizer treatment for asthma.
- Other conditions beyond the scope of practice of the midlevel provider (often dictated by state laws).

Retail Health Clinics

An increasing number of pharmacies also operate in-store medical clinics. According to MerchantMedicine.com, as of November 2009 there were 1,165 retail host model clinics in 40 states, about three-quarters of which are operated by the two largest pharmacy chains—Walgreens' Take Care Health and CVS' MinuteClinic.

Retail health clinics range from 100 to 300 square feet and are staffed by solo nurse practitioners or physician assistants whose scope of practice is limited by state regulations and the off-site supervising physician. Retail health clinics lack much of the basic equipment of an urgent care center, such as x-ray, slit lamps, and gynecology stirrups (many don't even have an exam table or a restroom), which further limits the scope of services to conditions like sore throat, athlete's foot, and pink eye.

Recognizing the provider and facility limitations of retail clinics, American Academy of Family Practice (AAFP) guidelines state, "Retail health clinics must have a referral system to physician practices or to other entities appropriate to the patient's symptoms beyond the clinic's scope of work." **Table 3** outlines common conditions a retail health clinic might refer to urgent care.

Although the retail clinic's corporate owner may be interested in steering referrals to affiliated hospitals or supervising physicians, midlevel practitioners take pride in their autonomy and rely on their own experience when making referrals.

Building a referral relationship with a retail health clinic starts with introducing the midlevel provider to urgent care and positioning urgent care as the solution to the retail clinic's limited practice scope. Meet with the retail clinic's practitioners one-on-one to review the services and hours of the urgent care center, explain cash pricing and insurance plans accepted, provide maps and other marketing collateral, and offer assurance that referrals will be treated on a priority basis. Also consider inviting retail practitioners to visit the urgent care center to see firsthand the good experience his or her patients will encounter.

Like pharmacists, retail clinic operators are interested in expanding their businesses; where there are services provided by the retail clinic that urgent care does not offer, agree to promote those services in the urgent care center. For example, many retail health clinics utilize a national distribution network to carry a broad range of

"Reciprocal referral relationships strengthen the urgent care center's standing in the medical community and improve coordination of patient care."

vaccinations that an individual urgent care center may find unprofitable to stock due to short shelf life, high inventory costs, and/or low insurance reimbursement.

A well-positioned retail health clinic may also function as overflow for a busy urgent care center. After the initial meeting with the practitioner, set a follow-up meeting to review data on number of patients referred, replenish marketing collateral, and seek feedback on how to improve the referral process.

Strategic Value of Referrals

Referrals should be viewed as a strategic asset of an urgent care center—they tie the urgent care center into other healthcare providers and solidify urgent care's position in consumer minds as a "front door" to the healthcare system.

Every time a patient is referred to an urgent care center, the urgent care provider has the opportunity to capture that patient's repeat business and spur word of mouth among the patient's friends and family. Reciprocal referral relationships strengthen the urgent care center's standing in the medical community, improve coordination of patient care, and build urgent care revenue and volume—a win-win solution. ■

Note: This article is part 1 in a two-part series on building referral relationships for urgent care. Part 2 will detail referral relationships with primary care, emergency rooms, and specialists, as well as describe the processes necessary to facilitate referrals and coordinate patient care.

Deconstructing the Ten Commandments of Urgent Care Medicine

JOHN SHUFELDT, MD, JD, MBA, FACEP

Since the holiday season was just upon us, I will take the opportunity to borrow heavily from the 1956 Cecil B. DeMille movie, *The Ten Commandments*. The movie portrays the life of Moses, from an infant floating down the Nile through his return to Egypt to lead the Hebrews across the Red Sea.

For the next few paragraphs, think of me as the Moses of Urgent Care World, as I attempt to lead you to the land of litigation-free tranquility!

1. *Know your alphabet*. Even in urgent care, the ABCs are crucial. Patients will occasionally present to the urgent care center in extremis, and it is imperative that the provider secure the ABCs while waiting for 911 to arrive to transport the patient to the closest appropriate emergency department.

   Many urgent care centers are not set up to handle life-threatening events. Ensure that, at the very minimum, you have nasal and oral airways available. That the oxygen tank is filled and that a bag-valve mask is available in the appropriate sizes. Practice "codes" once a quarter so that every member of your staff knows where the equipment is located and what their roles are. It does not happen often, but when it does happen, seconds count. An empty oxygen tank, an unsecured airway, or the absence of a bag-valve mask can lead to poor patient outcomes and getting booted out of Egypt.

2. *Assume every patient is trying to die.* Most providers are not trained to think like this. And, truth-be-told, it is not always the most "positive" way to approach life. "Hello, I'm Dr. Shufeldt, tell me how you are trying to die."

   Seriously, if you approach every patient with this perspective, you will often rule out, at least in your mind (and on the chart), the diseases which *will* kill them.

   For example, the patient with a runny nose, nasal congestion, low-grade temp and a "sinus pressure headache" switches from the guy with a sinus infection to "I have considered cavernous vein thrombosis in my differential diagnosis, however the patient does not have visual changes, is not exhibiting signs of increased intracranial pressure, and has a normal fundoscopic examination." As rare as any of the plagues, yes. Fatal if not caught, yes. Need to rule it out, absolutely, yes!

John Shufeldt is the founder of the Shufeldt Law Firm, as well as the chief executive officer of NextCare, Inc., and sits on the Editorial Board of *JUCM*. He may be contacted at *JJS@shufeldtlaw.com*.

3. *Document informed-consent discussions.* Here's what happens: The 40-year-old presents with atypical chest pain, limited risk factors, and a normal EKG. You tell him that he has a normal EKG; however, the "story buys the admission," at least to the ED, and you would like to send him over. He responds that he will follow up with his PCP in the next day and that he feels fine and does not want to go to the emergency department. You tell him that he really needs to go and you go over the risk-benefit discussion with him. He understands, yet still declines. You document that "Patient will follow up with PCP in AM." He does not follow up and drops dead three days later from his occluded left anterior descending coronary artery.

   All I can say is, "Get out your checkbook." Thirty seconds of documentation would have saved you a potential seven-figure settlement and seven years of locusts.

4. *Document pertinent negatives.* Would you ever send someone home with fever, stiff neck and a headache? Of course not. However, if you don't document the fact that the patient had no meningeal signs, someone looking at the chart with the retrospectoscope would assume you did if it was not documented.

   The "crossing the Red Sea" point: if the course of action you are planning to follow ultimately turns out to be the wrong decision, resulting in serious morbidity or mortality, you must ensure that you have documented your reasoning, including the pertinent negatives which influenced your decision.

5. *Order a pregnancy test, EKG, troponin, etc.* In urgent care medicine, we often only have "one bite of the apple," so we have to gather as much information as possible to make the appropriate decision.

   Make sure you are ordering tests which ultimately will support your eventual decision. Not ordering the test means you either did not think about it, or did not realize the importance of knowing the information, unless documented otherwise. Don't find yourself "adrift down the Nile" without a basket. Order the test.

   By the way, a woman post tubal ligation has a one in 200 chance of being pregnant.

6. *They are called "vital signs" for a reason.* One of the best answers I have heard in a deposition came from a plaintiff's expert who was asked why he would not have sent the patient home with the abnormal vital signs. He replied, "They are called 'vital' for a reason."

   At least half of the cases I review on behalf of urgent care centers involve sending a patient home with unaddressed abnormal vital signs. When this occurs, and the patient has a bad outcome, you might as well give up your firstborn, because the outcome is not going to be good.

7. *Trust no one.* Patients lie. Staff members misrepresent the facts. Colleagues can be dismissive of patients. Obtain the information yourself, examine the patient yourself, and document on the chart yourself. As importantly, check old records and read your own x-rays, etc. Solely trusting others may lead to you getting bit in the asp!

8. *Learn from your and others' mistakes.* Mistakes abound; maybe the purpose of my life, like the burning bush, is simply to serve as a warning for others. I hope not. However, if that is my lot in life so be it. If reading this column protects you and, more importantly, your patient from one of the plagues, then it is all worthwhile.

9. *Do unto others as you would your family.* We all know how we want to be treated, and we all know what it means to provide great care and great customer service. So, knowing that, what is stopping you from providing that level of service? Patients (and staff) can be challenging at times; nevertheless, treating them with anything short of the utmost courtesy at the end of the "walk down the mountain" gets you nowhere, and chances are you will have to spend additional time repairing the "damage to the tablets."

10. *Follow up on lab and x-ray results.* What is worse than not ordering an indicated x-ray or test? Ordering one and then not communicating the results to the patient.

    I know of many cases where a lab test or x-ray was ordered and showed a potential life-threatening condition and the patient was never contacted. Months go by, the patient's symptoms become fulminant, and someone goes back to check the old records and sees the liver enzymes elevated or a mass on the chest x-ray.

    When that happens, you will be sued on the "loss of a chance" theory and, even worse, the patient will most likely have a bad outcome due to your lack of warning. All you would have had to do is make the call and by painting the proverbial blood on the door, spare the patient their fateful outcome.

After studying the aforementioned Ten Commandments of urgent care medicine, if you still find yourself in a court of law, defending your or your employee's action, my advice to you is to quote Charlton Heston (Moses in *The Ten Commandments*) by screaming, "Let my people go!"

At this point, I am sure that at the very least you will have a good chance for an insanity plea. ■

CODING Q&A

Coding by Time, for Emergent Care, and for Nurse Practitioner Visits

DAVID STERN, MD, CPC

Q. How does one determine whether an E/M code can qualify for coding according to time spent? Obviously, any psychiatric counseling would fit the criteria, but what about "teaching" (e.g. how to use an inhaler, how to perform a breast exam), or preventive medicine counseling?
– Question submitted by Dr. Kim, Med7 Urgent Care, CA

A. The key issues on counting counseling or coordination of care toward the E/M code are:

- Counseling and/or coordination of care must take up over 50% of the time that the provider is face-to-face with the patient, and should be medically necessary.
- The content and amount of time spent counseling and total face-to-face time must be documented.
- Only count counseling toward the E/M if it relates to a patient complaint, a disease process, or an abnormal test result.

Counseling for preventive services does not count as counseling time toward a problem-oriented E/M code.

If the visit meets the above criteria, then you use the *total* face-to-face time (not just the time spent in counseling and coordination of care) to determine the appropriate E/M code.

Note 1: In the examples that you noted, e.g., inhaler education, etc., it is extremely unlikely that this counseling would take up over 50% of the face-to-face time.

Note 2: Counseling for preventive medicine services, such as "how to perform a breast exam," are not included in a problem-oriented E/M office visit (99201-99215), but rather would be included in codes for health maintenance physicals (99381-99387).

A rare exception might be if a patient presented with a chief complaint of a breast lump, but in reality the patient was noting normal breast tissue. Then the provider could use the time toward counseling on how to perform a breast exam toward the E/M (99201-99215) if this counseling consumed more than 50% of the face-to-face time of the visit; again, this seems unlikely.

Note 3: In the urgent care setting, if the history, exam, and complexity of medical decision-making are properly documented in the chart, it is quite rare, for the *time* element to raise the code above the E/M level calculated from the actual documentation on the chart.

David E. Stern, MD, CPC is a certified professional coder. He is a partner in Physicians Immediate Care, operating 12 urgent care centers in Oklahoma and Illinois. Stern serves on the Board of Directors of the Urgent Care Association of America and speaks frequently at urgent care conferences. He is CEO of Practice Velocity (*www.practicevelocity.com*), providing urgent care software solutions to more than 500 urgent care centers. He welcomes your questions about coding in urgent care.

Q. Is code 786.59 an emergent care code if the patient has been seen at a clinic, not at a hospital?
– Catherine Danca, Legislative Aide, Illinois State Sen. Pamela J. Althoff

A. The code that you inquire about is an ICD-9 code, which is a code set that is mainly devoted to diagnoses. The code is defined as follows:

- 786.59, "Other chest pain," also known as:
  - discomfort in chest
  - pressure in chest
  - tightness in chest.
- 786.59 *excludes*:
  - pain in breast (611.71)

If you are speaking of whether or not the code would justify the use of the CPT code 99058 (services provided on an

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Embracing a Culture of Constant Change

FRANK H. LEONE, MBA, MPH

Imagine a world in which nothing changes. We cannot, of course, because change is central to the human fabric.

Given that change is inevitable, it seems obvious that we want to be innovative by embracing change early, rather than being reactive to change and perpetually a step behind. The challenge arises with assuming some risk in order to be in the forefront.

How, then, does your clinic strike such a delicate balance?

1. *Assess.* Maintain an ongoing plan to examine your occupational health products, operational systems, staffing relationships, and sales/marketing initiatives on an annual basis.

   For example, routinely ask external clients for their opinion and suggestions for change. The more bluntly you ask the question, the more likely you will get direct answers that reveal valuable change opportunities.

2. *Balance the new with the old.* There should be a little change each and every year, rather than stability over many years followed by major and often reactive change. Your clinic should try out at least one major new initiative every year. Over the course of a decade you will try 10 or more initiatives. Although many will far short, you will hit a few home runs.

3. *Align on the culture of change continuum.* View change as a continuum with aversion to change on one end and constant change and upheaval on the other.

   Where should your clinic be on this continuum, and how will you determine this?

   It begins with your organizational culture. Some organizations are slow to innovate; at best, you can only buck this slightly at the program-level.

   Also consider clinic age. A newer clinic needs to work out the kinks and is unlikely to innovate in the short term. Conversely, a long-established program is more likely to have settled into old habits that need to be refreshed with new innovations.

4. *Be flexible.* Change works if processes are in place to monitor the impact of that change and modify the change plan as realities dictate.

   A new marketing scheme might look appealing, but face unexpected complications. Your clinic can A) proceed with the plan, B) drop the plan at the first sign of disappointment, or C) constantly tweak the plan in response to market reactions.

   Option A is the easy choice, option B the panic-induced choice, and option C usually the right choice.

5. *Do many small things.* Hedge your bets by introducing several small changes rather than a single major one. When it comes to marketing, try three new ideas every year. If even one of the new innovations works, you have something to build on during your next marketing cycle.

6. *Think "three."* Why three? Because of span of control and as a buffer for under-performance. That is, four or more initiatives (or divisions) are invariably unwieldy and difficult to monitor. One area usually fails to receive sufficient attention or is ignored altogether.

   On the other hand, do not put all of your eggs in one basket to protect yourself against unanticipated erosion in a single area. You might divide your efforts—

Continued on page 37

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and your client's attention—among injury management, prevention services, and consulting. Your services would, therefore, be somewhat insulated against, for example, a change in the state's fee schedule.

Likewise, a marketing initiative could include educational programs, one-on-one contact, and e-mail contact. If one area failed to meet expectations, the other two could carry it for a year while the first area was re-invigorated or replaced.

7. *Recognize synergisms*. Be certain that each of your three areas feeds one another. At my company, for example, our educational programs provide us with information for our publications and members, which converts to more consulting clients, which provide us with more insights to share in our educational programs.

   Likewise, the major components of your marketing plan should seldom be a "stand-alone" idea; rather, every idea should be connected to another in order to feed your program in multiple, synergistic ways.

8. *Embrace change-speak*. Embracing change means more than proactively introducing new products and marketing techniques every year. It also means embracing "change-speak" into your vocabulary. You should make judicious use of such words as "new," "modern," and "updated" in your sales and marketing discussions, literature, and personal contacts. You need to *project* constant change and improvement as much as you need to *effect* it.

9. *Keep abreast of technology.* When I established my company some 25 years ago, fax machines were considered cutting-edge technology, and there was no Microsoft Word, Excel, or PowerPoint. Nor was there much of an Internet, e-mail, or cell phones. Yet today, virtually all are central to my professional life each and every day. Looking back, I was probably a bit late in understanding and adopting virtually all of these technological advances.

   The message: stay a step ahead of the posse by keeping abreast of emerging technologies and using them to your advantage.

Status quo—so pervasive in healthcare management—quickly becomes old, tired and counter-productive. It is better to get *beyond* the status quo by asking yourself, "What can I do differently each year?" ■

emergency basis in the office), the answer would depend on the clinical situation.

Based on the definition of the code, it should be used only for patients seen in a physician office. It should not be used in conjunction with emergency department visits or for care rendered during a hospital admission. This code should be used as an add-on code. It is intended to compensate the physician for the interruption in the office schedule when the physician, based on the emergent nature of the patient visit, must leave another patient immediately to render services to the patient in question.

If a patient visits a physician with a chief complaint of chest pain, it is very likely that the physician was called from the care of another patient in order to evaluate the seriousness of the patient's chest pain. Thus, in many cases, CPT code 99058 could be used properly in conjunction with the ICD-9 for chest pain.

Q. Can a nurse practitioner bill under E&M codes?

– *Question submitted by April Knight, claims representative, AMCO Nationwide Insurance Company*

A. Provided that the appropriate state supervisory regulations (if any apply) are followed by the midlevel provider, then it is compliant to use E/M codes (99201-99215) for services rendered by a nurse practitioner or physician assistant. Medicare and some other payors reduce reimbursement by 15% for services rendered by the midlevel provider.

In order to get reimbursement at the full Medicare fee schedule, you may be tempted to bill all midlevel services with the supervising physician listed as the rendering provider.

For Medicare (and some other payors), however, it is important to understand the rules for incident-to billing. Incident-to is defined by Medicare and may not apply to a third-party payor, unless that payor requires the use of incident-to rules. If the midlevel's service meets the incident-to requirements, then the service may be reported using the supervising physician's national provider identification (NPI) number. Medicare will reimburse this service at full Medicare rates, as though the physician personally performed the service.

Under the incident-to rules, however, you may not bill with the physician as the rendering provider unless the visit meets specific criteria. To be considered incident-to, the physician must perform the initial visit for the patient's diagnosis/problem and document a treatment plan that the midlevel provider follows on subsequent visits. The physician must provide direct supervision of each service provided by the midlevel provider. "Direct supervision" does not mean that the physician must actually be present in the same room, but the physician must be present in the office and immediately available to provide assistance and direction to the midlevel provider. ■

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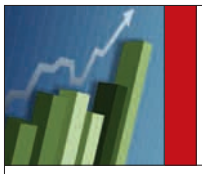
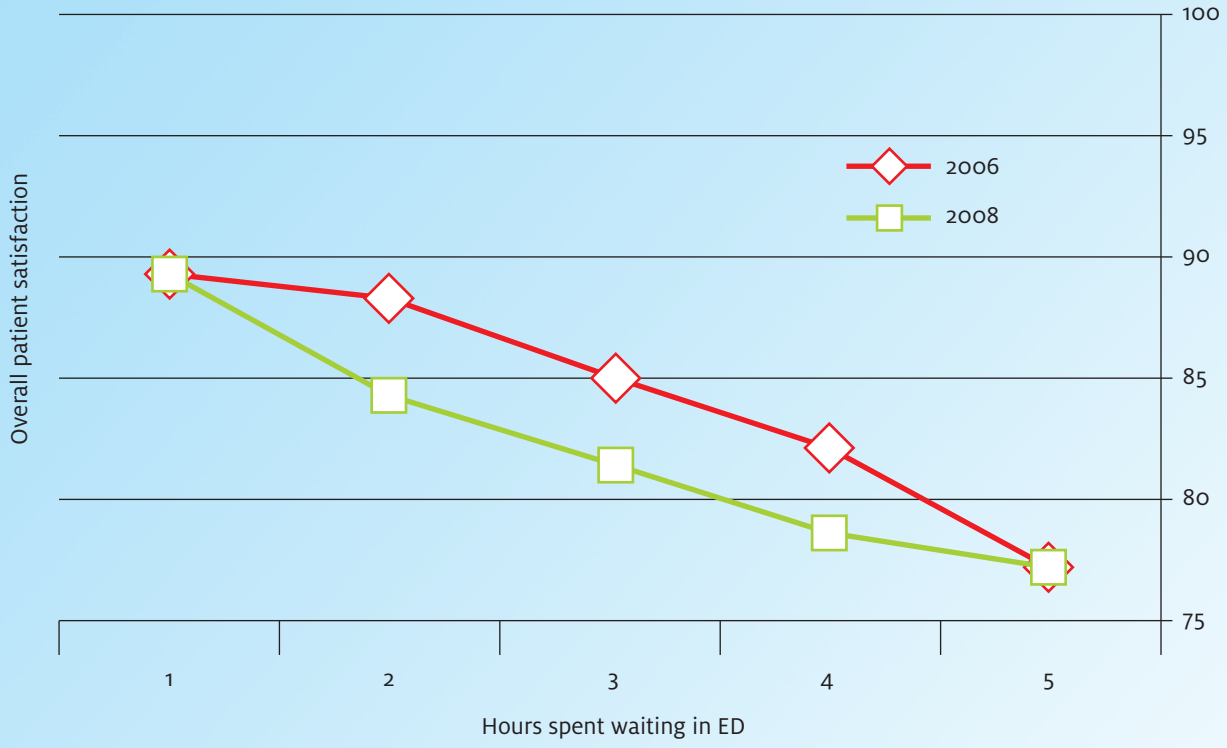


DEVELOPING DATA

In each issue on this page, we report on research from or relevant to the emerging urgent care marketplace. This month, we offer an analysis of how patient satisfaction is affected by time spent in the emergency room, and how current scores compare with research done two years prior.

Though not reflective of patient experiences in the urgent care settings, these data can serve as a lesson on the importance of respecting the patient's time while also arming your marketing efforts with up-to-date information for comparing the patient's experience between the two settings.

PATIENT SATISFACTION BY TIME SPENT IN THE ED



Source: *Pulse Report 2009: Emergency Department. Patient Perspectives on American Health Care* and *Emergency Department Pulse Report 2007. Patient Perspectives on American Health Care.* Press Ganey Associates, Inc.

Average ED wait times reflected in the current report are four hours, three minutes. This is a two-minute improvement over 2007, though in 2006 the average wait was "just" four hours. Either way, the message is clear: more waiting leads to less satisfaction.

While not all the patients treated in the ED could be appropriately managed in the urgent care center, it is those lower-acuity patients that *could* be treated in urgent care that tend to wait the longest while truly emergent cases take precedence.

If you are aware of new data that you've found useful in your practice, let us know via e-mail to *editor@jucm.com*. We'll share your discovery with your colleagues in an upcoming issue of *JUCM*.

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