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LETTER FROM THE EDITOR-IN-CHIEF

M.O.C.: What a Mess!



arauding Our Cash," "Mockery Of Certification, "Malady of Commonsense." I've had a lot of fun coming up with new definitions for the wildly unpopular Maintenance of Certification, or M.O.C. Back in 2003, the American Board of Medical Spe-

cialties (ABMS) and their member boards, decided unilaterally that 8 years of education, 3 to 7 years of residency training, MCATs, USMLE Parts I, II and III, specialty board certification exams, annual continuing medical education (CME) requirements, "specialty accredited" CME requirements, and specialty board recertification exams simply weren't enough to ensure that the public can have confidence that their physicians are qualified to care for them. And if that wasn't enough, just add a dose of PQRI, HIPAA, Stark, EMTALA, DEA, E-Rx, EHR, CPT, E&M, and ICD-9 (err...10), to the ever-growing list of required competencies...ahem...crushing burdens the lowly physician must endure. Is it any wonder that physicians feel more stressed today than in the history of the profession?

M.O.C. was apparently intended to improve healthcare quality and ensure the competency of its physicians in an effort to protect the public from all the bad doctors out there. What many physicians see, instead, is just another costly burden that does nothing more than distract from patient care. Most of them agree that while board certification has never been seen as a guarantee of competency, it is a logical attestation. Its initial intent was to be a declaration of completion for specialty training. While most physicians also agree that board certification should be followed with some form of CME, the introduction of one more burden in a sea of regulatory and compliance mandates is just too much to bear.

Worse yet, the requirements for most M.O.C. programs are intended to follow the most traditional career paths and leave non-traditional specialists scrambling for medical records from encounters for conditions they do not routinely see and scratching their heads for any relevancy of the exercise to their careers. As an urgent care practitioner, I have to file for an exemption or take more modules simply because I don't have any continuity patients to present. The process, of course, is expensive, costing more than \$2,000 to \$3,000 over the course of the program, and culminating in another re-certifying exam every 10 years at a cost of another \$2,000 (please add an additional \$2,000 for the board review course most of us will take to ensure that we didn't waste our time and money the last 10 years). All told, it will cost each physician a minimum of \$6,000 to \$7,000 every

The introduction of one more burden in a sea of regulatory and compliance mandates is just too much to bear.

10 years to maintain the privilege of certification.

In writing this column, I felt inclined to analyze the math to get a better appreciation for how much money was being spent. There are more than 100,000 board-certified family physicians in this country and each one of them will go through recertification an average of three times in their careers. So, 100,000 X \pm 0,000 to \pm ,000 to \pm ,000 X = 1.8 to \pm 2.1 billion. You heard me, billion with a "b." That number does not even include lost productivity and the less quantifiable cost of stress. The American Board of Family Medicine alone stands to earn at least half of that amount, with the rest spent on travel, review courses, etc. Is it any wonder that the ABMS member boards are defending the importance of M.O.C.?

There remains little, if any, evidence to show that maintenance of certification does anything to promote higher-quality care, and I can assure you that no one has examined the hidden costs. Why do we persistently, almost addictively pursue new regulations, examinations and professional development requirements without evaluating the quantifiable and intangible costs? No other profession comes close to our manic testing and regulatory obsession. Perhaps one day all this will rub off on the bankers.

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



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IN THE NEXT ISSUE OF JUCM

Diabetes is epidemic in the United States and many individuals with it are undiagnosed. Hyperglycemia is a common presenting symptom in patients who present to urgent care practices and the subject of next month's cover story. It reviews the latest literature on management of acute hyperglycemia in an urgent care setting, highlights unique challenges related to detection of significant hyperglycemia, and offers providers a rational algorithm-based approach to the problem.

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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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UCM CONTRIBUTORS

ur cover story this month is on lymphadenopathy, a presentation common in the urgent care setting that can be localized or generalized. The



condition usually is benign and self-limiting, but it can signal malignancy, serious infection or drug reaction. Maria Gibson, MD, PhD, and Daniel A. Cherry, MD, review causes of lymphadenopathy and associated conditions, presentation, anatomic arrangement and drainage distributions of the major palpable lymph nodes, "red flags" that should raise suspicion of malignancy, and appropriate laboratory testing. Follow up with a health care provider in 1 to 2 months is imperative for all patients who present with lymphadenopathy, and follow up earlier is advisable for those who have fever for more than 24 hours, increase in lymph node number or size, increase in tenderness, or other symptoms.

Dr. Gibson is a physician at Doctor's Care, Charleston, SC, and Associate Professor in the Department of Family Medicine at the Medical University of South Carolina, Charleston, SC. Dr. Cherry is a hematopathologist and Medical Director of Laboratory Services, Trident Health Care System, and Senior Partner, Lowcountry Pathology Associates, Charleston, SC.

Chest pain and related symptoms often bring patients to emer-

gency rooms in the United States, but exclusive new data in this month's issue show that patients with a clinical picture suggestive of acute coronary syndrome (ACS) also are seen at urgent care centers.



Results of a study of 500 patients who presented to any 1 of 5 urgent care centers in the greater Cleveland area with chest pain/possible ACS—by authors Jason T. Weingart, MD, Thomas P. Carrigan, MD, MHSA, Lee Resnick, MD, Daniel Ellenberger, BS, Daniel I. Simon, MD, and Richard A. Josephson, MS, MD—show that 1 in 10 required true emergent medical attention and therapy. The implication is that urgent care centers need to be integrated into pre-hospital cardiovascular care pathways.

Dr. Weingart is a Senior Clinical Instructor at Case Western Reserve University School of Medicine and Chief Resident in the Department of Medicine at University Hospitals Case Medical Center in Cleveland, OH. Dr. Carrigan is an Electrophysiology Fellow in the Division of Cardiovascular Medicine at the University of Michigan, Ann Arbor, MI. Dr. Resnick is an Assistant Clinical Professor in the Department of Family Medicine at Case Western Reserve University School of Medicine and the Medical Director of Urgent Care for University Hospitals Health System. Mr. Ellenberger is the Director of the EMS Training and Disaster Prepared-

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Congratulations!

JUCM would like to congratulate John Shufeldt, MD, JD, MBA, FACEP, for receiving a Silver Award in the American Society of Healthcare Publication Editors 2012 Awards Competition. His Health



Law column was recognized in the category of Best Regular Department, which was open to columns that appear regularly in healthcarerelated publications in the U.S. Dr. Shufeldt's July/August, September, and December 2011 columns were submitted.

We're proud of our association with Dr. Shufeldt, who has garnered several ASHPE awards for his columns, and pleased that ASHPE has formally recognized his contributions to the journal. We appreciate them, as do we the contributions of all our authors.

This is the fifth year in a row that *JUCM* has been recognized in the ASHPE competition and our second Silver Award.



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ness Institute for University Hospitals Health System. Dr. Simon is the Herman K. Hellerstein Professor of Cardiovascular Research at Case Western Reserve University School of Medicine, Director of University Hospitals Harrington Heart and Vascular Institute and Division Chief of Cardiovascular Medicine at University Hospitals Case Medical Center in Cleveland Ohio. Dr. Josephson is Professor of Medicine at Case Western Reserve University School of Medicine, Medical Director of the Cardiac Intensive Care Unit and Medical Director of CVP Rehabilitation at University Hospitals Case Medical Center in Cleveland, OH.

Our case report this month, by John K. Grandy, BS, MS, RPA-C, underscores the importance of stringent workup for individuals who present to urgent care centers with mild symptoms and history of



recent use of head shop products—especially mephedrone-containing products such as "Molly Mosquito Caps." Patients who have taken these "bath salts" may experience multisystem failure, but not until several days after consumption.

Mr. Grandy is a physician assistant (PA) with Whitestone Consulting LLC-subcontractor for the Department of Defense at Fort Drum, NY, and a part-time PA with North Country Urgent Care in Watertown, NY.



Think a little gossip in your workplace is benign? Well perhaps you should think again. That is the key message of our practice management article this month, which explores how toxic talk can under-

mine trust, service, and teamwork in an urgent care center. Author Alan A. Ayers, MBA, MAcc, explains how to spot toxic talk and root it out before it damages your operation.

Mr. Ayers is Vice President, Concentra Urgent Care and Content Advisor, Urgent Care Association of America. He is also the Associate Editor, Practice Management for *JUCM*.

Also in this issue:

John Shufeldt, MD, JD, MBA, FACEP, explores protocols for determining the actual condition of patients who demand narcotics and that you suspect may be misusing or abusing prescription painkillers.

Nahum Kovalski, BSc, MDCM, reviews new abstracts on literature germane to the urgent care clinician, including studies of oral antibiotics for pediatric pyelonephritis, bronchitis in children, noninvasive testing for severe VUR, aspirin for primary prevention of CVD, extremity fracture after ED treatment, risk of febrile seizure after DTaP-IPV-Hib, apixaban vs. aspirin for stroke prevention, macrolide resistance of Group A strep, bacteremia in infants aged 1 week to 3 months, and prehospital epinephrine for cardiac arrest, and new guidelines for acute bacterial rhinosinusitis.

In Coding Q&A, **David Stern, MD, CPC**, discusses benchmarks for E/M codes and place of service codes.

Our Developing Data end piece this month looks at use of computer systems for radiology services.



FROM THE EXECUTIVE DIRECTOR

Get Set...Go!

LOU ELLEN HORWITZ, MA

y the time you read this, our Industry Awareness Campaign will be out of the starting gate.

If you haven't already done so, go to the campaign website-ucaoa.org/rhyme-and forward to anyone you know who may want to help spread the word about urgent care. On that site, you'll find all the pieces for the summer campaign that you can download and use:

- A Toolkit to tell you how to use everything, with a guide to terminology and technical specs;
- A marketing calendar of ideas for marketing targets and techniques; and
- Art files for you and your printer to use (websites, posters, emails, giveaways—anything!)



NOTE: All of these resources are CUSTOMIZABLE to your centeryour name, your address, your logo.

The more centers, employers, and payors that participate, the better, so please share the resources with any-

one you like. While you are doing that, UCAOA is reaching out directly to all of our media, legislative, and payor contacts, and anyone else we can think of to involve. It's going to take some time for the message to start getting out there, so every little bit helps.

Soon we'll have a gallery for examples from participating centers, so if you want to send us photos of what you've done with the campaign in your community, we'll be sure to get it on our website and Facebook pages.

To the right you'll see our Board of Directors for 2012-2013we are pleased to welcome back Drs. Gluckman and Newman for a second term. We are honored to have these industry leaders representing our organization! Coming next month...UCAOA's new logo!



Lou Ellen Horwitz is Executive Director of the Urgent Care Association of America. She may be contacted at Ihorwitz@ucaoa.org.

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Clinical

Lymphadenopathy in urgent care: evaluation and management

Urgent message: Lymphadenopathy is a common presenting issue in urgent care. Most cases are benign, but be on the alert for "red flags" that could signal malignancy.

MARIA V. GIBSON, MD, PHD, and DANIEL A. CHERRY, MD

Consider how you would manage the following patient presenting with lymphadenopathy.

A 39-year-old male truck driver presented to the urgent care clinic with a 2- to 3-week history of "swollen glands" in both sides of his groin. They were not painful but "tender to touch." One week prior, he had a flu-like infection with body aches that had resolved. He had no penile discharge, hematuria or dysuria and no fever, night sweats or weight loss.

Physical examination, including genitalia, was normal except for palpable inguinal lymph nodes (group of 4, 0.5 to 1.0 cm on the right side and two nodes, 3.0 to 4.0 cm in diameter, on left) that were mobile and tender. The overlying skin was erythematous and pruritic. Urinalysis was normal, as were tests for gonorrhea, chlamydia, HIV, and reactive plasma reagin, and herpes simplex virus titer. Inguinal skin KOH prep was positive for fungus. The patient was treated with nystatin powder for tinea cruris. He returned 3 weeks later with persistent pruritic erythema in both sides of his groin and no change in the size or tenderness of the inguinal lymph nodes.

Maria Gibson is a physician at Doctor's Care, Charleston, SC, and Associate Professor in the Department of Family Medicine, Medical University of South Carolina, Charleston, SC. **Daniel Cherry** is a hematopathologist and Medical Director of Laboratory Services, Trident Health Care System, and Senior Partner, Lowcountry Pathology Associates, Charleston, SC.



Lymphadenopathy by Definition

Lymphadenopathy is enlargement of one or more lymph nodes. Lymph nodes are considered to be abnormal if one or more is 1.0 cm in diameter, or in the case of an epitrochlear node, > 0.5 cm diameter. Palpability of any lymph nodes in the supraclavicular, iliac, or popliteal regions constitutes lymphadenopathy. The condition can be either localized (single node, group of





nodes, or region) or generalized. Generalized lymphadenopathy is established by enlarged nodes in 2 distinct anatomic regions.

Causes and Associated Conditions

Lymphadenopathy is caused by proliferation of lymphocytes and/or associated monocytic/phagocytic cells (reactive or neoplastic) or by infiltration of metastatic malignant cells. In the United States, viral and bacterial infections are the most common etiologies of lymphadenopathy, with infectious mononucleosis (Epstein Barr virus or EBV) and cytomegalovirus (CMV) more frequently associated with generalized lymphadenopathy and beta-hemolytic streptococci more frequently associated with localized lymphadenopathy. In developing countries infections such as HIV, tuberculosis (TB), typhoid fever, leishmaniasis, trypanosomiasis, schistosomiasis and filariasis, and fungal diseases are common causes of lymphadenopathy.

The mnemonic acronym "MIAMI" is often used to remember the broad categories of diseases that present

with generalized lymphadenopathy.

- Malignancies (metastasis, lymphomas, skin neoplasms)
- Infections (infectious mononucleosis, pharyngitis, cat-scratch disease, mycobacterial, brucellosis, leishmaniasis, tularemia, toxoplasmosis, CMV, HIV, viral hepatitis, TB, syphilis, lymphogranuloma venereum, rubella)
- Autoimmune disorders (systemic lupus erythematosus, rheumatoid arthritis, dermatomyositis, Sjogren syndrome)
- Miscellaneous (sarcoidosis, Kawasaki disease)
- Iatrogenic (medications, hyperthyroidism, serum sickness, severe hypertrigliceridemia); numerous unusual systemic diseases (pneumoconioses, lysosomal storage diseases, Castleman's disease, Kimura's disease, Rosai-Dorfman disease, Kikuchi's lymphadenitis [histiocytic necrotizing lymphadenitis]).

Adverse drug reactions (allopurinol, atenolol, captopril, cephalosporins, carbamazepine, hydralazyne, peni-

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cillins, primidone, pyrimethamine, phenytoin, quinidine, trimethoprim/sulfamethoxazole, sulindac) can cause generalized lymphadenopathy that may be associated with a rash, fever, hepatosplenomegaly, jaundice, and anemia. A common example of such reactions can occur in patients a few weeks after taking phenytoin.

Lymphadenopathy Presentation

The occurrence of lymphadenopathy is disease-dependent and the cause often is obvious after a complete history and physical examination. Patients may present with general symptoms: fever, chills, night sweats, weight loss (infection/lymphoma "B" symptoms), easy bruising (lymphoma occupying the bone marrow), new skin lesions (infectious or neoplastic), jaundice (hepatitis), or arthritis (lupus or rheumatoid arthritis). Exposure to household pets, diseases, travel history, history of trauma or injury, or new medications provide key information relevant to the diagnosis of lymphadenopathy At the time of physical examination, all major palpable lymph node groups should be examined to evaluate for generalized lymphadenopathy because of its common association with serious systemic diseases (**Figures 1 and 2**). Assessment of the size, location, distribution, and character of the lymph nodes is essential. Painful and tender lymph nodes are often signs of localized infection. Inflamed lymph nodes due to local staphylococcal and streptococcal infections may progress to fluctuation, especially in children, and require incision and drainage and antibiotic administration. Multiple enlarged cervical nodes that develop over time and become fluctuant without significant inflammation or tenderness, with or without fever, suggest infection with *Mycobacterium* TB, atypical mycobacteria or *Bartonella henselae* (cat scratch disease).

Lymph nodes that are hard on palpation and nontender, particularly in older patients and in smokers, are suggestive of metastatic cancer (such as of the oropharynx, nasopharynx, larynx, thyroid, and esophagus). These patients should be referred to an otolaryngologist for upper airway endoscopy. Hard and painless lymph nodes are also seen with sarcoidosis. Bilateral,

| Table 1. Red Flags for Malignancy | | | | | |
|---|--|--|--|--|--|
| Red Flags | Clinician Alert | | | | |
| History Older age, duration of lymphadenopathy > 4 weeks, absence of infections, exposure to animals and insects, chronic use of medications, personal or family history of malignancy | Increased risk of malignancy | | | | |
| Recurrent fever, night sweats, and unexplained weight loss >10% | Suspicious for Hodgkin and non-Hodgkin lymphoma Environmental tobacco, alcohol, and ultraviolet radiation exposure | | | | |
| Suspicious for metastatic carcinoma of the lung, esophagus, stomach, liver, or cancers of the head and neck, and skin. | Patients who are immunocompromised and HIV-positive Increased risk of Kaposi sarcoma and non-Hodgkin lymphoma | | | | |
| Pain in the area of lymphadenopathy after even limited alcohol ingestion | Specific finding for Hodgkin lymphoma | | | | |
| Exam Lymph nodes that are firm, fixed, circumscribed, and painless | Increased significance for malignant or granulomatous disease; further investigation necessary | | | | |
| Supraclavicular lymphadenopathy | Most likely consistent with malignancy, and should always be investigated and biopsied, even in children | | | | |
| Palpable anterior and central axillary lymph nodes with lack of infection exposure | Suspicious for metastatic breast adenocarcinoma | | | | |
| Antecubital or epitrochlear lymphadenopathy | May suggest lymphoma or melanoma | | | | |
| Persistent inguinal lymphadenopathy with negative STD testing and absence of skin infection signs | Consider investigation for Hodgkin and non-Hodgkin lymphomas, penile, testicular and vulvar carcinomas, and melanoma | | | | |
| Any unexplained, non-inguinal lymphadenopathy lasting >4 weeks | Consider specific investigation and/or biopsy | | | | |

mobile, nontender lymphadenopathy may be associated with viral infection. Keep in mind that palpable "lymph nodes" may mimic other masses, such as branchial cleft cysts and other benign tumors.

Localized Lymphadenopathy

The anatomic arrangement and drainage distributions of the major palpable lymph nodes are shown in **Figures 1 and 2**.

In patients with cervical lymphadenopathy, thorough examination of the mouth, oropharynx, nose, and ears is essential. **Submandibular lymphadenopathy** is usually caused by infections of the head, sinuses, ears, eyes, scalp, mouth, pharynx and neck. Enlargement of **submental lymph nodes** is due to systemic infections such as infectious mononucleosis, CMV, and toxoplasmosis. **Jugular lymphadenopathy** is most common in patients with pharyngitis and rubella. Other viral causes of cervical lymphadenopathy include adenovirus, herpesvirus, coxsackievirus, HIV, and CMV. Bacterial infections may be localized within the lymph nodes themselves (lymphadenitis). **Posterior cervical lymph node** enlargement is often due to infection (EBV, TB), and less frequently to head and neck malignancies (lymphomas or metastatic squamous cell carcinoma). **Suboccipital and post- and pre-auricular lymph nodes** become enlarged with infections of the scalp or ear. The **supraclavicular nodes** are particularly important because their enlargement is strongly suggestive of metastatic malignancy.

Right supraclavicular lymphadenopathy may represent metastasis from the lung, retroperitoneum or gastrointestinal tract. In patients with left supraclavicular lymphadenopathy lymphoma, metastatic thoracic or retroperitoneal cancer and fungal infection should be excluded. Axillary lymph node enlargement can potentially be due to local infections, catscratch disease, lymphoma, breast cancer, silicone implant leakage, brucellosis, or melanoma. Hidradenitis suppurativa is a condition of enlarged tender lymph nodes that typically affects patients with obesity and includes recurrent abscesses of lymph nodes in the axillary chain, which may require treatment with incision and drainage and a course of antibiotics. Patients with epitrochlear lymphadenopathy, depending on history, should be evaluated for local infections, lymphoma, sarcoidosis, tularemia, and secondary syphilis. Enlarged periumbilical (Sister Mary Joseph) nodes are strongly associated with carcinoma, especially that of the pancreas.

Inguinal lymph nodes up to 1 to 2 cm in size are common in otherwise healthy adults and generally have a low suspicion for malignancy. Sexually transmitted infections (herpes simplex virus, gonococcus, syphilis, chancroid, granuloma inguinale, lymphogranuloma venereum), infections of the lower extremity, lymphoma, and pelvic malignancies are potential causes of inguinal lymphadenopathy. Primary malignancies of the skin of the lower extremities, cervix, vulva, skin of the trunk, rectum, anus, ovaries and penis may metastasize to the inguinal lymph nodes. In addition to palpation of the major lymph node groups, examination of the skin for malignancies (melanoma, Kaposi sarcoma) and infection is essential. Abdominal examination can reveal splenomegaly, which can be a sign of lymphoma or infectious mononucleosis.

Lymphadenopathy and Malignancy

In one model, clinical characteristics reported to predict the likelihood of malignancy in adults with lymphadenopathy included age >40 years, presence of other physical signs, abnormal CBC, abnormal liver function tests, negative Mantoux test, and generalized lymphadenopathy (multivariate predictor only). Additional evidence suggesting malignancy includes fixed, firm nodal character, duration of more than 2 weeks, and supraclavicular or periumbilical location. "Red flags" that should raise suspicion of malignancy are listed in **Table 1**.

Lymphomas are clonal neoplasms of B lymphocytes, T lymphocytes, and natural killer (NK) cells. In addition to lymphomas, a number of non-lymphocytic hematologic neoplasms can occur in lymph nodes such as those of histiocytes and Langerhan cells. Although lym-

Table 2. Considerations for Laboratory Testing for Lymphadenopathy

- **Localized infection:** CBC with differential cell count, KOH preparation if fungal etiology suspected, ESR, biopsy with culture and sensitivity.
- Systemic infection: brucellosis (culture, serology), catscratch disease (antibody titers, PCR, culture, biopsy), CMV (latex agglutination, PCR), HIV (rapid screening tests, Western blot, PCR), lymphogranuloma venereum (Chlamydia trachomatis culture, PCR), infectious mononucleosis (heterophile antibody test [monospot], EBV serology, PCR), rubella (serology, PCR), tularemia (serology, culture, PCR), typhoid fever (serology, PCR), toxoplasmosis (serology, PCR of cerebrospinal fluid), viral hepatitis (serology, specific testing based on initial serology results), syphilis (darkfield microscopy, RPR, VDRL test), tuberculosis (sputum cultures, AFB smear, interferon alpha release assays), streptococcal pharyngitis (rapid antigen detection, pharyngeal culture).
- Autoimmune diseases: ESR, serum compliment, ANA, anti-DNA antibodies, RF
- **Granulomatous diseases:** (ACE level, nodal biopsy, liver function tests, electrolytes, renal function)
- Immunocompromised patients: CMV (latex agglutination, PCR), HIV (RNA), TB (culture and Mantue PPD test), cryptococcal serology and culture, toxoplasmosis serology, Kaposi's sarcoma biopsy)
- **Dermatomyositis:** (creatine kinase, electromyography), skin malignancies: skin biopsy
- Hematological malignancies: CBC, blood smear, LDH, bone marrow biopsy, nodal biopsy

Abbreviations: ACE =angiotensin converting enzyme, AFB = acid fast bacilli, ANA = antinuclear antibodies, CBC = complete blood count, CMV = cytomegalovirus, EBV = Epstein – Barr virus, ESR = erythrocyte sedimentation rate, LDH = lactate dehydrogenase, PCR = polymerase chain reaction, RF = rheumatoid factor, RPR = reactive plasmin reagin, TB = tuberculosis, VDRL = venereal disease research laboratory

phomas comprise approximately 40 major entities plus subtypes, a few generalizations can be made:

Indolent lymphomas usually presents with more widespread (generalized) involvement than more aggressive lymphomas.

Non-Hodgkin lymphomas are most common in the upper middle age group and the elderly, lymphomas in young adults are most often Hodgkin lymphoma, and in infants and young children, lymphoblastic lymphoma is most prevalent.

Aggressive lymphomas are more often curable while indolent forms are usually chronic and incurable and may or may not significantly shorten the patient's lifespan, with or without treatment.

Keys to Evaluation of Lymphadenopathy

Additional testing must be driven by the clinical evaluation, as described in Table 2.

Examination of peripheral blood is an important element of lymphadenopathy evaluation. The automated WBC and differential cell counts may of an infectious or reactive

process, lymphocytosis hinting at a viral illness or lymphoma, or cytopenias raising suspicion for involvement of the bone marrow by lymphoma. Abnormal automated blood counts in the context of lymphadenopathy should prompt a request to have the peripheral blood smear examined by a pathologist. Bicytopenia or pancytopenia is particularly suspicious for bone marrow occupying disease. The erythroid sedimentation rate is a good general screening study for rheumatologic disease, which can be followed by specific serology as clinically indicated. Suppurative or necrotizing lymphadenitis should be evaluated with culture. Serologic tests are best for assessing for the possibility of CMV, EBV, and toxoplasmosis. An acid-fast bacillus smear, serum calcium, and serum angiotensin converting enzyme (ACE) levels may be helpful in the setting of granulomatous lymphadenitis (calcium and ACE may be elevated with sarcoidosis). Regarding reactive causes of lymphadenopathy, the pathologic findings are commonly nonspecific and rarely lead to a specific etiology.

Management

The first step in evaluation of lymphadenopathy is to assess the patient for the most common viral/bacterial infections and medication side effects. Risk factors for, exposure to, and generalized symptoms of systemic infections should be evaluated. If the findings suggest a benign etiology that is usually self-limited, then reassurance can be provided to the patient. Benign reactive adenopathy can be safely observed for months if there is no suspicion of malignancy. Follow up should be scheduled if the lymphadenopathy is persistent and/or a systemic cause is suspected. There are no evidencebased guidelines for the appropriate observation period but many authors justify a 3- to 4-week period after which biopsy is warranted. If malignancy is a serious consideration, biopsy should be done more urgently.

The first step in evaluation of lymphadenopathy is to assess the patient for the most common viral/bacterial infections reveal neutrophilia in support and medication side effects.

Treatment with antibiotics followed by reevaluation in 2 to 4 weeks is indicated if clinical findings suggest lymphadenitis. Consultation with a clinical hematologist, otolaryngologist, or surgeon should be requested when malignancy is suspected. Consultation with an infectious disease specialist may be warranted in cases of generalized lymphadenopathy that are

resistant to antibiotic treatment or when systemic infections such as brucellosis, leishmaniasis, tularemia, toxoplasmosis, or HIV are suspected.

Patient Education

Most of the time lymphadenopathy is a benign condition caused by bacterial or viral infection, but it can sometimes be a sign of malignancy, serious infection or drug reaction. Therefore, follow up with a health care provider in 1 to 2 months is imperative. Advise patients to follow up earlier if fever lasts longer than 24 hours, lymph nodes increase in number or size, tenderness increases, or other symptoms occur.

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Original Research

The Role of Urgent Care Centers in Regional Acute Coronary Syndrome Care

Urgent message: Patients with chest pain/acute coronary syndrome often present in outpatient medical settings—including urgent care centers—not designed to treat life-threatening conditions. Exclusive new data suggest that urgent care centers need to be integrated into pre-hospital cardiovascular care pathways.

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Introduction

mergency medical services and hospital-based emergency departments (EDs) are typically incorporated into systems of care for patients with chest pain/acute coronary syndrome (ACS) but the role of free-standing urgent care centers (UCCs) in the evaluation and treatment of such patients is underappreciated. Between May

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21, 2008 and June 9, 2009, 500 patients presented to any 1 of 5 UCCs in the greater Cleveland area with chest pain/possible ACS. Of those patients, 10.4% were troponin-positive on presentation. Detailed follow-up is

presented for the 155 patients admitted to the university medical center. Eighteen (11.6%) of those admitted were high acuity: 2 with ST elevation myocardial infarction (STEMI), 9 with non-ST elevation myocardial infarction (NSTEMI), 5 additional patients underwent urgent percutaneous coronary intervention (PCI) for unstable angina, 1 with pulmonary embolus, and 1 aortic dissection. UCCs provide pre-hospital access to patients presenting with chest pain/ACS and need to be integrated into cardiovascular care pathways.

Considerable public and professional education is directed at the importance and benefit of early and rapid evaluation of chest pain and related symptoms that may be indicative of ACS.¹ Many health care systems and geographic regions, including our own, have organized a regional approach to patients with possible ACS.^{2,3} These efforts typically focus on improving efficiencies between a patient's first medical contact via emergency medical systems or EDs and definitive treatment.⁴⁻⁸ Existing data demonstrate that improved treatment times and efficiencies offer a survival advantage, whereas delays can increase mortality rates.^{8,9} Our region has many hospital-based EDs and also a network of free-standing urgent care centers (UCCs). Nationally, there are estimated to be 4,600 EDs and more than 9,000 UCCs, which are a growing provider of outpatient services.¹⁰ The Urgent Care Association of America defines UCCs as walk-in medical clinics designed to treat non-life threatening illnesses and injuries, usually at lower cost and with shorter service times than EDs. These centers are staffed by a variety of physicians, many of whom are not board-certified in Emergency Medicine or Cardiovascular Disease, and thus, may not have received the same level of training regarding the diagnosis and treatment of ACS as these specialists. Furthermore, UCCs often have neither the diagnostic testing infrastructure nor the broad array of drugs to treat patients that are available in hospital-based EDs.

Despite the availability of hospital-based EDs and public education instructing patients to use UCCs for non-emergent/non-life-threatening symptoms, we observed that patients with ACS often present to UCCs. The purpose of this study was to examine this under-recognized and important patient population and evaluate the safety and efficacy of combining clinical decision-making tools with a single point-of-care troponin measurement to more accurately identify ACS while decreasing unnecessary admissions, transfers, and utilization for those at lower risk. Currently there exists no guideline to support patient assessment and triage of the ambulatory outpatient with possible ACS. Without effective means for triaging these patients, the provider is left with few practical options. The decision to transfer all of these patients to tertiary care centers results in a significant financial and psychological burden despite the low incidence of disease. However, triage by history and risk factors alone is fraught with low sensitivity and high risk. The medical liability issues pertaining to missed myocardial infarction have made it increasingly difficult to evaluate these patients in the outpatient setting without more sensitive and efficient methods of evaluation.

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patient disposition, were obtained. Medical history and coronary risk factors were determined by physician documentation in the medical record. Final diagnosis was obtained by review of inpatient medical records for 155 patients transferred and admitted to University Hospitals Case Medical Center. Eight patients referred for hospital transfer declined.

Results

The demographic information and characteristics of the study population are summarized in **Table 1**. The average age was age 58 and 60% of the population was female. The patient age distribution is summarized in **Fig**-

Methods

We analyzed 500 consecutive patients presenting with signs or symptoms suggestive of ACS who presented to any 1 of 5 UCCs in the University Hospitals Health System from May 21, 2008 to June 9, 2009. These 5 UCCs were geographically dispersed but administratively linked to a multi-hospital health system that included a university-affiliated quaternary care teaching hospital. Data were recorded prospectively by clinical staff at each UCC. All patients underwent expedited protocolguided evaluation, including focused history and physical exam, electrocardiogram (ECG), point-of-care troponin (iSTAT, Abbot Labs) and calculation of thrombolysis in myocardial infarction (TIMI) risk score,¹¹ Per protocol, patients with acutely abnormal ECG, elevated troponin I or a TIMI risk score >1, or a presentation of less than 8 hours since the onset of symptoms were referred to a hospital for evaluation. Additional patients were referred at the discretion of the treating physician (Figure 1). Referral to a particular area hospital, including our health system's quaternary care medical center, was based largely on geographical and/or insurance considerations.

Baseline characteristics, including chief complaint, medical history, coronary risk factors, UCC diagnosis, and **ure 2**. Many patients had known coronary artery disease, including 12% with prior myocardial infarction, 6% with prior coronary artery bypass graft, and 5% with prior PCI. Overall, the majority of patients had at least 1 major coronary artery disease (CAD) risk factor, including 49% with hypertension, 14% with cigarette smoking, and 12% with diabetes.

Of the 500 patients evaluated 52 (10.4%) were troponin-positive on presentation. All 52 troponin-positive patients and an additional 182 (36.4%) of patients who were initially troponin-negative but had a concerning clinical presentation as assessed by the UCC physician, often in telephone consultation with the attending cardiologist at the quaternary medical center, were referred for further evaluation and treatment (**Figures 3 and 4**).

Of the 155 patients referred to the quaternary medical center, 18 (11.6%) had serious and potentially lifethreatening disease: 2 with STEMI, 9 with NSTEMI, 5 unstable angina patients requiring urgent PCI, 1 pulmonary embolism, and 1 aortic dissection. These results are summarized in Figure 5.

Discussion

Chest pain and related symptoms are one of the most common reasons patients present to an ED in the

| Table 1: Baseline characteristics (n = 500) | | | | | |
|--|------------|--|--|--|--|
| Prior cardiac disease | | | | | |
| Prior MI (%) | 12 | | | | |
| Prior angioplasty/PCI (%) | 5 | | | | |
| Prior CABG (%) | 6 | | | | |
| Known valve disease (%) | 5 | | | | |
| Hx arrhythmia (%) | 8 | | | | |
| Heart failure (%) | 5 | | | | |
| CAD risk factors | | | | | |
| HTN (%) | 49 | | | | |
| Diabetes (%) | 12 | | | | |
| Smoker (%) | 14 | | | | |
| Family history of CAD (%) | 54 | | | | |
| Dyslipidemia (%) | 34 | | | | |
| Comorbidities | | | | | |
| Peripheral vascular disease (%) | 2 | | | | |
| COPD (%) | 3 | | | | |
| Chronic kidney disease (%) | 3 | | | | |
| Demographics | | | | | |
| Age (y) | 58 (14-98) | | | | |
| % Male | 40 | | | | |
| MI: Myocardial infarction; PCI: Percutaneous coronary intervention; CABG: Coronary artery bypass grafting; Hx: History; CAD: Coronary artery disease; HTN: Hypertension; COPD: Chronic obstructive pulmonary disease | | | | | |

United States each year. The 2006 Centers for Disease Control Emergency Department Summary reports that 6.4 million (5.4%) of the estimated 119 million ED visits in 2006 were for chest pain or related symptoms.¹² Despite public and professional education programs designed to alert patients to the signs and symptoms of ACS, and to seek care via emergency medical systems, our data illustrate that patients frequently present to UCCs with chest pain. The actual number of UCC patients is clearly large and significant and optimization of their care is a worthwhile goal. By way of comparison, the quaternary care medical center in our study that admitted 155 patients directly from the UCC system had 2,406 patients admitted with similar presenting symptoms from the hospital-based ED during that same time period (403 with acute myocardial infarction, 333 with angina pectoris, and 1,670 with chest pain).

Previous studies have suggested that community education programs on the signs and symptoms of a heart attack may improve resource utilization and patient out-

Figure 2. Patient Age Distribution





comes,¹³ yet recent evidence from a randomized, controlled trial suggests that even in a population of patients with known coronary disease, an intensive effort of education and counseling does not result in the reduc-





tion of pre-hospital delays.¹⁴ When taken in conjunction with our data, in a population of patients predominately without a prior history of CAD, public education programs on a local or national level are likely to be expensive and suboptimal. Therefore, as health systems begin to regionalize their ACS care, integration with UCCs should be strongly considered.

In our study of 500 consecutive patients in a typical US

metropolitan region over a 1year period presenting to an UCC with a clinical picture suggestive of ACS, patients with potentially life-threatening disease were frequently encountered. Furthermore, more than 1 in 10 of these patients required true emergent medical attention and therapy. These patients shared many characteristics of patients typically treated in hospital-based emergency departments. The outcomes of this population are also similar to those of an ED-based population with 5.8% with NSTEMI, 3.2% requiring urgent PCI, and 1.3% with STEMI.

The implication of our findings to the US healthcare system is worthy of consideration. The UCCs included in this study evaluated 48,958 patients (35,577 adult patients) during the study period. The Urgent Care Association of America estimates there are 130.6 million patient visits to urgent care centers each year.¹⁵ Based on our data indicating 1% of study patients present with chest pain or other symptoms concerning for ACS, we would speculate that over 1.3 million patient visits to urgent care centers annually are for these same symptoms.

Appropriate medical care was enhanced in our population by the incorporation of UCCs into our regional ACS network. UCC-specific protocols were developed and implemented that included a point-of-care troponin assay and pharmacologic therapy tailored to drugs easily stocked at UCCs. Prompt activation of the EMS system occurred via protocol guidelines that allowed for additional therapies, such as IV heparin and clopidogrel, to be administered by emergency medical personnel. Thus, this approach to treatment of UCC patients with possible ACS combined aspects of care typically rendered in non-medical facilities with treatments typically provided in EDs.

In the coming years, UCCs will play an increasing role in ambulatory care. It is estimated that the number of UCCs will continue to increase, with demand driven by patients looking for alternatives to overcrowded EDs with long wait times. While UCCs are designed to manage low-acuity patients, our study suggests that patients presenting with ACS are also encountered and should receive rapid and optimal care. Therefore, UCCs need to be incorporated into the planning and operation of pre-hospital systems of cardiac care with specific protocols for triage and integration of emergency medical transport in an effort to optimize the outcomes for this important and under recognized population of patients.

Despite its limitations, this study reflects the importance of identifying safe and effective mechanisms for outpatient evaluation and triage of patients with possible ACS. Additional study is necessary to determine the reproducibility of our data with greater statistical power. Recent studies have examined the use of "high-sensitivity" point-of-care troponin assays and their utility as a single measurement triage assay for possible ACS. While the use of these high-sensitivity assays may result in high false-positive rates, the potential for these tests as a triage tool in the outpatient setting is worth examining. Currently there exists no effective or accurate way to triage patients with possible ACS in the outpatient setting despite the large number of patients who present with these symptoms. Low specificity and high sensitivity in this population may be acceptable given the poor sensitivity and specificity of current mechanisms for evaluating these patients in the outpatient setting.

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Case Report

Drug Toxicity Following Trip to the Local Head Shop

Urgent message: Thorough work-up is mandatory for patients with mild symptoms from recent use of "bath salts" because of the potential for multi-systems failure.

JOHN K. GRANDY BS, MS, RPA-C

Case Presentation

A 19-year-old male is brought to an urgent care clinic by his mother, who states that her son and his friends took "Molly Mosquito Caps" 2 days ago that were purchased from a local head shop. The patient and his friends all experienced nausea and vomiting after taking the product. The patient's friends improved a day later and no longer have symptoms but the patient has not. His mother is very concerned because her son is still "sick" and there was blood in his emesis this morning.

Pertinent Physical Exam

On presentation the patient is very pale, cold to the touch on his hands, and appears obtunded. He is conscious but his verbal responses and eye contact are both poor. Bilateral mottling on his hands was noted during nursing triage. His blood pressure (after a second attempt) was 80/50, pulse was undetectable, respirations 12/min and shallow, O₂SAT 80% to 83% on room air. The patient was immediately placed on oxygen and 911 was called.

Upon admission to the emergency room, the patient was severely dehydrated and desaturating. His O₂SAT was fluctuating in the low 80s with oximetry maintained via nasal cannula. He was also found to have leukocytosis (likely reactive), polycythemia, an electrolyte imbalance, an elevated creatine kinase level,



and acute renal failure.

Observations and Findings

Evaluation of the patient revealed the following:

- Sodium: 128
- Potassium: 4.8
- Chloride: 95
- Bicarbonate: 22.4
- BUN: 4
- Creatinine: 2.8
- Glucose: 292
- Magnesium: 1.3

John K. Grandy is a physician assistant with Whitestone Consulting LLCsubcontractor for the Department of Defense at Fort Drum, NY, and part time PA with North Country Urgent Care in Watertown, NY.

- AST: 82
- Total CK: 544
- CK-MB: 59
- Lipase: 39
- WBC: 39.9
- Hgb: 21.5
- Hematocrit: 54.3
- Platelets: 342
- Urinalysis: Unremarkable
- Drug toxicology: Positive for cannabis and amphetamines

Chest X-ray showed evidence of pulmonary edema, with a slightly globular left heart border. Head CT was unremarkable.

Sinus tachycardia was noted on electrocardiogram (EKG), with a rate of 135 beats per minute. Additional findings included early repolarization, minor lateral ST changes, and a left axis deviation. Subsequent EKGs began to show pre-ventricular contractions (PVCs).

Echocardiogram showed an estimated ejection fraction (EF) of 10% and decreased global hypokinesis (decreased or abnormally slow movement).

According to mother, this patient has no known drug allergies, no significant past medical or surgical history, and takes no medications.

Course and Perspective on Mephedrone

Eventually this patient needed to be intubated, placed on mechanical respiration, and admitted to the intensive care unit (ICU). His O₂SAT was 93% on ventilator settings.

After the patient was intubated and admitted to the ICU at the local hospital, the Center for Poison Control (CPC) was contacted in an attempt to find out what active ingredients were in the Molly Mosquito Caps. Our office was later contacted and informed that this product contains mephedrone. This drug is also found in other products, such as "Bath Salts," which are available over the counter at many head shops and gas stations. These products typically have statements such as NOT INTENDED FOR HUMAN CONSUMPTION on them. However, this is sometimes taken as a "wink, wink, nod, nod" type of warning.

Currently there is only a limited amount of information about mephedrone effects on humans and its mechanism of action, toxicokinetics, metabolism, and toxicodynamics. In fact, many of the references used in this case report are very recent. However, what is known about mephedrone is that it is a synthetic cathinone that is a



designer drug of the phenethylamine class, which is structurally and pharmacologically similar to 3,4-methylenedioxymethaphetamine (MDMA or Ecstasy). The Drug Enforcement Administration (DEA) has issued an order to list mephedrone as a Schedule I controlled substance under the Controlled Substances Act (CSA).¹

A recent study employed *in vitro* and *in vivo* methods and compared the neurobiological effects of mephedrone and methylone with structurally related compounds MDMA and methamphetamine.² The results stated that mephedrone is a nonselective substrate for plasma membrane monoamine transporters with potency and selectivity similar to MDMA. In this study, mephedrone was also found to produce doserelated increases in extracellular dopamine and serotonin. That is most likely what produces the desired "high" that users are seeking.

Subjective effects of mephedrone that were reported by users are impaired working memory, stimulant-like effects, and binge use.³ Stimulant-like effects include palpitations, seizure, vomiting, sweating, headache, discoloration of the skin, hypertension, and hyper-reflexia. A different group of users reported increased energy, empathy, "openness," and increased libido.⁴

Another recent study, which was conducted in Ireland, demonstrated that mephedrone can also be used intravenously (IV) and intranasally (IN).⁵ This study reported that IV and IN users demonstrated compulsive re-injection with excessive binge use over long periods of time, intense paranoia, violent behavior, aggression, emergence of Parkinson-type symptoms (which were described as spasms and loss of coordination), and permanent numbness in the lower extremities. Interestingly, Parkinson-type symptoms are also commonly reported in chronic cocaine abusers.

The Federal Register reported that the use of mephedrone and other cathinones have resulted in emergency room admissions and deaths. Some of these deaths were due to the effects of the toxicity of these drugs, which caused multisystem failure, and also from

individuals acting violently and unpredictably while under the influence of the drugs. Other adverse effects associated with consumption of mephedrone are epitasis, bruxism, paranoia, hot flashes, dilated pupils, blurred vision, dry mouth, palpitations, muscular tension in the jaw and limbs, headache, nausea, vomiting, agitation, anxiety, tremor, fever, and sweating.

Mephedrone intoxication, also termed "stimulant toxidrome" or "bath salt intoxication delirium" can lead to severe cardiovascular and neurologic complications, and recurrent acute kidney injury, which has been reported with repeated use. This was seen in this patient after his admission to the ER and his subsequent admission to the ICU. More importantly, this is not an uncommon result of mephedrone use. In fact, this was seen in another case similar to this one. In the other case, a patient presented with severe cardiovascular and neurologic signs. That patient also developed rhabdomyolysis, hyperuricemia, and metabolic acidosis, and subsequently recurrent acute renal failure.⁶

Psychiatric complications (that is, intoxication delirium) have been reported with recurrent use of bath salts. According to one study, this intense psychosis is manageable acutely with antipsychotics.⁷ The symptoms are most likely caused by the increases in extracellular dopamine and serotonin discussed previously. Of course these mechanisms of action were extrapolated from rodent studies. In addition, the dopaminergic effects of mephedrone may contribute to the addictive nature of the drug that was seen in the Ireland study, where compulsive binge use of the drug was documented with IN and IM use. These direct routes circumvent the first-pass

Mephedrone intoxication, also termed "stimulant toxidrome" or "bath salt intoxication delirium" can lead to severe cardiovascular and neurologic complications, and recurrent acute kidney injury, which has been reported with repeated use.

effect of the liver and may also account for the more addictive behaviors in this group of patients. However, no current studies on human neuropharmacology have yet been completed. Consequently, the symptoms are real but the underlying pharmacology is intuitive speculation.

Patient Outcome

After 6 days in the ICU, this patient's renal status improved, eventually returning to normal. His leukocytosis improved, as did the metabolic abnormalities. His cardiac

status, however, never improved and his EF remained at 15%. At that point, he was transferred to a cardiac transplant center as a potential candidate for a heart transplant. Unfortunately, the patient died 1 week later while awaiting a heart transplant.

Discussion

This patient experienced multiple systems failure days after ingesting Molly Mosquito Caps, which contain mephedrone. This drug is a schedule I controlled substance. Overseas manufacturers are able to circumvent this by exploiting loopholes in federal laws and placing "tongue in cheek" warnings on the product. These opinions were verified by a conversation that I had with a representative of the DEA Office of Diversion Control.

Online chat rooms contain statements from individuals who claim that they have taken bath salts, it was great, and they had no serious medical complications. The fact of the matter is that products containing mephedrone should be considered dangerous and lifethreatening. In general, no product with the words-"NOT INTENDED FOR HUMAN CONSUMPTION" or anything similar to that written anywhere on the label should not be consumed under any circumstances.

Amphetamines typically do not cause myocardial necrosis. In some cases, patients can become so dehydrated that they suffer a cardiac event. Our patient's EKGs never showed any evidence of acute myocardial infarction. Furthermore, amphetamine cardiotoxicity typically presents with arrhythmias. In severe cases, ventricular fibrillation can be followed by cardiovascular collapse, but that is secondary to arrhythmia and not specifically to myocarditis or myositis. However, as in this and other reports, patients have clearly suffered cardiac failure days after mephedrone use.

The patient's mother asked why her son's friends were fine a day later but he developed severe medical complications. That question cannot be answered beyond speculation. The product is not regulated by the FDA. Therefore, the actual dose of mephedrone can vary unpredictably from capsule to capsule, as can any of the other ingredients in these types of products. The patient's friends may have received 2 mg or 5 mg of the active ingredients, while our patient may have received 10 mg or 20 mg! In addition, everybody's body is different with a unique genetic makeup.

Conclusion

As urgent care providers, it is important to keep in mind that patients may present to your clinic with milder symptoms after using mephedrone-containing products. However, multisystem failure could be at work and may not manifest for days after consumption. Therefore, a more stringent workup is mandatory, including ordering labs to evaluate renal and cardiac status, and performing a chest x-ray and EKG in an urgent care or primary care clinic. Our patient, for example, presented with more severe symptoms and was appropriately sent to the ER by ambulance and admitted into the ICU. Conversely, if he had presented a day earlier, his multiple system failure might not have been evident. Because clinical information and public awareness about the toxicity of mephedrone-containing products is limited, clinicians may be susceptible to missing the potentially life-threatening progression to multiple systems failure. Any patient presenting with milder symptoms with a history of recent use of any of these types of head shop products-especially mephedrone-containing productsdemands a more thorough work up.

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Practice Management

Workplace Gossip in Urgent Care: The Impact of Toxic Talk

Urgent message: Malicious gossip in an urgent care center can undermine trust, service, and teamwork. Knowing how to spot toxic talk is the first step to rooting it out before it takes hold.

ALAN A. AYERS, MBA, MACC

hat's the harm in a little workplace gossip? Well, consider what happens when a billing manager opines that an operations manager "slept" her way into a job. Or, when a new executive tells a staff member that he intends to replace his supervisor with a colleague from a previous job. Or, when a medical director repeatedly exclaims that one of the center's providers is incompetent. Or, finally, when a medical assistant-reviewing patient charts-uncovers a prescription written for a manager and shares her discovery with the front office staff.

Think a little gossip is harmless? Well, the harm is in undermining a medical professional's clinical credibility, personal reputation, and management authority. Gossip also fosters suspicion and hostility among coworkers and between managers and staff, potentially leading to hiring, firing, promotion, and pay raises based on factors irrelevant to performance. Gossip shifts staff attention from delivering an excellent patient experience to entertaining petty internal concerns. It robs "unpopular" employees of their dignity. And, it sets up an urgent care operation for litigation.

Gossip is toxic and it will work from within to destroy any organization where it's present. Gossip creates cultures where hard work, productivity, merit, loyalty and passion for the business are usurped by politics, favoritism, and game-playing—creating an overall atmosphere of uncertainty and stress.

So, the faster you take steps to identify and root out gossip—replacing it with a culture of trust, service and



teamwork-the more successful your operation can be.

Malicious Gossip is the Problem

Workplace gossip remains a somewhat ambiguous topic because the term "gossip" encompasses a continuum of human communication. As "chit-chat" or "small talk" about neutral topics, gossip can help workers bond and feel part of a group. "Grapevine" communications can also bring clarity and certainty when employees have questions or concerns. But when the tone of gossip turns neg-

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ative and becomes infused with ill will, when it's used to manipulate others, or when its purpose is to advance a personal non-business agenda, gossip crosses the line and becomes "malicious." It's malicious gossip that is so damaging to individuals and to organizations.

"Malicious gossip" bears a striking resemblance to a complaint—about a co-worker, manager or practice within the workplace—but is said to someone without power to Strong professional relationships are as vital to patient treatment as medication, because patients can sense when there's an undercurrent of tension.

Sue Jacques, Stopping Gossip at Your Medical Practice. Physicians Practice. Oct 26, 2011. http://www.physicianspractice.com/pearls/content/ article/1462168/1978206

do anything about it. Signs of malicious gossip include:

- Talk that creates conflict or keeps conflict alive;
- Criticism of people who are not present (and thus are unable to defend themselves);
- Conversation that can potentially hurt, embarrass or damage someone, whether he or she is present or not; and
- Conversation about a person that would not occur if that person were present.

Notice that the "truth" of what is said is not a factor in determining whether gossip is malicious. Rather, it's the intent, subject matter, and tone that are important. Some of the basic reasons that employees gossip maliciously are that they:

- Have no other way to resolve conflict either with coworkers or with the organization;
- Are not comfortable going to managers with problems;
- Are not getting important information about their work situation; and
- Are bored.

Managers or employees may gossip maliciously because they:

- Want to make themselves feel important;
- Want to manipulate people and opinions for their own gain; or
- Want to gain control within the organization

Occasional malicious gossip can occur in any organization, but urgent care centers are especially vulnerable because of their unique operating environment. Urgent care centers are typically small- to mid-sized operations where staff works in close proximity. As a result, management typically disseminates information verbally and informally instead of relying on structured, formal communication channels. Urgent care is a "people" business—as opposed to working with data or materials, medical services are performed on "people"—not by systems and machines but rather, by other "people." By definition, urgent care centers are "social" workplaces. Whenever people are in close proximity in a social environment, they will talk.

The walk-in model of urgent care results in ebbs in patient flow that can lead to

times of intense stress followed by "idle" times that enable non-productive talk. Stress is magnified by the fact that staff members must maintain a professional and optimistic front when working with patients.¹ In addition, many of the administrative jobs in urgent care centers are repetitive and boring. Because "talk" can provide a reprieve from job-related stress while stimulating the imagination, the social urgent care environment seems to be the perfect incubator for workplace gossip.

Despite all the seemingly legitimate reasons why gossip occurs in urgent care settings, the centers most susceptible to gossip are those in which gossip is *condoned by management*.

Adverse Impact of Gossip on Employees

Employees who are the subject of negative gossip find it difficult to establish cooperative working relationships with colleagues and tend to leave organizations sooner than if gossip were not present.² High turnover has implications for service consistency, productivity, and costs associated with staff recruitment and training. Workplace ostracism (a byproduct of workplace gossip) has been found to negatively impact customer service,³ which can impact patient perceptions, repeat business, and word-of-mouth. Urgent care centers cannot thrive with a bad reputation in the community.

Naturally gossip wastes time that could be spent on more valuable activities, but more importantly, it depletes employee morale and is adverse to feelings of well-being.⁴ The effects of gossip go well beyond "hurt feelings." Malicious gossip can affect personal health through loss of sleep, eating disorders, substance abuse, and diminished family relationships. Where gossip thrives, health care costs and absenteeism go up and pro-

| Table 1: Potential Legal Risks of Gossip | | | | | |
|--|---|--|--|--|--|
| Revealing Personal Information | Employees who have access to confidential personnel records and who tell other people about information in those records may be found to have invaded the privacy of the person whose information was disclosed. The Health Insurance Portability and Accountability Act (HIPAA) limits access to personal medical information. In a healthcare setting, gossip about a patient's medical condition or treatment can violate the patient's rights under HIPAA. | | | | |
| Sexual Harassment | Employers are required by federal law to eliminate all forms of sexual harassment. Accord- ing to the U.S. Equal Employment Opportunity Commission (EEOC), this includes: "Gossip regarding an individual's sex life, comments on an individual's body, comments about an individual's sexual activity, deficiencies, or prowess, or other lewd or obscene comments." | | | | |
| Defamation of Character | Malicious gossip in the workplace may lead to a claim for defamation. To state a claim for defamation <i>per se</i> , the plaintiff must show the intentional publication of a statement of fact that is false, unprivileged and has a natural tendency to injure or which causes special damage. ⁸ | | | | |
| Workplace Bullying | An employee who spreads information about another employee in order to hurt that per- son or who tells lies about a coworker can be considered a workplace bully. The bully attempts to gain power by alienating other people. ⁹ | | | | |

ductivity goes down. Gossip isn't just "idle" chatter—it can be more precise and destructive than a bullet.

Malicious gossip also destroys reputations and careers. It's hard enough for employees to hear co-workers circulating untruths about their personal lives, but when critical comments about professional skills get repeated, victims could lose their ability to earn a living. Given the choice between two candidates, a hiring board or promotions panel may bypass the one they've "heard some bad things about" without investigating whether that information was true or not.

Adverse Impact of Gossip on Organizational Effectiveness

At its most innocent, time spent talking about other people and speculating about business issues is time spent not working. The cost of this misused time can be measured in the hundreds of dollars but the greater organizational costs of malicious gossip can be in the thousands or millions. Ultimately, gossip can cost a business owner his or her entire investment.

It's been suggested that negative gossip is used to socially control (or sanction) uncooperative behavior in groups. After all, it becomes much easier to refuse to follow a safety policy or abide by a physician's instructions, for instance, if everyone else is refusing to do so. In a workplace where gossip goes unchecked, individuals often cooperate with subversive group norms because they fear being gossiped about if they don't.⁵

Malicious gossip is the polar opposite of effective communication. Unhealthy organizations allow gossip

because it circumvents the need for difficult conversations. In this way, gossip undermines formal channels of communication by offering an alternative, albeit untrustworthy, source of information.

Because managers cannot control the "grapevine," workplace gossip has the ability to undermine a manager's authority,⁶ affecting his or her ability to direct staff and affect organizational outcomes. One study found that low-status employees were able to exert collective power over management by the nature of their gossip, subsequently diminishing their managers' reputations.⁷ How does a business owner or hired manager control the operation if, in the staff's mind, he or she has no "authority" to do so?

Gossip undermines trust and the ability to work together as a team. When gossip is prevalent workers start to wonder what their peers are saying about them behind their backs. When management does not provide timely and accurate information about issues that affect the business, employees do not know what and whom to trust. They become distracted from their jobs and assume the worst. Resentment surfaces.

Without trust and teamwork, the work environment turns toxic. Morale declines, dissatisfaction increases. Employees who have been injured by gossip or who do not like working in a toxic environment leave, taking with them their training, skills, and knowledge of the operation's processes, systems, contracts, and clients. Productivity and quality of service suffer. The organization decays from within.

How Gossip Increases Legal Risk

Managers who do not effectively address the problem of malicious gossip expose themselves and their organizations to legal liability. When gossip escalates into bullying, harassment, or defamation, the organization faces legal risks that can consume already scarce resources. **Table 1** describes the ways that gossip can land an urgent care operator in court.^{8,9} Put an end to gossip in your medical practice; doing so will improve the emotional health of your practice, your staff, and the patients who rely on them.

Sue Jacques, Stopping Gossip at Your Medical Practice. Physicians Practice. Oct 26, 2011. http://www.physicianspractice.com/pearls/content/ article/1462168/1978206 sip can cause for them and for the organization. Encourage employees to vent their frustrations in appropriate ways and to seek accurate information about business issues from management.

3. Develop Formal Policies. Addressing workplace gossip in the employee handbook helps employees understand their obligations and helps to define an organization's culture. Human resources policies can define unacceptable gossip and impose progressive discipline for violation of the policies. Such policies should

Fostering a Gossip-Free Workplace

Given the magnitude of business risk, urgent care operators must be particularly vigilant in guarding against workplace gossip. Like any employee, a manager experiences stress and frustration, and sometimes venting these emotions to colleagues can be therapeutic. Yet, employees look to management for cues on what is acceptable behavior at work. If management engages in workplace gossip, there's no question that this behavior will become "normalized" and employees will do the same. In fact, a manager who gossips will soon find himself or herself the subject of the toxic culture he/she has created.

Managing gossip takes a multi-pronged effort aimed at building a supportive culture:

- 1. Walk the Walk. Managers and supervisors must make it clear that they do not and will not participate in gossip. Gossip requires a sender and a receiver, so it's not enough for management to not spread gossip; they can't even listen to it. Here's an appropriate response to an employee who wants to talk negatively about someone else: "It's not okay to talk like that about someone who is not here. If you don't have anything else you need to talk to me about, I'm going to get back to work."
- 2. Spread the Word. Managers and supervisors need to make it clear that gossip is not appropriate and will not be tolerated. One high-volume urgent care center has adopted a "zero tolerance" attitude toward gossip—employees sign a pledge to not gossip and if they are caught gossiping, they are fired on the spot. There is no ambiguity in management's stance. Employees need to know the damage gos-

be reviewed at least annually and communicated clearly to employees (possibly addressing the policy and obtaining written agreement during performance reviews). They should be actively followed and promoted at all times. Performance management and employee evaluation policies can include communication skills and professional behavior. Such policies make it clear to employees that behaviors that create discord or undermine teamwork are not sanctioned within the organization. As with any new employment policy, management should consult with legal counsel to ensure anti-gossip policies meet all legal requirements.

- 4. *Improve Communication.* Lack of information from the top about important business issues necessitates "grapevine" communication. In the absence of authoritative information, employees tend to speculate, and gossip spreads the speculation. Reliable and timely communication trumps gossip; there's no need to speculate and spread rumors if everyone knows exactly what is going on with the business. In addition, supervisors can teach employees techniques for derailing gossip, such as changing the conversation to a neutral topic or making positive comments about the subject.
- 5. *Confront Gossip Mongers*. Supervisors may need to talk individually with employees who repeatedly spread gossip, especially if their behavior exposes the organization to legal risk. Employees need to understand the damage their gossip can cause and that it can become a performance issue if it continues. Employees may not realize the impact of their actions;

Social Media: The Modern Vehicle for Workplace Gossip

With nearly a half-billion users on Facebook and millions of others on social "networking" sites like Google+, LinkedIn and Twitter, businesses need to realize the risk of gossip moving from the office to the online arena. The damage that can occur when employees bad-mouth co-workers, managers or employers online is not only that it's in writing, but it's generally more widely read and its consequences can be more enduring.

As a result, many businesses have instituted separate policies for electronic communications that prohibit employees from making defamatory statements about the company or its workers, competitors, agents, or partners.

But larger employers must keep in mind that a recent ruling by the National Labor Relations Board (NLRB) establishes the right of employees to communicate with one another via social media about wages, hours, and other workplace conditions. A survey of social media issues before the NLRB in 2011 conducted by the US Chamber of Commerce found that the most commonly raised issue brought to the board was whether an employer has overbroad policies restricting employee use of social media, or that an employer unlawfully disciplined—or fired—an employee over social media activity.¹¹

In today's "networked" world, an employee handbook should include a social media policy. Simply having such a policy tells your employees that you are aware of sites like Facebook and Twitter and that you may be keeping an eye on what they are posting. But be clear on exactly what sort of communication is prohibited (for example, the sharing of confidential information, photos of the workplace, proprietary information and disparaging remarks about other employees, which typically falls under bullying and harassment legislation) and detail the consequences of such behavior.

If applicable, the policy should include a disclaimer stating that the policy is not intended to limit employees' rights under the National Labor Relations Act. With social media law still evolving, in order to ensure the handbook is in line with relevant legislation, employers should hire competent legal counsel and stay abreast of NLRB developments.

tactful and direct communication is often an effective way to stop an employee from gossiping.

- 6. *Provide Regular Training*. Providing employees with regular training on acceptable workplace behavior is another way to build a successful organizational culture that minimizes workplace gossip. Training on effective communication, dealing with conflict in the workplace, professional courtesy, etc. can all help to build a more productive team. Training should be adapted to the dynamics of the specific operation (a good trainer will do this) and should involve practical applications like role-plays and discussions about day-to-day scenarios encountered by employees.
- 7. Promote Acceptable Outlets for Stress. It's important for everyone in a demanding workplace to find healthy outlets for stress, such as spending time with friends outside of the organization or regular exercise. It may be beneficial to adopt a workplace policy that encourages exercise to ensure employees have an opportunity to manage stress. For instance, consider holding "walking" team meetings, instead of conducting these inside. Another idea that can both reduce stress and foster team morale is to incentivize employees as a team to take part in structured programs like the *Ten Thousand Steps Challenge*.

Perhaps most importantly—in an anti-gossip organization, employees should feel comfortable going to management if they are concerned that gossip is affecting the work environment. Gossip can never be addressed if it's not a problem anyone is willing to own up to.

Interviewing and Hiring

A factor in workplace gossip frequently attributed to urgent care centers is that they tend to employ an entrylevel workforce that skews heavily young and female. Some operators have actually expressed that if they increased "diversity" in their centers—presumably by recruiting less "gossipy" individuals—they could improve workplace dynamics. The false assumption is that women tend to gossip more than men and those in lower-level positions gossip more than managers and providers. The fact of the matter is that people of all ages, genders, and educational levels engage in gossip.

Although stereotypes cannot be blamed, it is known that people with a strong need for social approval and dominance tend to gossip more, while independent, high-achieving people tend to gossip less.¹⁰ Identifying these types of people at the recruitment stage (that is, through psychometric testing) may be prudent, although an individual's propensity to gossip is significantly influenced by the culture and behavior of his/her peers and making policy and cultural changes may be a more effective mechanism of curtailing gossip in an existing team.

Utilize Formal Communication Methods...Frequently

Because gossip thrives in cultures where organizational information is scarce, operators can reduce gossip by using formal communication methods as much as possible. Weekly team meetings with the purpose of explaining decisions and directions within the business can be useful. In times of significant change or high stress, daily "huddles" may be required to ease employee anxiety. In these sessions, management must be open and responsive to employee feedback and concerns. It's always better to take the time to provide requested information (where possible) than to have employees guessing about the content of closed-door sessions.

Conclusion

Workplace gossip is extremely common in organizations where staff works in close proximity delivering "people-oriented" services. However, gossip also has the power to be extremely destructive, undermining working relationships and morale and affecting productivity and customer service. While gossip is often thought to be an inevitable fact of working life, there are strategies that managers can adopt to minimize its pervasiveness. Using formal communication methods on a regular basis, encouraging healthy outlets for stress, having a clear policy on workplace gossip and providing regular training on acceptable workplace behavior can help diminish workplace gossip and create a stronger and more effective organizational culture.

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Now Online in JUCM Social Media Primer for Urgent Care Providers

Use of social media is fast becoming one of the most vital tools in patient decision-making about providers. Urgent care providers without a social media presence may potentially be losing patients, but how do you launch an effective social media marketing campaign? This month's *JUCM* web-exclusive article—based on a popular session at the recent UCAOA conference—explores the evolving social media landscape and gives urgent care providers the information and tools they need to start their own effective social media campaigns. Learn the rules of the Internet road for blogs, Facebook, Twitter, and other social media outlets by visiting *http://jucm.com/read/casereport.php?casereport=31*, online only.





HEALTH LAW

Sister Morphine

JOHN SHUFELDT, MD, JD, MBA, FACEP

The hard core rockers amongst us know that *Sister Morphine* was written and recorded by Marianne Faithful while she was dating Mick Jagger during the time he and the Stones were recording *Let it Bleed* in 1969. Marianne's version tanked early, but the song was later covered by the Stones and received more acclaim. Parenthetically, she did not receive credit until the Stones' 1998 *No Security* album.

The song (I believe) is about a man who is hospitalized after a car accident and dies while demanding more narcotics. Allegedly, some of the lyrics were inspired by Keith Richard's girlfriend who, during her own hospitalization, was given narcotics.

Sister Morphine (First and last verse)

Here I lie in my hospital bed Tell me, Sister Morphine, when are you coming round again? Oh, I don't think I can wait that long Oh you see that I'm not that strong

Sweet cousin cocaine, lay your cool cool hands on my head Ah come on, Sister Morphine, you better make up my bed 'Cause you know and I know in the morning I'll be dead You can sit around and you can watch all the clean white sheets stained red.

The term "narcotic" is believed to have been used first by Galen in reference to agents that cause numbing or deadening. The word is based upon a Greek term used by Hippocrates to describe the process of causing an altered state or numbness.

Abuse of prescription painkillers is at an all-time high. In 2010, more than 12 million people reported using prescription painkillers for "non-medical" reasons. Prescription narcotics were responsible for 475,000 emergency department (ED) visits and more than 15,000 deaths. Cast in a different light, for



John Shufeldt is principal of Shufeldt Consulting and sits on the Editorial Board of JUCM. He may be contacted at Jshufeldt@Shufeldtconsulting.com. every death, there are 10 individuals in treatment for narcotic abuse, 32 ED visits for misuse or abuse, 130 people who are narcotic-dependent, and 825 people who are using narcotics for nonmedical reasons.

The explosion of narcotic abuse is, of course, also a huge issue for medical professionals. For example, Dr. Hsiu-Ying Teng, a physician in Rowland Heights, California, has been charged with second-degree murder following the deaths due to overdose of three of her patients. If convicted, she faces a sentence of 45 years to life.

Prosecutors hope to prove that Dr. Teng—nicknamed "Dr. Feelgood"—has a long history of over-prescribing medications and that her prescribing habits were directly responsible for the deaths of three of her patients. Allegedly, she was writing prescriptions for Xanax, OxyContin, Vicodin, and Adderall at a rate far greater than other providers. Apparently the California Medical Board and the Drug Enforcement Administration believe that she has written more than 27,000 prescriptions over 3 years. Assuming she works 240 days per calendar year, she is writing 37 prescriptions per day for the medications above.

In Arizona, a physician's license was revoked for inappropriate prescribing habits that may have led to the death of his patient. The Arizona Medical Board found that the physician had a recurring pattern of prescribing large amounts of opioid pain medication and Soma without sufficient historical, physical or imaging data.

If your state is anything like Arizona, I suspect that even a cursory search of the physician databank would show a trend of adverse actions on physicians' licenses surrounding overprescribing and personal use of opioid and other addictive medications. This increased scrutiny is on top of an already-addicted and demanding patient population who travel from provider to provider demanding help. Not all patients are addicted; some are simply selling the medication on the street as a way to support themselves. A quick Google search revealed that the price on the street for Vicodin 5/500 is \$1 to \$2 per pill and the price of Ocycontin 10 mg is \$5 to \$10 per pill. I have heard that in some areas, the street price is much higher.

In the ED, we have become very accustomed to patients demanding narcotics. We have set up pain protocols for patients

HEALTH LAW

and use an Arizona-specific pharmacy database to see how many prescriptions a patient has filled and from how many different providers. I routinely ask, "Have you seen any other providers who have given you narcotic prescriptions?" The look on patients' faces is always priceless when I come back with two or three pages revealing multiple narcotic scripts after they have denied receiving other prescriptions. Nine times out of 10, the answer is, "someone stole my identity." In some cases, that has actually what happened. When I hear that response, I always insist upon calling the police to report the identify theft and that someone is obtaining narcotics fraudulently.

This issue is so prevalent in EDs and we are so accustomed to dealing with it that I suspect urgent care centers will be an even bigger target than they are already for those sorry individuals who are addicted or who support themselves by selling prescription pain meds.

Here is how you can protect yourself:

- Confirm the patient's identity: I have personally discovered numerous instances where patients (or pretend patients) have fraudulent identification under which they try to obtain narcotics. The most comical one was a patient who was clearly of Hispanic origin who was using the driver's license of a person who was clearly of Asian descent.
- Request and review past medical records: Reportedly, patients are now even forging magnetic resonance imaging (MRI) and computed tomography results that demonstrate significant pathology necessitating narcotics. Beware of entrepreneurs with significant pathology documented on their MRI reports who are redacting their names and selling their results!
- Take and document a thorough history: Often times, under direct questioning, a patient's story will start to unravel and he or she will become rattled and reveal his or her true intent.
- Perform and document a complete physical: It is hard to fake pathology. A thorough exam often detects malingerers.
- Beware of doctor hoppers: Be more discriminating about your prescribing habits. Not all "doctor-hoppers" are trying to obtain narcotics fraudulently but some are, so have your guard up.
- Be on your guard with last-minute patients and outof-state patients: I have found, over the years, that patients who arrive 1 minute before the doors are locked often do so very purposely, hoping that you will simply prescribe them something quickly so that you can get out on time. Narcotics abusers will also cross state lines to obtain drugs.
- Limit the number of pills and refills: I have seen multiple instances where providers have written Lortab 7.5/500
 1-2 q6 #90 with 5 refills. BFRF!!! (Big F—-ing Red Flag!).

Never prescribe narcotics for family members: State laws vary, but in general, never prescribe narcotics or other Schedule 2 medications for family members. I have two clients who prescribed for their wives. When they got divorced, their jilted spouses notified the medical board and the board asked for the former spouses medical records. One of the physicians created the records, backdated the page, signed it and turned it in!

The bottom line

Patients should never be denied appropriate pain medication for their conditions. It's determining their actual condition that can be challenging. Never write the phrase "drug seeker" on the medical record. Documenting "pain out of proportion to history or physical exam findings" alerts subsequent readers while protecting you from appearing uncaring.

Document as thoroughly as possible and get informed consent from patients regarding their pain medication in words such as these: "We will absolutely treat your pain. Your medical records show that you have received multiple prescriptions for Percocet, which clearly is not working. I am concerned that you are starting to develop a tolerance to this medication, so I will not be giving you narcotics for your pain. Instead, we will be treating you with XXXX."

Or, sometimes I simply start singing the Jefferson Airplane song:

One pill makes you larger And one pill makes you small And the ones that mother gives you Don't do anything at all Go ask Alice, when she's ten feet tall.

If my informed consent soliloquy does not cause patients to run out the door, my falsetto singing often does!

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ABSTRACTS IN URGENT CARE

- Oral antibiotics for pediatric pyelonephritis
- Bronchitis in children
- Guideline for acute bacterial rhinosinusitis
- Noninvasive Test for Severe VUR
- Aspirin for Primary Prevention of CVD
- Extremity Fracture Pain After ED Treatment

- Risk of Febrile Seizure After DTaP-IPV-Hib
- Apixaban vs. Aspirin for Stroke Prevention
- Macrolide Resistance of Group A Strep
- Bacteremia in Infants Aged
 1 Week to 3 Months

NAHUM KOVALSKI, BSc, MDCM

ach 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.

Is Oral Antibiotic Therapy Enough for Children with Acute Pyelonephritis?

Key point: A randomized trial failed to prove the acceptability of oral antibiotic monotherapy relative to sequential intravenous and oral therapy, but evidence supporting oral treatment alone as an option is accumulating.

Citation: Bocquet N, Sergent AA, Jais JP, et al. Randomized trial of oral versus sequential IV/oral antibiotic for acute pyelonephritis in children. *Pediatrics*. 2012; 129(2):e269-275.

Children with acute pyelonephritis typically receive intravenous (IV) antibiotic therapy as initial standard treatment. At 10 pediatric centers in France, researchers randomized 171 children (age range, 1–36 months) with their first case of acute pyelonephritis to receive oral cefixime for 10 days or IV ceftriaxone for 4 days followed by oral cefixime for 6 days (sequential antibiotics). All participants had an abnormal dimercapto-



Nahum Kovalski is an urgent care practitioner and Assistant Medical Director/CIO at Terem Emergency Medical Centers in Jerusalem, Israel. He also sits on the JUCM Editorial Board. succinic acid (DMSA) scintigraphy result within 8 days of diagnosis and an elevated serum procalcitonin concentration.

Among 96 patients in a per-protocol analysis, the incidence of renal scarring, measured with DMSA scintigraphy 6 to 8 months after treatment, was 31% in the oral cefixime-alone group and 27% in the sequential-therapy group — a nonsignificant difference. The sample size was too small to prove the noninferiority of oral treatment alone (an estimated 349 children would have been needed in each group).

Published in J Watch Ped Adol Med. March 21, 2012 — Louis M. Bell, MD.

Bronchitis in Children: Does It Really Exist?

Key point: The authors of this retrospective study suggest that some children with "chronic wet cough" have bacterial infection of the lower airway — also known as bacterial bronchitis Citation: Zgherea D, Pagala S, Mendiratta M, et al. Bronchoscopic findings in children with chronic wet cough. *Pediatrics* . 2012;129(2): e364-369.

Is protracted bacterial bronchitis a real phenomenon in children? To find out, researchers retrospectively studied 197 children (55% age o-3 years; 9% >7 years) who had been re-

ferred to an academic pediatric pulmonary clinic from 2004 to 2008. All had experienced "wet cough" for more than 4 weeks and had not responded to what the authors describe as "conventional therapy with antibiotics and corticosteroids." Some patients were referred for reasons other than chronic cough, including possible foreign-body aspiration or wheezing that was unresponsive to bronchodilators; patients identified as having underlying conditions were excluded.

All patients underwent flexible bronchoscopy. The character of the bronchial secretions was recorded, and bronchoalveolar lavage fluid was sent for Gram stain, quantitative bacterial culture, and white-blood-cell differential and count. Of the 197 children, 110 (56%) had visibly purulent bronchitis. Ninetyone patients (46%) had positive cultures detected, which included bacteria colonizing the oropharynx. Of the 108 children 3 years, 33 (30%) were found to have laryngomalacia, tracheomalacia, or both.

Published in J Watch Ped Adol Med. February 29, 2012 — Louis M. Bell, MD.

Guideline Issued for Managing Acute Bacterial Rhinosinusitis

Key point: Remember that MANY cases of recurrent sinusitis (especially when they manifest as headache with few other symptoms) are in fact undiagnosed migraines.

Citation: Chow AW, Benninger MS, Brook I, et al. IDSA clinical practice guideline for acute bacterial rhinosinusitis in children and adults. *Clin Infect Dis.* 2012 doi: 10.1093/cid/cir1043

The guideline, published in *Clinical Infectious Diseases*, first points out that a bacterial cause accounts for 2%-10% of acute rhinosinusitis cases. Among the recommendations:

- Bacterial rather than viral rhinosinusitis should be diagnosed when any of the following occurs:
 - persistent symptoms lasting at least 10 days, without improvement;
 - severe symptoms or high fever and purulent nasal discharge or facial pain for 3–4 days at illness onset;
 - worsening symptoms after an initial respiratory infection, lasting 5–6 days, has started to improve.
- Empirical therapy should be started as soon as acute bacterial rhinosinusitis is diagnosed clinically; amoxicillinclavulanate, instead of amoxicillin alone, is recommended for both children and adults.
- Macrolides and trimethoprim-sulfamethoxazole are not recommended as empirical therapy, because of high rates of antimicrobial resistance.

The guideline includes an algorithm for sinusitis management, with recommendations for treating patients who do not respond to initial empirical therapy.

A Noninvasive Test for Severe Vesicoureteral Reflux

Key point: Urinary proteome analysis showed promise in excluding high-grade VUR.

Citation: Drube J, Schiffer E, Lau E, et al. Urinary proteome analysis to exclude severe vesicoureteral reflux. *Pediatrics*. 2012;129(2): e356-363.

To diagnose vesicoureteral reflux (VUR) currently requires a voiding cystourethrogram (VCUG), which exposes a child to radiation and discomfort. At four hospitals in Europe, researchers examined how well capillary-electrophoresis mass spectroscopy of urinary proteins identifies biomarkers of high-grade VUR. VCUG was used as the gold standard. The study was led by the founder and co-owner of the company that developed the urinary proteome analysis system.

Of 73 children with suspected VUR who met inclusion criteria, 18 with severe (grade IV–V) VUR and 19 without VUR (controls) were randomly selected for identification of urinary proteome patterns. Comparative urinary proteome analysis revealed nine polypeptides associated with severe VUR; all nine candidate biomarkers were excreted in lesser amounts among cases than controls.

The researchers then conducted a blinded analysis of this urinary proteome pattern in the remaining 36 children: 17 with severe, VCUG-identified VUR and 19 without VUR. The noninvasive test detected high-grade VUR with a sensitivity of 88% and a specificity of 79%. The odds ratio of reduced excretion of the nine polypeptides for severe VUR was 28 (95% confidence interval, 4.5–176). The result was independent of age, sex, hypertension, and renal impairment. The estimated negative predictive value of the proteome pattern analysis method was 98%.

Published in J Watch Ped Adol Med. February 29, 2012 — F. Bruder Stapleton, MD. ■

The Risks and Benefits of Aspirin in Primary Prevention of CVD

Key point: Risk for nontrivial bleeding roughly equals benefit in preventing nonfatal myocardial infarction.

Citations: Seshasai SR, Wijesuriya S, Sivakumaran R, et al. Effect of aspirin on vascular and nonvascular outcomes: Metaanalysis of randomized controlled trials. *Arch Intern Med.* 2012; 172(3):209-216. Mora S. Aspirin therapy in primary prevention: To use or not to use? *Arch Intern Med.* 2012;172(3):217-218.

Aspirin's benefits in preventing cardiovascular (CV) events in patients with cardiovascular disease (CVD) are clear. The benefit in patients not known to have CVD is more modest and has not been weighed fully against the risk for bleeding. In this meta-analysis, researchers analyzed data from nine randomized, controlled trials of aspirin use in primary prevention;



The Urgent Care Association of America congratulates the following centers that recently earned their Certified Urgent Care designation.

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We would like to say "Thank You" to all of the Certified Urgent Care Centers that have been awarded this designation in our program since its inception in 2009. We are proud to say that the program has grown to over 435 centers nationwide. If your center is not yet certified, we encourage you to apply in 2012.

For more information go to www.ucaoa.org/certification and find out how you can get certified today! most of the 102,000 participants (mean age, 57; 47% men) were at elevated risk for CVD.

During mean follow-up of 6 years, nearly 2200 CV events were identified, including 1540 nonfatal myocardial infarctions (MIs) and 592 fatal events. More than 10,000 nontrivial bleeding events (defined in various studies as gastrointestinal bleeding, hemorrhagic stroke, nasal bleeding, and hematuria) were also identified. Aspirin treatment lowered risk for nonfatal CV events by about 20% (number needed to treat, 162), did not lower risk for fatal CV events, and raised risk for nontrivial bleeding events by 31% (number needed to harm, 73).

Published in J Watch Gen Med. March 1, 2012 — Thomas L. Schwenk, MD. ■

Extremity Fracture Pain After Emergency Department Reduction and Casting: Predictors of Pain After Discharge

Key point: Pain control is still insufficient.

Citation: Thompson RW, Krauss B, Kim YJ, et al. Extremity fracture pain after emergency department reduction and casting: Predictors of pain after discharge. *Ann Emerg Med.* 2012 Mar 2 [Epub ahead of print]

The aims of this study are to determine the prevalence of pediatric extremity fracture pain after emergency department (ED) discharge, compare pain severity between fractures requiring simple casting versus sedated reduction and casting, and explore predictors of postdischarge pain.

This is a prospective observational study of children aged 4 to younger than 18 years and presenting to the ED with extremity fracture from May 2010 to February 2011. The Parents' Postoperative Pain Measure, which scores pain according to 15 behavior-related questions, was completed 48 to 72 hours after discharge. A score greater than or equal to 6 of 15 indicates clinically meaningful pain. Univariate tests and multivariable regression analyses were used to compare Parents' Postoperative Pain Measure scores between cohorts.

Two hundred fifty-seven patients were enrolled; 202 (79%) had Parents' Postoperative Pain Measure scores for analysis. Pain scores greater than or equal to 6 were reported by 37 of 102 (36%) of the simple casted and 44 of 100 (44%) of the reduced casted children. There was no difference in scores between the simple (median 4.0) and reduced casted (median 5.0) cohorts (difference 16.7%; 95% confidence interval [CI] -3.0% to 40%). In the multivariate analysis, ED narcotic administration was associated with 24% higher Parents' Postoperative Pain Measure scores (95% CI 0.95% to 53.6%). Children receiving ED narcotics had more than 2 times increased odds of pain scores greater than or equal to 6 after discharge (95% CI 1.24 to 5.39).

Children in both simple casted and reduced casted groups had clinically meaningful pain after ED discharge. Identifying these children is important to improving pain management and discharge care.

Low Risk for Febrile Seizure After DTaP-IPV-Hib Vaccination

Key point: In a population-based study from Denmark, risk for epilepsy was not increased, but a small increased risk for febrile seizures was observed on the day of the first and second vaccine doses.

Citation: Sun Y, Christensen J, Hviid A, et al. Risk of febrile seizures and epilepsy after vaccination with diphtheria, tetanus, acellular pertussis, inactivated poliovirus, and *Haemophilus influenzae* type b. JAMA. 2012;307(8):823-831.

As some families become concerned about the risks and adverse effects of immunization, population-based studies can provide useful information about vaccine safety. Using data from the Danish Civil Registry, researchers analyzed the risks for febrile seizures and epilepsy among 378,834 children who were immunized, from 2003 through 2008, with the diphtheria-tetanus toxoids-acellular pertussis-inactivated poliovirus-*Haemophilus influenzae* type b (DTaP-IPV-Hib) vaccine.

Within the first 18 months after vaccination, 7811 children (2%) developed febrile seizures; only 250 seizures occurred during the first 7 days (17 cases after dose 1, 32 after dose 2, and 201 after dose 3). The overall risk for febrile seizures within the first 7 days after vaccination was similar between this cohort and a reference cohort of children who were not within a 7-day postvaccination window. However, on the single days when doses 1 and 2 were given, the risk for febrile seizures was significantly higher in the main cohort than in the reference cohort (hazard ratios: 6.02 for dose 1 and 3.94 for dose 2). Having a febrile seizure during the week after vaccination did not confer any excess risk for subsequent epilepsy or for recurrent febrile seizures. Furthermore, vaccination was not associated with an increased risk for epilepsy.

Published in J Watch Ped Adol Med. March 14, 2012 — Peggy Sue Weintrub, MD.

Apixaban vs. Aspirin for Secondary Stroke Prevention in Atrial Fibrillation

Key point: This new oral anticoagulant drug significantly reduced the rate of thromboembolism without increasing intracranial hemorrhages.

Citation: Lawrence J, Pogue J, Synhorst D, et al. Apixaban versus aspirin in patients with atrial fibrillation and previous stroke or transient ischaemic attack: A predefined subgroup analysis from AVERROES, a randomised trial. *Lancet Neurol* 2012;11(3): 225-231. Anticoagulation with warfarin decreases the risk for stroke from atrial fibrillation (AF) significantly more than antiplatelet therapy. However, one third of patients with AF and prior stroke or transient ischemic attack (TIA) who are eligible for warfarin instead receive antiplatelet therapy, often because of concerns about bleeding. For these patients, new drugs are clearly needed that are as effective as warfarin but as safe as aspirin.

To address this need, investigators have performed an industry-sponsored, prespecified subgroup analysis of patients with prior stroke or TIA enrolled in the AVERROES trial. AVERROES compared outcomes with 5 mg twice daily of apixaban (a factor Xa inhibitor currently available in Europe) and with 81 to 324 mg of aspirin daily in 5599 patients with AF and at least one stroke risk factor who were considered ineligible for warfarin therapy. Exclusion criteria included high risk for bleeding or having experienced serious bleeding within the previous 6 months. Mean follow-up was 1.1 years. The current subgroup analysis included the 764 participants with a prior stroke or TIA.

In the subgroup, the cumulative annual risk for ischemic stroke was 7.46% with aspirin versus 2.12% with apixaban (hazard ratio, 0.33). The rate of intracranial hemorrhage was 1.56% with aspirin versus 1.17% with apixaban. Major bleeding occurred more often with apixaban (4.10%) than with aspirin (2.89%).

Published in J Watch Neuro. March 6, 2012 — Hooman Kamel, MD.

Macrolide Resistance of Group A Streptococcus

Key point: Acute rheumatic fever developed in two children treated for streptococcal pharyngitis with azithromycin. Citation: Logan LK, McAuley JB, Shulman ST. Macrolide treatment failure in streptococcal pharyngitis resulting in acute rheumatic fever. *Pediatrics*. 2012;129(3): e798.

Macrolide resistance in group A *Streptococcus* (GAS) — and the unfortunate consequences of such resistance — are of increasing concern worldwide. Investigators in the U.S. recently presented two case reports from their own practice and reviewed the literature for relevant studies published between 2000 and 2011.

The case reports described two children in whom streptococcal pharyngitis was diagnosed by rapid antigen-detection test; both were treated with azithromycin. Soon thereafter, they presented with migratory arthritis, increased antistreptolysin O titers, leukocytosis, and elevated erythrocyte sedimentation rates. They were determined to have acute rheumatic fever and recovered without sequelae. In one case, a subsequent throat culture revealed an erythromycin-resistant strain of GAS. Macrolide resistance was presumed (but not proven) for the GAS strain causing pharyngitis in the second case.

Macrolide resistance in GAS is generally caused by an active efflux pump or by ribosomal target site modification. Such resistance — first reported in the 1950s — became much more common in the 1970s, following greatly increased macrolide consumption in some countries. The literature review yielded resistance rates ranging from 1% (in Cyprus, 2003–2004) to 98% (among children in China, 2007). In the U.S., single-center studies have shown rates as high as 48% during a single season; multicenter surveillance studies have found rates between 3% and 9% in 2000–2003, rising to between 12% and 15% at the same centers in 2007.

Published in J Watch Infect Diseases. March 14, 2012 — Robert S. Baltimore, MD.

Incidence of Bacteremia in Infants Aged 1 Week to 3 Months

Key point: Incidence of bacteremia in previously healthy full-term infants was 2.2%, and Escherichia coli was the most common pathogen.

Citation: Greenhow TL, Hung Y-Y, Herz AM. Changing epidemiology of bacteremia in infants aged 1 week to 3 months. *Pediatrics*. 2012 Mar;129:e590.

To evaluate the epidemiology of infant bacteremia, investigators retrospectively analyzed charts of previously healthy fullterm infants aged 1 week to 3 months who had undergone blood cultures at a California hospital system from 2005 through 2009. Of 4255 blood cultures, 2.2% were positive for a pathogen and 5.8% were positive for contaminants (coagulase-negative staphylococci, *Micrococcus* species, and diphtheroids). Pathogens included *Escherichia coli* (56%), group B *Streptococcus* (21%), and methicillin-sensitive *Staphylococcus aureus* (8%). Ten bacteremic patients also had meningitis, and 7 were described as "ill appearing." There were no cases of *Listeria monocytogenes* or meningococcemia and only one case of enterococcal bacteremia.

Ninety-eight percent of patients with *E. coli* bacteremia also had *E. coli* bacteriuria. Of the *E. coli* strains, 44% were resistant to ampicillin, 6% to gentamicin, and 2% to cefazolin; none were resistant to ceftriaxone. Overall, 93% of bacteremic patients had documented temperature >38°C at or before presentation; two hypothermic patients died soon after presentation. Mean white blood cell counts did not differ significantly between bacteremic infants and nonbacteremic controls. Multivariate logistic regression analysis did not identify any predictors of bacteremia.

Published in *J Watch Emergency Med*. March 16, 2012 — Katherine Bakes, MD. ■



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 email the relevant materials and presenting information to *editor@jucm.com*.



THE RESOLUTION



Diagnosis: The x-ray reveals fracture of the pelvis. The key in these cases is to rule out matching posterior fractures (and the resulting instability of the pelvis) and internal organ damage. In the event that all further evaluations are normal, this patient can be followed as an outpatient.

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



CLINICAL CHALLENGE: CASE 2



The patient, a 42-year-old female, presented with a complaint of red bumps on her lower extremities that were warm and painful to touch. She reported that the lesions appeared 2 days ago, and she was running a fever and feeling tired and generally ill (headache, joint stiffness, and body aches). The patient denied taking any medication except for ibuprofen for symptom relief.

On exam, multiple poorly defined erythematous nodules and plaques were observed in a bilateral distribution on the knees and shins. The patient was febrile (100.1°F [37.8°C]). On questioning, she recalled having an upper respiratory infection 3 weeks prior.

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

THE RESOLUTION



The diagnosis is erythema nodosum, the most common type of inflammatory panniculitis.

Erythema nodosum is characterized by erythematous tender nodules and plaques that are initially bright red and slightly elevated. They are typically symmetrical and located on the pretibial region but can occur elsewhere. Upper respiratory tract infection or flu-like symptoms may precede or accompany the development of the eruption. Streptococcal infections are a common etiologic factor. Sarcoidosis, inflammatory bowel disease, and medications have also been implicated. Patients with malignancies, patients undergoing radiation treatment for malignancies, and those with Behçet's syndrome, reactive arthritis, Sweet's syndrome, ulcerative acne conglobata, and Sjögren syndrome may develop erythema nodosum. Often a cause or trigger is never found. The eruption typically persists for 3 to 6 weeks and spontaneously regresses without scarring or atrophy. Bed rest and limb elevation are important alleviating measures, and NSAIDs may also be helpful.

It is important to identify and treat any underlying causes of the condition. Investigations may include ASO titers, throat culture, tuberculin skin testing, and/or histoplasmin complement fixation. All patients with erythema nodosum should have a complete blood count and chest x-ray to rule out associated pulmonary tuberculosis, coccidioidomycosis, or sarcoidosis. The need for further investigation depends on the patient's age (child vs. adult) and history.

Acknowledgement: Case reprinted with permission from the Logical Images digital medical image library. For more information, visit http://www.logicalimages.com



CODING Q&A

Benchmarks for E/M Codes; Place of Service (POS) Codes

DAVID STERN, MD, CPC

Is there a benchmark for E/M codes in the urgent care setting? For instance, are there a certain percentage of 99213 vs. 99214 for established patients? Currently our urgent care providers' coding is being compared to CMS Family Practice standard.

To my knowledge, there is no published information detailing E/M distribution for urgent care facilities. If there was, however, it would simply document what was actually being coded by urgent care facilities. We know from multiple studies that provider coding is quite inaccurate; 30% to 50% of charts are miscoded. Thus, just as with the family practice data, it is much better to audit your charts and know for certain that your providers are coding compliantly, based on both documentation and medical necessity.

Can you charge for braces, wrist splints, and slings with L codes in an urgent care center or do you need a different Place of Service code? One of our payors said to use POS-12 and E/M POS-11.

Using Place of Service code 12 (Home) is not a typical approach to bill out orthopedic supplies for an urgent care facility. However, payors sometimes make their own unique and sometimes inexplicable rules. Before you bill using this method, you may want to request this directive in writing from the payor.

There is a specific benefit for urgent care facilities identified via the Place of Service code 20 (urgent care facility). It seems most urgent care centers bill with

David E. Stern is a certified professional coder. He is a partner in Physicians Immediate Care, operating 18 clinics in Illinois, Oklahoma, and Nebraska. Dr. Stern was a Director on the founding Board of UCAOA and has received the Lifetime Membership Award of UCAOA. He serves as CEO of Practice Velocity (*www.practicevelocity.com*), providing software solutions to over 750 urgent care centers in 48 states. He welcomes your questions about urgent care in general and about coding issues in particular. a Place of Service code 11 (office), which pays a lesser benefit. Is there a reason most, if not all, urgent care centers do not bill with a Place of Service code of 20 instead of 11?

A the specific required Place of Service code is generally the choice of the payor.

Can an urgent care center that is billing only Professional Fee billing use a POS code 11 (Office)?

Generally, an urgent care center that bills a professional fee only (on CMS-1500) and the "facility" fee (on UB-04) will be billing this way because it operates as an outpatient department of the hospital. The typical Place of Service code would be POS-22 (outpatient hospital).

A physician office (POS-11) or an urgent care facility (POS-20) would not be considered part of a hospital, so it would not generally be appropriate to use these POS codes for an urgent care center that bills the professional and "facility" components separately. Normally the payor's software will not properly process separate CMS-1500/UB-04 claims for a clinic with a code POS-11. The expected edit would be to deny the facility fee UB-04 and pay on the professional fee CMS-1500. If the payor paid on both, it would likely overpay on the professional fee CMS-1500 claims, and you would have a compliance issue that might result in accusations of fraud or large refunds to the payor.

However, the caveat that always applies is this: As long as you clearly communicate with the payor as to the nature of your facility, the payor may choose to ask you to bill with any POS code. If you deviate from the norm, it is a good idea to specify the nature of the facility and to get the directive in writing. Should the payor's corporate memory fade, you will have a written directive to back up your particular procedure.

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EXPERIENCED & COMPASSIONATE PROVIDERS needed for busy/high volume urgent care facility. PCMH, positions also available for Family Practice, Pediatric, Internal Medicine, Endocrinology, and Rheumatology. Innovative practice with multiple locations, student loan repayment up to \$170,000, paperless office, EHR/ Meaningful Use Participant, profit sharing plans, premium benefits, paid malpractice, CME, and vacation. Aggressive packages including signing bonus, salary paid up front, and housing stipend provided for right candidate. No call, no pagers, no OB, work 3-4 shifts per week. Submit CV to: HR@MYDRNOW.com



Missoula, Montana

Full or part-time BC/BE physician to join existing department staffing two urgent care facilities. Lab and x-ray on site; open 7 days/week, no call; shifts are 8-12 hours/day. Western Montana Clinic is a 45 provider multi-specialty practice, physicianowned and has been in operation since 1922. Amazing quality of life, university town of 65,000, skiing, fishing, hiking, great schools, active symphony and arts community. Competitive salary benefits package.

Contact Valeri Saffer, CEO at vsaffer@tmimontana.com or fax 406-721-3907 www.westernmontanaclinic.com

WELLSTAR.

Urgent Care Physician Suburban Atlanta

WellStar Medical Group is seeking Board Certified Family Medicine, Med/Peds, or Emergency Physician for high volume urgent care setting located in

Marietta, approximately 25 miles northwest of downtown Atlanta, GA. Past emergency dept/urgent care experience a plus. This is a full-time position.

Treating ages 2 and up. Broad range of services, including but not limited to minor illness and injury, lacerations and suturing, I&D, splinting and casting, DOT and sports physicals.

Competitive salary. Comprehensive benefits package to include: malpractice coverage, medical/dental/ vision insurance, disability/life insurance, 403b plus defined pension plan, and vacation/sick/CME allowance.

WellStar is a non-profit system of five premier hospitals in the Northwest suburbs of Atlanta. WellStar Medical Group is the largest non-academic medical group in Georgia with more than 520 primary care providers, specialists and advanced practitioners. Also, more than 1,100 affiliated physicians practice within WellStar.

Contact: WellStar Provider Services Phone: (770) 792-7539 Fax: (770) 792-1738 Email: provider.positions@wellstar.org Please visit our website: www.wellstar.org

Help Build a Gateway for Better Health



At Northwest Permanente, P.C., we want every patient we see to receive the medical care they need to live long and thrive. We also offer NWP physicians the opportunity to pursue their personal and professional goals with equal passion through cross-specialty collaboration and work-life balance. Together, our engaging practice allows our members—from the people we treat to the practitioners we employ to live longer, healthier, happier lives.

URGENT CARE PHYSICIANS- Generous Sign-On Bonuses!

Our physician-managed, multi-specialty group of 1,000 physicians care for 479,000 members throughout Oregon and Southwest Washington. We're currently seeking BC/BE physicians who are interested in our unique pay structure that allows you to earn more while working less hours. We invite you to join us in the **Portland/ Vancouver** metro area, a cosmopolitan community known for its breathtaking beauty and countless natural attractions, or **Salem**, **O**R, a growing community that offers physicians transportation service from the Portland metro area. These unique communities boast diverse neighborhoods, affordable housing, excellent school systems and a variety of recreational and cultural opportunities.

NWP offers physicians the opportunity to have sustained, fulfilling careers in their practices while enjoying the benefits of one of the largest integrated health care organizations in the country. **Help us** shape the future of health care by applying today at: http://physiciancareers.kp.org/nw/. For more information please call (800) 813-3762. We are an equal opportunity employer and value diversity within our organization.

Kaiser Permanente.

Iorthwest Permanente, P.C. hysicians and Surgeons



When you join the Mid-Atlantic Permanente Medical Group (MAPMG), you'll be able to get more out of your life and your career. As a physician-owned and managed multi-specialty group with over 900 physicians serving 500,000 patients at 30 medical centers, we know firsthand what it takes to advance professionally and thrive personally.

CHIEF OF URGENT CARE & URGENT CARE PHYSICIANS

We seek a Chief of Urgent Care in Baltimore, MD and Staff Urgent Care Physicians for our Baltimore/DC/Suburban Maryland and Northern Virginia locations. For the Chief opening, must be a BC Physician in Family Practice or Emergency Medicine who has or can obtain an active Maryland, Virginia and District of Columbia Medical License. Three years of team lead or supervisory experience is essential. Staff openings offer flexible schedules and require a BC Family Medicine Physician or BC Med/Peds Physician who has or can obtain an active Maryland, Virginia and District of Columbia Medical License. All positions require ACLS and PALS certification and computer/typing, advanced communication and organizational skills.

Join us and benefit from an integrated medical information system, excellent team approach, reasonable and predictable schedules, clinical autonomy, subspecialist support, energetic focus on excellence and comprehensive benefits, including 100% paid occurrence based malpractice, a pension plan and a 401K.

To apply, please contact Cooper J. Drangmeister at: (301) 816-6532 or apply online at: http://physiciancareers.kp.org/midatl/

Kaiser Permanente.

Mid-Atlantic Permanente Medical Group, P.C.

CAREERS

ospitals & Clinics

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URGENT CARE

Join a renowned trend setting healthcare organization in the Minneapolis-St. Paul, Minnesota metro area. We are seeking BC/ BE family medicine, internal medicine-pediatric or emergency medicine physicians to provide medical care on a walk-in basis. We offer part or full time options, eight convenient clinic locations, competitive salary, and excellent benefits, including malpractice.

For more information, please contact:

Julie Juba, Allina Hospitals & Clinics Physician Recruitment 612-262-3041 | toll-free: 866-415-2600 fax: 612-262-4163 | email: julie.juba@allina.com Online: allina.com/jobs

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Uncompromising Excellence. Commitment to Care.

Carolinas HealthCare System is the largest health care system in the Carolinas (2nd largest in the United States) and operates one of the most successful Urgent Care networks in the Southeast. We own and operate 19 urgent care facilities throughout the greater Charlotte area. These urgent care facilities are open 12 hours a day, 7 days a week from 8am-8pm.

Each facility has two physicians on staff and they take turns covering the 12 hour shifts. There is also a nurse, lab/x-ray tech, and front desk staff. Most of the urgent care facilities see the traditional urgent care needs; however some of our facilities have a higher population of occupational medicine. Due to tremendous expansion and growth, positions are available for BC/BE FM or ER Physicians.

- Sign On Bonus!
- · Salary guarantee with incentives
- Employer paid benefits
- No call or inpatient care
- Episodic care only
- 12 hour shifts
- · Flexible schedule (work only 7 days within a two week period)

A lifestyle you deserve!

To discover more, visit our website: http://www.carolinashealthcareurgentcare.org/

To submit a CV, please contact **Sarah Foster**, Physician Services: sarah.foster@carolinashealthcare.org or call: **800-847-5084 •** fax: **704-355-5033**

EOE/AA



Velocity Care has several opportunities for a Board Certified Urgent Care, Emergency Medicine or Family Practice Physician. We are expanding in the Shreveport/Bossier area in Louisiana and opening a new facility in Little Rock, Arkansas.

Our preferred candidate will be Board Certified, have at least one or two years experience in an Urgent Care or Emergency setting, and have experience with typical UC procedures such as Laceration Repair, Incision & Drainage, Foreign Body Removal and Fracture Diagnosis. Our physicians are independent contractors who are paid on an hourly basis as well as monthly productivity bonuess. We have 12-24 hours of mid level of coverage.

Velocity Care is an enjoyable working environment with a well trained staff. Our facility is focused on patient care and customer service. We were recently awarded Small Business of the Year by the Shreveport Chamber of Commerce. For more information about our clinics, visit our website at www.velocitycare.com

If you are interested in joining our team, please contact our Practice Administrator, Leslie Oakes at loakes@velocitycare.com.

A PRESBYTERIAN

PRESBYTERIAN HEALTHCARE SERVICES

Albuquerque, New Mexico

Presbyterian Healthcare Services (PHS) is New Mexico's largest, private, non-profit health care system and named one of the "Top Ten Healthcare Systems in America". Over 600 providers are employed by PHS and represent almost every specialty. PHS is seeking four BE/BC Family Practice Physicians to work in our Urgent Care Centers. There are five Urgent Care Centers in the Albuquerque area and full-time providers work 14 shifts per month. We currently employ over 12 MDs and over 20 midlevel providers in urgent care.

Enjoy over 300 days of sunshine, a multi-cultural environment and the casual southwestern lifestyle. Albuquerque has been recognized as "One of the Top Five Cities to Live". It is also home to University of New Mexico, a world class university.

These opportunities offer: a competitive hourly salary * sign-on bonus * relocation * CME allowance * 403(b) w/match * 457(b) * health, life, AD&D, disability insurance, life * dental * vision * pre-tax health and child care spending accounts * occurrence type malpractice insurance, etc. (Not a J-1, H-1 opportunity) EOE.

> For more information contact: Kay Kernaghan, PHS PO Box 26666, Albuquerque, NM 87125 kkernagh@phs.org 505-823-8770 • 866-757-5263 fax: 505-823-8734



URGENT CARE CENTER WITH LOCATIONS IN

Clarksville, TN, seeks full-time physician with primary care experience. Our walk-in clinics are open 7 days a week, and see a mixture of both occupational medicine and urgent care patients. Board certified or board eligible in Emergency Medicine, Ambulatory Medicine, Family Medicine, or Internal Medicine required. Must have current Tennessee medical license and DEA certificate. Strong work ethic and exceptional clinical and customer service skills are a must. We offer a friendly work environment with a competitive compensation package. No on-call required. Interested applicants email CV to: greg.smith@DrsCare.com.



Mountain Medical Services URGENT CARE

is looking to hire Four Practitioners to work in a fast paced medical facility in upstate New York.

- Positions in primary care or urgent care settings
- Four great locations Lake Placid, Saranac Lake, Massena & Malone offices
- Full-time, Part-time & Per Diem Positions
- Salay dependent on experience
- Prefer 1 2 years experience

Please contact Lindsay LaPointe for more information. To apply please email: Ladams@mountainmedical.net

Dunkirk and Solomons, Maryland

Seeking part-time BC/BE EM, IM, and FP physicians to practice urgent care medicine at Dunkirk and Solomons Urgent Care

Centers in Calvert County, Maryland. Enjoy a collegial relationship with nurses, mid-level providers, and urgent care support staff. excellent work environment, a flexible schedule, and competitive compensation. Send CV: Emergency Medicine Associates 20010 Century Blvd, Suite 200 Germantown, MD 20874

Fax: (240) 686-2334 Email: Recruitment@EMAonline.com

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w/interpretation, full page printout & alphanumeric keyboard \$2,275

AT-2 plus: Multi-channel EKG w/interpretation, full page printout, alphanumeric keyboard & EKG waveform display \$2,677 Add spirometry for \$1,000



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MEDICAL EQUIPMENT



DEVELOPING DATA

hese data from the 2010 Urgent Care Benchmarking Survey are based on responses of 1,691 US urgent care centers; 32% were UCAOA members. The survey was limited to "full-fledged urgent care centers" accepting walk-ins during all hours of operation; having a licensed provider and x-ray and lab equipment onsite; the ability to administer IV fluids and perform minor procedures; and having minimal business hours of seven days per week, four hours per day.

In this issue: Is your center using computerized systems for radiology services?

USE OF COMPUTER SYSTEMS FOR RADIOLOGY SERVICES

The 2008 survey revealed that utilization of computerized systems was fairly heavy for certain aspects of operations, such as billing and claims management, and less so for other aspects, such as prescription ordering. The 2010 survey looked at this data a little differently, examining also time in use. Where computerized systems were not in use, respondents were asked about plans for the center's future use.



Acknowledgement: The 2010 Urgent Care Benchmarking Study was funded by the Urgent Care Association of America and administered by Professional Research Associates, based in Omaha, NE. The full 40-page report can be purchased at www.ucaoa.org/benchmarking.



COMPREHENSIVE CLINIC STARTUP CLINICAL MASTERCLASSES MARKETING YOUR CENTER FROM RESEARCH TO ROI ADVANCED FINANCIAL MANAGEMENT

More information coming this Summer!

Ranked #1 Urgent Care EMR

Overall Vendor Performance Comparison

Prepared by KLAS — April 13, 2012

| | Well Above Average | Above Average 🔶 Ave | | erage | rage Below Average | | | Well Below Average | |
|--------------------|------------------------------|---------------------|----------|------------------------|--------------------|-------------|----------|--------------------|--|
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| | Product works as promoted | • | • | 000 | - | | | \mathbf{O} | |
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| 2 | Quality of implementation | • | | • | • | | | • | |
| Σ | Quality of training | • | • | • | • | | | | |
| ш | Overall product quality | • | • | • | • | • | • | • | |
| ∠ icia | Delivery of new technology | • | • | • | • | • | • | | |
| ysi | Ease of use | | | • | • | • | | | |
| ы на Га | Supports integration goals | | • | • | | • | • | • | |
| D a | Proactive service | | | O | • | • | • | | |
| ਼ਰ ਤੋ | Vendor executive involvement | | • | O | • | • | O | | |
| 5 | Lives up to expectations | | | | • | | | \mathbf{O} | |
| | Keeps promises | | - | | U | • | | | |
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| | Product works as promoted | • | | • | | | • | • | |
| ut I | Money's worth | • | | • | | | • | | |
| Je | Quality of implementation | | | • | | | • | | |
| E (| Quality of training | O | | • | • | | • | | |
| ang d | Overall product quality | | | | | | | | |
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| ce Mar -10 Phys | Ease of use | | | | | | | - | |
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- Only companies that offer a full suite of EMR & practice management products are included in this comparison -

Software Konfidence Levels

ing E

6-14 15-19

Limited data, typically early trending data on new products Highest possibility in variability of score with each new survey (min. required to publish a ranking)

20–29 30+ Medium possibility in variability of score with each new survey Lowest possibility in variability of score with each new survey Stoplights represent the variance from the average of all products in the KLAS database

- Well Above Average Rating of 1 or more points (10% for Business Indicators) above industry average
- Above Average Rating is between 5 and 9 points (%-% for Business Indicators) above industry average
 Average Rating is between 5 and 9 points (%-% for Business Indicators) of industry average
 Below Average Rating is between 5 and 9 points (%-% for Business Indicators) or that industry average
- Well Below Average Rating of 1 or more points (10% for Business Indicators) below industry average



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