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Urgent Care
Association
of America



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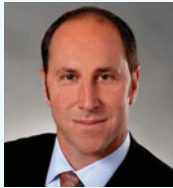
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LETTER FROM THE EDITOR-IN-CHIEF

“Why Are You Calling Me?”

The Problem with Patient Transfers in Urgent Care



According to the 2012 Benchmarking Survey from the Urgent Care Association of America, about 4% of urgent care patients are referred to an emergency department (ED) for ongoing care. Some get there by personal vehicle, and others are transferred by emergency services, private ambulance, or other critical-care transportation. Given an average patient volume of 40 patients per day for a single urgent care center, that is 1.5 ED transfers per day. Every day, we are involved in emergency hand-offs, yet not much has been reported about how well we are doing. It is well known that effective communication is critical to the quality and safety of patient-care hand-offs.

Although most urgent care centers have electronic medical records, very few of these are linked to local and regional hospitals. That means all communication about transfers is done by phone, written discharge instructions, or, more frequently, not at all. How did we get here? What has transpired to create such a gaping hole in emergency-care coordination? What can be done to fix this mess?

Three main stressors contribute to poor communication during urgent care to ED transfers: poor professional relationships and culture, work-flow and productivity issues, and inadequate resources and directives.

Poor Professional Relationships and Culture

We have all been the victims of berating and condescending ED physicians, and quite frankly, such a situation is likely to be the largest contributor to communication failures. In an effort to protect ourselves, we simply do not call unless we feel it is absolutely necessary. For example, a patient with abdominal pain whom you determine needs a computed tomography scan and a surgical consult is stable at the time of transfer. You anticipate a barrage of questions and second-guessing from the ED physician that produce no benefit for anyone, including the patient. Instead, you print your note and discharge instructions clearly documenting your reason for transfer. Now it is the hospital's risk to bear if no one there follows through on your recommendations. To add insult to injury, the ED staff members take great pleasure in telling patients: “That urgent care doesn't know what

it's doing.” To be honest, we have all taken very little time and completed very little training in transfer communication skills, and we could probably do a better job if we developed this skill. Or perhaps the whole relationship is just too broken to fix.

Work-Flow and Productivity Issues

It has become increasingly difficult to take the time necessary for effective transfer communication. Both the ED physician and the urgent care practitioner are simply too busy. Treating 40 to 50 patients per day requires such an efficiency of flow that even 1 or 2 transfers can completely disrupt the day if we are not careful. These patients have already consumed limited resources and time, and the urgent care physicians can ill afford to spend more. Likewise, the ED physicians are overworked and understandably distracted by patients in critical condition. There is a palpable “this had better be good” tone in their voices whenever they pick up the phone. Everyone loses in this scenario.

Inadequate Resources and Directives

Many large health-care systems have transfer command centers, but such vital resources are still somewhat limited in community hospitals and rural settings. This leads to massive gaps in communication unless the urgent care physician takes the time to inform all parties about the transfer. Making matters worse, most hospitals lack specific policies and expectations regarding transfer communications. This confusion exacerbates the already strained relationships between most urgent care centers and EDs.

It is in everyone's interest to develop effective solutions. Any improvement should have a considerable impact on quality, safety, risk, and our relationship with our emergency medicine colleagues. In my next column, I will discuss the specific steps necessary to achieve dynamic results. ■

Lee A. Resnick, MD, FFAFP

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



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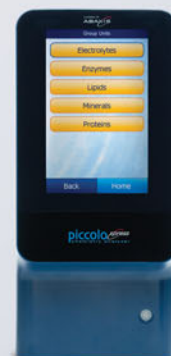
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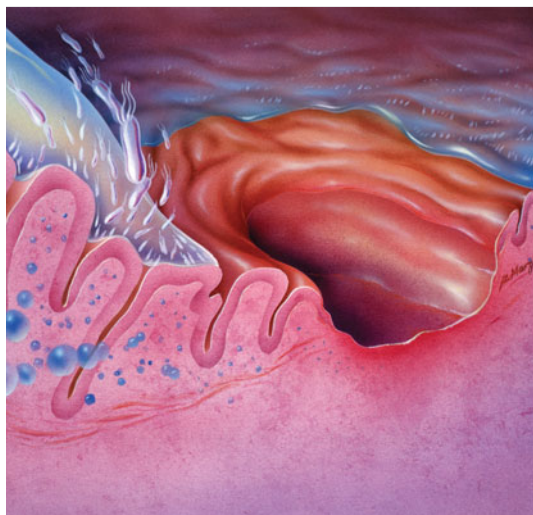
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CLINICAL

8 Upper Gastrointestinal Disorders in Urgent Care, Part 1: Gastritis, Peptic Ulcer Disease, and *Helicobacter pylori*

Is it dyspepsia, cholelithiasis, lymphoma, or pancreatitis? No, but it just might be gastritis or peptic ulcer disease.

Tracey Q. Davidoff, MD

◀ *Peptic ulcer disease: Helicobacter pylori at the site of gastritis, polymorphonuclear leukocyte infiltration, and peptic ulceration.*

PRACTICE MANAGEMENT



23 Recognizing Employee Disengagement and Taking Steps to Re-engage

Rampant employee disengagement can destroy your urgent care center's reputation and thus its profit margin. Learn how to turn attitudes around.

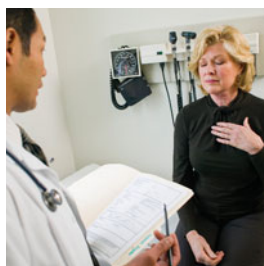
Alan A. Ayers, MBA, MAcc

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33 Aortic Dissection

Chest pain in young adults is often benign, but aortic dissection can sometimes be difficult to spot.

Zana Alattar and
John Shufeldt, MD, JD, MBA, FACEP



IN THE NEXT ISSUE OF JUCM

Our series on gastrointestinal disorders in urgent care continues, taking practitioners through evaluation, diagnosis, and disposition of gallbladder disease and acute pancreatitis.

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JUCM The Journal of Urgent Care Medicine supports the evolution of urgent care medicine by creating content that addresses both the clinical practice of urgent care medicine and the practice management challenges of keeping pace with an ever-changing 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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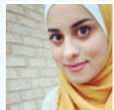


JUCM CONTRIBUTORS

In part 1 of our series on gastrointestinal disorders in urgent care, Tracey Q. Davidoff, MD, focuses on gastritis and peptic ulcer disease (PUD), which can range from mild to serious and can indicate other health issues. This article takes you through gathering a thorough disease history and performing a detailed physical examination, necessary because both conditions can be mistaken for quite a few other entities. You will find helpful tables detailing causes of gastritis, alarm signs in PUD, and aspects of PUD in several special populations. In part 2 of the series next month, Davidoff will concentrate on pancreatitis and gallbladder disease.



Davidoff is an urgent care physician at Accelcare Medical Urgent Care in Rochester, New York, is on the Board of Directors of the Urgent Care College of Physicians, and is a member of the editorial board of the *Journal of Urgent Care Medicine*.



In this month's case report, Zana Alattar and John Shufeldt, MD, JD, MBA, FACEP, write about a thin, athletic, 44-year-old woman who presented to an urgent care center with sudden-onset chest pain that had started the prior evening. The diagnosis: aortic dissection, Stanford type B. The authors note that aortic dissection can be easy to miss, so it may be necessary to do a lot of detective work to dig up pertinent information in the patient's family history.

Alattar is a premed undergraduate student at Arizona State University in Tempe, Arizona. Shufeldt is principal at Shufeldt Consulting in Scottsdale, Arizona, and is on the editorial board of the *Journal of Urgent Care Medicine*.

Attitudes really are catching. When the frontline staff and health-care providers in your urgent care center are fully engaged in their work—when they are eager to start each workday—it

shows, and patients respond well by returning for additional care and by telling everyone how wonderful your center is. But when they are disengaged, doing their work grudgingly, their attitudes will drive patients away and your profit down. This month's Practice Management feature, by Alan A. Ayers, MBA, MACC, helps you recognize employee disengagement and take steps toward re-engagement.



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**, continues the journey through a medical malpractice trial, taking readers through pretrial events, including testimony from experts. Next month, we will learn about the trial and its outcome, within the context of the state of medical malpractice in the United States.

Sean M. McNeeley, MD, and the **Urgent Care College of Physicians** review new abstracts from the literature on several issues: the return of measles, *Fusobacterium necrophorum* in adolescents, the possible connection between varicella zoster virus and giant cell arteritis, administration of epinephrine in schools, and new pregnancy and lactation labeling for medications.

In Coding Q&A, **David Stern, MD, CPC**, discusses the new code modifier -X from the Centers for Medicare & Medicaid Services, and reimbursement limits on pneumonia vaccines.

Our Developing Data piece breaks down the U.S. urgent care patient population by age group. ■

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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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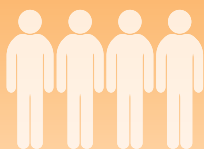
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Urgent care centers are encouraged to host community events and staff activities during the week of May 18-22. Visit ucaoa.org for ideas and resources to start your planning process.

Get social about National Urgent Care Awareness Month, share your center's activities with UCAOA and be sure to use #UrgentCare. [f](#) [in](#) [t](#)



FROM THE UCAOA PRESIDENT

Two Years Too Fast

■ NATHAN NEWMAN, MD, FAAFP

As my 2-year term as UCAOA president draws to a close, I am amazed that it has flown by so quickly. Wasn't it just the other day that Dr. Marc Salzberg passed the gavel to me? I recall visions of a redesigned organizational structure, making use of committee work rather than having the board of directors get in the weeds, which would optimize all of the hard work from team UCAOA.

We planned to raise awareness of the benefits of urgent care medicine in our communities, hold off regulatory and legislative challenges, be an educational resource for all members large and small, and work to stabilize reimbursement. I imagined an organization supporting parallel initiatives in education, advocacy, patient safety, new service lines, and integration of UCAOA with other large organizations in medicine.

In looking back, it is apparent that we did so much more! Our committee chairs boosted volunteerism by seeking out interested urgent care leaders. They developed goals and objectives to meet our 3-year strategy. These are some of our successes:

■ **Accreditation/Certification Committee:** There are now more than 775 certified centers, and more than 127 centers have been surveyed and have received UCAOA accreditation. The addition of accreditation has filled a true need, because many US regions are reporting that insurers now require accreditation.

■ **Health and Public Policy Committee:** We met with Centers for Medicare & Medicaid Services to ensure that urgent care clinicians would avoid a penalty because the Physician Quality Reporting System benchmarks are primary-care driven. We also partnered with members in New York and hired a lobbyist to thwart a regulatory and legislative push to require Certificates of Need, emergency medicine training, and Medicaid participation for urgent care centers.

■ **Strategic Development Partnership Committee:** We worked with the American Academy of Family Physicians and the American Academy of Pediatrics for policies on

emergency preparedness and met with their leadership on future partnering opportunities. Also, we brought in our first two Diamond Corporate Support Partners (DocuTAP and Practice Velocity) and developed an Exhibitor Advisory Committee to enhance the opportunities for exhibitor feedback and input. Now we boast the largest urgent care exhibit hall for participants ever!

■ **Education Committee:** We have enhanced our Fall Conference, adding new educational tracks such as Health Reform, Hands-On Splinting/Casting, Suturing, and Department of Transportation certification classes. Our Spring Convention and Fall Conference are the most well-attended events in the history of UCAOA!

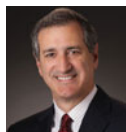
■ **Public Relations Committee:** We have now placed stories in *USA Today*, *The New York Times*, *Forbes Magazine*, and many other news outlets, and local television news coverage of urgent care's role in Ebola was picked up nationally. The UCAOA Benchmarking Survey is the top source of urgent care information in the United States, and the 2014 survey had more participating centers than ever before.

■ **Membership Committee:** We now have the most members in our history, and new types of membership are available. The initiation of UCAOA state chapters will add a national presence to members' local issues.

Now we are set for a new team to take the controls. Recognizing the importance of diversity, our board of directors voted unanimously that UCAOA leadership may now include a non-physician president; however, the core majority of our board of directors will remain physicians.

Last—but far from least—is the growth and maturity of our UCAOA staff. Without this, no progress toward any of our goals would have been possible.

Thank you for this great opportunity to lead. As Sir William Osler said, "The best preparation for tomorrow is to do today's work superbly well." Team UCAOA certainly has done so! ■



Nathan Newman, MD, FAAFP, serves as president of the Urgent Care Association of America. He took office in 2013, and his term ends in 2015. He is Vice President of Medical Services of Righttime Medical Care in Annapolis, Maryland.

Upper Gastrointestinal Disorders in Urgent Care, Part 1: Gastritis, Peptic Ulcer Disease, and *Helicobacter pylori*

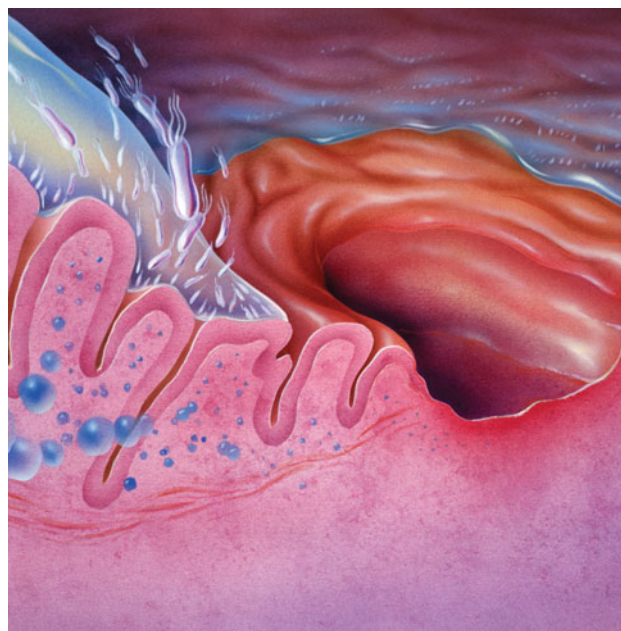
Urgent message: Gastritis and peptic ulcer disease are a spectrum of diseases that can range from mild to serious; urgent care providers must be on the alert for these conditions. Early diagnosis and treatment, along with recommendations for follow-up care with appropriate specialists, can help prevent long-term sequelae.

TRACEY Q. DAVIDOFF, MD

Gastritis and peptic ulcer disease (PUD) represent a continuum along a path of inflammation of the gastric mucosa, from superficial irritation of the stomach lining to full-blown ulceration with perforation or penetration. They are caused by varying degrees of disruption of the aggressive and defensive factors that maintain the integrity of the mucosa. Aggressive factors include gastric acid and pepsin, and defensive factors include mucus and bicarbonate. For the urgent care practitioner, it is imperative to recognize the alarm symptoms that may represent more serious disease progression. Identifying patients who are less ill and may benefit from treatment, starting that treatment, and suggesting appropriate follow-up measures are the keys to urgent care management of these conditions.

Gastritis

The term *gastritis* encompasses a broad spectrum of entities caused by inflammatory changes in the gastric



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Tracey Q. Davidoff, MD, is an urgent care physician at Accelcare Medical Urgent Care in Rochester, New York, is on the Board of Directors of the Urgent Care College of Physicians, and is a member of the JUCM Editorial Board.

mucosa. The clinical presentation is similar for many of them, but it differs histologically when samples of inflamed tissue are viewed under the microscope. The

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inflammation may involve the entire stomach or only specific regions. Gastritis may be erosive (superficial, deep, or hemorrhagic) or non-erosive; the latter type is mostly caused by infection with *Helicobacter pylori*.

Gastritis is common in the United States, accounting for approximately 2 million physician visits annually. Patients older than 60 years are more likely than younger patients to have gastritis. The disease affects all age groups and both sexes. Although patients with *H. pylori* are more likely to have gastritis, not all patients with gastritis will have positive test findings for *H. pylori*.¹

Many factors can cause erosive gastritis (**Table 1**), although nonsteroidal anti-inflammatory drugs (NSAIDs) and aspirin are the most common agents. Both oral and systemic administration of these drugs at any dosage, either therapeutic or supratherapeutic, may cause gastritis. The gastric mucosa exhibits hemorrhages, erosions, and ulcerations when viewed on endoscopy. Long-term effects include fibrosis and stricture.

The effect of *H. pylori* results from chronic rather than acute infection. It is usually acquired in childhood, and the percentage of infected individuals increases with age. It is found in 20% of those younger than 40 years with gastritis or PUD and in 50% of those older than 60 years. Transmission is thought to be from person to person through the oral–fecal route or through the ingestion of contaminated water or food. This explains

the increased prevalence in lower socioeconomic groups. *H. pylori* infection is asymptomatic unless the patient has developed gastritis or PUD.

The acute symptoms of uncomplicated gastritis include abdominal pain, epigastric discomfort, nausea, vomiting, loss of appetite, belching, and bloating. Fever, chills, and hiccups may also be present. Symptoms may be indistinguishable from peptic ulcer disease, and no specific symptom makes one more likely than the other.² Oddly enough, however, most patients with histologic evidence of acute gastritis are asymptomatic.¹ The diagnosis is frequently made during endoscopy that is being performed for other indications.

History of Present Illness

In obtaining a thorough history of the current illness, ask about the following:

- Gnawing or burning epigastric discomfort that may be described as aching, as a hungry feeling, or as an empty feeling
- Nausea and/or vomiting
- Pain that awakens the patient at night
- Symptoms relief achieved with food, milk, or antacids
- Specific food intolerances, although no specific food is pathognomonic
- Previous history of gastritis, PUD, or *H. pylori*
- History of eating raw fish
- Exposure to aggravating drugs or chemicals such as NSAIDs or steroids, even a single dose
- Routine use of aspirin or NSAIDs
- Alcohol use, which may cause gastritis, generally considered a separate disease process (beyond the scope of this article)
- Alarm symptoms signifying more serious disease; these are the same as for peptic ulcer disease (**Table 2**)

Physical Examination

Be aware of the following points when conducting a physical examination:

- Normal findings are most likely
- Mild midepigastric abdominal tenderness
- More abnormalities may develop if the patient develops complications such as gastrointestinal (GI) bleeding, perforation, and penetration.
- Alarm findings on examination
- Hypotension
- Pallor
- GI bleeding or heme-positive stools

Table 1. Causes of Gastritis

Drugs • NSAIDs • Alcoholic beverages • Bile • Acetaminophen, especially in combination with NSAIDs • Bisphosphonates • Glucocorticoids • Clopidogrel and other antiplatelet drugs • Sirolimus • Spironolactone • SSRIs • 5-fluorouracil	Ischemia Acute stress Infection • Bacterial • Fungal • Viral Radiation Allergy Food poisoning Trauma
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Data from Soll AH, Vakil NB. Unusual causes of peptic ulcer disease. Waltham (MA): Wolters Kluwer Health, UpToDate. © 2015 [updated 2014 June 11; cited 2015 January]. Available from: http://www.uptodate.com/contents/unusual-causes-of-peptic-ulcer-disease?source=search_result&search=peptic+ulcer+disease&selectedTitle=6~150, and from Wehbi M. Acute gastritis. New York (NY): WebMD Health Professional Network, Medscape. © 2015 [updated 2014 September 18; cited 2015 January 8]. Available from: <http://emedicine.medscape.com/article/175909-overview>. NSAID = nonsteroidal anti-inflammatory drug; SSI = selective serotonin reuptake inhibitor.

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Table 2. Alarm Symptoms in Gastritis and Peptic Ulcer Disease

Symptom or Sign	Complication
Anemia	Bleeding
Hematemesis	
Melena	
Heme-positive stools	
Vomiting	Obstruction
Anorexia	Carcinoma
Weight loss	
Early satiety	
Progressive dysphagia or odynophagia	
History of gastrointestinal cancers	Penetration
Persisting upper abdominal pain	
Radiation of pain to the back	Perforation
Severe, sharp upper abdominal pain	
Spreading upper abdominal pain	

Data from Ramakrishnan K, Salinas R. Peptic ulcer disease. *Am Fam Physician*. 2007;76:1005–1012; Soll AH, Vakil NB. Overview of the natural history and treatment of peptic ulcer disease. *UpToDate* [website]. Baltimore, MD: Wolters Kluwer Health [last updated 2013 February 2; accessed 2015 January 5]. Available from: http://www.uptodate.com/contents/overview-of-the-natural-history-and-treatment-of-peptic-ulcer-disease?source=search_result&search=peptic+ulcer+disease&selectedTitle=1~150; Anand BS. Peptic ulcer disease. *Medscape* [website]. New York, New York: Medscape, LLC [accessed 2015 January 11]. Available from: <http://emedicine.medscape.com/article/181753-overview#showall>; and Gratton MD. Peptic ulcer disease and gastritis. In: Tintinalli JE, Stapczynski JS, Cline DM, et al, editors. *Tintinalli's Emergency Medicine*, 7th ed. New York, New York: McGraw-Hill Professional. 2010:554–557.

- Severe abdominal tenderness, rebound, guarding, or other signs of acute abdomen

Differential Diagnoses for Both Gastritis and Peptic Ulcer Disease

Gastritis and PUD can be mistaken for quite a few entities:

- Dyspepsia
- Irritable bowel disorder
- PUD
- Cholelithiasis
- Crohn disease
- Gastric cancer
- Viral gastroenteritis
- Lymphoma
- Pregnancy
- Sarcoidosis
- Pancreatitis^{1,3}

No work-up may be necessary in the urgent care center

if the provider has a high index of suspicion and no alarm symptoms are present (Table 2). In the acutely ill patient, it may be helpful to rule out other disease processes with a complete blood count, liver and kidney function tests, amylase and lipase tests, pregnancy test, and stool test for occult blood. Tests for *H. pylori* (see the section “Testing for *Helicobacter pylori*”) may be indicated. Radiographic studies are generally not useful in an urgent care center unless it is suspected that the patient has a perforation. In that case, an upright chest radiograph will suffice to document the presence or absence of free air. Barium radiography may be of use diagnostically but should generally be ordered by the primary-care physician or gastroenterologist. The American Society for Gastrointestinal Endoscopy guidelines recommend endoscopy for patients older than 50 years with suspected gastritis or PUD with alarm features, such as weight loss and anemia (Table 2). Endoscopy should be considered in symptomatic patients who have negative findings for *H. pylori*, regardless of age.

Treatment of gastritis alone is strictly supportive, unless the disease is caused by *H. pylori*.⁴ NSAIDs, if being used, should be discontinued. When *H. pylori* is present, the patient should be treated for it. Fluids and electrolytes should be replaced if the patient is dehydrated, vomiting, and/or unable to take fluids by mouth.

Acid blocking either with H₂-blockers or proton pump inhibitors (PPIs) may be of benefit in patients in whom it is difficult to treat *H. pylori*, or in those patients suspected of having PUD.

H₂-blockers provide competitive inhibition of histamine at the histamine-2 (H₂) receptor, thereby decreasing gastric acid secretion. This effect suppresses basal gastric acid output as well as acid output stimulated by food and the neurologic system.

PPIs inhibit the proton (acid) pump in the secretory membrane of the parietal cells, thus completely inhibiting acid secretion. They have a long duration of action and are the most effective acid blockers. If cost is a concern, it is helpful to know that PPIs are more expensive than H₂-blockers.

Practitioners should be aware that there is growing concern over the interaction between PPIs and clopidogrel and other antiplatelet agents. A decrease in the antiplatelet activity and increase in adverse cardiac

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events is possible because of an interaction between these 2 classes of drugs. Pantoprazole seems to be the safest choice in these cases.¹ Consultation with the patient's cardiologist is necessary if treatment with a PPI is unavoidable, as would be the case for a patient with gastritis with newly placed cardiac stents.

Peptic Ulcer Disease

PUD occurs most commonly in the stomach and proximal duodenum, and less commonly in the lower esophagus, distal duodenum, and jejunum. It is more common in patients with hypersecretory states such as Zollinger-Ellison syndrome, in patients with hiatal hernias, and in areas of ectopic gastric mucosa such as Meckel diverticulum. Approximately 500,000 persons in the United States are affected with PUD annually, and 70% of them are between the ages of 25 and 64 years. The direct and indirect health-care costs total over \$10 billion annually. Fortunately the incidence is declining, likely due to the increased use of PPIs and the decreasing rate of *H. pylori* infection.³ Improving American diets and the decreasing incidence of smoking may also play a role.

Untreated ulcers may heal spontaneously, and then may recur within a few months. Some are highly symptomatic, and some are asymptomatic. Some ulcers are prone to complications, and some remain refractory to treatment. Prior ulcer history tends to predict future behavior.

More than 48% of cases of PUD can be related to *H. pylori* infection, and 24% of the remaining cases can be related to NSAID use. Other less common causes include steroids, bisphosphonates, 5-fluorouracil, stress, and malignancy. Comorbidities that increase the incidence of PUD include cytomegalovirus or tuberculosis, Crohn disease, cirrhosis, chronic renal failure, sarcoidosis, myeloproliferative disorders, critical illness, a stay in an intensive care unit, surgery, and hypovolemia causing hypoperfusion of the gastric mucosa.⁵ Smoking increases the risk of recurrence of PUD and slows the healing process in established ulcers. **Table 3** outlines concerns of special populations with PUD.

Helicobacter pylori

Most patients with duodenal ulcers have documented *H. pylori* in their gastroduodenal mucosa; however, only 10% to 15% of patients with *H. pylori* infection actually develop PUD. It is believed that these patients are infected with a variety of *H. pylori* that has a chromosomal variance that increases its virulence and ulcerogenic potential. Persons with *H. pylori* have increased resting and meal-stimulated

gastrin levels as well as decreased gastric mucus production and duodenal mucosal bicarbonate secretion, which contributes to ulcer formation. Eradication of *H. pylori* decreases risk of ulcer recurrence from 67% to 6% in duodenal ulcers and from 59% to 4% in patients with gastric ulcers.³ Relapse is generally the rule if *H. pylori* is not treated.

Nonsteroidal Anti-inflammatory Drugs

NSAIDs are the second most common cause of PUD. They cause peptic ulcer disease in two ways, first by direct contact, which causes submucosal erosions, and second, systemically by inhibiting cyclooxygenase, which decreases mucosal protection, bicarbonate secretion, epithelial cell proliferation, and mucosal blood flow. For this reason parenteral NSAIDs may be as deleterious as oral NSAIDs. *H. pylori* increases the intensity of NSAID damage. In chronic NSAID users, the annual risk of a life-threatening ulcer complication is 1% to 4%. Older patients are at highest risk. NSAID use is thought to be responsible for more than half of all perforated ulcers. PPIs and misoprostol minimize the ulcerogenic potential of NSAIDs and reduce ulcer recurrence in these patients.

Diagnosis

Diagnosis of PUD is usually based on clinical features and testing either with contrast radiographic studies or endoscopy. Signs and symptoms alone are generally unreliable, especially when differentiating gastric ulcers from duodenal ulcers.

The clinical features of PUD include episodic mid-epigastric pain described as gnawing or burning that occurs 2 to 5 hours after eating or when the stomach is empty. Pain may occur at night and awaken the patient from sleep. It may be relieved by food or antacids; this is the most specific finding for PUD and may help make the diagnosis. Other symptoms may include indigestion, vomiting, anorexia, fatty-food intolerance, a sensation of heartburn, and a family history of PUD. The physical examination is often nonspecific and may or may not include epigastric or left upper quadrant tenderness. Abdominal findings such as tenderness, including guarding and rebound, may be prominent in the case of perforation or penetration of the ulcer.

Older patients with PUD are more likely to have abdominal pain. Patients with duodenal ulcers are more likely to have pain relieved by food or antacids than are patients with gastric ulcers. Weight loss due to fear that eating will cause recurrent pain is more common in those who have gastric ulcers than in those with duodenal ulcers.



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Table 3. Peptic Ulcer Disease in Special Populations

Group	Incidence	Causes	Presentation	Recommended Testing	Treatment	Complications
Children	Rare; those aged 8–17 years are most commonly affected	<i>H. pylori</i> most common	Poorly localized abdominal pain	EGD; if ulcer is present, should test for <i>H. pylori</i>	PPI	Silent bleeding, rarely perforation or penetration
Elderly	Unclear, because the disease goes undiagnosed in many	NSAIDs	Painless bleeding most common; 50% present with perforation; nonspecific symptoms common	EGD if perforation is absent	Treat during EGD if possible; prescribe PPI to prevent recurrence	Increased mortality with perforation or bleeding, more likely to need blood transfusion
Stress ulceration	Up to 15% of ICU patients without prophylaxis	Breakdown of protective mechanisms	Asymptomatic or bleeding or perforation	EGD if suspected	PPI prophylaxis to minimize risk	Nosocomial pneumonia and <i>Clostridium difficile</i> . Diarrhea risk increased with PPI and H ₂ -blockers
Pregnancy		<i>H. pylori</i>	Mild abdominal discomfort, third-trimester vomiting that is nocturnal or postprandial	Based on medical history or EGD if required	PPI, misoprostol contraindicated; treat <i>H. pylori</i> when pregnancy has concluded	Infrequent

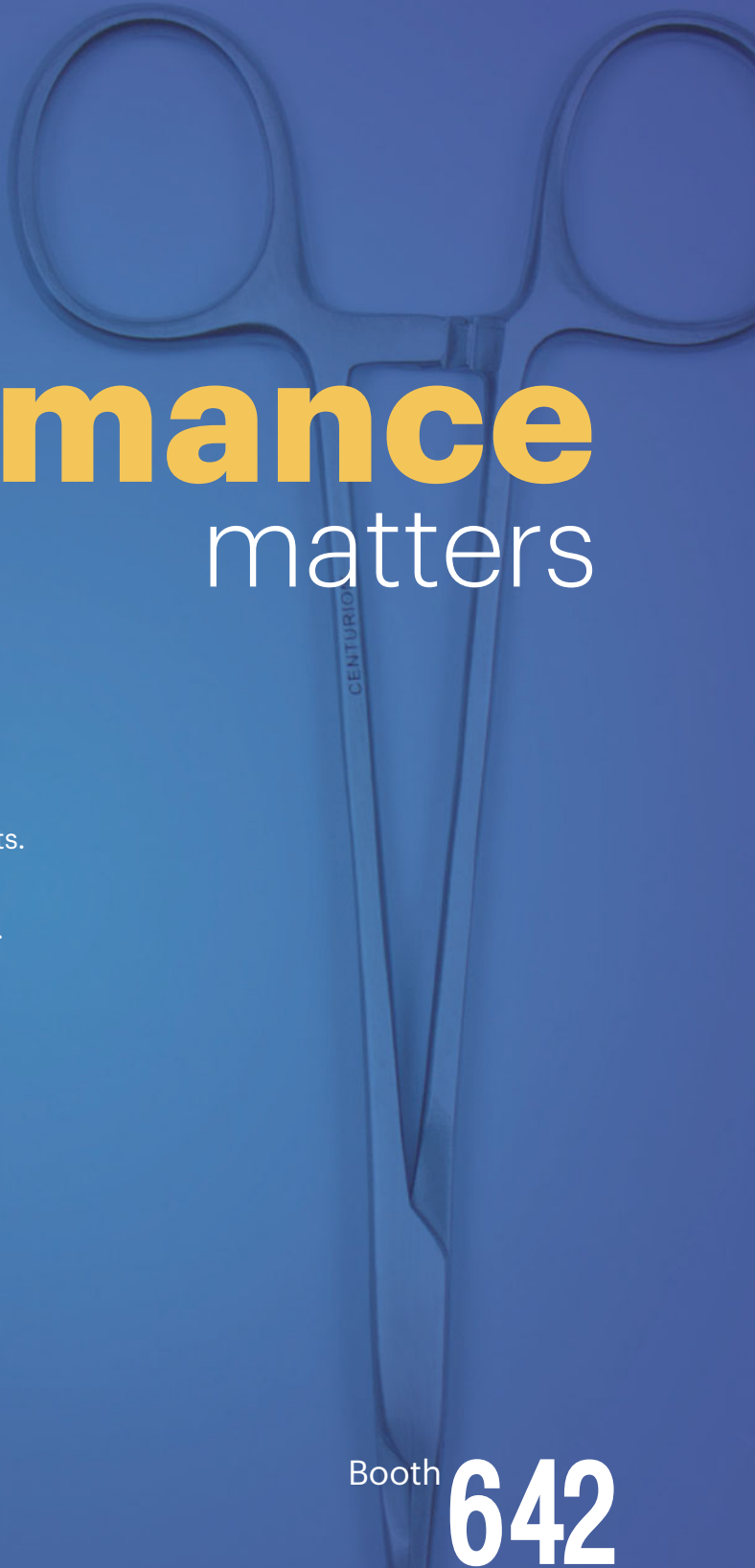
Data from Ramakrishnan K, Salinas R. Peptic ulcer disease. *Am Fam Physician*. 2007;76:1005–1012.
EGD = esophagogastroduodenoscopy; *H. pylori* = *Helicobacter pylori*; ICU = intensive care unit; NSAID = nonsteroidal anti-inflammatory drug; PPI = proton-pump inhibitor.

If the clinical presentation is consistent with PUD, assess the patient for alarm symptoms (Table 2). Any alarm symptoms should prompt further evaluation. Patients older than 55 years who have alarm symptoms should be referred to a gastroenterologist for urgent esophagogastroduodenoscopy (EGD). EGD is more sensitive than a radiologic contrast procedure and biopsy, and treatment can be performed during the test, essentially saving time and procedures. It is also more sensitive and specific. Patients younger than 55 years without alarm symptoms should be tested for *H. pylori*; NSAIDs should be discontinued for these patients, and so should use of alcohol and illicit drugs. In addition, the patient should start a trial of PPIs. Patients with positive test findings for *H. pylori* should be treated for infection and treated with a PPI for at least 4 weeks. Patients with persistent symptoms

should undergo EGD at that point to rule out refractory ulcers and malignancy. Patients with gastric ulcers are at increased risk of developing gastric malignancy. Duodenal ulcers, however, are not at increased risk of malignancy.⁶

Testing for *Helicobacter pylori*

H. pylori testing should be done in all patients suspected or confirmed to have PUD or gastritis. In most cases, this testing is not necessary in the urgent care center and can be left to the primary-care provider, unless it is the case that the patient is using an urgent care center for primary care, that they will not be seeing their primary-care provider before treatment must be instituted, or that blood is being drawn for another reason. Serum ELISA testing is the least accurate and should only be used for initial infection, but it is the most practical for



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Table 4. Testing for *Helicobacter pylori*

Test	Used For	Sensitivity (%)	Specificity (%)	Comment
Serologic ELISA	Initial testing	85	79	Cannot confirm eradication
Urea breath test	Confirm eradication	95–100	91–98 ¹	Expensive; must stop PPIs 2 weeks before test
Stool antigen test	Confirm eradication	91–98	94–99	Inconvenient
Urine-based ELISA/rapid urine test	Initial testing	70–96	77–95	Convenient; cannot confirm eradication
Endoscopic biopsy, culture	Both	70–80	100	
Endoscopic biopsy, histology	Both	>95	100	
Endoscopic biopsy, rapid urease (CLO) test	Both	93–97	100	

Data from Data from Ramakrishnan K, Salinas R. Peptic ulcer disease. *Am Fam Physician*. 2007;76:1005–1012, and from Wehbi M. Acute gastritis. New York (NY): WebMD Health Professional Network, Medscape. © 2015 [updated 2014 September 18; cited 2015 January 8]. Available from: <http://emedicine.medscape.com/article/175909-overview>. Both = initial testing and confirm eradication; CLO = *Campylobacter*-like organism; ELISA = enzyme-linked immunosorbent assay; PPI = proton pump inhibitor.

urgent care use. Serum tests for *H. pylori* are useful only in patients who have never been treated before, because serum antibodies can remain positive for up to 3 years after eradication (**Table 4**). The urea breath test uses radiolabeled ¹³C or ¹⁴C urea taken orally. The bacteria then split the urea, which can be quantified in breath samples. This test is best used to confirm that treatment has successfully eradicated *H. pylori*. The stool antigen test for *H. pylori* is highly accurate, but it too is best used to confirm eradication. Endoscopic biopsy and staining is the first-line test for *H. pylori*. PPIs, bismuth, many antibiotics, and upper GI bleeding may lead to false-negative test results. When a high index of suspicion is present, 2 negative sets of test findings are required to rule out *H. pylori* infection.⁵

The most common cause of *H. pylori*-negative ulcers are false negative test results for *H. pylori* and undiscovered NSAID consumption.⁵ In patients who are at high risk for *H. pylori*, positive findings on a single test confirms infection, whereas negative findings on 2 tests are required to rule out *H. pylori* infection.

Treatment of Peptic Ulcer Disease
Treatment of PUD is first focused at treating the underlying cause. NSAIDs or other inciting factors should be discontinued if possible. *H. pylori* should be treated for 10 to 14 days.

Treatment for *Helicobacter pylori*
Table 5 outlines standard treatments for *H. pylori*.

Adjunct treatments with pre-biotics and probiotics may be helpful in increasing eradication rates and decreasing the side effects of treatment. Treatment failures are largely due to antibiotic resistance and patient non-compliance because of intolerable side effects.⁶

Testing for *H. pylori* eradication may be performed at 4 weeks after completion of therapy using either the rapid urease breath test or the stool antigen test. It may not be cost-effective and thus may be omitted in patients with uncomplicated gastritis whose condition im-

proves with treatment. Patients with ulcers or cancer and those whose condition does not improve after treatment must be checked for resolution. Antibiotics and PPIs must be discontinued for 2 weeks prior to testing.

Other Treatment

H₂-blockers or PPIs should be continued for 4 weeks because they induce healing in most duodenal ulcers.³ PPIs have superior acid suppression, healing rates, and symptom relief compared with H₂-blockers and are recommended as first-line treatment for most patients. PPIs heal duodenal ulcers in more than 95% of patients by 4 weeks, and gastric ulcers in 80% to 90% of patients in 8 weeks. Maintenance therapy with either H₂-blockers or PPIs is recommended to prevent recurrence in high-risk patients: those with a history of complications, frequent recurrences, negative test findings for *H. pylori*, refractory giant ulcers, or severely fibrosed ulcers. If *H. pylori* has been eradicated and the patient is no longer taking NSAIDs, no maintenance treatment is required.

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Table 5. Standard Treatments for *Helicobacter pylori*

First-line therapy

- Standard triple therapy: generic PPI twice a day *and* clarithromycin 500 mg twice a day *and* amoxicillin 1 g twice a day for 14 days

or

- Bismuth quadruple therapy: generic PPI twice a day *and* tetracycline 500 mg 4×/d, metronidazole 500 mg 3×/d, and bismuth subsalicylate 300 mg 4×/d for 14 days

Second-line therapy for treatment failures

- Levaquin–amoxicillin combination therapy: generic PPI *and* amoxicillin 1 g twice a day *and* Levaquin (levofloxacin) 500 mg daily for 10 days

or

- Bismuth quadruple therapy: generic PPI twice a day *and* tetracycline 500 mg 4×/d *and* metronidazole 500 mg 3×/d *and* bismuth subsalicylate 300 mg 4×/d for 14 days

Initial treatment in the penicillin-allergic patient

- Metronidazole–clarithromycin combination therapy: generic PPI twice a day *and* clarithromycin 500 mg twice a day *and* metronidazole 500 mg twice a day for 14 days

or

- Bismuth quadruple therapy: generic PPI twice a day *and* tetracycline 500 mg 4×/d *and* metronidazole 500 mg 3×/day *and* bismuth subsalicylate 4×/d for 14 days

Second-line therapy for treatment failures in the penicillin-allergic patient

- Levofloxacin–clarithromycin combination therapy: generic PPI twice a day *and* levofloxacin 500 mg twice a day *and* clarithromycin 500 mg twice a day for 10 days

Third-line treatment for when therapy has failed

- Referral to a gastroenterologist⁷

PPI = proton pump inhibitor.

Antacids and sucralfate are superior to placebo in healing NSAID-induced duodenal ulcers, but neither has been established as treatment for any other variety of ulcers. Because H₂-blockers and PPIs are superior, sucralfate cannot be recommended as treatment.⁵ Antacids may be useful for symptom reduction.

Misoprostol is better than placebo for treatment of PUD, but has no advantage over H₂-blockers and PPIs. It may be useful in non-menstruating patients who must take NSAIDs to prevent recurrent gastritis or ulceration. It is available in a combination NSAID product mixed with diclofenac. It is contraindicated in pregnancy (category X) because it is an abortion-inducing agent.⁵

Gastritis and Peptic Ulcer Disease in Pregnancy

In a pregnant patient who develops PUD, treatment should be aimed at acid suppression. All of the PPIs are low risk in pregnancy, and are therefore category C. Most obstetricians will recommend them. Pregnant patients with positive test findings for *H. pylori* should be treated after delivery unless they are experiencing severe nausea and

vomiting. There is some evidence that *H. pylori* contributes to hyperemesis gravidarum. Treatment with anti-*H. pylori* drugs, with the exception of tetracycline and bismuth, is generally safe in pregnancy, especially after 14 weeks' gestation. Conversely, bismuth and metronidazole are unsafe in breastfeeding infants.⁵

Refractory Ulcers

Refractory PUD is defined as disease that fails to heal after 8 to 12 weeks of therapy. This may be due to persistent or resistant *H. pylori* infection, continued NSAID use, giant ulcers, cancer, tolerance of or resistance to medications, or hypersecretory states. The underlying cause should be addressed, and treatment should continue for longer than 8 weeks if required. These patients should be evaluated by a gastroenterologist.^{3,5}

Surgery

Surgery may be required for patients who are intolerant of medications, do not comply with medication instructions, or are at high risk of complications, such as transplant patients, chronic steroid or NSAID users, those with giant gastric or duodenal ulcers, or those whose disease fails to heal with adequate treatment. Patients who experience relapse after multiple courses of medication should also be considered for surgery.³

Complications

About 25% of patients with PUD will have a serious complication such as hemorrhage, perforation, or gastric outlet obstruction (GOO). Silent ulcers and complications are more prevalent in older patients and in patients taking NSAIDs. Upper GI bleeding, which occurs in 12% to 20% of patients with PUD, is the most common cause of death and the most common reason for surgery.³ Patients may present with bright-red or coffee-ground hematemesis, melena, fatigue due to anemia, orthostasis, or syncope. Most patients in an urgent care center with documented GI bleeding should be transferred to an emergency department for further evaluation.

In stable patients with GI bleeding, ulcerogenic medications should be discontinued and a PPI should be administered. EGD should be performed as soon as possible. Testing and subsequent treatment for *H. pylori* should be done to prevent recurrent bleeding. If the patient must continue to take aspirin or NSAIDs, misoprostol or a PPI administered concurrently should be considered.

Perforation may occur in 2% to 10% of patients with peptic ulcers. It is usually found in the anterior wall of the duodenum (60%), the antral wall of the stomach (20%), or the lesser curvature of the stomach (20%).³ Perforation of ulcers in children is rare. Perforation into the peritoneum and resulting peritonitis constitute a surgical emergency. Perforation is characterized by sudden and rapidly spreading severe upper abdominal pain exacerbated by movement. It may radiate to the right lower abdomen or to both shoulders. Fever, hypotension, and oliguria suggest sepsis syndrome. Generalized abdominal

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GOO may occur from PUD, but it is the underlying cause in less than 5% to 8% of patients.³ Patients with recurrent duodenal or pyloric channel ulcers may develop pyloric stenosis because of inflammation, spasm, edema, or scarring and fibrosis. Symptoms of GOO include recurrent episodes of emesis with large volumes of vomit containing undigested food, bloating, fullness after eating, and early satiety. Weight loss, dehydration, and hypochloremic hypokalemic metabolic alkalosis may result. EGD or gastroduodenography is recommended to determine the site, cause, and degree of obstruction. Malignancy is responsible for more than 50% of GOO and should be ruled out. Other causes of GOO include acute inflammation or edema of the gastric mucosa due to *H. pylori*.

No firm dietary recommendations are necessary; however, it should be noted that patients should avoid any foods that are known to precipitate their symptoms.⁵

Conclusion

Gastritis and PUD are due to an imbalance of the acid balance and the protective factors in the stomach. The most common causes are NSAID use and infection with *H. pylori*. The health-care provider should be aware of alarm symptoms that can point to more serious complications such as cancer, perforation, bleeding, and penetration. Treatment is aimed at removing the inciting factors, eradicating *H. pylori* if present, and acid suppression with H₂-blockers or PPIs. Refractory or complicated cases should be evaluated by a gastroenterologist.

Part 2 of this series will discuss gallbladder disease and acute pancreatitis. ■

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Recognizing Employee Disengagement and Taking Steps to Re-engage

Urgent message: Employee disengagement is pandemic in the American workplace. At urgent care centers, operators have to work especially hard to keep frontline staff members motivated. Re-engaging employees starts with a strong management culture committed to establishing affinity with employees and ensuring that systems and processes support day-to-day operations.

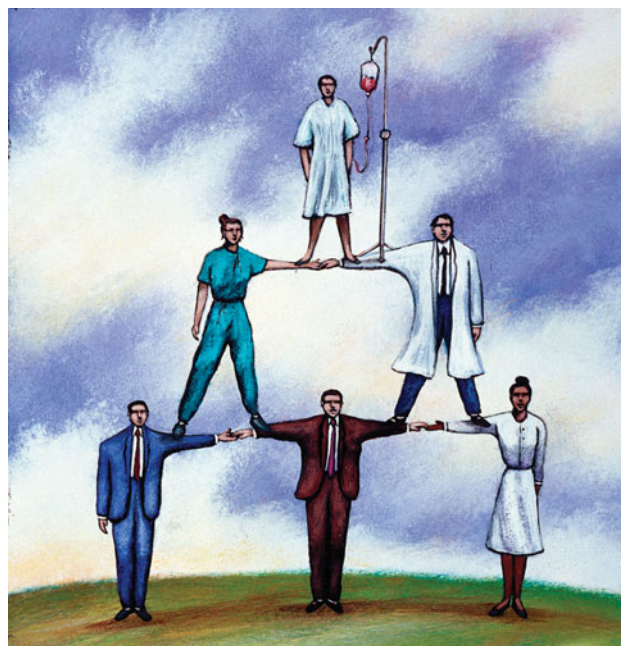
ALAN A. AYERS, MBA, MACC

For many urgent care operators—clinically adept physician-owners who are likely green as entrepreneurs—it can be sobering to realize just how many hats they must wear in support of a thriving clinic. They have to be

- **Aggressive and opportunistic marketers** committed to driving patient volume through a variety of paid and grassroots tactics
- **Gracious, customer-oriented hosts** charged with ensuring that patients feel like welcome guests whose patronage is appreciated
- **Charismatic leaders and managers of people**—in particular, the kind of diverse clinical staff necessary to form an effective urgent care team

Despite their lack of entrepreneurial training, physician-owners do seem to at least recognize the importance of quickly learning basic marketing and customer-

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service concepts for attracting and retaining patients. What they are often painfully slow to realize, however, is how critically important a firm grasp of workplace culture and leadership principles is to a center's long-term

success. Because regardless of patient volumes, a rudderless center with a wayward, fractious, and dysfunctional work culture inevitably results in a disengaged staff. Unchecked employee can bring an urgent care center to its proverbial knees.

Employee Disengagement

Employee disengagement is an enormous problem in the United States of America, with renowned polling company Gallup asserting that 70% of America's workforce is either unengaged or actively disengaged. Translated into dollars, the total economic cost of a vastly disengaged national workforce is estimated to be \$550 billion annually in terms of lost productivity.¹ That comes out to about \$3,400 of lost value for every \$10,000 of salary paid. Staggering figures indeed, but they still leave a somewhat cloudy picture. So what is the face of disengagement, then? Human resource experts and workplace psychologists are in consensus regarding these common traits:

- Subpar productivity (especially in comparison to historic benchmarks)

- Shoddy, mistake-prone work
- Frequent tardiness and absenteeism
- Aloof, disinterested, and nonexistent communication (with colleagues, superiors, and customers)
- Noncompliance with internal policies and external regulations (contributing to mistakes and legal liability)
- Incessant complaining
- Excessive gossip (especially malicious)
- Curt and rude behavior toward customers
- Excuse-making
- Shunning of accountability
- Listless, unenthusiastic
- Irresponsible conduct
- Lack of initiative

In short, unengaged employees lack energy and passion toward their jobs and are content to sleepwalk through their days and simply collect a paycheck. Still, those types are at least an improvement over *actively disengaged* employees, because those workers are not only

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unhappy but are even working willfully to undermine the company and the efforts of their more engaged coworkers.

Causes of Employee Disengagement

So what is causing the disengagement of more than two-thirds of America's workforce? Although there can be numerous factors depending on the specific profession and/or company, here are 13 commonly cited causes:

- **Ineffective or problematic manager:** Engagement experts of every stripe cite bad managers or bad direct supervisors as by far the number 1 cause of employee disengagement.
- **Emotional labor:** Having to constantly feign a pleasant, upbeat demeanor, which is something that especially customer-facing—or frontline—employees must do, is said to be engaging in emotional labor.
- **Repetitive work:** Monotonous work devoid of stimulation, variety, or challenge
- **Unclear expectations:** Employees are not sure exactly what is expected from them.
- **Lack of recognition:** Employees are never recognized for their efforts or accomplishments.
- **Poor communication:** Managers do not keep employees in the loop in regard to important company happenings. Managers also talk down to employees in front of coworkers and customers.
- **Insufficient onboarding:** Also known as organization socialization—when training or orientation resources are lacking or inadequate
- **Poor work relationships:** Friction, enmity, disagreement, and conflict with coworkers and managers
- **Broken promises:** When managers promises problem resolution or perks such as raises and promotions that do not actually come to fruition
- **Unheard opinions and suggestions:** According to engagement experts, ignoring employee opinions and suggestions is a top cause of employee disengagement
- **Workplace stress:** Fast-paced, hectic, and chaotic work environments laden with unrelenting mental and physical demands
- **Personal life stress:** Marital, health, financial, and child-care concerns that leave an employee preoccupied and unfocused during working hours
- **System and process issues:** Technology, systems, processes, and procedures that are error-prone, out-



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Table 1. Financial Consequences of Employee Disengagement	
Engagement Level	Return on Salary (%)
Fully engaged	120
Engaged	100
Somewhat engaged	80
Disengaged	60
Data from Employee engagement [Internet]. Albertson, NY: Employer Assistance and Resource Network; 2014 [cited 2015 March 2]. Available from: http://askearn.org/refdesk/Diversity_Goals/Engagement	

dated, or poorly configured (resulting in an inordinate amount of time spent correcting errors)

Although a few of these factors are simply part of the job sometimes, many are manifestations of a dysfunctional workplace culture. And culture always flows from the top.

How Employee Disengagement Affects Urgent Care

Many urgent care centers are independent, physician-led entrepreneurial practices with limited capital. They operate with slim margins, and managers work diligently to control costs and expenses. So how does a disengaged staff hurt an urgent care center's bottom line?

Table 1 breaks down the financial implications of employee engagement versus disengagement. Although physicians can be (and often are) susceptible to disengagement, for an urgent care it is the frontline staff members who are by far the most vulnerable. Urgent care managers, though strong technically and clinically, probably lack training in how to manage a team and create an engaged culture. So the frontline staff members, enduring the daily slings and arrows of patient and provider demands without a strong organizational culture to fall back on, steadily slip toward disengagement. Performance invariably suffers, and the value provided relative to their salary plummets. The trickle-down effect, obvious across many fronts, is that the center directly and indirectly loses money.

Examples of Disengagement in the Urgent Care Setting

Undoubtedly, the frontline staff is the linchpin of an urgent care center and generally comprises the front-office specialists, medical assistants, and technicians who support physicians and other providers. Here is a brief list of the areas they govern:

- Management of communication between patients and providers

- Receipt of payment for services rendered
- Control of clinic and patient documentation of every type
- Managing the tone of the patient experience
- Regulation of patient traffic flow
- Keeping management in the loop regarding important center issues

In fact, frontline staff members are so integral to the smooth functioning of an urgent care center that their performance level can literally make or break a center. Add to their clinic responsibilities the need for a keen focus on the patient experience and customer service, and it becomes obvious that they are by far a center's most valuable resource.

Clearly, an urgent care center cannot afford unengaged frontline staff members. The numbers paint a compelling picture as to why, but a closer look at the anecdotal aspect of urgent care disengagement serves to hammer the point home more succinctly.

Example 1

A registration specialist has ideas for operational improvements, but they are continually ignored, and so she is demoralized. To make matters worse, managers openly treat her position as expendable because it requires the least amount of formal education and pays the lowest salary of all positions at the urgent care center. Thus, her work becomes sloppy and error prone; she has mentally checked out.

She frequently makes careless errors in capturing accurate patient demographics, resulting in the center later receiving numerous "zero EOB" notifications, which of course indicate denied insurance claims. Afterward, the costs in time and labor to go back and correct each error will essentially cancel out the profit realized from the pertinent patient encounters. The billing function is now burdened with rework, and if the registration specialist is eventually let go or quits, the center will incur onboarding, recruiting, and training costs equal to 100% to 150% of her salary. This is just one costly instance of turnover, but there will be many more without an improved workplace culture.

Human resources consulting firm Towers Watson, in a global workplace study,² asserts that disengaged employees make *100 times* more errors than their engaged counterparts.

Example 2

A front-desk team member, disgruntled over being openly belittled by providers over several minor mis-

takes, is fed up. There is also an ongoing issue of unfulfilled promises made by providers concerning a more flexible work schedule. Hence, she is actively seeking different employment, and in the meantime she intends to undermine the urgent care center whenever possible. Typically, this involves being aloof and rude toward patients during check-in and check-out. She barely makes eye contact, and she sighs impatiently when patients ask too many questions or a registration issue arises, for example. In general, she would rather be anywhere else but work, and it shows. Additionally, she does not bother to reassure or update visibly ill and uncomfortable patients that they will be seen shortly. As the unquestioned face of the brand, this frontline employee sends a very negative message about how the center views its patients.

Of course patients will be displeased with this level of service and will not return to the center. They will also take to online review sites to chronicle their negative experiences to an audience of thousands and advise their friends and family to stay away. Not only does the urgent

care center lose future business from each aggrieved patient but also every potential patient is influenced by the negative word of mouth. The two types of losses exponentially increase the financial impact on the center to thousands of dollars in lost revenue.

There are many more disengagement examples, such as the medical assistant who is a single mother working late hours and feeling stressed because she believes she is neglecting her children, or the busy physician assistant buckling under the weight of excessive emotional labor from steady patient interactions. Regardless of the cause of disengagement, if it is left unchecked it will hurt the center's bottom line, either through greatly diminished performance or increased turnover expenses.

What Does Engagement Look Like?

An engaged employee can be defined as one who is fully absorbed by and enthusiastic about their work and so takes positive action to further the organization's reputation and interests. Fully engaged employees are

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Table 2. Engagement ROI in a Nutshell

Employee Engagement	ROI
Increases income growth	By 7 times
Improves productivity	By 18%
Improves performance (such as reduction in errors or downtime)	Equivalent to 1 extra free-of-charge employee to every 8 engaged employees
Improves customer satisfaction/engagement	3.4 times more financially effective
Increases innovation	Results in 58% of engaged employees feeling creative at work, and only 3% of less engaged
Decreases absences and improves well-being	Engaged employees take 2.69 sick days per annum compared with 6.19 sick days for disengaged employees
Increases retention	Reduction in staff turnover of 87%
Increases health and safety	Low engagement results in 62% more accidents
ROI = return on investment. Data from Employee engagement: The most powerful way to create ROI. Hadlow Down, UK: Maria Paviour Company; ©2013 [cited 2015 March 2]. Available from: http://www.mariapaviour.com/userfiles/image/Engagement%20ROI%20with%20MPC.pdf	

extremely powerful allies to a company, as evidenced by the 120% return on salary they provide, according to the talent management company Human Capital Institute.³ **Table 2** further clarifies the workforce-related return on investment (ROI) of time, effort, and capital investment in engagement.

An engaged urgent care team exudes an energy that is irresistible to patients and staff members alike. The personalities of the providers and staff members are magnetic and empathetic, and everyone moves with a purpose. The entire team buys into the center's vision, is enthusiastic about its roles, and makes extra effort without a second thought. A stellar team like this—strongly united in working toward patient satisfaction and clinic success—is possible only when there is a workplace culture in place deliberately crafted to foster a supportive, uplifting work environment.

To illustrate the point further, **Table 3** compares the typical attitudes and behaviors of an engaged versus unengaged urgent care team.

Creating an Engaged Culture

With the causes and symptoms of disengagement now clearly identified, the next step is to recapture and re-engage disengaged staff members. However, this can begin only when there is an understanding that

- The existing workplace culture must be thoroughly examined and, if necessary, overhauled
- It is necessary to put demonstrable time, effort, and capital ROI toward creating an engaged culture
- Culture always flows down from the standards set by clinic managers

There are 3 key elements to creating an engaged urgent care team:

- Implementing the drivers of employee engagement
- Giving managers the keys to being good leaders
- Creating affinity with frontline staff members

Implementing the Drivers of Employee Engagement

Human resource specialists, workplace psychologists, and engagement experts are in nearly unanimous agreement on these drivers of employee engagement:

- **Expectations:** When expectations are unclear or fuzzy, employees focus more on surviving than on making a meaningful contribution to the company. By contrast, when employees know exactly what is expected of them (along with having the proper resources to meet those expectations), their sense of shared accountability is enhanced, which is crucial for long-term engagement.
- **Regular feedback:** Employees love feedback. In fact, they crave it, which is why the annual performance review is so outdated. Employees want to know *right now* where they stand and where they are going, and frequent feedback accomplishes this.
- **Advancement opportunities:** For employees to be fully engaged, they must feel like they have an opportunity to grow and advance within an organization.
- **Meaning:** To be truly engaged, people must feel like their job has meaning, is important, and is making a larger impact on others' lives.
- **Recognition:** The employee-engagement specialists of RedBalloon maintain that a whopping 77% of employees are starved for recognition. They claim that the desire for recognition is so strong is that many employees will forgo a cash bonus for a heartfelt "Thank you—you did a wonderful job"

from management. Additionally, awards and incentives are also appreciated by employees.

- **Relationships:** Employees need good working relationships with their colleagues and supervisors for sustainable engagement.
- **Autonomy:** Companies want results and accountability from their employees, and employees want empowerment and freedom to do their jobs in the ways that they know is most effective. Autonomy is what bridges accountability and empowerment.
- **Soliciting and then implementing employee opinions and suggestions:** Many engagement specialists place this driver atop the list of factors for engaging employees. This technique can include inviting employees to participate in meetings and brainstorming sessions, letting them lead a task force, and sincerely asking, "What do you think about this?"

Giving Managers the Keys to Being Good Leaders

Gallup Chief Executive Officer Jim Clifton is known for

stating that the single most important decision a company can make is who it names as a manager. He goes on to say that if a bad manager is put in place, there is absolutely nothing else that can offset the impending damage that this manager will wreak.

Although most physician-owners simply have not had the management training necessary to build an engaged culture, they can learn and adhere to the basic principles of good management required to lay the foundation for an engaged culture. **Table 4**, based on data gleaned from Google's management initiative Project Oxygen, highlights the qualities of a good manager.

Creating Affinity with Frontline Staff

A big part of being a good urgent care leader is developing a genuine connection with your staff members. This is relatively easy to achieve in smaller organizations, but larger, more departmentalized organizations will require more vigilance. Thus, the suggestions in **Table 5** will help leadership create an emotional connection with their staff members.



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Table 3. Unengaged Versus Engaged Urgent Care Staff Members

Unengaged: Hired Help (“It’s just a job”)	Engaged: Business Partners (“I love my job”)
• Negative and bored with their jobs—walk around like zombies, looking forward to quitting time	• Enthusiastic and interested in their jobs—are happy and it shows, and they look forward to each new day
• Speak negatively about the center to others and tell friends and family about its shortcomings	• Take pride in telling others where they work and encourage friends and family to use the center
• Blame others for their lack of performance and/or failure of the center	• Feel accountable for their performance and the success of the center
• Motivated by lower-order needs to provide food, shelter, and other necessities or by fear of losing their jobs or of fear of criticism, punishment, or embarrassment	• Motivation comes from within and from higher-order needs such as esteem and self-actualization
• Usually end up being rewarded twice for doing the basics of their job	• Eager to go above and beyond for benefits other than money
• Timid with poor self-image—discouraging and bringing down everyone around them	• Confident with high self-esteem—encouraging and building up everyone around them
• Not sure what they are supposed to do and/or lack the training, skills, or tools to do their job well—feel like a small part of a big machine	• Know exactly what is expected of them, how their job impacts others, and how their job contributes to the center’s bottom line
• Do not feel the need to do anything other than the minimum required for their role; work is sloppy and error-prone	• Eager to do anything they can—or find the best person who can—to help patients and drive the business; conscientious and detail-oriented
• Never challenge the status quo, do everything by the book or are restricted by policies and procedures	• Encouraged to find new and creative ways to do their jobs, resulting in improved efficiency and smoother operations
• Restricted by their title or position—feel powerless to do anything beyond their narrow area of responsibility; “not my job” or “not my problem”	• Able to work across functions or roles—free to exercise good judgment and common sense in solving problems; “it is my job and I will make it my problem”
• Collaborates with colleagues in an adversarial “us versus them” stance against patients and/or management	• Collaborates with colleagues to ensure efficient and smooth patient flow and with management to improve the overall operation.
• Managers are distrustful of employees and spend time micromanaging, look over employee shoulders, and make a big deal out of mistakes	• Managers have delegated responsibility to employees and spend time in developing and providing them the resources they need and in celebrating their successes
• Disinterested in the center and are secretly undermining its future success—do not plan to be with the center long-term	• Interested in the center—how it started, how it grew, and where it is headed—and vested in seeing it succeed
• Employees are responsible for actions but managers are responsible for results	• Employees are responsible for actions, and the entire team is responsible for results
• Unaware of what’s going on with the business and furthermore, doesn’t care.	• Aware of how the business is doing—including financial metrics like profitability and cash flow
• Pays little attention to the industry and/or believes the “grass is greener” at competitors.	• Understand the competition and evaluate what competitors are doing well and what can be learned from them to woo patients away

From Ayers A. Five activities for cultivating a motivated center team. Newsletter of the Urgent Care Association of America. 2010 July 9.

Addressing Broken Processes

Processes, technology, and systems that are ineffective, cumbersome, and error-prone are also major contribu-

tors to employee disengagement. In urgent care, a staff that has to spend more time on fixing problems, malfunctions, and errors than on providing patient service

Table 4. Qualities of a Good Manager

- 1. Is a good coach:** This was the number 1 factor, after all of the data were crunched, that made a good boss. Being a good coach is key to employees.
- 2. Empowers the team:** This one is obvious and well known, but data showed that empowering the team is a great characteristic of a good manager.
- 3. Treats employees like people:** Getting to know your employees as humans and showing an interest in their personal lives and personal well-being is an important characteristic of a good boss.
- 4. Is results-oriented:** Focus on results and help your team achieve their goals by removing any obstacle.
- 5. Is a good listener:** Listen to your employees and encourage open and free dialogue.
- 6. Encourages career development:** Make your employees aware of how they can advance their careers.
- 7. Has a clear vision:** Help your team understand the vision behind what you're doing.

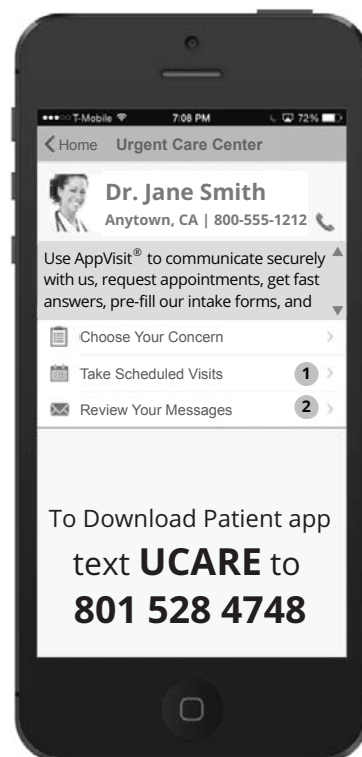
Data from Bryant A. Google's quest to build a better boss. *New York Times*. 2011 March 12. Available from: <http://www.nytimes.com/2011/03/13/business/13hire.html>

will, over time, become demoralized and frustrated. Add to that the patient vitriol related to resulting service failures that customer-facing team members must deal with, and work can morph into a existence straight out of the 1993 movie *Groundhog Day*. Most people who take health-care jobs truly want to serve people, but spending a significant portion of each day battling angry patients over service failures can wear anyone down. That is one reason many frontline staff members are looking to get out of urgent care and into what they perceive as less-stressful health-care practices like primary-care offices.

The difficulty with fixing systemic problems such as these, however, is that they generally involve an expenditure of investment capital, both for analyses done by consultants and for the purchase of updated technology and computer systems. Because many smaller centers may be struggling financially already, the investment capital necessary is likely unavailable.

One possible solution is to place a focus on workplace culture improvements, which if implemented wholeheartedly will indirectly improve the clinic's bottom line. Recall that engagement has a proven, demonstrable ROI, and decreased rates of turnover, onboarding, and error save the center money. Couple that with the increase in happy patients being served by a happier care team, and revenues via subsequent patient volume increases should see an appreciable spike. Clinic revenues should then allow for enough capital investment to make incremental process improvements, and the entire operation will run more smoothly. Eventually, technology like online preregistration, online payment, online medical records, and patient self-scheduling becomes affordable for the center, which will free up staff members to direct even more of their time and energy toward patient care.

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Table 5. Suggestions for Establishing Affinity with Frontline Staff Members

- Know and use the first name of every staff member.
- Make eye contact with staff members and acknowledge them by name when passing
- Smile and be happy to see staff members. Ask how their day is going or how their weekend was.
- When choosing between helping an employee and finishing a report, choose to help the employee.
- When choosing between answering an employee's question and socializing with a superior, choose the employee.
- When meeting with staff members, give your full attention and do not rush. You are investing in your staff.
- Protect staff members from abuse from providers, patients, vendors, injuries, and overwork at every turn.
- Get to know employees and the people around them (e.g., family and children). Remember to ask about what you know is important to your staff members, but ask for permission before asking a personal question.
- Respect personal space and working territory. Keep the staff restroom and breakroom clean and supplied.
- Treat staff members equally and courteously. Stay person-centered, not task centered.
- Listen when staff members speak. Do not discount what they say or how they feel, and never speak down to them or correct them in front of others.
- Know staff members' assigned schedules. Invite the return of staff members after maternity or paternity leave with encouragement and flexible schedules.
- Jump in to help with any task when needed in a crisis or when the center is short-staffed (to be differentiated from solving others' problems or taking over because no one else knows how or does it well enough).
- Allow and expect staff members to solve problems, allow them to improve processes, and allow them to suggest solutions.
- Recognize staff members' achievements—both individually and collectively—through verbal recognition and tangible rewards that are visible to everyone associated with the center. Make staff look good in front of others (e.g., other staff, their families, and patients).
- Surprise staff members by providing lunch on busy days, giving spot bonuses, or providing some other unexpected recognition.

From Ayers A. Five activities for cultivating a motivated center team. Newsletter of the Urgent Care Association of America. 2010 July 9.

Conclusion

“Heart, spirit, mind, and hands”⁴—that is true engagement. If organizations genuinely want it from their employees, a long-overdue paradigm shift must take place. The rigid hierarchal structures of yesterday's workplace that promised little more than salary and benefits must give way to a more collaborative, enriching employment culture, one where employees go from replaceable cogs in a big machine, to indispensable business partners respected and cherished by managers. The numbers are conclusive: Corporations are hemorrhaging billions because they fail to engage their employees, while at the same time they lose their best and brightest to the competition.

An urgent care center, with its late hours, irregular work pace, need for precision and accuracy, and heavy customer/patient emphasis, can become the ideal environment for disengagement to take root and fester. Managerially inexperienced physician-owners might be unwittingly playing a role in disengaging the very staff members whose good performance their clinic depends on. Hence, providers must come to realize that their staff members need a specifically crafted workplace culture that fosters connection on all levels, places respect for the individual at the forefront, and recognizes and celebrates hard work. Moreover, they need a culture where communication and feedback are encouraged, autonomy is supported, and patient service is emphasized in a united effort.

In sum, employee re-engagement is not simply a nice thing to do; its influence profoundly affects the bottom line. When you treat your staff members with the same reverence as you do your patients, your urgent care center will know engagement—and shortly thereafter, it will know sustained success. ■

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Case Report

Aortic Dissection

Urgent message: Although chest pain in young adults is often benign, it is important to realize that emergency cases can sometimes be disguised as normal examination findings in adults.

ZANA ALATTAR and JOHN SHUFELDT, MD, JD, MBA, FACEP

Introduction

This case demonstrates the importance of considering and ruling out rare cases of aortic dissection in patients with chest pain. We describe a case illustrating the approach to the management and work-up of chest pain in young patients to identify the underlying cause.

Case Presentation

A 44-year-old woman presented to an urgent care center reporting sudden-onset chest pain that had started the prior evening. On initial evaluation, the patient reported constant and worsening pain since onset, describing it as a “squeezing” pain associated with nausea and a single episode of vomiting.

Physical Examination

The initial physical examination revealed a patient in no acute distress and with stable vital signs as follows:

- Temperature: 36.7°C
- Heart rate: 78 beats/min
- Noninvasive systolic blood pressure: 135 mm Hg
- Noninvasive diastolic blood pressure: 70 mm Hg
- Respiratory rate: 16 breaths/min
- O₂ saturation: 97% on room air

Her lungs were clear to auscultation bilaterally, respirations were not labored, and breath sounds were equal. The cardiovascular examination revealed normal peripheral perfusion and a regular heart rate and rhythm

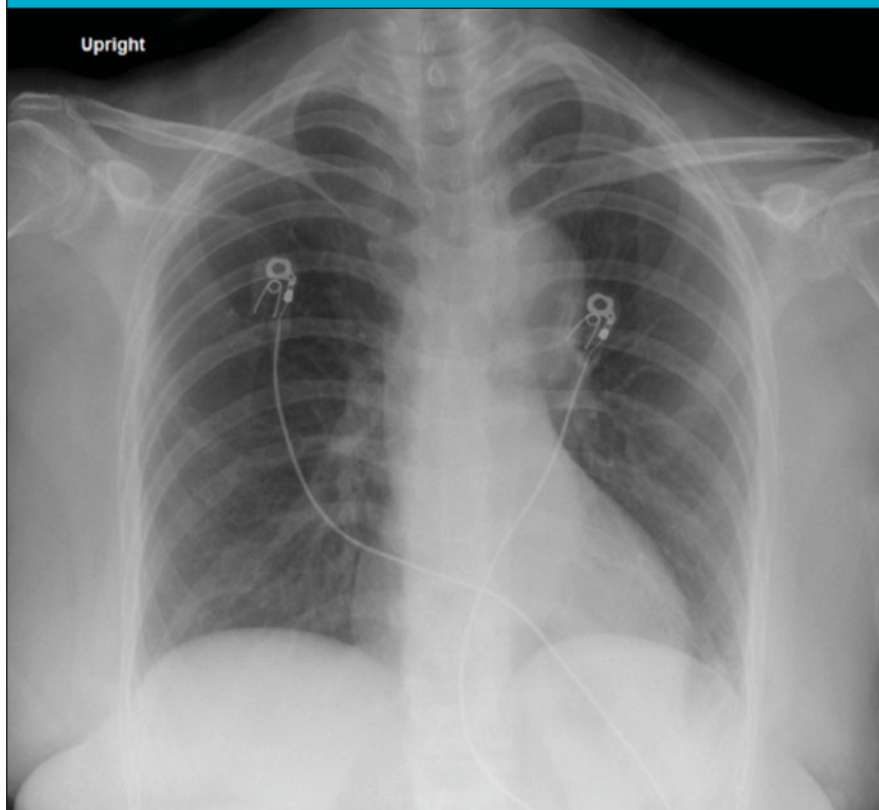


without murmur. The chest wall was tender to palpation, which was consistent with her report. The abdomen and back were nontender. The neurologic examination showed no focal neurologic deficit; that cranial nerves II through XII were intact; and normal sensory, motor, speech, and coordination findings.

The patient's past medical history was significant for patent foramen ovale, transient ischemic attack, mitral valve prolapse, and atrial fibrillation with cardiac ablation 5 years earlier. Her social history was negative for alcohol, tobacco, or drugs of abuse. Her family history revealed that her mother had significant coronary artery disease.

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Figure 1. Anteroposterior chest x-ray showing an enlarged aortic knob.



Diagnostic Results

An electrocardiogram showed no acute changes. Findings on laboratory tests, including complete blood count, basic metabolic panel, and cardiac enzymes, were normal. However, a chest x-ray (**Figure 1**) showed an enlarged aortic knob, which concerned the urgent care provider and prompted transfer to an emergency department (ED) for further evaluation.

On ED presentation, the patient continued to report chest pain to the left anterior chest, radiating to the left upper back and left side of neck. She described a sharp, stabbing pain with associated diaphoresis, shortness of breath, and near syncope at time of onset. Upon further questioning, the patient described constant and worsening pain throughout the night that prevented her from sleeping, with associated nausea, diaphoresis, and a single episode of vomiting. She reported no pain relief with aspirin or Tylenol with Codeine, both of which she took prior to her visit.

A noncontrast computed tomography (CT) scan of the chest, abdomen, and pelvis revealed an aortic dissection arising just distal to the left subclavian artery and extending

through the descending aorta. Bilateral blood pressures were measured and found to be equal at 97 mm Hg/54 mm Hg on the right and 99 mm Hg/54 mm Hg on the left.

CT angiography of the aorta revealed a type B aortic dissection and a 4.3-cm aneurysmal dilation of the aortic root (**Figures 2 and 3**).

Diagnosis

Aortic dissection, Stanford type B.

Course and Treatment

Further questioning revealed that the patient's brother had a history of Marfan syndrome and that her father died of cardiac arrest at the age of 52. The patient remained in the intensive care unit under close observation and medical management for 2 days until the hemodynamic goal was achieved and she was in stable enough condition to be transferred to the

medical floor. With continued use of β -blockers and with consults from cardiology and cardiothoracic surgery, the patient's condition remained stable and the dissection did not extend. After a 5-day admission, the patient was prescribed aggressive β -blockers and lisinopril, advised to follow up with cardiology and cardiothoracic surgery, and discharged home.

Overview

An aortic dissection is a tear in the lining of the aorta, which causes a change in blood flow from the normal arterial pathway. Relatively uncommon, this condition is frequently misdiagnosed and has a high mortality rate. Aortic dissections are three times more common in men than women and about 75% of the time, they are found in patients between the ages of 40 and 70 years.³ Risk factors for the condition include hypertension, atherosclerosis, hypercholesterolemia, smoking, and certain inherited disorders, such as Marfan syndrome and Ehlers-Danlos syndrome.¹

Aortic dissection should be considered whenever there are risk factors and telltale clinical signs from the medical

history and physical examination. The patient typically presents with severe, sharp, or “tearing” chest pain from a location that depends on the type of dissection. Ascending aortic dissections typically present as anterior chest pain, whereas dissections distal to the left subclavian present as posterior chest or back pain. With either type, if the dissection has progressed to the point of impairing or preventing blood flow to peripheral vessels, the physical examination may reveal weakened or absent carotid, brachial, or femoral pulses unilaterally or bilaterally.²

Take-Home Points

This case of aortic dissection was easy to miss. The patient was thin, nonsmoking, and athletic and had normal findings on electrocardiography. Moreover, she had somewhat reproducible chest wall pain. The key to this case was the correct and timely identification of the enlarged aortic knob on the chest x-ray and then linking this finding to the possibility of a dissection. Although the family history in this case provided a critically important clue, it took obtaining histories via 3 separate providers before it was revealed that her brother had Marfan syndrome and that her father experienced sudden cardiac death. ■

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Figure 2. Axial noncontrast computed tomography scan showing the ascending and descending aorta.

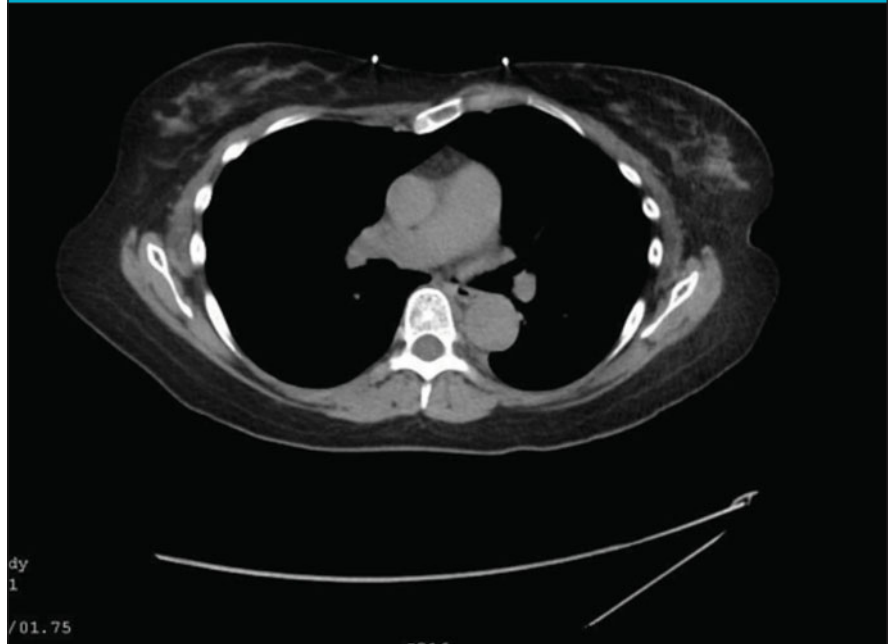
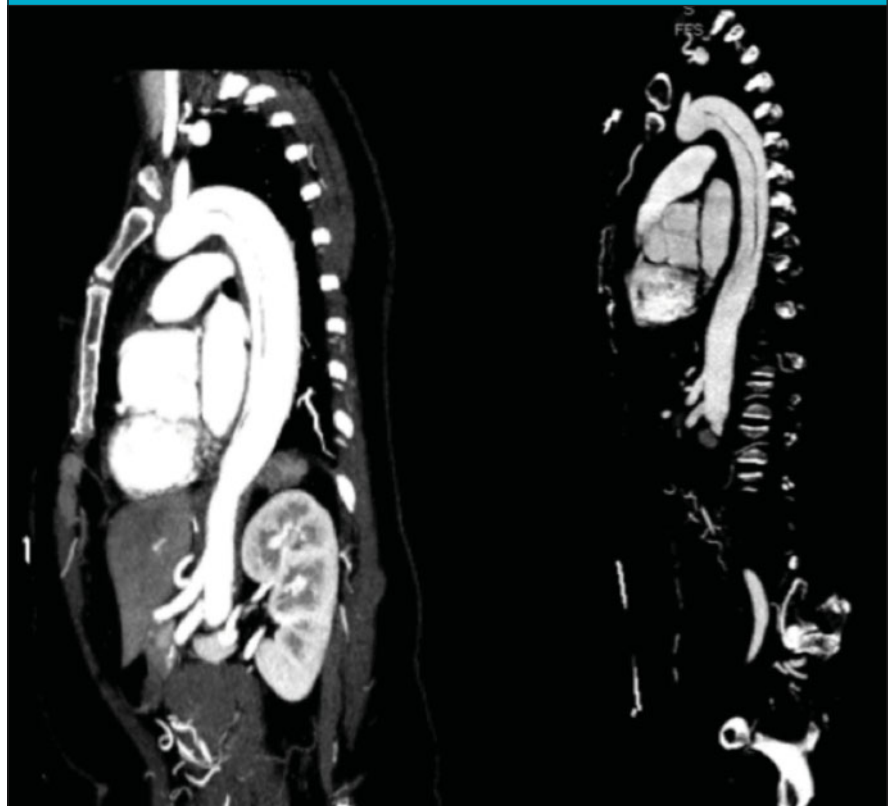
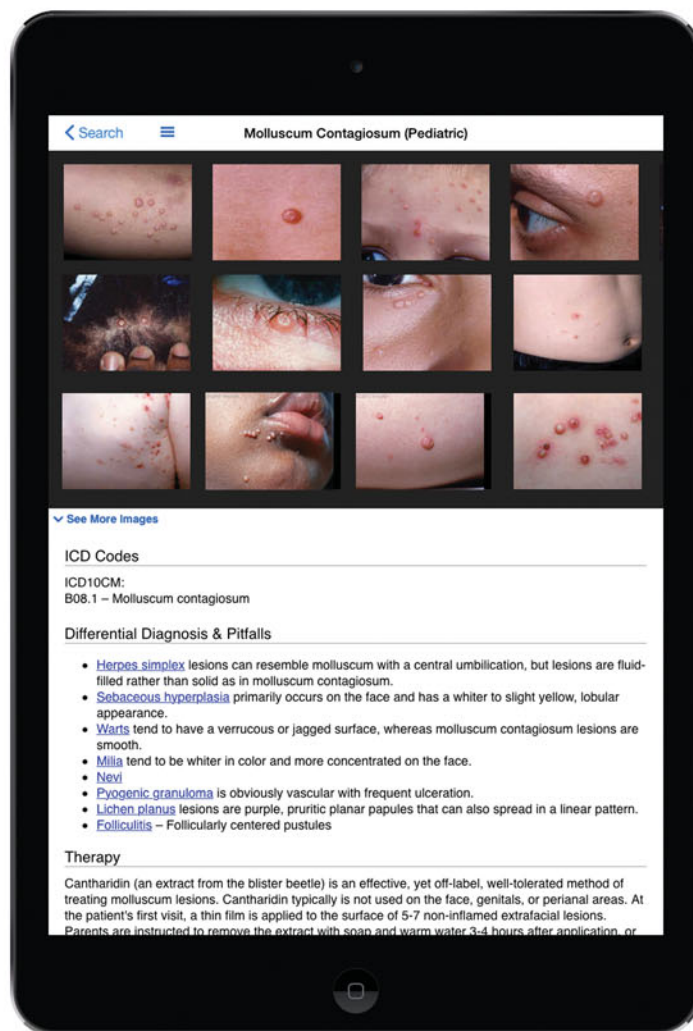


Figure 3. Sagittal computed tomography angiographs of the aorta.



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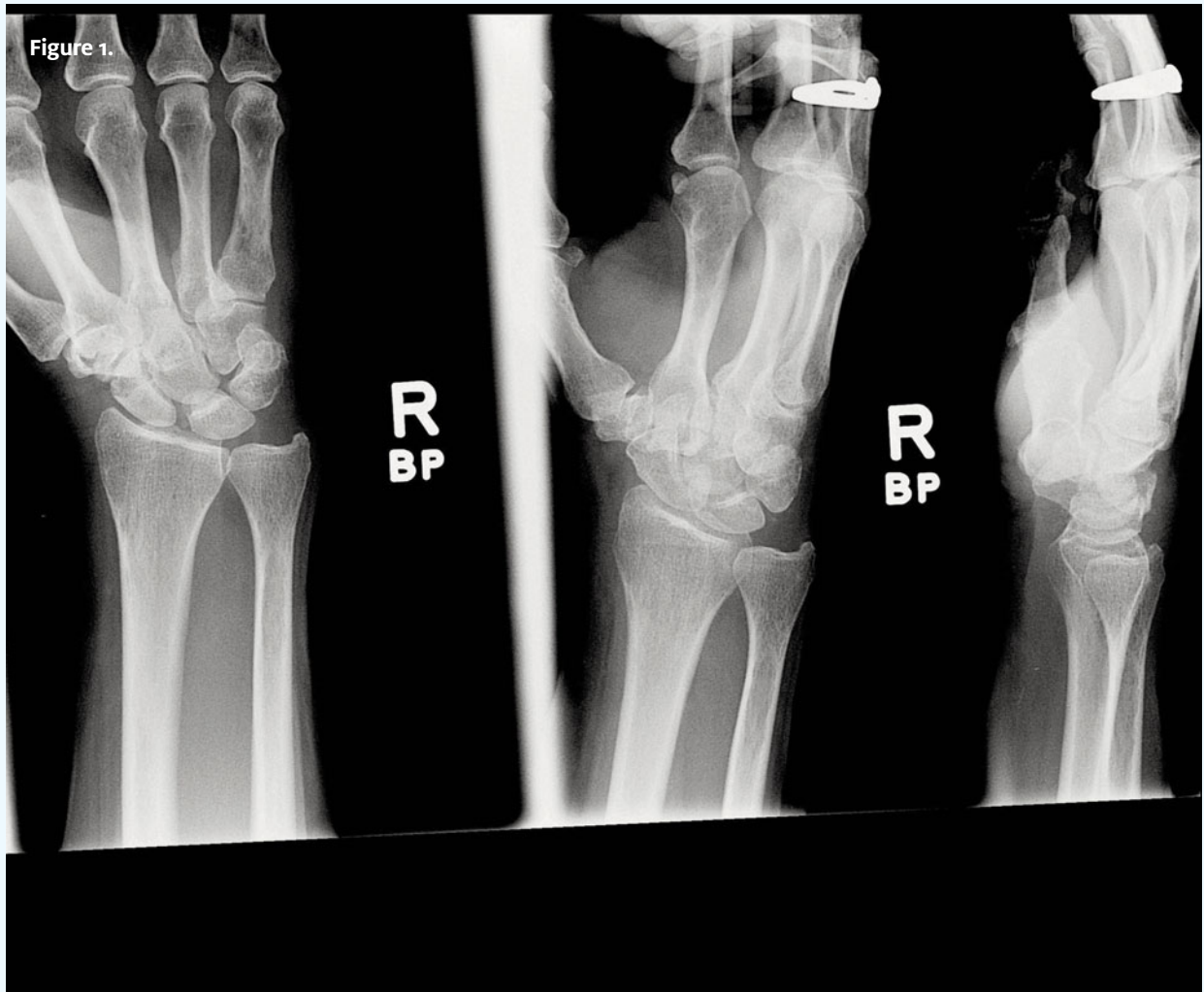


INSIGHTS IN IMAGES

CLINICAL CHALLENGE

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.

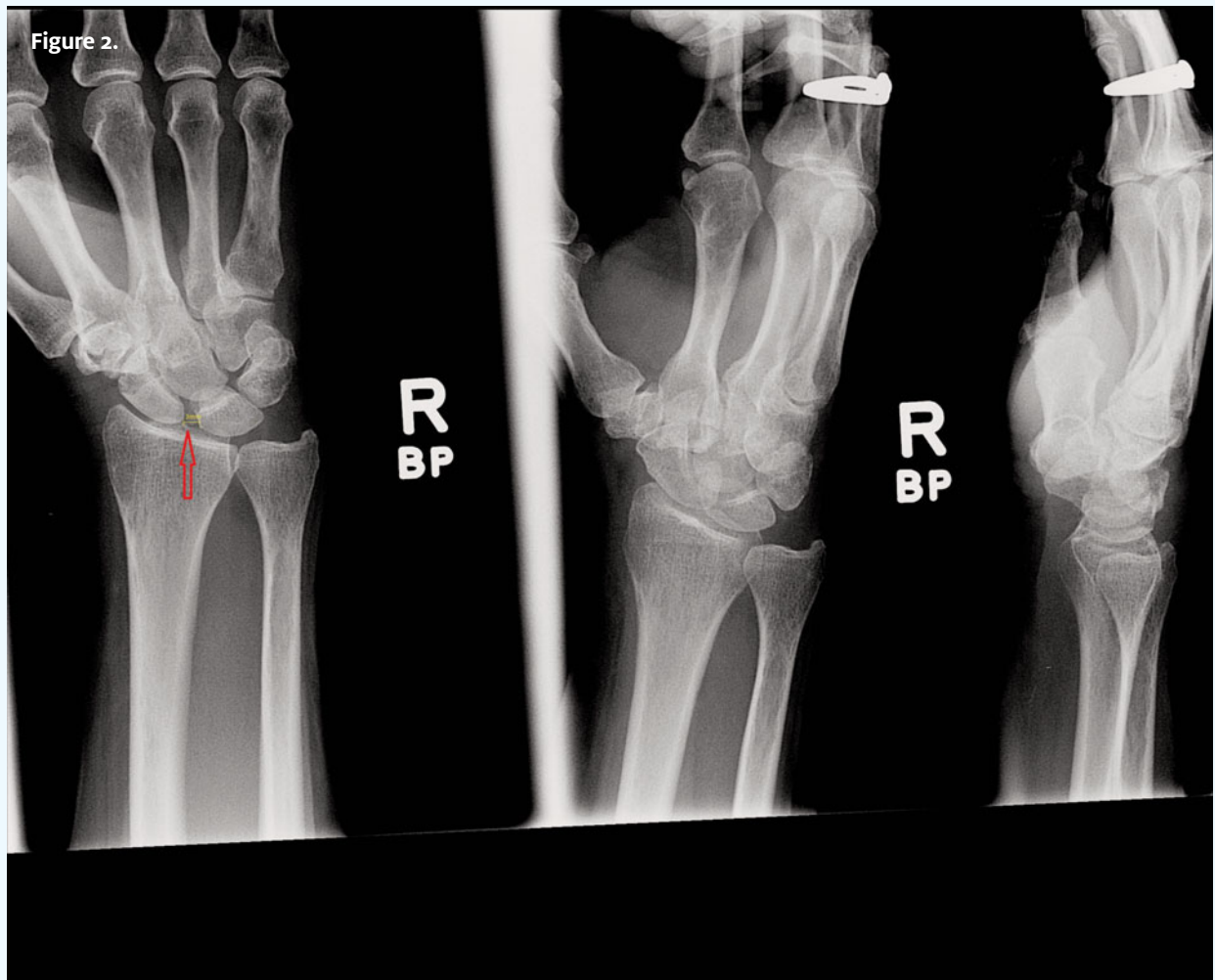


The patient presented with wrist pain after a fall on an outstretched hand (FOOSH).

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: Scapholunate dissociation. This is a significant ligamentous wrist injury. Findings on x-ray can be subtle but are important to identify. There is disruption of the scapholunate ligament with resultant instability.

Anteroposterior radiographs may demonstrate a widened scapholunate space (>3 mm), known as the Leon Spinks sign (a gap-tooth appearance; *red arrow* in **Figure 2**). This is best seen in clenched-fist views and posteroanterior views with the wrist in ulnar deviation.



Medical Malpractice Trial, Part 2: Pretrial

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

Recap of Last Month

Johnny Dalton presented to the emergency department (ED) at St. Jacob's Hospital after ingesting liquid methadone, a long-acting opioid. Responsive Emergency Medicine and Dr. Beth Ange evaluated and monitored Johnny for nearly 12 hours and discharged him home. Johnny was found dead by his family approximately 20 hours after discharge.

- **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.

Filing the Suit

The lawsuit was filed in Maricopa Superior Court, and our group was served by courier on January 22, 2013. Plaintiffs alleged that the St. Jacob's Hospital and Dr. Ange 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.

Response of St. Jacob's Hospital and Responsive Emergency Medicine

St. Jacob's, Dr. Ange, and Responsive Emergency Medicine all deny wrongdoing and assert that Johnny's treatment conformed to the standard of care. In addition, the defendants assert that the injuries and damages alleged by plaintiff were not the result of any negligent act or omission.

Commentary

Up to this point, everything about the case was fairly standard.



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"St. Jacob's, Dr. Ange, and Responsive Emergency Medicine all deny wrongdoing and assert that Johnny's treatment conformed to the standard of care."

A 21-year-old died shortly after discharge from the ED; someone is obviously to blame.

I have told providers for years that medical-malpractice plaintiff attorneys do not take cases with bad facts or sketchy plaintiffs. It cost approximately \$60,000 to \$100,000 to bring a case to trial, and most attorneys simply cannot afford to roll the dice on anything other than a sure thing.

A very well respected medical-malpractice plaintiff's attorney once told me that he takes only 1 or 2 cases out of 100 that present to his firm. So generally speaking, the vast majority of medical-malpractice cases that are pursued have at least some merit on some level.

Plaintiff's Experts

In many jurisdictions, in order to file a medical-malpractice case, an attorney has to file an affidavit by a physician that attests to the merits of the case. The goal of this is to prevent frivolous lawsuits.

In this instance, the plaintiff retained a number of experts, including an emergency medicine physician for standard of care, a pharmacist for causation, a drug addiction specialist, a pathologist, an intensivist, and someone who claimed to do forensic analysis of electronic health records. The 2 principle experts were the emergency medicine physician, who testified that all people with methadone overdoses must be admitted, and the pharmacist, who opined on all sorts of things, including postmortem drug distribution and the pharmacologic effects of methadone.

“In many jurisdictions, in order to file a medical-malpractice case, an attorney has to file an affidavit by a physician that attests to the merits of the case.”

In short, the emergency medicine physician testified that Johnny’s death was due to the overdose of methadone consumed 33 hours earlier, because of to a heretofore-unknown bimodal secondary effect or a very prolonged (30-plus-hour) primary respiratory depression. He also opined that despite minimal findings in the ED (somnolence and a respiratory rate measured one time at 11 breaths/minute), Johnny should have been admitted to the hospital, as opposed to simply being observed in the ED for 11 hours. From the testimony transcript:

- 21 Q. And you’re saying, based on this graph, that
22 the respiratory effects of methadone, the respiratory
23 depressant effects, can peak at 24 hours after
24 ingestion?
25 A. That’s correct.

The pharmacist testified about causation, saying that not admitting the patient to the hospital caused his death. In addition, he held forth that the large amount of methadone found in the patient’s stomach after his death was from postmortem redistribution caused by the *initial ingestion* occurring 33 hours prior. In his testimony, he implied that an article and chapter he authored on the subject of redistribution offered evidence to support this high level of methadone. However, the article he referenced never even mentions the drug methadone.

- 13 So the finding of the metabolite as well as the
14 active methadone is consistent with an
15 additional dose of methadone being taken after
16 he left the emergency room, correct?
17 A. Incorrect. That would be consistent with the
18 drug moving. Again, it’s a one-way street so
19 it had to have moved backward.
20 Q. So after death the methadone moved backwards
21 into the stomach in your opinion?
22 A. Not my opinion. There’s post-mortem
23 redistribution literature that would support
24 that, that’s correct, based on the properties
25 of methadone.

In the end, the pathologist, the information technology expert, the addictionologist, and the intensivist added little to the

case, but because they were presented as experts, we had to depose them.

Defense Experts

The defense was fortunate to get 2 experts who were simply the gold standard. The ED physician was an academician out of a large California university and emergency medicine program, and the toxicologist literally wrote the book on toxicology. He was also the head of the California Poison Control System. Likely in an effort to save money (the side deposing the experts pays for their time and expense), the plaintiff’s attorney never deposed the 2 defense experts, so other than what was contained in their disclosures, he had no idea what they were going to say.

New Facts

During the 2 years between serving the defendants and the trial, a number of very interesting facts came to light that I believed altered the very fabric of the case for the plaintiffs. These facts certainly made their case more difficult to present, inasmuch as the new information painted their client in a much less favorable light:

1. Johnny had a large amount of methadone in his stomach at the time of his death.
2. Johnny had tested positive for cocaine, opiates, and marijuana on prior ED visits.
3. Johnny had been arrested for domestic violence approximately 5 months prior to his death. The police report stated that according to his mother, he was buying and selling drugs in the neighborhood.
4. Johnny had 2 empty bottles of lorazepam in his room at the time of death that together had contained 150 pills and were both now empty. Also, lorazepam and its metabolite found in his blood on repeated analysis that specifically tested for the medication.
5. Postmortem toxicology screen results were as follows:
 - Methadone: 16,000 ng/mL in gastric fluid
 - Lorazepam: 5 ng/mL in iliac blood
 - Methadone: 450 ng/mL in iliac blood
 - EDDP (2-ethylidene-1, 5-dimethyl-3, 3-diphenylpyrrolidine): 75 ng/mL in iliac blood

Pretrial Motion Practice

As was his custom, the plaintiff’s attorney made many pretrial motions. Some of them were as follows:

1. Not allowing the jury to know he was also a physician
2. Making a motion to disallow admission of evidence of prior arrests, domestic violence, drug use, or positive findings on drug screens from previous admissions
3. Making a motion to disallow further toxicologic testing specific for Lorazepam

“During the 2 years between serving the defendants and the trial, a number of very interesting facts came to light that I believed altered the very fabric of the case for the plaintiffs. ... [The] new information painted their client in a much less favorable light:”

4. Making a motion alleging punitive damages and hedonic damages
5. Making a motion to lower the burden of proof from clear and convincing to preponderance of the evidence. In Arizona, there is a specific statute that provides that care in an ED is held to a higher standard of proof for malpractice. In other words, the elements to prove malpractice must be grounded in clear and convincing evidence.

Commentary

With each new revelation of a fact—the previous drug use, the police report detailing domestic violence, the large amount of methadone in Johnny’s stomach on postmortem analysis, and the lorazepam in his system—I firmly believed that Greyson would drop the case. However, each time a seemingly adverse fact was revealed, Greyson doubled down and his experts found new theories that supported the new facts. At the same time, the plaintiffs made overtures to settle the case, with decreasing demands every time.

St. Jacob’s submitted an offer of judgment for \$2500, which the plaintiffs accepted. An offer of judgment, if not accepted, obligates the opposing party to pay for all costs and fees if the verdict comes in at an amount less than the offer. For example, if an offer of judgment is made for \$10,000 by the defendants that the plaintiffs refuse, then the plaintiffs are liable for all costs and fees that occur after the offer is made if the verdict is for less than \$10,000. Upon plaintiff’s acceptance, St. Jacob’s was no longer a party to the case.

Responsive Emergency Medicine and Dr. Ange made an offer of judgment for \$10,000, which was refused by the plaintiffs. In addition, Responsive Emergency Medicine and Dr. Ange agreed to settle case for a nominal amount that was well below the plaintiffs’ cost. The plaintiffs refused the offer, and we continued our trial preparation.

Next month, I will recount the trial and the outcome, and I will comment on the state of medical malpractice in the United States. ■

Call for Articles

JUCM, the Official Publication of the Urgent Care Association of America, is looking for a few good authors.

Physicians, physician assistants, and nurse practitioners, whether practicing in an urgent care, primary care, hospital, or office environment, are invited to submit a review article or original research for publication in a forthcoming issue.

Submissions on clinical or practice management topics, ranging in length from 2,500 to 3,500 words are welcome. The key requirement is that the article address a topic relevant to the real-world practice of medicine in the urgent care setting.

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Lee Resnick, MD at

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He will be happy to discuss it with you.





ABSTRACTS IN URGENT CARE

- The Return of Measles
- Treating *Fusobacterium necrophorum* in Adolescents
- Giving Epinephrine for Food Allergies Without a Physician's Diagnosis
- Does Varicella Zoster Virus Cause Giant Cell Arteritis?
- New Pregnancy and Lactation Labeling for Medications

■ 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.

The Return of Measles

Key point: Measles is back, so watch for it among your patients.

Citation: Centers for Disease Control and Prevention. Measles (rubeola). Atlanta, GA: Centers for Disease Control and Prevention [updated February 12, 2015; cited February 18, 2015]. Available from: <http://www.cdc.gov/measles/hcp/index.html>

Unfortunately measles is making a comeback. Most likely because of decisions to delay or avoid immunizations, a measles outbreak began in California in December 2014 and has spread to many other states. No matter your beliefs on the decision to avoid immunization, it is important to consider the possibility of measles in those patients at risk.

Measles is uncommon these days, so a review of the Centers for Disease Control and Prevention (CDC) website is a good idea for all urgent care providers. The following are highlights from the CDC:

- Signs and symptoms include fever as high as 105°F, malaise, cough, coryza, and conjunctivitis, followed by maculopapular rash.
- Koplick spots, which present in the mouth, are pathognomonic.



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.

- The incubation period is 7 to 21 days, and patients are contagious 4 days before and after the rash.
- Of every 1000 patients with measles, 1 to 2 will have life-threatening neurologic or respiratory complications.
- There is no specific treatment, other than observation, for secondary bacterial infections such as otitis media or pneumonia.

From an urgent care perspective, it is wise to consider the possibility of measles and to be aware of its signs and symptoms during an outbreak like this one. ■

Treating *Fusobacterium necrophorum* in Adolescents

Key point: There is another potential cause of pharyngitis.

Citation: Centor RM, Atkinson TP, Ratliff AE, et al. The clinical presentation of *Fusobacterium*-positive and streptococcal-positive pharyngitis in a university health clinic: a cross-sectional study. *Ann Intern Med.* 2015;162:241–247.

Recent data from Europe have shown that pharyngitis in adolescents may be caused by bacteria other than group A *Streptococcus*, including *Fusobacterium necrophorum*, which is known to be the most common cause of peritonsillar abscess in this age group. It also is the most common cause of Lemierre syndrome, which is more common than rheumatic fever in adolescents and young adults, includes suppurative internal jugular thrombophlebitis, and may infect the lungs, brain, or joints. This study assessed 312 patients with pharyngitis and 180 healthy volunteers between the ages of 15 and 30 years to determine the prevalence of *F. necrophorum* compared with the

prevalence of group A *Streptococcus*, group C and G *Streptococcus*, and mycoplasma. Patients were evaluated by polymerase chain reaction shown on throat swab cultures as well as by Centor score. Results were complex and showed a prevalence of group A *Streptococcus* of 10% in symptomatic patients and 1% in study volunteers. *F. necrophorum* was present in 20% of symptomatic patients as well as in 10% of volunteers. The authors also reported that a Centor score of ≥ 2 correlated with a 40% risk of one of these bacterial infections, and that a score of 4 correlated with a 70% risk.

Unfortunately *F. necrophorum* does not grow on standard throat cultures, and there is no a commercial test for it available at this time. The study's findings require further confirmation, especially to prove causation. For urgent care providers, the take-home message is that *F. necrophorum* is sensitive to penicillins and first-generation cephalosporins but not to macrolides, tetracyclines, or fluoroquinolones. If you are going to treat a patient of this age, using antibiotics that cover *F. necrophorum* should be a consideration. ■

Giving Epinephrine for Food Allergies Without a Physician's Diagnosis

Key point: *Chicago schools now have epinephrine for use in allergic reactions to foods.*

Citation: DeSantiago-Cardenas L, Rivkina V, Whyte SA, et al. Emergency epinephrine use for food allergy reactions in Chicago public schools. *Am J Prev Med.* 2015;48:170–173.

This article describes the experience in Chicago public schools with undesignated epinephrine injectors and food-induced allergic reactions. In the past, epinephrine was available to patients only with prior prescriptions on file at the schools, and school staff members were not permitted to use injectors not prescribed for a particular patient even when the patient was known to have an allergy. The new option was used to assist 38 students and staff members. More than half of these cases involved first-time reactions. No negative results were reported. From an urgent care perspective, it is important to determine whether a patient presenting with an allergic reaction has already received epinephrine without a physician's diagnosis. ■

Does Varicella Zoster Virus Cause Giant Cell Arteritis?

Key point: *Another problem potentially caused by zoster virus.*

Citation: Gilden D, White T, Khmeleva N, et al. Prevalence and distribution of VZV in temporal arteries of patients with giant cell arteritis. *Neurology.* 2015 Feb 18. doi: 10.1212/wnl.0000000000000014. [Epub ahead of print.]

Giant cell arteritis (GCA) is an uncommon but important diagnosis in the acute-care setting. The authors of this study

*“For urgent care providers, the take-home message is that *F. necrophorum* is sensitive to penicillins and first-generation cephalosporins but not to macrolides, tetracyclines, or fluoroquinolones.”*

attempted to determine whether the varicella zoster virus (VZV), believed to cause several other syndromes such as Bell palsy, might cause GCA as well. Specimens from patients with biopsy-proven GCA as well as specimens from 13 cadavers of people who died after age 50 years were reviewed to determine the presence of VZV. The authors found that 61 of 82 GCA specimens (74%) contained VZV, whereas only 1 of 13 cadaver specimens of the temporal artery had VZV. Although the authors proposed treating these patients with antivirals, they presented no evidence of any benefit, only speculating that long-term use of steroids may suppress a patient's ability to clear the virus. These findings are very preliminary and do not prove causation. However, urgent care providers should watch for further research that will provide information on potential benefits from antivirals and on appropriate doses. ■

New Pregnancy and Lactation Labeling for Medications

Key point: *Federal changes to labels for medications will help physicians with risk-to-benefit assessment when prescribing for pregnant and lactating women.*

Citation: Pregnancy and lactation labeling final rule. Silver Spring, MD: U.S. Food and Drug Administration [updated 2014 December 4; cited 2015 February 11]. Available from: <http://www.fda.gov/Drugs/DevelopmentApprovalProcess/DevelopmentResources/Labeling/ucm093307.htm>

The U.S. Food and Drug Administration (FDA) has published new labeling requirements for medications prescribed to pregnant and lactating. Before this ruling, the FDA used a five-letter system (A, B, C, D, and X) to rate medications according to several parameters. The labeling revisions, which will take effect on June 30, 2015, came about because of feedback provided to the FDA that the letter system was confusing and simplistic. The new labeling will have information for contacting relevant pregnancy drug-exposure registries. A sample of the sections to be used under the new labeling system can be found at <http://www.fda.gov/ucm/groups/fdagov-public/documents/image/ucm425205.png>. The ruling does not mandate label changes for over-the-counter medications. In the urgent care setting, the new labeling should help make it easier for clinicians to weigh risks and benefits when prescribing for this population of women. ■



Modifier -X {EPSU}, Pneumococcal Immunizations

■ DAVID STERN, MD, CPC

Q. Have there been any updates from CMS (Centers for Medicare & Medicaid Services) regarding the new -X modifiers that were introduced in January of this year?

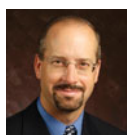
A. CMS released MLN Special Edition article SE1503 on January 22, 2015 (see <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLN-MattersArticles/Downloads/SE1503.pdf>), stating that there would be forthcoming guidance as to the appropriate use of the new -X {EPSU} modifiers and “that guidance will include additional descriptive information about the new modifiers” before implementing edits or audits.

The bottom line is that you should continue to use the -59 modifier where appropriate. You should not use an -X modifier until CMS publishes “specific guidance.”

You will also want to check with Medicare Administrative Contractors (MACs) as well as commercial payors for guidance before using any -X modifiers. It is likely that most payors will wait until CMS releases more information and case scenarios before providing their own rules, or their current rules may change on the basis of what CMS releases in the future.

I will continue to monitor CMS and other payors nationally for updates and offer assistance where I can. ■

Q. I understand that Medicare considers the pneumonia vaccine benefit a “once in a lifetime” benefit unless the patient is at high risk for the disease. Is this true? What do we do in the case where our patients cannot remember whether they have received the vaccine?



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 bottom line is that you should continue to use the -59 modifier where appropriate.”

A. There are two vaccines for pneumococcal immunization in adults: 23-valent pneumococcal polysaccharide vaccine (PPSV23) and 13-valent pneumococcal conjugate vaccine (PCV13). The brand names for these are Pneumovax 23 and Prevnar 13, respectively. PPSV23 is the most commonly known and since 1983 has been used for adults aged 65 years and older. PCV13 was approved, effective December 30, 2011, for adults aged 50 years and older.

Medicare states that routine revaccinations of people age 65 or older who are not at high risk are not appropriate and that payment will be denied unless there is a diagnosis to substantiate it.

Examples of chronic diseases and conditions warranting vaccination include cardiovascular disease, diabetes, pulmonary disease, alcoholism, cirrhosis of the liver, and spinal cord leakage. Examples of immunocompromised patients include those with asplenia, splenic dysfunction, lymphoma, Hodgkin disease, chronic renal failure, human immunodeficiency virus, sickle cell disease, malignancies, or nephrotic syndrome and those receiving immunosuppressive chemotherapy or undergoing organ transplantation.

Further, according to the *Medicare Claims Processing Manual*, those administering the vaccine should not require the patient to present an immunization record, nor should they feel compelled to review the patient's complete medical record if it is not available. Instead, they should rely on the patient's verbal history, as long as the patient is mentally competent. If the patient is uncertain about their vaccination history in the past 5 years, the vaccine should be given. However, if the patient is certain that they were vaccinated in the last 5 years, the

CODING Q & A

vaccine should not be given. If the patient is certain that they were vaccinated more than 5 years earlier, revaccination is not appropriate unless the patient is at highest risk.

Recently, the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP) recommended that both PPSV23 and PCV13 be given routinely as a series to all adults aged 65 years and older. If a patient in that age group has not been previously immunized, or their immunization history is unknown, the CDC recommends a dose of PCV13 first, followed by PPSV23 in the following 6 to 12 months.

This certainly presents a dilemma for the provider trying to care for the patient but also get paid for services provided. Providers should ask Medicare patients to sign an Advance Beneficiary Notice (ABN) prior to receiving the vaccine, depending on frequency or unknown vaccine status. The ABN allows a provider to balance-bill the patient to recoup the cost of the vaccine if Medicare denies the claim.

Each vaccine has its own *Current Procedural Terminology* (CPT) code for billing. Coders should bill as follows:

- Code 90670, "Pneumococcal conjugate vaccine, 13 valent, for intramuscular use," for PCV13
- Code 90732, "Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use," for PPSV23

The administration code for either vaccine is HCPCS code G0009, "Administration of pneumococcal vaccine."

With any revaccination, remember to discuss the risks and benefits with the patient and have the patient sign an ABN.

In addition to the codes for billing, the coder must always be aware of the appropriate modifiers when issuing an ABN or if there is an uncertainty regarding payment:

- **GA:** "Waiver of liability statement issued as required by payer policy, individual case"
- **GK:** "Reasonable and necessary item/service associated with GA or GZ modifier"
- **GZ:** "Item or service expected to be denied as not reasonable and necessary"

As long as there is conflict between the CDC, ACIP, and CMS recommendations, health-care providers must use their clinical judgment, based on the patient's medical history, need, chronic conditions, and degree of risk, when documenting and billing for this service. ■

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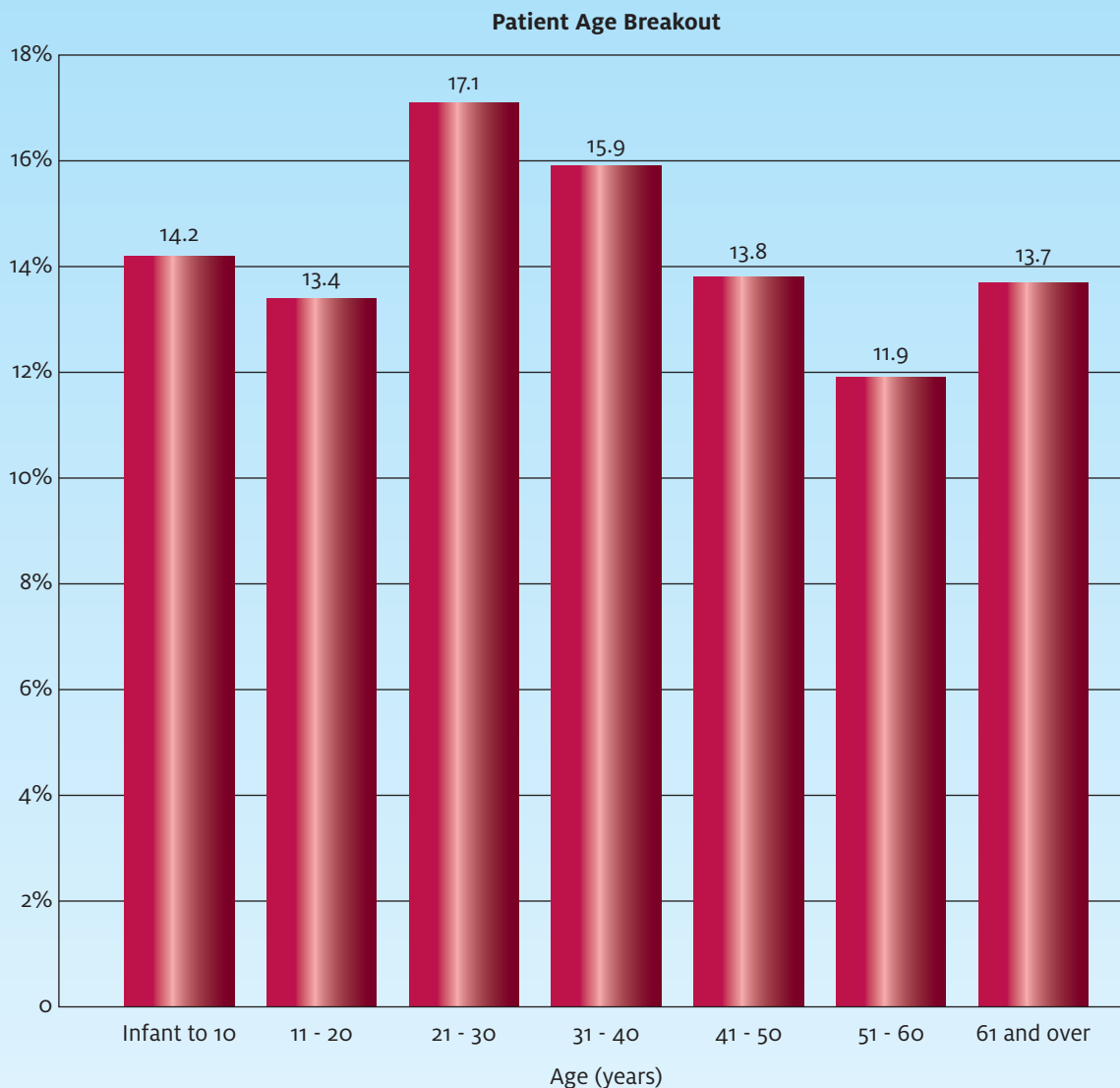


DEVELOPING DATA

Data from the 2014 Urgent Care Chart Survey of 1,778,075 blinded patient visits to more than 800 different urgent care clinics, conducted by the *Journal of Urgent Care Medicine*, show that the 2 largest age groups of patients using urgent care centers were 21 to 30 years (17.1%) and 31 to 40 years (15.9%); the smallest age group was 51 to 60 years (11.9%).

The survey's methodology and data abstraction forms were initially designed in 2008 by researcher Robin M. Weinick, PhD, then an assistant professor at Harvard Medical School and a senior scientist at the Institute for Health Policy at Massachusetts General Hospital, and now associate director of RAND Health.

PATIENT AGE BREAKOUT FOR THE U.S. URGENT CARE MARKET IN 2014



Source: 2014 Urgent Care Chart Survey, *Journal of Urgent Care Medicine*.



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