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### LETTER FROM THE EDITOR-IN-CHIEF

# Bubble, Bubble, Toil and Trouble?



Blowing bubbles is fun. As a kid, I marveled at the almost magical way bubbles rose through the air, powered by a mere puff from my lungs, on a seemingly endless journey upward. And then they popped, unable to withstand the laws of nature.

Market bubbles behave similarly, rising with indifference to the laws of nature. And much like their soapy namesakes, market bubbles always pop, with the remnants of their inflated selves crashing down to earth, unable to avoid the powerful forces of market gravity. Behavioral economists blame groupthink and confirmation bias as the leading culprits in bubble markets. As investors follow the herd, prices inflate, often despite decreasing marginal returns. The peak of the bubble often coincides with the peak in price regardless of a dip in profits that portends the crash.

Several factors drive unnatural economics in the urgent care marketplace:

- Gold rush: Physicians and other novice investors, eager to get their piece of the urgent care pie, are opening up new urgent care centers in saturated markets with limited growth potential.
- Investor stampede: Private equity and other institutional investors are jockeying for position in what is now a crowded space. Outgrowing the competition has become a means to an end for many of these investor-owned networks. Outlasting weaker competition is the bet.
- Health systems: The last to the party and looking for a dance partner, health systems are the fastest-growing segment of the urgent care market. They are also the greatest contributor to unnatural competitive forces. The reason is simple: Urgent care is a strategic investment for health systems, not a financial one. In other words, health systems make decisions that don't always look like smartmoney decisions. And as one health system begins to enter the market, it triggers other competing systems to do the same, often in defense of their own market share. This behavior further dilutes the market, and patient volumes suffer for everyone.
- Payor pressure: As if market saturation and declining volumes weren't challenging enough, payors have begun

"Behavioral economists blame groupthink and confirmation bias as the leading culprits in bubble markets."

to pinch reimbursement for urgent care, or are turning away new urgent care centers altogether. Diversion to emergency departments is still meaningful to payors. But more access, which urgent care offers, often leads to more utilization overall. The payors just aren't seeing the savings that they hoped for.

Does all this doom and gloom mean the end of urgent care as we know it? I don't think so. I believe that health systems can sustain the growth of urgent care for some time, and though independent operators will need to ensure that they are differentiating themselves, there is always room for a better product. Consolidation remains a growth area, and with it come efficiencies and payor leverage that should help sustain urgent care in an increasingly competitive market.

There is still more lift in this bubble. When and if it will pop is anyone's guess. For now, my advice is simple: (1) focus on differentiating your service, (2) expand your scope of services to help supplement declining urgent care volume, and (3) be relentless about ensuring that your staff is delivering an exceptional patient experience.

Once again, urgent care providers find themselves with the opportunity to disrupt health care. Round two will require us to be even more creative and consumer-centric. Success remains attainable for those who create a better product that identifies and addresses the changing needs of patients.



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



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Neck pain has many causes, from simple whiplash to unstable cervical spine fractures. Can you identify the etiologies in your patients? *Jennifer Maccagnano, DO* 

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Michael Cirone, MD, Beatrice D. Probst, MD, FACEP, Jerry Goldstein, MPH, and Aurora Trnka, RN, BSN

### IN THE NEXT ISSUE OF JUCM

The prevalence of cancer is increasing, and so are malignancy-associated complications. Drew A. Long, BS, Brit Long, MD, and Alex Koyfman, MD, explain how to recognize and treat these conditions.

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Stuart Williams swilliams@jucm.com • (201) 529-4004 CLASSIFIED AND RECRUITMENT ADVERTISING Kyle Graichen YM Careers kgraichen@yourmembership.com • (727) 497-6565 x5960

**Mission Statement** 

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

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JUCM The Journal of Urgent Care Medicine (www.jucm.com) is published through a partnership between Braveheart Group, LLC (www.braveheart-group.com) and the Urgent Care Association of America (www.ucaoa.org).

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#### Address Changes

JUCM (ISSN 1938-002X) printed edition is published monthly except for August for \$50.00 by Braveheart Group LLC, 185 State Route 17, Mahwah, NJ 07430. Standard postage paid, permit no. 372, at Midland, MI, and at additional mailing offices. POSTMASTER: Send address changees to Braveheart Group LLC, 185 State Route 17, Mahwah, NJ 07430. Email: address.change@jucm.com



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The urgent care industry is in a market bubble, writes Editorin-Chief Lee Resnick, MD, FAAFP. Creating that bubble are a gold rush, in which everyone wants a piece of urgent care; an investor stampede, meaning more competition; the entrance of health systems into the urgent care arena, diluting the market; and payor pressure.

Does that patient with neck pain have a neck sprain, or is transfer to an emergency department required? Jennifer Maccagnano, DO, discusses evaluation of the cervical spine for traumatic neck pain.



Maccagnano is an emergency medicine attending physician at Maimonides Medical Center in Brooklyn, New York, and is an Advanced Trauma Life Support instructor. She gained experience in urgent care while working at IHA Urgent Care-Domino's Farms, in Ann Arbor, Michigan.





Many Americans do not know their human immunodeficiency virus (HIV) serostatus, which contributes to the spread of infection. Michael Cirone, MD, Beatrice D. Probst, MD, FACEP, Jerry Goldstein, MPH, and Aurora Trnka, RN, BSN, report on their research on the fea-

sibility of implementing rapid HIV testing in urgent care centers to get more patients connected with treatment.

Cirone is Chief Resident in the Department of Emergency Medicine at Advocate Christ Medical Center in Oak Lawn, Illinois; Probst is Professor of Emergency Medicine at Loyola University Chicago's Stritch School of Medicine in Chicago, Illinois, and Associate Medical Director of Primary Care and Medical Director of Immediate Care at Loyola University Medical Center in Maywood, Illinois; Goldstein is Director of the Master of Public Health Program at Loyola University Chicago; and Trnka is Clinical Coordinator for the Immediate Care Pain Management Clinic at Loyola University Medical Center in Maywood.

It is vital for long-term health that diabetes mellitus be diagnosed and treated early on. But Cynthia Romero, MD, explains that missing this



diagnosis in children and adolescents is more common than you think.

Romero is a resident physician in emergency medicine at Vanderbilt University Medical Center, in Nashville, Tennessee.

When your urgent care center receives a subpoena for patients' medical information, you still have to protect your patients' privacy and confidentiality. In our *Health Law and Compliance* sec-



tion, Stacey L. Zill, JD, walks you through the steps you should take.

Zill is a Los Angeles-based health-care litigator for Michelman & Robinson, LLC, focused on provider representation, including business and payment disputes, practice formation and corporate governance, compliance, breach of contracts, fiduciary duties, and unfair competition.



There are specific issues to focus on to ensure that members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community feel

welcome at your urgent care center. In our *Practice Management* section, Alan A. Ayers, MBA, MAcc, and Dorothy Wallheimer explain what you can do to make sure all patients are respected.

Ayers is Vice President of Strategic Initiatives for Practice Velocity, LLC and is Practice Management Editor of the *Journal* of *Urgent Care Medicine*. Wallheimer is a freelance writer and journalist from Rockford, Illinois.

#### Also in this issue:

Sean M. McNeeley, MD, and the Urgent Care College of Physicians review new reports from the literature on azithromycin for asthma, medical scribes and physician work-load, codeine and children, an increase in sexually transmitted infections, douching, air-conditioning and the elderly, back pain and imaging, and Zika virus and Guillain-Barré syndrome.

In our *Coding Q@A* column, **David E. Stern, MD, CPC,** discusses the effects of the National Correct Coding Initiative on billing.

In our *Developing Data* column, we show you data on the seasonality of urgent care visits, so that you can plan better for adequate staffing.

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### **CONTINUING** MEDICAL EDUCATION

### Release Date: December 1, 2016 Expiration Date: November 30, 2017

### **Target Audience**

This continuing medical education (CME) program is intended for urgent care physicians, primary-care physicians, resident physicians, nurse-practitioners, and physician assistants currently practicing, or seeking proficiency in, urgent care medicine.

### **Learning Objectives**

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

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Case Western Reserve University School of Medicine designates this journal-based CME activity for a maximum of 3 AMA PRA Category 1 Credits<sup>TM</sup>. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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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.

#### Urgent Evaluation of Traumatic Neck Pain (p. 11)

- 1. The following location of pain is concerning for fractures and/or ligamentous injuries:
  - a. Cervical paraspinal
  - b. Cervical midline
  - c. Scalene muscles
  - d. Sternocleidomastoid muscle
- 2. A 45-year-old man presents to the urgent care center with neck pain after a motor vehicle crash. You would like to clear his spine using the NEXUS criteria. He must have
  - a. No signs of intoxication and no neurologic deficits
  - b. No midline cervical spine tenderness
  - c. No pain with flexion/extension/side-bending/rotation of the neck
  - d. No distracting injury
  - e. All of the above
  - f. a, b, and d
  - g.a, b, and c
- 3. A 70-year-old woman with osteoporosis falls after tripping on her slipper in her bedroom. She presents to the urgent care center with neck pain. She has mild tenderness at C4. How do you best treat this patient?
  - a. Place her in a soft collar and discharge her to home with instructions to follow up with her primary-care provider.
  - b. Obtain an x-ray and discharge her to home if no fracture is noted on the x-ray.
  - c. Place her in a cervical collar and transfer her to the emergency department for advanced imaging.

### Making Your Urgent Care Center Welcoming for LGBTQ Patients (p. 17)

- Which is the approximate percentage of the U.S. population who identifies as lesbian, gay, bisexual, transgender, or queer (LGBTQ)?
  - a. 1%
  - b. 10%
  - c. 4%
  - d. 1.4%
  - e. None of the above
- 2. Segments within the LGBTQ population experience an increased incidence of which of the following?
  - a. Tobacco, alcohol, and other drug use
  - b. Infection with human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs)

- c. Obesity and other chronic health issues
- d. Mental health issues
- e. All of the above
- 3. Urgent care providers can address the health disparities historically facing the LGBTQ population by doing which of the following?
  - a. Encouraging HIV and STI testing or raising awareness of STI screening as a service offering
  - Creating a network of referrals for specialized care for patients with positive test results for HIV
  - c. Hiring a diverse clinical support team and engaging staff members in training in diversity and sensitivity issues
  - d. Conducting specific outreach to and education for the LGBTQ community about relevant services offered at the urgent care center
  - e. All of the above

### A 14-Year-Old with Vomiting and Bumps on the Tongue (p. 21)

- What are two important symptoms of diabetes that are rarely reported by parents or guardians unless they are prompted by the health-care provider?
  - a. Weight loss and dehydration
  - b. Nausea and vomiting
  - c. Anorexia and abdominal pain
  - d. Polvuria and polvdipsia
  - e. Irritability and fatigue
- 2. What age group is at highest risk of presenting in diabetic ketoacidosis (DKA) at the time of diagnosis?
  - a. <2 years
  - b. 8-9 years
  - c. 10-11 years
  - d. 11-13 years
  - e. >75 years
- 3. What is one of the main risk factors for children presenting in DKA at the time of diagnosis?
  - a. Increased intake of snack foods
  - b. Private insurance coverage
  - c. High body mass index
  - d. Type 2 diabetes mellitus
  - e. Low socioeconomic status



### **GIVE YOUR COLLEAGUES THE RECOGNITION THEY DESERVE**

UCAOA invites you to nominate deserving individuals for their achievements in or contributions to urgent care medicine, industry, advocacy, or community service. Nominations will be accepted through Monday, February 20, 2017.

.....

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Recognizes an individual or organization for successful volunteer initiatives that positively impact community health

### FOR MORE INFORMATION, VISIT UCAOA.ORG/AWARDS

Award recipients will be recognized during a ceremony to be held at the UCAOA Urgent Care Convention & Expo, April 30-May 3, 2017, National Harbor, MD.



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# The Season of Giving: The Urgent Care Foundation's Disaster Relief Fund

■ LAUREL STOIMENOFF, PT, CHC

olidays cause us to reflect on things that are important to us, including our family and our community. The Urgent Care Association of America (UCAOA) is a diverse community connected by a commitment to either supporting or directly providing health care to those who may otherwise experience barriers. There are challenges and opportunities because we are a relatively small community compared with many of our peer organizations. For a nascent and burgeoning sector of health care, UCAOA provides the best platform to network with support your peers.

But what happens when there is an unanticipated disruption in the ability of members of this unique community to deliver care? And how can we respond when access to health care is interrupted, typically when it is needed most?

The Urgent Care Foundation (UCF; https://ucaoa.siteym.com/page/UCFoundation) was established in 2011 to raise and disburse funds related to research, educational development, and humanitarian healthcare efforts directly for urgent care medicine. The UCF is a 501(c)(3) organization with a distinct mission and a volunteer board of trustees working with UCAOA and the Urgent Care College of Physicians to advance the industry and support our peers. Although the UCF has a full agenda of activities related to research, antibiotic stewardship, and the convening of thought leaders, it is most fitting as we enter the season of giving to focus attention on the UCF's humanitarian mission.

During a meeting at the UCAOA Fall Conference, the board of trustees found overwhelming support for establishing a fund



Laurel Stoimenoff, PT, CHC, is Chair of the Urgent Care Foundation and serves on the foundation's board of trustees

### "The UCF fund will specifically target urgent care centers in the communities they serve."

to provide disaster relief for urgent care services. A percentage of all unrestricted donations will be pooled and reserved for response to events like the following:

- A disaster affects the ability of an urgent care center to provide needed treatment
- A center's finite resources are maxed out in response to a disaster
- A center is asked to play an integral role as part of the post-disaster safety net

We know the need is there. Recent disasters have resulted in requests that UCAOA support our peers. Although other disaster funds must balance distributions among multiple recipients, the UCF fund will specifically target urgent care centers in the communities they serve.

All the planning in the world is for naught without your help. I'm asking for your support not only financially but also in getting the word out about the fund. Beyond direct and taxdeductible donations, you can support the UCF by

- Contributing your speaking honorarium
- Attending the Annual Awards Ceremony at National Harbor, which recognizes industry peers and humanitarians. The event is inspirational, and the proceeds benefit the foundation.
- Donating auction items to the awards ceremony
- Making Amazon.com purchases through an Amazon Smile account that benefits the foundation. Amazon will donate 0.5% of your purchases to the UCF. Use this link for making future purchases: http://smile.amazon.com/ ch/27-4216985

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### Clinical

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## Urgent Evaluation of Traumatic Neck Pain

**Urgent message:** Clinicians must be able to determine the cause and severity of injury in patients with neck pain, especially in the very young, whose symptoms vary according to their developmental status, and in the elderly, who have weaker bones and degenerative changes.

JENNIFER MACCAGNANO, DO

### Introduction

A variety of patients from children to the elderly will present to an urgent care Center with the chief symptom of neck pain. Cervical spine (C-spine) injuries occur in 3.7% of adults who sustain blunt trauma and present to an emergency department (ED), and almost half of those are unstable injuries, which if not diagnosed and treated can result in spinal cord injury.<sup>1</sup> For urgent care clinicians, these are some of the issues at hand to consider:

- Who needs C-spine imaging?
- Is an x-ray sufficient?
- Who needs transfer to a hospital for further trauma evaluation?

### **Medical History**

The mechanism of injury helps determine whether the patient is at minimal or high risk for significant injuries and provides clues in the identification of more specific injury patterns. Determining the location and duration of pain, exacerbating factors, relieving factors, time of onset, and associated symptoms helps the clinician come up with a differential diagnosis. Characterizing the pain can be helpful when considering the specific organ systems involved; for example, pain that shoots down the arm is associated with a neurologic injury until proven otherwise.

### **Physical Examination**

After obtaining a medical history, ascertain the location of neck tenderness. Is the pain localized to the bony



C-spine or instead to the musculature? Is the pain worse with movement through the range of motion? Are there neurologic symptoms when the patient is at rest or instead when the patient moves through the range of motion? Initially, assess airways, breathing, and circulation. This can usually be done within seconds in a patient who is ambulatory and who responds verbally. A complete neurologic examination, including assessment of the pupils, sensation, strength, and cerebellum, is needed because neck injuries are often associated with neurologic injuries. During the musculoskeletal examination, palpate from

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Patients with significant midline C-spine tenderness or focal neurologic deficits should be placed in a cervical collar and transported to an ED for advanced imaging.

### Testing

To guide the examination and to determine the need for imaging, two clinical rules have been validated: the NEXUS Low-Risk Criteria<sup>2</sup> and the Canadian C-Spine Rule. The NEXUS criteria were developed to reduce the need for C-spine imaging. As research continued, the Canadian C-Spine Rule was also developed, with a similar focus: to clear C-spines without radiographs and at the same time recognize clinically significant injuries.

The National Emergency X-Radiography Utilization Study (NEXUS) was a multicenter, prospective, observational study of ED patients in multiple hospitals concerning the presence or absence of clinical criteria in those for whom C-spine imaging was ordered. Patients studied in NEXUS were considered to need C-spine radiography unless they met all of these criteria<sup>3</sup>:

- No neurologic abnormalities; the level of alertness is normal and there are no focal deficits
- No evidence of intoxication
- No posterior midline C-spine tenderness
- No other distracting painful injuries. These include long bone fractures, visceral injuries requiring surgical consultation, large lacerations, degloving injuries, crush injuries, large burns, or any injury producing acute functional impairment. If the patient cannot focus on the C-spine assessment because of other injuries, the patient has a distracting injury.

If a patient meets the NEXUS criteria, there is a 99.8% negative predictive value for C-spine injury, with a sensitivity of 99% and specificity of 12.9%.<sup>2</sup>

The Canadian C-Spine Rule goes through a flowchart of questions to discern the need for imaging. First, the clinician determines whether the patient has high risk factors that mandate radiologic studies<sup>4</sup>:

- Age ≥65 years
- Dangerous mechanism of injury, including
  - A fall from >1 m or down 5 stairs

- Axial load to the head, as in diving
- A high-speed crash of >100 km/h
- A rollover in or ejection from a motor vehicle or motorized recreational vehicle, or a bicycle collision
- Paresthesias in the extremities

If the patient has none of those high risks, the clinician can evaluate whether the patient has any conditions that allow safe range-of-motion testing: involvement in a simple rear-end motor vehicle collision, ability to sit upright in the urgent care center, ability to be ambulatory at any time, delayed onset of neck pain, and absence of midline C-spine tenderness. If patients do not have any of these low-risk findings, they can undergo imaging. However, if they can actively rotate their neck 45° to the left and right, imaging is not required.<sup>4</sup>

### When to Obtain C-Spine Images

A patient with neck pain and the following characteristics can be discharged to home with pain medications and instructions to obtain follow-up care<sup>5</sup>:

- Can be cleared by the NEXUS criteria or the Canadian C-spine Rule
- Is an adult between the ages of 18 and 65 years
- Has normal findings on a neurologic examination
- Has no neck pain or tenderness with movement through the full range of motion

Patients who are alert and who have distracting injuries, neurologic deficits, and neck pain or tenderness on full range of motion need imaging. Although the course for Advanced Trauma Life Support (ATLS) touches on plain films, their current role in traumatic injuries of the neck is unclear. The EAST Practice Management Guidelines (from the Eastern Association for the Surgery of Trauma) recommend computed tomography scans, given the potential for missed injury on plain films.<sup>5</sup>

If the mechanism of injury involved a low level of force and there is only a low suspicion that there is an unstable injury, clinical judgment can guide a decision about the need for imaging and the type of imaging. Consider obtaining plain films initially to assess alignment, check for fractures, and find soft-tissue swelling. However, plain films cannot definitively exclude a fracture and do not allow assessment for cord injury.

### Interpreting Plain Film Cervical Spine Images

Cross-table lateral, odontoid, and anteroposterior views are obtained in a trauma C-spine series. On the antero(From Kuntz AF, Lai W-S, Norton PT, et al. Imaging Evaluation of the Cervical Spine [website], with permission. Charlottesville, VA: University of Virginia Health Sciences Center, Department of Radiology; © 2013 [cited 2016 July 4]. Available from: https://www.med-ed.virginia.edu/courses/rad/cspine/interpretation2.html)

posterior view, a straight line should connect the spinous processes. If the line is not straight, the clinician must assess for a unilateral facet dislocation. An adequate lateral film is essential to spot injury and includes the area from the base of the skull to T1.<sup>6</sup> Assess C-spine alignment by reviewing the smooth lordotic curves of the anterior vertebral line, posterior vertebral line, spinolaminar line, and posterior spinous line (**Figures 1 and 2**).

Next, review the vertebral bodies for fractures or changes in bone density. Both the vertebral bodies and the intervertebral discs should be of uniform height.<sup>6</sup> For example, if the anterior height of a vertebral body is  $\geq$ 3 mm less than the posterior height, this should raise suspicion that there is a wedge compression fracture. On the lateral view, measure the predental space (distance between the anterior aspect of the odontoid and the posterior aspect of the Figure 2. Drawing of the lateral view of the cervical spine identifying the four lordotic curves to be assessed: the anterior vertebral line, the posterior vertebral line, the spinolaminar line, and the posterior spinous line.



Sciences Center, Department of Radiology; © 2013 [Cited 2016 July 4]. Available from: https://www.med-ed.virginia.edu/courses/rad/cspine/interpretation2.html)

anterior arch of C1), which should be no more than 3 mm in an adult and 5 mm in a child. To check the extra-axial soft tissues, measure the prevertebral space, which should be <7 mm at C2 and <22 mm at C6. If widening is noted, consider the presence of a hematoma in the area secondary to a fracture. Finally, assess the odontoid view. Check lateral masses for symmetry,<sup>6</sup> and the dens for integrity. Patients with x-ray abnormalities should be transferred to an ED and reevaluation. Plain radiographs alone should not be used in patients at high risk (e.g., those who are  $\geq$ 65 years of age, have severe arthritis, have osteoporosis).<sup>2</sup>

#### **Urgent Care Evaluation of Geriatric Patients**

Elderly patients with negative findings for the NEXUS criteria are a high-risk group for C-spine injuries, given their weaker bones and degenerative changes. The FINE study showed that that the NEXUS criteria were not a valid tool for patients older than 65 years of age who presented after a fall from standing. Although groundlevel falls are a low-energy mechanism of injury, they can produce injury patterns in elderly patients that are typically found in high-energy, high-impact trauma. The FINE study showed that using the NEXUS criteria in patients older than 65 years of age would have meant missing 4.1% of clinically significant C-spine injuries and wrongly avoiding imaging in 29% of patients,<sup>7</sup> which is a reminder to clinicians to maintain vigilance and consider advanced imaging in elderly patients with neck pain secondary to trauma.

### Urgent Care Evaluation of Pediatric Patients

Pediatric patients present with different injury patterns, given their various stages of development, and these differences must be considered when applying clinical decision rules to children. In 2001, a prospective study evaluated the application of the NEXUS criteria to pediatric patients who had sustained blunt trauma. All of those with C-spine injuries had positive findings for one or more NEXUS criteria.<sup>8</sup> The NEXUS criteria can most likely be used in pediatric patients; however, given the low number of patients in the study and the minimal number of infants and young children enrolled, caution must be used especially in younger children, because the NEXUS criteria are not officially validated for children.

Four independent risk factors for C-spine injury have been identified for younger children<sup>9</sup>:

- Having a Glasgow Coma Scale (GCS) score of <14
- Having a GCS eye score of 1
- Having been in an MVA
- Being  $\geq$ 2 years of age

These risk factors were scored on the basis of a retrospective study reviewing trauma in children younger than age 3 years. Three points were given for a GCS score of <14, 2 points for a GCS eye score of 1, 2 points for having been in an MVA, and 1 point for age 2 years and older. A total score of <2 had a 99.9% negative predictive value in ruling out C-spine injury without radiographic imaging.<sup>9</sup>

Through retrospective research, clinicians found that pediatric patients at high risk present with abnormal

findings on neurologic examinations, decreased mental status, neck pain, or torticollis, and thus they recommend imaging for these patients.<sup>10</sup> In children not considered to be at high risk, examination is easily done in the urgent care setting. Clinicians examine them for cervical tenderness in conjunction with the NEXUS criteria. Observe nonverbal children for a normal neck range of motion. If they are moving their neck without discomfort and have full range of motion, C-spine imaging is not needed.<sup>10</sup> If they do not move their neck or if they have severe discomfort when moving through the range of motion, place them in a pediatric cervical collar and pursue radiographic studies.

#### Conclusion

C-spine evaluation is important in order to diagnose unstable injuries. Begin the evaluation with the NEXUS criteria or the Canadian C-Spine Rule, and when imaging is necessary, use clinical judgment to determine the need for transfer to a hospital versus radiographic studies in the urgent care setting. Special consideration for geriatric and pediatric patients is crucial, given the lack of randomized control trials and the potential for significant injuries even with minor mechanisms of injury in geriatric patients. When the mechanism of injury is concerning, when it is hard to obtain an adequate medical history and conduct a thorough physical examination, or when patients are from populations at greater risk for significant injury, remain alert for the need to arrange for an ED transfer.

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# Making Your Urgent Care Center Welcoming for LGBTQ Patients

**Urgent message:** There is a growing need for awareness of medical, safety, and social issues involving the lesbian, gay, bisexual, transgender, and queer community in health care. Here's how urgent care fits in.

ALAN A. AYERS, MBA, MACC, AND DOROTHY WALLHEIMER

### Introduction

There are significant unmet health needs among members of the U.S. lesbian, gay, bisexual, transgender, and queer (LGBTQ) population, many of whom are afraid to access the health-care system and face barriers to care even if they do seek treatment. Clearly there is room for urgent care centers to step up with services and customer service that welcome this community.

Nearly 4% of the U.S. population identifies as part of the LGBTQ community, according to a 2015 study.<sup>1</sup> Population estimates fluctuate, partly because reporting methods are not always reliable. Research reported in 2016 showed that about 1.4 million adults in the United States identify as transgender, which is twice the previous estimate.<sup>2</sup> That figure came from the Williams Institute at the UCLA School of Law, which focuses on law and poverty issues related to sexual orientation and gender identity, and was derived from studying a large database. "From prior research, we know that trans people are more likely to be from racial and ethnic minorities, particularly from Latino backgrounds," Jody L. Herman, a public policy scholar at the Williams Institute, told the *New York Times.*<sup>3</sup>

Four main health disparities face the LGBTQ population. Members of this community are

- Less likely to have health insurance
- More likely to delay treatment or not seek medical care
- More likely to delay or not get needed prescription medicine



More likely to seek care in an emergency department

As a whole, LGBTQ populations have the highest rates of tobacco, alcohol, and other drug use. Lesbian and bisexual females are more likely to be overweight or obese. The transgender population has a higher prevalence of human immunodeficiency virus (HIV), sexually transmitted infections (STIs), and mental health issues—and is less likely to have health insurance coverage than heterosexual or LGBQ individuals.<sup>4</sup> A 2015 Kaiser Family Foundation study found the LGBTQ pop-

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### Sidebar 1. Checklist for Care, Treatment, and Services

Urgent care entails delivery of typically low- and moderateacuity health care quickly with a retail-like patient experience. This includes service that is inclusive of all members of the community, including LGBTQ people. The following activities can ensure that your center offers LGBTQ patients the type of experience that creates high-quality medical outcomes and spurs repeat visits and positive word of mouth.

- Create a welcoming environment that is inclusive of LGBTQ patients:
- Prominently post the center's nondiscrimination policy or patient bill of rights.
- Set up waiting rooms and other common areas that reflect and are inclusive of LGBTQ patients and families.
- Create or designate unisex or single-stall restrooms.
- Ensure that visitation policies are implemented in a fair and nondiscriminatory manner.
- Foster an environment that supports and nurtures all patients and families.
- Avoid assumptions about sexual orientation and gender identity:
  - Refrain from making assumptions about a person's sexual orientation or gender identity that are based on appearance.
  - Be aware of misconceptions, bias, stereotypes, and other communication barriers.
  - Recognize that self-identification and behaviors do not always align.
- Facilitate disclosure of sexual orientation and gender identity, but be aware that disclosure, or coming out, is an individual process:
- Honor and respect the individual's decision and pacing in providing information.
- Make sure that all forms to be completed by patients contain inclusive, gender-neutral language that allows for self-identification.
- Use neutral and inclusive language in interviews and when talking with patients.
- Listen to and reflect patients' choice of language when they describe their own sexual orientation and how they refer to their relationship or partner.
- Provide information and guidance for the specific health concerns facing lesbian and bisexual women, gay and bisexual men, and transgender people:
- Become familiar with online and local resources available for LGBTQ people.
- Seek information and stay up to date on LGBTQ health topics. Be prepared with appropriate information and referrals.

LGBTQ = lesbian, gay, bisexual, transgender, and queer.

Adapted from the Joint Commission. Advancing effective communication, cultural competence, and patient- and family-centered care for the lesbian, gay, bisexual, and transgender (LGBT) community: a field guide. Oak Brook, IL: the Joint Commission [published 2011 October; accessed 2016 October 5]. Available from: http://www.jointcommission.org/assets/1/18/LGBTFieldGuide.pdf

ulation has higher rates than other populations of chronic conditions such as asthma, hepatitis B and C, cancer, and cardiovascular disease.<sup>5</sup>

#### How to Offer Welcoming Care

A symposium held in September 2016 in North Carolina tackled how health-care providers can offer better care for the transgender community. Barriers, some of the speakers said, can start at the front desk if staff members embarrass a patient by addressing them by the wrong name and cause them to leave. There is much to be gained by cross-training center staff on procedures, terminology, and welcoming practices for those in the LGBTQ community.

"Train other people, it'll save your workload and to have a cadre of clinicians in your area will save that one person who's currently seeing everyone from burning out," said Holiday Simmons, a black transgender Cherokee man and social worker, to symposium attendees. "For example, my primary care provider is that person in my area. People come from all over Georgia to see him, and I know he's maxed out."<sup>6</sup>

Training that raises the level of diversity awareness is key, said Dr. William Valenti, a specialist in infectious diseases and a senior vice president at Trillium Health in Rochester, New York. It helps to actually diversify your staff when possible. "They need to have sensitivity and awareness for patients, to be nonjudgmental and welcoming," Valenti said. "Not everyone will be on the same page in terms of understanding, but a little understanding can go a long way."

### **Offering Expanded Testing and Prophylaxis**

There is an opportunity for urgent care centers to join in efforts to expand testing for HIV and STIs. There are still about 55,000 new HIV infections in the United States each year. "I see urgent care as a partner in activities that deal with HIV testing and prevention, and in sexual health for LGBTQ people, particularly men who have sex with men," Valenti said. "If we take a broad view of HIV testing and its importance, urgent care settings can be pivotal in that effort."

The population at highest risk for HIV is men who are between the ages of 18 and 30 years. This younger demographic is more likely than older community members to get testing where they get their health care, and that is often in an urgent care setting because they do not have a relationship with a primary-care physician.

Urgent care centers can be another outlet for encouraging STI testing and rapid HIV screening. A number of recently reported cases of HIV were missed when the patients had prior encounters with the health system. If providers are considering a diagnosis of infectious mononucleosis, they should also do a rapid HIV test to rule out that type of infection.

Further, urgent care providers can encourage preexposure prophylaxis treatment for those in the at-risk population who have negative test results for HIV. This one-pill-a-day regimen reduces HIV risk by 95% in the people who follow it.

Urgent care centers likely will not be able to provide long-term care for a patient with positive test results for HIV. However, providers can make referrals, get those patients connected to the health-care system, and help prevent further spread of infection.

### **Bias in Health Care**

The popularity of patient-centered care is resurging, and the implementation of such care must be purposeful and intentional (**Sidebar 1**). Learning some key terminology regarding the LGBTQ population is a good start, but you may want to go further at your center and conduct an assessment of unconscious bias among staff members. Harvard University offers for free online the Implicit Association Test,<sup>7</sup> which measures the associations between concepts that can help measure attitudes and beliefs that people may be unwilling or unable to report.

The implicit bias measured on the test's website is pervasive. The research findings have prompted many organizations, including health-care groups, to step up training and open lines of communication. When bias (**Sidebar 2**) plays out in health-care settings, it can go beyond making a patient feel uncomfortable—it can mean the difference between lifesaving care and death.

#### Conclusion

There are several steps to be considered in the urgent care setting for better addressing the health-care gaps facing the LGBTQ population:

- Management can work with organizations that offer ongoing training for staff members to broaden their cultural and medical understanding of a variety of patient groups.
- Management can ask employees to explore (or test) their implicit bias to help them recognize areas for improvement.
- Urgent care centers can conduct specific outreach to the LGBTQ community about testing services offered or can host community education programs to raise awareness.

#### Sidebar 2. Barriers to Equitable Care

Historically, LGBTQ people have faced barriers in attaining high-quality health care, including these:

- Refusal of medical care
- Delayed or substandard care
- Perceptions of mistreatment by medical personnel
- Inequitable policies or procedures in the medical practice
- Inadequate training or support by medical personnel
- Little or no inclusion in health outreach or education
- Inappropriate restrictions or limits on visitation
- Use of harsh or abusive language by medical personnel
- Medical personnel who are physically rough or abusive with patients
- Medical personnel who refuse to touch or use excessive precautions with patients
- Inadequate resources to address substance abuse issues
- Medical personnel who blame the patient for their medical condition

LGBTQ = lesbian, gay, bisexual, transgender, and queer. Data from Lambda Legal: When health care isn't caring: Lambda Legal's survey on discrimination against LGBT people and people living with HIV. New York: Lambda Legal; © 2010 [cited 2016 October 5]. Available from: http://www.lambdalegal.org/sites/default/files/publications/downloads/whcicreport when-health-care-isnt-caring.pdf

Providers across the country are striving toward patient-centered care with this population and others. The medical community is also working to rebuild trust with the LGBTQ community after decades of blatant discrimination that began during the epidemic of HIV and acquired immunodeficiency syndrome (AIDS) in the early 1980s. Urgent care centers can and should play a role in reaching these communities through outreach and convenient care.

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# A 14-Year-Old with Vomiting and Bumps on the Tongue

In *Bouncebacks*, which appears periodically in *JUCM*, we provide the documentation of an actual patient encounter, discuss patient safety and risk-management principles, and then reveal the patient's bounceback diagnosis. This case is from the book *Bouncebacks! Pediatrics*, by Michael B. Weinstock, Kevin M. Klauer, Madeline Matar Joseph, and Gregory L. Henry, and is available at www.anadem.com and www.amazon.com. Can you spot the red flags without knowing the outcome?

### CYNTHIA ROMERO, MD

### Introduction

Note: The following is the actual documentation of the provider.

### Initial Visit: 07/05/2013

Chief complaint: Vomiting, bumps on tongue

### History of Present Illness

Patient is a 14-year-old male who presented with complaints of vomiting, dry mouth, and bumps on the tongue associated with trouble breathing and the feeling of heartburn. Nausea started last night with one episode of vomiting. Bumps developed over the past week and are painful. No complaints of fever, diarrhea, rhinorrhea, congestion, or other pain. ROS [review of systems] is pan-negative, including no weight loss, no urinary symptoms, and no recurrent infections [Table 1].

### Past Medical History

Negative Social history: Unimmunized Family history: None on file Medications: None Allergies: NKDA [no known drug allergies]



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Table 1. Vital Signs at Initial Visit				
Parameter	Value			
Time	19:46			
Temperature	97.7°F oral			
Pulse rate	92 beats/min			
Respiration rate	17 breaths/min			
Systolic blood pressure	111 mm Hg			
Diastolic blood pressure	76 mm Hg			
Oxygen saturation	100% on room air			

### Physical Examination

General appearance: Awake, alert, no distress, oriented ×3

Skin: Warm, well perfused, with no diaphoresis/rash HEENT [Head, Eyes, Ears, Nose, and Throat]: Normocephalic, atraumatic; conjunctivae not injected, corneas clear, PERRL [pupils equal, round, reactive to light]; no sinus TTP [tenderness to palpation] or rhinorrhea; symmetric posterior OP [oropharynx] without exudate/ erythema, tongue with yellowish-white plaques, moist mucous membranes

Neck: Supple, no lymphadenopathy

**Lungs:** Clear to auscultation, breath sounds equal and symmetric bilaterally, no wheezes/rales/rhonchi, no signs of respiratory distress

**Heart:** Regular rate and rhythm, normal S1 and S2, no murmurs/clicks/gallops

**Abdomen:** Soft, mild epigastric TTP, negative Murphy sign, no TTP over McBurney point

**Extremities:** Moves all extremities; no deformities, edema, or skin discoloration; normal peripheral perfusion/pulses

**Orders/results (21:42):** Zofran, 4 mg PO; magic mouthwash, 10 mL, swish and swallow. PO fluids tolerated in urgent care.

Diagnosis: (1) Gastritis. (2) Leukoplakia of tongue.

**Disposition (22:08):** Patient discharged to home stable. Prescriptions for Pepcid (20 mg PO) and Phenergan (25 mg PO). Instructed to follow up with PCP [primarycare provider]. Strict return precautions given. Appropriate discharge instructions provided in written form.

### The Bounceback

1 day later, 07/06/2013.

**23:10:** Mom returns with patient, stating patient is lethargic, nonvocal, with eyes rolling back.

HPI [history of present illness]: Ongoing chest and

Table 2. Vital Signs at the Bounceback				
Parameter	Value			
Time	23:13			
Temperature	96.8°F oral			
Pulse rate	148 beats/min			
Respiration rate	26 breaths/min			
Systolic blood pressure	127 mm Hg			
Diastolic blood pressure	52 mm Hg			
Oxygen saturation	98% on room air			

abdominal burning with generalized body pain since this morning. No improvement with Pepcid. Progressively lethargic and unresponsive throughout day with visual hallucinations and nonsensical speech [Table 2]. **ROS:** +12-lb weight loss over past week, anorexia, no polyuria or polydipsia

- Examination: GCS [Glasgow Coma Scale] 8, dry mucous membranes, no acetone on breath, Kussmaul breathing
- Orders/actions:
  - 23:15: Glucose >600 mg/dL; 1-L IVF [intravascular fluid] bolus; ECG [electrocardiogram]: sinus tachycardia; IV access and blood work obtained
  - 23:45: 1-L IVF bolus
  - **00:04:** Physician report called to nearest children's hospital PICU [pediatric intensive care unit] for transfer; insulin drip started per their consultation
- Laboratory tests (00:21):
  - ABG [arterial blood gases]: pH, 6.87; PCO<sub>2</sub>, 26 mm Hg; HCO<sub>3</sub>, 5 mmol/L
  - CBC [complete blood cell] count: WBC [white blood cell] count, 33.3/mm<sup>3</sup> with 12% bands; H/H [hemoglobin and hematocrit], 16.6 g/dL and 52%
  - BMP [basic metabolic panel]: Na, 132 mmol/L; K, 7.1 mEq/L; Cl, 98 mEq/L; HCO<sub>3</sub>, 5 mmol/L; BUN, 44 mg/dL; Cr, 2.5 mg/dL; glucose, 942 mg/dL; Mg, 4.1 mEq/L; phosphorus, 9.0 mg/dL

**Diagnosis:** (1) DKA [diabetic ketoacidosis]. (2) Severe electrolyte derangement. (3) Acute renal failure.

**Disposition (00:58):** Patient transferred to nearest children's hospital PICU

Hospital course: Four-day hospital stay marked by prolonged AMS [altered mental status] and fluctuating GCS score, with difficulty transitioning from insulin drip to subcutaneous insulin and PO tolerance. Treated with both NS [normal saline] and D5NS [dextrose 5% in normal saline]; serial laboratory tests showed progressive improvement in metabolic derangements. Head CT [computed tomography] and EEG [electroencephalography] on HD2 [hospital day 2] showed no intracranial abnormalities and generalized encephalopathy, respectively. Transferred to the floor on HD3 following improvement in mental status, subcutaneous insulin, and PO tolerance. Discharged without neurologic deficits and baseline mental status on HD4.

**Final diagnosis:** (1) DKA. (2) Acute kidney injury. (3) New-onset DM [diabetes mellitus].

### Discussion

### Diabetes Mellitus in Children: General

Diabetes (type 1 more so than type 2) is one of the most common endocrine and chronic diseases in childhood and adolescence. The incidence of diabetes in children is increasing worldwide, making early recognition and proper treatment crucial to reducing morbidity and mortality caused by delayed diagnosis. Duration of symptoms prior to diagnosis can vary from a few days to several months.<sup>1–3</sup> The gradual onset of diabetes in children is more common than previously realized, with approximately half of children with newly diagnosed diabetes reporting symptoms lasting for more than a month.<sup>4,5</sup> However, clinical presentation is most acute in children younger than 5 years of age, in whom early diagnosis is especially difficult.<sup>1,6,7</sup> Delay in diagnosis is relatively common, with mistakes in diagnosis occurring from misinterpretation of symptoms<sup>5,6</sup> or from the general belief that diabetes is rare in children.<sup>3,7</sup> Therefore, increased awareness by both the public and provider is needed for improved outcomes.

### Difficulty of Diagnosing

Despite physicians' familiarity with diabetes, catching new-onset diabetes before it reaches the severity of DKA remains difficult. In children, the onset may be acute or gradual. Although it can be diagnosed simply with a bed-side glucose test or urinalysis, it must first be suspected. Clinical features in children can be nonspecific and challenging to notice in younger children, especially those younger than 5 years of age.<sup>1,4,6,7</sup> There is a consistently recognizable cluster of symptoms that are present weeks before patients develop DKA, but parents or guardians are often unaware that these are concerning symptoms.<sup>3,5,8</sup> Diabetes-specific symptoms such as polyuria

and polydipsia are often not mentioned by parents or guardians and must be elicited by the health-care provider when obtaining a medical history.<sup>6</sup> The patient may be brought in for what the parents or guardians consider more concerning symptoms, causing the provider to overlook diabetes symptoms.<sup>3,7</sup> In studies, somewhere between 20% and 38.8% of children with newly diagnosed diabetes were found to have at least one related medical visit before the diagnosis, suggesting that providers are missing opportunities for early diagnosis and DKA prevention.<sup>2,6,8</sup>

### **Presenting Symptoms**

Clinical features are usually equivocal and vague, requiring a high index of suspicion for proper diagnosis. Polydipsia and polyuria are the main symptoms of diabetes in all age groups, occurring in up to three-quarters of school-age children, whereas nocturnal enuresis in a previously "dry" child is the earliest symptom in 89% of children older than 4 years.<sup>1,6</sup> Weight loss is more common in adolescents than in younger children.<sup>1</sup> Lethargy and constipation secondary to dehydration are also frequently seen. Dehydration of unclear etiology is often observed in infants and young children.<sup>7</sup>

Other important symptoms include irritability, blurred vision, and fatigue. Symptoms are often mixed with other misleading complaints such as headache, abdominal pain, dizziness, and rapid breathing.<sup>9</sup> In this case, the patient presented with all of the classic yet vague symptoms of early DKA: abdominal pain, nausea, vomiting, and anorexia. The abdominal pain in such children is most often vague in nature and diffuse. Common misdiagnoses in the weeks leading up to diagnosis include gastrointestinal, urinary, and respiratory disorders.<sup>4,6,8</sup>

### **Atypical Presentations**

Providers are more aware of common yet nonspecific symptoms of diabetes; however, they are less aware of the infrequent yet specific symptoms such as enuresis and thrush.<sup>1,5</sup> Although it might be difficult to elicit the symptom of polyuria, parents or guardians tend to be more aware of enuresis, which is secondary to polyuria. In this case, the mother finally recalled, after being asked multiple times, that her son had polydipsia and polyuria. The other overlooked symptom in this patient was thrush. When patients present in DKA, it is often found that candidiasis (oral and perineal) was detected during a prior visit with a PCP.<sup>2,4,7</sup>

In this case, we have an adolescent male complaining of dry mouth and painful bumps on his tongue that were



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teleradiologyspecialists.com info@teleradiologyspecialists.com 888-819-0808 noted to be yellowish-white plaques. The plaques of leukoplakia are bright white, usually found on the buccal mucosa, gums, and sides of the tongue, and like thrush, they do not easily rub off. *Candida* is common in infants and adolescent females, but young females and boys should not be predisposed to it, so a diagnosis of thrush or stomatitis should prompt concern that diabetes is present.<sup>7</sup> Candidiasis is rarely the first and only sign of diabetes. Oral irritation, sore throat, and mouth plaques more often coexist with typical diabetes signs yet are recognized only as stomatitis or isolated candidiasis.

A key aspect in this case was that the patient had abdominal pain *plus* oral symptoms. A crucial piece to making the diagnosis of diabetes is being cognizant of the multiple symptoms and having a heightened awareness of the subtle signs of diabetes and DKA. Had more time been spent investigating the patient's oral symptoms, the information would have revealed that the oral lesions did not develop in relation to the emesis. Instead, as already noted, the oral lesions preceded the emesis by almost 1 week, which could have alerted the provider to look for a more unifying diagnosis that would explain these seemingly unrelated diagnoses of gastritis and leukoplakia.

### High-Risk Patients

Early diagnosis of diabetes is needed to avoid progression to DKA. The prevalence of DKA at the time of diagnosis in the pediatric population ranges from 10% to 70%.<sup>2</sup> Children can develop dehydration and acidosis within 24 hours of first presentation, with children younger than 5 years being at greatest risk. The leading cause of mortality and morbidity in children with type 1 diabetes mellitus is DKA.<sup>4</sup>

Risk factors for children presenting in DKA include the following<sup>1–3,6–9</sup>:

- Age <5 years, particularly <2 years
- New-onset diabetes
- Type 1 diabetes mellitus
- Delayed diagnosis of diabetes
- No family history of diabetes
- Low socioeconomic status
- Low-level education of parents or guardians
- Low body mass index
- Being part of an ethnic minority group
- Lack of private health insurance

#### Conclusion

The early diagnosis of diabetes will lead to better outcomes and likely avoid DKA on a subsequent presentation. To achieve this, however, the provider must maintain a high degree of suspicion for the presence of diabetes. The type of patient described here is frequently seen in the urgent care setting, particularly because such patients appear to be relatively well on initial presentation, without vital sign abnormalities or very alarming symptoms. A significant percentage of patients with new-onset diabetes present to a provider before developing DKA, and their condition is misdiagnosed when the provider addresses only one symptom or a few symptoms rather than seeking a unifying diagnosis of seemingly nonrelated symptoms. Next time a child presents with discordant and vague symptoms, consider diagnoses beyond self-limiting illnesses and remember that children with diabetes do not always appear sick on initial presentation. With increased awareness of this disease, a simple blood or urine test can allow for early diagnosis and prompt treatment.

Keep these points in mind:

- Polyuria and polydipsia are pathognomonic for diabetes, and parents or guardians or the patient may require repeated prompting before the presence of these conditions is elicited.
- Painful oral plaques are classic for candidiasis. It is not normal for preadolescent girls or males past infancy to develop plaques in isolation, so the presence of plaques should raise concern that there is a more pernicious cause.
- Phenergan can alter mental status, making the diagnosis of DKA more difficult.
- Do not give insulin until electrolyte levels are known, because hypokalemia is a real risk.
- An insulin bolus is not recommended in children, because it is associated with increased risk for cerebral edema.

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### HEALTH LAW AND COMPLIANCE

# Extreme Caution: The HIPAA Dos and Don'ts When Responding to a Subpoena for Patient Medical Information

Stacey L. Zill, JD

**Urgent message:** When health-care providers or urgent care centers respond to subpoenas for patients' medical information, it is vital that they respond promptly, respond with exactly the information requested and nothing more, and protect patients' privacy and confidentiality.

### Introduction

When producing documents in response to a subpoena demanding patient medical information, a health-care provider must know the *dos* and *don'ts* to avoid privacy and confidentiality violations, sanctions, and penalties. A subpoena is a court or administrative order requiring a provider to testify and/or produce documents at a specified time and location. This article offers guidance about what to do and what not to do after being served with a subpoena calling for the production of protected health information (PHI).<sup>1</sup>

### The Dos and Don'ts

Don't ignore a valid subpoena; it will not go away if it is placed in a drawer or deposited in the round file. In fact, failure to respond can subject a provider to contempt sanctions. Even though the subpoena must be respected, *don't* produce PHI without protecting patient privacy and confidentiality, because the ramifications of not properly responding to a subpoena can be even more severe than those of ignoring the subpoena al-



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together. Indeed, the Health Insurance Portability and Accountability Act (HIPAA) and its implementing regulations authorize heavy fines and potential criminal charges for the unlawful disclosure—whether oral, paper, or electronic—of PHI. Even inadvertent breaches can result in corrective action, hefty fines, administrative investigations, reputation damage, and loss of business. Therefore, it is critical that the responding provider know the *dos* for responding to a subpoena.

After being served with a subpoena, *do* confirm that it has been validly issued. For the subpoena to be valid and enforceable, the court or issuing agency must have jurisdiction over the provider. This generally means that a provider is located in the same state as the court or issuing agency. If there is no jurisdiction, a provider does not have to respond. In an abundance of caution, a provider should consult with counsel and/or serve objections in a timely manner. A provider can also file a motion to quash the subpoena, although this is an expensive option that may be overkill.

Once it has been determined that the subpoena requesting PHI was validly issued, the next step is to examine HIPAA privacy rules, which explain when a provider—or "covered entity"2—can disclose PHI. There are also state laws that govern the handling and production of patient medical records.<sup>3</sup> The general rule is that PHI must not be disclosed unless a regula-

<sup>1.</sup> Discussion of a subpoena requesting mental health records is beyond the scope of this article.

<sup>2.</sup> A covered entity includes (1) a health plan, (2) a health-care clearinghouse, and (3) a health-care provider who transmits any health information in electronic form (title 45 of the Code of Federal Regulations, subtile A, subchapter C, part 160, subpart A, section 160.103; available from http://www.ecfr.gov/cgi-bin/text-idx? SID=7675be34ca66e589d7a13c552a9d69fc&mc=true&node=se45.1.60\_1103&rgn=div8). 3. If there is a conflict between state law and the Health Insurance Portability and Accountability Act, the law that provides the greater protection applies.

tory exception applies.<sup>4</sup> HIPAA contains exceptions for responding to subpoenas, but the rules differ according to the type of subpoena that is issued.

- **Subpoena signed by judge:** A provider should respond to a subpoena by providing the requested documents at the date and time set forth in the subpoena, issued by a judge or magistrate having jurisdiction over the provider, because HIPAA assumes that the issuing judge or magistrate considered patient privacy and confidentiality rights before signing the subpoena.<sup>5</sup> A provider, however, must be cautioned not to disclose more PHI than is ordered. For example, a provider should remove patient identifying information (e.g., patients' names, addresses, Social Security numbers, telephone numbers) if such details are not necessary to comply with the demands of the subpoena. A provider should not do an information dump and provide all of its documents relating to a patient if all that is requested is, for example, billing records. When documents are produced, it is helpful to affix a "confidential" stamp on each page.
- Grand jury subpoena: A provider may comply with a grand jury subpoena without violating HIPAA.<sup>6</sup> Grand jury proceedings are closed to the public, and because the information is kept confidential, HIPAA presumes that the patient's privacy interests are protected.
- Administrative demand: A provider may respond to an administrative subpoena if the administrative agent confirms (1) that the PHI sought is relevant and material to a legitimate law-enforcement inquiry, (2) that the request is specific and limited in scope to the extent reasonably practicable to accomplish the purpose for the demand, and (3) that deidentified information could not reasonably be used.<sup>7</sup>
- Subpoena signed by clerk or attorney: A provider may disclose PHI in response to a subpoena signed by a court clerk or attorney if one of the following conditions is satisfied:
  - First, the subpoena is accompanied by a written statement from the issuing party that (1) reasonable good faith efforts have been made to notify the patient in writing of the subpoena, (2) the notice included suffi-

cient detail to permit the patient to object to the subpoena in court, and (3) the time for the patient to object to the subpoena has lapsed and either no objections were filed or the court has overruled the objections.<sup>8</sup>

- *Second*, the subpoena is accompanied by a written statement from the issuing party that the parties to the proceeding have agreed to a qualified protective order that maintains the confidentiality of the information to be produced, or that such a protective order has been requested.<sup>9</sup> HIPAA defines a *qualified protective order* as an order of a court or of an administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding that prohibits the parties from using or disclosing the PHI for any purpose other than the litigation or proceeding for which such information was requested, and requires the return or the destruction of the PHI, including all copies made, at the end of the litigation or proceeding. Alternatively, a provider may seek its own protective order, but this is not likely to be a preferred option, given the expense.
- *Third*, (1) the provider makes reasonable efforts to notify the patient (or the patient's lawyer) of the subpoena in writing, (2) the notice includes sufficient detail to permit the patient to object to the subpoena in court, and (3) the patient fails to quash or modify the subpoena and notify the provider of same.<sup>10</sup> By providing the patient with sufficient notice, a provider essentially shifts the burden to the patient to take appropriate steps to protect his or her own information. Alternatively, a provider may obtain a valid HIPAA authorization executed by the patient that complies with section 164.508 of title 45 of the Code of Federal Regulations. Although these may be the preferred options when the records of a few patients are being sought, such avenues may be unavailable or not practical where PHI of hundreds or thousands of patients is being sought.

If a provider cannot satisfy one of the foregoing, it may not disclose PHI but must instead wait for the court to order disclosure. Specifically, a provider should serve objections, which may be enough. In federal civil cases in which documents are requested, sending written objections based on HIPAA, and any other objections, to the party issuing

<sup>4.</sup> Title 45 of the Code of Federal Regulations, subtitle A, subchapter C, part 164, subpart E, section 164.502; available from http://www.ecfr.gov/cgi-bin/text-idx?SID=ba4of680a4doff4784e55a7167df9638&mc=true&node=se45.1.164\_1502&rgn =div8

<sup>5.</sup> Title 45 of the Code of Federal Regulations, subtitle A, subchapter C, part 164, subpart E, section 164.512, paragraphs (e)(1)(i) and (f)(1); available from http://www.ecfr.gov/cgi-bin/text-idx?SID=ba4of680a4doff4784e55a7167df9 638&mc=true&node=se45.1.164\_1512&rgn=div8

<sup>6.</sup> Title 45 of the Code of Federal Regulations, subtitle A, subchapter C, part 164, subpart E, section 164,512, paragraph (f)(1)(ii)(B); available from http://www.ecfr.gov/cgi-bin/text-idx?SID=ba4of68oa4doff4784e55a7167df9638&mc=true&node= se45.1.164\_1512&grm=div8

<sup>7.</sup> Title 45 of the Code of Federal Regulations, subtitle A, subchapter C, part 164, subpart E, section 164.512, paragraph (f)(1)(ii)(C); available from http://www.ecfr.gov /cgi-bin/text-idx?SID=ba4of68oa4doff4784e55a7167df9638&mc=true&node= se45.1.164\_1512&rgn=div8

<sup>8.</sup> Title 45 of the Code of Federal Regulations, subtitle A, subchapter C, part 164, subpart E, section 164.512, paragraphs (e)(1)(ii)–(iii); available from http://www.ecfr.gov/cgi-bin/text-idx?SID=ba4of68oa4doff4784e55a7167df9638&mc= true&node=se45.1.164\_1512&rgn=div8

<sup>9.</sup> Title 45 of the Code of Federal Regulations, subtitle A, subchapter C, part 164, subpart E, section 164.512, paragraphs (e)(1)(i), (iv), and (v); available from http://www.ecfr.gov/cgi-bin/text-idx?SID=ba4of68oa4doff4784e55a7167df9638&mc=true&node=se45.1.164\_1512&rgn=div8

<sup>10.</sup> Title 45 of the Code of Federal Regulations, subtitle A, subchapter C, part 164, subpart E, section 164.512, paragraph (e)(1)(vi); available from http://www.ecfr.gov /cgi-bin/text-idx?SID=ba4of680a4doff4784e55a7167df9638&mc=true&node=se45.1.1 64\_1512&rgn=div8

the subpoena places the burden on the issuer to obtain a court order to compel production.<sup>11</sup>

A provider, however, should confirm whether the applicable state law has a similar provision. For example, some states have laws that will require a provider not only to object but also to file a motion to limit or quash the subpoena; simply objecting is not enough. If the subpoena calls for personal appearance as well as the production of documents, then as an alternative to serving objections or filing a motion to quash or limit the subpoena, a provider may simply show up at the date and time stated in the subpoena and, when asked to disclose PHI, object to disclosure on the basis of HIPAA. If a judge is present, a provider may then ask the judge whether disclosure is being ordered. In most cases, the judge will order the disclosure, and a provider may disclose such information pursuant to title 45 of the Code of Federal Regulations, section 164.512, paragraph (e)(1)(i),12 and thus comply with the obligation to protect the patient's PHI.

### Checklist for Responding to a Subpoena Requesting Protected Health Information

In light of the foregoing discussion, there are steps to be taken to comply with a subpoena while, at the same time, protecting patient privacy and confidentiality. A provider should do the following:

- 1. Confirm that the subpoena is validly issued
- Identify the type of subpoena issued (e.g., grand jury, administrative demand) and the signatory to the subpoena (e.g., judge, administrative agency, attorney)
- 3. If the subpoena is signed by an attorney, contact the party issuing the subpoena to obtain satisfactory written assurances or a qualified protective order as already described
- 4. In an abundance of caution, and when the subpoena is requesting records relating to a limited number of patients, notify the patients whose records are being sought as already outlined and/or determine whether the patients will provide a valid HIPAA authorization that complies with title 45 of the Code of Federal Regulations, section 164.508<sup>13</sup>
- 5. If there are any questions about whether documents can be produced, serve objections on the party issuing the subpoena
- Consider whether other laws in addition to HIPAA limit disclosures (e.g., limits on disclosures for mental health records and drug/alcohol treatment records, state laws

13. http://www.ecfr.gov/cgi<sup>-</sup>bin/retrieveECFR?gp=1&SID=c77fd854b916b1fdeb3c7 6b1eobebof6&ty=HTML&h=L&mc=true&r=SECTION&n=se45.1.164\_1508

### "Don't ignore a valid subpoena; it will not go away if it is placed in a drawer or deposited in the round file. In fact, failure to respond can subject a provider to contempt sanctions."

relating to patient privacy, attorney-client privilege, peer review privilege)

7. Reach out to the party issuing the subpoena to discuss what exactly is being requested and a methodology by which a provider can comply with the subpoena while staying within the restrictions of HIPAA and applicable state laws (as, in most cases, that party is happy to reach an agreement)

If a provider is producing documents in response to the subpoena, *do* respect the exact terms of the subpoena. *Don't* produce more than required. *Don't* produce documents before the date and time identified in the subpoena, because the patient may need that time to take whatever action is necessary to attack or limit the subpoena. *Do* stamp documents as "confidential." Finally, *do* maintain a copy of the subpoena and a log of what was produced in response to it.<sup>14</sup>

### Reimbursement of Costs Related to Compliance with a Subpoena

Federal law and most state laws allow a provider to recover its "reasonable costs" in responding to a subpoena, including, for example, postage, clerical charges, and fees for reproduction of documents. Before the production is made, a provider should contact the issuer of the subpoena to provide a cost estimate and secure an agreement that those costs will be paid before the production. States differ as to whether a provider still must produce the documents if an agreement is not reached or prepayment is not made. If the costs associated with compliance are significant, a provider may want to assert objections that are based on compliance being "burdensome and oppressive" and/or to seek judicial relief. This objection usually requires a showing of more than mere inconvenience.

### Conclusion

When responding to a subpoena requesting PHI, a provider must *do* all that is required under HIPAA and applicable state laws to respect patient privacy and confidentiality. *Don't* take this responsibility lightly, because the repercussions may be severe. When in doubt, consult with counsel.

14. Title 45 of the Code of Federal Regulations, section 164.528; available from: http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=c77fd854b916b1fdeb3c76b1e obebof6&ty=HTML&h=L&mc=true&r=SECTION&n=se45.1.164\_1528

<sup>11.</sup> Title VI of the Federal Rules of Civil Procedure, rule 45, paragraph (c)(2)(B); available from https://www.federalrulesofcivilprocedure.org/frcp/title-vi-trials/ rule-45-subpoena/

<sup>12.</sup> http://www.ecfr.gov/cgi-bin/text-idx?SID=ba40f680a4doff4784e55a7167df9638& mc=true&node=se45.1.164\_1512&rgn=div8

### Clinical

# Original Research: HIV Screening in the Urgent Care Setting

**Urgent message:** Increasingly, Americans do not know their human immunodeficiency virus (HIV) serostatus. Implementing rapid HIV testing can allow your center to play a key role in identifying new cases of HIV and linking patients to care.

MICHAEL CIRONE, MD, BEATRICE D. PROBST, MD, FACEP, JERRY GOLDSTEIN, MPH, and AURORA TRNKA, RN, BSN

### Abstract

*Background:* Data from the Centers for Disease Control and Prevention (CDC) suggest that an increasing number of Americans do not know their human immunodeficiency virus (HIV) serostatus. The CDC recommends routine screening for all patients 13 to 64 years of age, in all health-care settings.

*Objective:* A pilot study was developed to determine the feasibility of implementing an opt-in, point-of-care, rapid HIV testing program in the urgent care setting.

*Methods:* A 12-month rollout of point-of-care HIV testing at four urgent care sites was implemented. All patients between the ages of 18 and 64 years were offered a rapid fingerstick HIV test performed by nurses or medical assistants.

*Results:* During the pilot study, 12,237 urgent care patients were approached for HIV testing and 2751 (22%) were tested. One patient was identified as HIV positive and linked to care.

*Conclusion:* Rapid point-of-care HIV testing is feasible in the urgent care setting without additional support staff.

### Introduction

Since 1993, emergency departments (EDs) have played a prominent role in screening for human immunodeficiency virus (HIV).<sup>1</sup> The Centers for Disease Control and Prevention (CDC) has long identified the ED as a key location for HIV testing because EDs serve as the most



common health-care access point for seropositive patients who are unaware of their HIV status.<sup>2</sup> As the number of urgent care centers increases throughout the United States, it is natural to question whether urgent care centers may play a role similar to that of EDs in the identification of new HIV infections. There is a paucity of data regarding HIV screening in the urgent care setting, allowing a unique opportunity for analysis and discussion about the implementation of similar programs in an effort to more aggressively identify new cases of HIV. The study reported here explored whether pointof-care HIV testing in the urgent care setting is feasible.

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#### Background

Although HIV mortality rates have been declining since 2000, the rate of new infections has remained relatively stable.<sup>1</sup> This plateau has been attributed to the spread of infection by patients who are unaware of their HIV serostatus. According to the CDC, 1.2 million people in the United States are living with HIV, and 1 in 8 are unaware that they have the virus.<sup>3</sup> Data show that the diagnosis of HIV is being made in increasingly older Americans, suggesting that a growing number of young Americans are unaware of their serostatus. Later diagnosis of HIV has implications for response to therapy and continued transmission of the virus. In addition, longer periods of untreated infection, and lower CD4 levels at diagnosis, may reflect more rapid disease progression.<sup>4</sup>

In 2006 the CDC recommended that HIV testing be offered in all health-care settings in an effort to increase the number of HIV-infected persons who are aware of their serostatus. EDs are explicitly emphasized in the initiative.<sup>5</sup> In March 2013, the U.S. Preventive Services Task Force (USPSTF) released a draft statement<sup>6</sup> changing its assigned recommendation grade for routine HIV screening from a C to an A. Currently available commercial assays allow for increasingly early detection of HIV infection. HIV testing in the urgent care setting was preceded by implementation of testing in the Loyola Emergency Department in conjunction with the Illinois Department of Public Health in a CDC Care and Prevention in the United States (CAPUS) grant using the fourth-generation Abbott Architect HIV antibody assay.<sup>7</sup> In 12 months, 1968 ED patients were tested and 16 new cases of HIV were identified. After the successful implementation of the ED screening program, a point-of-care HIV screening program was created at Loyola's urgent care sites.

#### **Objectives**

We developed a pilot study, and obtained approval of Loyola's institutional review board, to determine the feasibility of implementing an opt-in, point-of-care, rapid HIV testing program in four urgent care clinics.

#### Methods

On January 1, 2014, a 12-month rollout of point-of-care HIV testing at four urgent care sites was implemented. All patients between the ages of 18 and 64 years were offered a Clearview HIV 1/2 immunochromatographic test (sensitivity, 99.7%; specificity, 99.9%) by urgent care nurses or medical assistants. Tests results were available within approximately 20 minutes. Unlike the buccal swabs used in our prior ED testing efforts, Clearview fin-

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### Figure 2. Informational sheet given to patients with nonreactive test results.

### **Today's Result**

The HIV test you had today shows no signs of infection. This is good news. However, within the last 3 months if you have

- had unprotected sex
- shared a needle
- become pregnant
- been exposed at work (for instance, a needlestick) or
- received a blood transfusion or organ transplant (rare in the United States)

then the test you took today may still not be able to determine if you have HIV. If you are concerned, please get tested again in 3 months. Below is a list of clinics that may be helpful to consult:

#### **Clinics:**

Loyola University Medical Center Infectious Disease 2160 S. First Ave. Maywood, IL 60153 HIV RN/Ryan White Care Coordinator: (708) 216-5024

The Ruth M. Rothstein CORE Center 220 W. Harrison St. Chicago, IL 60612 Main: (312) 572-4500 or Health Educator: (312) 208-6004

Austin Health Center of Cook County 4800 W. Chicago Ave. Chicago, IL 60651 (773) 826-9600

HIV stands for the human immunodeficiency virus (HIV), which is the virus that can cause AIDS. Testing reactive for HIV does not mean that you have AIDS. Getting tested regularly and finding out early that you have HIV, along with taking medications and seeing your doctor, can help you live a long and happy life. If you would like more information about HIV, please contact:

- The State of Illinois HIV/AIDS & STD Hotline: (800) 243-2437
- The Centers for Disease Control and Prevention: (800) 448-0440
- If you have internet access or a smartphone, point your browser to www.hivtest.org

#### **Prevention:**

Although your test today shows that you did not test reactive to HIV, you should still be careful! You can still become infected if you have unprotected sex or share needles or works. Remember to always use a condom when having sex, and ask your partners about their status before having sex.

gerstick technology was chosen in the urgent care initiative for its ease of use and increased sensitivity.

Study personnel were trained in obtaining verbal consent, completing documentation in the electronic health record, administering the test, disclosing results, and providing routine HIV counseling. Examination rooms were stocked with an HIV informational brochure regarding the value of testing for everyone. The consent process was integrated into the rooming process using a standardized questionnaire (Figure 1) embedded in the electronic health record; total time devoted to consenting was less than 2 minutes, and tests were completed in parallel with other pointof-care tests. Timers ensured that tests were run and results were obtained within 20 minutes. A process for counseling and confirmatory testing of preliminary positive findings involved physician champions, members of the infectious-disease staff, social workers, and the state health department. Patients with nonreactive test results were provided with an informational sheet (Figure 2) about nonreactive results, resources for further testing, and general HIV facts.

### **Results**

Between January 2014 and October 2015, a total of 12,237 urgent care patients were approached for HIV testing, and 2751 were tested (22%). Women and men accounted for 62% and 38% of those tested, respectively. The average patient was 40 years of age. Of those patients tested, white persons accounted for 53% and persons of color accounted for 47%. All patients were notified of their results before discharge. One patient was identified as HIV positive and was linked to care with an affiliated infectious-disease clinic. There was no statistically significant difference in the demographics (age, ethnicity, etc.) of patients who opted out of testing compared with those who consented.

### Discussion

When HIV screening is implemented in a health-care setting (emergency, urgent care, or primary care), there are often concerns,

including possible interruptions in office work flow and the impact on overall cost of care to the patient. Technological advances in rapid testing for HIV have helped alleviate some of these concerns. HIV testing in this study was performed at the patient's bedside after consent was obtained by a nurse or medical assistant. Because the consent process was integrated into the rooming process and tests were completed in parallel with other point-of-care tests, there was little or no effect on throughput for patients with nonreactive test results.

Whether payors will cover the cost of HIV screening in the ED or urgent care setting has been discussed as a potential barrier to testing. Under the Patient Protection and Affordable Care Act, preventive services, including HIV testing, must be covered without the requirement of copayment, co-insurance, or meeting a deductible.<sup>8</sup> The change in USPSTF rating to an A in 2013 was believed to translate into full coverage by payors for HIV testing. Our experience in transferring the cost of testing in the ED to the payors has been without denials or patient complaints.

Screening for and identifying new cases of HIV are just the first step in minimizing transmission. It is equally important to ensure that seropositive patients are linked to continued care. As part of an integrated health system, including one with a department of infectious disease that had funding from the federal Ryan White HIV/AIDS Program, Loyola was well positioned to link patients to care. However, provision of similar institutional follow-up is not required so long as a process is created to provide resources and referrals for follow-up at privately funded or publicly funded infectious-disease and HIV clinics in the United States.

### Limitations

Because a single patient with reactive test results was identified across the four urgent care centers participating in the study, covering a large geographic region, the demographics regarding our population with reactive results were limited. Anecdotal feedback from staff members negated concerns that HIV testing would prolong patients' overall time in the department, but we did not include a time analysis in the initial evaluation of our urgent care HIV testing program. A comparison of patients who refused testing and healthy patients would have been of value to other institutions considering a similar process. Barriers to testing were not addressed directly in this study but were acknowledged to have affected testing rates, and they included urgent care location, time of day, overall patient volume, biases of health-care providers, and age, sex, and ethnicity of providers.

#### Conclusion

Rapid point-of-care HIV testing is feasible in the urgent care setting without the need for additional support staff members. The CDC has long identified EDs as a key location for HIV testing because they serve as the most common health-care access point for seropositive patients who are unaware of their HIV status. Urgent care centers provide a similar opportunity for screening. Since the implementation of the Patient Protection and Affordable Care Act, the number of urgent care visits has increased,<sup>9</sup> whereas the ability of both insured and uninsured patients to access primary-care providers has become more difficult.<sup>10</sup> As a result, urgent care centers will serve a similarly important role as health-care access points for patients with HIV. As the U.S. health-care system and the CDC work toward reaching the UNAIDS 90-90-90 goal<sup>11</sup> (90% of all HIV-infected patients identified, 90% receiving treatment with antiretroviral therapy, and 90% having an undetectable HIV RNA level), urgent care sites may serve an essential role in the identification of new cases of HIV. Changes in USPSTF ratings regarding strength of evidence for HIV testing to level A have made it financially more feasible for healthcare providers and facilities with a concern for public health to screen for HIV. We recommend that state and national public health departments consider the urgent care setting for future HIV screening efforts.

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### ABSTRACTS IN URGENT CARE

- Azithromycin May Not Be Helpful for Asthma
- Medical Scribes May Help Decrease Physician Workload
- The Unpredictable Metabolism of Codeine Is a Problem
- The Number of Sexually Transmitted Infections Is at an All-Time High

- Douching Is Correlated with Increased Risk of Ovarian Cancer
- Air-Conditioning Reduces the Risk of Heat Illness in the Elderly
- Physicians Order Imaging for Back Pain Despite Knowing That It Is Unhelpful
- Zika Virus May Be Associated with Guillain-Barré Syndrome

SEAN M. MCNEELEY, MD

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

### Azithromycin May Not Be Helpful for Asthma

### *Key point: There is no proven benefit from taking azithromycin for asthma.*

Citation: Johnston SL, Szigeti M, Cross M, et al; AZALEA Trial Team. Azithromycin for acute exacerbations of asthma: the AZALEA randomized clinical trial. *JAMA Intern Med*. 2016;176:1630-1637.

The randomized, double-blind, placebo-controlled trial reported here focused on treatment for 3 days for 199 adults with asthma exacerbations. One group received 500 mg of azithromycin; the other group received a placebo. Unfortunately, a limitation of the study was the number of patients who had already taken an antibiotic prior to enrollment. The primary outcome was a score on a self-reported symptom scale. The researchers found no effect of azithromycin on asthma exacerbations. Urgent care providers can glean two important points from the study: First, antibiotics are commonly prescribed for patients experiencing



**Sean M. McNeeley, MD,** is an urgent care practitioner and Network Medical Director at University Hospitals of Cleveland, home of the first fellowship in urgent care medicine. Dr. McNeeley is a board member of UCAOA and UCCOP. He also sits on the *JUCM* editorial board. an asthma exacerbation. Second, azithromycin may not have any effect on exacerbations.

### Medical Scribes May Help Decrease Physician Workload

*Key point: More research is needed on the effectiveness of scribes in health care.* 

Citation: Yan C, Rose S, Rothberg MB, et al. Physician, scribe, and patient perspectives on clinical scribes in primary care. *J Gen Intern Med.* 2016;31:990–995.

Although this study was done in a primary-care setting, its focus on the relationships among medical scribes, physicians, and patients provides useful information for urgent care centers. The use of electronic medical records (EMRs) has been shown to improve the quality of health care and reduce its cost, but using EMRs has also increased the workload of health-care providers. Thus, medical scribes have been increasingly brought in to reduce that workload. Study participants were 18 physicians and 17 scribes from 6 health-care systems, and 36 patients from a single health-care system. Physicians, patients, and scribes alike perceived EMR notes to be more detailed than paper records. Overall, patients were comfortable with scribes being in the examination room. Scribes who were also medical assistants got work done in addition to documentation while in the room. The biggest issues were with physician–scribe fit. As the



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need for increased productivity and the need for increased documentation collide, scribes may be the best solution. [*Editor's note: See also "The Rise of Medical Scribes: A Fit for Urgent Care?" in the September 2016 issue of* JUCM: http://www.jucm.com/risemedical-scribes-fit-urgent-care/.]

### The Unpredictable Metabolism of Codeine Is a Problem

### Key point: Just say no to codeine.

Citation: Tobias JD, Green TP, Coté CJ; Section on Anesthesiology and Pain Medicine; Committee on Drugs. Codeine: time to say "no." *Pediatrics*. 2016;138:e20162396.

This review of the literature focuses on just saying no to the use of codeine, which has been prescribed for decades to calm coughs and relieve pain. Codeine itself is not the concern in this scenario. The drug is rather easily dosed, but problems occur when it is metabolized to morphine. The drug's metabolism is unpredictable and may be accelerated in some patients, creating more morphine than is safe. Nonsteroidal anti-inflammatory drugs have been repeatedly shown to relieve pain without negative effects, but no definite evidence of benefit from codeine for relieving cough has been found. Urgent care providers should give strong consideration to the evidence before prescribing codeine to a child.

### The Number of Sexually Transmitted Infections Is at an All-Time High

Key point: Sexually transmitted infections are on the rise. Citation: Centers for Disease Control and Prevention. Sexually transmitted disease surveillance 2015. Atlanta, GA: U.S. Department of Health and Human Services; 2016. Available from: http://www.cdc.gov/std/stats15/std-surveillance-2015-print.pdf

Findings from the 2015 surveillance study by the Centers for Disease Control and Prevention (CDC) of sexually transmitted infections (STIs) in the United States are anything but good: The occurrence rate for STIs is at the highest level on record. Chlamydia is seen twice as frequently among women as among men, and its rate was up 6%, to 479 per 100,000 population. The rate for gonorrhea was up 13% from the previous year, to 124 per 100,000 population. Of note is that resistance to azithromycin increased from 0.6% to 2.6%. The occurrence rate for syphilis (primary and secondary) also increased 19%, to 8 cases per 100,000 population. In 90% of cases, the patients were male. It is concerning for urgent care providers that both the number of cases and the resistance of the causative bacteria have increased. Although the CDC report is huge (176 pages), it is important to know at least about the general increase in the number of cases. Urgent care providers will also want to see https://www.cdc.gov/std/tg2015/default.htm

for the CDC's treatment guidelines for STIs.

### Douching Is Correlated with Increased Risk of Ovarian Cancer

Key point: Douching is not safe.

Citation: Gonzalez NL, O'Brien KM, D'Aloisio AA, et al. Douching, talc use, and risk of ovarian cancer. *Epidemiology*. 2016;27:797-802.

Ovarian cancer is difficult to detect and usually is found at a late stage. In 2015 there were 21,290 cases of ovarian cancer and 14,180 deaths from the disease in the United States. Researchers sought to determine whether the use of talc or douching increases the risk of ovarian cancer. The Sister Study monitored women who had a sister with breast cancer; such women, like those with a family history of ovarian cancer or nulliparity, are at increased risk for ovarian cancer. Participants were asked about whether they douched and used talc. Douching was shown to increase the risk for pelvic inflammatory disease and ectopic pregnancy, and it was correlated with increased ovarian cancer risk. Urgent care providers treating women with vaginal discharge or possible sexually transmitted infection should remind these patients of the potential harmful outcomes of douching. Larger studies may clarify the correlation between douching and risk of developing ovarian cancer. 🔳

### Air-Conditioning Reduces the Risk of Heat Illness in the Elderly

Key point: Turn on the air conditioner for the elderly. Citation: Gagnon D, Romero SA, Cramer MN, et al. Cardiac and thermal strain of elderly adults exposed to extreme heat and humidity with and without electric fan use. JAMA. 2016;316:989–991.

Significant concern has been raised about heat illness in the elderly and about electric fans dehydrating rather than cooling patients. Most studies of the use of electric fans have focused on young patients, but in this small study of fewer than 10 participants, fan use did not reduce core temperature or prevent tachycardia in elderly patients exposed to high temperatures and humidity. Although larger studies would be helpful, this evidence should cause urgent care providers to rethink telling elderly patients that fans are adequate to counter high temperature and high humidity. Patients should be encouraged to be creative about finding air-conditioning on long summer days.

### Physicians Order Imaging for Back Pain Despite Knowing That It Is Unhelpful

Key point: Knowing is not always doing.

Citation: Sears ED, Caverly TJ, Kullgren JT, et al. Clinicians' perceptions of barriers to avoiding inappropriate imaging for

### ABSTRACTS IN URGENT CARE

low back pain—knowing is not enough. *JAMA Intern Med.* 2016 October 17. doi: 10.1001/jamainternmed.2016 .6364. [Epub ahead of print.]

The study reported in this research letter concerns knowledge of appropriate use of magnetic resonance imaging (MRI) for assessing causes of back pain, along with barriers to following imaging guidelines. Although the findings are not directly applicable to most urgent care providers, the barriers noted are similar to those seen when any treatment varies from what is usually recommended. Unfortunately, the letter does not provide all the answers to address the barriers. This study was performed within the U.S. Veterans Affairs system. Health-care providers were surveyed about how and why they would respond in a fictional case of a 45-year-old woman with back pain and no red flags who requested MRI or computed tomography. The good news is that only 3.3% of respondents thought that the patient would benefit from imaging, and 77% believed that imaging might cause further unnecessary testing. However, about 75% of clinicians believed that they must order further testing before referring the patient to a specialist. About half worried that the patient would be upset, and 25% believed that they would not have enough time to discuss the risks and benefits of imaging with the patient. Finally, more than 25% of physicians worried that they would be at risk for legal action if they did not order imaging.

### Zika Virus May Be Associated with Guillain-Barré Syndrome

Key point: The Zika virus has additional consequences. Citation: Parra B, Lizarazo J, Jiménez-Arango JA, et al. Guillain-Barré syndrome associated with Zika virus infection in Colombia. N Engl J Med. 2016;375:1513–1523.

The Zika virus has already caused significant fear throughout the Americas. What may be less widely known is that the virus may also be associated with Guillain-Barré syndrome (GBS). The authors of the study reported here noted an increased incidence of GBS in areas with Zika virus infections, and they decided to determine whether there was a relationship. Of 68 patients with GBS, 66 had symptoms of infection with the Zika virus. The mean time between exposure and appearance of GBS almost immediately after infection. Most of the tested patients had some type of test findings consistent with Zika virus infection. Symptoms consisted of ascending limb weakness, paresthesia, and facial palsy. Although there were other interesting findings, the message for urgent care providers is to watch for GBS as a result of Zika virus infection.

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# 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*.

### Hip Pain in an 80-Year-Old Woman



### Case

An 80-year-old woman presents to an urgent care center with left hip pain that she has had for 4 years but that has worsened in the last week. She reports that before the pain worsened, she had gone on a long walk with her grandson. The pain is worse with movement through the range of motion. She has taken ibuprofen, but it did not reduce her pain. She says that she has not had any back pain or knee pain and has not fallen. She has no fever or vomiting, and no paresthesias. She has a past medical history of hypertension, for which she takes hydrochlorothiazide. She is a nonsmoker.

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

### THE RESOLUTION



### **Differential Diagnosis**

- Intertrochanteric hip fracture
- Osteosarcoma
- Fracture of the inferior pubic ramus
- Hip osteoarthritis
- Subcapital hip fracture
- Septic arthritis

### **Physical Examination**

On physical examination, her vital signs are as follows: temperature, 99.1°F (37.3°C); pulse rate, 108 beats/min; respiration rate, 20 breaths/min; blood pressure, 164/94 mm Hg; oxygen saturation, 98% on room air. She is alert and oriented, is not in acute distress, and is breathing comfortably.

Externally, her left hip appears normal, without erythema or swelling, and there are no cuts or breaks in the skin. She has moderate pain with flexion and extension of the hip, and with passive internal and external rotation through the range of motion. She has no pain with movement through the range of motion of the left knee. Her neurovascular status is intact, with a 2+ dorsalis pedis pulse, and sensation is grossly intact.

### Diagnosis

An x-ray (**Figure 2**) shows arthritic changes (*arrows*) in the left hip and evidence of replacement of the right hip.

### What to Look For

To differentiate between traumatic hip pain and atraumatic pain when obtaining the medical history, first evaluate the mechanism at the onset of pain. Arthritic pain will typically be chronic pain that may have been exacerbated by a specific mechanism. The pain will be worse with movement through the range of motion during weight-bearing. Inquire about ability to ambulate and activities that are limited because of pain, paresthesia, or a sensation of warmth or coolness of the extremity. The past history should include information about any past injuries, surgeries, and therapies.

When performing the physical examination, document the patient's general appearance and ability to ambulate. Inspect and palpate for skin changes such as erythema, abrasions, lacerations, fluctuance, necrosis, crepitus, and ecchymosis. Palpate for location of pain, and look for pain exacerbators such as weight-bearing and movement through the range of motion.

A plain x-ray will typically reveal arthritic changes in the hip, but clinical correlation is important. An x-ray of an arthritic hip will show joint-space narrowing, osteophytes, and subchondral sclerosis. The diagnosis requires not only x-ray findings but also symptoms typical of arthritis. Advanced imaging is not required.

### Treatment

Symptom management is the initial intervention, through prescribing acetaminophen, exercise, weight loss, icing, movement through the range of motion, and physical therapy. Indications for transfer to an emergency department are as follows:

- Concern that there is a hip fracture
- Intractable pain
- Inability to exclude septic arthritis

Acknowledgment: The image for Figure 1 was produced by Connie Raab as a work of the National Institutes of Health and is in the public domain. Available from: https://commons .wikimedia.org/w/index.php?curid=789996. Figure 2 is an adaptation of Figure 1.



# CLINICAL CHALLENGE: CASE 2

## Fever, Conjunctival Injection, and a Facial Papule



### Case

A mother brings her 10-year-old son to an urgent care center with a fever, conjunctival injection, and pharyngitis. She points out a smooth papule on his face that developed over the last few days. She says that he played with some kittens at a friend's house about a week earlier, and she wonders if maybe he is extremely allergic to cats, because he has been rubbing his eyes ever since.

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

### THE RESOLUTION

### **Differential Diagnosis**

- Toxoplasmosis
- Tularemia
- Abscess
- Cat-scratch disease

### Diagnosis

The patient has cat-scratch disease.

### What to Look For

Cat-scratch disease is a benign and self-limited bacterial infection with *Bartonella henselae*. It is characterized in most cases by a primary papulopustular skin lesion and enlarged localized lymph nodes, with a history of cat contact distal to the involved node. Fatigue, malaise, pharyngitis, conjunctivitis, headache, and low-grade fever may be present. After inoculation, the incubation period is generally a few days to several weeks.

Dermatologic involvement is seen in approximately twothirds of patients and includes evidence of a scratch with or without a papulopustular lesion, a widespread morbilliform eruption, erythema nodosum (warm, erythematous, and painful nodules in the lower extremities), erythema multiforme, and/or thrombocytopenic purpura. Splenomegaly, weight loss, and parotid swelling rarely occur.

The eye is involved in less than 10% of cases. Usually only one eye is involved, with either granulomatous conjunctivitis

(pinkeye), eyelid lesions (bacillary angiomatosis), or neuroretinitis. Parinaud oculoglandular syndrome is the most common ocular manifestation, with preauricular lymph node swelling on the side of the affected eye and granulomatous conjunctivitis.

In two-thirds of patients, the lesion lasts for less than 1 month, although it may persist for 2 months or more in some cases. Nodes are tender, gradually increase in size, become erythematous and fluctuant, and may become suppurative. Most patients recover without sequelae. Encephalitis may occur in 1% to 7% of cases, typically appearing 2 to 6 weeks after classic cat-scratch disease. Patients may present with associated seizures or status epilepticus.

### Treatment

The Infectious Diseases Society of America recommends giving patients with cat-scratch disease 500 mg of azithromycin by mouth on day 1, followed by 250 mg/d for 4 additional days. If the patient weighs less than 45 kg, the recommendation is for 10 mg/kg on day 1, followed by 5 mg/kg for 4 additional days. For bacillary angiomatosis, the recommendation is to give 500 mg of erythromycin four times per day or 100 mg of doxy-cycline two times per day for 2 weeks to 2 months.

Acknowledgment: Image courtesy of Logical Images, Inc. (www.VisualDx.com/JUCM).

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### CODING Q&A

# The Effects of the National Correct Coding Initiative

DAVID E. STERN, MD, CPC



### I understand that the Centers for Medicare & Medicaid Services has added National Correct Coding Initiative (NCCI) edits that no longer allow the billing of debridement with hundreds of surgical codes. What is the impact? How do NCCI edits affect us in general?

A. NCCI edits define when two procedure codes may not be reported together except under special circumstances. Medicare implemented NCCI to promote national correct coding methodologies and to control improper coding, which leads to inappropriate payment. Your billers should check the edits whenever two or more procedures are billed for the same patient on the same date of service. If procedures are billed incorrectly and denied, Medicare prohibits you from billing the patient for the denied services, and an Advance Beneficiary Notice of Noncoverage (ABN) cannot be used.

P

David E. Stern, MD, CPC, is a certified professional coder and is board-certified in internal medicine. He was a director on the founding board of UCAOA and has received the organization's Lifetime Membership Award. He is CEO of Practice Velocity, LLC (www.practicevelocity.com), NMN Consultants (www.urgentcare consultants.com), and PV Billing (www.practicevelocity.com/ urgent-care-billing/), providers of software, billing, and urgent care consulting services. Dr. Stern welcomes your questions about urgent care in general and about coding issues in particular. When a claim is processed by Medicare or a Medicare contractor, the system tests every pair of procedures with the NCCI edit rules. The column 2 code of the Column One/Column Two Correct Coding edit file of the NCCI is often a component of a more comprehensive column 1 code. If a pair of billed codes matches a pair of codes listed in the edits, the code listed in column 2 of the Column One/Column Two Correct Coding edit file of the NCCI will be denied. However, an appropriate modifier can bypass the edit, providing the procedures are performed at different anatomic sites, or in the case of repeat clinical diagnostic laboratory tests. Supporting documentation must be in the beneficiary's medical record.

The NCCI-associated modifiers are as follows:

E1	FA	LC	RC	TA	XE	24
E2	F1	LD	RI	T1	XS	25
E3	F2	LM	RT	T2	XP	27
E4	F3	LT		T3	XU	57
	F4			T4		58
	F5			T5		59
	F6			T6		78
	F7			T7		79
	F8			Т8		91
				Το		

**Table 1** defines modifier indicators and notes whether a modifier allows for the code pair to bypass the edit. Guidance on how to use all NCCI tools can be found at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools.pdf.

In October 2016, thousands of new code pairs were added to the list of bundled codes, many of which bundle debridement services into other surgical and medical procedures. [*Editor's note: See "Imaging: X-Rays and Computed Tomography" in the November 2016 issue of* JUCM: http://www.jucm.com/ imaging-x-rays-computed-tomography/.] These are the debridement codes added to the edits:

11000 through 11006, debridement of extensive eczematous or infected skin

### CODING Q&A

Table 1. Modifier Indicators				
Modifier Indicator	Definition			
o (not allowed)	There are no modifiers associated with NCCI that are allowed to be used with this PTP code pair; there are no circumstances in which both procedures of the PTP code pair should be paid for the same beneficiary on the same day by the same provider.			
1 (allowed)	The modifiers associated with NCCI are allowed with this PTP code pair when appropriate.			
9 (not applicable)	This indicator means that an NCCI edit does not apply to this PTP code pair. The edit for this PTP code pair was deleted retroactively.			

NCCI = National Correct Coding Initiative; PTP = procedure-to-procedure. Adapted from Centers for Medicare & Medicaid Services. How to use the Medicare National Correct Coding Initiative (NCCI) tools. Baltimore, MD: Centers for Medicare & Medicaid Services [published June 2016]. Available from: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools.pdf

- 11042 through 11047, debridement of subcutaneous tissue
- **97597** through **97598**, debridement without excision

For example, *Current Procedural Terminology* (CPT) codes **10120** ("Incision and removal of foreign body, subcutaneous tissues; simple") and **10121** ("... complicated") are now bundled with the debridement codes listed before this paragraph. If you were performing debridement in a separate body area from where the removal of the foreign body took place, your biller would have to add modifier **-59** to the debridement code in order for it to pass the NCCI edit. If the modifier is not there, the procedure will be denied as being included in the service performed for CPT code **10120** or **10121**.

Additional bundled code pairs involving debridement services are the cast application and strapping codes, **29000** through **29584**. These also have a modifier indicator of "**1**" so that an appropriate modifier will bypass the edit when necessary.

Note: CPT codes, descriptions, and other data only are © 2011, American Medical Association (AMA). All Rights Reserved (or such other date of publication of CPT). CPT is a trademark of the AMA.

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### DEVELOPING DATA

he following chart, based on data from a Practice Velocity study of more than 20,000,000 patient visits over a 5-year period, shows that urgent care exhibits a strong pattern of seasonality. The average daily visits in each month vary from average daily visits over the course of a year. For example, on an average day in July, there are 14% fewer patients than the baseline number, whereas on an average day in December, there are 25% more visits. Although between 2010 and 2015 there were a number of strong influenza outbreaks in December and January, it is clear that November through March is respiratory season, driving the bulk of urgent care visits. Seasonality often differs by region, with Sunbelt winter vacation or retirement communities (i.e., those in Florida and Arizona) seeing more exaggerated variances than regions without seasonal population migration. Understanding the seasonality curve is important in determining when to open a new urgent care center, when developing marketing campaigns, and when hiring and scheduling health-care providers and staff. For example, a center that maintains level staffing throughout the year may experience long wait times in December and low provider efficiencies in July. Centers thus provide contraseasonal ancillary services, such as occupational medicine, to flatten demand over the course of the year.

### URGENT CARE SEASONALITY: MONTHLY AVERAGE VISITS AS A PERCENTAGE OF AVERAGE DAILY VISITS



Note: To properly account for "sick and injured" visits that require more of a health-care provider's time, the visits in this chart include only provider encounters in which an evaluation and management (E/M) code is charged and exclude workers' compensation, employer-paid services, sports physical examinations, and nonprovider services that are not offered at all urgent care centers. (*Source*: Practice Velocity, LLC.)

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