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College of Urgent Care Medicine

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The Official Publication of the UCAOA and UCCOP

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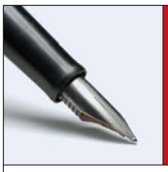
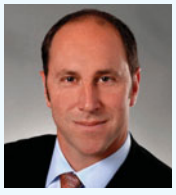


LETTER FROM THE EDITOR-IN-CHIEF

Regulatory Creep: An Urgent Care Response



Connecticut Democrats Seek Regulations for Urgent Care Centers.

When this alert hit my inbox, I must say it was a bit alarming. Whenever I see "urgent care" and "regulations" in the news it's unsettling to say the least. I am probably not alone. The regulatory rumblings have come and gone before, but this one has me more concerned. Here's a little background:

Connecticut legislators and the state Department of Public Health (CDPH) have been interested in looking for ways to reduce the healthcare expenditures related to emergency department utilization for some time now. In fact, some regional urgent care leaders had proactively reached out to CDPH to discuss the matter. There was excitement about a potential solution, and discussions quickly leaned toward improved reimbursement for urgent care services.

So, what's the catch? Well, what followed can only be described as an unforeseen twist of fate. There were so many practices claiming to be *urgent care*, that CDPH couldn't effectively identify those who should be considered for higher reimbursements. The conversations quickly shifted to the lack of a good definition for "urgent care" and the public confusion this might entail. The debate spilled over into the state legislature and before anyone could redirect, the need to define urgent care became the focus.

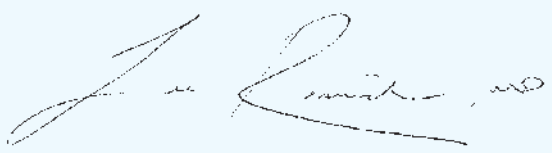
Since then, fiscally starved legislators saw the issue as regulatory fresh meat—with licensing requirements (and fees) written all over it. Despite the best of intentions, urgent care operators in Connecticut saw their extended hand get the proverbial chop! And now a healthcare spending bill sits in front of the governor that includes a line-item requiring licensure for urgent care centers in Connecticut.

So why does all this matter so much? After all, a better definition could only be a good thing for any urgent care center operating within reasonable industry standards. But what are those standards and who makes them? Who gets invited to the ball and who gets left scrubbing the floors? There are many things to be concerned with here. Let's take a closer look:

1. Urgent care is a clinical practice, and clinical practice is already regulated. Whether you are a physician or an advanced practitioner, you have more than a few hoops to jump through to get a license to practice medicine. So, why do we need another licensing process to practice medicine in accordance with our existing license?!
2. Why should we accept regulation on a medical service just because it is growing to meet consumer demand?
3. Licensing is expensive, and inevitably leaves the small independent practices disadvantaged.
4. The indirect costs are even more expensive. Updating every physician practice to a Joint Commission standard (think "bathrooms per square feet") would be cost prohibitive and do little to improve care. In addition, delays in licensure (and these are common) put an already precarious ramp up to profitability on a precipitous cliff.

It should be obvious by now that unreasonable regulations and licensing requirements would create a real threat to urgent care owners, in Connecticut and beyond. It should be equally obvious that this issue should be important to all of us in the urgent care space. Perhaps we should have seen this coming. Perhaps we have not done enough to better define urgent care as a discipline and as an industry. Perhaps...but regardless, we should all be collectively dismayed by what is happening in Connecticut and work together to fight it.

The Urgent Care Association of America (UCAOA) already has a pretty good definition in place and some fairly reasonable ways to attain recognition. The Certified Urgent Care (CUC) program covers the basics, with hours of operation, access, scope, and licensure expectations clearly defined. Urgent Care Accreditation takes it one step further, with facility and operational requirements that make sense for urgent care and the communities we serve. If we must subject ourselves to this exercise, both are reasonable places to start. ■



Lee A. Resnick, MD, FAAFP
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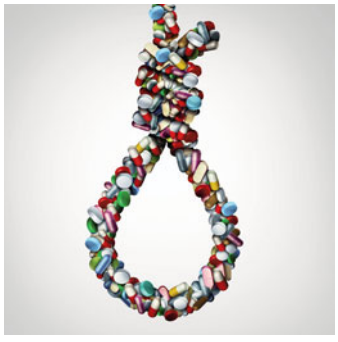


CLINICAL

11 The Potential Role of Urgent Care in Addressing the Opiate Epidemic

Opioid abuse continues to run rampant in the U.S. Too many patients suffer dire consequences, including death, as a result. Well-prepared urgent care providers can help.

Robert S. Crausman, MD, MMS and Jason M. Ramos

PRACTICE MANAGEMENT

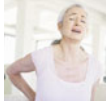
18 Disaster Strikes—What's the Plan for Your Urgent Care Center?

Urgent care centers can be affected along with everyone else by natural (and manmade) disasters. Many also answer the call to assist employees, neighbors, and whole communities. Read how a handful prepared, and responded, when disaster struck.

Panelists: Payman Arabzadeh, MD, Alan A. Ayers, MBA, MAcc, Stan Bevis, PA, Peter Lamelas, MD, and Steve Sellars, MBA

CASE REPORT

27 Lumbar Hernia: An Unusual Cause of Back Pain



Back pain is a common complaint in the urgent care setting. Common causes are often relatively benign. Correctly identifying those that are not is essential for positive outcomes.

Crystal N. Bharat MD, Ronald Dvorkin, MD, and Glenn G. Gray MD

HEALTH LAW AND COMPLIANCE

30 What Constitutes Consent for Treatment of a Minor in Urgent Care?

Most urgent care centers are on point with informed-consent laws. How do the rules change when the patient is a minor, though?

Alan A. Ayers, MBA, MAcc

IN THE NEXT ISSUE OF *JUCM*

The child's parents are sketchy on the details—they heard their 2-year-old in another room, gagging, and rush in to find him holding his neck, and sitting on the floor next to a pile of coins. Did he swallow any? And if so, how many? They simply don't know, but are panicked and looking to you for answers. Some variation of this scenario takes place around 80,000 a year in the U.S. Read An Urgent Care Approach to Ingested Foreign Bodies in Children in the December issue of JUCM *to be sure you're prepared if one of them presents to your urgent care center.*

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Mission Statement
JUCM The Journal of Urgent Care Medicine supports the evolution of urgent care medicine by creating content that addresses both the clinical practice of urgent care medicine and the practice management challenges of keeping pace with an ever-changing health-care marketplace. As the Official Publication of the Urgent Care Association of America and the Urgent Care College of Physicians, *JUCM* seeks to provide a forum for the exchange of ideas regarding the clinical and business best-practices for running an urgent care center.

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You may have heard the statistics so many times that they've ceased to make an impression—and that's the best reason of all to repeat them here, because each one of the half a million people who have died from opioid abuse-related problems since 2000 was an individual human being who might have been saved had they received the right treatment, at the right time, from the right provider.


Our cover article this month makes the case that *you* could be that provider for some other patient you might not even know yet. The Potential Role of Urgent Care in Addressing the Opioid Epidemic (page 11), by **Robert S. Crausman MD, MMS** and **Jason M. Ramos** explains how medication-assisted treatment, for one thing, might be ideally suited for use in the urgent care setting.

Dr. Crausman is a clinical professor of medicine at Alpert School of Medicine at Brown University and a partner at Ocean State Healthcare. Mr. Ramos is an undergraduate student at Hofstra University.





We've also all seen our share of headlines related to disasters this year—multiple catastrophic hurricanes, raging forest fires, and more have killed far too many and razed countless acres of communities and natural resources. Urgent care centers have certainly been affected along with their neighbors, but at the same time are staffed with professionals committed to helping others on a daily basis. How does that balance play out when the worst occurs? We asked a handful of true leaders in the urgent care marketplace how their organizations prepare, and how they react to all manner of disaster. That roundtable discussion can be found in Disaster Strikes—What's the Plan for Your Urgent Care Center (page 18). Our panelists include **Payman Arabzadeh, MD**, founder and owner of Davam Urgent Care in Magnolia, TX; **Alan A. Ayers, MBA, MAcc**, vice president of strategic initiatives for Practice Velocity, LLC and practice management editor of *JUCM*; **Stan Bevis, PA**, the founder of Fast Pace; **Peter Lamelas, MD**, CEO of MD Now; and **Steve Sellars, MBA**, chief executive officer of Premier Health.

Back pain is probably a complaint we think of as more common in the urgent care setting. But not all causes are related to over-use or acute injury; before offering a diagnosis based on incomplete information, consideration must be given to disc herniation, metastasis, osteoporosis, arthritis, spinal stenosis, nephrolithiasis, and more. **Crystal N. Bharat, MD**, **Ronald Dvorkin, MD**, and **Glenn G. Gray, MD** share the details of on actual patient in this month's case report. Lumbar Hernia: An Unusual Cause of Back Pain starts on page 27.



Dr. Bharat graduated from St. Matthew's University and has been working at CityMD Urgent Care; she is currently seeking a residency position and finishing her MBA in Healthcare Administration at Davenport University. Dr. Dvorkin is a physician with CityMD Urgent Care. Dr. Gray is in private practice on Long Island, NY.

While back pain can be a challenge clinically, treating minors, regardless of presenting complaint, can bring a whole set of procedural details that have to be adhered to in order to provide care ethically. For starters, how does the concept of patient consent come into play for patients who are still minors? Alan Ayers looks at that question in What Constitutes Consent for Treatment of a Minor in Urgent Care, our Health Law feature on page 30.

Also in this issue:

Glenn Harnett, MD mines recently published journals for nuggets of information that could help urgent care clinicians stay up to date on the latest literature in Abstracts in Urgent Care (page 23). This month, that includes reviews of articles on football and CTE, supplemental oxygen for myocardial infarction, oral corticosteroids and lower respiratory tract infections, new tests for influenza, and more.

As always, **David Stern, MD, CPC** offers his expert insights on getting maximum reimbursement through proper billing and coding practices. On page 40, he offers advice related to the new flu vaccine codes, as well as proposed updates to the E/M guidelines. ■

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CONTINUING MEDICAL EDUCATION

Release Date: November 1, 2017
Expiration Date: October 31, 2018

Target Audience
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Learning Objectives
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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

***JUCM* CME subscribers can submit responses for CME credit at www.jucm.com/cme/. Quiz questions are featured below for your convenience. This issue is approved for up to *3 AMA PRA Category 1 Credits*™. Credits may be claimed for 1 year from the date of this issue.**

The Potential Role of Urgent Care in Addressing the Opiate Epidemic (p. 11)

1. How many Americans abuse prescription opioids?
   a. 10,000
   b. 100,000
   c. 2,000,000
   d. 100,000,000
   e. 200,000,000

2. While historically medication-assisted treatment (MAT) was limited to opiate treatment facilities (OTPs), since the year 2000 federal law has allowed for the use of buprenorphine by qualified practicing physicians in ambulatory care settings, including urgent care.
   a. True
   b. False

3. In addition to physician overprescribing, which other factors contribute to opioid abuse?
   a. Homelessness
   b. Joblessness
   c. Mental illness
   d. Inexpensive heroin
   e. All of the above

Disaster Strikes—What's the Plan for Your Urgent Care Center? (p. 18)

1. Which of the following is a key to ensuring the community is up to date on your availability during a disaster?
   a. Updating signage daily
   b. Constant communication with local government
   c. Projecting expected operating hours based on National Weather Service forecasts
   d. Maintaining a call list of frequent patients, and asking staff to update them as situations evolve
   e. Assume your location will be closed, and advertise such through local media

2. According to the article, which of the following should be made aware of your ability to accept patients during a disaster:
   a. Emergency medical services
   b. Primary care providers
   c. Hospital emergency rooms
   d. Occupational medicine customers
   3. All of the above should be made aware

3. How can urgent care operators support local communities, beyond their own locations, in times of disaster?
   a. Work in collaboration with the Red Cross
   b. Open your doors as a drop-off center for community members who want to donate relief supplies
   c. Offer free care and shelter to those who need it
   d. None of the above; your focus should be on getting back to full capacity
   3. A and B

Lumbar Hernia: An Unusual Cause of Back Pain (p. 27)

1. Which of the following are "red flags" of a serious cause of back pain?
   a. Fever
   b. Weight loss
   c. Numbness
   d. Nighttime pain
   e. All of the above

2. With a lumbar hernia, there is always a mass or bulge palpated in the lumbar area.
   a. True
   b. False

3. Which imaging modality is best to appreciate a lumbar hernia?
   a. X-ray
   b. CT scan
   c. IVP
   d. Ultrasound

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Urgent Care Foundation Provides Care During Disasters

LAUREL STOIMENOFF, PT, CHC

As demonstrated in the aftermath of hurricanes Harvey and Irma, urgent care centers play a vital role in communities affected by natural disasters and other emergencies. Contributions to the Urgent Care Foundation's Disaster Relief Fund support your dedicated colleagues who strive to keep their doors open and serve their patients in times of crisis.

There in Time of Need

When disaster strikes, healthcare organizations became focal points for outreach, care, and distribution of resources as communities look to rebuild. After Hurricane Harvey ravaged southeast Texas and parts of Louisiana this summer, the Urgent Care Foundation reached out to centers in the region to offer help.

Tapping into the fund to subsidize local urgent care operations, the foundation helped coordinate a *Weekend of Service* as local urgent care centers worked to ensure the community had access to affordable healthcare in a time of intense need. Patient needs included routine care, treatment of flood-related illnesses and injuries, and providing needed prescriptions to those who could not get back into their residences. For patients who were without health insurance or were simply unable to pay their portion of the claim, the urgent care centers provided free or discounted services throughout the weekend campaign. Some centers were able to provide immediate treatment, while others burdened with more damage kept their doors open to distribute resources such as food, water, and information to the community—still playing a crucial role in relief efforts. Practice Velocity donated the resources of its marketing department to get the word out so patients could seek care from the many generous centers who offered to participate.

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

To learn how select urgent care operators respond to disaster, both internally and in the community, read Disaster Strikes—What's the Plan for Your Urgent Care Center?, page 18.

Responding to the Call

UCAOA established the Urgent Care Foundation to enhance the role, purpose, and awareness of urgent care medicine by inspiring and contributing to research, education, and clinical and practice management leadership, as well as innovation in new and emerging healthcare delivery models.

Charity is also central to its mission. In the fall of 2016, the foundation Trustees cited the need for a disaster fund following the devastating floods that hit Baton Rouge, LA earlier that year. Lake After Hours and Lake Urgent Care initiated a *We're Here for You* campaign where a volunteer team of administrative and clinical staff joined medical providers in working tirelessly to feed, treat, and comfort displaced residents. Despite some of their locations experiencing significant flooding which also personally affected many employees and providers, the urgent care centers became of hub of support, informing residents on where to access care if they couldn't provide it themselves and simply providing water, comfort, and other necessities.

In contrast to other giving opportunities, the Urgent Care Foundation's Disaster Relief Fund's sole purpose is to ensure access to the affordable same-day care offered by urgent care centers. The Foundation wants to thank our past, present, and future contributors as it aspires to more generously support our affected colleagues in future years when disaster strikes.

The recent response of the urgent care community following this series of hurricanes reminds all of us at UCAOA why we are privileged to serve you.

To donate to the Disaster Relief Fund, please visit the Urgent Care Foundation's page at http://www.ucaoa.org/Getinvolved. ■

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See **CME Quiz Questions** on page 7.

The Potential Role of Urgent Care in Addressing the Opiate Epidemic

Urgent message: Opioid abuse, addiction, and resultant deaths have drawn the attention of both the medical community and governmental bodies from the local health department to the White House. Urgent care is a frequent destination for addicts trying to secure drugs illicitly—but it also has the potential to be the first stop on the road to recovery.

ROBERT S. CRAUSMAN, MD, MMS and JASON M. RAMOS

Case Presentation

Manny is a middle-aged white male who presented to our urgent care for the third time in 2 weeks complaining of severe arthritic low back and left knee pain. Although he claimed to have a primary care physician, he reported that he was unable to obtain timely follow-up and requested a prescription of Percocet.

A review of the state prescription monitoring program (PMP) revealed that Manny had received numerous, near weekly, short-term prescriptions for Percocet and other narcotic analgesics from multiple medical providers over the preceding year; the treating provider's clinical impression was that the patient was "narcotic seeking" and likely abusing prescribed opiates.

The provider spoke candidly about this with the patient as they reviewed the findings on the PMP, and the patient was asked if he would like to be evaluated for possible treatment with the medication buprenorphine.

Although the patient initially denied that he was misusing narcotics and left the practice, he later returned and requested the evaluation—and subsequently began treatment.

He has now been on daily treatment with a buprenorphine-containing medication for many months, and regular reviews of his PMP have shown that he has no longer been receiving narcotic prescriptions from other providers.

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Opiate Epidemic

Opioid abuse and addiction is the dominant public health crisis of our time. The Centers for Disease Control and Prevention (CDC) estimates that this epidemic has claimed over 500,000 lives in the U.S. since 2000.[1] Opioids were involved in over 33,000 deaths in 2015, the most recent year for which data are available, and the numbers are increasing. States in the Northeast and South show the most significant change over 2014; and West Virginia (41.5/100,000 population), New Hamp-

Robert S. Crausman, MD, MMS is a Clinical Professor of Medicine at Alpert School of Medicine at Brown University and a partner at Ocean State Healthcare. **Jason M. Ramos** is an undergraduate student at Hofstra University. The authors have no relevant financial relationships with any commercial interests.

shire (34.3), Kentucky (29.9), Ohio (29.9) and Rhode Island (28.2) led the nation with the highest rates.[2] It is estimated that 2 million Americans abuse prescription opioids and another 500,000 abuse heroin.

Clearly, much has changed since 1999, when many advocated that pain be considered as a fifth vital sign, when many states enacted statutes compelling physicians to evaluate all patients for pain, and when so-called experts routinely minimized the risks of addiction.

Much more than physician overprescribing lay at the root of this epidemic. Homelessness, joblessness, mental illness, high rates of incarceration, inexpensive heroin, synthetic high-potency opioids (eg, fentanyl, carfentanil) and, perhaps critically, inadequate access to effective treatment are also very relevant. Still, prescriptions for opioids remain a central issue, with 249 million prescriptions having been written by U.S. prescribers in 2013 alone. We therefore have a multifaceted public health emergency with no simple solutions.

Fortunately, medication-assisted treatment (MAT) with methadone, buprenorphine, or naltrexone has been shown to effectively treat opioid addiction and reduce overdose deaths,[3] but currently only 20% of patients who could benefit actually receive MAT due largely to limited access. While historically MAT was limited to opiate treatment facilities (OTPs), since 2000 federal law has allowed for the use of buprenorphine by qualified practicing physicians in ambulatory care settings,[4] including urgent care.

Urgent Care

Urgent care providers and centers have the potential to be very important in responding to this epidemic. There are approximately 9,000 urgent care centers nationally, located in every state and most communities, representing convenient and affordable access points to our healthcare system.[5]

First, urgent care centers can have an impact through appropriate prescribing and by implementing policies and practices consistent with CDC guidelines.[6]

These guidelines direct that risks and benefits of opioid analgesics be clearly reviewed through appropriate informed consent, and that mutually agreed-upon treatment goals emphasizing function (not analgesia) be established; that clinicians increase consideration for nonpharmacologic therapies prior to initiating medications, especially for nonmalignant pain; and that they recognize opioids should not be considered first-line therapy for either acute or chronic pain. When opiates are to be prescribed, the lowest effective doses of immediate-release preparations are preferred over extended-release or long-acting opioids. Particular caution should be taken for daily doses above 50 morphine mg equivalents, and with patients taking any other controlled substances—especially benzodiazepines, which should be avoided if possible—or if there is a history of illicit drug use or alcohol abuse. Only limited quantities of narcotic analgesics should be prescribed for acute injuries, typically only ≤3 days and almost never >7 days; and there should be no prescribing for chronic pain syndromes outside of a longitudinal provider-patient relationship.

Prescribers must also review state prescription monitoring program information, where available, to help identify patients at highest risk for abuse or diversion with each new prescription, and at least every 3 months for patients treated chronically. Patients should also be offered naloxone (eg, naloxone nasal 4 mg spray or naloxone auto-injector 2 mg Sc or IM) if they have any risk factors for overdose.

Second, patients with addiction often present to urgent care centers, making them appropriate sites for screening, applying brief interventions, and referral for treatment (SBIRT).

Third, urgent care centers are attractive as potential sites where patients could be introduced to and initiated on MAT with buprenorphine or naltrexone, and then either maintained or referred elsewhere.

Although urgent care centers generally focus on acute care services, fully two thirds offer services more traditionally offered in primary care, such as routine immunization, and 50% actually offer primary care.[5] Further, many patients, particularly millennials, identify urgent care centers as their only source of healthcare. Thus, the suggestion that urgent care centers provide MAT for opiate addiction treatment is very sensible and not without precedent.

Urgent care treatment models

There are essentially three models of evaluation and treatment to be considered for urgent care.

Three Treatment Models		
Identify and refer	Identify, induce, and refer	Identify, induce, and maintain

First is the straightforward *identify and refer* model. This is essentially the minimum standard for what should be done in any healthcare setting. Patients with addiction are identified; some immediate counseling

and education may be provided; and appropriate referral for definitive treatment is made. Unfortunately, many patients not offered immediate treatment will continue with illicit use of drugs; thus, this model is suboptimal.

Second, federal law, by virtue of the Drug Addiction Treatment Act (DATA) and the Comprehensive Addiction and Recovery Act (CARA) now creates the opportunity for prescribers in urgent care settings not only to identify but also to initiate treatment. This second model, *identify, induce, and refer*, has the advantage of timeliness, with patients subsequently being referred for further stabilization and maintenance.

Third, with appropriate referral relationships for mental health treatment, counseling, and primary care, patients can be *identified, induced and maintained* safely through an urgent care center. Subsequent visits can be scheduled to allow for better matching of staffing and patient flow. There is no expectation that subsequent visits be done as "walk-ins," although that is certainly a possible approach.

Billing to third-party insurers follows the typical evaluation-and-management code sets and guidelines.

There are many practices that bill cash for management of patients on buprenorphine. A full discussion of cash billing is beyond the scope of this article, but it is important to note that there are several pitfalls to this approach and to urge that providers review their relevant provider agreements, as many insurers consider addiction management to be a covered service; it may also be considered Medicaid and Medicare fraud and abuse.[7]

Treatment

Waiver, screening, harm-reduction education, targeted assessment and MAT

Many urgent care providers may be unfamiliar with the process and requirements for becoming a buprenorphine prescriber. We will therefore outline the process for doing so and review SBIRT; harm-reduction education, an addiction-focused patient assessment; and MAT with buprenorphine.

There are no medication-specific regulatory requirements for a prescriber to treat patients with naltrexone for alcohol or opiate abuse beyond familiarity with the medication, its risks, and indications. Unfortunately, we find the requirement that a patient be fully abstinent from opiates for 10 days while on oral naltrexone therapy before initiating injectable naltrexone to be limiting in urgent care settings. So, we will therefore note it as another *potentially* useful MAT but focus primarily on buprenorphine because of its comparative effectiveness, ease of use, and general ready acceptance by patients.

Waiver process

Physicians at the turn of the 20th century routinely managed patients with opioid addiction by prescribing opiates. However, the federal government outlawed this practice in 1914 with the Harrison narcotics tax act, which ended the practice until 1965 with the advent of methadone substitution therapy in state regulated OTPs.[4] Still, community-based prescribers were not allowed to use methadone to treat addiction. In 2000, DATA permitted physicians who meet certain qualifications to treat opioid dependency with buprenorphine-containing medications in treatment settings other than OTPs.[8] However, only about 4% of physicians nationally have qualified to do this (and only about half of them are actively prescribing buprenorphine).

To qualify, a prescriber must be granted a waiver of the registration requirements of the narcotic addiction treatment act of 1974. Physician prescribers must have an active controlled substance registration with the DEA, a state medical license plus either board certification in addiction psychiatry or addiction medicine, or have completed a minimum of 8 hours of specific training provided by the American Association of Addiction Psychiatry, the American Society of Addiction Medicine, the American Medical Association, the American Osteopathic Association or the American Psychiatric Association. In 2016, CARA expanded this provision to allow nurse practitioner and physician assistant prescribers to also be granted a waiver.[9] To qualify, PAs and NPs must complete the same 8 hours of required education plus an additional 16 hours of specified coursework. (The process is explained on the website of the Substance Abuse and Mental Health Services Administration [SAMHSA; see https://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training]).[10]

After being granted a waiver, a prescriber may manage up to 30 patients in the first year. Subsequently, the provider can apply for a cap extension to either 100 patients or, in certain circumstances, 275 patients. It is incumbent upon the prescriber to maintain accurate records documenting that they are functioning under these cap limits; FDA inspectors routinely do site visits to waivered providers to inspect these records. Of note, some states have additional regulations and requirements. Prescribers can generally review these requirements at the state medical board website.

SBIRT

Establishing a baseline approach to all patients that includes targeted screening for addiction coupled with real-time intervention with focused education and referral for treatment should be standard at all urgent care centers regardless of whether a site offers MAT. The SBIRT process for addiction can be implemented using the 5As approach (ie, ask, advise, assess, assist and arrange follow-up) familiar to many by virtue of its role in smoking cessation. As a practical matter, medical assistant staff can readily perform preliminary screening. The SAMHSA website has a page dedicated to helpful resources and validated screening tools (https://www.integration.samhsa.gov/clinical-practice/sbirt/screening).[11-13] Additional helpful resources are available at the Physician's Clinical Support System websites;[14] alternately, although not validated scientifically, a simple invitation from a medical assistant with a question such as "Would you like to discuss addiction treatment and recovery services with your provider?" is likely sufficient to prompt many patients.

Harm-reduction education

Thoughtful harm-reduction education should be widely implemented and can be offered efficiently to patients who abuse drugs in the context of a clinical encounter. Patients who abuse opioids should be educated regarding the importance of using clean, sterile needles—the importance of never sharing needles cannot be over emphasized. Also, by comparison, snorting is safer than injection, and smoking is least risky for overdose.

Patients who abuse opioids should be cautioned to avoid using drugs with strangers, in strange places, or when alone; should be advised to avoid mixing drugs such as heroin and prescription opiates, opiates and other drug types such as cocaine and benzodiazepines or using alcohol with drugs (all of which increase the risk of overdose); and to avoid obtaining drugs from unfamiliar sources.

They must also be educated about the effects of abstinence on drug tolerance. Specifically, an opioid abuser can overdose on a previously well-tolerated dose of narcotics after a period of abstinence such as might take place during incarceration.

Patients who abuse opioids, and their close contacts, should be offered a prescription for Narcan (naloxone HCl), which is rapidly becoming a minimum standard of care. They should also be taught to recognize the signs of an opiate overdose in others and to administer Narcan, and to activate emergency services. Signs of an opiate overdose that laypersons can readily recognize include small, constricted pupils, slurred speech, confusion, lethargy, reduced respiratory rate, blue lips, decreased responsiveness, confusion, and loss of consciousness.

Focused history, physical examination and laboratories

Appropriate use of MAT in an office-based setting necessitates performing a history and physical examination, as well as targeted laboratory testing. The substance use history should include attention to the circumstances and timing of initiation of drug abusing behaviors, relevant transition points, and their precipitants. Additional pertinent historical factors include a patient's experience with prior treatment; history of incarceration, domestic violence and abuse; social history, including attention to the patient's living situation and available home supports; family history of drug abuse or mental illness; and a listing of past medical and psychiatric problems, including depression, anxiety, ADD/ADHD, or bipolar illness. Coexisting mental health disorders are very common, with approximately 40% having a "dual diagnosis" at presentation.

We also ask about cigarette smoking, alcohol consumption, and other illicit use of drugs, specifically inquiring about cocaine, stimulants, benzodiazepines, hallucinogens, and including marijuana, inhalants, and bath salts.

A focused physical examination looks specifically for drug-related signs, eg, needle track marks, skin abscesses, heart murmurs, and jaundice. Recommended laboratories include urine toxicology, blood testing for hepatitis B and C and HIV; and consideration for tuberculosis skin tests and STD testing.

Not every patient will be an appropriate candidate for treatment in an urgent care center, and patient preference is only one consideration. The assessment appropriately also includes attention to the patient's ability to comply with expected behaviors and treatment plans. Treatment goals, risks, and alternatives should be reviewed; and patient and program responsibilities should be outlined in discussion and in writing with an informed consent document including criteria for dismissal.[13] Draft policies and forms are available at the Provider Clinical Support System website.[14] Patients may be referred to an OTP at the outset if treatment at the UCC is inappropriate.

MAT with buprenorphine

Once identified as appropriate, patients can be offered

Table 1. Buprenorphine-Containing Medications Used in Treatment for Opioid Addiction

Trade name	Generic name	Recommended dose range**	Administration route	Form	Strength
Bunavail	buprenorphine and naloxone	2.1 mg/0.3 mg–12.6 mg/ 2.1 mg daily	buccal	Film	2.1/0.3, 4.2/0.7, 6.3/1 mg
Suboxone	buprenorphine and naloxone	2 mg/0.5 mg–24 mg/ 6 mg daily	sublingual	Film, tablet	2/0.5, 4/1, 8/2, 12/19.2 mg
Subutex*	buprenorphine	4-16 mg daily	sublingual	Tablet	2 mg, 8 mg
Zubsolv	buprenorphine and naloxone	2.8 mg /0.72 mg– 17.2 mg /4.2 mg daily	sublingual	Tablet	0.7/0.18, 1.4/0.36, 2.9/0.71, 5.7/1.4 mg

**Brand discontinued in U.S. market, generic available*
***In practice, some patients require doses above recommended range*

MAT. In the office setting, the two options are buprenorphine-containing medications or naltrexone, available orally or as a monthly injectable preparation. As noted, focus of this treatment review will be buprenorphine; the reader is referred elsewhere for a discussion of the use of naltrexone.[15]

Buprenorphine is a partial agonist of the opiate mu receptor that differs significantly from full agonists (eg, methadone). As a partial agonist, buprenorphine only weakly activates mu receptors and simultaneously acts as a "blocker" of the same receptors. Thus, while increasing doses of full agonists such as methadone elicits ever-increasing effects including obtundation, respiratory suppression, and death, buprenorphine demonstrates an early plateau effect with limited additional effect above therapeutic dosing. Further, quite separately from naloxone, which is often included in available preparations (**Table 1**) as an abuse deterrent, buprenorphine has opiate-blocking properties and can precipitate opioid withdrawal if administered when a patient is still under the influence of opiates.[10]

Although transcutaneous preparations are available for treatment of pain, the FDA recently approved a 6-month implant for addiction, and injectable depot preparations are in trials; most patients on buprenorphine maintenance receive it sublingually or, less often, transbucally.

Specific Drugs

Buprenorphine/naloxone (Suboxone)

Of the buprenorphine-containing medications available for addiction treatment, Suboxone has been on the market the longest (approved in 2002) and is the most widely used. Unlike Zubsolv and Bunavail, Suboxone is offered in a generic form and at a lesser cost, which contributes to its popularity. All three include naloxone as an abuse deterrent.

There are two equipotent formulations of Suboxone available as either a tablet or more rapidly dissolving film, both of which must be administered sublingually in order for effective absorption to occur. Films are packaged in child-deterrent individual foil packaging, making them the preferred preparation if young children are in the home.

Buprenorphine (Subutex)

Subutex, although discontinued in the U.S. market, is still available as a generic. It is recommended for pregnant patients or those who have an allergy to, or experience severe nausea with, the naloxone component of the combination preparations.

Buprenorphine/naloxone (Zubsolv)

Zubsolv, another combination formulation of buprenorphine and naloxone, has better bioavailability than Suboxone; comparable dosages are obtained with fewer milligrams of buprenorphine. Zubsolv is said to have improved taste, mouthfeel, and ease of use but is not yet available as a generic. In our experience, the comparative differences in patient satisfaction are minimal.

Buprenorphine/naloxone (Bunavail)

Like Zubsolv, Bunavail is more effective at lower milligram doses because of its better bioavailability. The buccal formulation allows for an easier, more convenient administration, as it does not preclude speaking after placement while absorbing and may be preferred by patients with dentures.

Of note, except in pregnant women, for whom Subutex is recommended, and patients with young children, for whom Suboxone films are standard, third-party insurers often limit prescribers to a single buprenorphine-containing product.

"We are in the midst of a public health crisis whose impact is measured in overdoses, hospital admissions, and deaths."

Once a medication is selected, medical assistance in taking the first dose is offered; this process, known as *induction*, requires that the patient be in mild to moderate opiate withdrawal. Opiate withdrawal can be measured by a standard instrument such as the clinical opiate withdrawal scale (COWS).[12] Too-early administration of the buprenorphine can precipitate acute, usually mild, withdrawal. In our practice, we do not stock narcotics on site and so give patients a prescription and instruct them to return with their medication for assessment of withdrawal, first dose administration, and observation for 1-2 hours thereafter.

After induction, there is considerable flexibility for visit frequency that allows for tailoring of the approach to an individual patient or to a specific treatment setting as patients progress through an early stabilization phase and move on to maintenance and potentially, later on, to medication tapering and discontinuation.[13]

Ongoing Treatment and Monitoring

After induction, the expected standard for ongoing treatment and monitoring includes regular visits with urine toxicology testing. Patients may be seen several times during the first week for frequent dose adjustments as they are stabilized. Most patients quickly progress to weekly visits and then continue weekly until medication dosing is stable, urines are free of the substances germane to the patient, and they have entered counseling or begun 12-step meetings or both. We then gradually advance to 2-week and then 4-week visits. Although buprenorphine is a schedule 3 medication and refills are allowed, we have chosen not to see patients any less frequently then every 4 weeks.

Of note, some patients are already experienced with the medication through prior treatment or may have been purchasing it on the street and therefore decline to return for an induction. It is a reality of practice and we do not penalize patients, but rather ensure that they are aware of the associated risks. Once stabilized, most patients do well attending office visits regularly and continue to meet with a counselor and/or attend 12-step meetings.

SAMHSA recommendations specify a minimum of eight drug abuse tests annually.[11] We do toxicology testing, typically urine, at all visits. It is debatable whether point-of-care urine toxicology cups are adequate or if more formal laboratory-based confirmatory toxicology testing is necessary. We generally use point-of-care CLIA-waived urine toxicology cup testing and reserve formal laboratory-based confirmation testing for suspected false positives or negatives. Toxicology testing via oral secretions or hair samples are alternatives that we use occasionally to discourage substituted urines; observed urine testing can serve the same purpose. Some programs also include random urine testing. In addition, some programs employ pill or film wrapper counts at visits as an added measure to encourage and monitor medication adherence.

Some programs adopt a *three strikes and you're out* paradigm whereby patients are discharged after three "dirty urines." While this is common, our approach recognizes that "slips" are expected in recovery and are not considered a treatment failure. We use them as an opportunity to encourage learning, to motivate development of new behavioral tools, and often as an indication that increased counseling or medical visits are required. We place an emphasis on appropriate in-practice behaviors, timely attendance to scheduled visits, and compliance with treatment plans and required follow-up. We have zero tolerance for use of profanity or aggressive behavior in the practice, with staff or other patients or over the phone.

For patients with coexistent psychiatric diagnoses, comanagement with a psychiatrist is helpful. Whether an urgent care provider is willing to medically manage psychiatric comorbidity is one aspect that can be specifically individualized. In our own program, we are "benzo-free," choosing to only prescribe benzodiazepines infrequently, and generally only prescribe stimulants and mood stabilizers as a bridge until a patient can secure formal psychiatric follow-up. We do frequently initiate patients on selective serotonin reuptake inhibitor antidepressants for depression or anxiety, and often prescribe the alpha-2 agonist clonidine as adjunctive therapy.

Integrating MAT into an Urgent Care Center

The integration of MAT into an urgent care practice can

take many forms, and there is clearly no "one size fits all." For programs that elect to implement an induce-and-refer model, evaluations and inductions may be offered at all hours of operation, as with most other walk-in type conditions. Alternately, strict scheduling is another reasonable option. For programs that elect to also provide maintenance therapy, a program may elect to see follow-up patients on a walk-in or a scheduled basis. Scheduled patients may further be sorted throughout the schedule or batched, depending on facility resources and availability. Finally, one should expect a program to evolve over time as the practice gains experience and comfort caring for patients in recovery.

Discussion

We are in the midst of a rapidly evolving public health crisis whose impact is being measured in overdoses, hospital admissions, and deaths. These patients come from every conceivable demographic, as this epidemic has cut across all racial, ethnic, religious, geographic, and socioeconomic boundaries. They are our neighbors, friends, family members, and colleagues.

People suffering from addiction are already our patients and are often recognized by providers either because they volunteer the information and may ask for help, or by identification of associated behaviors such as doctor shopping and narcotic seeking, medical complications, or formal screening. Unfortunately, too often patients are not identified or, when recognized, not offered timely treatment; consequently, they continue to abuse drugs.

Our communities are struggling to find effective strategies and to respond with limited resources. MAT with buprenorphine is one of the few proven means of reducing drug abuse and overdoses and facilitating recovery, but there is very limited availability and a large unmet need. This represents both a critical failing of our healthcare system and an incredible opportunity for the field of urgent care medicine. Urgent care centers could and should be a vital component of our nation's successful response. Urgent care centers have become ubiquitous, have extended and weekend hours, and are widely recognized as easy access points into the healthcare system

At a basic level, all urgent care centers should prescribe appropriately, consistent with CDC and applicable state-specific guidelines; actively screen; offer harm-reduction education; provide prescriptions for naloxone; and refer patients for treatment. SBIRT is not yet standard, and adding it to any practice will save lives.

We advocate for an even more impactful role for urgent care. Ideally, patients presenting to an urgent care center should not only be screened, but, when appropriate, be offered MAT and then either referred or offered maintenance treatment on site.

A simple, hypothetical calculation demonstrates that if each of 9,000 urgent care centers in the U.S. offered MAT to only 56 patients, then all 500,000 individuals addicted to heroin could be treated. Further, this is an excellent example of how a practice can "do well by doing good." Each stable patient in maintenance is generally seen monthly, so a clinician practicing to the limit of a waiver (maximum 275) would add at least 3,300 additional patient visits to a practice's annual volume.

As urgent care centers continue to define their expanding role in our ever-changing healthcare system, we assert that treatment of addiction and recovery represents a most important and rewarding new area of practice. ■

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CME: This article is offered for *AMA PRA Category 1 Credit*.™
See **CME Quiz Questions** on page 7.

Disaster Strikes—What's the Plan for Your Urgent Care Center?

Urgent message: Urgent care centers exist to help people who need to see a healthcare professional today. When that need coincides with a natural or manmade disaster, every location must have a plan of action to ensure any downtime is minimal, staff needs are met, and the business is able to survive.

Introduction

No region of the country—for that matter, no state, town, neighborhood, or block—is immune from disabling disasters. Hurricanes, tornadoes, flooding, forest fires, earthquakes, even lightning strikes don't care whether yours is a single location owned by the physician on duty, part of a hospital system, or the flagship of a national chain. Urgent care centers face the same risks as any other structure, while at the same time existing for the purpose of helping area residents who need medical care right away.

The challenge is, how do you ensure you're prepared not only to protect your business, but to ensure your staff's personal and professional needs are met and that your patients have somewhere to turn no matter what else is going on in the world?

We asked a handful of true leaders in our industry just that. Here's what they had to say.

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Do you have an operational disaster plan specific to your urgent care clinic in place? If so, how often is the plan reviewed and updated?

PAYMAN ARABZADEH, MD: Davam Urgent Care does have an operational disaster plan in place, and it's reviewed and updated at least biannually. It takes into account multiple forms of potential disasters. We have every new hire read it prior to coming on board. However, we also communicate with the staff throughout the year to keep everyone educated and up to date on procedures necessary in times of potential disasters.

PETER LAMELAS, MD: We have a well-developed and time-tested plan that addresses each location, operations, corporate, staffing, etc. We review it yearly, before the start of every hurricane season in Florida. We also always all sit down at the end of every hurricane season, or after any actual disaster, to do a postevent analysis. We review what happened, our performance, and any immediate improvements that might be needed going forward. We learn something new from every hurricane.

STEVE SELLARS, MBA Many of our urgent care centers are also located in areas vulnerable to hurricanes, so

Dr. Arabzadeh, Mr. Ayers and Mr. Bevis reported no relevant financial relationships with any commercial interests. Dr. Lamelas receives salary from MD Now Urgent Care, and the CME Program has determined there is no conflict of interest. Mr. Sellars receives salary and has ownership interest in Premier Health, and the CME Program has determined there is no conflict of interest.

Panelists

Payman Arabzadeh, MD is the founder and owner of Davam Urgent Care in Magnolia, TX.

Alan A. Ayers, MBA, MAcc is vice president of Strategic Initiatives for Practice Velocity, LLC and is practice management editor of *JUCM*.

Stan Bevis, PA is the founder of Fast Pace.

Peter Lamelas, MD is founder and CEO of MD Now.

Steve Sellars, MBA is chief executive officer of Premier Health.

our centers—our entire business—could lose a great deal if we didn't have the right disaster plan in place. Besides direct damage in areas where low elevations and local waterways invite flooding, we need to be prepared for other consequences including power outages, infrastructure and property damage, mold, and contaminated water supply. Not many businesses can withstand being put on hold for very long, so our disaster plan is reviewed at least annually, sometimes more often depending on the need.

ALAN AYERS, MBA, MAcc: We consult with independent, network, and hospital-affiliated urgent care centers across the country. The disaster risks, needs, and mitigation strategies vary significantly by region of the country. In California, it may be earthquakes and wild fires, hurricanes along the East and Gulf coasts, and blizzards or tornadoes in the Midwest. We advise every urgent care to have a disaster and business continuity plan in place that's appropriate for the risks in their operating area. All new staff members should be oriented on the plan, annual training should occur on the plan (just prior to the season of highest risk), and the plan should be reviewed by leadership at least annually for relevance and detail. It's also a good idea to engage in disaster simulations—to actually walk through everyone's role and the steps to be followed.

Who do you communicate with on a governmental level regarding curfews, civil disaster plans (eg, a formal state of emergency), and your ability to open your urgent care clinic?

STAN BEVIS, PA: The director of the county Emergency Management System is our point of contact in local government before and during disasters.

ARABZADEH: Constant communication with local government is key to making sure our community knows whether we are available to help in a disaster situation. They usually can get out information faster and to a broader audience then we might be able to. When Hurricane Harvey hit Houston, about an hour away, we were in touch with our local fire department to let them know whether we were open or closed. The more people know their options for securing medical needs, the better off the community will be.

LAMELAS: We do not have ongoing, direct communication unless the health department, local municipalities, fire rescue, and police departments reach out to us. Having weathered a few hurricanes since opening here in south Florida in 2005, they all know we stay open as long as safely possible, and then try to reopen locations that are safe and have electricity or a generator as soon as possible. We do, however, keep an up-to-the-minute list of all our open sites and times on our webpage. Social media and radio are ideal for keeping the public informed.

SELLARS: One challenge is that phone systems, the internet, and cell phones may fail or be unreliable during a disaster. Trusted relationships are important to surviving a disaster situation; those may include our hospital partners caring for our patients should our centers be closed; local, county, and state government offices that have certain expertise and resources available in relieving disaster-related problems beyond our capabilities; and local media and social media outlets to provide updates to the community on operating hours and status. We also communicate with our vendors and other business partners as needed, and law enforcement agencies if necessary.

AYERS: Emergency medical services, hospital emergency rooms, and primary care providers should be aware of the urgent care center's availability in case of a natural disaster. Developing local relationships and keeping others appraised of the urgent care's operating status can

result in referrals to urgent care when physician offices are unavailable, and knowing that ambulatory, nonemergent patients can walk in to urgent care can open capacity for first responders and hospital EDs to focus on more acute needs in the community. Because urgent care benefits from patient referrals, it's always a good idea to develop relationships with community providers, regardless of whether there's a disaster.

"When a car crashed into our lobby, our priority was to ensure the safety and health of our patients and staff."
- Stan Bevis

How do you decide who to schedule if you do stay open?

SELLARS: Our chief operating officer serves as the Incident Commander during any disaster situation and works with the owners, partners, and other members of the administrative team to initiate and coordinate all aspects of the Emergency Preparedness Plan.

BEVIS: First we decide if it is safe for patients and our staff to be open. From there, our regional directors work with staff to determine who is able to cover shifts.

ARABZEDAH: Yes, in the event of a disaster, scheduling is based on who is available to come in, depending on the severity of the disaster. Those who have not been affected, and can safely come to work, come help if possible. We have an in-house communication program that we used to keep in constant communication with the staff during normal working hours, as well as in disaster situations. The leadership team continually monitors and discusses implementation of these plans on a disaster-by-disaster basis.

LAMELAS: We are not open during the hurricane, and we try to close 24-36 hours before the event, depending on the storm, since the track is not as well established until then. I make that final call with input from my executive team and weather reports. As a physician, I always want the patients to come first, without risking the safety of our staff, and like to say, "We are here for our patients and because of our patients."

Who can (or should) be on call if needed?

LAMELAS: From an urgent care operations perspective, that is the single most difficult part of dealing with any hurricane here in south Florida. School and daycare closings that force parents to stay home, people being evacuated from their homes or having difficulty traveling because of downed trees or power lines, as well as big and small things you would have never thought of, affect staffing. We try to determine which staff live in an evacuation zone, then create a list of staff and providers willing to take calls and be available. Lots of people step up during these difficult times and perform above and beyond what is expected. Others do not. It is always good to hope for the best, but be prepared by staffing extra employees, calling them in advance of their shifts, and having on-call staff and back-up plans. The most important thing is to communicate clear and concise messaging with staff before and after the hurricane.

SELLARS: While no staff members are expected to take any action that may endanger his/her life, all clinical staff members are considered essential and are expected to report to work to provide medical care to the community. Disaster on-call teams are established to provide additional coverage at high-volume clinics.

What if staff members have been affected directly by the disaster?

SELLARS: Adequate staffing is critical to meet increased healthcare demands during and after a disaster. However, staff may become both victims *and* responders when a disaster occurs. When this happens, staff member availability may be impacted for the first several days following a disaster. At Premier Health, we make every effort to assist staff members with their own personal disaster planning by incorporating preparedness efforts into our overall communications.

LAMELAS: We try to be supportive of our staff and keep open lines of communication, emails, group text, phone contact, radios, etc. on an ongoing basis. If employees have been personally affected, we try and shift them around between open sites so they can keep their hours/pay, give bonuses and extra personal time for outstanding performance, and even have been very charitable to them in times of need.

AYERS: Larger urgent care providers often have an employee assistance fund, to which employees can apply for support when facing individual hardship. Employees can donate to help their peers and there's a review process to determine which requests are funded. Smaller operators will provide direct contributions, paycheck advances, or collections among employees. Also, it's very common for employees to be able to donate

their unused paid time off to colleagues in need.

And what's the procedure for letting staff and patients know when your location has been affected—by physical damage or power outages, for example? Do you refer patients elsewhere on your website or building signage?

ARABZADEH: We use our social media network (Facebook, Google Plus, Instagram, website, etc.) to get information directly to our patients. We do our best to find out which alternate locations, whether it be hospitals, emergency rooms, or other urgent cares, are open and to pass the information along to our patients until we can get our location back up and running.

BEVIS: In 2017 we had an automobile crash into our front lobby. Our immediate priority was to ensure the safety and health of our patients and staff. Fortunately, nobody was seriously hurt. We did, however, have to immediately close the clinic. We called 911, and local fire and police departments arrived quickly to secure the area. We announced on signage, social media, and phone messages that we would close temporarily. Patients were referred to neighboring clinics.

LAMELAS: MD Now locations have been affected in different ways over the years—loss of power, window and building damage, floods, etc., so we have had single and multisite closures. In addition to our website, social media, and front-door signage, we use our office phone outgoing message to refer patients to our open sites or the ED. We email our corporate accounts and call patients proactively to reschedule appointments. After the storm, we do status call three to five times a day between management teams and corporate, and also group texts. It's helpful to have a few different methods of communication available.

SELLARS: We utilize an Emergency Notification Call Tree to communicate with staff members. It's distributed to all staff and posted at all worksite locations. Communication may be in the form of text, phone, email, social media, or through a dedicated emergency message phone line with recorded message updates. The Incident Commander coordinates messages with senior managers, regional administrators, and other associates that may include hospital command centers, media, insurance carriers, utility services, law enforcement, and others. If necessary, patients may be referred to affiliated entities through press releases, on websites, social media channels, LED signs, and temporary signs. In short, it's important to have a plan to communicate before, during, and after a disaster through alternate channels, if necessary.

"Planning, preparing, and training in advance of any event is essential, as is reviewing the disaster plan annually."
- Peter Lamelas

What have you learned from prior natural disasters that would be relevant to operating your urgent care clinic?

SELLARS: We've experienced catastrophic flooding, civil unrest, and three hurricanes in markets where we operate urgent care centers in the past year. All of these situations required the activation of our Emergency Preparedness Plan. The most important lesson we've learned is to have a well-developed disaster plan in place, and to clearly and emphatically communicate that plan to all staff members *before* a disaster occurs. Advance planning is critical to ensure the plan is implemented and executed effectively. That said, what may look good on paper doesn't always apply in a real-life situation, so it's extremely important to spend time not just preparing but to regroup after the disaster to make necessary adjustments.

ARABZADEH: We have had the luxury of having "only" one major disaster in our tenure here, but it was a horrible hurricane that resulted in catastrophic flooding. From that we have learned to always expect the unexpected. There was no way anyone could have prepared for the amount of damage and destruction that occurred. Our biggest takeaway was the fact that constant communication with your staff and outside emergency services will ensure the quickest and safest possible road to recovery.

LAMELAS: Four very important lessons: 1) Frequent communication is the single most important factor. 2) Planning, preparing, and training far in advance of any storm or event is essential, as is reviewing the disaster plan annually. 3) Selecting a responsible and available executive team and managers/supervisors, with a clear chain of command is a requirement. 4) Order extra medications—both in-house meds and dispensed prescription meds—plus certain vaccines, such as tetanus, and address proper storage issues. Other essential medical supplies, water, and even toilet paper have to be stocked, as well, upon increased probability of hurricane impact by weather models.

Not all valuable lessons come from within urgent care, by the way. I actually am very impressed and would like

to model our clinics to perform as well as the most time-tested hurricane-impacted business in south Florida: believe it or not, Publix Supermarkets. They have weathered these storms for over 87 years, and they're among the last to close and first to reopen. As urgent care operators, we need to think outside the box (or typical healthcare) and consider all industry "best practices."

"Coming together to help the community, and to open the urgent care back up as soon as possible, can truly be the cornerstone of recovery after a disaster."
- Payman Arabzadeh

AYERS: You have to balance what's right for the employees, patients, and what's needed in the community. One client decided to keep its centers open during a blizzard (an unusual occurrence in their temperate climate), notifying its primary care and hospital ED partners that the urgent care would be available. Generators were connected to power the centers, employees were housed in hotels near the centers, overtime labor costs were incurred, and referral providers were notified urgent care would be available. But because virtually nobody in the community was leaving home, the centers only saw three or four patients during the days of the storm and as a result, the urgent care lost its shirt in its service to the community, not to mention frustrating employees who were kept away from home and family.

What role can urgent care operators play in helping communities start to rebuild?

BEVIS: When an F5 tornado hit Lutts, TN in 2015 we sent providers, nurses, and staff with supplies to render emergency medical care and relief supplies. This was all possible because of our close proximity to this community. More recently, with hurricanes Irma and Harvey, we established drop-off locations for much-needed supplies at each of our clinics. We consolidated donations at our Waynesboro, TN headquarters and loaded a 50-foot trailer to each impacted state. Announcements were made through social media and email.

LAMELAS: Urgent care centers play an increasingly important role in the healthcare infrastructure and local medical community. At MD Now, we have been involved in community events, local outreach, charitable events, and contributions in the U.S., but especially in south Florida and the local communities we serve. We also support the Red Cross and others in relief efforts here and abroad as we did during the earthquake in Haiti by donating resources, money, and medical supplies.

It goes beyond our patients; urgent care is becoming more and more a respected and essential "medical safety net" that hospitals, private physicians and medical practices, and our communities cannot live without. Having said that, the urgent care industry as a whole is still *not* well integrated and connected into the U.S. healthcare infrastructure. I believe we need to remedy that through continuing outreach efforts, both as an industry and individually, to further develop the formal integration of our clinics and specialty into that existing infrastructure.

SELLARS: We can and should play an important role in disaster recovery. After serious, damaging floods hit the Baton Rouge area last year, we initiated a campaign called *We're Here for You* to help meet the community's healthcare needs during the time of crisis. Despite some clinics experiencing flooding of more than 4 feet of water, our volunteer team of administrative, clinical, and medical providers worked in the 100° postflood heat to feed, treat, and comfort displaced residents. With many cell towers down, we informed residents about clinic openings and closings, operational hours, tetanus shot information, and school/road closures on Facebook. Additionally, our medical leadership team appeared on local TV and radio to direct residents where to seek treatment for flood-related and other health issues, as well as to provide tips for safe flood cleanup.

ARABZADEH: As an urgent care operator, the more you can help and give back to your community, the more successful and sought-after you will become. In the aftermath of Hurricane Harvey, our biggest goal was giving back to the community. We encouraged others to do the same by posting on our social media networks that we were taking in donations for those who had been affected by the flooding. Most recently, we partnered up with UCAOA for the *Weekend of Service,* in which we provided free medical assistance to those affected by the flooding. We are also running a flu shot drive, with the proceeds going to those affected by the flooding and hurricane damage.

Coming together as a family to help the community and to open the urgent care back up as soon as possible, without causing extra risk to anyone, can truly be the cornerstone of recovery during and after a disaster. ■

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New York State and New York City: The Health Department is Enforcing Quality Assurance Regulations for Primary Diagnostic Monitors, Are You in Compliance?

New York State and New York City's Health Departments Inspections include verification of your reading radiologist's primary diagnostic monitors (PDM).

These monitors are vital to a patient's diagnosis if they require an x-ray or radiology reading, which is why the health department has created a QA program for PDM's. New York State and New York City have enforced more stringent regulations due to the density of the population puts a great demand on urgent cares, requiring doctors to be more cautious when it comes to reading x-rays and radiology reports.

While these requirements are not new, as they have been in place for some time, the respective health departments make sure that registrants are in compliance.

Here at Teleradiology Specialists, we want urgent cares in the New York State and New York City area to be informed of the QA regulations, and to also show how we can help your urgent care succeed.

What Are The Quality Assurance Regulations?

The regulations are in regard to the monitors used to make a final diagnosis for patients. The PDM's must pass acceptance requirements before being utilized, which involves measuring the grayscale, luminance uniformity and ratio, and evaluating viewing conditions of the monitor.

In addition, registrants must perform bi-weekly, quarterly, and annual testing on PDM's, all of which must be meticulously documented.

Bi-weekly PDM testing involves using a test pattern to evaluate grayscale squares, thorough cleaning of monitors, brightness uniformity, and color trueness.

The quarterly testing revolves around the Grayscale Standard Display Function (GSDF) calibration verification. Registrants are required to run and document tests, either through software or manually, verifying that GSDF is calibrated correctly.

Annual testing is more detailed. Registrants are required to check all viewing conditions of monitors, luminance ratio and uniformity, measurement of Grayscale, and are required to bring in a licensed medical physicist for the review of all monitor QA testing done throughout the year. All documentation must be readily available for Health Department officials when visiting.

How Does This Affect Your Urgent Care?

The most difficult part about the compliance laws is the heavy documentation. Each acceptance, bi-weekly, quarterly, and annual test, along with any repairs made to the primary diagnostic monitors, must be recorded. Keeping up with these compliance and quality assurance laws is difficult and tedious work.

This process essentially takes away time from seeing patients. Instead of focusing on the needs of your patients, registrants are attempting to keep up with compliance laws and regulations.

Teleradiology Specialists work with clients all over the U.S., doing over-reads for urgent cares and practices, ensuring high quality readings and compliance with state and city regulations. We have always prioritized speed and price, but also risk mitigation; we want to protect the future of our clients by upholding regulations.

We do all of our own testing on PDM's used by our radiology specialists, so our clients never have to worry about documenting any tests. We provide all clients with accessible information about all our testing and documentation, having it readily available to clients for health department visits.

We prioritize compliance, so that you can do your job better. We want our clients to spend more time with patients, ensuring that they can get the best care possible. With more pressure on registrants to prove compliance, there is an even greater need for urgent cares to uphold integrity and respect in the community; don't put your urgent care at risk.

To learn more about Teleradiology Specialists, visit teleradiologyspecialists.com/compliance.

"Our service promise is not only quality of the reads, but they have to be done with speed because we want to get the final report in the patient's hands before they leave the urgent care center."

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ABSTRACTS IN URGENT CARE

- Supplemental O2 for MI
- Football and CTE
- Oral Corticosteroids and Lower RTIs
- Gabapentinoids in Chronic Low Back Pain
- New Tests for Flu
- Impact of AEDs on Survival
- New Drug for BV

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.

Supplemental Oxygen May Not Reduce All-Cause Mortality in MI Patients

Key point: Routine use of supplemental oxygen in patients with suspected myocardial infarction who did not have hypoxemia was not found to reduce 1-year all-cause mortality.

Citation: Hofmann R, James SK, Jernberg T, et al. Oxygen therapy in suspected acute myocardial infarction. *N Engl J Med*. August 28, 2017. [Epub ahead of publication]

The rationale behind oxygen therapy is to increase oxygen delivery to the ischemic myocardium and thereby limit infarct size and subsequent complications. However, the basis for this practice is limited to experimental laboratory data and small clinical studies. This registry-based randomized control trial enrolled 6,629 patients (gathered from nationwide Swedish registries) with suspected myocardial infarction who had an oxygen saturation of ≥90% and randomized them to receive either supplemental oxygen or ambient air. At the time of randomization, the median oxygen saturation was 97%. The primary endpoint of death from any cause within 1 year after randomization occurred in 5% of patients assigned to oxygen and in 5.1% of patients assigned to ambient air. The difference was not statistically significant. Rehospitalization with myocardial infarction within 1 year occurred in 3.8% assigned to oxygen and in 3.3% assigned to ambient air. This difference was also not statistically significant. Hypoxemia developed in 1.9% in the oxygen group, compared with 7.7% in the ambient-air group. The median of the highest troponin level during hospitalization was 946.5 ng/L in the oxygen group and 983 ng/L in the ambient-air group. This also was not a statistically significant difference. These results show that the routine use of supplemental oxygen in patients with suspected myocardial infarction (who do not have hypoxemia) does not reduce 1-year all-cause mortality or readmission rates for myocardial infarction. ■

Glenn Harnett, MD is principal of the No Resistance Consulting Group in Mountain Brook, AL; a board member of the College of Urgent Care Medicine and the Urgent Care Foundation; and sits on the *JUCM* editorial board.

Brain Study Suggests a Link Between CTE and Football—Even Among Youths

Key point: A high proportion of deceased players of American football showed pathological evidence of chronic traumatic encephalopathy, suggesting that CTE may be related to prior participation in football.

Citation: Mez J, Daneshvar DH, Kiernan PT, et al. Clinicopathological evaluation of chronic traumatic encephalopathy in players of American football. *JAMA*. 2017;318(4):360–370.

This widely referenced *JAMA* study presents a convenience sample of 202 deceased players of American football from a brain bank established to study the neuropathological sequelae of repetitive traumatic brain injury. Their brains were neuropathologically examined and diagnoses of neurodegenerative diseases, including chronic traumatic encephalopathy (CTE), were determined based on defined diagnostic criteria. Retrospective telephone clinical assessments (including head trauma history, informant-reported athletic history and, for players who died in 2014 or later, clinical presentation, including behavior, mood, and

cognitive symptoms and dementia) with informants were also performed. Among the 202 players studied (median age at death, 66 years), CTE was neuropathologically diagnosed in 177 (87%; mean years of football participation, 15). This included 0 of 2 pre-high school, 3 of 14 high school (21%), 48 of 53 college (91%), 9 of 14 semiprofessional (64%), 7 of 8 Canadian Football League (88%), and 110 of 111 National Football League (99%) players. Like the incidence rates above, the neuropathological severity of CTE rose along with a higher level of play. All three former high school players had mild pathology, while the majority of former college (56%), semiprofessional (56%), and professional (86%) players had severe pathology. The rates of behavioral or mood symptoms reported were similar among both the mild and severe groups. Cognitive symptoms were higher in the severe pathology group (95%) than the mild pathology group (85%). Rates of dementia were markedly higher in the severe pathology group (85%) as compared to the mild pathology group (33%). The key shortcoming of this study, acknowledged by its authors, is the likely potential selection bias that players and their relatives may have submitted their brains due to clinical symptoms of CTE, noticed while they were living. Because of that, one cannot draw any inferences about the exact likelihood that a football player will develop CTE. Still, these were not incidental findings. Most of the athletes manifested severe signs of mental illness, fully one-third of the patients displayed suicidality (ideation, attempts, or completion), and more than a quarter of the patients with mild CTE in this series committed suicide. At the very least, these results suggest that people who play advanced levels of football are at risk for CTE.

New Data Question Oral Corticosteroids for Lower RTIs

Key point: Oral corticosteroids should not be used for acute lower respiratory tract infection symptoms in adults without asthma because they do not reduce symptom duration or severity.

Citation: Hay AD, Little P, Harnden A, et al. Effect of oral prednisolone on symptom duration and severity in nonasthmatic adults with acute lower respiratory tract infection: A randomized clinical trial. *JAMA*. 2017;318(8):721-730.

This multicenter, placebo-controlled, randomized trial was conducted in 54 family practices in England among 401 adults with acute cough and at least one other with lower respiratory tract symptom who did not require immediate antibiotic treatment and had no history of chronic pulmonary disease or use of asthma medication in the past 5 years. The intervention was either two 20 mg prednisolone tablets (n=199) or matched placebo (n=202) once daily for 5 days. The primary outcomes were duration of moderately bad or worsening cough and mean severity of symptoms on days 2 to 4. Treatment with oral prednisolone, 40 mg/d for 5 days, compared with placebo did not significantly reduce the median duration of moderately bad or worse cough (5 days in each group) or the mean severity of symptoms between days 2 and 4 (1.99 vs 2.16 points out of 6). No significant treatment effects were observed for duration or severity of other acute lower respiratory tract infection symptoms, duration of abnormal peak flow, antibiotic use, or nonserious adverse events. These findings do not support the use of oral steroids for the treatment of acute lower respiratory tract infection in the absence of asthma. ■

New Data on Gabapentinoids in Chronic Low Back Pain

Key point: Existing evidence on the use of gabapentinoids in chronic low back pain is limited and demonstrates significant risk of adverse effects without any demonstrated benefit.

Citation: Shanthanna H, Gillon I, Rajarathinam M, et al. Benefits and safety of gabapentinoids in chronic low back pain: a systematic review and meta-analysis of randomized controlled trials. *PLoS Med.* 2017;14(8):e1002369.

This was a systemic review and meta-analysis of randomized controlled trials on the benefits and safety of gabapentinoids in chronic low back pain (CLBP). Pregabalin and gabapentin are gabapentinoids that have demonstrated benefit in neuropathic pain conditions. Despite no clear rationale, they are increasingly used for nonspecific CLBP. The authors included eight randomized control trials reporting the use of gabapentinoids for the treatment of CLBP of >3 months duration in adult patients. Three studies compared gabapentin with placebo and showed minimal improvement of pain. Three studies compared pregabalin with other types of analgesics which showed greater improvement in the other analgesic group. The largest study using pregabalin as an adjuvant to tapentadol showed no pain improvement with the addition of pregabalin. The following adverse events were more commonly reported with gabapentin: dizziness (RR = 1.99); fatigue (RR = 1.85); difficulties with mentation (RR = 3.34); and visual disturbances (RR = 5.72). The number needed to harm with 95% CI for dizziness, fatigue, difficulties with mentation, and visual disturbances were 7, 8, 6, and 6 respectively. Functional and emotional improvements were reported by few studies and showed no significant improvements. These results suggest caution in the use of gabapentinoids in CLBP, as there is limited evidence of efficacy and adverse events are relatively common. ■

New Tests May Be More Highly Sensitive for Flu

Key point: Newer, novel digital immunoassays and rapid nucleic acid amplification tests had markedly higher sensitivities for influenza A and B in both children and adults than did traditional rapid influenza diagnostic tests, with equally high specificities.

Citation: Merckx J, Wali R, Schiller I, et al. Diagnostic accuracy

of novel and traditional rapid tests for influenza infection compared with reverse transcriptase polymerase chain reaction: a systematic review and meta-analysis. *Ann Intern Med*. 2017;19(167):394-409.

The authors did a meta-analysis of 162 published studies and compared commercialized rapid tests (ie, those providing results in <30 minutes) of 130 older rapid influenza diagnostic tests (RIDTs), 19 digital immunoassays (DIAs), and 13 newer rapid nucleic acid amplification tests (NAATs) to compare their sensitivity and specificity for influenza A and B. Reverse transcriptase polymerase chain reaction was the reference standard for influenza diagnosis. DIAs differ from older rapid tests by using instrument-based digital scanning of the test strips. Rapid NAATs are simplified reverse transcriptase polymerase chain reaction (RT-PCR)–based tests. Pooled sensitivities for detecting influenza A were 54% for RIDTs, 80% for DIAs, and 92% for NAATs. Those for detecting influenza B were 53% for RIDTs, 77% for DIAs, and 95% for NAATs. Pooled specificities were uniformly high (>98%) for all tests. An editorialist called for "revision of guidelines to encourage use of these newer diagnostic strategies." Rapid NAATs and DIAs are still considerably more expensive than other, older tests and their point-of-care utility still needs confirmation. However, if the costs of these newer DIAs and NAATs can be brought down to encourage use, their increased sensitivity provides the potential to rationally increase the use of antivirals and decrease the use of antibiotics in the urgent care setting. ■

AEDs Improve Intact Survival in Some Cardiac Arrests

Key point: Since Rochester, MN began distributing automatic external defibrillators (AEDs) to police and firefighters in the 1990s there has been an improving trend in neurologically intact survival of ventricular fibrillation/pulseless ventricular tachycardia (VF/pVT) out-of-hospital cardiac arrests.

Citation: Okubo M, Atkinson EJ, Hess EP, White RD. Improving trend in ventricular fibrillation/pulseless ventricular tachycardia out-of-hospital cardiac arrest in Rochester Minnesota: a 26-year observational study from 1991 to 2016. *Resuscitation*. 2017;120:31-37.

In 2009–2016, neurologically intact survival to discharge from overall VF/pVT and bystander-witnessed VF/pVT increased to 54% and 65%, respectively, compared with 39% and 43% in 1991–1997. Using multivariable analysis, survival significantly increased in 2009–2016 among all VF/pVT arrests (adjusted OR, 3.10) and bystander-witnessed VF/pVT (adjusted OR, 4.28), compared with those in 1991–1997. Comparing the earliest period (1991–1997) to the latest (2009–2016), survival to hospital admission changed (from 70% to 73%), and mean call-to-shock time increased (from 6.5 to 7.7 minutes). The rate of bystander CPR increased (from 48% to 57%), as did the rate of first shock provided by first responders (police or firefighters), from 44% to 69%. Use of targeted temperature management also increased from 0% to 44% after being initiated in 2005. Neurologically intact survival increased among patients with shockable rhythms, from 40% to 54%, and among those with bystander-witnessed arrest, from 43% to 65%. These increases were both statistically significant. These neurologically intact survival rates support the continued use and greater adoption of AEDs, along with increasing the percentage of first responders trained to use them. ■

A New Option for Bacterial Vaginosis

Key point: The Food and Drug Administration has approved a new antibiotic for women with bacterial vaginosis.

Citation: Schwebke JR, Morgan FG Jr, Koltun W, Nyirjesy P. A phase 3, double-blind, placebo-controlled study of the effectiveness and safety of single oral doses of secnidazole 2 g for the treatment of women with bacterial vaginosis. *Am J Obstet Gynecol*. September 1, 2017. [Epub ahead of print]

This phase 3, randomized, double-blind, dose-ranging, placebo-controlled, multicenter study evaluated a single 2 g dose of oral secnidazole (Solosec) and placebo for the treatment of bacterial vaginosis (BV). In the trial, 189 women with BV who met all Amsel criteria (ie, characteristic discharge; pH ≥4.7; ≥20% clue cells; positive whiff test) were randomized 2:1 at 21 U.S. centers to 1 or 2 g secnidazole compared with placebo. The primary endpoint was the proportion of clinical outcome responders (normalization of discharge, amine odor, and clue cells) 21–30 days after treatment. Secondary endpoints included clinical cure rates (normalization of discharge, amine odor and clue cells) assessed 7–14 days after treatment and test of cure 21–30 days after treatment. Clinical cure rates based on the 2016 FDA guidance of 7–14 days after treatment were 64% for 2 g secnidazole compared with 26.4% for placebo. Significantly more patients receiving single-dose secnidazole 2 g compared with placebo required no additional BV treatment (68% vs 29.6%). The overall adverse event rate was 34.4% for single-dose secnidazole 2 g vs 21.9% for placebo. Vulvovaginal candidiasis was the most common adverse event. A dose of secnidazole comes in the form of a 2 g packet of granules. Patients sprinkle the granules on applesauce, yogurt, or pudding and eat the mixture within 30 minutes without chewing or crunching the granules. Most current antibiotics for bacterial vaginosis must be taken for 5 to 7 days, and often more than once a day. As a single-dose treatment, secnidazole has the potential to improve adherence and the likelihood of a cure for BV. ■

CME: This article is offered for *AMA PRA Category 1 Credit*.™
See **CME Quiz Questions** on page 7.

Lumbar Hernia: An Unusual Cause of Back Pain

Urgent message: Back pain is a common complaint in the urgent care setting. Common causes of musculoskeletal back pain include overuse and work-related injury. Other causes can include disc herniation, metastasis, osteoporosis, arthritis, spinal stenosis, and nephrolithiasis.

CRYSTAL N. BHARAT, MD, RONALD DVORKIN, MD, FACEP, and GLENN G. GRAY MD

Case Presentation

A 65-year-old female complained of 1 day of low back pain radiating to her left flank, which was aggravated with movement. Symptoms began while at work. Patient denied nausea, vomiting, diarrhea, fever, urinary frequency, urinary urgency, dysuria and hematuria, bowel or bladder dysfunction, or lower-extremity or gluteal paresthesias. On her physical exam, paravertebral muscle spasm was appreciated with mild midline tenderness and no mass. Neurological sensation was intact. Motor strength was 5/5 and reflexes 2+ in the lower extremities bilaterally. Lumbar radiographs were negative, without acute findings. Patient was diagnosed with lumbar strain and treated with cyclobenzaprine (Flexeril) and naproxen sodium (Naprosyn).

The patient returned the following day due to her inability to perform normal work activities. She complained of left flank pain radiating to her left abdominal region. Abdominal and flank palpation elicited mild left lower quadrant tenderness. Urinalysis did not show evidence of blood or infection. A CT of the abdomen and pelvis without contrast was ordered to evaluate for a ureteral stone, diverticulitis, or incarcerated hernia. Radiology reported an incidental left posterior flank soft tissue lipoma; the scan was otherwise unremarkable. Patient was advised to continue with current medication, rest, and return in 2 days for reevaluation.

Upon the third visit, the patient reported persistent left flank pain with radiation to the left inguinal region. Repeat urinalysis was within normal limits. A radiologist was called to discuss and review previous CT scan of the

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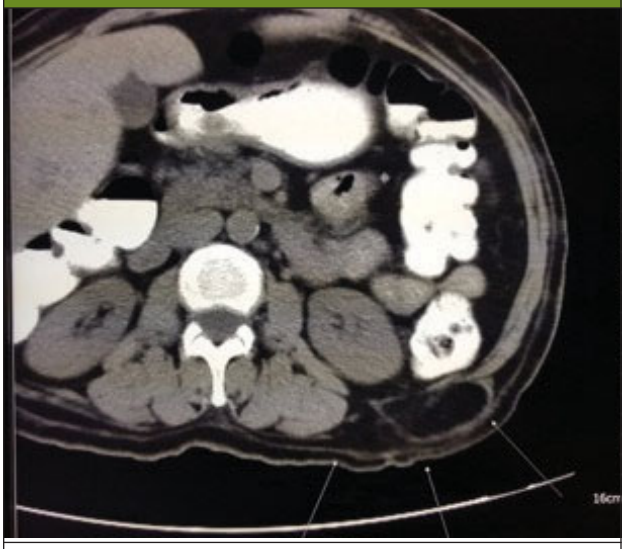
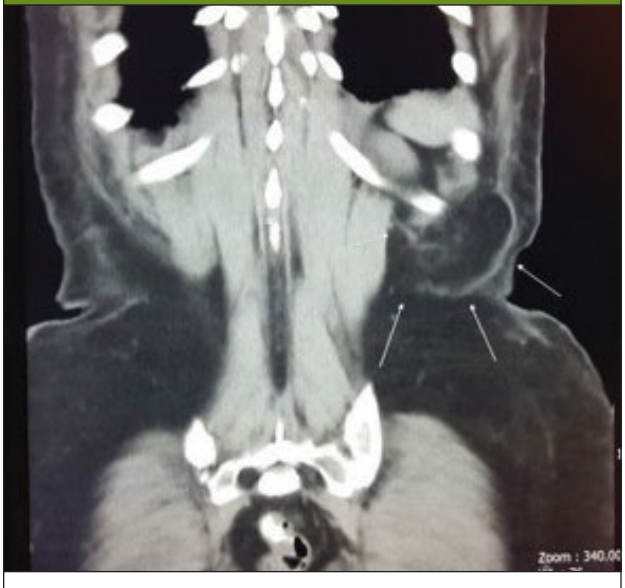
Figure 1.



Axial image from CT scan abdomen without contrast. Retroperitoneal fat (arrows) can be seen at the level of the lower pole left kidney, just below 12th rib, herniating through the posterior abdominal wall to the left flank.

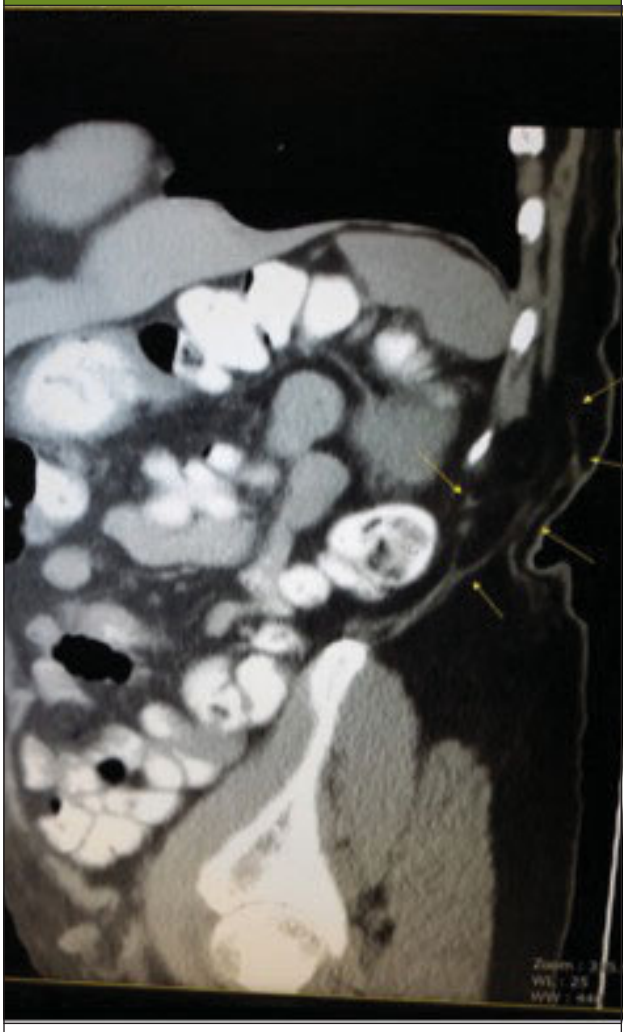
Figure 2.



Coronal image from CT scan abdomen with oral contrast. Herniated retroperitoneal fat (arrows) just inferior to left 12th rib, extending into the left flank subcutaneous tissues.

abdomen and pelvis. Upon further review, it was noted that the previously described left flank fatty lesion was herniated fat posterior to the left kidney which progressed through the superior lumbar triangle.

Figure 3.



Sagittal image from CT scan abdomen with oral contrast. Herniated retroperitoneal fat (arrows) projecting posteriorly and laterally at the left 12th rib level, into the extraperitoneal flank region.

CT scan showed a lumbar hernia at the level of L1/L2, consistent with the patient's current symptoms. (See **Figures 1–3**.)

Discharge Instructions

Patient was advised to follow up with general surgery.

Discussion

The differential diagnosis of low back pain is broad. Though older adults can experience pain related to any condition affecting younger adults, patients over

60 years of age are more likely to have pain related to degeneration of the spinal joint, including osteoporosis and spinal stenosis. Consideration should also be made for neoplasm, infection, and abdominal aortic aneurysm.

Red flags for serious causes of back pain include fever, weight loss, numbness, history of malignancy, nighttime pain, and urinary retention or incontinence. Chronic undifferentiated low back pain (>6 weeks) may also deserve additional work-up.

A lumbar hernia is a rare entity, with <300 cases reported in the literature.[1] Symptoms can vary and may be difficult to distinguish between other etiologies. Palpation of both superior and inferior triangles may confirm an important clinical finding, a bulge.[2] However, a palpable mass or bulge in the lumbar area does not need to be appreciated, as seen in our case. The ability to diagnose a lumbar hernia during the initial patient visit may be challenging without further diagnostic testing, such as a CT scan.

The superior lumbar triangle is bordered by the 12th rib superiorly, iliac crest inferiorly, erector spinae muscle medially, and posterior oblique muscle laterally.[3] There are two types of hernias that are determined by their anatomical location—the superior lumbar hernia (Grynfeltt-Lesshaft hernia), as in this case, and the inferior lumbar hernia (Petit hernia). If initial treatment fails and clinical symptoms do not correlate with radiological exam, it is important to reevaluate past diagnostic imaging and question initial radiology reports.

The most effective treatment approach is best determined by properly identifying classification, size, location, and contents of defect with CT imaging, which allows surgeons to choose which method (open vs laparoscopic) to perform.[4] Surgical repair with synthetic mesh has been found to be successful with minor complications and tissue damage.[5]

Conclusion

Since lumbar hernias are rare, diagnosis may often be made retrospectively. In this case, the symptoms were not consistent with the initial radiological interpretation. When clinical suspicion is discordant with an imaging study, direct consultation with a radiologist can often help in establishing an unusual diagnosis. ■

Summary

- Lumbar hernia is an uncommon diagnosis in any setting, but it bears consideration because urgent care is a frequent destination for patients with low back pain.
- Symptoms of lumbar hernia may not be consistent with the initial radiological interpretation.
- CT scan is the best choice for imaging to identify a lumbar hernia.
- Back pain accompanied by any of the following may warrant more intensive evaluation:
  - fever
  - weight loss
  - numbness
  - history of malignancy
  - nighttime pain
  - urinary retention or incontinence
  - chronic undifferentiated back pain lasting >6 weeks
- While the differential diagnosis of low back pain is broad, patients over age 60 are more likely than younger patients to have pain related to degeneration of the spinal joint, including osteoporosis and spinal stenosis. Neoplasm, infection, and abdominal aortic aneurysm should also be considered.

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What Constitutes Consent for Treatment of a Minor in Urgent Care?

ALAN A. AYERS, MBA, MAcc

Urgent message: Urgent care centers must use all reasonable efforts to comply with informed-consent and consent-to-minors laws. This should include consulting with legal counsel on the specific laws of the state and developing protocols to shield the center from possible litigation.

Introduction

Medical practices like urgent care centers are generally required to obtain patient consent for treatment in nonemergency situations. However, what constitutes *consent* when the patient is a minor may be hard to discern for urgent care owners, practice managers, and clinicians. As we will see in this discussion, many states (eg, Connecticut) have enacted statutes providing that minors may consent to medical treatment only in certain limited circumstances. However, generally, most states have recognized the common law rule that minors are presumed to be incompetent to make medical decisions, and as result, parental consent is required.[1]

Background

Examining the basis of the U.S. legal system of torts, the unwanted touching of an individual by another without consent and without legal justification constitutes a physical battery.[2] Traditionally, this has been the same result when a doctor treats a patient without informed consent.

The United States Supreme Court stated in 1891 that "no right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."[3]

The idea of bodily integrity is exhibited in the general requirement that informed consent is required for medical treatment. Justice Benjamin Cardozo described this doctrine: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."[4]

For more than 100 years, the notion of informed consent has been part of American tort law.[5]

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Consent to Treatment or Informed Consent

In General

As the doctrine simply implies, informed consent requires that a physician must inform the patient of the "diagnosis, the general nature of the contemplated procedure, the risks involved, the prospects of success, the prognosis if the procedure is not performed, and alternative medical treatment" before any medical treatment is performed.[6] The doctrine's rationale is to allow the patient to have the ability to make an informed, intelligent decision on his or her pending medical treatment.[7] Medical malpractice stems from the failure to disclose, or an insufficient disclosure of material risks of a procedure that a "reasonable medical practitioner would have disclosed under the same or similar circumstances."[8]

Substituted Consent for a Minor—Consent by Adult Other than Patient

Each individual state determines the exact role or status of a person who is permitted to give consent for a minor's medical treatment. Typically, if the patient is not legally competent (in this instance, meaning he or she is a minor) to consent to medical treatment, substituted consent must be sought. This is usually a guardian or other person temporarily in *loco parentis* (in the place of a parent) who may provide consent for a minor.[9] For example, Louisiana law states that several persons are authorized to consent to medical treatment that are directed by a physician if the parent is not available:

- Any person temporarily standing in *loco parentis*, whether formally serving or not, for the minor under his care and any guardian for his ward.

- Any adult, for his minor brother or sister.
- Any grandparent for his minor grandchild.[10]

Further, the law in Louisiana states that this provision is to be "liberally construed."[10] All relationships include marital, adoptive, foster, and step-relations, in addition to natural whole blood. A consent by one person so authorized is satisfactory.

The law also provides some protection for medical professionals, noting that a person acting in good faith is justified in relying on the representations of a person "purporting" to give consent, including—but not limited to—that person's identity, age, marital status, emancipation, and relationship to any other person for whom the consent is purportedly given."

If consent to treatment can't be obtained from either the patient or one providing substituted consent, a physician may medicate the patient only if he or she determines that failure to medicate the patient would render him "unsafe" to himself or others.

Consent by Minors

State statutes again set out their specific guidelines for situations in which a minor can consent to medical treatment.

The Tennessee Supreme Court held in 1987 that a minor 14 years of age or older is presumed to have the capacity to consent to treatment.[11] In Massachusetts, a minor may give consent to his medical care when that care is sought if the minor:

- is married, widowed, divorced
- is the parent of a child, in which case he may also give consent to medical or dental care of the child
- is a member of any of the armed forces
- is pregnant or believes herself to be pregnant
- is living separate and apart from his parent or legal guardian, and is managing his own financial affair
- reasonably believes himself to be suffering from or to have come in contact with any disease defined as dangerous to the public health—pursuant, however, the minor may only consent to care which relates to the diagnosis or treatment of that disease.[12]

Emancipated Minors

California law stipulates that an emancipated minor may, *inter alia* (among other things), "consent to medical, dental, or psychiatric care, without parental consent, knowledge, or liability."[13] Likewise, West Virginia has recognized the "mature minor" exception to the common law rule that parental consent is required prior to rendering medical treatment to a minor.[14]

Elements of Informed Consent

When there is an issue of consent, states commonly look to the negligence elements and those of medical malpractice to determine whether there has been a breach of informed consent law in the medical facility. Many states have laws like that of Washington, which requires a plaintiff to show the following to demonstrate informed consent was not given:

- The healthcare provider failed to inform the patient of a material fact or facts relating to the treatment
- The patient consented to the treatment without being aware of or fully informed of such material fact or facts
- A reasonably prudent patient under similar circumstances would *not* have consented to the treatment if informed of such material fact or facts
- The treatment in question caused injury to the patient[15]

Application to Urgent Care Centers

Urgent care centers must use all reasonable efforts to comply with informed consent and consent-to-minors laws. This should include consulting with legal counsel on the specific laws of the state and developing protocols to shield the center from possible litigation.

As a reminder, many states allow that those acting in good faith are justified in relying on the representations of a person purporting to give consent.[16] Nonetheless, thorough documentation and record-keeping is mandatory in such situations.

Medical emergencies provide more latitude for medical care providers, permitting treatment without parental consent in certain situations.[17] Obviously, urgent care personnel should attempt to secure parental consent, if possible; however, there will, in most situations, be no liability in emergent circumstances when life-sustaining treatment is provided to a minor child.[18]

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10. La. R.S. § 40:1299.53. See *Stafford v. Louisiana State University,* 448 So. 2d 852, 855 (La.App. 2 Cir. 1984).
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INSIGHTS IN IMAGES

CLINICAL CHALLENGE: CASE 1

In each issue, *JUCM* will challenge your diagnostic acumen with a glimpse of x-rays, electrocardiograms, and photographs of conditions that real urgent care patients have presented with.

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

A 9-Year-Old Boy with Pain After Twisting His Knee

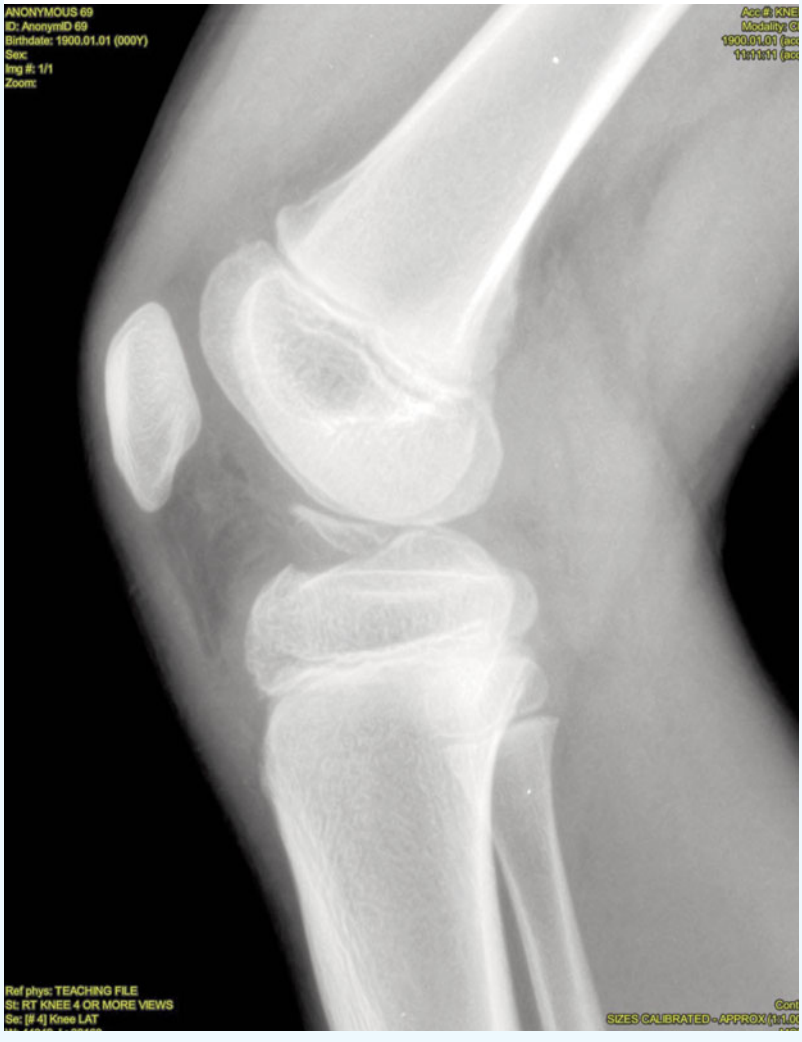


Figure 1.

Case

The patient is a 9-year-old boy who was brought in by his parents with right knee pain. He reports that he twisted it while reenacting *Star Wars* battles in the backyard with friends. His parents did not witness the injury.

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

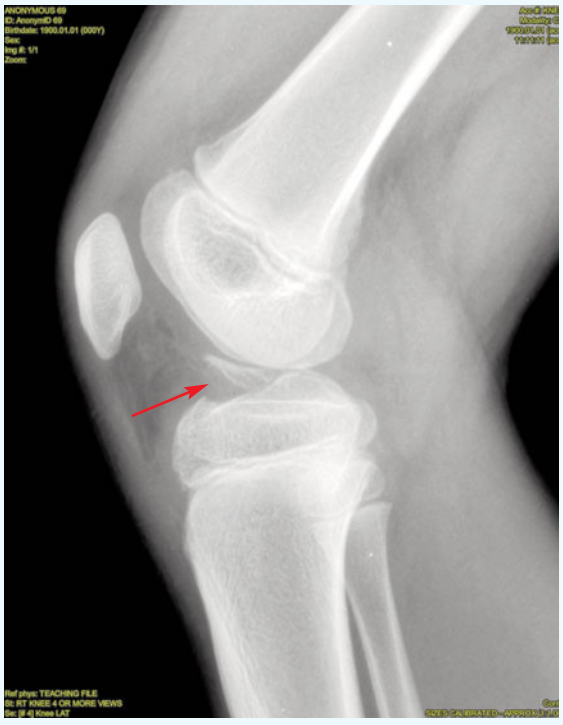


Figure 2.

Differential Diagnosis

- Meniscal tear
- ACL/PCL tear
- Maisonneuve fracture
- Displaced avulsion fracture of the tibial spine
- Dislocation

Diagnosis

The oval-shaped bone density projecting in the intercondylar notch region is a displaced avulsion fracture of the tibial spine, otherwise known as tibial eminence fractures or ACL avulsion fractures.

Learnings

- ACL avulsion fractures are often associated with sports or other vigorous physical activity in children 8—13 years of age
- The fracture occurs secondary to relative weakness of incompletely ossified tibial eminence compared to native ACL fibres

Pearls for Urgent Care Management and Considerations for Transfer

- This injury is painful—the knee should be immobilized prior to transfer
- Evaluate and document neurovascular status
- Pain medication should be administered, with consideration to potential emergent surgical repair which would require NPO status
- Evaluate for more serious considerations such as an open fracture, compartment syndrome, or fracture/dislocation in the proximal or distal joint ■

CLINICAL CHALLENGE: CASE 2

A 26-Year-Old Man with Palpitations

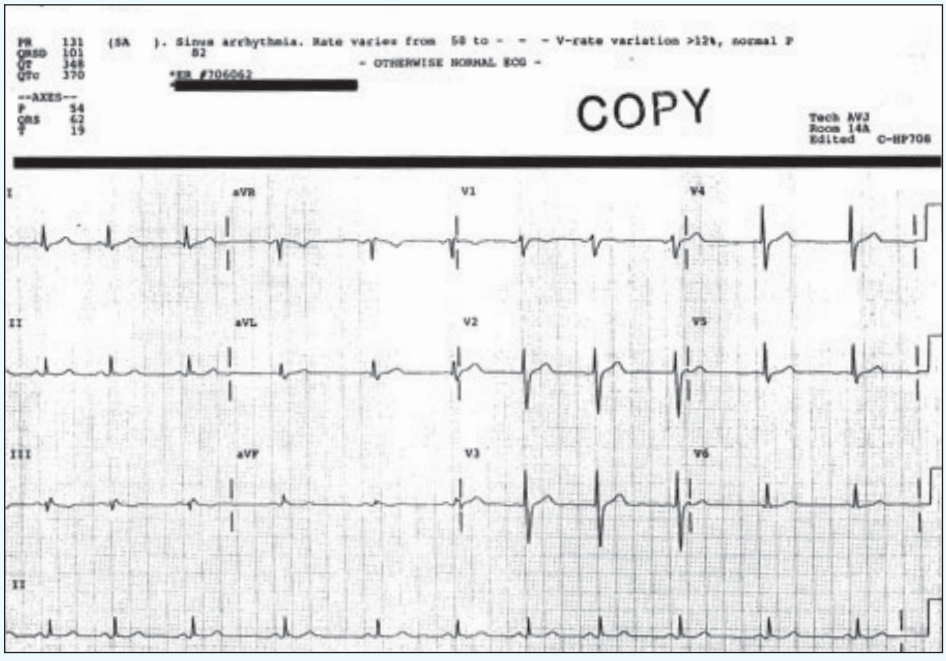


Figure 1.

Case

The patient is a 26-year-old man who presents after 3 days of palpitations. He denies any chest pain, shortness of breath, diaphoresis, fever, or dizziness. He does use home oxygen (2 L/min), but denies any new shortness of breath.

Upon exam, you find:

- **General:** Alert and oriented X 3
- **Lungs:** Clear to auscultation bilaterally
- **Cardiovascular:** Regular and tachycardic without murmur, rub, or gallop
- **Abdomen:** Soft and nontender without rigidity, rebound, or guarding
- **Extremities:** No pain or swelling, pulses are 2+ and equal in all 4 extremities

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

THE RESOLUTION

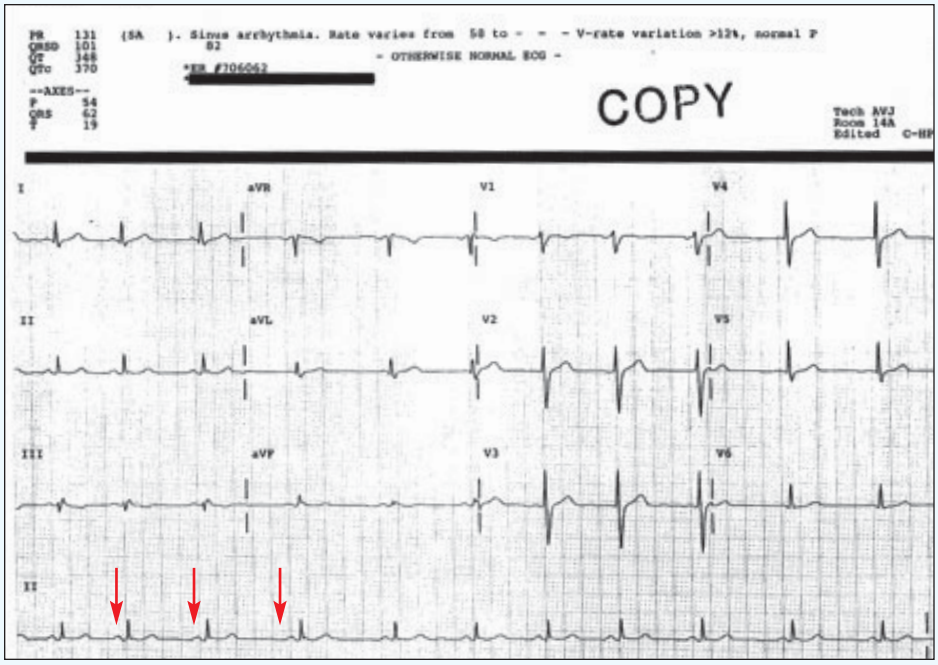


Figure 2.

Differential Diagnosis

- Sinus tachycardia
- Supraventricular tachycardia
- Atrial fibrillation
- Multifocal atrial tachycardia
- Sinus arrhythmia

Diagnosis

The ECG revels sinus arrhythmia, with "p" waves preceding each QRS, excluding atrial fibrillation. The rate is between 60-100, so this is not a tachycardic ECG (excluding MAT, SVT, or sinus tachycardia). The PR and QRS intervals are normal, arguing against a bundle branch block or a ventricular rhythm. There are no ischemic changes suggestive of acute coronary syndrome (no ischemic ST changes or abnormal T wave inversions).

Learnings

- Sinus arrhythmia is common in young patients and is a normal physiologic response, typically due to increased or decreased vagal tone during breathing (inspiration decreases the vagal tone, causing an increase in the heart rate)
- This is a benign rhythm that sometimes will be appreciated by the patient and other times may be asymptomatic
- The complaint of palpitations is common, and a history should be taken looking for electrolyte abnormalities, ischemia, SVT, drug use, and medication interactions/effects
- If the history is not suggestive or concerning for a serious underlying problem, lab testing is not required

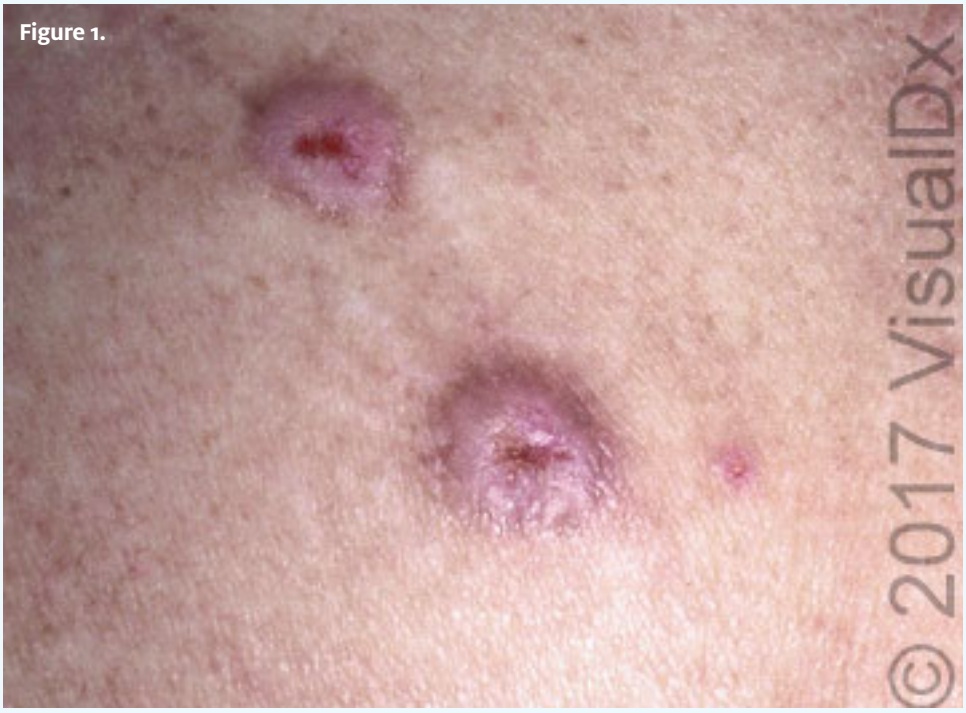
Pearls for Urgent Care Management and Considerations for Transfer

- Although a sinus arrhythmia is a benign rhythm, the patient should be questioned for a serious underlying cause
- If the rhythm is found incidentally and the patient is asymptomatic/without new symptoms, no further testing is necessary
- Compare the ECG to previous ECGs if available
- Indications for transfer include suspicion of ischemia, cerebral hypoperfusion (dizziness, altered consciousness, hypotension), sepsis, respiratory distress, pulmonary embolism, drug toxicity, or consideration of other life-threatening etiology ■

CLINICAL CHALLENGE: CASE 3

A 48-Year-Old Female with Pruritic Lesions

Figure 1.



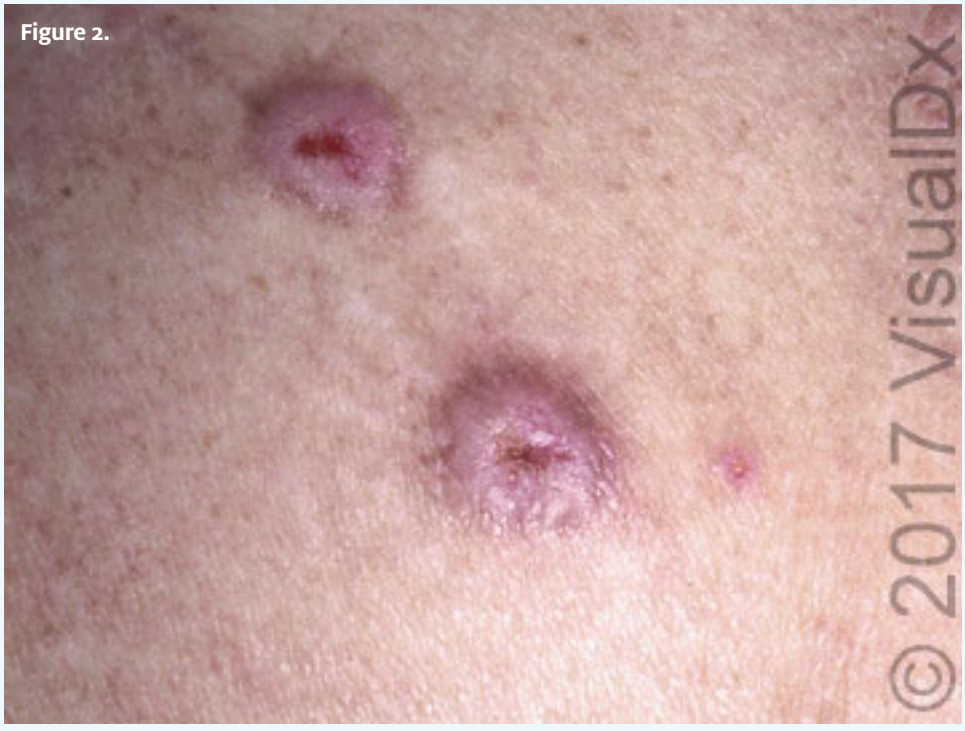
Case

A 48-year-old woman presents with several red lesions that are extremely pruritic. They are scattered haphazardly on the back of her leg. A few of the lesions are still smooth nodules, but others are now excoriations; she just can't stop scratching them no matter how hard she tries. She estimates they appeared nearly a month ago. She reports a history of atopic dermatitis, but "this doesn't feel like the same thing."

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

- Prurigo nodularis
- Scabies
- Lichen planus
- Molluscum contagiosum

Diagnosis

The size and nature of the nodules—firm, dome-shaped, and smooth-topped—indicate a case point to prurigo nodularis. This is seen most commonly in patients ≥45 years of age, and more often in women than in men. Lesions can also be crusty, and can range in size from 1 to 2 cm, often enlarging slowly over time. They appear most often on the extensor surfaces of extremities and anterior areas of the thighs and legs (rarely on the face).

Learnings

- Prurigo nodularis may be secondary to skin conditions associated with pruritus (eg, atopic dermatitis, xerosis), as well as systemic conditions associated with generalized pruritus without a primary skin rash (eg, psychiatric conditions, HIV, iron-deficiency anemia, gluten enteropathy, renal or hepatic impairment, malignancies)
- In most cases of prurigo nodularis, the etiology of pruritus is unknown.
- Studies suggest prurigo nodularis may be a form of subclinical small fiber neuropathy, and that Th2 cytokines play an important role in pathogenesis
- Lesions are triggered by repetitive rubbing or scratching discrete areas of the skin or by repetitive picking or rubbing of nonpruritic skin ■

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New Flu Vaccine Codes—and an Update on Proposed Changes to the E/M Guidelines

DAVID E. STERN, MD, CPC

Q. Do you have information on the 2017-2018 influenza vaccine codes?

A. The American Medical Association (AMA) recently published a list of new and revised vaccine codes on their website (https://www.ama-assn.org/sites/default/files/media-browser/public/cpt/vaccine-long-desc-july-2017.pdf). These codes will be published in the 2018 Current Procedural Terminology (CPT) manual. The two new influenza vaccines on the list are:

- 90682, "Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use"
- 90756, "Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use"

CPT code 90682 was made effective January 1, 2017, and CPT code 90756 will be effective as of January 1, 2018. The latter, however, comes with some special billing instructions since the vaccine is currently available for use. The Centers for Medicare and Medicaid Services (CMS) recently revised MLN Matters Number: MM10196 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10196.pdf) with distinct instructions on how to bill when ccIIV4 is given before and when it is given after January 1, 2018.

For vaccinations administered between August 1, 2017 and December 31, 2017, Medicare Advantage Carriers (MACs) will use Healthcare Common Procedure Coding System (HCPCS) Level II code Q2039, "Influenza virus vaccine, not otherwise specified." (Check with your commercial payors to see if they expect to see this HCPCS code on claims or if they prefer CPT code 90749, "Unlisted vaccine/toxoid.")

CPT code 90756 is not retroactive to August 1, 2017, and CMS states that claims using CPT code 90756 billed after January 1, 2018 for dates of service between August 1, 2017, and December 31, 2017, will be rejected or returned as unprocessable. Likewise, claims billed with HCPCS code Q2039 for the vaccine after December 31, 2017, will be rejected or returned as unprocessable.

CMS has published its payment allowance for the 2017-2018 flu season, also denoting the billing instructions for CPT code 90756 in the 2017 flu season. You can view the rates on the CMS website https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html.

Remember to bill the correct vaccine administration code(s) along with any vaccine(s) given. When billing Medicare, you will use the following HCPCS codes for influenza, pneumococcal, and hepatitis B, respectively:

- G0008, "Administration of influenza virus vaccine"
- G0009, "Administration of pneumococcal vaccine"
- G0010, "Administration of hepatitis B vaccine"

CPT offers vaccine administration codes based on whether there is only one or multiple vaccines administered, the age of the patient, the number of components in the vaccine, and if face-to-face counseling was provided. When billing your commercial payers, you have the following administration codes to choose from:

- 90460, "Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered"
- 90461, "...each additional vaccine or toxoid component administered (List separately in addition to code for pri-

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mary procedure)"
- Use 90460 for each vaccine administered. For vaccines with multiple components (combination vaccines), report 90460 in conjunction with 90461 for each additional component in a given vaccine.
- 90471, "Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)"
- 90472, "...each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)"
  - Use 90472 in conjunction with 90460, 90471, and 90473.
- 90473, "Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)"
- 90474, "...each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)"
  - Use 90474 in conjunction with 90460, 90471, and 90473.

The diagnosis code to use when billing vaccinations is Z23, "Encounter for immunization." ■

Q. Do you have any details on how the Centers for Medicare and Medicaid Services (CMS) is planning to update the Evaluation and Management (E/M) coding guidelines and when that will happen?

A. CMS announced this past July that they were ready to move forward with reforming E/M documentation guidelines in the 2018 proposed Medicare physician fee schedule released July 13, 2017 (https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-P.html). The idea was to better align E/M coding and documentation with the current practice of medicine. CMS anticipates the most significant changes to be in the history and physical exam components of the E/M service, with the possibility of removing the documentation requirements at all levels, stating that medical decision-making (MDM) and time are the more significant factors contributing to the level of E/M service provided. According to *Part B News* (July 13, 2017), "CMS may overhaul E/M coding; history (and exam) may be history."

CMS states that "as long as a history and physical exam are documented and generally consistent with complexity of MDM, there may no longer be a need for us to maintain such detailed specifications for what must be performed and documented for the history and physical exam."

If CMS moves forward with the proposal, it is expected to take many years and coordination with multiple entities and professionals of the medical and healthcare industry. ■

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MEDICAL EQUIPMENT/SUPPLIES

DEVELOPING DATA

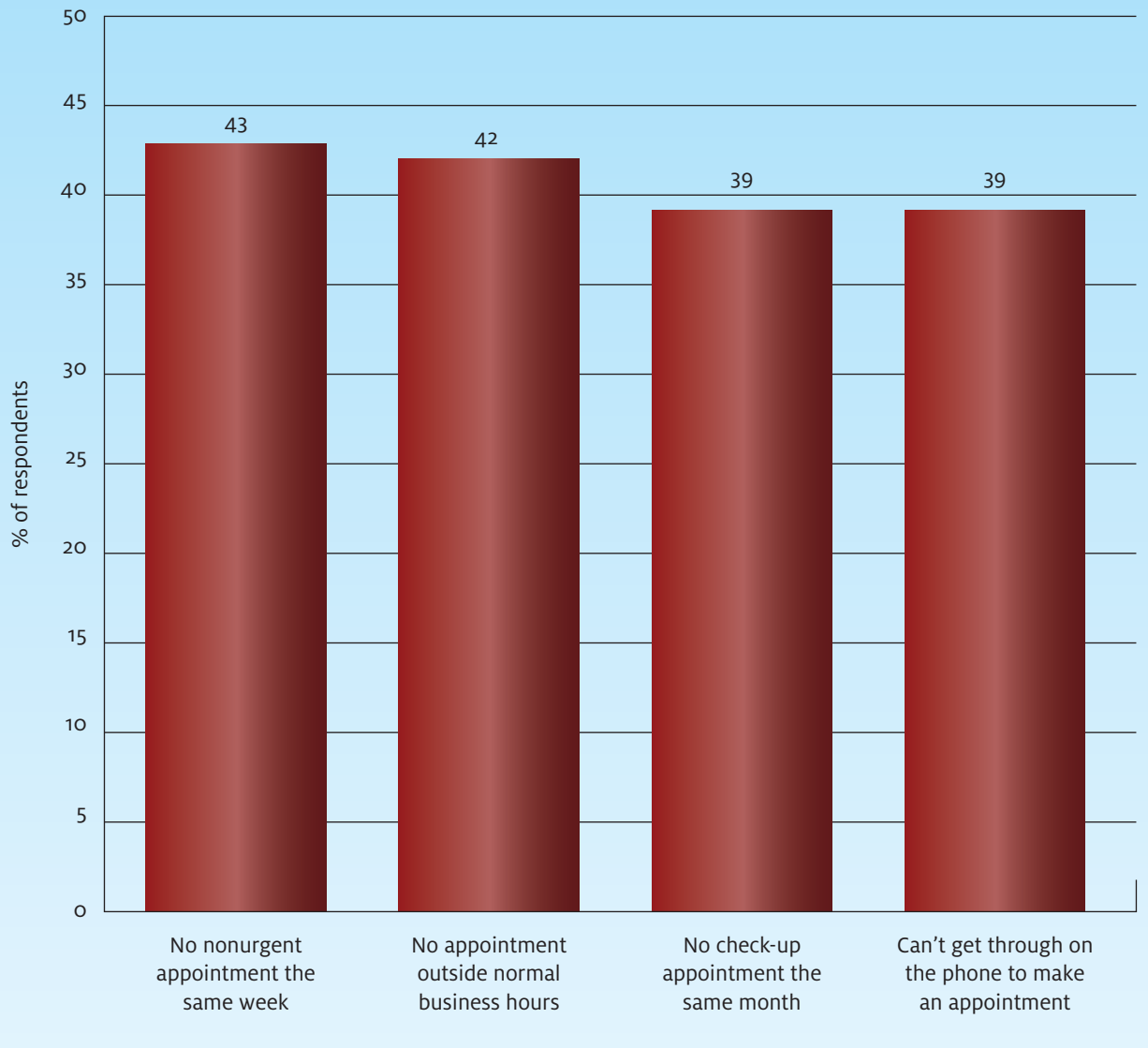
Hard Data on Why Patients Keep Flocking to Urgent Care Centers

Urgent care insiders know our industry continues to grow and evolve, and understand that convenience, cost, and quality of care are what keep patients coming back. Data from outside the industry diving a bit deeper into the "why" of patient volume has been a bit scarce, however.

A Harris Poll commissioned by Mercy Health System of Southeastern Pennsylvania takes a step toward remedying that shortage, however.

Not surprisingly, a strong majority (66%) of the 1,700 U.S. adults who took part in the survey said they would seek care from an alternate source, including urgent care, if their primary care provider is not available at a time convenient to them. Their definitions of *convenient*—and each's relative importance—are illustrated below. ■

"INCONVENIENCE" FACTORS DRIVING PATIENTS BEYOND THE PCP'S OFFICE



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