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Urgent Care Association of America
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Urgent Care Evaluation of Fatigue

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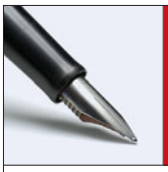


LETTER FROM THE EDITOR-IN-CHIEF

Evaluating Chest Pain in Urgent Care—"Catch 22 and the Three Bears": Part 2

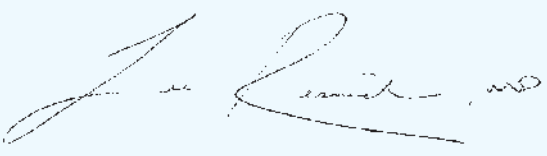
In my last column, I introduced a framework for evaluating chest pain in urgent care. In this month's column I discuss a risk and probability stratification that can assist in disposition decision-making. The following discussion considers existing evidence, but there is no formal guideline for this process in the outpatient setting. Our goal is to make a risky scenario into something we can live with. This model is for risk-stratification purposes only and recognizes that the ultimate treatment and disposition decisions grow out of the patient–physician relationship and shared decision-making.

Although the clinical evidence is certainly imperfect, there is some support for discharge for a select group of patients. Strong evidence suggests that patients should be referred to an emergency department for additional evaluation and treatment if their chest pain is exertional, radiating to one or both arms, similar to previous cardiac chest pain, or associated with nausea, vomiting, or diaphoresis. Yet there is also good evidence that patients with chest pain that is stabbing, pleuritic, positional, *and* reproducible with palpation are at very low risk for acute coronary syndrome and *most* likely have chest wall pain instead.

Of course, other life-threatening causes of chest pain must be considered, including pulmonary embolus and aortic dissection. Established clinical decision tools for both can be applied in the urgent care setting. The three most common noncardiac causes of chest pain are gastroesophageal reflux disease, chest wall syndrome, and panic disorder. In the absence of ominous signs and symptoms and without abnormalities on an electrocardiogram (ECG), patients with classic symptoms of these disorders can be reasonably evaluated as outpatients with close follow-up. I use the term *reasonably* here because I cannot say *without fail*. If, despite "reasonable" care, a bad outcome ensues, there is no malpractice. If the clinician's documentation supports the decision-making, then the standard of care is met. The plaintiff's attorneys are very unlikely to pursue a case that looks like the one I have presented here. They may subpoena the records and they may create a lot of anxiety, but their entire case hinges on standard of care, and this closely mirrors the "reasonable care" standard.

The utility and meaning of point-of-care troponin testing are often misunderstood. Troponins are enzymes released by injured heart muscle and therefore are evidence of myocardial injury, *not* of coronary artery disease. Why does this matter? A patient with unstable angina may have no myocardial injury, and therefore findings for troponins will be negative. Yet unstable angina is an acute coronary syndrome, and patients with it should be referred for cardiac evaluation. When symptoms of unstable angina are not classic, a decision tool like a thrombolysis in myocardial infarction (TIMI) score can help stratify risk. A patient with a TIMI score of 0 or 1, normal ECG findings, and negative findings for troponin has a low risk of morbidity and mortality. Thus, it is reasonable to refer these patients for outpatient cardiology follow-up (within 24 to 48 hours). A clinician can further reduce risk in these patients through the judicious use of aspirin and β-blockers. In the evaluation of patients presenting with symptoms of a duration shorter than 8 hours, a single troponin test should never be used to rule out myocardial infarction, because the enzyme will not be reliably detectable until at least 6 hours after injury. The reliability of the findings of a single test is controversial even when symptoms have been present for 8 hours. However, when negative troponin findings are considered only for those patients at lowest risk (TIMI 0 or 1) and with normal ECG findings at least 8 hours after the onset of symptoms, it is reasonable to use the test. A combination of a troponin test with close follow-up, selective stress testing, and preventive pharmaceuticals is an evidence-based approach in the outpatient setting. Documentation of the patient's understanding and acceptance of the remaining risk further supports the approach.

Remember, the realistic goal is to minimize—not eliminate—risk. A reasonable standard of care is the definitive defense against medical malpractice complaints. ■



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Editor-in-Chief, *JUCM, The Journal of Urgent Care Medicine*

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March 2015

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CLINICAL

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Fatigue can be particularly difficult to diagnose because its causes can originate from every major body system and can range from benign to life-threatening. To obtain an accurate diagnosis, use a fatigue-plus approach.

Michael B. Weinstock, MD, and Mizuho Spangler, DO

PRACTICE MANAGEMENT

17 Image Check: Impact of Employee Appearance on the Patient Experience

No matter how skilled your urgent care center's health-care providers and staff members are, patients will judge their professionalism in part on their clothing and grooming.

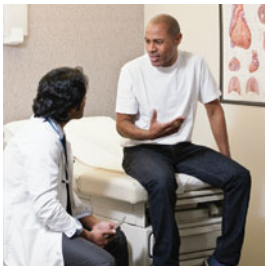
Alan A. Ayers, MBA, MAcc

CASE REPORT

25 Fracture of the Penis with Urethral Rupture

Be alert for cases of penile trauma. Undiagnosed fracture can have devastating consequences: stricture, fistula, and long-term voiding difficulty.

Tayt Ellison, MS-3, Shailendra Saxena, MD, PhD, Laura Klug, PharmD, and Sanjeev Sharma, MD



IN THE NEXT ISSUE OF *JUCM*

Gastritis is common, accounting for approximately 2 million visits annually to U.S. physicians' offices. Patients age 60 years and older are more likely than younger patients to develop gastritis, but it affects all age groups and both sexes. Peptic ulcer disease affects about 500,000 Americans each year, most of them between the ages of 25 and 64, resulting in health-care costs of more than $10 billion annually. Our cover story guides clinicians through the steps of assessment, testing, diagnosis, and treatment for these two gastrointestinal disorders.

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

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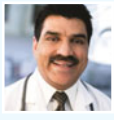
Fatigue affects 6% to 7% of the U.S. population and costs American businesses more than $130 billion per year. Yet it has so many etiologies that its diagnosis is not straightforward. Authors Michael B. Weinstock, MD, and Mizuho Spangler, DO, help clinicians zero in on what is behind this common condition in each patient.

Weinstock is a professor of emergency medicine and adjunct in the Department of Emergency Medicine at Ohio State University College of Medicine, and Emergency Department chairman and director of medical education in the Department of Emergency Medicine at Mount Carmel St. Ann's Hospital in Columbus, Ohio. Spangler is an assistant professor of emergency medicine in the Department of Emergency Medicine at LAC+USC Medical Center in Los Angeles, California.



This month's case report concerns a 51-year-old man who presented to an urgent care center with penile pain that had lasted 2 days. Penile trauma is underreported because patients are often embarrassed. The diagnosis: penile fracture. Authors Tayt Ellison, MS-3, Shailendra Saxena, MD, PhD, Laura Klug, PharmD, and Sanjeev Sharma, MD, note that failure to diagnose and, if necessary, repair rupture can result in devastating consequences such as stricture, fistula, and long-term voiding difficulty.

At Creighton University School of Medicine in Omaha, Nebraska, Ellison is a third-year medical student and Saxena and Sharma are associate professors of family medicine. Klug is an assistant professor of pharmacy practice at Creighton University School of Pharmacy and Health Practice, also in Omaha.

Like it or not, patients at urgent care centers judge clinicians and staff members in part by outward appearances. Author Alan A. Ayers, MBA, MAcc, explains how implementing a dress code that deals with clothing, grooming, and body art can help balance the need to project a professional image and to ensure workplace safety with employees' desire for self-expression.

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

Also in this issue:

In Health Law this month, **John Shufeldt, MD, JD, MBA, FACEP**, starts readers on a journey through a medical malpractice trial, a journey that will continue next month.

Sean M. McNeeley, MD, and the **Urgent Care College of Physicians** review new abstracts from the literature on research important to urgent care practitioners, including the role of strict rest after concussion, the development of a new antibiotic, management of atypically presenting anaphylaxis, the availability of epinephrine in public schools for food allergies, and revisions to labels for medications regarding their effects in pregnant and lactating patients.

In Coding Q&A, **David Stern, MD, CPC**, discusses changes in drug screen codes and new code modifiers from Medicare.

Our Developing Data piece breaks down the main sources of payment for services in the urgent care market. ■

To Submit an Article to *JUCM*

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

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

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

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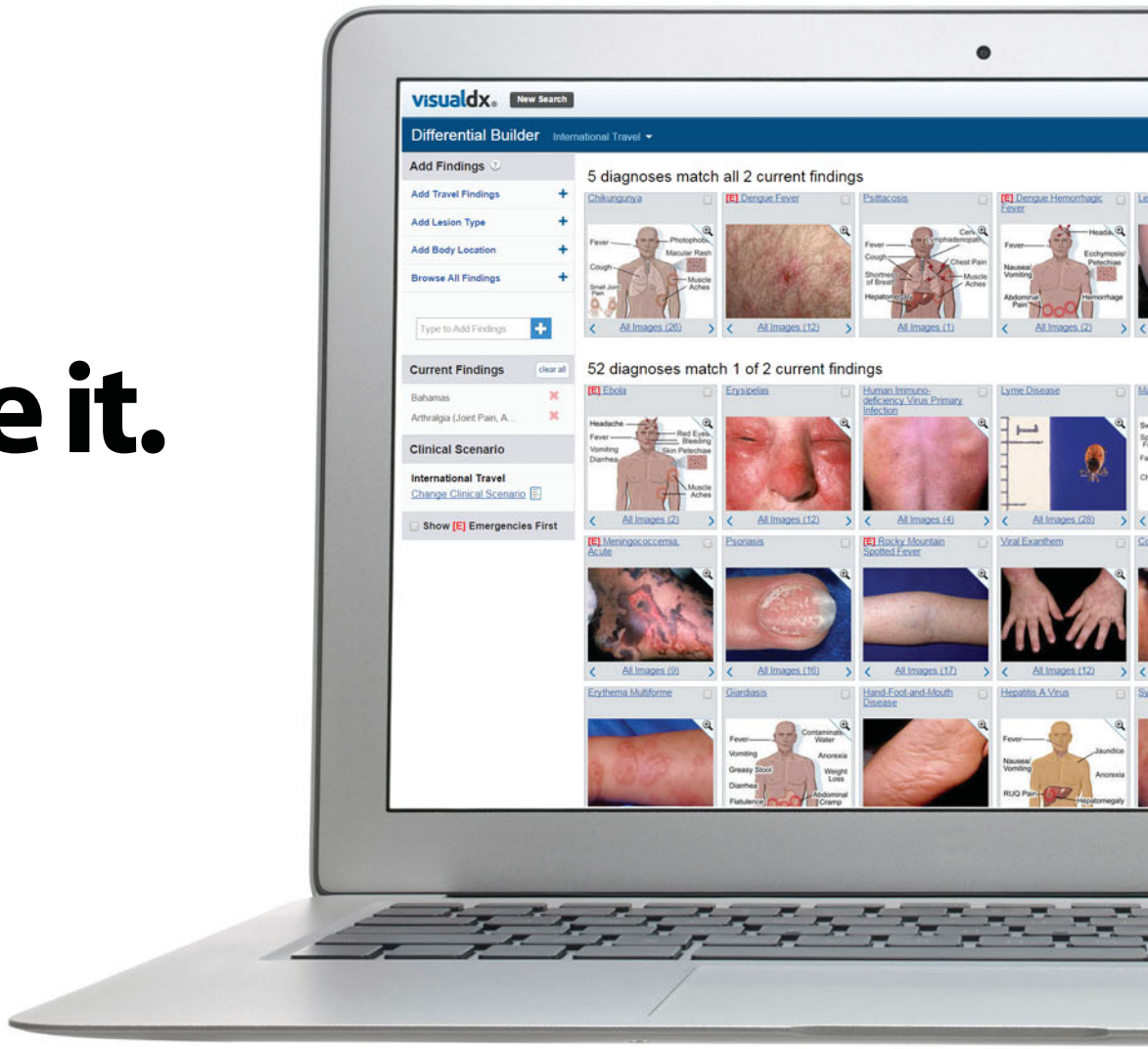

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UCAOA: A Review of Accomplishments and Benefits in 2014

P. JOANNE RAY

On behalf of the UCAOA board of directors and staff, it is my pleasure to share with you some of our accomplishments in 2014. Our dynamically robust growth, commitment, service, and vision demonstrates why your involvement is vital.

UCAOA leaders and managers view these accomplishments not as summits reached but as destinations on a dynamic path to the future of urgent care.

These are some of the highlights driven by UCAOA volunteer and staff leaders for you in 2014:

- Educational and networking meetings:
  - Record-breaking Spring Convention and Fall Conference meeting attendance
  - Initiation of a mobile application extending connectivity and resource access at meetings
  - Establishment of one-on-one appointments, enhancing exhibitor–attendee interaction
  - Clinical hands-on courses offering beginning and advanced skill work
  - Enhanced online library (254 hours available; 230 with continuing medical education credit)
  - Discounted offering of education and testing for U.S. Department of Transportation medical examiners
- Accreditation and certification:
  - Accreditation Program and Standards, launched in March—14 organizations and 127 urgent care centers accredited by UCAOA
  - Growing numbers of Certified Urgent Care Centers (CUC)—775 urgent care centers certified by UCAOA
- Strategic discussions and partnerships for health and public-policy advocacy:
  - Centers for Medicare & Medicaid Services (CMS)
  - DOT
  - Consumer Product Safety Commission (CPSC)
  - National Association of Insurance Commissioners (NAIC)
  - National Committee for Quality Assurance (NCQA)
  - CMS and the Physician Quality Reporting System (PQRS) and the Physician Feedback/Value-Based Payment Modifier Program
  - Federal legislators
- Corporate support and exhibitor resources:
  - Diamond-level corporate support partners (unrestricted support) launched with DocuTAP and Practice Velocity as first diamond partners
  - Record number of exhibitors, including new products and services showcased
  - Online virtual exhibit hall providing year-round access
  - Classified listings for real estate and equipment
- Communications:
  - Updated and integrated website
  - Increased presence, driving enhanced interest, traffic, and visibility at American Academy of Family Physicians and American College of Emergency Physicians meetings
  - Increased social media presence
  - National inclusion in Ebola coverage and enhanced presence in mainstream major media
  - *JUCM* awards
- Grassroots member involvement:
  - Launched committee structure for grassroots member involvement
  - Initiated state and regional chapter discussions
  - Set up online elections that invite *all* members to vote (versus only those in attendance at UCAOA meetings)
  - Enhanced organizational member benefits
- Industry benchmarking and member feedback:
  - Benchmarking—online platform allowing filtering to truly compare quartiles and "like" characteristics
  - UCAccess Surveys

Details about these highlights can be found on the UCAOA website (www.ucaoa.org). ■

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

Urgent Care Evaluation of Fatigue

Urgent message: Fatigue can be particularly difficult to diagnose because its causes can originate from every major body system and can range from benign to life-threatening. To obtain an accurate diagnosis, use a fatigue-plus approach.

MICHAEL B. WEINSTOCK, MD, and MIZUHO SPANGLER, DO

Introduction

Ever heard the old (and not so funny) joke about two health-care providers having a conversation at the urgent care center?

First provider: "Ever seen a case of _____?"
Second provider: "Turns out I have seen plenty of cases . . . just never *diagnosed* any!"

With a nonspecific presenting condition such as fatigue, it is difficult to obtain an adequate medical history and to perform a thorough physical examination unless the differential diagnosis is defined well enough to direct the clinician's questions. Though evaluation of fatigue is not conducive to rapid patient throughput, its assessment is actually well suited to the urgent care setting. Our bedside evaluation can clinically exclude life-threatening etiologies while sometimes localizing a diagnosis, which can make a difference in a patient's life. A systematic approach serves to identify those at high risk for complication, especially in the near term (acute coronary syndrome; ACS), and in the longer term (hypothyroidism). Careful disposition and follow-up can mitigate the uncertainty that sometimes follows an initial evaluation, further reducing the incidence of missed or delayed diagnoses and, ultimately, bad outcomes.

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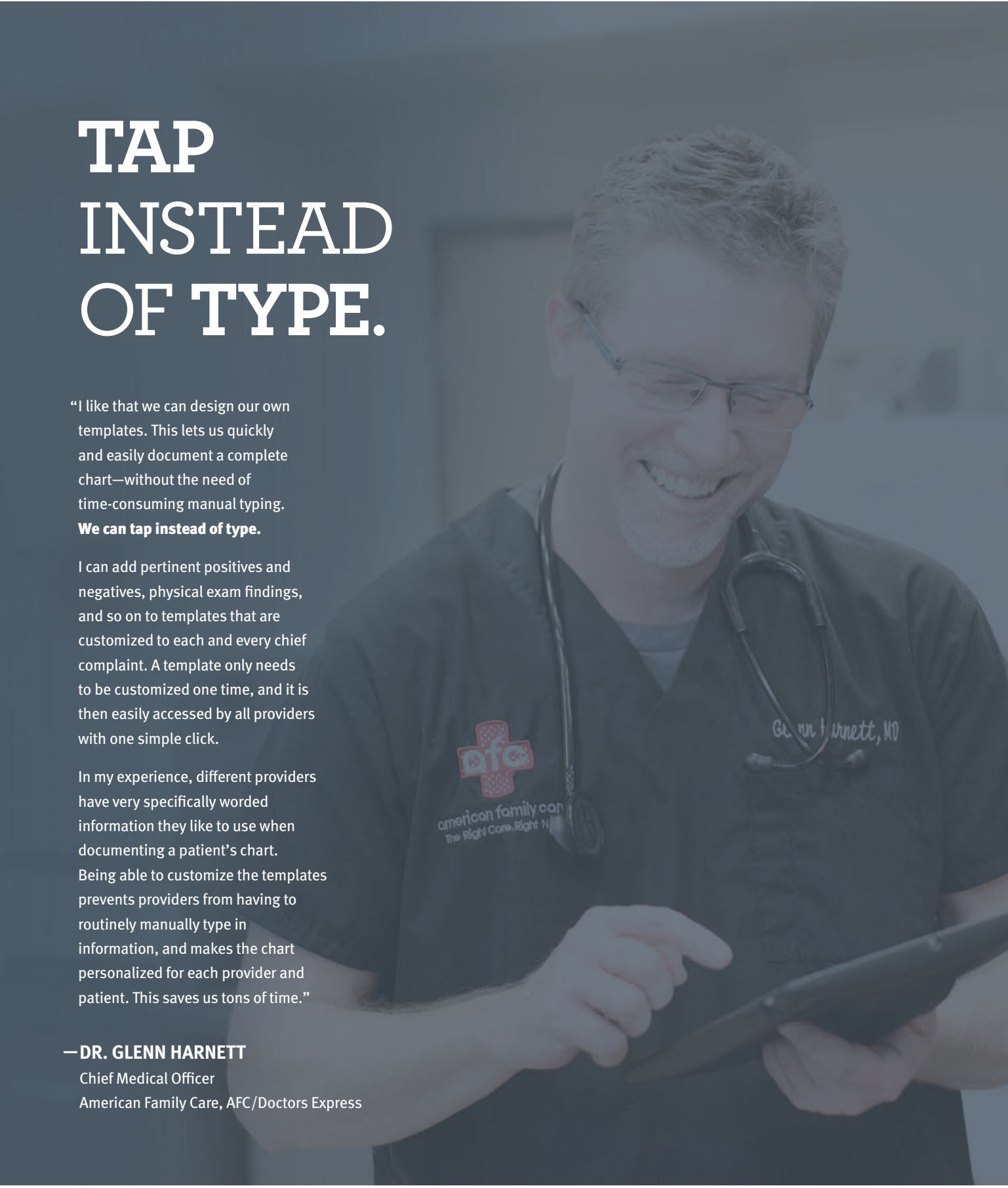
TAP INSTEAD OF TYPE.



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

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

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

—DR. GLENN HARNETT
Chief Medical Officer
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Consider the following clinical scenarios:

1. A 50-year-old man who lately cannot get through the day without taking a nap—strange.
2. A 32-year-old mother who is unusually tired to the point that it is difficult for her to care for her newborn—is that odd?
3. An 82-year-old woman, accompanied by her husband, presents at the urgent care center with a 2-week history of fatigue—seriously?
4. A 17-year-old high school football quarterback states that he has been tired for weeks and is concerned about having enough energy for an upcoming big game—perhaps understandable?
5. A 62-year-old man with type 2 diabetes who has been tired all morning, now has some mild confusion, and, while waiting in the lobby, develops diaphoresis, so the receptionist recommends that he drive himself to the emergency department—good idea?

Although even the most devoted urgent care clinicians may initially feel an urge to roll their eyes and then may feel resigned in each of these scenarios, there is an underlying diagnosis in each case that will be missed if not considered. This article discusses bedside evaluation of patients with fatigue through assessment focused on the differential diagnosis. The cause of fatigue in each of these patients is revealed at the end of the article.

The Consequences of Undiagnosed Fatigue

Fatigue is common, affecting 6% to 7% of the U.S. population and costing American businesses more than $130 billion per year. Psychiatric illness is present in 60% to 80% of patients with chronic symptoms (fatigue for more than 6 months), complicating clinicians' ability to determine a definitive diagnosis with objective testing.

Initial Rapid Assessment

The initial assessment should focus on rapid assessment, looking for concerning vital signs such as tachycardia, hypotension, or tachypnea. The patient's general appearance on entering the examination room may reveal respiratory distress, an ashen or mottled color, agitation, or cachexia. It is surprising who will go to an urgent care center with an imminently life-threatening illness or even acutely decompensate in the lobby. Caution is warranted in special patient populations, because myocardial ischemia may be the sole presentation in women, patients with diabetes, and the elderly.[1] If immediately life-threatening findings are present, consider ordering transport to an acute-care setting.

General Differential Diagnosis

Evaluating patients with fatigue begins with an exploration of the symptoms, with special emphasis on duration, associated symptoms, and previous therapies. Such a general problem is a good opportunity to use a "front-door, back-door" approach. In other words, after the history of present illness is further explored, then consider the differential diagnosis and ask questions specifically targeting difficult-to-miss etiologies.

Narrowing Down the Differential Diagnosis

The following considerations are helpful for closing in on the conditions underlying fatigue:

- **Was the onset of fatigue abrupt or insidious?** Was it gradual, coming on slowly after a recent viral illness, or was it more sudden, as in after the loss of a life partner?
- **What is the duration of symptoms?** Has the fatigue lasted for day, weeks, months, or even years?
- **Does the patient have a history of similar symptoms?** If so, what treatment, if any did the patient undergo? Past treatments will help elucidate the patient's medical history, particularly if they have a history of depression or anxiety that might be affecting them again.
- **How do the symptoms affect everyday life? Home life? Work life? Diet? Exercise?** There are many clues here that might help you differentiate social or environmental causes (i.e., work or home stress) versus organic causes. Additionally, determining if the patient has had to make adjustments to their home life will help the clinician objectively quantify the severity of the symptoms (e.g., has the fatigue caused loss of work, divorce, dropping out of school?).
- **What lifestyle habits does the patient have, and do these improve or exacerbate the fatigue?**
  - **Engaging in self-medication:** Smoking tobacco or cannabis, drinking alcohol, taking prescription drugs
  - **Taking antidepressants**
  - **Engaging in sports**

It is important to note that isolated fatigue is rare, so the goal is to find fatigue-plus—in other words, fatigue *plus* something else that can help pinpoint the diagno-

sis. The diagnosis of fatigue can be particularly difficult because it can originate from every major body system. Dividing the systems into five main categories, then considering the different elements that make up each one, may assist with directed questioning:

- Cardiopulmonary
- Neurologic and mental health
- Infectious
- Rheumatologic, endocrinologic, and oncologic
- Medications and pregnancy

Etiologies of Fatigue with Directed Questions

Cardiopulmonary Causes

Consideration of the etiologies in the following list warrants questions about the presence of chest pain or discomfort (worsening with exertion and decreasing with rest), shortness of breath, orthopnea, paroxysmal nocturnal dyspnea, peripheral edema, fever, cough, history of intravenous drug use, or presence of prosthetic heart valves. Ask these questions with a focus on symptom duration, keeping in mind that heart failure will often have a more gradual onset but atypical chest pain from ischemia may be brief. Painless angina is the presentation in 40% of patients older than 65 years and in 60% to 70% of patients older than 85 years. More common presentations of ACS are dyspnea, diaphoresis, vomiting, dizziness, and fatigue. Women with ACS are more likely than men to present without chest pain and have a higher mortality rate[2]:

- Heart failure
- Coronary artery disease or acute myocardial infarction
- Endocarditis
- Chronic obstructive pulmonary disease
- Pneumonia
- Bronchitis

Neurologic and Mental Health Causes

The neurologic and mental health causes of fatigue are not only the hardest to definitively diagnose but also the most challenging to explain to the patient. Screening questions about paresthesias, focal weakness,

ascending paralysis, and respiratory difficulty will localize some of the organic causes in the following list. Inquiring specifically about sadness, crying spells, increased or decreased appetite and sleep, visual or auditory hallucinations, or previous treatment for depression and anxiety may yield important information not spontaneously offered by the patient. When there is even the slightest concern, addressing the presence of suicidal ideation may save a life.

Caution should be exercised with attributing fatigue to a mental health issue, because you may be exactly correct on the diagnosis . . . but not the reason for the fatigue.

- Multiple sclerosis
- Myasthenia gravis
- Polymyositis
- Amyotrophic lateral sclerosis
- Guillain-Barré syndrome
- Sleep disorder including sleep apnea, chronic cough, gastroesophageal reflux disease
- Depression
- Anxiety or panic
- Somatization
- Bipolar disorder

Infectious Causes

An in-your-face diagnosis such as acute bacterial pneumonia is unlikely to be missed in the evaluation for an infectious etiology of fatigue, but other infectious causes are classically missed, such as subacute bacterial endocarditis and acquired immunodeficiency syndrome (AIDS), especially the acute antiretroviral syndrome consisting of fever, generalized lymphadenopathy, chills, and fatigue. Scanning the following list prompts questions about fever, headache, sore throat, swollen lymph nodes, night sweats, weight loss, or high-risk behaviors such as intravenous drug use or sex between men.

- Meningitis
- Mononucleosis or Epstein-Barr virus
- Hepatitis or cirrhosis
- Parasitic disease such as malaria
- Human immunodeficiency virus (HIV) or AIDS
- Tuberculosis
- Cytomegalovirus
- Syphilis

Autoimmune, Inflammatory, or Rheumatologic Plus Endocrine Plus Oncologic Causes

Some of the diagnoses in the following list must be confirmed by laboratory testing or imaging, but their likelihood can be suspected at the bedside in the urgent care center. The diagnoses in the list are classic for the fatigue-plus approach; the presence of arthralgias or myalgias, rash, polyuria or polydipsia or polyphagia, weight loss, prolonged cough, headaches, hematuria, hematochezia, confusion, or a history of cancer (with consideration of recurrence) will make the clinician concerned enough to pursue further testing.

- Rheumatoid arthritis
- Lupus
- Diabetes mellitus
- Thyroid abnormality
- Pituitary insufficiency
- Hypercalcemia
- Adrenal insufficiency
- Chronic kidney disease
- Liver failure
- Cancer

Medications or Substances of Abuse Plus Pregnancy

Remember that joke (again . . . not *that* funny) from the beginning? A medication list transcribed by your technical assistant or the patient may not include over-the-counter medications and *certainly* will not include illicit drugs. Obtaining accurate data on which to base your decision will help you to pinpoint the cause of fatigue in three ways:

1. Excessive use may be the cause of the fatigue (benzodiazepines, sedative hypnotics, opiates).
2. There may be untoward effects from prolonged and excessive use (liver failure with acetaminophen, renal failure with salicylates, anemia from chemotherapy, or electrolyte disturbance or hypotension from antihypertensives).
3. Further exploration of the reason your patient is taking the medications may reveal a hidden underlying problem (using over-the-counter medications from chronic headaches due to brain cancer or carbon monoxide toxicity, taking proton-pump inhibitors for epigastric pain due to an ulcer or gastric carcinoma, self-medicating with alcohol for depression or anxiety).

A special note of caution: Order a pregnancy test even if the patient says that she is not sexually active. Also, clusters of family members with headaches or morning headaches raise concern for carbon-monoxide toxicity, an unusual cause of fatigue, but if it is missed, the result may be a preventable adverse outcome. Check for these conditions:

- Use of sedative hypnotics, including muscle relaxants

- Use of pain medications, including over-the-counter medications such as salicylates, acetaminophen, and cough syrups
- Use of antihypertensives
- Chemotherapy
- Alcohol use
- Pregnancy
- Carbon monoxide toxicity

History of Present Illness

The differential approach will start us on the long road to a medical history in the patient with undifferentiated fatigue, but how about starting from scratch? The term *fatigue* may mean different things to different people, so give patients time to describe their symptoms without being prompted with questions. Fatigue is not a presenting condition for working on your throughput numbers. After the patient finishes, speaking consider asking these questions:

- **Is the fatigue worse at rest or with exertion?** Exertional fatigue is more likely related to anemia, hypoxemia, or acute coronary syndrome.
- **Is the fatigue constant or intermittent?** Fatigue that is intermittent may reveal clues as to such causes as stressful situations, fatigue during after a prolonged time at home (carbon-monoxide toxicity), or in relation to medication use.
- **Has the fatigue been present for over 6 months?** Chronic fatigue syndrome[3] is not a focus of this chapter, but it is important to check for it.
- **Are there focal aspects?** Unilateral symptoms suggest a stroke, carotid or vertebral artery dissection, or brain mass.
- **Can you tell me more about the duration of your fatigue?** Often patients overstate the duration of their symptoms to ensure that their symptoms are taken seriously. Give patients *permission* to be truthful with their history and ensure that the gravity of their condition is appreciated. Long-standing fatigue that has worsened may be difficult for the patient to elucidate if not prompted.
- **Has your sleep changed so that you are sleeping more or less than usual?** Association with sleep may highlight an etiology such as anxiety or depression. Early-morning wakening is a classic sign of anxiety. Depression will often cause a patient to sleep more or less than usual. Use caution to avoid *diagnosis momentum*[4] (latch-

ing onto a previous provider's diagnosis of psychosocial factors).

- **How does your fatigue affect your daily activities?** The answer to this question will help you quantify the severity of the fatigue. Are they able to continue to work, drive, and pay their bills? How has the fatigue affected their participation in social situations such as marriage or partnership or parenting?

Physical Examination

With such a general condition as fatigue, a head-to-toe examination is in order. The following list breaks down the findings for each body system that will point to an organic etiology of fatigue. Failure to perform a multisystem examination not only leads to potentially missed diagnoses but also gives patients the impression that you do not care or are dismissive regarding their problem. Remember this equation:

Missed Diagnoses + Inattentive Provider = Lawsuit

Taking your time and explaining to patients the purpose and findings for each part of your multisystem examination goes a long way to reduce risk, even when a diagnosis is missed or delayed.

- Eyes:
  - Papilledema (space-occupying brain lesion or pseudotumor cerebri)
  - Retinal hemorrhages or evidence of diabetic retinopathy (diabetes mellitus, hypertension)
  - Pupillary size (meiotic pupils from opiates, Horner syndrome)
  - Kayser-Fleischer rings (Wilson disease)
  - Icterus (jaundice)
- Neck:
  - Mass (cancer)
  - Lymphadenopathy (lymphoma, infection such as strep throat or mononucleosis)
  - Jugular vein distention (heart failure or valvular disease)
  - Nuchal rigidity (meningitis—this is a late finding)
  - Thyroid gland enlargement, tenderness, or nodules
- Pulmonary:
  - Rales (pneumonia, congestive heart failure, infection)
  - Decreased breath sounds (pneumothorax or effusion)
  - Normal examination findings (pulmonary embolism)
- Cardiovascular:
  - Tachycardia—multiple etiologies, including
  - Dehydration
  - Ischemia or infarction
  - Pulmonary embolism
  - Irregular rhythm (arrhythmia)
  - Normal rhythm (if bradycardic, consider medications as cause, or a third-degree arteriovenous block)
- Murmur:
  - Valvular disorder
  - Vegetations or endocarditis
  - Distant heart sounds (effusion or tamponade)
- Abdomen:
  - Inspection (scars, herpes zoster, distention)
  - Tenderness (check location; consider multiple etiologies)
  - Pulsatile mass (abdominal aortic aneurysm)
  - Hepatomegaly (hepatitis)
  - Splenomegaly (mononucleosis, multiple other etiologies)
- Skin:
  - Temperature
  - Rash
  - Changes seen with thyroid abnormalities
  - Poor turgor (dehydration)
  - Bruising (coagulopathy, leukemia, or abuse)
- Neurologic:
  - Check cranial nerve examination
  - Check for focal neurologic deficits:
  - Muscle strength
  - Cerebellar function
  - Mental status if applicable
  - Observation of patient ambulation if applicable

Clinical Decision-Making

To assist the clinician with medical decision-making, presentations of fatigue can be categorized in the following three ways:

- Fatigue of short duration without associated symptoms or findings
- Fatigue of moderate duration without associated symptoms or findings
- Fatigue with associated symptoms or findings
- Red flag symptoms (**Table 1**), which may include symptoms that help to make a diagnosis and thus require a change in management or

require emergency management. Fever may prompt evaluation for strep throat (self-limiting and benign), subacute bacterial endocarditis (prompting echocardiography and intravenous antibiotics), or AIDS (managed with long-term antiretrovirals and public health recommendations for safe sex).

Table 1. Red Flag Symptoms in Fatigue

• Acute onset or long-term duration	• Headache or neurologic symptoms
• Fever	• Bleeding or bruising
• Chest pain	• Lymphadenopathy
• Shortness of breath	• Jaundice
• Weight change	• Edema

Short Duration Without Associated Symptoms or Findings
One strategy for short-duration fatigue or fatigue with an alternative explanation such as a new baby, new job, increased stress, or family death can be a recheck in the urgent care center or with the primary-care provider in 1 or 2 weeks. At that time, if the fatigue is decreasing or has resolved, the patient can be monitored closely. If there has been no improvement, an initial workup and confirmation of lack of associated symptoms can be obtained with initial screening tests, including the following:

- Complete blood count
- Basic metabolic panel
- Thyroid tests
- Urinalysis (and pregnancy testing in women)

For patients with chronic disease and with short-duration symptoms of fatigue but no associated symptoms, testing can be targeted to the underlying process. Examples include (1) a patients with a history of diabetes in whom results of a glycated hemoglobin test may reveal poor long-term control of blood sugar and (2) patients who are receiving thyroid hormone replacement therapy in whom testing may show that the amount of medication should be increased. For those with history of long-term conditions such as breast cancer, heart failure, or arrhythmia, laboratory testing will have limited utility, but a medical history and physical examination directed to the specific complications (brain metastasis, fluid retention, or syncope and light-headedness) will be necessary to exclude disease progression.

Without associated symptoms related to cardiopulmonary processes, a screening chest x-ray and electrocardiogram will have limited utility and are not recommended.

Moderate Duration Without Associated Symptoms or Findings
If the symptoms have been present for a moderate amount of time—weeks to months—without a likely alternative explanation, then obtaining screening laboratory tests at the initial visit is appropriate. This can be given further consideration at the bedside using a shared decision-making model. In addition to discussing the situation with the patient, elicit information from others who have accompanied the patient to the urgent care center, including their spouse or partner, children or parents, or friends. Often they will provide information the patient may be unwilling to share, and having them buy into the treatment plan will empower the patient to follow through with it and to return for a recheck.

With Associated Symptoms or Findings
When the patient has associated symptoms or findings, consider further evaluation based on the additional conditions (the fatigue-plus). This will be directed to the possible underlying cause of the symptoms, with the realization that somatic conditions may cause some of these symptoms, including chest pain, abdominal pain, difficulty concentrating, and headaches.

Treatment and Disposition

Treatment is focused on the underlying etiology of fatigue, which could be as disparate as ordering emergency transfer because of pericardial effusion that is progressing to tamponade and prescribing iron for a woman with menorrhagia whose hemoglobin level is found to be low.

Disposition is also directed at the potential underlying cause of the fatigue and may include a recommendation to return to the urgent care for follow-up on laboratory test results, a specialty referral, or a 911 call for an unstable patient with crashing vital signs. Follow-up for special-population patients is particularly important, because there are expanded differential considerations for those with diabetes, children, the elderly, and those with a history of chronic heart disease or cancer, to name just a few. These patients often require ongoing care for their specific condition, and making a call to establish or confirm primary-care follow-up is important.

Documenting that discharge instructions are action-specific and time-specific will leave room for error should the patient decompensate. Involving the patient and family, friends, and caregivers in the discharge planning and documenting their comfort level with urgent

care discharge will reinforce their responsibility for ongoing care of the patient and watching for signs that indicate a need to return to the urgent care center. This is the most important aspect of case management if you cannot find a specific reason for the fatigue. For stable and non-life-threatening conditions, a reasonable time frame for follow-up is 1 to 2 weeks, but a longer, though *defined*, follow-up period is acceptable if there is no immediate concern for a serious illness. Phone follow-up for all of these patients within 1 to 2 days is a good strategy. This should be documented in the chart and provides a bridge to a follow-up appointment.

Patients should be informed that lack of an initial diagnosis does not exclude a subsequent different diagnosis if symptoms progress, change, or do not resolve. The shared decision-making and partnership-in-health-care models fit nicely with a nonspecific and often long-standing diagnosis such as fatigue.

So what was the cause of the fatigue for our five patients at the beginning of the chapter?

1. The inability of a 50-year-old man to make it through the day without taking a nap seemed strange until the health-care provider discovered that according his state medication prescription report, the man was getting prescriptions for diazepam at multiple primary-care and urgent care offices. On further questioning, he admitted having significant anxiety and that his diazepam has not been working as well, so he had been taking more to get a better effect. A candid discussion ensued, and he was referred to a detoxification center.
2. A 32-year-old mother who was unusually tired, finding it difficult to care for her newborn . . . was that unusual? The answer was no, sort of . . . until the health-care provider asked questions specific to postpartum depression. The patient then revealed that she had been having crying spells and feelings of sadness and hopelessness. She was cautioned to seek help if she developed suicidal or homicidal ideations and was referred for targeted care.
3. An 82-year-old who presented with her husband to the urgent care center with 2 weeks of fatigue… seriously? Yes. It turned out that she had mild dementia, and questioning her husband revealed that she had been taking over-the-counter aspirin for osteoarthritis. Blood work showed that she was acidotic and that her salicylate level was three times normal. Hydration and stopping the salicylates resulted in a return to baseline laboratory values.
4. A 17-year-old high school football quarterback states who has been tired for weeks and is concerned about an upcoming big game . . . understandable. But he reported that he had had a sore throat and fever and that his girlfriend had similar symptoms 2 weeks ago. The urgent care provider suspected infectious mononucleosis (Epstein-Barr virus) and confirmed that there was evidence of pharyngitis, cervical lymphadenopathy, and splenomegaly.[5] The provider recommended supportive care, but more importantly, the provider advised him to avoid contact sports, to prevent splenic rupture,[6,7] potentially saving the quarterback's life.
5. A 62-year-old man with type 2 diabetes who has been tired all morning, now has some mild confusion, and while waiting in the lobby develops diaphoresis, so the receptionist recommends that he drive himself to the emergency department—good idea? No. The patient was immediately brought back to an examination room, where a fingerstick showed his blood sugar level to be 42 mg/dL. The patient rapidly felt better after drinking a glass of orange juice. The patient's medical history showed that the patient had been fasting to lose weight but had not decreased the amount of his oral hypoglycemia medication and had not increased the frequency of his fingerstick checks. If the patient's blood sugar had dropped further while he was driving to the emergency department, he and everyone around him would have been in danger.

Each of these cases was appropriately managed at the bedside in an urgent care center by obtaining a complete medical history, conducting a thorough physical examination, and ordering directed laboratory testing. Outcomes for all of these patients were improved because they received excellent care. ■

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Image Check: Impact of Employee Appearance on the Patient Experience

Urgent message: Patients often infer quality on the basis of outward appearances. Adopting a policy that addresses clothing, grooming, and body art can help balance the need to project a professional image in the urgent care center and to ensure workplace safety with employees' desire to express themselves.

ALAN A. AYERS, MBA, MAcc

Remember the popular 1990s advertising slogan "Image is everything"? What was back then a trendy catchphrase created to peddle expensive gadgets is now synonymous with an entire marketing philosophy—one that has served as a foundation for many flourishing businesses. Indeed, image lies at the very heart of a brand, and how well a desired image is cultivated can be decisive in the success or failure of an organization.

So crucial is image that it is not uncommon for organizations to allocate significant portions of their gross revenue strictly to marketing and branding budgets. Additionally, successful companies consistently demonstrate that crafting a stellar image is one of the keys to developing highly coveted mind share. Capturing mind share within an industry, as any brand expert will tell you, ultimately leads to new customers, additional referrals, and, of course, increased profits. Health care, as fiercely competitive as ever, is one such industry; to thrive and prosper, health-care providers must absolutely place a high priority on projecting a favorable image to patients, who are in effect their customers.

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This careful image cultivation must go beyond sporting a catchy logo and having immaculate facilities. In the urgent care setting, with its decidedly retail, walk-in business model, presenting a care team with a capable and profes-

sional appearance takes on a heightened importance. After all, as owner or operator of an urgent care center, your aim is to attract patients, deliver great service, and keep them returning time and again. So take a hard look at the care team at your center, and then ask yourself: What does our collective image say about my urgent care facility?

How Physician and Staff-Member Appearance Affect Patient Perceptions

In urgent care, image-building efforts are usually geared toward producing a marketing result. Examples of favorable marketing results include the following:

- **Increased brand awareness:** Consumers begin associating walk-in medical care with the center's brand.
- **Increased mind share:** The center becomes the first place consumers think of to go when an episodic health need arises.
- **Increased sales and revenue:** Additional patient volume spurred by loyalty and word of mouth contributes directly to the center's bottom line.

A health-care provider's personal appearance must project professionalism and competence to engender trust in patients. Additionally, a professional appearance communicates expertise and authority, increasing the likelihood that patients will comply with care instructions—which results in improved clinical outcomes and patient satisfaction. For some anecdotal insight, there is a great article at the website *TheDO* (doctors of osteopathic medicine) that expertly addresses the issue.[1] Draion M. Burch, DO, an obstetrician-gynecologist quoted in the article, sums it up thusly:

> Even patients of a lower socioeconomic status want to see doctors who look professional. On the few occasions when I haven't worn a [signature] bow tie, patients have complained. It's part of my brand.

Simply put, one component of being a health-care provider is looking the part. An urgent care center, with its brisk patient flow and customer-service orientation, should definitely ensure that its necessarily brief patient visits are positively reinforcing its image. When a care team is uniformly attired in a neat and businesslike manner, patients take notice. Conversely, staff members dressed in an unkempt manner hurt the center's brand and hinder positive word of mouth.

Tattoos, Piercings, and Other Body Art

Members of generation Y—young, smart, brash millennials born in the 1980s and 1990s—are now crashing the workforce, and they are bringing their tattoos and piercings along for the ride. A recent Harris Poll survey showed that as of 2012, 1 in 5 U.S. adults has at least one tattoo, with nearly 50% of Gen Y-ers sporting some form of body art.[2] No longer the sole province of bikers and gangsters, tattoos and piercings are becoming the norm in mainstream America. Yet they are still met with trepidation in traditional, image-conscious professions like health care. Here is Dr. Burch on tattoos and appearance:

> The most outrageous example I've seen was a medical student whose neck is tattooed with his girlfriend's name. He had to hide it under makeup. I've also seen a pierced belly button on a student who wore a blouse that was too short. If I had tattoos and piercings and wore jeans, my patients wouldn't take me as seriously…[Not protecting] your brand can also affect referrals.[1]

By contrast, many medical practices do not mind employees having conservative tattoos and traditional piercings as long as they meet other professional standards. So where do you, the urgent care operator, draw the line in this burgeoning culture clash? Aside from new hires, how do you handle the situation when current employees come to work with new yet unprofessional body art? Does the law protect body art deemed by its wearer to be religious and/or ethnic self-expression?

As a general rule, employers have wide discretion in setting appearance standards that have their basis in social norms. Policies against employees having tattoos or piercings on the face, neck, hands, or uncovered arms are allowable and not considered to be discriminatory in nature. If, however, these policies differ between the genders (such as allowing body art for men but not for women), there may be valid grounds for legal action.

For instance, one employer was discovered enforcing a policy that discriminated on the basis of gender. It allowed male employees to have tattooed forearms but discharged a female employee for having similar body art. What made the policy illegal was that it was clearly gender-biased and not related to the content of the tattoo. Conversely, a visible tattoo that is deemed to be vulgar, obscene, or hate-oriented (such as a swastika) can be disallowed in any circumstance.

The bottom line here? Employers have the right to enforce policies against tattoos if

- They are conspicuous and clearly visible to the public
- There exists a reasonable belief that tattoos hurt the company's image or public relations[3]

Sidebar 1. Practical Considerations in Developing a Uniform Policy

- Employee appearance should be consistent with patients' expectations for the facility.
- Consider the demographics of the patients served and whether they would feel comfortable interacting with the center's employees.
- Employees should wear uniforms and not their own clothes to work.
- Uniforms create the appearance of a cohesive team.
- Uniforms reinforce employees' positions in the center.
- Wearing street clothes creates a safety hazard because pathogens—including *Staphylococcus* and methicillin-resistant *S. aureus*—harbored in clothing fibers can contaminate the clothing of other family members if the clothing is washed in cold water.
- Uniforms should be compliant with the regulations of the U.S. Occupational Safety and Health Administration.
- Uniform fibers should be resistant to absorbing blood and other bodily fluids.
- Uniforms should fit well, shield the body from splashes or spills, and avoid any decoration that could create a safety hazard or obstruct an employee's ability to perform tasks safely.
- Employee uniforms should be selected for durability and wearability.
- The difference between $14 scrubs and $40 scrubs is an investment in quality. Higher-quality scrubs last longer and are less likely to fade, fray, or tear. They are also more comfortable for employees.
- Employees are more likely to comply with dress codes if they like the uniform.
- Employers should provide a set of uniforms for employees upon hiring and annually at their hire date.
- Forcing employees to buy their own uniforms increases the likelihood employees will not replace worn or faded uniforms and/or will wear noncompliant clothing to work.
- If the difference between an employee's salary and the uniform cost pulls the employee's total compensation below the minimum wage, the employer can run afoul of wage laws.
- To ensure that employees have a clean appearance, they should be provided a sufficient number of uniform sets to last 1 week without doing laundry.
- Dress codes must not be discriminatory unless there is a compelling safety or business justification.
- Uniforms must be available from a vendor offering a wide range of sizes, from petite to XXXXL.
- Dress codes cannot arbitrarily treat men and women differently and cannot create additional burden on any specific group, except when gender differences (i.e., makeup on women but not on men) are rooted in social norms.
- Women must be offered a choice between skirts and pants.
- Beards must be permitted for religious or medical purposes.
- Head scarves, native dress, and other recognized religious expressions must be permitted.
- Uniforms must be adapted for individuals with disabilities.
- A name tag should be part of the uniform and should include the employee's name and job title.
- Guidelines should be provided regarding "flair"—pins, buttons, or additions and modifications to the uniform.
- When in doubt, or when questions arise, engage legal counsel. Uniform and dress-code issues can be cause for claims under numerous state and federal laws.

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2015 Spring Convention Schedule-at-a-Glance

Monday, April 27, 2015	
3-6pm	**Check-In/Registration**
4:30-6pm	**Exhibit Hall Opening Reception** **Join your colleagues for an evening of cocktails and hors d'oeuvres as you visit the exhibit booths.**

Be sure to maximize your time away from the center and add on one of the five Pre-Convention Courses available Sunday, Apr. 26 and/or Monday, Apr. 27!

Tuesday, April 28, 2015						
6:30am-7pm	**Check-In/Registration**					
7-8am	**Continental Breakfast**					
8-9:15am	**Opening Keynote Session** **How to Fascinate: From First Impression to Lasting Value** **Sally Hogshead**					
9:15-10am	**Exhibit Hall Coffee Break**					
	Basic Clinical Track	**Advanced Clinical Track**	**Practice Management Track**	**NEW! Urgent Care at the Crossroads Track**	**Practice Management Track**	**Practice Management Track**
10-11am	X-Ray Findings You Don't Want to Miss **Jonathan Gusdorff, DO**	The Rapid Urgent Care Neurological Exam **Gregory Henry, MD**	Ticketed Breakout Session **Sally Hogshead**	Dealing With Case Rates: Getting Paid for Higher Acuity Visits and Procedures **Olga Khabinskay**	PR 101: The Importance of Media Relations and How to Work With Media **Shannon Quinn**	The Early Years: 0-5 Years of Urgent Care Operation **Paula Dunne, MHA, RN**
11-11:15am	**Break**					
11:15am-12:15pm	Treating the Pregnant Patient for Common Ailments **Mary Ann Yehl, DO**	Medial Quicksand: The Patient **Gregory Henry, MD**	Integration of Urgent Care and Primary Care **Teri Lash-Ritter, MD**	Role of Urgent Care in Integrated Care Delivery Systems **Ulana Bilynsky**	PR 201 **Phil Rainier**	Sustaining Customer Service Success in the Urgent Care **Mary Kate Dilts-Skaggs, MSN, RN, NE-BC**
12:15-1pm	**Attendee Lunch**					
1-2pm	**Exhibit Hall Dessert Break**					
2-3pm	Gynecological Case Studies **Mary Ann Yehl, DO**	Urgent Care Approach to the Evaluation and Management of Low Risk Chest Pain **Michael Weinstock, MD**	Goals, Organizational Priorities, Leadership, and Performance Indicators **Manny Garza and Steve Sellars, MBA**	Connecting With the Greater Healthcare System: Urgent Care in ACOs, Skinny Networks, Capitation, etc. **Michael Boyle, MD, MBA**	Smart Strategies for Employee Termination **Damaris Medina**	How to Connect and Make an Impact on Local Government Panel
3-3:15pm	**Break**					
3:15-4:15pm	Dermatology Review **Tracey Davidoff, MD**	More X-Ray Findings You Don't Want to Miss **Jonathan Gusdorff, DO**	Developing a Patient-Focused Culture **Jennifer Swanson, MD**	Beyond Urgent Care: Building Bridges With Primary and Specialist Care **Evan Berg, MD and Phyllis Kennedy, BS, MMP**	Language Translation and Accessibility Compliance: Working With Patients Who Are Multilingual and/or Have Disabilities **Carolyn Stern, MD**	Mergers & Acquisitions Panel
4:15-4:30pm	**Coffee Break**					
4:30-5:30pm	Incorporating Occupational Health Services Into Urgent Care **Don Herip, MD, MPH**	Urgent Evaluation of Syncope: How to Rule Out Life-Threatening Illness **Michael Weinstock, MD**	Positioning for Growth: Developing Scalable, Repeatable Processes **Katrina Catto and John Hennegan**	Hospital Urgent Care Strategies for Driving Downstream Revenue **Michael Boyle, MD, MBA**	Value Stream Mapping **Jason Call**	Mergers & Acquisitions Panel
5:30-7pm	**Exhibit Hall Reception** **Join your colleagues for an evening of cocktails and hors d'oeuvres as you visit the exhibit booths.**					

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- **2 Keynotes by Industry Experts**
- **2 Evening Receptions With Cocktails and Hors D'oeuvres**

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Wednesday, April 29, 2015

6:30am-5pm	**Check-In/Registration**					
8-9:15am	**Members' Breakfast Meeting**					
	Basic Clinical Track	**Advanced Clinical Track**	**Practice Management Track**	**NEW! Urgent Care at the Crossroads Track**	**Practice Management Track**	**NEW! UCAOA Accreditation Track**
9:30-10:30am	Management for Physicians **Victor Chou, MD**	Clinical Practice Risk Management When Working With Physician Assistants and Nurse Practitioners (Part 1) **Marsha Niven, MPAS, PA-C**	Achieving Optimal Clinical Flow **Steven Engelberg, PA-C, PhD**	Consumer Attitudes, Awareness, Understanding, and Behavior Regarding Urgent Care **Stephanie Stockton**	ICD-10 Readiness: Things to Do Before You Start **Amy Dunatov, MPH, CCS-P, ICDCT-CM**	Starting the Accreditation Process: Application and Certification **Laurel Stoimenoff, PT, CHC**
10:30-10:45am	**Coffee Break**					
10:45-11:45am	Are You Making These Common Pediatric Mistakes? **Victor Chou, MD**	Clinical Practice Risk Management When Working With Physician Assistants and Nurse Practitioners (Part 2) **Marsha Niven, MPAS, PA-C**	Utlizing Part Time Employees **Logan McCall**	Differentiating Your Practice in a Market Saturated With Walk-In Choices **Cameron Cox, MHA**	Billing and Coding in the World of Flat Fee Contracts **Tammy Mallow**	Achieving UCAOA Accreditation: Benefits to Your Organization **Moderator: Barbara McKee** **Panelists: Cindi Lang, RN, MS, Laurel Stoimenoff, PT, CHC, Bob Barrese, David Wood, and Molly Fulton**
11:45am-1:30pm	**Exhibit Hall Boxed Lunch**					
1:30-2:30pm	Evaluation of TB Exposures and Blood Borne Pathogen Exposures **Don Herip, MD, MPH**	Making Sound Decisions **Joe Toscano, MD**	Recruiting, Interview-ing and Hiring Insights **Spencer Hamer**	Process Improvement Via Patient-Facing Technology Panel **Jared Dowland, Atul Kumar, MD, MBA, Michael Trader, and Jon West**	Why Coding Knowledge is Important Even With an EMR System **Amy Dunatov, MPH, CCS-P, ICDCT-CM**	Achieving Best Practices Through the Accreditation Standards: Governance, Human Resources and Physical Environment **Ian Vanore**
2:30-2:45pm	**Break**					
2:45-3:45pm	Pediatric Cough **Shannon Crabtree, MMS, PA-C**	Jeopardy **Sean McNeeley, MD**	Utilization of Physician Assistants and Nurse Practitioners in Your Clinic **Steven Engelberg, PA-C, PhD**	Leveraging Digital, Social and Mobile Marketing to Drive Volumes **Chris Behan**	Coding Compliance and Audits **Damaris Medina**	Achieving Best Practices Through the Accreditation Standards: Patient Care Processes and Patient Privacy, Rights and Responsibilities **Janice Suhajda, MD**
3:45-4pm	**Coffee Break**					
4-5pm	Ask the Experts Panel **Tracey Davidoff, MD, Joe Toscano, MD, Sean McNeely, MD, Jasmeet Bhogal, MD, and William Gluckman, DO, MBA, CPE, CPC**		Disruptive Providers and How to Deal With Them **John Shufeldt, MD, JD, MBA**	Medical Malpractice Insurance Cost Containment and Risk Management Panel **William Duggan, Jr., Shaun Ginter, Jordan Ready, ACI, CPCU, CRIS, and Lee Resnick, MD**	Operationalizing Your Mission: Strategies for Translating Values and Vision to Front-Line Staff **LouAnne Giangreco, MD**	Achieving Best Practices Through the Accreditation Standards: Health Record Management and Quality Improvement **Janice Suhajda, MD**
5:15-6:15pm	**State Networking Meetings**					

Thursday, April 30, 2015

6:30-9:15am	**Check-In/Registration**			
7:30-8am	**Continental Breakfast**			
8-9:15am	**Closing Keynote Session** **Jonathan Bush**			
	Basic Clinical Track	**Advanced Clinical Track**	**Practice Management Track**	**Practice Management Track**
9:30-10:30am	Should I X-Ray That? When X-Rays Are Not Always Necessary **Tracey Davidoff, MD**	EKG Lecture **Joe Toscano, MD**	Megatrend of Patient Centricity and the Role of Retail and Digital Health **Patrick Carroll, MD**	The Role of Telemedicine in Urgent Care **Nicholas Lorenzo, MD, MHCM, CPE**
10:30-10:45am	**Coffee Break**			
10:45-11:45am	Sexually Transmitted Infections & the New HIV Protection **Shannon Crabtree, MMS, PA-C**	Drug Testing **William Gluckman, DO, MBA, CPE, CPC**	Business Contracts: Turn Any Contract Into Your Advantage **Laura Becker, MA, MBA, JD, CHC, CHCP**	The Future of Urgent Care **Alan Ayers, MBA, MAcc**
11:45am	**Convention Adjourns**			

Sidebar 2. Clarifying the Dress Code for Health-Care Providers and Staff Members

Even when an urgent care center has adopted a uniform and dress code, employees still take great latitude within the bounds of the policy. As a result, further clarification is required as to management's expectations for personal appearance, including grooming; tattoos, piercing, and other body art; and adornments like jewelry and perfume. The following is an example of how one urgent care center communicates its expectations to health-care providers and staff members.

Hair (Including Facial Hair)
- Hair should be neat and clean.
- Facial hair must be moderate in length for beard and mustache, and must be appropriately trimmed and groomed. Growing a beard and not shaving are two different things.
- Barrettes, headbands, and so forth should be plain and closely match the hair color.
- No extreme hair colors (e.g., blue, purple, pink, orange).
- No excessive hair bleaching or streaking. Any highlights must be an appropriate color that complements the team member's existing hair color.

Jewelry
- Earrings: No more than 2 earrings per ear worn in the earlobes. Stretching of the earlobes is prohibited.
- Dangly and hoop earrings must be 0.5 inch or shorter for *direct patient-contact areas* and 1 inch or shorter for *non-patient-contact areas* (measured below the earlobe).
- No large costume jewelry.
- No visible body piercings (must be covered or removed).
- No tongue piercings.
- Rings should be tasteful, and they should be worn in moderate numbers.
- Bracelets: In *patient-contact areas*, 1 per arm, no porous bracelets, no large bracelets, and no charm bracelets. Bracelets should not be a threat to clean or sterile areas. In *non-patient-contact areas*, bracelets should be moderate and tasteful.
- Watches are allowed.
- Necklaces: Two necklaces are acceptable for *patient-contact areas*, but they must be no more than 18 inches in length. In *non-patient-contact areas*, 2 necklaces are acceptable, but they must be moderate in length.
- Ankle bracelets are acceptable for all areas.

Shoes
- Shoes must be all one color or mostly one color. If the first thing someone notices about you is your shoes, then they are too bright.
- Shoes must be clean and in good repair.
- Laces must match shoes.
- No flip-flops, sandals, or slippers.
- Closed-toe shoes are required in clinical areas.
- Socks must be worn with sneakers.

Tattoos
- All tattoos must be covered by sleeves, bandages, or other means.

Perfumes
- Because strong fragrances can cause respiratory distress in patients and other staff members, perfume, aftershave, and deodorant should not be noticeable.
- Good personal hygiene is expected of all employees—no body odor.
- Cigarette-smoke odor is not acceptable.

Clothing (Patient-Contact and Non-Patient-Contact Areas)
- Clothing must fit properly, be neat, and be clean.
- No midriff tops.
- No tube tops or tank tops.
- No T-shirts unless worn under other garments.
- No shorts.
- Slits in skirts and dresses should not be any higher than 2 inches above the knee.
- Skirts are acceptable if they end no more than 2 inches above the knee.
- No spandex tops or pants, no leggings, and no sweat suits, jogging suits, wind suits, or any other exercise attire.
- Jeans are not allowed to be worn unless approved by the manager (special days).
- Appropriate holiday attire is acceptable in *patient-contact areas*.
- Long-sleeved or short-sleeved, collared dress knit shirts or sport shirts are acceptable.
- No gloves of any kind other than medical gloves (i.e., no knit gloves with or without fingers, no solid or print trendy gloves).

Nails
- For infection control and patient safety, fingernails should be an appropriate length (not longer than 0.25 inch in *direct patient-contact areas*), be clean, and be well manicured.
- No artificial fingernails in clinical areas.
- Nail polish should not be chipped and should be subdued, tasteful, and complementary to your complexion in color.
- No nail jewelry.

Name Tags
- Name tags must always be worn on the outermost garment on the upper chest area in order to be easily read.

Scrubs
- Scrubs must be clean and pressed; no outside uniforms or jackets.
- Solid white crew neck T-shirts or long-sleeved shirts can be worn under a scrub top.

Logos
- Clothing and jewelry with advertisements, sayings, causes, campaigns, or logos of other organizations are not permitted.
- Politically oriented material is prohibited.

Lockers
- Lockers are to be used to store and secure all personal items.
- Cell phones will be turned off and/or kept in your locker.

Although employers' right to set grooming standards for their employees is protected by the law, there should be room for case-by-case discretion. If you run an urgent care center, you do a disservice to your staff members, health-care providers, and patients by disqualifying talented and credentialed yet discreetly tattooed candidates right off the bat. Talent is hard to find, and even harder to keep.

The Importance of Developing a Uniform Policy

A great way to support your health-care team in furthering the center's image and brand is by implementing a dress code that includes a uniform policy (**Sidebars 1 and 2**). In fact, you will achieve greater consistency in the appearance of health-care providers and staff members by implementing a dress code that balances business needs (including promoting the center's brand) with job function and legal requirements. The law actually gives employers a lot of flexibility in deciding what they can require employees wear to work, so you will have some creative control over the process.

Most urgent care clinics do in fact utilize a dress code, which typically requires scrubs for front- and back-office staff members, and white laboratory coats for health-care providers. Actually, scrubs are often preferred by health-care teams because they associate the wearer with professional clinical work, are relatively inexpensive, and are easily maintained. Although some owners of urgent care centers prefer khaki pants and polo shirts for the front-office staff, the frequency of cross-training between front- and back-office team members (i.e., a registration specialist who doubles as a medical assistant) leads most owners to require all nonproviders to wear scrubs.

Regardless the type of uniform policy you decide to adopt, you should ensure that it addresses the following questions:

- Does the appearance of staff members convey the professional image you desire for your center?
- Do providers and staff members have the appearance of one cohesive team?
- Are the common branding elements—such as color, style, and accessories—consistent in everyone's appearance?
- Would an off-site team member be recognized as an employee of the center solely by their appearance?
- Does the dress code provide examples of what employees are expected to wear (i.e., blue scrubs, khaki slacks, polo shirt, closed-toe shoes) and what is considered inappropriate for the workplace (i.e., shorts, sandals, tank tops)?
- Has the uniform policy been reviewed to ensure compliance with the regulations of the U.S. Occupational Safety and Health Administration and other health and safety authorities?

How Other Service-Oriented Businesses Address Employee Appearance

The whole "image is everything" concept is hardly limited to the health-care industry. In fact, employee appearance and how it can strengthen or weaken a brand is one of the hottest marketing topics

in business today, particularly within the service industry. This issue seems especially important in "retail medicine" (i.e., the urgent care industry). If your business model places employees in frontline, face-to-face interactions with customers, then those employees necessarily become the standard-bearers for your brand.

How do other service-oriented businesses leverage employee appearance to promote their brands? Primarily through uniforms. Here is the take of Paul Mangiameles, president and chief executive officer of Bennigan's[4]:

> Employee uniforms are a great representation of where the brand is headed. They are creative, fun, and modern, which is what we want the atmosphere and décor of every Bennigan's to be. I believe that having a cohesive theme throughout allows guests to get an accurate perception of our brand concept.

Most other customer-oriented service industries have a similar philosophy: Putting on a uniform places you in an at-work frame of mind and clearly distinguishes you as an employee of the company. You are there to serve and help create the most enjoyable customer experience possible.

Conclusion

When people seek out medical treatment, they want to believe that they have placed their health in the hands of knowledgeable, capable professionals. Right or wrong, it is human nature to associate expertise, authority, and clinical knowledge with a well-put-together appearance. Whether professionals wear a starched white laboratory coat with a dress, a skirt and blouse, or a shirt and pants and tie that are office-appropriate, or they wear a crisp pair of scrubs, those who meet with them subconsciously equate a well-crafted image with superior service. A care team that is clean-cut and immaculate will convey that image, and numerous studies show that such an image indeed does improve patient outcomes.

Furthermore, it is an inescapable truth that in service and retail-based industries, frontline employees are often the primary shapers of a company's image and, by extension, its brand. At your urgent care center—a decidedly retail business—your physician and care team members must always project a professional image to successfully promote your center's brand. ■

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Case Report

Fracture of the Penis with Urethral Rupture

Urgent message: Failure to diagnose and, if necessary, repair penile fracture can result in devastating consequences such as stricture, fistula, and long-term voiding difficulty.

TAYT ELLISON, MS-3, SHAILENDRA SAXENA, MD, PhD, LAURA KLUG, PharmD, and SANJEEV SHARMA, MD

Introduction

Although penile trauma is not a common presentation in the urgent care setting, it is underreported because of embarrassment, as are other injuries related to sexual activity. The urgent care clinician should be prepared to evaluate these conditions with an emphasis on the identification of more complicated injuries requiring surgical intervention. In this case report, we discuss penile fracture complicated by urethral rupture. This is a concerning condition requiring emergency surgical repair to reduce the potential for consequences such as stricture, fistula, and long-term voiding difficulty.

Case Presentation

A 51-year-old healthy man presented to an urgent care center because of penile pain. He reported experiencing trauma during sexual intercourse that occurred 2 days before he was seen at the center. He delayed seeking treatment because he was embarrassed. He reported gross hematuria, rapid detumescence, audible cracking sounds, and the formation of a hematoma occurring at the time of the trauma. His vital signs and findings on physical examination were normal except for the penile trauma. The external genitals and scrotum were normal. His circumcised penis was nontender, but the ventral surface was swollen, and there was a hematoma. He reported no pain but had experienced difficulty voiding since the injury, and urinalysis findings were positive for blood.

At Creighton University School of Medicine in Omaha, Nebraska, **Tayt Ellison, BA**, is a third-year medical student and **Shailendra Saxena, MD, PhD**, and **Sanjeev Sharma, MD**, are associate professors of family medicine. **Laura Klug, PharmD**, is an assistant professor of pharmacy practice at Creighton University School of Pharmacy and Health Practice, also in Omaha.

Diagnosis and Disposition

Because of the reported trauma and our findings on clinical examination, we suspected that our patient had sustained a penile fracture.

We referred the patient for surgical evaluation and repair. During surgical intervention, a urethral tear was

Table 1. Red Flags for Penile Trauma
• A cracking noise
• Immediate loss of erection
• Penile swelling
• Blood at the tip of the penis
• Blood in the semen
• Blood in the urine
• Penile bruising
• Penile dents
• Penile pain

"Penile trauma is underreported because of embarrassment, as are other injuries related to sexual activity."

identified and repaired. At the time of publication, the patient was fully recovered and all symptoms had resolved.

Discussion

Anatomy

The penis has 3 main components: shaft, root, and glans. In trauma to the erect penis, fracture occurs in the shaft. Erectile tissues engorge with blood to attain erection. Erectile tissues are composed of the paired corpus cavernosa on the dorsal surface and the corpus spongiosum in the midline of the ventral surface facing the scrotum. Deep arteries, extending from the internal pudendal arteries, run centrally in the cavernosa, supplying blood to the helical arteries, which then supply blood to the erectile tissues. The urethra is located within the spongiosum on the ventral side of the penis. The paired corpus cavernosa are covered by a fibrous sheath known as the tunica albuginea. Superficial to this, just below the skin and encasing the venous drainage, is Buck fascia. The deep dorsal penile vein runs outside the tunica albuginea under the Buck fascia, whereas the superficial dorsal vein runs over it.[1]

Clinical Presentation

Penile fracture, or ripping of the tunica albuginea, is an underreported injury.[2] During erection, the tunica becomes increasingly thin, down to about 0.25 mm, as opposed to 2.5 mm in the flaccid penis.[2–4] In trauma, the engorged penis is forcibly bent, creating pressure in the corpus cavernosa and spongiosum of up to 1500 mm Hg. This massive pressure causes ripping of the thinned tunica albuginea.[4] **Table 1** summarizes red flags in penile trauma.

Penile fracture is diagnosed by the presence of hematoma, rapid detumescence, and audible cracking.[5] All three conditions need not be present for diagnosis, however. El Atat et al found that of 300 patients with penile fracture, 100% reported penile swelling, ecchymosis, and rapid detumescence, but only 50% had audible cracking.[6] Other studies have reported swelling and ecchymosis in 100% of patients, and penile pain, detumescence, and acoustic cracking in 64.7%, 52.9%, and 35.3%, respectively.[7] Dorsal vein rupture can be mistaken for penile fracture and usually differs only in the lack of audible cracking sounds and gradual, rather than rapid, detumescence.[2,8]

Urethral damage with long-term voiding complications is of concern with penile fracture. Urethral rupture can result from a corporal fracture, damaging the spongiosum and resulting in hemorrhage.[9] Gross hematuria after injury or microscopic hematuria detected by dipstick urinalysis warrants a clinical work-up.[7] In one study, 5 of 7 (71.4%) urethral injuries resulted in microscopic hematuria, and 3 of 4 bilateral corporal tears were associated with urethral injury, versus 4 of 21 unilateral corporal tears.[7] The findings of Yamaçake et al also support a strong relationship between urethra rupture and bilateral corporal tears.[10] It has also been suggested that urethral injury is related to the mechanism of injury. Urethral injury is correlated with sexual intercourse because torque is applied to the penis, increasing the risk of a spongiosum or urethral tear.[6] Moreno Sierra et al found urethral injury to be more prominent with trauma of greater intensity such as coitus. That study suggested that urethral injuries occur in 10% to 30% of penile fractures.[9] Despite the risk of urethral damage, most penile fractures are small, unilateral tears with no urethral involvement.[2,6] In fact, El Atat et al found that of 300 patients presenting with penile fracture, only 5 (1.6%) had urethral injury.[6] Yonguc et al reported that bilateral corporal rupture accounts for only 2% to 10% of penile fractures and that of those fractures, urethral tears occur in 9% to 20% of cases.[11] Regardless, suspicion of urethral injury with penile fracture should be high when there is penile

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trauma, and a thorough medical history, including the mechanism of injury, should be obtained to assess possible urethral damage.

Treatment

Surgical exploration is the most common means of assessing urethral patency. During surgical repair, intraoperative urethrography may also be used to assess urethral patency.[12] Preoperative retrograde urethrography may also be performed.[10] During a urethrogram, contrast agent is injected into the urethra, and rupture is identified by the agent entering and collecting in the corpora cavernosa.[13] Although urethrography is not the current standard of care in assessing urethral injury, some believe that it is underutilized and that only in the setting of complete lack of urinary symptoms and clinical findings should it be forgone. For patients with voiding difficulty, hematuria, or blood at the meatus, urethrography should be considered.[4] Although effective in diagnosing urethral rupture, urethrography also presents risks, such as increasing existing damage and infection.[9] Further, the sensitivity of urethrography in diagnosing urethral rupture with penile fracture is only 50%. Other available imaging options to assess urethral patency include ultrasonography and intraoperative flexible cystoscopy.[10]

Conservative care, which entails using compression sleeves, ice packs, and nonsteroidal anti-inflammatory drugs, is no longer recommended because it can lead to sequelae such as penile curvature, erectile dysfunction, and painful erection.[3–6,8–10,12] Surgical repair of the tunica and urethra is the standard of care for penile fracture; it may be followed by a period of catheter use.[9,14] The timing of surgical intervention, however, is under review. Current literature promotes urgent surgical repair within 48 hours of injury.[4,10] However, emerging data suggest that postponing surgical intervention for 7 to 12 days may be beneficial.[5] Naraynsingh et al reported details of a case involving a patient presenting for surgical repair 3 weeks after injury. By then, swelling had subsided, making damage location easier and minimizing invasive surgical repair.[14]

"Conservative care, which entails using compression sleeves, ice packs, and nonsteroidal anti-inflammatory drugs, is no longer recommended because it can lead to sequelae such as penile curvature, erectile dysfunction, and painful erection."

Gross hematuria after injury, microscopic hematuria detected by dipstick urinalysis, and bilateral corporal fractures warrant further clinical work-up for urethral rupture associated with penile fracture. In addition to surgical exploration, intraoperative or preoperative urethrography may also be used to assess urethral patency.

Take-Home Points

Surgical ligation and catheter placement are essential to repair a ruptured urethra. Failure to diagnose and, if necessary, repair rupture can result in devastating consequences such as stricture, fistula, and long-term voiding difficulty. However, clinicians should keep in mind that the timing of repair is under review, with immediate repair being the standard practice and delayed repair suggested by recent case reports. ■

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Medical Malpractice Trial, Part 1: The Events

JOHN SHUFELDT, MD, JD, MBA, FACEP

I recently spent 3 amazing weeks in a medical malpractice trial. Over the next few months, I would like to share the experience with you. Despite the fact that I practice law and have been an expert witness for more than 20 years, the experience opened my eyes and has definitely changed how I practice medicine in the urgent care setting.

I took copious notes during the trial and have access to all of the depositions and trial testimony, so I will do my best to make this series as factual as possible. That said, I will change the names of the defendants and plaintiffs; however, I will keep the names of the attorneys and expert witnesses in the case.

Case name: *John and Cathy Dalton v. Dr. Beth Ange and Responsive Emergency Medicine*

Decedent: Johnny Trey Dalton

Attorney for plaintiff: Bernard Elliot Greyson, MD, JD

Attorney for defendants: Cristy Chait, Esq.

Defendant's Disclosure

On February 5, 2012, Johnny Dalton was brought by his mother and sister to the emergency department (ED) at St. Jacob's Hospital at 2:00 a.m. He arrived ambulatory, stating that he had taken methadone pills. He was not sure of the amount; however, his family believed it was liquid methadone and that he took 80 to 90 mg.

His vitals on admission were as follows: blood pressure, 114/77 mm Hg; pulse, 75 beats/min; temperature, 37°C, respiratory rate, 11 breaths/min; oxygen saturation, 98% on room air. He was initially seen and evaluated by Dr. Bob Scott. The clinical nursing notes indicate that he had ingested 2 bottles of methadone, 30 mg each, while at a party. He also told the nurse he was suicidal.

On presentation, he was noted to be sleepy but able to answer questions and interact appropriately. The patient's chart notes that Dr. Scott was speaking with the patient and family at about 2:15 a.m. Laboratory tests were ordered, and all findings were within the normal range, including levels of aspirin and Tylenol. Johnny refused to submit a urine specimen for a urine toxicology screen. Suicide precautions were ordered. A sitter was with the patient reportedly from 2:37 a.m. until discharge. At 5:16 a.m., Dr. Scott ordered a psychiatric consult. At 5:19 a.m., the patient was noted to request water.

"Despite the fact that I practice law and have been an expert witness for more than 20 years, the trial opened my eyes and has definitely changed how I practice medicine in the urgent care setting."

The patient's care was assumed at 6:52 a.m. by Dr. Beth Ange, who is the chairperson of the Department of Emergency Medicine, and at about 7:30 a.m. by the day nurse. Symptoms, physical findings, and pending evaluations were reported to Dr. Ange. It was noted that the patient was resting quietly and was awake in no distress at about 7:30 a.m. Family members were at the bedside as well. The patient was noted to be sleeping at 9:10 a.m., with a respiratory rate of 14 breaths/min, unlabored breathing, and no acute distress.

At about 9:15 a.m., a psychiatric evaluation was done. According to the psychiatric report, the patient had been brought to the ED by emergency medical services after his mother called 911 because the patient looked "really pale and wasn't answering right." The patient was at a party and took some liquid methadone. He was told that they were like "Oxys." The patient denied any attempt to harm himself and reported that he just "wanted to get high."

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"Both the mother and the patient stated that he had no history of making remarks with suicidal ideation or of ever attempting to harm himself. In addition, he reported a moderate history of abusing substances."

Both the mother and the patient stated that he had no history of making remarks with suicidal ideation or of ever attempting to harm himself. In addition, he reported a moderate history of abusing substances, and his mother agreed. He was recently seen at a behavioral health center and prescribed lorazepam. He was given lorazepam 4 days earlier for generalized anxiety disorder. He was not receiving any counseling.

He reported moderate depression over "lots of stuff." He had been arrested for domestic violence toward his family on October 4, 2011. In his substance abuse history, he reported marijuana use from age 17 to 18 years, opiate pain pills 1 or 2 times per month in the last 4 months, a one-time use of cocaine at age 18 years, and "pretty heavy binges" of dextromethorphan for approximately 1 year. He denied alcohol abuse.

The diagnosis was generalized anxiety disorder and opioid abuse. Depressive disorder was ruled out. The crisis worker noted that he was to be discharged home with his mother. At 9:33 a.m., he was given 4 mg of Zofran. At 9:45 a.m., the patient was observed to be vomiting into a trash can, and Dr. Ange was notified. A breakfast tray was provided to the patient at 9:50 a.m.

Dr. Ange confirmed with the patient that he was not suicidal at that time. At 11:25 a.m., it was noted that the patient's symptoms were improving. He was ordered discharged home in good condition and was to await a ride home. The intravenous line was removed at approximately 12:49 p.m. without incident. Discharge instructions and plans for follow-up care were reviewed. He was discharged home at 12:49 p.m. The discharge instructions included calling for an appointment as soon as possible with his physician, health maintenance organization, or clinic. He was to return to the ED if his symptoms worsened. He signed his own discharge instructions with very legible handwriting and walked out of the ED on his own.

The following day, approximately 22 hours after discharge from the ED and 35 hours after the reported ingestion, the fire department was contacted at 11:37 a.m. because Johnny was found not breathing. It was reported that he had last been seen 1 hour earlier. The fire department was reported to be on the scene at 11:41 a.m. Johnny was pronounced dead on the scene. Police were notified, and they searched the home, finding empty liquor bottles and 2 empty Ativan bottles in Johnny's room. The 90 Ativan pills he was prescribed 4 days before the methadone ingestion were gone.

An autopsy was performed. The pathology diagnosis was methadone intoxication. The toxicology report noted positive findings for methadone: 0.42 mg/L. His urine test findings were positive for methadone, methadone metabolite, and cocaine metabolite. He also had a high level of methadone in his stomach. A follow-up toxicology panel showed him to have relatively small amounts of Ativan in his blood and stomach. No blood alcohol content could be detected.

Legal Basis of Claim

The defendants violated the applicable standard of care while Johnny was in the ED by not admitting him to the hospital and by discharging him home after his presentation with an overdose of methadone and related symptoms.

"Police were notified, and they searched the home, finding empty liquor bottles and 2 empty Ativan bottles in Johnny's room. The 90 Ativan pills he was prescribed 4 days before the methadone ingestion were gone."

Commentary

The long and short of it is that methadone is a long-acting opioid, and the plaintiffs believe that Johnny's overdose 35 hours earlier was the cause of his death. Of particular importance in the medical record was Johnny's respiratory rate, his reported vomiting, whether he was in fact actually ambulatory, the lack of urine toxicology findings, and the way he looked in a photo that the family took of him at 2:30 a.m. on the day he presented to the ED.

The suit filed 15 months after Johnny's death named Dr. Ange, Responsive Emergency Medicine, and St. Jacob's Hospital as defendants.

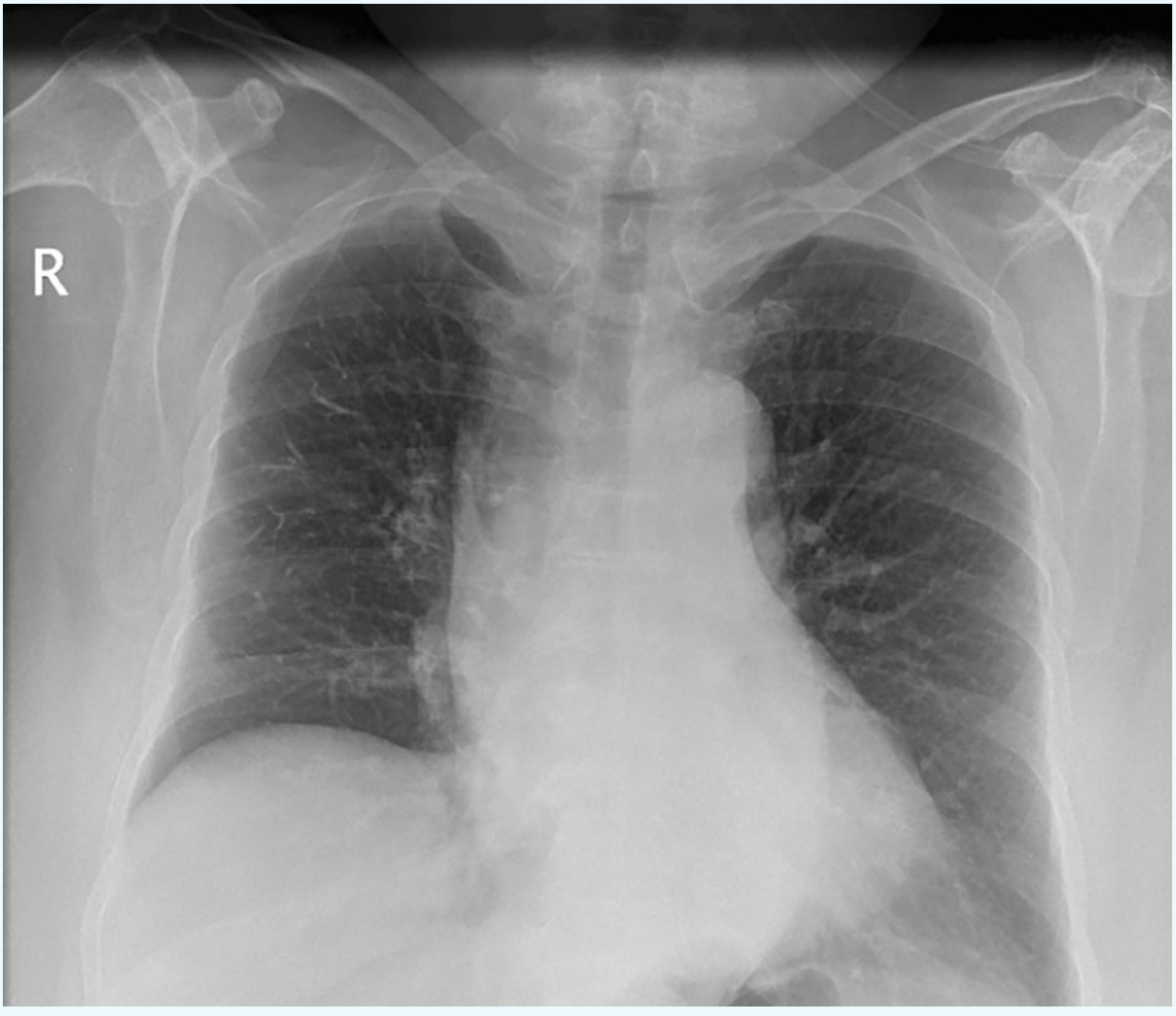
In the next issue, I will discuss the relevant lessons for urgent care to be learned from preparation for the trial, including the expert witness's testimony, the family's testimony, and the motions filed by both sides. ■

INSIGHTS IN IMAGES

CLINICAL CHALLENGE: CASE 1

This feature will challenge your diagnostic acumen with a glimpse of x-rays, electrocardiograms, and photographs of conditions that real urgent care patients have presented with.

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

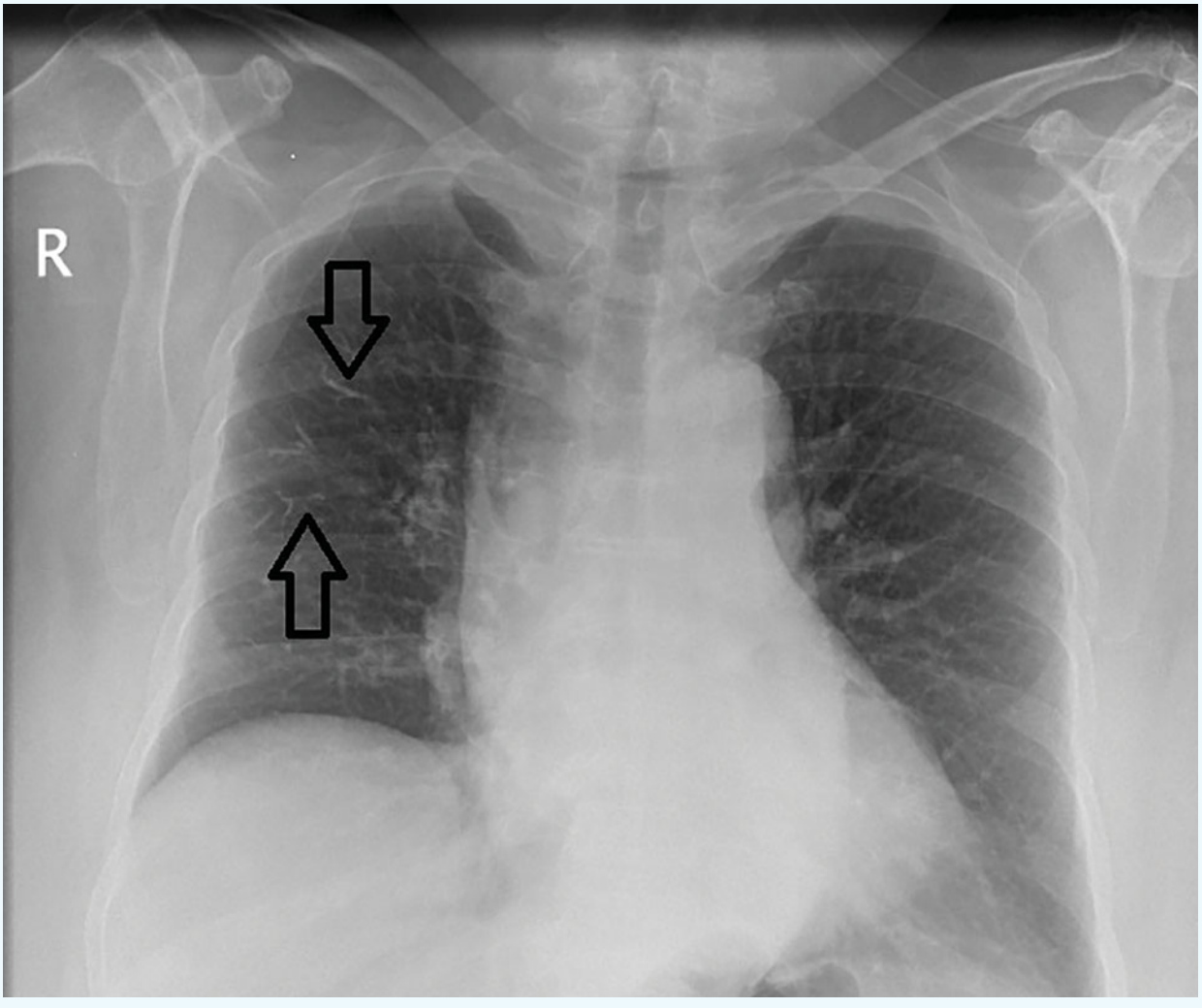


The patient presented with an upper respiratory infection after vertebroplasty. A chest x-ray was ordered to rule out pneumonia.

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

Resolution of the case is described on the next page.

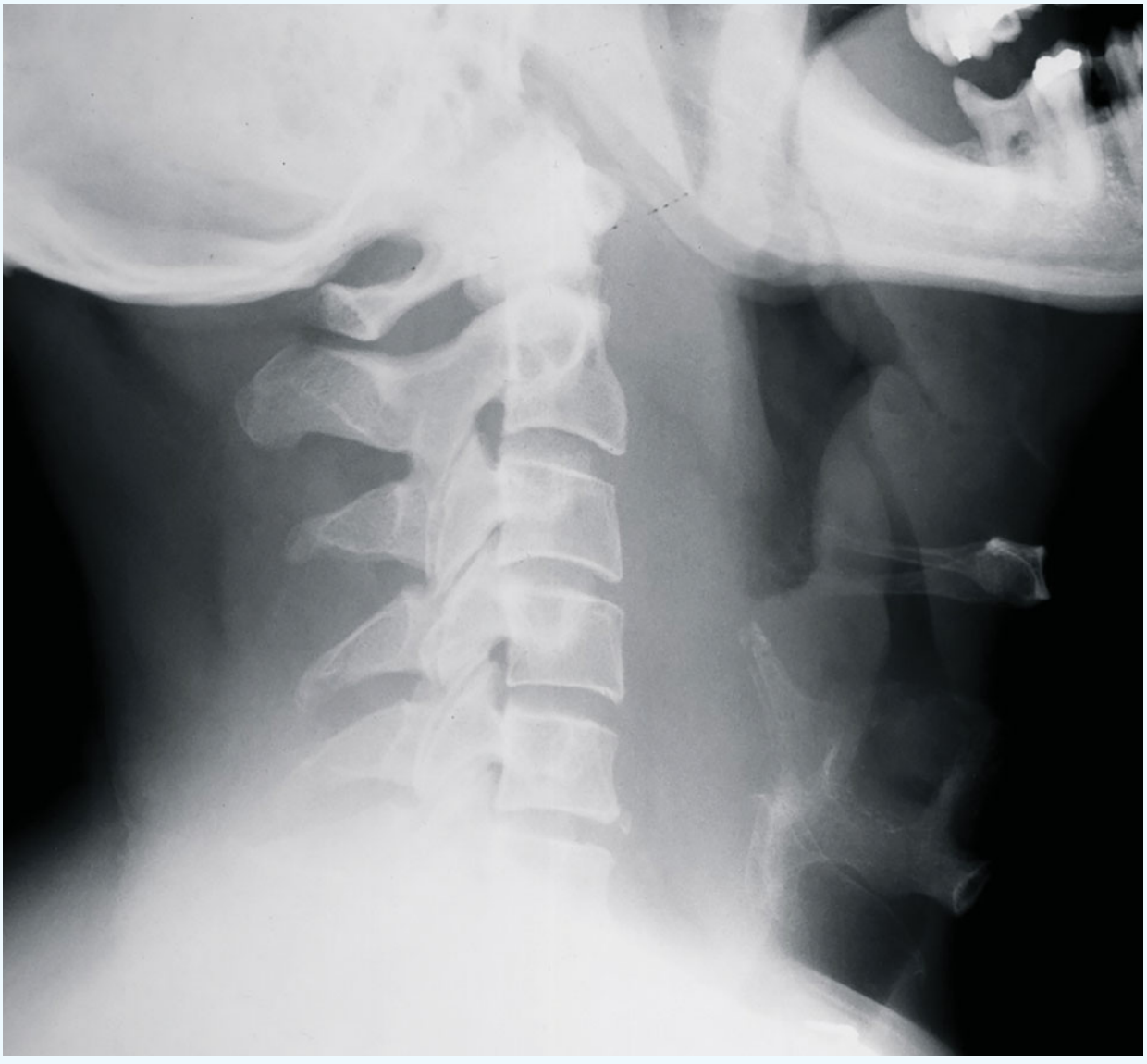
THE RESOLUTION



Diagnosis: Cement embolus. Note the several thin linear densities in the right mid-lung (**Figure 2)**. These represent vertebroplasty cement particles that have embolized into distal pulmonary artery branches. Patients are usually asymptomatic, and treatment is supportive, though some require anticoagulation or embolectomy. Most cases resolve within 1 year. Computed tomography chest x-rays should be obtained to rule out cardiac complications, including perforation.

INSIGHTS IN IMAGES

CLINICAL CHALLENGE: CASE 2

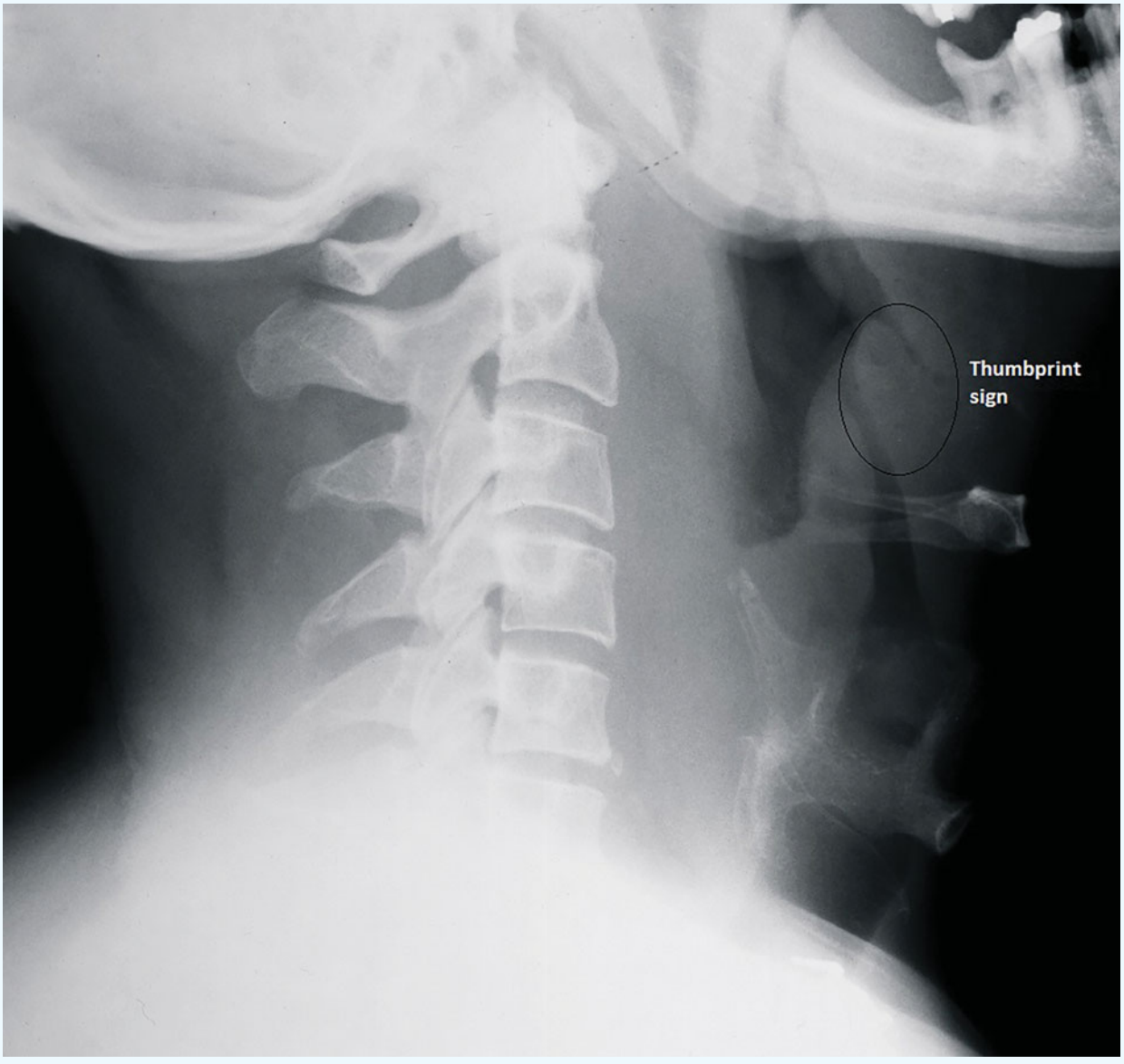


The patient presented with fever and difficulty swallowing. He was visibly anxious, leaning forward on the examination table and spitting into a cup.

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

Resolution of the case is described on the next page.

THE RESOLUTION



Diagnosis: Epiglottitis. The film (**Figure 2**) demonstrates the classic thumbprint sign associated with epiglottitis. There has been a recent resurgence of cases of this condition that was largely eliminated in the vaccine era. Vaccine avoidance because of concern over adverse effects has been identified as one contributor. Early airway management and emergency transfer are indicated when there is an underlying systemic abnormality.

ABSTRACTS IN URGENT CARE

- Strict Rest Unnecessary After Concussion
- New Antibiotic: Teixobactin
- Parameters for Managing Atypical Presentations of Anaphylaxis

SEAN M. McNEELEY, MD

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

Strict Rest Unnecessary After Concussion

Key point: strict rest after a concussion offers no advantage over standard stepwise return to play.

Citation: Thomas DG, Apps JN, Hoffmann RG, et al. Benefits of strict rest after acute concussion: a randomized controlled trial. *Pediatrics* 2015;135:213–223.

Concussion treatment has been frequently debated. In this prospective study, patients with concussion were treated with either strict rest for 5 days or standard stepwise return to play. A total of 88 patients completed the study, 45 in the intervention group and 43 in the control group. There were no statistical differences between the groups regarding neurocognitive or balance outcomes. The intervention group missed more days of school and sports participation. For the urgent care provider, these findings will help temper the tendency to prescribe strict rest after concussions. Rest is good, but strict rest seems to provide no additional benefit. ■

New Antibiotic: Teixobactin

Key point: New antibiotics may be on the way.

Citation: Ling LL, Schneider T, Peoples AJ, et al. A new antibiotic kills pathogens without detectable resistance. *Nature*. 2015;517:455–459.

Researchers have found a new antibiotic, teixobactin. Starting with penicillin, there has been a cycle in which new antibiotics are introduced and then the bacteria that they target develop resistance. Most antibiotics were found by cultivating soil microorganisms, but overuse in the 1960s led to a halt in production of unique antibiotics from this source. Unfortunately, 99% of microorganisms needed for new antibiotics cannot be cultured in the laboratory. However, the authors developed new ways to grow these uncultured organisms, discovering teixobactin in the process. They report no resistance to teixobactin from *Staphylococcus aureus*. This development provides a bit of hope to urgent care providers. ■

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

Parameters for Managing Atypical Presentations of Anaphylaxis

Key point: Atypical presentation of anaphylaxis must be considered, to avoid a missed diagnosis.

Citation: Campbell RL, Li JT, Nicklas RA, et al; Practice Parameter Workgroup. Emergency department diagnosis and treatment of anaphylaxis: a practice parameter. *Ann Allergy Asthma Immunol*. 2014;113:599–608. Available from: http://www.annallergy.org/article/S1081-1206(14)00743-1/pdf

A practice parameter has been created for emergency treatment of anaphylaxis by researchers representing three allergy and immunology organizations. Considering the emergent nature of this reaction and the potential for presenting to an urgent care center, clinicians should consider a complete review of the document. The group made many important recommendations, including the following:

- Basing diagnosis on the medical history and physical examination findings rather than waiting for signs of shock
- Using the supine position for patients, except for pregnant patients, who should lie on the left side
- Administering epinephrine intramuscularly in the anterolateral thigh
- Administering antihistamines and steroids rather than epinephrine
- Instructing patients to follow up with an allergist after discharge ■

CODING Q&A

Drug Screen Codes and New Medicare Modifiers

DAVID STERN, MD, CPC

Q. I was told that we can no longer use code 80100 for drug screens. We have several employers who send employees and potential employees to our urgent care center for pre-employment, random, and post-accident drug screens. What code should we use now?

A. Effective January 1, 2015, several drug-screen *Current Procedural Terminology* (CPT) codes were deleted by the American Medical Association:

- **80100:** "Drug screen, qualitative; multiple drug classes chromatographic method, each procedure"
- **80101:** ". . . . single drug class method (e.g., immunoassay, enzyme assay), each drug class"
- **80104:** ". . . . multiple drug classes other than chromatographic method, each procedure"
- **80102:** "Drug confirmation, each procedure"
- **80103:** "Tissue preparation for drug analysis"

Drug-screen procedures are now divided into three subsections: Therapeutic Drug Assay, Drug Assay, and Chemistry. Code selection depends on the purpose and type of result obtained.

Therapeutic drug assays are performed to monitor clinical response to a known, prescribed medication. The two major categories for drug testing in the Drug Assay subsection are

1. **Presumptive Drug Class procedures:** These are used to identify possible use or nonuse of a drug or drug class. A presumptive test may be followed by a definitive test to specifically identify drugs or metabolites.
2. **Definitive Drug Class procedures:** Qualitative or quantitative tests to identify possible use or nonuse of a drug. These tests identify specific drugs and associated metabolites. A presumptive test is not required prior to a definitive drug test.

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

"The two major categories for drug testing in the Drug Assay subsection are Presumptive Drug Class procedures and Definitive Drug Class procedures."

Drugs or classes of drugs may be commonly assayed first by a presumptive screening method (CPT codes 80300 through 80304) and followed by a definitive drug identification assessment. Drugs are divided into two classes, A and B (Table 1). Presumptive drug class procedure codes are as follows:

- **80300:** "Drug screen, any number of drug classes from Drug Class List A; any number of non-thin layer chromatography (TLC) devices or procedures (e.g., immunoassay) capable of being read by direct optical observation, including instrument-assisted when performed (e.g., dipsticks, cups, cards, cartridges), per date of service."
- **80301:** ". . . . single drug class method, by instrumented test systems (e.g., discrete multichannel chemistry analyzers utilizing immunoassay or enzyme assay), per date of service."
- **80302:** "Drug screen, presumptive, single drug class from Drug Class List B, by immunoassay (e.g., ELISA [enzyme-linked immunosorbent assay]) or non-TLC chromatography without mass spectrometry (e.g., GC [gas chromatography], HPLC [high-performance liquid chromatography]), each procedure."
- **80303:** "Drug screen, any number of drug classes, presumptive, single or multiple drug class method; thin layer chromatography procedure(s) (TLC) (e.g., acid, neutral, alkaloid plate), per date of service."

Table 1. Drug Classes	
A	**B**
Alcohol (ethanol)	Acetaminophen
Amphetamines	Carisoprodol/meprobamate
Barbiturates	Ethyl glucuronide
Benzodiazepines	Fentanyl
Buprenorphine	Ketamine
Cocaine metabolite	Meperidine
Heroin metabolite (6-monoacetylmorphine)	Methylphenidate
Methadone	Nicotine/cotinine
Methadone metabolite 2-ethylidene-1,5-dimethyl-3,3-diphenylpyrrolidine (EDDP)	Salicylate
Methamphetamine	Synthetic cannabinoids
Methaqualone	Tapentadol
Methylenedioxymethamphetamine (MDMA; street name: ecstasy)	Tramadol
Opiates	Zolpidem
Oxycodone	Not otherwise specified
Phencyclidine	
Propoxyphene	
Tetrahydrocannabinol (THC) metabolites (marijuana)	
Tricyclic antidepressants	

- **80304:** ". . . . not otherwise specified presumptive procedure (e.g., TOF [time of flight], MALDI [matrix-assisted laser desorption/ionization], LDTD [laser diode thermal desorption], DESI [desorption electrospray ionization], DART [Drug and Alcohol Random Testing]), each procedure."

If a drug class does not appear in list A or list B and it is not performed by TLC, use code 80304 unless the specific analyte is listed in the Chemistry section (codes 82009 through 84830). See CPT codes 80320 through 80377 for definitive drug testing and CPT codes 80150 through 80299 for therapeutic drug assays. ■

Q. I was told that Medicare has new code modifiers in place of modifier -59. What are the new modifiers, and when should I start using them?

A. Effective January 1, 2015, Centers for Medicare & Medicaid Services (CMS) introduced four new Healthcare Common Procedure Coding System (HCPCS) modifiers that will further refine modifier -59, "distinct procedural service." According to CMS, modifier -59 is the most widely used modifier and is used inappropriately in many cases.

The CPT mandates the use of modifier -59 when "under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M [non–evaluation and management] services performed on the same day." It is used in circumstances that identify services performed in different procedures and different anatomic sites on the same day by the same provider. Thus, CMS decided to establish the new modifiers to define specific subsets of the -59 modifier referred to collectively as -X{EPSU} modifiers:

- **XE separate encounter:** A service that is distinct because it occurred during a separate encounter
- **XS separate structure:** A service that is distinct because it was performed on a separate organ or structure
- **XP separate practitioner:** A service that is distinct because it was performed by a different practitioner
- **XU unusual non-overlapping service:** The use of a service that is distinct because it does not overlap usual components of the main service

"Modifier -59 is used in circumstances that identify services performed in different procedures and different anatomic sites on the same day by the same provider."

These new modifiers took effect January 1, 2015; however, as of the time this column was written, CMS was not *requiring* use of these modifiers. Instead, CMS is encouraging providers to make a "rapid migration" to the new modifiers. CMS can be expected to require a specific -X modifier for certain code pairs. Unfortunately, it has not provided more specific guidance with case examples. CMS is allowing its contractors to edit for and require more selective modifiers in lieu of modifier -59. I encourage you to contact your local Medicare administrative contractors (MACs) with specific examples. To see the official instructions issued to your MAC regarding this change, download the document at http://www.cms.gov/Regulations-and-guidance/Guidance/Transmittals/Downloads/R1422OTN.pdf from the CMS website. ■

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MEDICAL EQUIPMENT

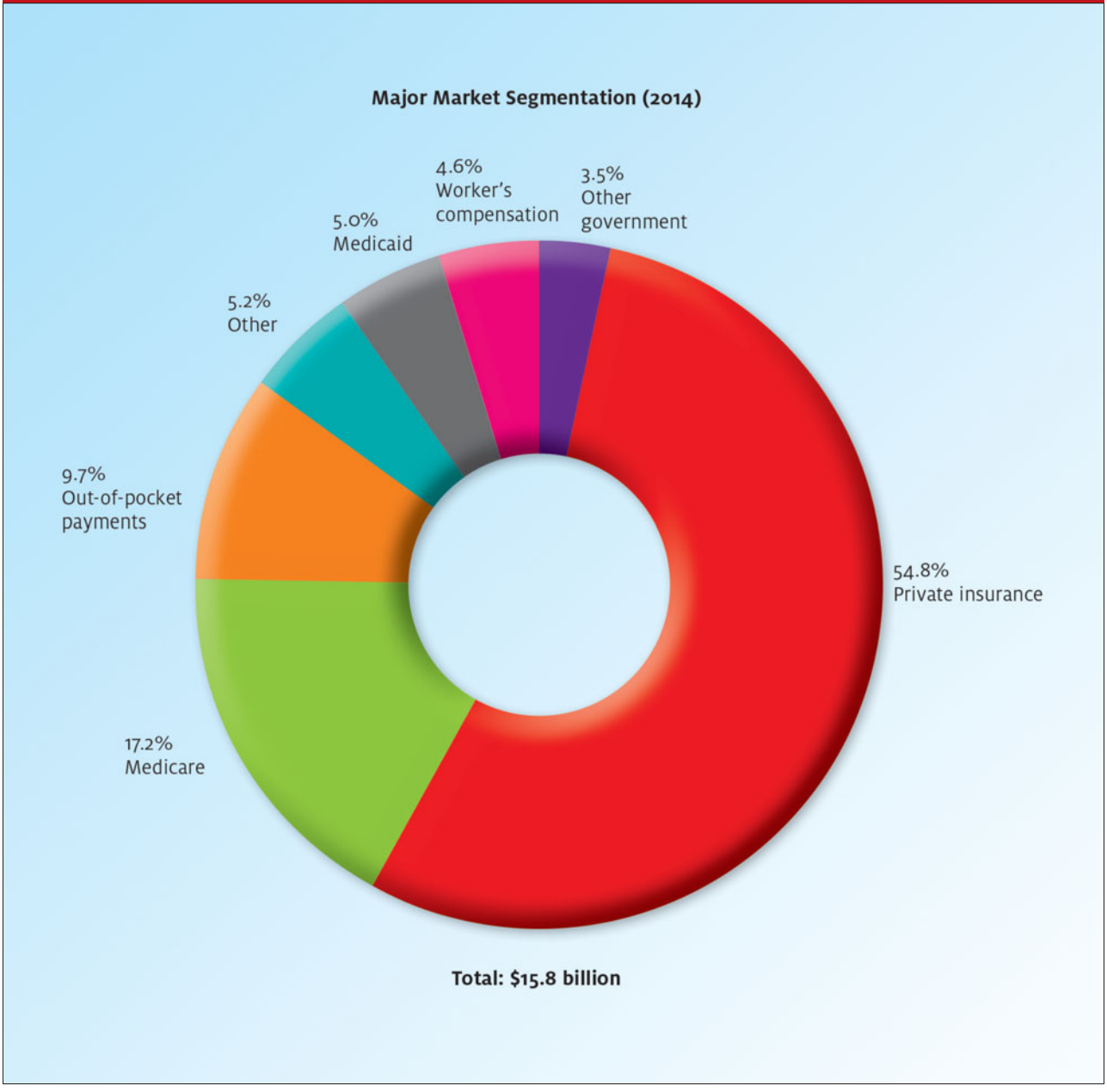
MEDICAL EQUIPMENT

DEVELOPING DATA

Data from the IBISWorld Industry Report *Urgent Care Centers in the US, March 2014* show that the urgent care market can be segmented by the source of payment for services. On the basis of data from the U.S. Census Bureau, IBISWorld finds that the main sources of revenue for urgent care are private insurance, Medicare, patients (out-of-pocket payments), and Medicaid. Private insurance accounted for about 54.8% of industry revenue in 2014. Many private insurance companies have encouraged their clients to use urgent care centers rather than high-cost emergency departments for noncritical health conditions.

Source: IBISWorld Industry Report: *Urgent Care Centers in the US, March 2014*.

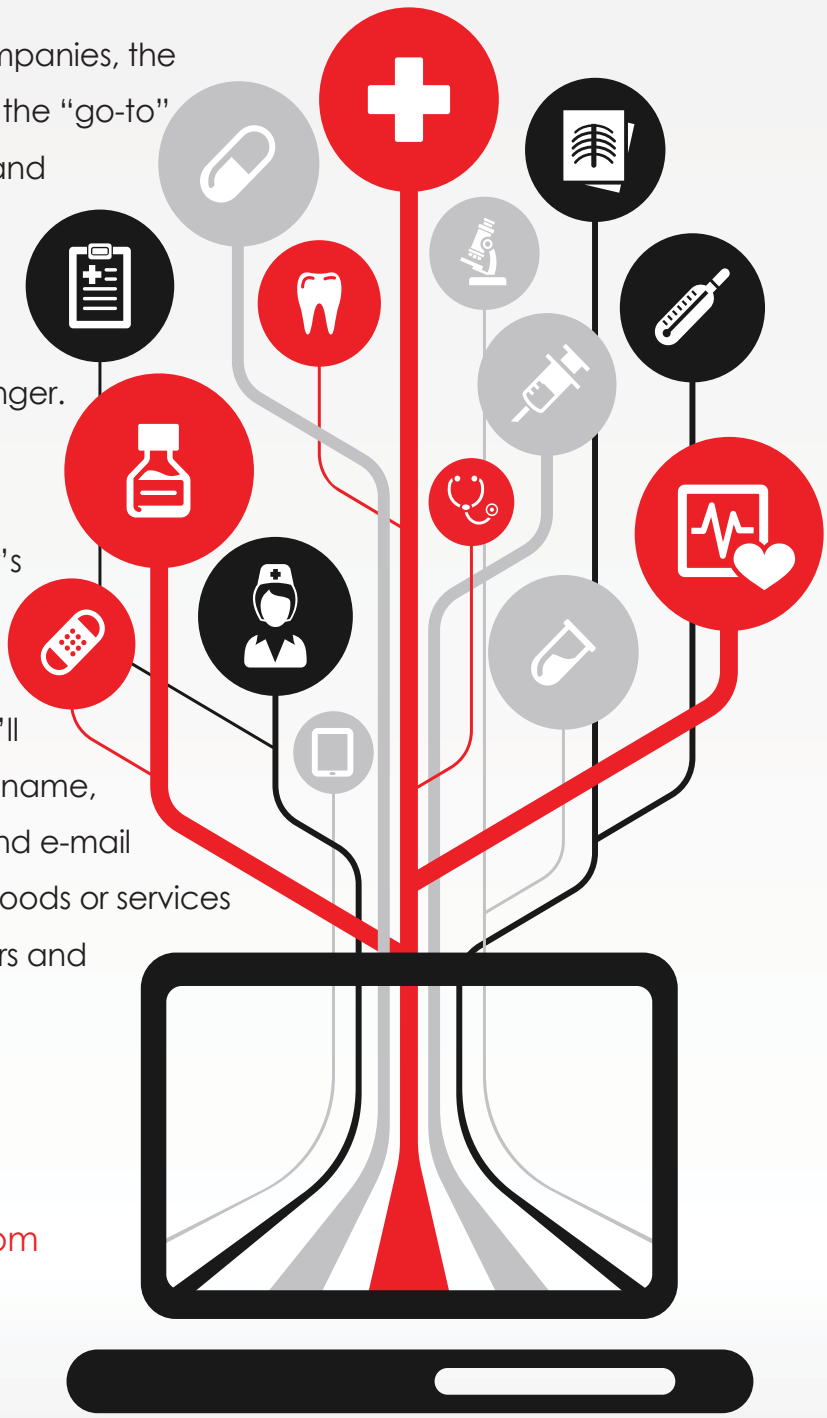
URGENT CARE MARKET SEGMENTATION BY PAYMENT SOURCE IN 2014.



UC+BG URGENT CARE Buyer's Guide™

One-Stop Shopping for All Your Urgent Care Needs

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



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

www.urgentcarebuyersguide.com

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