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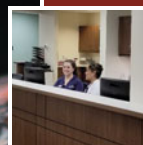
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LETTER FROM THE EDITOR-IN-CHIEF

The Change Gang: Adopting a Disruptive Culture



We've all heard it: *Why do we have to change? This is the way we've always done things!* Change is difficult, even for those of us who embrace it. But it is especially difficult for non-owner employees.

After all, why welcome the discomfort and uncertainty of change if there is no upside to your personal bottom line? This is perhaps one of the biggest challenges we face as the urgent care industry matures and competition for a finite number of patients increases. If we don't differentiate, we die. But getting everyone on board with disruptive change is a difficult task.

Perhaps the most important first step we can take is to develop a mutual understanding that change is necessary.

Setting the tone for an adaptive and innovative culture starts with a conversation about the future and the challenges to continued success in a rapidly changing business environment. Our staff understands that we are dependent on our patients as consumers of healthcare and can certainly comprehend the need to adapt to their evolving preferences. They also understand that we are competing with others for their business.

It can help to start the conversation with a little history. When urgent care first came on the scene, there was a pent-up demand for access to healthcare. Some forward-thinking physician entrepreneurs made up the bulk of the early growth in urgent care by addressing the access issues. The mere availability of healthcare at convenient times and locations was enough to attract large numbers of patients. Everyone was happy, and business was plentiful.

Fast forward to the last 5 years and access is no longer an issue. There is an urgent care on every corner, a retail clinic in every pharmacy, and even an inexpensive video consult available from every phone. Even traditional healthcare has entered the fray, making primary, specialty, and emergency care more patient-centric and accessible. Access is of little value anymore. Now the industry is focused on providing superior service and efficiency with more sophisticated operations, technologies, and other innovations to serve an increasingly demanding clientele. Everything about the urgent care encounter is now ripe for disruption, from navigation to registration, payment to care coordination; it's all under review. And despite what

"Urgent care is at a crossroads; the status quo is not going to get the job done."

some might declare, nobody knows for certain which levers to pull for success. This is where we have to get our staff comfortable piloting ideas, with all the flexibility and patience that comes with it.

Once your staff understands the necessity for change, soliciting their suggestions will help them feel like they are an active part of the evolution, rather than victims of it. The practice leader's job is to set the stage, identify customer dissatisfiers, and then enlist the staff to help solve the problem without any boundaries for ideas. Consider the way we historically welcome our patients to their care encounter: "Driver's license, insurance and credit card...please." Now go sit down, fill out a lot of redundant paperwork, and then *wait* until we privilege you with our care. Not the most inviting way to show we care, but this is how we've done it forever. You can't change it now! Or can you? You will be surprised by the creative energy your staff can demonstrate when you enlist them in the process. You may even ask them to rank the ideas based on cost, feasibility, and impact. If you can choose at least one of these ideas to pilot, you have successfully engaged your team in the process of disruptive change and given them a sense of ownership and responsibility for its success. Suddenly, they are leading on their own, willingly embracing what they once bemoaned.

Urgent care is at a crossroads and the status quo is not going to get the job done. Creating a disruptive culture that generates enthusiasm for change and staff ownership will help propel your urgent care down the challenging roads ahead. ■

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

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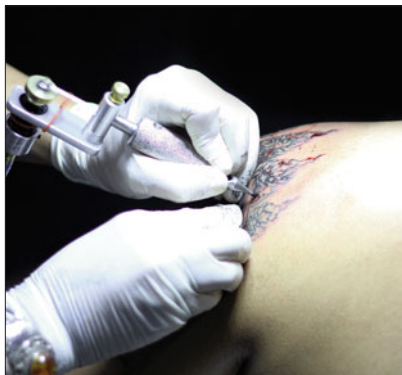
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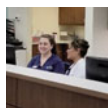
11 Tattoos and Piercings: What the Urgent Care Provider Needs to Know

The popularity of body art has grown dramatically among all ages, ethnicities, and gender groups. And the occurrence of complications has grown right along with it. Be prepared to assess and treat them, and to counsel patients who may have 'buyer's regret' about adorning their bodies.

Tracey Quail Davidoff, MD

PRACTICE MANAGEMENT

21 Facility Design: Cultivating Collaboration in the Back Office

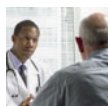


Current trends in office design favor open spaces that reflect a team approach with an open design. On the other hand, managers and clinicians may feel strongly about having a private office. What's best for your location?

Alan A. Ayers, MBA, MAcc

CASE REPORT

29 Cardiopulmonary Emergency Masquerading as Gastrointestinal Symptoms



A patient complaining of gastrointestinal pain or discomfort could have simply had a bad meal, or be experiencing a life-threatening event. Be prepared to see the distinctions on the spot.

Nihar B. Gala, MD

HEALTH LAW AND COMPLIANCE

33 The Importance and Validity of Nondisclosure and Nonsolicitation Clauses for Urgent Care Center Owners



Nondisclosure and nonsolicitation clauses offer urgent care operators some level of protection from outgoing employees' taking proprietary information, customers, and patients with them when they leave your employ. Make sure you understand their limitations.

Alan A. Ayers, MBA, MAcc

IN THE NEXT ISSUE OF JUCM

You've seen them in your urgent care center. One or two may have cornered you at your child's soccer game. The fact is that patients with back pain are everywhere—up to 80% of the U.S. population experiences it at some point in their lives, in fact. If you're among them, you know firsthand the only thing that matters during an acute episode is getting relief. Are you prepared to evaluate them; treat, transfer, or reassure them; and distinguish people in real anguish from those who are seeking medication to use recreationally or feed an addiction? Read the cover article in the May issue of JUCM and you will be.

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Mission Statement

JUCM The Journal of Urgent Care Medicine (ISSN 19380011) 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 College of Urgent Care Medicine, *JUCM* seeks to provide a forum for the exchange of ideas regarding the clinical and business best-practices for running an urgent care center.

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Tattoos and piercings have gone from novelties one expected to see on sailors, bikers, and criminals to being widely perceived as colorful forms of self-expression. The style has kept pace, too; instead of the name of a battleship or a cartoonish hula dancer, some devotees see their skin as a blank canvas for honest-to-goodness art. And what used to be a rite of passage for young American females has broken through all barriers of gender, age, and anatomy: piercings seem to be nearly as prominent as tattoos and men and women continue to find creative ways to carry them in nearly every conceivable body part.

Unfortunately, no matter how much societal norms change or how modernized the equipment has become there is still a wide range of risks associated with any penetration of the human skin. If you haven't seen a patient with a possibly infected new tattoo or a septal hematoma from a nose piercing gone awry yet, don't assume it couldn't happen next week.

Fortunately, this week—today—you have an opportunity to read up on how to recognize, assess, and manage complications from tattoos and piercings. A new original article by **Tracey Quail Davidoff, MD** on that very subject starts on page 11 of this issue.



Dr. Davidoff practices at Rochester (NY) Regional Health/Immediate Care and is a senior clinical instructor in the Department of Emergency Medicine at Rochester General Hospital. She is also a member of the JUCM Editorial Board.

Perhaps more challenging to identify than such complications



is what's ailing a patient who comes in complaining of gastrointestinal discomfort. Sure, it could be something relatively simple and benign—or it could be something far more impactful than a stomach virus or minor food poisoning, something deadly in disguise. This is the subject of *Cardiopulmonary Emergency Masquerading as Gastrointestinal Symptoms* (page 29), a new case report by **Nihar B. Gala, MD**, an urgent care and primary care physician with Alpha Health Centers and Alpha Care Medical in Delaware. A graduate of Rutgers University New Jersey Medical School, he is currently enrolled in the Temple University Fox Graduate Online MBA program.

These are all scenarios where good communication between the provider and the patient is essential. Without it, outcomes may be poor. Likewise, communication among colleagues is paramount to running an efficient, profitable urgent care center where all patients can receive excellent care. Have you considered, however, whether the layout of your workspaces supports that mission—or works against it? It's true: Whether your location is a traditional office where providers are sequestered behind closed doors when they're not seeing patients or a more modern, "open" space could be affecting the efficiency of your whole

operation, from patient throughput to HIPAA compliance to team morale. Find out how by reading *Facility Design: Cultivating Collaboration in the Back Office* (page 21) by **Alan A. Ayers, MBA, MAcc.**



Mr. Ayers is the chief executive officer of Velocity Urgent Care and is practice management editor of *The Journal of Urgent Care Medicine*.

In addition to his expertise in running urgent care centers of the highest caliber, Mr. Ayers knows a thing or two about keeping the operation running above board and in compliance. One area some operators may not consider is, what happens when employees who know your whole playbook, have a legion of loyal patients, or who have established relationships with some of your biggest occupational medicine customers leave your employ? You can diminish the odds that your business will suffer unduly if you prepare before anybody jumps ship. Mr. Ayers' second article in this issue, *The Importance and Validity of Nondisclosure and Nonsolicitation Clauses for Urgent Care Center Owners* is a great place to start. You can find it on page 33.

Also in this issue:

Lower A1c targets for patients with type 2 diabetes and overuse of self-prescribed ibuprofen are subjects that have crossed over from "medical news" to mainstream media recently. In *Abstracts in Urgent Care* (page 24), **Glenn Harnett, MD** takes a closer look at what they really mean to you, the urgent care provider. He also reviews new literature on redocumenting student E/M entries (or not), excessive fluoroquinolone use, referring patients with presumed cellulitis, curbing childhood obesity, and more. Dr. Harnett is principal, No Resistance Consulting Group, as well as a contributing editor and member of the JUCM Editorial Board.

Another of our highly esteemed contributing editors shares his considerable expertise on ensuring you get the most revenue from every patient encounter in *Revenue Cycle Management* every month. In this issue, **David E. Stern, MD, CPC** answers questions about the intricacies of "incident-to" billing when nonphysician providers treat patients. Turn to page 36 to read all about it.

A Note of Thanks to Our Peer Reviewers

We appreciate the time the following urgent care leaders took to review and comment on content for the April issue:

- Victoria Boisen, DO
- Joseph Toscano, MD
- Elisabeth Scheufele, MD, MS, FAAP

Their efforts are essential to our mission of providing content that is relevant to urgent care readers, in an urgent care voice. ■



CONTINUING MEDICAL EDUCATION

Release Date: April 1, 2018

Expiration Date: March 31, 2019

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Learning Objectives

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

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CONTINUING MEDICAL EDUCATION

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Tattoos and Piercings: What the Urgent Care Provider Needs to Know (p. 11)

1. Complications of tattooing may include:

- a. Infection
- b. Inflammatory reaction, such as keloid formation
- c. Allergic reaction
- d. Granulomatous reaction such as sarcoid
- e. All of the above

2. Complications from tattooing are extremely rare

- a. True
- b. False

3. What are the most common pathogens complicating an ear piercing?

- a. *E coli*
- b. *Klebsiella*
- c. *Mycobacteria*
- d. *Staphylococcal aureus* and *Streptococcal pyogenes*
- e. *Mycoplasma*

Facility Design: Cultivating Collaboration in the Back Office (p. 21)

1. In what way does HIPAA compliance affect the facility design of an urgent care?

- a. HIPAA does not affect the facility design
- b. HIPAA states that physicians must have their own offices
- c. Providing an office for a doctor would help ensure that doctors are in compliance with HIPAA
- d. None of the above

2. How would the elimination of private offices impact clinic flow?

- a. There would be less time to be distracted with idle web-surfing and emails
- b. It would allow more timely communication between staff
- c. Increase door-to-door time for patients
- d. None of the above

3. How can urgent cares accommodate the needs of privacy for staff members?

- a. Designated quiet rooms
- b. Phone rooms
- c. Consultation rooms
- d. Conference rooms
- e. All of the above

Case Report: Cardiopulmonary Emergency Masquerading as Gastrointestinal Symptoms (p. 29)

1. Which of the following are indications for obtaining a chest radiograph?

- a. Chest pain
- b. Low O₂ saturation
- c. Cough with fever and shortness of breath
- d. Palpitations, shortness of breath, and a sense of “impending doom”
- e. All of the above

2. What is the mortality rate for acute respiratory distress syndrome (ARDS)?

- a. 5%
- b. 10%
- c. 35%–46%
- d. 95%
- e. 99%

3. A 40-year-old obese male presents with acute epigastric tenderness, nausea, and vomiting. He has a history of alcoholism. Which of the following diagnoses needs to be emergently excluded?

- a. Acute pancreatitis
- b. Gastroesophageal reflux disease
- c. Abdominal muscular strain
- d. Viral pleurisy
- e. Acute bronchitis



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Start a Revolution at Evolution 2.0

■ LAUREL STOIMENOFF, PT, CHC

It's not surprising that Amazon, Berkshire Hathaway, and JPMorgan Chase have joined forces to impact the rising costs of healthcare. The complexities of healthcare and the billions spent annually on healthcare lobbying have limited the ability of the government to implement any material change. The 1976 movie *Network* features fictional broadcaster Howard Beale's famous speech where he implores the people to open their windows and yell out, "I'm not going to take this anymore!" He tells his listeners to first get mad, then we'll all figure out how to solve the problem.

This seems to be the approach being taken by these titan corporations. They have indicated that they intend to leverage technology as a solution, but little else is known about how they are going to revolutionize healthcare delivery. But they're mad. And we can help.

The Affordable Care Act made changes, but 11.7% of adults were uninsured in 2017.¹ And the average family who *did* have coverage experienced their employer-sponsored healthcare premium grow 20% from 2011 to 2016, with an anticipated increase of another 6.5% in 2018.² Some predict that as healthcare costs increase and income remains relatively constant, staying well will consume the average worker's income in the not-too-distant future. And when two lines cross on a graph, something big is bound to happen. Mike Ferguson, chief operating officer of the Self-Insured Institute of America, wrote "By breaking free of the conventional coverage model, self-insured companies are finding innovative ways to improve the health of their workers, and at lower cost. Business leaders and policy-makers should take note."³

Consumer-driven healthcare isn't going away. But we need to do more than adapt to these inevitable changes. We need to collaborate with these innovators and invent the future. Telemedicine's growth was catalyzed by the self-insured employers. When Cigna and United Health put their toe in the

"We need to do more than adapt to change. We need to collaborate and invent the future."

water to cover telemedicine visits several years ago, the coverage was limited to the self-insured groups they administered.

So, what can we do? Our growth strategies must extend beyond penetrating the traditional payer community to partnering with employers. The next time you have an opportunity to speak with an employer about their injured worker, why not bring up the benefits you can provide by caring for their entire workforce? You can set up an on-site or provide care in your near-site center. Many payer contracts restrict you from providing care that extends beyond episodic illness and injury, but employers shouldn't care where the wellness care is taking place. You have the opportunity to provide unfettered care where the employee's health and future savings are the ultimate goals.

Embrace change, embrace technology, and embrace integration. Get involved in healthcare policy at the state level and help UCAOA when we need your voice at the federal level. It's much more satisfying to proactively influence policy than fall victim to it.

I hope you'll join us next month at the Paris Hotel in Las Vegas for UCAOA's Annual Convention & Expo. We will address employer strategies and update you on the regulatory climate. We'll host state and chapter networking discussions and encourage thought leadership on strategies to influence meaningful change. The convention has been dubbed Evolution 2.0 to reflect the next trajectory of our relatively nascent industry. Think of it as **(R)EVOLUTION 2.0**, and together, let's lead it. ■

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



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Tattoos and Piercings: What the Urgent Care Provider Needs to Know

Urgent message: Tattoos and piercings are becoming commonplace, but patients who experience complications with these forms of body art may present to urgent care centers, as access to dermatology and plastics specialists frequently requires a referral or extended wait periods. The urgent care provider should possess a working knowledge about how tattoos and piercings are performed, how to recognize the complications, and how to treat them appropriately.

TRACEY QUAIL DAVIDOFF, MD

TATTOOS

Introduction

The term *tattoo* is derived from the Tahitian word *tattau*, which translates “to mark.”¹ Tattoos occur when pigment granules are embedded into the skin either purposefully or accidentally. Purposeful tattoos have been performed for thousands of years to identify individuals, associate them with groups, for protection, and for artistic expression. Accidental tattoos occur when pigment, such as graphite, dirt, or other substances are ground into the skin during an injury. This article will focus on purposeful tattoos.

Previously in the Western world, decorative tattoos were primarily seen in men, especially in members of the armed forces or other groups to inspire solidarity. Beginning in the 1990s, tattooing gained more popularity and is now quite common in young people of both sexes, including professionals.

“Cosmetic” tattoos are tattoos performed in areas where makeup is typically applied. Also called *permanent makeup*, common applications include eye brows, eye liner, lip liner, and lip stick. Some may have birthmarks tattooed on their skin.

Reconstructive tattoos are done after cancer treatments to replace lost hair and pigmentation, either by surgical removal or loss due to chemotherapy. Examples include areola, brows, and eyelashes. Tattoos may also be used to mark areas undergoing radiation treatment.



A tattoo is created by using a pointed object to introduce particles of pigment into the dermis. In the most basic of forms, this is done by placing the pigment on the skin and using a pin or other sharp object to pierce the skin, allowing the pigment to enter the dermis and remain there permanently; examples include prison tattoos and self-made tattoos in adolescents, gangs, and

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Figure 1. Henna tattoo. (Photo courtesy of Dewanshi Patel, PA-C.)



persons who cannot afford a professional tattoo. Pigments used include the ink from a pen or graphite from a pencil, or mascara. On the other hand, professional tattoo artists use electric needles to inject the colored particles into the dermis.

Henna is a form of tattoo that does not require use of needles. Instead, temporary stains are applied to the skin (**Figure 1**); these wear off in days to weeks. Also called mehndi, henna is made from a vegetable dye made from hina, or the henna tree. This practice originated in the middle east and expanded to Asia and Africa. It is used to stain skin, hair and fingernails, as well as fabrics and leather. Henna pigment is applied as a wet paste to the skin and allowed to dry. The crusted pigment is then brushed off and the skin remains stained in the design applied.

Although there are generally few complications, in some cases the henna is mixed with p-phenylenediamine (PPD) to produce a blacker color. This can cause an acute allergic contact dermatitis which may even be associated with systemic reactions, such as generalized lymphadenopathy and fever.¹ Experienced artists will not use PPD, and will make their own henna to be sure PPD is not present in the product.

Complications

The most common complication of tattooing is regret and dissatisfaction—for example, tattooing the name of a romantic interest with eventual termination of the relationship. Younger persons may tattoo images such as cartoon characters, musicians, or reflecting other

interests that change as they age. Tattoos placed in areas such as the neck, face, or hands cannot be covered and may prevent job advancement; tattoo artists call these “career enders.” Sometimes the image does not turn out as the person intended, is off center or crooked, or was poorly done. Most tattoos will fade or stretch over time, especially if the person gains weight. The only corrections for these problems are modification of the original tattoo (by tattooing over the original tattoo) or removal.

Medical complications from decorative tattooing in the developed world are surprisingly rare, but as the incidence of tattooing increases, so do the complications. In most countries, there are few regulations promoting safe tattooing, making complications more common.¹ The introduction of foreign substances into the skin can result in toxic or immunologic reactions to the pigment, transmission of infections in the event of improper sterilization, and the localization of skin disease within the tattoo. Immunologic reactions include acute inflammatory reactions and allergic hypersensitivity.

Acute inflammatory reactions can occur due to the physical tissue injury of the skin, or reaction to the dyes or metals used to produce the pigment. These reactions usually resolve spontaneously in about 2-3 weeks and are *expected* adverse events of the tattooing process. (See **Figure 2** and **Figure 3**.)

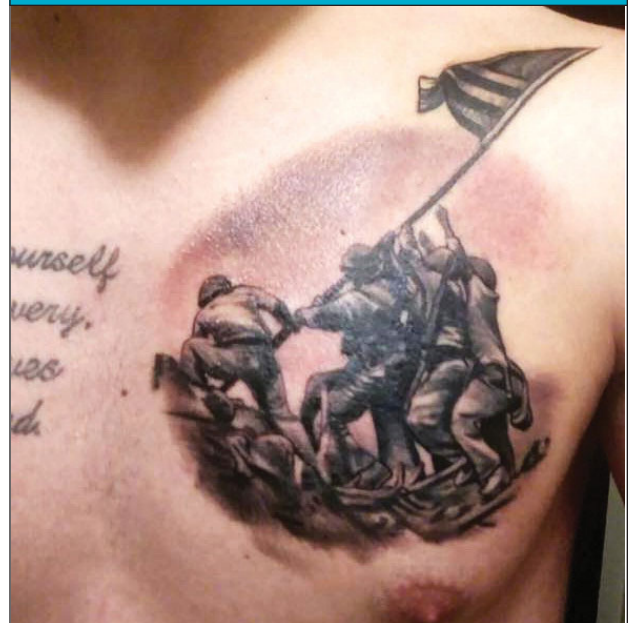
Infection can occur due to a break in the skin, as in any other skin injury. This can result in cellulitis, fasciitis, and even sepsis. The most common pathogens are Staphylococcal and Streptococcal species, including MRSA. Improper disinfection of the skin prior to tattooing, as well as improper aftercare, can contribute to infection.¹ There have been reports of *Vibrio vulnificus* infection causing sepsis and death from swimming in ocean water with a recent, unhealed tattoo.² Transmission of blood-borne diseases such as tuberculosis, syphilis, hepatitis B and C, and HIV have also been reported from tattooing, most likely from using improperly sterilized needles; occurrence of these events is unknown. In some areas, persons with recent tattoos are prohibited from giving blood for fear of transmitting hepatitis and HIV. Person-to-person transmission of viruses such as vaccinia and HPV have also been reported.³ Infectious agents may also be present in ink; it is estimated that approximately 10% of new inks are contaminated with pathogenic bacteria.⁴ Trauma to the skin can also reactivate infections such as HSV and VZV.¹ Leprosy has been reported related to tattooing in India.¹

Later reactions include an allergic sensitivity to the elements of the pigment in the tattoo. Red pigments

Figure 2. Tattoo, 1 day old. Note the red inflammation around the tattooed area. (Photo courtesy of Mary Ann Ventura, RN.)



Figure 3. Same tattoo 2 weeks later. (Photo courtesy of Mary Ann Ventura, RN.)



are a common offender. This results in acute or chronic contact dermatitis or a photoallergic dermatitis. This can manifest as localized eczematous eruptions or as an exfoliative dermatitis. Photoaggravated reactions are most commonly caused by yellow pigment, which contains cadmium sulfide, a chemical used in photoelectric cells. Reactions to green, blue, and black pigments are much less common. Green tattoos have been linked to eczema at the site of the pigment, as well as more generalized eczematous reactions.⁵ Blue pigments containing cobalt aluminate may cause a localized hypersensitivity, and rarely uveitis. Allergic reactions to black pigment are very rare, and presumably due to a sensitivity to carbon.

Granulomatous reactions can occur due to any pigment, and in rare cases can be linked to sarcoidosis. Such cases may warrant further investigation for systemic sarcoid. Lichenoid reactions are even less common and may be related to a delayed hypersensitivity, similar to a graft-vs-host reaction, with mercury found in red pigment the most common offending agent. The area of red in the tattoo is usually affected, but warty papules or plaques may be more generalized.⁶ Pseudolymphoma-like lesions may also occur as red nodules in or around the tattooed area.

Several generalized cutaneous disorders also show affinity for tattooed skin. Lichen planus, psoriasis, sarcoidosis,

and lupus erythematosus have all been shown to localize to tattooed skin. Other trauma-related lesions may occur (eg, keratoacanthoma, squamous carcinoma, basal cell carcinoma, and melanoma). Primary melanomas may be difficult to see if they lie within a tattooed area, preventing timely diagnosis. The carcinogenic effects of the deposited metal in the pigments are unknown.

Newly tattooed skin should be covered with petroleum jelly to prevent oozing of serosanguinous fluid if this has not already been done by the tattoo artist or the patient. The area should be cleaned twice daily with a gentle antimicrobial soap and the petroleum jelly reapplied. The patient should avoid contact with the tattoo except for cleaning. Tattoos generally take about 2 weeks to heal. Patients should be instructed to avoid baths, swimming, and sun exposure, and to wear loose clothing that will not stick to the tattoo.

Treatment of Complications

Infections should be treated as any other skin infection (eg, abscess and cellulitis). Incision and drainage may be necessary. Wound cultures may be helpful to guide treatment. Cellulitis may require IV antibiotics in severe cases or disseminated infection. Empiric antibiotic choices in accord with local recommendations and antibiograms should be aimed at the usual suspects: *Staphylococcus*, *Streptococcus*, and MRSA.

Figure 4. Tattoo with bleeding of the pigment over time. Note the bluish discoloration of the skin.

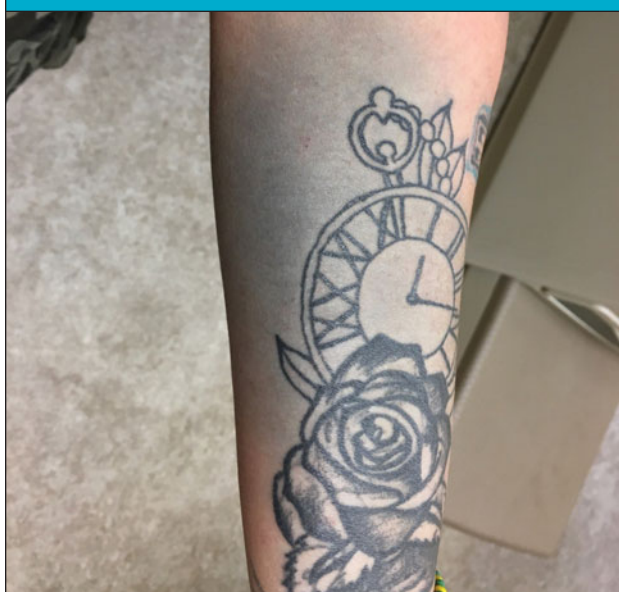
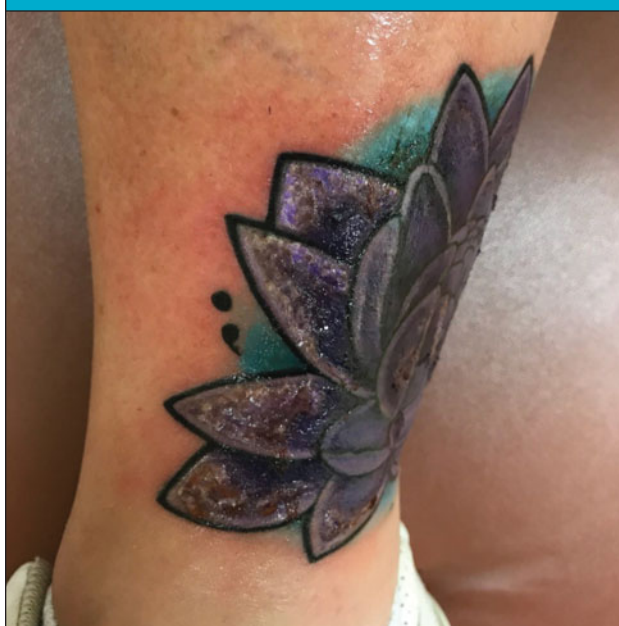


Figure 5. Note contact dermatitis at the edges of the petals from the dark purple ink in this 1-week old tattoo. (Photo courtesy of Marygrace Fogg, PA-C.)



Topical, intralesional, and, rarely, systemic steroids may be useful in inflammatory cases. Remember, nothing stronger than 1% hydrocortisone should be used on the face, and for the shortest time possible.

Table 1. Tattoo Pigments

Black	Carbon (India Ink), iron oxide, logwood
Blue	Cobalt aluminate
Brown	Ferric oxide, silica
Green	Chromic oxide, lead chromate, phthalocyanine dyes, malachite
Purple	Manganese, aluminum
Red	Mercuric sulfide (cinnabar), sienna (ferric hydrate), sandalwood, brazilwood, organic pigment, cadmium red
White	Titanium oxide, zinc oxide, lead white
Yellow	Cadmium sulfide

Tattoo Removal

Removal is usually sought for social or aesthetic reasons, regret being the most common. Although numerous treatments to remove tattoos have been described in the past, the Q-switched ruby laser have been the most successful. Multiple treatments are required, and complete resolution of color may not be achieved in all cases. Some scarring or “ghost” of the previous pigment may remain. Recently developed picosecond lasers have been showing more promise. In both cases, the laser causes the pigments to become extracellular, and then drained through the lymphatic system or by formation of a scale-crust. Rarely after removal, tattoo pigments can be found in lymph nodes and be confused with metastatic changes.¹

Special tattoo inks can be more easily destroyed during laser treatments. These are bioresorbable dyes encapsulated in beads with pigments specially designed to permit targeting of the tattoo by specific laser wavelengths.¹ They are easier to remove than standard tattoo ink.

Acute complications of laser tattoo removal include pain, blistering, crusting, and pinpoint hemorrhage. Rarely, laser removal attempts may cause permanent darkening of the tattoo. Localized reactions may become more generalized. Scarring may occur. Amateur tattoos are easier to remove than professional tattoos,¹ as they are not placed as deep in the dermis. Cosmetic tattoos are more difficult to remove because they contain iron or titanium oxide, which becomes darker when exposed to the laser.

PIERCINGS

Introduction

The trend of piercing areas other than the ear lobe has

Figure 6. Right elbow with multiple abscesses 1 week after tattooing. The patient had abscesses at distant sites (Figure 7), indicating bacteremia. Cultures from the abscess, as well as blood, were positive for CA-MRSA.



increased in the last 2 decades and is now commonplace. Between 25% and 35% of adolescents and young adults between the ages of 13 and 29 have body piercings at a site other than the ear lobe,⁷ including the tongue, lips, nose, eyebrows, nipples, navel, and genitals. Complications can include local and systemic infections, poor cosmesis, and foreign body rejection. Swelling and bleeding (generally, site-specific) can occur with complications. Patients who present with complications, or who inquire in advance of piercings, should be counseled so they can make informed decisions before undertaking piercings in the future.

The jewelry used to pierce varies by site, and may include hoops, studs, and barbell-shaped devices that may be straight or curved. Tongues are usually pierced with straight barbells, umbilical piercings use curved barbells, noses may be studs or hoops in the nostril, and curved barbells or rings in the nasal septum. Genitals and nipples may be rings or barbells. Options for ears are many, based on patient preference and location.

Jewelry is usually made from stainless steel, gold, niobium, titanium, or various other alloys. Contact allergies are common when alloys containing nickel are used. Rarely, plastic is used. Some may have a mechanism to

Figure 7. Left wrist of the same patient. There were no tattoos on this arm.



keep them in place, such as screw backs, and others are more easily removed (eg, spirals, hooks, or rings). Jewelry with locking backs is recommended for piercings in small children to prevent aspiration, choking, or loss.

No reliable estimates are available for the number of persons who have experienced complications related to body piercing.⁸ Patients who are vulnerable to infection and susceptible to hemorrhage are at greater risk of complications from piercing.

Site-Specific Concerns

Ear

Traditionally, a single piercing in the lobe was the only socially acceptable piercing in Western society. Multiple piercings within the lobe are now common, as are “high” ear piercing in the chondral cartilage. Up to 35% of pierced ears may have complications; 77% would be considered minor infections, 43% allergic reactions, 2.5% keloid formation, and 2.5% traumatic tearing.⁸ Stretching of the hole is also common, especially when large, heavy earrings are worn; this increases the risk of tearing. (See **Figure 8**.)

High piercings are associated with poor healing and infection due to the avascular nature of the chondral cartilage. More serious infections may result in disfigurement from perichondritis, causing some degree of cauliflower ear. Patients with perichondral infection, as opposed to a

Figure 8. Traumatic tear of an ear lobe due to earring (healed).



superficial infection, will have pain with deflection of the ear. The most common pathogens are the usual skin suspects, including *Staphylococcus aureus* and *Streptococcus pyogenes*, but the high piercings are also prone to *Pseudomonas aeruginosa*. Antibiotic choices should be tailored to location, with ciprofloxacin or another skin fluoroquinolone being used if chondral infection is suspected. Abscesses should be incised and drained. If an abscess develops in the upper ear, scarring and perichondritis may result in a poor cosmetic outcome.

Earrings and their backings can become embedded in the skin, especially the fleshy ear lobe, either due to inflammation, from trauma, or if the patient is careless when removing the jewelry; this may also be a complication of using piercing guns.⁸ Using longer earring posts when piercing can prevent this. Gentle probing may facilitate removal of the embedded jewelry, but in some cases local lidocaine and a small incision may be required to locate and remove embedded object.⁸

Patients with atopic dermatitis or a history of contact dermatitis are more likely to develop minor skin infections related to piercings, but it may be difficult to differentiate contact dermatitis from superficial infection. Superficial infections may be treated with local cleaning, moist packs, and over-the-counter antibiotic ointment or mupirocin. Contact dermatitis should be “treated” with switching the jewelry to a different metal that is less

Figure 9. Contact dermatitis from the jewelry used in this umbilical piercing.



allergenic, and topical steroids. The skin surrounding silver jewelry may develop argyria, a greyish discoloration, which should also resolve when the jewelry is removed.

Tongue and oral

The infection rate of oral piercings is surprisingly low, despite the number of bacteria in the mouth. Rinsing with dilute antiseptic mouthwash or carbamide peroxide oral rinse can reduce the rate of infection while the fresh piercing heals. Ludwig's angina, a rare type of deep tissue infection in the submandibular space, is a possible complication and may be life threatening if not identified and treated aggressively. Airway compromise is possible with spread to the mediastinum; surgical debridement and IV antibiotics are urgently required.⁸ However, tongue piercings can initially result in swelling that can be uncomfortable and make eating and drinking difficult. Ice and a soft diet may be advised. Experienced piercers will use a longer barbell for piercing and switch to a shorter one when the swelling subsides. Rarely, tongue swelling can cause airway compromise. Tooth chipping from the piercing is so common it should be *expected*.

Nose

Nose piercings can be either at the lateral nares or the base of the cartilaginous septum. Piercing of the cartilage

Figure 10. Abscess around a nose piercing.

can cause a fair amount of bleeding, a septal hematoma, and infection. Perichondritis can also occur in this location and should be treated for possible *Pseudomonas* infection. Aspiration and embedding of the jewelry may also occur in this location.

Navel

The navel is a popular site of piercing in young girls, and is often pierced unprofessionally, either by the patient or their friend. The jewelry may rub on clothing or be compressed in tight clothing and is prone to trauma from the waistband. If placed too superficially, the jewelry may migrate to the skin surface. Weight gain and pregnancy can contribute to this problem. Curved barbells are less likely to migrate.

Nipple

Nipple piercings may take 2-4 months to heal properly. Patients should be prepared for this. Infection including abscess formation and cellulitis is possible. There is no information about piercing nipples of breasts that have had augmentation. Scar tissue could impair latching or milk flow when attempting to breast feed.⁸

Genitals

The purpose of genital piercing is to enhance sexual sensitivity. Sites in men include the glans, foreskin, and

Table 2. Common Complications of Piercings, by Site

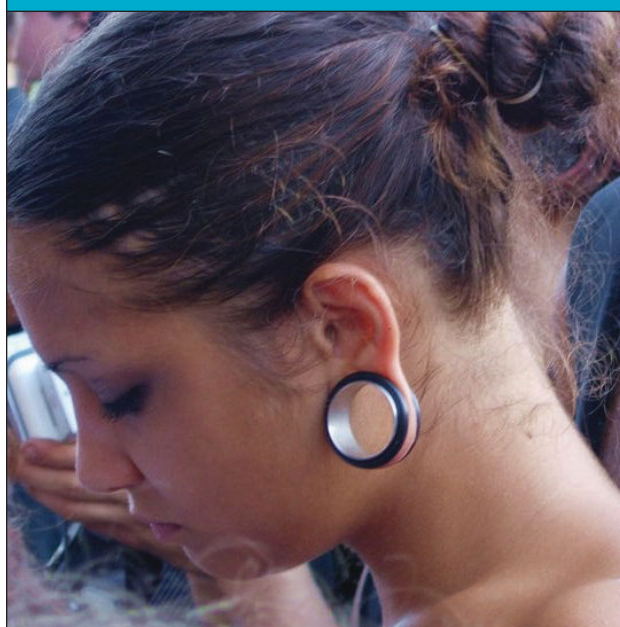
Site	Complication
Ear	Allergic reaction, embedded earrings, infection, keloid, traumatic tear
High ear	Auricular perichondritis, perichondral abscess, pain
Female genitals	Allergic reaction, compromise of barrier contraception, infection, keloid formation
Male genitals	Frictional irritation, infection, paraphimosis, penile engorgement, priapism, condyloma, urethral rupture, urethral stricture, urinary flow interruption
Mouth	Airway compromise, alteration in eating, gingival trauma, hematoma formation, increased salivation, infection, injury to salivary glands, loss of taste, Ludwig's angina, pain, permanent numbness, speech impediments, tooth chipping or fracture, uncontrolled drooling
Navel	Bacterial endocarditis, frictional irritation, infection, jewelry migration and rejection
Nipples	Abscess formation, bacterial endocarditis, breastfeeding impairment, infection
Nose	Infection, jewelry swallowing or aspiration, perichondritis, and necrosis of nasal wall, septal hematoma formation

scrotum. In women the clitoral prepuce or body, labia minora or majora, and perineum may all be pierced. Genital piercings may take several months to heal.

Concerns common to all sites

Hypertrophic scarring and keloid formation may occur; the ear lobe is a common site for this. The keloid may itch or hurt. Treatment includes intralesional steroid injections and surgical excision, but the keloid frequently recurs. Patients who are predisposed to keloids (eg, those of African descent and patients who have had keloids in the past) should be aware of this complication before piercing.

Figure 11. A large gauge in the ear lobe. (Source: Your Teen for Parents.)



If inflammation and infection are severe, the jewelry should be removed. If the patient wishes to maintain the piercing, a 20 g Teflon IV catheter can be used to thread surgical silicone into the opening. Nylon suture material can also be used to keep the opening patent while healing occurs.⁸ If the patient no longer desires the piercing, the jewelry can be removed, and the hole allowed to close. If the piercing is then again desired, it can be re-pierced when healing is complete (in ≥ 6 -8 weeks, depending on location).

Mild infections can be treated with diligent cleaning and topical antibiotics such as bacitracin or mupirocin. If oral antibiotics are required, they should have good Staph and Strep coverage, including MRSA coverage, if it is prevalent in the area. Choices may include a first-generation cephalosporin such as cephalexin or cefadroxil, clindamycin for those who are allergic, and either trimethoprim/sulfamethoxazole or doxycycline if MRSA coverage is desired.

Trauma to a piercing site is common and can result from falls, accidents, contact sports, violence, or accidental pulling. The area should be cleaned and repaired as soon as possible. If the provider is not comfortable repairing the area, the patient should be referred to the emergency department or a plastic surgeon. If the opening is damaged, the area can be re-pierced after healing, in about 6-8 weeks.

Figure 12. Chronic inflammatory changes from irritation of a dermal implant.



Other Types of Piercings

Gauges

Gauges are another type of piercing—usually in the ear lobe, in which larger and larger jewelry is introduced into the hole, gradually increasing the size. This is usually done every 4 to 6 weeks. Large discs or rings are then inserted into the hole to hold the shape. Some of these can be quite large, as this skin has great potential to be stretched over time. Infection is very uncommon after the initial piercing because increasing the size does not produce a break in the skin. When the gauge is no longer desired, a large hole with stretched out skin remains; surgical repair is necessary to restore the ear lobe to its normal size.

Dermal implants

Dermal implants are another type of piercing in which a tool is used to place a backing under the dermis, then a post-type stud can be screwed into the backing. These can be introduced anywhere. Complications include infection, migration, scarring, granuloma formation, pain, and chronic irritation, depending on location. The stud can be unscrewed and removed, but the backing remains under the skin, requiring a minor procedure to remove it. The area can be field blocked with lidocaine, a small incision made with a scalpel, and then the back can be pulled out with forceps. Blunt dissection may be required, as may a suture or two to close the skin following removal. Infection may require skin-specific antibiotics.

Fins, spikes, and horns can all be added as deep dermal implants and are generally not removable; these are beyond the scope of this article.

Patients should have been counseled at the time of piercing that the skin should be cleaned twice daily with antimicrobial soap and water, and that contact with the freshly pierced site should be avoided except for clean-

Figure 13 and Figure 14. Cartilage piercing; stud type earring embedded in ear lobe.



ing. Ask if they've used commercial products sold at piercing and jewelry shops. Generally, these are to be avoided because they contain benzalkonium chloride, which does not have activity against *Pseudomonas sp*, and may be contaminated.⁷

Most patients will know how their jewelry is removed, but may need instruction if it is new, or if they had inadequate education after the procedure. The process varies according to the type of jewelry. For example:

- Studs have backings that are simply pulled off, or screwed on and off.
- The ends of barbells usually screw off, allowing the jewelry to be removed.
- Hoops bend, revealing the opening, similar to a keyring.
- Gauges are removed by stretching the earlobe.

- Spirals are removed by rotating and pulling the jewelry until it is removed.
- Embedded and bent jewelry may need to be manipulated, cut with wire cutters, bent using pliers or needle drivers, or disassembled to be fully removed.

Rarely, dissection similar to removing a splinter or other foreign body is necessary. Topical or local anesthesia may facilitate removal. Some creativity may be required.

Summary

Urgent care providers will likely encounter patients presenting for management of the complications associated with body art. Patients should be counselled about the potential health risks of piercings and tattoos. The urgent care provider needs to be aware of the complications that can occur and how to treat them. Familiarity with the specific jewelry and how to remove it, how to treat infections, and recommending cleaning procedures is good practice. ■

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Additional Resources

Alliance of Professional Tattooists, Inc.; www.safe-tattoos.com.

Association of Professional Piercers; www.safepiercing.org.

U.S. National Library of Medicine. Piercing and tattoos. Available at: www.nlm.nih.gov.

Take-home points

- Acute inflammatory reactions such as redness, oozing, and swelling are expected results of the tattooing process and do not require treatment other than local care.
- Careful hygiene, including washing with antibacterial soap and water, and applying petroleum jelly twice daily can prevent infectious complications of tattooing.
- Infections related to tattooing and piercing should be treated as any other skin infection, with coverage for Staphylococcal and Streptococcal species, including MRSA.
- Tooth chipping is an expected complication of tongue piercing.
- Piercing-related trauma should be repaired as soon as possible.
- Infections in sites of cartilage piercings should be treated with a skin fluoroquinolone such as ciprofloxacin. Deformities are common following the treatment of such infections.

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Facility Design: Cultivating Collaboration in the Back Office

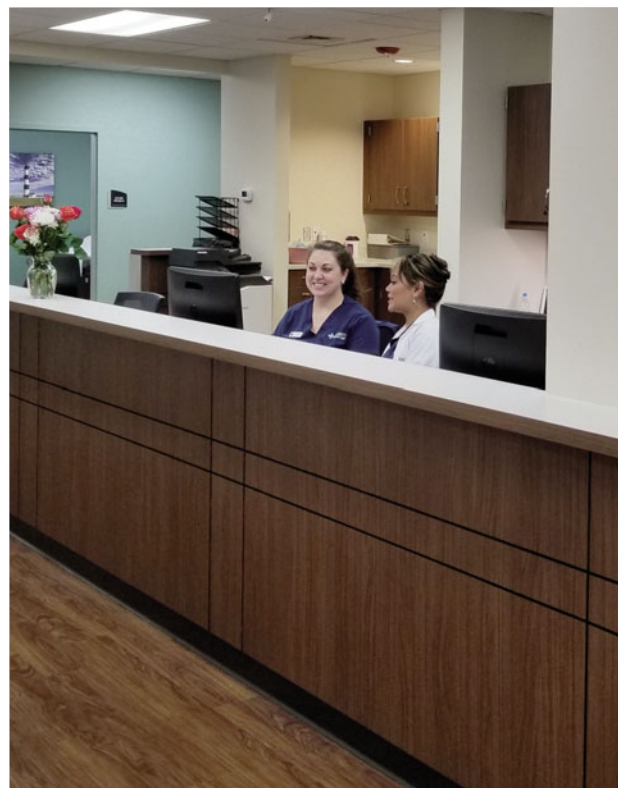
Urgent message: To move patients through the center quickly, urgent care demands near-constant communication among providers and staff. Eliminating enclosed provider offices in favor of shared workspaces promotes back office collaboration while keeping providers focused on clinic activities in real time.

ALAN A. AYERS, MBA, MACC

Urgent care reflects the seismic shift occurring in healthcare—traditional, provider-centric approaches of doctors' offices and hospitals giving way to an innovative, patient-driven focus on convenience, affordability, and customer service delivered in a collaborative, team-oriented environment. As a result, urgent care operators have taken their cues in site selection and facility design from retail and hospitality leaders. But the neatly finished, high-traffic, high-visibility location that's necessary to draw patients off the street and produce quality outcomes typically comes with high rents. To compensate, operators must continually find ways for their centers to "do more with less."

As you approach the development of your urgent care center, there remains one potentially thorny issue to consider: with space now at a premium, do you part with the formerly standard, private physician's office in favor of an "open" floor plan with no personal workspaces? Or are you of the opinion that physicians (and particularly the center's medical director) have earned the privilege and status afforded by, among other things, a private office?

Even in specialist and primary care settings, many physicians no longer have a dedicated office with the trappings of their profession (eg, diplomas and certificates on the wall, trophies and books on shelves, and family photos and pharmaceutical swag adorning desktops).



Source: Alan A. Ayers, MBA, MACC

Arguments for an Enclosed Provider's Office

As one of the current trends in healthcare design calls for cutting costs via substantially decreasing facility footprints, the areas previously allotted for private offices are increasingly being repurposed into extra floor space

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for open-plan layouts with physicians working in communal “stations” alongside other providers, nurses, technicians, and assistants. However, there are several valid reasons why an urgent care operator might be swayed to buck this trend and include a private physician’s office in the center’s floor plan:

- **HIPAA compliance.** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was created to protect individuals’ private health information, with hefty fines imposed on healthcare providers for noncompliance. A personal office allows a physician to dictate charts or converse with patients—either over the phone, by video consult, or in person—without fear of other patients inadvertently overhearing the consultation. Likewise, patient charts and electronic devices used to access electronic health records are more easily safeguarded in an office with a closed, lockable door.
- **Privacy.** Apart from HIPAA, there are plenty of common occurrences in which urgent care providers need to have a confidential discussion with an employee or complete some heads-down work without distractions. Oftentimes, providers simply desire a few minutes alone to get organized and recharge between patients.
- **Status.** Having a private office helps reinforce the provider’s importance to the center’s leadership team, particularly when others, such as the business manager, have their own offices. An office distinguishes the provider from the rest of the clinical staff who doesn’t have offices. It also sends a positive message that the center’s ownership places a high value on the provider’s position within the organization.
- **Engagement.** A private office can help a physician leader “settle in” and solidify their attachment to the urgent care center. Most doctors faced with the prospect of working in an open-plan office express worry that they will have no place for important keepsakes such as family photos, diplomas, and books. Having a private workspace to personalize and decorate can help the provider establish a strong sense of engagement and ownership at the center, and provide an incentive to work toward building a successful and thriving practice.
- **Awkward culture change.** Removing an employee’s private office while implementing an open-plan layout can be perceived as a “take away.” This in part explains why organizations encounter so

much difficulty getting their staff to buy in to communal workspaces, and why physicians who count themselves among the center’s most important team members are especially resistant to the idea. When a practice is acquired by a group who wants to convert the facility to an open-plan office, there must be a considerable effort undertaken to get providers to understand and accept the culture change, while keeping them on-board with the center’s long-term vision.

- **Recruiting and retention.** The United States is bracing for an acute shortage of primary care physicians in the next decade. When demand exceeds supply, it stands to reason that the resultant smaller pool of physicians will have more choices of where to practice. Even if having an office is not a “deal killer,” when faced with otherwise equal career options, it can serve as a “perk” for recruiting and retention. Given the exorbitant costs of replacing a physician—not only in terms of direct recruiting and onboarding expenses, but also bringing in interim providers and the potential loss of the departed doctor’s regular patients—absorbing the rental cost of a private office may be a money-saver if the lack/removal of a private office leaves the physician dissatisfied and/or with a wandering eye.

Opening Up the Back Office

Healthcare architects and designers have anticipated the enormous strain an aging and increasingly ill population will have on medical facilities nationwide, and they are rightly espousing reducing costs, more efficient use of space resources, and flexibility, innovation, and collaboration in care models. To this end, here is a breakdown of the reasons why an urgent care operator may decide to forgo allotting space for a physician’s office:

- **Private offices disrupt clinic flow.** In the economics of urgent care, speed is key. Door-to-door time directly correlates to patient satisfaction, which drives future revenue through repeat visits, positive online reviews, and word of mouth. Additionally, labor is the largest operating expense—meaning the more efficient providers and staff can be (ie, maximizing the number of patients each employee sees per hour), the more profitable a center will be. The absence of a private office eliminates the potentially distracting temptations of idle web-surfing, email checking, and television watching behind closed doors, and helps the physician stay focused on maintaining patient throughput.

According to the Kaizen Institute, “lean philosophy” is the “systematic identification and elimination of waste and the implementation of concepts of continuous flow and customer pull.” If providers are the most important people to keep the center running as efficiently as possible, why not put them at the center of the facility? To eliminate footsteps, equipment, supplies, printers, and other resources should be within immediate reach.

- *Clinics often have more providers than they do space.* Many providers enjoy working in urgent care due to the “work-life balance” of 12-hour shifts followed by multiple days away from work. To cover all shifts, centers frequently use floating, flexible, or per diem labor, and considering how many different physicians may rotate through a given urgent care center, it may seem impractical to assign a private office to any one individual when they’ll actually occupy it only part of the time.
- *High retail rent means all space must be used judiciously.* The high traffic counts and strong traffic visibility of a retail location are needed to raise awareness of an urgent care center. However, due to retail’s high rental rates per square foot, all available space must be optimized toward making the center’s operations as efficient and streamlined as possible. This means that the additional square footage required for a separate private physician’s office might instead have to be used for “revenue-producing” patient care.
- *Open workspaces can curb potential sexual harassment claims.* When it comes to dealing with sexual harassment claims in a medical practice, most experts agree that prevention is the best approach. The same goes for workplace bullying and toxic gossip. If there are no private offices, then there are fewer closed-off, private places in which an incident can occur either between a physician and a patient or a physician and a co-worker. Keeping all interactions in the view of others helps prevent “he-said, she-said” conflicts.
- *Privacy needs can be accommodated.* Just because a physician doesn’t have a private office at the urgent care center doesn’t necessarily mean that they will never have a private moment. Newer centers without private offices are instead being designed with quiet rooms, consultation rooms, conference rooms, phone rooms, or provider lounges to accom-

modate physicians’ need for occasional privacy while practicing in an open-plan office layout. In centers in which a provider is assigned a block of exam rooms, one room can be used to store personal belongings, for documentation, and staff instruction while the others are used for patients.

- *Changing provider expectations.* The lack of a private office is generally not a deal-breaker for today’s physicians, especially younger physicians who are willingly embracing collaboration and technology. Most likely, a provider’s friends who work in other fields—including law, engineering, and business—work in open-space arrangements. In many corporate cultures there is no concept of personal space—everything belongs to the company. Also, the prevalence of handheld computing devices, with their abundance of powerful medical apps, tends to engender and support a more mobile medical workforce. Doctors now laud the ability to quickly store and retrieve medical information, take notes and dictation, log in to their PC remotely, and monitor patient vital signs all from a handheld device. For providers who have never owned their own practice, they likely have not expected an office and may actually prefer the flexibility of working wherever, whenever.

In the past, medical office floor plans were simply designed, usually a rectangle with an entrance, waiting room, hallway to exam rooms, doctors and business offices at the periphery, and an exit. Today, the most cost-effective use of space is a “hub-and-wheel” design with a medical station right in the middle, wide open, with sufficient space for providers and medical assistants to work with electronic medical records and communicate between patients.

Conclusion

The decision whether to include a private physician’s office in an urgent care center ultimately has to align with the core values and the culture of the organization—not to mention the bottom line. Is a physician’s office an indispensable tool for running a medical practice smoothly, or is it a waste of money and precious real estate? Are collaborative, streamlined care models and lean principles just the latest trend, or do they reside at the forefront of the most transformative era that the healthcare industry has ever undergone? Whatever design a center adopts, the end result should always be the same: quality medical care and an outstanding patient experience. ■



ABSTRACTS IN URGENT CARE

- Lower A1c Targets for Type 2 Diabetes
- No More Redocumenting Student E/M Entries
- Overuse of Self-Prescribed Ibuprofen
- Excessive Fluoroquinolone Use
- Referring Patients with Presumed Cellulitis
- Curbing Childhood Obesity
- Clarifying Use of the mTBI Blood Test
- FDA Targets Opioid-Containing Meds for Children

■ GLENN HARNETT, MD

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

ACP Eases Up on A1c Ceiling for Patients with Type 2 Diabetes

Key point: *The American College of Physicians suggests slightly higher hemoglobin A1c target levels for patients with type 2 diabetes.*

Citation: Qaseem A, Wilt TJ, Kansagara D, et al. Hemoglobin A1c targets for glycemic control with pharmacologic therapy for nonpregnant adults with type 2 diabetes mellitus: a guidance statement update from the American College of Physicians. *Ann Intern Med.* March 6, 2018. [Epub ahead of print]

The American College of Physicians published new evidence-based guidelines for blood glucose control in the *Annals of Internal Medicine*. They suggest that for most patients with type 2 diabetes, clinicians should aim for a hemoglobin A1c level between 7% and 8%—slightly higher than their 2007 recommendation, which concluded that a level <7% should be the target. Reasoning for the less-intensive control of A1c levels included evidence that increasing target levels to between 7% and 8% does not increase the risk for death or macrovascular events such as myocardial infarction or stroke over a 5–10-year period. They also expressed concern that in some patients, attempts to lower A1c levels below 7% can lead to substantial harm, including an increased risk for hypoglycemic events. Jack Ende, MD, the president of the ACP, stated “The evidence shows

that for most people with type 2 diabetes, achieving an A1c between 7% and 8% will best balance long-term benefits with harms such as low blood sugar, medication burden, and costs.” He went on to say that “reducing drug interventions for patients with A1c levels persistently below 6.5% will reduce unnecessary medication harms, burdens, and costs without negatively impacting the risk of death, heart attacks, strokes, kidney failure, amputations, visual impairment, or painful neuropathy.” ■

CMS Does Away with Need to Redocument Student E/M Entries

Key point: *Teaching physicians can now verify student documentation instead of redocumenting.*

Citation: Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual, Chapter 12, Section 100.1.1 (Revised, February 2, 2018). Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3971CP.pdf>. Accessed March 12, 2018.

The Centers for Medicare & Medicaid Services has changed the Medicare Claims Processing Manual, Chapter 12, Section 100.1.1, to allow teaching physicians to verify, rather than redocument, student documentation of components of evaluation and management services in the medical record. However, the teaching physician still must verify in the medical record all student documentation or findings, including history, physical exam, and/or medical decision making. Teaching physicians still must personally perform or reperform physical exams and handle decision-making steps for an E/M service, but can now simply verify the students’ documentation of them in the medical record. Prior CMS rulings required that teaching physicians both verify and



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redocument notes on the physical exam and medical decisions. Jack Ende, MD, president of the American College of Physicians, stated that “Prior to the change, physicians were required to redocument most work performed by medical students—which is often very thorough and based on careful and supervised evaluation—rather than review, refer to, amend, and/or correct the student note.” This new rule arises from CMS efforts to reduce documentation and bureaucratic burdens on physicians. The changes regarding medical students’ documentation took effect March 5, 2018. ■

Patients May Be Harming Themselves by Overusing Ibuprofen

Key point: Many patients self-medicate with dangerously high levels of ibuprofen.

Citation: Kaufman DW, Kelly JP, Battista DR, et al. Exceeding the daily dosing limit of nonsteroidal anti-inflammatory drugs among ibuprofen users. *Pharmacoepidemiol Drug Saf.* 2018;27(3):322-331.

Ibuprofen is the second- or third-most commonly used drug in the U.S. after acetaminophen and the most commonly used non-aspirin NSAID. While NSAIDs are effective for their intended purposes, they also have considerable side effects which are generally dose-related and can be fatal, including major upper gastrointestinal bleeding and acute renal injury. A recent study published in *Pharmacoepidemiology & Drug Safety*, using online medication diaries from 1,326 people, revealed that almost 15% of adults taking ibuprofen (Motrin, Advil) or other NSAIDs like aspirin, naproxen (Aleve), celecoxib (Celebrex), meloxicam (Mobic), and diclofenac (Voltaren) exceeded the maximum recommended daily dose for these drugs. Personal characteristics associated with exceeding the daily limit (EDL) included male sex, ongoing pain, poor physical function, daily smoking, having the attitudes of “choosing my own dose” and not starting with the lowest dose, and poor knowledge of the recommended one-time and 24-hour doses. The authors suggested that the prevalence of EDL among NSAID users is nontrivial, and it is associated with potentially modifiable factors. Educating consumers about NSAIDs and their dosing directions could reduce excess dosing. ■

One Quarter of Fluoroquinolones Prescriptions May Be Beyond Guidelines

Key point: 25% of U.S. prescriptions for fluoroquinolones (FQ) are for conditions where they are not recommended first-line therapy or where no antibiotics should be prescribed.

Citation: Kabbani S, Hersh AL, Shapiro DJ, et al. Opportunities to improve fluoroquinolone prescribing in the United States for adult ambulatory care visits. *Clin Infect Dis.* January 24, 2018. [Epub ahead of print]

Fluoroquinolones are the third-most commonly prescribed outpatient antibiotic class in the United States in adults, with an estimated 115 prescriptions per 1,000 persons annually. In 2016, the Food and Drug Administration updated the 2008 black box warning to highlight serious side effects associated with systemic FQ use, including damage to tendons, muscles, joints, nerves, and the central nervous system. The warning advises healthcare providers to not use FQs when the potential risks outweigh the benefits, specifically in conditions such as acute bronchitis where antibiotics are not typically required, and acute sinusitis and uncomplicated urinary tract infections for which other effective antibiotic treatment options exist. The authors accessed the QuintilesIMS™ Xponent database to report the number of outpatient FQ prescriptions dispensed in 2014. This database represents 100% of outpatient prescription activity for retail pharmacies, projected from data collected from over 90% of retail pharmacies in the U.S. In 2014, 31.5 million FQ prescriptions were dispensed; visits for genitourinary, respiratory, skin, and gastrointestinal conditions accounted for most FQ prescriptions. An estimated 7.9 million FQ prescriptions were for conditions where no antibiotics should be prescribed, or for which FQ are not first-line recommended therapy, which include acute bronchitis, acute sinusitis, and uncomplicated urinary tract infections, conditions recently highlighted in the FDA warning. Viral upper respiratory tract infections and bronchitis, for which no antibiotics should be prescribed, led to an estimated 1.6 million FQ prescriptions (5.1% of total). Sinusitis and uncomplicated urinary tract infections, for which FQ are not first-line recommended therapy, accounted for an estimated 6.3 million FQ prescriptions (19.9% of total). The authors concluded that with the threats to patient safety and rising rates of antibiotic resistance, FQs should not be prescribed for conditions where alternative effective therapies are recommended. Antibiotic stewardship efforts should target inappropriate FQ prescribing in adults, specifically for acute respiratory tract infections for which no antibiotics are needed, and for ambulatory infections for which FQ are not recommended first-line therapy. ■

Derm Referrals for Presumed Cellulitis Can Lower Cost, Improve Outcomes

Key point: Early dermatology consults for patients with presumed cellulitis are cost effective and improve patient outcomes.

Citation: Li DG, Xia FD, Khosravi H, et al. Outcomes of early dermatology consultation for inpatients diagnosed with cellulitis. *JAMA Dermatol.* February 16, 2018. [Epub ahead of print]

Many inflammatory skin conditions mimic cellulitis (pseudo-cellulitis) and are treated with antibiotics and/or hospitalization, leading to unnecessary patient morbidity and substantial

healthcare spending. This prospective cohort study published in *JAMA Dermatology* enrolled patients with presumed diagnosis of cellulitis in the emergency department, in the ED observation unit, or within 24 hours of admission to an inpatient unit of a large urban teaching hospital between February and September 2017. The objective was to evaluate the impact of early dermatology consultation on clinical and economic outcomes associated with misdiagnosed cellulitis. Of 116 patients (54.3% women; 78.4% non-Hispanic white; mean age, 58.4 years), 33.6% were diagnosed with pseudo-cellulitis by dermatologists. The dermatology team recommended antibiotic discontinuation in 28 of 34 patients (82.4%), and antibiotics were stopped in 26 of 28 cases (92.9%). The dermatologists also recommended discharge from planned observation or inpatient admission in 20 of 39 patients with pseudo-cellulitis (51.3%). Extrapolating the impact of dermatology consultation for presumed cellulitis nationally, the researchers estimated 97,000 to 256,000 avoided hospitalization days, 34,000 to 91,000 patients avoiding unnecessary antibiotic exposure, and \$80 million to \$210 million in net cost savings annually. Scalability to the urgent care environment would, of course, present operational challenges that could affect cost benefits in our clinical setting. ■

Urgent Care Providers: Be Vigilant for Obese Children

Key point: *Childhood obesity rates continue to rise, especially in some demographic groups.*

Citation: Skinner AC, Ravanbakht SN, Skelton JA, et al. Prevalence of obesity and severe obesity in U.S. children, 1999–2016. *Pediatrics*. February 26, 2018. [Epub ahead of print]

This paper published in *Pediatrics* reviewed data from 1999 to 2016, garnered from the National Health and Nutrition Examination Survey (NHANES). Results revealed that white and Asian American children have significantly lower rates of obesity than African-American children, Hispanic children, or children of other races. In 2015–16, 35% of all U.S. youth were overweight or obese, compared with 1999–2000, when this figure was 29%. The prevalence of females aged 16 to 19 who were overweight or obese also grew, from 36% in 2013–14 to 48% in 2015–16. The prevalence of overweight and obesity among Hispanic females also increased from 32% to 46% in the 17-year data collection period. The rates did not increase significantly for white and African-American females. In children aged 2 to 5, the prevalence of class I obesity (BMI ≥95th percentile) increased from 9% in 2013–14 to 14% in 2015–16. Commentator David Ludwig, MD referred to a recent study in the *New England Journal of Medicine* that predicted more than 50% of today's 2-year-olds will be obese by age 35. He also noted that "If current rates have not yet plateaued, as suggested in the NHANES 2015

and 2016 survey data, then even this bleak projection may underestimate the magnitude of the problem." The authors commented that despite recent public health efforts to combat childhood obesity, more resources are clearly necessary. They also stated that the obesity epidemic is becoming endemic, and the resultant decline in Americans' health is occurring without impactful policy at the national level.

FDA: Blood Test Good for Evaluating Need for Head CT, Not Diagnosing Concussion

Key point: *There is confusion regarding FDA-approved blood test to evaluate need for head CT in adult patients with mild traumatic brain injury.*

Citation: Federal Drug Administration. (2018, February 14). *FDA authorizes marketing of first blood test to aid in the evaluation of concussion in adults*. Press release. Available at: <https://www.fda.gov/newsevents/newsroom/pressannouncements/ucm596531.htm>. Accessed March 12, 2018.

The FDA approved a blood test that could help physicians determine the need for head CT in adult patients suspected of having mTBI. However, the widely reported FDA news release regarding the benefits of the test was misinterpreted by many who believed it was approved as a concussion diagnosis tool. The headline of the release, *FDA Authorizes Marketing of First Blood Test to Aid in the Evaluation of Concussion in Adults*, contributed to the confusion, as did subsequent stories that reported on it. The prospective device validation study cited in the approval involved 1,947 individual blood samples from adults suspected of having mTBI. Called the Brain Trauma Indicator (BTI), the device measures levels of two proteins, ubiquitin C-terminal hydrolase and glial fibrillary acidic protein, which are released from the brain into blood within 20 minutes of a head injury. The test results are typically available within 3 to 4 hours. The BTI was able to predict the presence of intracranial lesions on CT 97.5% of the time, and those who did not have intracranial lesions on a CT scan 99.6% of the time. This may help doctors determine whether a patient may need a CT scan to detect possible intracranial bleed or injury after a head injury. The FDA stated that providers could incorporate this test into the standard of care for patients, alleviating the need for a CT scan in at least one-third of adult patients who are suspected of having mTBI. However, Dr. James P. MacDonald, a physician and sports medicine specialist at Nationwide Children's Hospital in Ohio, cautioned that "this new test does not diagnose concussion. It cannot 'detect' concussions." He also stated that the new device doesn't rule out concussions, either. "What it does do is help a doctor determine whether a patient may need computed tomography scans after a head injury to see if an 'intracranial lesion' may be visible," he said. Of note, the test was not studied nor approved for use in children. ■

Upcoming Label Changes Will Limit Opioid Cough and Cold Medicines for Children

Key point: Prescription opioid cough and cold medicines no longer indicated for children.

Citation: Federal Drug Administration. *FDA acts to protect kids from serious risks of opioid ingredients contained in some prescription cough and cold products by revising labeling to limit pediatric use.* [Press release] Available at: <https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm592109.htm>. Accessed March 12, 2018.

The FDA announced that it is requiring safety labeling changes to limit the use of prescription opioid cough and cold medicines containing codeine or hydrocodone in children <18-years-old because the serious risks of these medicines outweigh their potential benefits in this population. The FDA held an expert roundtable and convened a meeting of its Pediatric Advisory Committee to look at all the risks associated with the use of codeine- or hydrocodone-containing cough and cold products in these patients. Experts indicated that although some pediatric cough symptoms do require treatment, cough due to a

“The serious risks of opioid cough and cold medicines outweigh their potential benefits in pediatric patients.”

cold or upper respiratory infection typically does not. Moreover, the risks of using prescription opioid cough products in children of all ages generally outweigh the potential benefits. After safety labeling changes are made, these products will no longer be indicated for use to treat cough in any pediatric population and will be labeled for use only in adults aged ≥18 years. Labeling for the medications is also being updated with additional safety information for adults—including an expanded Boxed Warning, the FDA’s most prominent warning—notifying about the risks of misuse, abuse, addiction, overdose and death, and slowed or difficult breathing that can result from exposure to codeine or hydrocodone. The FDA instructed parents to also read the labels of over-the-counter cough and cold medicines because codeine is still being sold without a prescription in some states. ■



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Cardiopulmonary Emergency Masquerading as Gastrointestinal Symptoms

Urgent message: The ability to distinguish between urgent and truly emergent conditions is an essential skill for all urgent care providers. That distinction is especially challenging when symptoms could indicate either a relatively benign diagnosis that is well within the purview of the urgent care setting or a more dire diagnosis better suited for a higher-acuity setting.

NIHAR B. GALA, MD

Introduction

"Familiar" symptoms such as vomiting, diarrhea, and abdominal pain *could* be due to a mild viral infection—or, as in this case, a potentially life-threatening emergency. The key to forming the correct diagnosis and providing appropriate medical treatment is in the history and physical examination. This case illustrates the importance of maintaining a wide differential and recognition of distress.

Case Presentation

A 58-year-old gentleman presented to an urgent care center accompanied by his daughter with the complaint of nausea, vomiting, and diarrhea for 2 days. The daughter noted that he had been breathing heavily for the past 24 hours, and that he appeared to be tired.

Past Medical History

The patient's past medical history included coronary artery disease with previous coronary stent placement, congestive heart failure, diabetes, hypertension, asthma, and alcoholism.

Social History

His daughter revealed that he has a history of alcohol abuse and has recently consumed several alcoholic

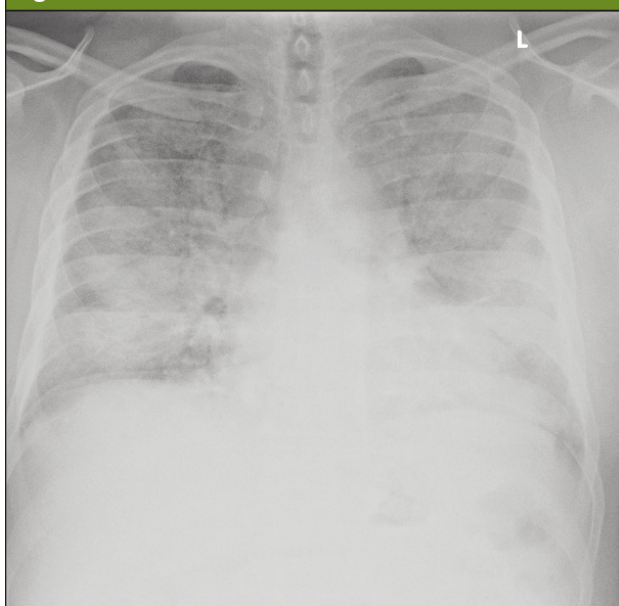


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drinks. On physical examination, the patient was somnolent yet easily arousable, alert, and oriented to person, place, and time. When asked if he was short of breath, the patient said that he was "fine," only to resume his labored breathing. His vital signs were as follows:

- Temperature: 99.1°F
- Blood pressure: 200/60 mmHg

Nihar B. Gala, MD is an urgent care and primary care physician with Alpha Health Centers and Alpha Care Medical in Delaware. The author has no relevant financial relationships with any commercial interests.

Figure 1.

Upright posterior-anterior chest radiograph showing prominent bilateral pulmonary infiltrates.

- Pulse: 105 bpm
- Respirations: 18 breaths/min
- O₂ saturation: 68% on room air
- Weight: 242 lb (109.77 kg)

Chest exam confirmed use of accessory muscles for inspiration. Pulmonary auscultation revealed bilateral rales during inspiration and expiration, with symmetric chest expansion. Cardiovascular examination revealed normal S1 and S2 with bounding peripheral pulses bilaterally. He grimaced and guarded his abdomen with deep epigastric palpation. No rebound tenderness or rigidity was noted. He followed commands with all four extremities with full strength on each side. Cranial nerves II to XII were grossly intact.

When he was placed on 100% oxygen via non rebreather face mask, his O₂ saturation improved to 94%.

Testing

A chest x-ray revealed diffuse bilateral pulmonary infiltrates (**Figure 1**). Electrocardiogram showed sinus tachycardia with no ST changes

Differential Diagnosis

- Pneumonia

- Diabetic ketoacidosis
- Acute pneumonitis
- Myocardial infarction
- Sepsis
- Gastritis
- Acute pancreatitis
- Pulmonary embolism
- Acute liver failure
- Acute alcohol intoxication
- Esophageal rupture
- Aortic dissection
- Pulmonary edema
- Pericarditis
- Cholangitis

The key points from the patient's presentation are:

- Hypoxia
- Systolic hypertension
- Epigastric pain
- Nausea/vomiting
- History of alcoholism

The most critical element of the patient's presentation is the hypoxia that improves with supplemental oxygen, suggesting a primary pulmonary etiology. Of note, hypoxia may be causing the altered mental status (or, conversely, altered mental status may be causing the hypoxia).

Clinical Course

Paramedics were summoned to transport the patient. He maintained adequate ventilation and oxygenation with no hemodynamic changes, but decompensated en route and was subsequently intubated. Laboratory studies in the ED showed significantly elevated lipase enzymes and a PaO₂/FIO₂ fraction of 150 mmHg.

Hospital Course

The patient was treated with corticosteroids, invasive mechanical ventilation, and fluid management and was discharged 21 days after admission.

Diagnosis

The patient was diagnosed with acute respiratory distress syndrome (ARDS), likely secondary to acute alcoholic pancreatitis.

Discussion

Approximately 200,000 patients become afflicted with ARDS annually, accounting for 10.4% of all ICU admissions.^{3,4} The mortality rate ranges from 34.9% to 46.1%,

Table 1. The Berlin Definition of ARDS²

Timing	Within 1 week of a known clinical insult or new/worsening respiratory symptoms
Origin of edema	Not fully explained from cardiac failure or fluid overload, may require objective assessment to exclude hydrostatic edema
Chest imaging	Bilateral opacities not fully explained by effusions, collapse, or nodules
Oxygenation	
• Mild	200 mmHg < PaO ₂ /FIO ₂ ≤ 300 mmHg with PEEP or CPAP ≥ 5 cmH ₂ O
• Moderate	100 mmHg < PaO ₂ /FIO ₂ ≤ 200 mmHg with PEEP ≥ 5 cmH ₂ O
• Severe	PaO ₂ /FIO ₂ ≤ 100 mmHg with PEEP ≥ 5 cmH ₂ O

depending on the severity of the disease.⁴

Although recognized in the 1960s, ARDS was first defined in 1994 by the American European Consensus Conference (AECC) as the most severe form of acute lung injury, characterized by the acute onset of bilateral pulmonary infiltrates and severe hypoxemia in the absence of cardiogenic etiology.¹ The Berlin Definition, published in 2011, defined acute onset of respiratory symptoms within 1 week of known clinical insult; origin of pulmonary edema not fully explained by cardiac failure or fluid overload, requiring objective assessment to exclude hydrostatic edema when no risk factor present; and classification of mild, moderate, and severe ARDS² (Table 1). The revised definition improved risk factor identification and prognostic determination, increasing the clinical value of epidemiologic studies.

ARDS is characterized by three overlapping physiologic phases (Table 2).^{5,6} In early ARDS, increased permeability of the alveolar capillary barrier results in accumulation of protein-rich fluids within the alveoli.⁷ The subsequent release of pro-inflammatory mediators augments pulmonary edema and hypoxemia. The acute phase of ARDS usually resolves completely. However, chronic pulmonary fibrosis often occurs due to accumulation of mesenchymal cells within alveoli spaces. Death is usually a result of progressive multisystem organ failure rather than respiratory deterioration.

Causes are varied, and include:

- Pneumonia
- Sepsis
- Transfusion-related acute lung injury
- Severe burns

Table 2. The Three Pathophysiologic Phases of ARDS⁵

Exudative Phase (0-7 days)	Inflammatory mediation of alveolar and endothelial damage resulting in pulmonary edema
Proliferative Phase (7-21 days)	Proliferation of type II alveolar cells resulting in epithelial cell regeneration, fibroblastic reaction, and remodeling
Fibrotic Phase (After 7-10 days)	Collagen deposition in alveolar, vascular, and interstitial beds with development of microcysts

- Trauma
- Pancreatitis
- Drowning
- Aspiration
- Inhalation injury
- Drug reaction
- Post traumatic fluid over-resuscitation

There is no definitive treatment for ARDS⁵; however, there has been considerable progress by the use of lung-protective ventilation strategies,⁸ as well as conservative fluid management.³ Survivors usually begin recovery within 2 weeks of onset and show progressive improvement in pulmonary functional studies up to a year.⁹

Summary

Patients may present to an urgent care center with a variety of nonspecific symptoms, including nausea and vomiting as a manifestation of more severe illness. A wide differential diagnosis is essential. ARDS has a mortality of 34.9%-46.1%, making the timely diagnosis crucial. ■

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The Importance and Validity of Nondisclosure and Nonsolicitation Clauses for Urgent Care Center Owners

■ ALAN A. AYERS, MBA, MAcc

Urgent message: Nondisclosure and nonsolicitation clauses are necessary to protect an urgent care center from providers and staff utilizing information gained in their employment in ways that may be damaging to the business. To be effective, however, their restrictions and limitations must be understood.

Businesses frequently rely upon important and confidential information for the success of the company. This information, often referred to as *trade secrets*, can include a sales strategy, client lists, or some form of intellectual property.

An employer must guard against former employees taking this valuable and secret information learned while on the job and using it when they join a competitor.¹ Former employees' actions can be very damaging to morale if they use their former position and corporate knowledge to hurt the standing of the remaining employees.

This article will examine the different types of contractual tools that employers such as urgent care center owners can leverage to reduce or eliminate the potential risk of losing valuable and confidential corporate information.²

Nondisclosure and Confidentiality Agreements

Use of nondisclosure agreements (NDAs) or confidentiality agreements is an ideal method for an employer to prevent the

loss of confidential information. An NDA is a contract in which the employee pledges to protect the confidentiality of secret information that's disclosed during their tenure with the organization. The NDA also sets out the company's legal remedies against an employee if they divulge this information.³

There are several essential components to a nondisclosure agreement:

- A definition of what constitutes "confidential information" for purposes of the NDA
- Any exclusions from that confidential information
- The employee's obligations and duties as to the confidential information
- The time in which the NDA is valid and enforceable
- Any other miscellaneous provisions³

In effect, an NDA is protection for permitting employees access to confidential and proprietary information of the employer's business during the course of their job.⁴

Exclusions

An NDA will also contain specific exclusions from the obligations of the employee to address circumstances where it would be unfair or overly burdensome for an individual to keep the information confidential. Common exclusions include information that is:

- Already known to the employee
- Already public knowledge (provided the employee didn't wrongfully release it to the public)
- Independently developed by the employee without reference to or without use of the employer's confidential information
- Disclosed to the employee by some other source that has



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“Generally, to be enforceable, agreements must have reasonable limits in terms of time, area, and types of work.”

no duty of confidentiality to the employer⁴

While these clauses can be an effective tool to control what former employees say about the company and what they can do with confidential information, there are some restrictions on the scope of these contract clauses.

NDA that contain a catch-all clause rather than limiting the contract to only necessary confidentiality information may be found to be overbroad. Likewise, an agreement that is overly restrictive is frowned upon by the courts.⁵ For example, Virginia courts will enforce a clause restricting postemployment activities only if the contract: 1) is narrowly drawn to protect the employer's legitimate business interest; 2) is not unduly harsh and oppressive in curtailing the employee's ability to earn a living; and 3) is not against sound public policy.⁶

Courts require any confidentiality agreement to be “reasonable.” To determine the reasonableness of a confidentiality agreement, courts will usually balance several factors, including:

- The employer's legitimate business interests in keeping the information private
- The duration of the obligation (1 or 2 years is typically acceptable)
- The burden on the employee
- The interests of the public⁷

Nonsolicitation Clauses

A nonsolicitation agreement is a contract in which an employee agrees to refrain from soliciting a company's clients or customers—for their own benefit or for the benefit of a competitor—after leaving the company.⁸ Typically, these types of agreements are found in service or sales businesses, especially when the potential list of customer prospects is limited.⁸ Another common scenario is when a long-time employee starts their own business and attempts to take clients and key personnel with them.

An enforceable agreement must satisfy the following requirements:

- As mentioned above, the employer must have a valid or legitimate business reason, such as protecting a valuable customer list, protecting trade secrets, or protecting the company from the mass exodus of valuable employees with specialized skills, knowledge, and access to trade secrets.
- The customer list must be worth protecting, as such the employer must show that it has spent time, energy, and

money establishing its client database, and that the list must contain data that's not readily available to the general public.

- An agreement can't prevent a client, customer, or employee from moving to a competitor voluntarily, but the departing employee can't pressure clients or use their former employer's information to solicit their business (like pricing to outbid their former employer).⁹

In 2018, in *Manitowoc Co. v Lanning*,⁹ the Wisconsin Supreme Court held that, although a provision of an employment agreement that prohibited soliciting employees didn't use the words *covenant not to compete* and didn't restrict the employee from working for a competing company, it was found to be a restraint of trade under state law because it restricted access to the labor pool by a competitor that hired the employee. As a result, the provision was unenforceable because it was overbroad for lack of a specified territory or class of employees to which it applied. The clause failed to meet the statutory requirement that a restriction be “reasonably necessary” for the protection of the employer.¹⁰

Employer Limitations

Generally, to be enforceable, these agreements must have reasonable limits in terms of time, area, and types of work. An agreement cannot be considered a restraint of trade found to unreasonably restrict an individual from doing business.

However, the complexion of these limitations can be changed when the employee signs a *severance agreement* or *separation package* at termination. This is a contract between an employer and an employee who's about to leave the company.¹¹ In a typical severance agreement, the employer will consent to provide the employee with additional compensation (severance pay) in exchange for the soon-to-be former employee's agreement not to sue the employer for any employment-related claims such as wrongful termination or back wages.¹¹

It is important to note that in order to be valid, these agreements require consideration or something of value. The requirements for consideration will often depend on whether the agreement was signed at *the time of hire* or *during employment*. If the contract was signed when the employee was hired, the job offer itself can constitute consideration. However, if the nonsolicitation agreement or confidentiality agreement was signed during employment, the company must offer the employee something to serve as consideration—typically, some amount of money, as is seen in a severance agreement.¹²

Issues with HIPAA information

In addition to NDAs, some organizations have their employees sign a HIPAA employee confidentiality agreement. In this document, the employee acknowledges that the use and disclosure of patient information is governed by the rules and regulations

established under HIPAA and that the employees agree to handle such information in a confidential manner at all times during and after employment.

These clauses can stipulate that an employee may not disclose or communicate any information that is proprietary to the healthcare organization, or information that may be considered private to the consumer—including information protected by HIPAA regulations.^{13,14}

In one Maryland case, a HIPAA agreement barred an employee from disclosing or removing confidential information, which it defined as including, but not limited to, “[protected health information], financial information, business data or information, customer information, reports, pricing information, projections, employee lists and personnel information, records, notes, analyses, studies[,] or other information related in any manner to the operations of the Company.”^{15,16}

The federal HIPAA law will supersede any contractual terms that are in conflict with an NDA.

Employer Remedies

An employer who has a nondisclosure agreement signed by an individual who then later uses the company’s confidential information without authorization can petition a court for injunctive relief—requesting that a judge order that person to stop violating the nondisclosure agreement. Employers can also bring suit for any damages the company has suffered because of the breach of confidentiality.¹⁷

Application to the Urgent Care Setting

Nondisclosure and nonsolicitation agreements may vary slightly when applied to licensed professionals like physicians, compared with nonlicensed employees or managers.

Courts have recognized that reasonable physician restrictive covenants are legally enforceable in most states. These agreements typically restrict a physician from soliciting employees of the practice to join them at the physician’s new practice.

Courts make a distinction between agreements that prevent a physician from *soliciting* former patients—which typically are enforceable—and those that keep a physician from *treating* former patients—which typically are unenforceable.¹⁸

The term “solicitation” is arguably an ambiguous term. As a result, it would be wise to define it in an employment agreement. One way to define the term is to state what it *doesn’t* mean. For example, an employee will not be considered to have solicited a patient or employee of the urgent care center, provided:

1. the patient initiates the contact with the former physician;
2. the patient was known to the former physician prior to his or her employment by the urgent care center; or
3. the patient responds to a notice that the former physician publishes that is available to the general public.¹⁹

In Pennsylvania, for example, a nonsolicitation agreement

“Agreements typically restrict a physician from soliciting employees of the practice to join them at the physician’s new practice.”

must have been signed near the time the physician signed their employment agreement, or received some sort of improvement in the terms or conditions of work. Again, consideration is essential in enforcing the nonsolicitation agreement.²⁰

Summary

Urgent care center owners should be certain that they create clear and unambiguous terms that will support the enforceability of these clauses and provide adequate consideration to ensure that the agreement will be found legally enforceable. Consult with an employment law attorney for specific rules in your state. ■

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The Incidentals of ‘Incident-to’ Billing

■ DAVID E. STERN, MD, CPC

Q. I plan to hire physician assistants and other non-physician providers in my urgent care clinic. I understand that I can use “incident to” billing to have their patient visits reimbursed at the physician rate. What are the rules for “incident-to” billing?

A. The Centers for Medicare and Medicaid Services (CMS) defines “incident to” as “those services that are furnished incident to physician professional services in the physician’s office (whether located in a separate office suite or within an institution) or in a patient’s home.” Services must be provided by a healthcare worker that the physician directly supervises and who is an employee, leased employee, or an independent contractor. The services are billed as Part B services to the insurance carrier as if the physician personally provided them and are paid at 100% of the physician fee schedule.

An example for proper utilization of incident-to billing is when a physician is overseeing fracture care for a Medicare patient, and the medical record reflects the diagnosis and treatment plan. The patient is seen for a follow-up visit by the non-physician providers (NPP), and the physician is in the office and available to answer questions or assist with the visit if necessary. The NPP documents in the medical record that the physician’s treatment plan was being followed. The visit can be billed using the physician’s National Provider Identifier (NPI).

It is very rare in the urgent care setting for visits to qualify for incident-to billing. First, a supervising physician must physically be on site during the visit. Second, even with a physician on site, not all visits performed by NPP will qualify for “incident to” billing. For example, if the NPP sees a new patient without the history, physical exam, assessment and plan being reviewed by the physician face-to-face with the patient, the visit will

need to be billed under the NPI of the nonphysician provider. This is also the case for:

1. an established patient who presents with a new problem, or
2. an established patient that was scheduled to be seen for an established problem and brings up a new problem during the visit.

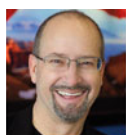
Incident-to billing guidelines were developed by CMS, so be sure to check with your private payers to see if they follow CMS guidelines or even allow incident-to billing. ■

Q. Do urgent care visits qualify for incident-to billing?

A. Incident-to services are also relevant to services supervised by certain nonphysician practitioners, such as physician assistants (PA), nurse practitioners (NP), clinical nurse specialists (CNS), nurse midwives (CNM), or clinical psychologists (CP). These services are subject to the same requirements as physician-supervised services, but are reimbursed at 85% of the physician fee schedule.

To qualify for payment under the “incident to” rules, the services must be part of the patient’s normal course of treatment, during which a physician personally performed the initial face-to-face evaluation and remains actively involved in the course of treatment. The physician does not have to be physically present in the patient’s treatment room while the services are being provided, but must be physically present in the office suite to render assistance if necessary. To be covered incident-to the services of a physician or other practitioner, services and supplies must be:

- following a previously documented treatment plan that has been personally designed by the physician for this patient’s condition(s)
- an integral, although incidental, part of the physician’s professional services in the course of diagnosis or treatment of an injury or illness
- commonly rendered without charge or included in the physician’s bill
 - For example, where a patient purchases a drug and



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REVENUE CYCLE MANAGEMENT Q&A

“Incident-to billing requires an NPP to be following a treatment plan that has been documented by the physician.”

the physician administers it, the cost of the drug is not covered. However, the administration of the drug, regardless of the source, is a service that represents an expense to the physician. Therefore, administration of the drug is payable if the drug would have been covered if the physician purchased it.

- of a type commonly furnished in physicians' offices or clinics
- furnished by auxiliary personnel under the direct supervision of the physician, who is physically present in the facility where the encounter occurs. ■

Q. How often does the physician need to see the patient for the NPP to still consider services as being “incident to?”

A. CMS has not stipulated a specific timeframe of physician involvement, so this is left to the physician's medical judgment, based on the patient's condition and needs. CMS does offer some guidance in the Medicare Benefit Policy Manual (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>), stating, “there must be subsequent services by the physician of a frequency that reflects the physician's continuing active participation in and management of the course of treatment.” ■

Q. If the physician can be reached immediately by phone if needed, can the NPP still bill an incident-to visit?

A. No. The physician must provide direct personal supervision by being physically present and available in the office suite to render assistance if needed and be prepared to step in and perform the service if necessary or be available to change the course of treatment if needed. ■

Q. Why does incident-to billing not apply to a patient's visit to be evaluated for a new problem or for a problem that has not been previously evaluated by the physician?

A. Incident-to billing requires an NPP to be following a treatment plan that has been documented by the physician in the patient's chart after the physician has examined the patient face-to-face for that specific condition. Since the physician has never seen the patient for that condition before, the physician could not have previously documented a treatment plan for that condition. Thus, incident-to billing should not be used for this visit. ■



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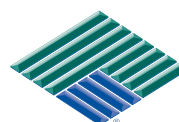
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A 51-Year-Old Woman with Wrist Pain After a Fall



Figure 1.

Case

A 51-year-old woman presents with wrist pain and swelling after tripping on a loose piece of carpeting and falling on her outstretched hand.

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

THE RESOLUTION



Figure 2.

Differential Diagnosis

- Barton's fracture
- Distal radial metaphysis fracture
- Distal styloid fracture
- Radial styloid fracture

Diagnosis

The patient has an acute fracture of the distal radial metaphysis.

Learnings

- Often, as in this case, the fracture can be very subtle if nondisplaced. In elderly patients with osteopenia, the diagnosis can be very difficult. Subtle linear lucency or cortical disruption should be viewed with suspicion

- The eponyms *Colles* and *Smith* are used for fractures which are angulated dorsally and volarly, respectively
- It is very important to look for complicating factors such as intra-articular extension, involvement of distal ulnar joint, or radial shortening

Pearls for Urgent Care Management and Considerations for Transfer

- If there is a question of a fracture, splint and have the patient follow up
- High-risk fractures include scaphoid, interarticular, Salter-Harris, and fracture/dislocations
- Splinting and rapid follow-up are essential



A 74-Year-Old Man with Epigastric Pain

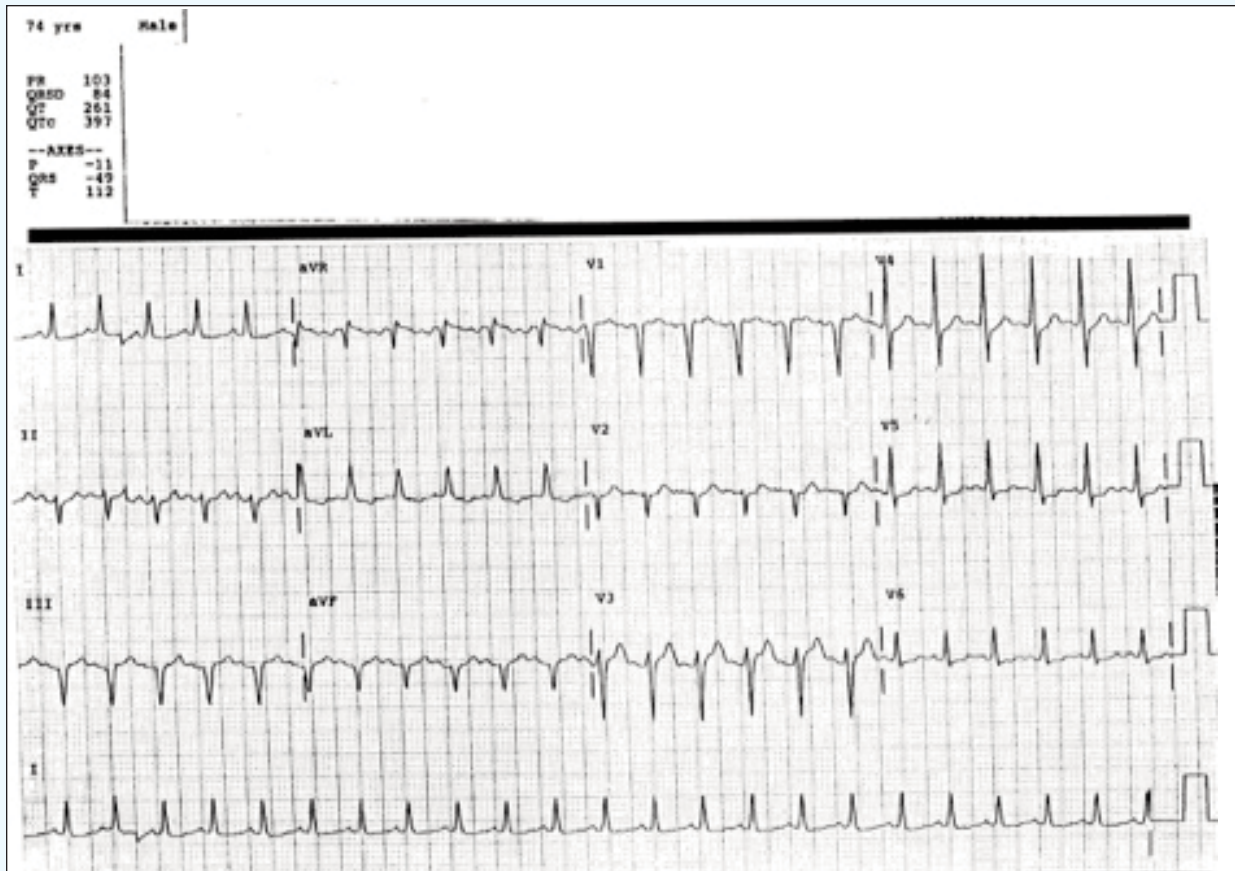


Figure 1.

Case

The patient is a 74-year-old man who complains of epigastric pain. He is an alcoholic who has had multiple episodes of pancreatitis. He has no chest pain, shortness of breath, or diaphoresis. An ECG is performed by staff prior to provider evaluation.

Upon exam, you find:

General: Alert and oriented

Lungs: CTAB

Cardiovascular: RRR without murmur, rub, or gallop, occasional irregular beats

Abdomen: Soft and NT without r/t/g

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

THE RESOLUTION

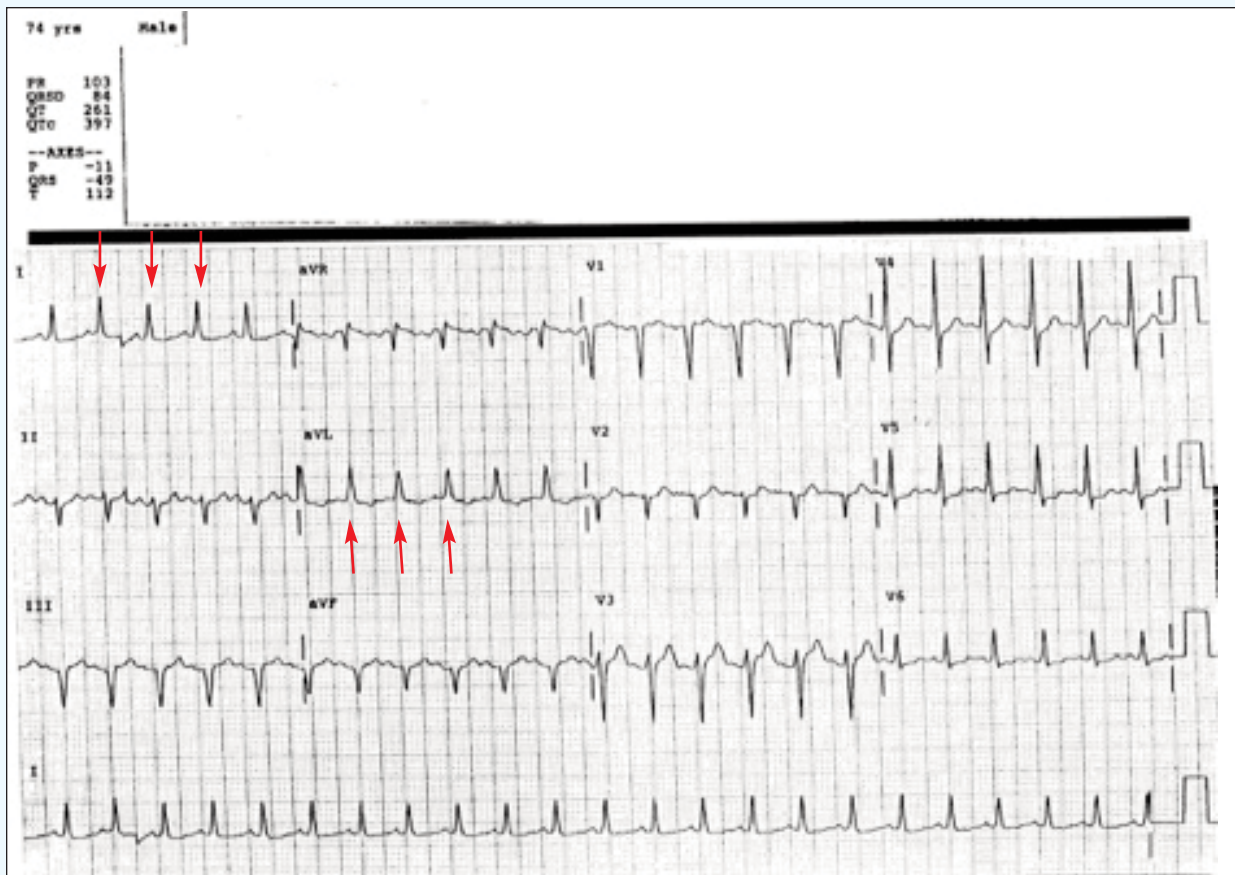


Figure 2.

Differential Diagnosis

- Anterior STEMI
- Right bundle branch block
- Left axis deviation
- Brugada syndrome
- Wellen's syndrome

Diagnosis

The patient was diagnosed with a left axis deviation. The ECG reveals normal sinus rhythm with an axis of -49, confirming left axis deviation (LAD). There are also some ST depressions laterally (I, aVL, V5, V6) which could indicate ischemia.

Learnings/What to Look for:

- The normal axis of an ECG is -30 to +90
- LAD is defined as -30 to -90

- Causes of left axis deviation may include idiopathic/normal variation, left ventricular hypertrophy, inferior MI, paced rhythm, left anterior hemiblock/left bundle branch block (LBBB), preexcitation such as Wolff-Parkinson-White (WPW), and congenital heart disease

Pearls for Urgent Care Management and Considerations for Transfer

- Compare with a previous ECG, if available
- Though this finding is often benign, the history will help to direct consideration of more serious etiologies
- Consideration of ischemia/infarction, new-onset LBBB, or symptomatic preexcitation requires transfer and emergent management, though most of the time a finding of LAD will be a normal variation and often present on previous tracings



A Patient with HIV and New Vesicles on the Leg

Figure 1.



Case

A 35-year-old, HIV-infected patient who recently started highly active antiretroviral therapy (HAART) presents to your urgent care center very concerned about a large group of vesicles that had appeared on her leg. She recalls feeling a burning sensation for several days before they appeared. Upon probing, she tells you that she's also had headache, neck pain, and fatigue.

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

THE RESOLUTION

Figure 2.

**Differential Diagnosis**

- Allergic contact dermatitis
- Erysipelas
- Herpes simplex virus infection
- Herpes zoster in immunocompromised patient

Diagnosis

The image shows herpes zoster in this immunocompromised patient.

Learnings

- Herpes zoster (shingles) is a reactivation of a latent infection with the varicella-zoster virus
- After primary infection (chickenpox), the virus lays dormant for life. Reactivation may be triggered by immunosuppression, medications, infections, and physical or emotional stress

- Disseminated zoster (>20 vesicles) outside of the primary and adjacent dermatomes is chiefly a problem of patients with AIDS, those on immunosuppressive drugs, and patients with cancer

Pearls for Urgent Care Management and Considerations for Transfer

- Antiviral agents are indicated within 48-72 hours of onset of symptoms. Prednisone will decrease severity and duration of symptoms, but does not decrease incidence of postherpetic neuralgia
- Consider emergent transfer with disseminated zoster, hemodynamic instability, altered level of consciousness, or diagnostic uncertainty

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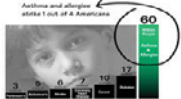
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A Snapshot of Flu Vaccination Rates

The ongoing 2017–18 flu season is already one of the worst in recent memory. Recently released data from the Centers for Disease Control and Prevention may offer a clue as to one reason: Based on a complete study of the 2016–17 season, the CDC conjectures that influenza immunization rates may have plateaued. During that most recently completed season, just 46.8% of patients age 6 months or older got a flu shot—an increase of just 1.2% over the previous season—which CDC officials say, specifically, increases the risk of outbreaks like the one we’re still experiencing.

The data below offer a snapshot of where strengths of efforts to get patient immunized lie, and where more attention may need to be paid. It also shows how impactful immunization can be even if the efficacy of the vaccine is “only” 42%. (Occupational medicine providers, take special note of how workers respond to immunization promotion by their employers.) ■

Immunization and Prevention

42%

efficacy of the
2016–17 flu vaccine

5.4 million

cases

2.7 million

doctor visits

86,000

hospitalizations

Prevented

What Works at Work?



if employers mandate
and offer shots on site for
>1 day at no cost



if employers mandate
and offer shots for >1 day,
but the worker pays



if flu shots are promoted
but not available at work



if flu shots not mandated,
provided on site at no
cost, or promoted

Workers who get a flu shot

A Look at Healthcare Workers



for all workers in
healthcare facilities



for clinicians (physicians,
NPs, PAs, RNs, pharmacists)
when mandated



for nonclinical staff
eg, food service, maintenance,
administrative

Data source: Centers for Disease Control and Prevention

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