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PRACTICE MANAGEMENT (cme)

How Urgent Care Gets the **Competition Up and Running**

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Urgent Care Association of America

COLLEGE OF URGENT CARE MEDICINE

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LETTER FROM THE EDITOR-IN-CHIEF

Opioid Crisis: What Next, and What's Lurking?



t pains me to write this column. The opioid epidemic is arguably the most catastrophic and enduring public health crisis since the flu epidemic of 1918—yes, even worse than the HIV/AIDS epidemic of the '80s. Since 2000, over 200,000 people have died from

overdoses of prescription opioids alone, another 300,000 from heroin and synthetic opioids. Now synthetic fentanyl has infiltrated the market with the most toxic opioid ever known. The overdose death curve is steepening. There is no fix in sight and our response is already too little, too late.

Of course, there is no shortage of commentary on the root cause of the crisis, and there are many people and motivations to blame. During residency, I distinctly remember all those *No Pain* buttons the anesthesiologists wore proudly on their lab coats. That campaign, not surprisingly, was initiated and funded by big pharma. Pain was first promoted as the "5th vital sign" (a concept long-since discredited) by the VA hospital system in the late 1990s; then, in 2001, the Joint Commission published pain assessment and management standards supported by Purdue Pharmaceuticals, the makers of OxyContin.

Scientific inquiry obsessed over short-term pain reduction, not long-term addiction. And what about the doctors? Like entranced rats, we followed the sweet music of the Pied Piper, diligently parroting the benefits of pain medication without any pause for doubt about the potential for addiction.

So, we are finally awakening to our self-made catastrophe and taking pride in our reversal of course. The pharma companies have paid some fines (no executives are going to jail), pill mills are being raided, and physicians have self-imposed restrictions on their own prescribing. And what is all this doing? Driving addicts that we "created" into the streets to use heroin and synthetic fentanyl.

Reducing access to prescription opioids does not solve the immediate crisis for patients who are already addicted. Thousands more will die before this fire burns out. What a tragic shame and a major blemish on our profession!

But, is this really a one-off story of greed and blind trust, or is this just the tip of the iceberg? Isn't it time that all of us in the scientific community scrutinize other ticking time bombs and intervene on behalf of our patients before it's too late?

"As physicians, we must resist making the same mistakes that led to the opioid crisis."

Go back, if you will, to your training and think about negative feedback loops and receptor downregulation. Much of physiology and pathophysiology as we know it follows this pattern. When the balance is disrupted, endogenously or exogenously, dysfunction ensues and over time the physiology becomes resistant and treatments become less effective (eg, insulin and Lasix). Now think about neurotransmitters. Yes, the same neurotransmitters that are manipulated by one of the most profitable classes of medications in history: so-called "lifestyle" medications. These include the antidepressants, anxiolytics, ADHD treatments, and a host of other stimulants and sedatives. And every one of them has the potential for dependence and tolerance in one way or the other. But if you are a pharmaceutical company, what better way to ensure a customer for life than to make him/her dependent on your drugs? The opioid epidemic has already demonstrated that pharma is a poor moral steward, so don't expect it to police itself. All told, you see many of the same patterns evolving here: Lots of direct-to-consumer advertising, praying on societal and social ills, blurred lines between disease and "dis-ease," and too many physicians falling victim to patient/parental pressure and pharma influence.

As physicians and scientists, we must stand up to these influences and resist the same mistakes that led to the opioid crisis. We must learn the hard lessons, and scrutinize more diligently. We must remember the mechanisms of dependence and addiction. We must be very wary of manipulating delicate physiology in the absence of real disease. And we must never be complicit with dangerous pharma tactics again.

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



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PRACTICE MANAGEMENT

11 How Urgent Care Cultivates **Competition in Healthcare**

Converging market forces are transforming the formerly stagnant healthcare marketplace into a hotbed of competition. How is urgent care contributing?

Alan A. Ayers, MBA, MAcc

CLINICAL





Some children who've swallowed foreign bodies need emergent referral, but most can be treated endoscopically or can wait for spontaneous passing. You need to recognize the difference-quickly.

Herlene Chatha. MD and Hansel Otero. MD

CASE REPORT

Boerhaave Syndrome in a 41-Year-Old Female



Seldom-seen conditions that could be deadly demand every ounce of clinical suspicion a provider can muster. Some, like Boerhaave syndrome, are likely to present to urgent care.

John Shufeldt, MD, MBA, JD, FACEP, Amber Hawkins, and Carli Nichta. MS₄

HEALTH LAW AND COMPLIANCE

What HIPAA Is and What It's Not



HIPAA is widely known as "the privacy law," but there's a lot more to it. Understanding all the implications will help your urgent care center run smoothly and stay in compliance.

Alan A. Ayers, MBA, MAcc

IN THE NEXT ISSUE OF JUCM

Arrhythmias send more than a few patients running to their closest urgent care center. Some need nothing more than reassurance they're not about to die. while others may be advised to take medication or initiate lifestyle changes. Then there are those who need emergent care. Understanding who needs what, on the spot, is where the urgent care clinician shines. Read all about it in the January issue of JUCM.

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EDITOR-IN-CHIEF Lee A. Resnick, MD, FAAFP editor@jucm.com MANAGING EDITOR Harris Fleming hflemina@iucm.com ASSOCIATE EDITOR, PRACTICE MANAGEMENT Alan A. Ayers, MBA, MAcc ASSOCIATE EDITOR, CLINICAL Michael B. Weinstock, MD CONTRIBUTING EDITORS Sean M. McNeeley, MD David E. Stern, MD, CPC MANAGER, DIGITAL CONTENT Brandon Napolitano bnapolitano@jucm.com ART DIRECTOR

Tom DePrenda tdeprenda@jucm.com 185 State Route 17, Mahwah, NJ 07430

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

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t's something every parent frets about—a child puts something in their mouth that doesn't belong there, and the next thing they know it's gone down the hatch. The concern is so prevalent that we even have a name for guarding against it before a baby is born. Remember "childproofing" your home?

One of the most concerning things is, especially if it's a very young child, they might not even be able to communicate what it was they swallowed. This puts the physician the parents run to in a challenging position. Do you assume it was something extremely hazardous—or take the opposite perspective and try to reassure the parents while you consider the possibilities? Statistics say only one out of a hundred cases of children ingesting foreign bodies requires surgical intervention—but is the child in your exam room right now *that one*?

In Approach to Ingested Foreign Bodies in Children (page 14), **Herlene Chatha, MD** and **Hanzel Otero, MD** walk us through these



scenarios, with an aim of explaining how to determine which children really do need emergent care, who requires endoscopic removal, and who can wait for spontaneous passage.

Dr. Chatha is an attending physician at PM Pediatrics and an attending physician at Anne Arundel Medical Center. Dr. Otero is a radiologist at Children's Hospital of Philadelphia.

Boerhaave syndrome is a rare finding, too—and one with equally dire consequences for the patient if it's not identified and treated quickly and correctly. That takes acute awareness and a suspicious nature (in the best possible sense, clinically speaking). This is especially important for the urgent care clinician, who is more likely to see a case of Boerhaave syndrome than their primary care counterparts.





B

should be required reading in your practice. Authors John Shufeldt, MD, JD, MBA, FACEP, Amber Hawkins, and Carli Nichta, MS4 have done a great job of explaining the nuances

of an actual case—one that could help you be

prepared for a similar presentation in your urgent care center.

Dr. Shufeldt is interim chief medical officer at San Carlos Healthcare Center in Peridot, AZ and adjunct professor at Creighton University School of Medicine. Ms. Hawkins is a graduate of the University of Arizona and a care coordinator with MeMD. Ms. Nichta is a fourth-year medical student at Creighton University School of Medicine. The consequences of not recognizing challenges and their solutions on the business side of an urgent care operation are not as hazardous to the patient, of course, but they can kill a prac-



tice just as quickly. And that's not limited to urgent care, either. In fact, one could make the case that urgent care has already done a lot to shake up the healthcare establishment, which author **Alan A. Ayers, MBA, MAcc** says has had the luxury of operating as "a monolith of inefficiency, limited access, and untenable costs for decades." His article explains the affect urgent care has had on the marketplace right from its title— How Urgent Care Cultivates Competition in Healthcare starts on page 11.

Mr. Ayers, who is vice president of strategic initiatives for Practice Velocity, LLC and is practice management editor of *JUCM, The Journal of Urgent Care Medicine*, also corrects some common misconceptions about the Health Insurance Portability and Accountability Act of 1996—better, if not more clearly, known as HIPAA—in What HIPAA Is and What It's Not on page 26. (Hint: If you think of HIPAA as *that patient privacy law*, you need to read the article.)

Also in this issue:

Glenn Harnett, MD culls urgent care-relevant lessons from articles published recently in other publications. This month, his Abstracts in Urgent Care (page 19) deal with new rapid flu tests; patients with angina; new herpes vaccine recommendations; trimethoprim-sulfamethoxazole in skin abscesses; low-dose corticosteroid for sore throat; preventing the spread of disease in organized sports; and more.

And, last but never least, **David Stern, MD, CPC** seeks to help you understand the finer points of case-rate (aka flat rate) reimbursement. As always, Dr. Stern's expertise and experience is there to help you avoid leaving money on the table.

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CONTINUING MEDICAL EDUCATION

Release Date: December 1, 2017 Expiration Date: November 30, 2018

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- To provide unbiased, expert advice regarding the management and operational success of urgent care practices
- 4. To support content and recommendations with evidence and literature references rather than personal opinion

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CONTINUING MEDICAL EDUCATION

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

Approach to Ingested Foreign Bodies in Children (p. 14)1. Of the foreign bodies ingested by pediatric patients, how often is endoscopic removal required?

- a. 1% of the time
- b. 5% of the time
- c. 20% of the time
- c. 20% of the time
- d. 80% of the time
- e. 99% of the time

2. Which of the following may indicate a tracheal foreign body or tracheal compression caused by an object lodged in the esophagus?

- a. Fever
- b. Unilateral rhinorrhea
- c. Supine position and breathing comfortably
- d. The presence of stridor or wheezing
- e. Stomach ache

3. Which of the following suggests referral to an emergency department (ED)?

- a. Signs of airway compromise (stridor, wheezing)
- b. Signs of esophageal obstruction (inability to swallow or handle secretions)
- c. Concern for intestinal obstruction (abdominal pain or distention, vomiting, fever)
- d. Concern for an esophageal button battery
- e. All of the above

How Urgent Care Fosters Competition in Healthcare (p. 11)

- 1. Compared to other industries, which of the following does the article say about competition in healthcare?
 - a. Healthcare has historically embraced competition, which has pushed innovation in the healthcare sector, giving the U.S. the world's most efficient healthcare delivery system
 - Unlike other industries, in which competition leads to increased innovation and quality at lower prices, healthcare in the United States has historically thwarted agents of change
 - c. Healthcare providers don't need to compete with one another; illness and injury will always occur, so the demand will always be there
 - d. All of the above
 - e. None of the above

- 2. According to Harvard researchers, which of the following has been a historic barrier to competition in healthcare?
 - a. Limited reimbursement-based incentives
 - b. Limited market-share incentives
 - c. Inadequate data on value
 - d. Inadequate know-how
 - e. All of the above
- 3. Which is the primary way that urgent care fosters competition in the healthcare system?
 - a. Urgent care embraces "core concepts of consumerism" that include affordability, cost transparency, digital platforms, on-demand care, widened access, etc.
 - b. Urgent care integrates with hospitals and health systems, providing a seamless medical record
 - c. Urgent care provides a mid-acuity plank in primary care medical home, gatekeeper-model HMOs
 - d. Urgent care accepts Medicare and Medicaid, as well as private insurance
 - e. Urgent care has deep experience with value-based payments in population health management

Case Report: Boerhaave Syndrome in a 41-Year-Old Female (p. 22)

- 1. Boerhaave syndrome is a spontaneous esophageal rupture sometimes characterized by Mackler's triad, which includes subcutaneous emphysema, vomiting, and lower chest pain.
 - a. True
 - b. False
- 2. Which of the following patients should cause greater concern for Boerhaave syndrome?
 - a. Patients with severe vomiting
 - b. Patients who abuse alcohol
 - c. Patients with bulimia
 - d. Men 50-70 years of age
 - e. All of the above
- 3. Which chest x-ray findings should prompt consideration of esophageal rupture?
 - a. Lobar infiltrate
 - b. Tension pneumothoraxc. Pneumomediastinum
 - d. Free air under the diaphragm
 - a. Dib fracture
 - e. Rib fracture

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To learn more about antibiotic prescribing and use, visit www.cdc.gov/antibiotic-use.





FROM THE UCAOA CEO

UCAOA Members: The Rising Tide

■ LAUREL STOIMENOFF, PT, CHC

recently attended a conference of the Northeast Regional Urgent Care Association (NERUCA), a chapter of UCAOA, to meet and network with our mutual members and participate in its leadership education track. Shaun Ginter, CEO of CareWell Urgent Care and a UCAOA director, presented "Creating a Culture of Service," during which he shared personal experiences of what works and what doesn't work in his organization, and how CareWell measures service success. Following his presentation, gratitude was expressed for Shaun's complete transparency in the information shared with a group that included potential competitors. John Kulin, DO, president of NERUCA, commented that too often all urgent care centers are painted with the same brush and a patient experience is a reflection on all centers. As an oftmisunderstood industry, elevating that experience and openly sharing successes and failures is a necessity. Dr. Kulin summarized his comments by stating, "A rising tide raises all ships."

A Gift from Our Members to Urgent Care

UCAOA members have a history of sharing and supporting one another. As a result, urgent care medicine has gained greater credibility from the perspective of patients, payers, the medical community, and employers. Additionally, member support through dues, purchases, and conference and convention attendance has allowed UCAOA to do the work we do on your behalf. We work diligently and thoughtfully to provide support to individual and organizational members. But, we never forget what our members and vendors *do for us* through their support. In the spirit of the season, it is truly a gift to passionately serve you and your centers.

Members Matter Through Support and Volunteerism

UCAOA was able to achieve a myriad of accomplishments in 2017—spanning industry advancement, education, outreach, and growth—thanks to the support and volunteerism of our members. Here are some highlights from the past year:



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

Leadership & Advocacy

In May, UCAOA participated in a Day on the Hill, advocating on behalf of urgent care centers across the country. UCAOA also provided the resources and expertise to publish a stateof-the-industry whitepaper, as well as the annual Benchmarking Report—which is arguably the most-quoted resource on the industry.

Education

UCAOA's Education Committee worked tirelessly to offer the most relevant educational experiences for urgent care physicians, advanced practice clinicians, operators, and administrators. The College of Urgent Care Medicine (CUCM) advanced its strategic agenda, produced a clinical newsletter, and expanded its influence by welcoming NPs and PAs into the College alongside the many esteemed physicians it already serves.

Support

The Urgent Care Foundation raised funds through the support of attendees at the Annual Foundation Celebration, as well as sponsored grants to provide research, including antibiotic stewardship. The funds also facilitated a scientific symposium on concussion care in the urgent care setting, convened a thought leaders' forum on the future of urgent care, and established a disaster-relief fund to assist urgent care center recovery.

Expansion

UCAOA launched Pediatric, Telemedicine, and Hospital and Health System sections for members, with more of these special interest groups in the planning stages. The California Urgent Care Association (CALUCA) joined UCAOA as a chapter—further expanding the organization's reach and membership—and a consulting arm was created to better assist urgent care centers interested in pursuing accreditation. Looking ahead, the UCAOA Board drafted a 3-year strategic plan for future growth.

UCAOA turned 13 in 2017, and while we have the energy and passion of a teenager, we could not do our work without the rising tide that is provided by our members and industry supporters. Thank you to all who collectively "raise the ships" so they may continue to deliver high-value, quality care to patients everywhere.

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How Urgent Care Cultivates Competition in Healthcare

Urgent message: U.S. healthcare has been a monolith of inefficiency, limited access, and untenable costs for decades, due mainly to a lack of healthy competition. Today's healthcare landscape, however, spurred by converging market forces, is rapidly evolving into a competitive marketplace, with urgent care being one of the key catalysts for this welcomed and long overdue change.

ALAN A. AYERS, MBA, MACC

n most industries and sectors, there exists an underlying dynamic: competition forces companies to continually innovate, improve quality, and deliver increasing value. Or lose market share. U.S. healthcare has been the exception; not only has intra-industry competition been scarce, but the industry itself has actively thwarted and undermined positive agents of change.

Hospitals and health systems deny such claims, asserting that they face plenty of competition for patients from market rivals and disruptive new entrants, and in response are increasingly consolidating and merging with the aim of both mitigating financial risk and stymying competition. Still, healthcare costs remain exorbitant, access limited, and care delivery underwhelming, mostly due to the lack of natural innovation that true competition engenders.

Of course, people will never stop getting sick or injured; thus, the industry is essential. But stifled competition means healthcare will continue to be inefficient and chaotic, with costs, access, and quality of care improving little—not to mention the continuing toll such a massive and broken system takes on the economy. Indeed, it's a critical issue that the esteemed business journal *Harvard Business Review* (*HBR*) tackled in Health Care Needs Competition, an in-depth article by Leemore S. Dafny and Thomas H. Lee, MD. The authors arrived at an elucidating takeaway: Converging market forces are causing longstanding competition barriers to



crumble, forcing stakeholders to embrace the competitive landscape necessary for healthcare to evolve naturally via the agents. Among the players that will assume a key role in shaping the new competitive marketplace, the urgent care model can help erode competitive barriers and serve to cultivate competition.

Alan A. Ayers, MBAS, MAcc is Vice President of Strategic Initiatives for Practice Velocity, LLC and is Practice Management Editor of *The Journal of Urgent Care Medicine*. The author has no relevant financial relationships with any commercial interests.

Barriers to Competition

Competing on value—ie, providers meeting patients' needs at a lower cost than the competition—must become the central tenet in healthcare. Hence, in its examination of the dearth of healthcare competition, the aforementioned *HBR* article identified four interrelated barriers:

- Limited reimbursement-based incentives. Traditionally, providers have realized little financial reward for delivering value; nor have they faced financial consequences for failing to do so. The strength of their brands and their marketing messages have, until now, allowed them to meet their financial objectives, irrespective of the actual cost, patient experience, and/or clinical outcomes.
- Limited market-share incentives. Before healthcare reform and market trends like the prevalence of high-deductible health plans (HDHPs) took hold, consumers had largely been insulated from healthcare costs. As such, price-insensitive consumers weren't shopping around for bargains; thus, improvements in quality had not directly translated into an influx of patients.
- Inadequate data on value. Any value-based healthcare initiative relies heavily on precise costs and outcomes data, but due to a lack of standardization across providers, differing data collection methodologies have led to difficult comparative analysis.
- Inadequate know-how. Absent financial incentives for pursuing value, and without precise data for helping stakeholders make data-driven decisions, the younger generation of healthcare leaders tasked with ushering in the next era of transformative care delivery has not been properly developed.

Consequences for Stakeholders

A healthcare system buckling under the weight of its own inefficiency and the growing point-of-care consumerism movement have been the primary impetus driving change across healthcare. Still, the industry lags in fostering competition, which holds ongoing consequences for all stakeholders:

Government – Agencies like the Federal Trade Commission, the antitrust division of the Department of the Justice, will continue struggling to curtail the rising number of anticompetitive hospital mergers amid overtaxed regulatory and enforcement resources. Additionally, government programs such as Medicare and Medicaid will continue to bear the costly burden of subsidizing expensive healthcare for a growing and aging population.

- Payers Insurers and providers will continue to jostle over shrinking reimbursements, as payers increasingly resist fee-for-service payment increases. Payers, both public private, will also continue to foist higher levels of financial risk onto providers.
- Providers While a few notable providers are adapting to the changing landscape, most remain behind the times. This put them in a *reactive* position, where they're scrambling to stem the tide of competing players siphoning patients, rather than *proactively* meeting the consumerism push headon, and protecting market share.
- Consumers In the absence of competition, consumers are denied the choice, price transparency, affordability, and convenience they've come to expect in other industries. Innovation is what spurs improved offerings, and without competition, there is simply no impetus for innovation.

How Urgent Care Fosters Competition

The *HBR* team, after combing through the data and interviewing key stakeholders, effectively documented how market forces are causing the barriers to competition to crumble. Their researchers also outlined the specific roles stakeholders must play to transform healthcare. Urgent care, with its retail-based, customercentric delivery channel, is uniquely positioned to help catalyze the competitive market that healthcare so desperately needs. While not a panacea or cure-all for healthcare's competitive shortcomings, urgent care plays a key role in fostering a competitive and innovative environment. Here, a brief breakdown of the urgent care model's various value propositions, and the competitive advantage it affords key stakeholders:

Overall urgent care value proposition: Provides underserved consumers an affordable and convenient point of access that fills the gap between the ED and primary care. Urgent care in general has long been steeped in the core tenets of healthcare consumerism—affordability, cost transparency, digital platforms (ie, mobile apps and self-scheduling), patient experience measures, short visits, on-demand care, and widened access. In addition, it allows cost-conscious insurers to steer insured patients away from expensive care options such as freestanding and/or hospital EDs, and toward more affordable care appropriate to their acuity.

Competitive beneficiary – consumers: Helps patients avoid costly and lengthy ED visits, and provides a low-to mid-acuity access point for patients who either don't have a PCP or can't wait for an appointment. Further-

more, a low-cost (compared with the ED) urgent care option is an ideal venue for price-sensitive HDHP consumers and offers a broader scope of service (eg, casting, suturing, etc.) than PCPs or retail clinics. As such, it sets the bar on access, quality, and price, forcing traditional providers to compete or lose market share.

Urgent care value proposition: Capable of vertical integration with existing hospital and health systems.

Competitive beneficiary – consumers and hospitals/health systems: Hospitals and health systems entering into joint ventures and mergers with urgent care operators are on a significant upswing, as the partnership model affords several competitive advantages that appeal to consumers:

- Functions as a central piece of value-based care initiatives—for example, steering patients away from costly and unnecessary ED visits.
- Supports health system ambulatory strategies of offering additional points of care throughout surrounding communities.
- Provides a hospital-branded urgent care option, which studies show many consumers prefer over standalone centers.
- Captures overflow patient foot traffic on nights and weekends when PCPs are closed, widening PCPaffiliated access.
- Supports accountable care and population health initiatives—effective for building patient populations and delivering low- to midlevel acuity care in the most convenient, affordable, and appropriate setting.
- Acts as a ready entry point for patients into hospital/health systems, with the potential to garner preferential referrals and downstream revenues.
- Allows improved continuity of care for primary care patients who utilize affiliated urgent care centers when PCPs and specialists aren't accessible.

Competitive beneficiary – payers and consumers: With ED copayments doubling and even tripling in some markets, it's critical that consumers have suitable options for nonemergent care. Urgent care allows payers to control costs by directing patients to more appropriate care sites. It's not uncommon for a payer, after analyzing ED data, to uncover vast ED overutilization for visits better suited to, say, an urgent care facility. Invariably, payers who partner with urgent care or health systems that own them—while also educating and incentivizing patients to use them in lieu of the ED—see a significant drop in ED claims. Wider adoption, experts assert, will also allow payers to pass the savings onto consumers.

Falling barriers: Though the HBR team rightfully asserts

that the four erstwhile barriers to competition are interrelated, a well-executed urgent care initiative serves to directly address two of them: providing market-share incentives, and reimbursement-based incentives.

The market-share advantages to an urgent care component are readily apparent: Providers looking to add a consumer-centric access point to their larger delivery system stand to realize significant gains by investing in the urgent care space. In addition to the consumer-friendly entry point urgent care provides, it allows organizations to cobrand, expanding their geographic footprint in a cost-effective manner without having to procure a certificate of need necessary for a new hospital.

Reimbursement-based incentives are growing, as well. Payers of every stripe are increasingly demanding providers share in financial risk, while moving toward value-based, accountable-care payment models. This means population health, patient experience, price transparency, expanded access, and digital channel offerings must go from being the exception to becoming the rule. Urgent care helps providers check all those boxes, while partnering with experienced, technically excellent operators to facilitate the embrace of the consumerism-centric delivery models necessary to stay competitive.

Conclusion

Government reform, consumerism, and falling technology barriers are among the many causal agents propelling healthcare forward, with still more disruptive change on the horizon. For U.S. healthcare to grow into a model on par with other thriving industries (and even other exemplary national healthcare systems), it must make a concerted effort to stop deflecting competition, and erode the barriers to it.

Urgent care is a proven catalyst for competition. For consumers who demand lower costs and better access to care, urgent care centers remain an excellent alternative to primary care and the ED. For health systems that want to expand vertically while growing their patient populations, an urgent care component helps deliver the retaillike experience consumers increasingly expect. Payers and insurers looking to move patients away from high-cost treatment venues toward lower-costs alternatives (without sacrificing quality and wherever clinically appropriate) are demonstrating renewed interest in urgent care. Urgent care operators with multiple locations and good contracts are in an especially advantageous position.

In short, urgent care provides real choice—which spurs competition, which then begets the innovation healthcare needs to transform.



Approach to Ingested Foreign Bodies in Children

Urgent message: Less than one out of a hundred cases of children ingesting foreign bodies requires surgical intervention. Identifying which children that could apply to, which need endoscopic removal, and those who can wait for spontaneous passage is an essential role for the urgent care provider.

HERLENE CHATHA, MD and HANSEL OTERO, MD

The case: An otherwise healthy 2-year-old boy is brought to your urgent care center by his parents, who are concerned that he may have swallowed one or more coins. Approximately 30 minutes ago, the child's mother heard him gagging and when she found him he was crying and holding his neck. He reports that he swallowed money he found on the floor. On arrival, he is quiet and tearful, in no distress, but points to his throat.

ach year in the United States there are more than 100,000 cases of foreign body ingestions reported, with over 80% of them in children.¹ Most of these occur in children under the age of 5, and many are unwitnessed by a caregiver, making it difficult to obtain an accurate history. Whereas intentional ingestions are much more common in adult patients, the vast majority of cases in the pediatric population are unintentional ingestions of common household objects. Coins are the most common of these, accounting for up to two-thirds of ingested foreign bodies identified in children under the age of 10.²

Once in the gastrointestinal tract, most foreign bodies will pass spontaneously and without incident. However, certain objects carry a much higher risk of complications if not removed in a timely fashion. Endoscopic removal is required in up to 20% of cases in which foreign bodies have been ingested by pediatric patients, while surgical intervention is required in <1%.³ Appropriate management of foreign body ingestions relies on accurate identification and localization of the object or objects



ingested. This article will review the approach to evaluation, management, and disposition of a pediatric patient who presents to an urgent care facility with a known or suspected foreign body ingestion.

Evaluation

The majority of children who have swallowed a foreign body are relatively asymptomatic, so special attention is

Herlene Chatha, MD is a per diem attending at PM Pediatrics and at Anne Arundel Medical Center. She receives salary from Mytonomy Inc., and the CME Program has determined there is no conflict of interest. Hansel Otero, MD is a radiologist at Children's Hospital of Philadelphia. He has no relevant financial relationships with any commercial interests.

required for concerning symptoms and for those objects that carry the risk of potential complications.

The initial evaluation should assess for signs of airway compromise or esophageal obstruction, as well as for the ingestion of specific objects that would require emergent care. Stridor or wheezing may indicate a tracheal foreign body or tracheal compression caused by an object lodged in the esophagus. The inability to handle secretions suggests a near or complete esophageal obstruction. Severe neck pain, swelling, or crepitus in the neck may signal perforation of the esophagus by a sharp object.

In the absence of these acute

symptoms, immediate attention should be given to accurately identifying the object in question. Button batteries are of particular concern and can be emergent if lodged in the esophagus, even without signs of distress. Since the majority of children with a suspected foreign body ingestion are asymptomatic at presentation, every effort should be made to obtain an accurate history as to the timing, quantity, and type of object believed to be ingested. The remainder of the physical exam should focus on signs of intestinal obstruction or perforation, such as abdominal distention, guarding, and tenderness.

Initial diagnostic evaluation for patients with a suspected radio-opaque foreign body ingestion consists of simple radiographs. The traditional approach is to obtain a complete foreign body series, including biplane radiographs (anteroposterior and lateral) of the neck, chest, and abdomen.⁴ A stepwise approach is reasonable if there is low suspicion for a poly-ingestion and the initial radiograph yields enough diagnostic information for appropriate management (eg, a coin that has passed the pylorus and is in the intestine).

A lateral radiograph of the neck/chest is suggested to confirm the absence of a tracheal foreign body when a presumed esophageal foreign body is visualized on the AP view. Additional views are important for recognition of discrete objects in a suspected poly-ingestion, particularly for objects with the potential to cause complications, such as multiple magnets. In addition to plain



radiographs, any patient with high suspicion for ingestion of a radiolucent foreign body or with concern for intestinal obstruction may require referral for further imaging, such as a CT scan.⁴

Management

Referral to an emergency department is indicated for any symptomatic patient, especially those with:

- signs of airway compromise (eg, stridor, wheezing)
- signs of esophageal obstruction (inability to swallow or handle secretions)
- concern for intestinal obstruction (abdominal pain or distention, vomiting, fever)
- concern for an esophageal button battery

The patient with potential for airway obstruction or esophageal erosion requires immediate ambulance transport for emergent airway management and endoscopic removal of the ingested foreign body.

In an asymptomatic patient, management depends on the type and location of the specific object ingested. Radio-opaque foreign bodies found in the esophagus, especially those lodged at the cricoid notch, should be referred for endoscopic removal,⁵ although certain objects in the distal esophagus can often be observed to assess for safe passage into the stomach. With the exception of certain high-risk ingestions, most foreign bodies that have already passed through to the stomach may be allowed to pass through the intestines spontaneously.



Frontal abdominal radiograph in a 7-year-old boy showing three round metallic foreign body lodge in the upper thoracic esophagus. Note the double lucency of the outer edge, which differentiates this button battery from a coin.

A small number of high-risk patients will require transfer to an ED for continued monitoring, or will need close outpatient follow-up. Further management based on the specific type of foreign body is detailed below:

Coins: Most coins will pass through the gastrointestinal tract without causing any complications. Up to 30% of coins lodged in the esophagus will pass into the stomach spontaneously, more commonly in asymptomatic older children and for coins found in the distal esophagus on initial radiograph.⁶ Any child with an esophageal coin should be referred to a setting with pediatric endoscopy capabilities. For distal esophageal coins, endoscopy may only be necessary if the coin is in an unchanged position on repeat radiographs or if the history suggests the coin was ingested >24 hours prior to presentation.⁵

If the coin has passed through the esophagus into the stomach, the patient may be followed at home with monitoring of stools and follow-up with their primary physician to discuss repeat radiographs should the coin fail to pass in 1-2 weeks.⁴ Parents must be instructed to recognize the signs of intestinal obstruction (eg, abdominal pain, vomiting).

Batteries: Disk (button) batteries are similar to coins in that they are small and shiny, making them appealing to young children. The use of larger and more powerful lithium batteries in many common household products has been linked to the increase in serious complications over the past two decades.⁷ Batteries lodged in the esophagus are a true medical emergency because conduction of electrical current can cause liquefaction and necrosis of the esophageal mucosa, leading to ulceration and perforation in as little as 8 hours following ingestion.⁵ Any battery in the esophagus warrants emergent endoscopic removal.

Close inspection of radiographs is needed to distinguish esophageal coins from disk batteries. A "double-halo" sign on the anteroposterior view and a "step-off" sign on the lateral view are characteristic of disk batteries. It may be difficult to distinguish stacked coins from disk batteries on plain radiographs; without reliable history, the approach to management should assume a disk battery ingestion.

The presence of a battery in the stomach does not preclude esophageal damage;⁷ retained batteries can cause ongoing mucosal damage from direct pressure necrosis or leaking of caustic materials.³ Larger batteries, especially in a younger child, pose a greater risk for gastric outlet or intestinal obstruction; these patients should be referred for close observation and possible endoscopic removal if the battery fails to pass through the stomach in 48 hours.³

In the older asymptomatic child with a gastric battery <15 mm in size, close observation at home by a reliable caregiver may be an acceptable option. Stools should be inspected to confirm passage of the battery, and repeat x-rays may be indicated if the battery fails to pass within 1-2 weeks.⁸ Caregiver education should be provided, focusing on the signs of intestinal obstruction and perforation. Follow-up with the primary care provider is important to coordinate this ongoing care and to assure safe passage.

Magnets: High-powered magnets composed of neodymium (also called rare earth magnets) are commonly found in many household appliances and toys. While most cases of unintentional magnet ingestions occur in small children, accidental ingestion has also been reported in adolescents using magnets to mimic piercings of the tongue and lips.⁵ Any child with a suspected magnet ingestion should have biplane radiographs of the neck, chest, and abdomen. Multiple magnets may stack together and mimic a single magnet on x-ray; at least two views are needed to accurately determine the number of magnets present.

Ingestion of multiple magnets or co-ingestion of a single magnet with a metallic object carries a high



Frontal chest radiograph in a 21-month-old boy showing a 2 cm metallic foreign body lodged in the upper thoracic esophagus. Note the double lucency of the outer edge, which differentiates this button battery from a coin.

risk for complications because the attraction across adjacent bowel loops can result in pressure necrosis of the bowel wall, volvulus, obstruction, formation of a fistula, perforation, or infection.⁹

Patients with multiple discrete magnets apparent on radiographs warrant referral to a pediatric specialty center to consider options for removal, including endoscopy or exploratory laparotomy. A single magnet identified in the esophagus or stomach is typically managed with observation alone unless the child has other risk factors warranting endoscopic removal. Subsequent imaging to follow progress of the magnet through the gastrointestinal tract should consist of biplane radiographs to ensure the absence of additional magnets that may not have been identified initially.¹⁰ Follow-up care with the primary care physician should be arranged prior to discharge, and both patients and caregivers should be instructed to avoid contact with any external magnets or metallic objects until passage has been confirmed.

Sharp objects: Pointed objects such as pins, needles, fish bones, and toothpicks pose a high risk for perforation if lodged in the esophagus, and a high risk of complications as they pass through the gastrointestinal tract. Any patient with a sharp foreign body visualized in the esophagus on x-ray should be



The lateral chest radiograph confirms the battery lodge just below the thoracic inlet and surrounding soft tissue swelling (arrows) mildly narrowing the upper trachea (asterisk). Note that in the lateral view, batteries have a beveled edge, which differentiate them from coins H&P at admission.

referred immediately to a pediatric specialty center. Many sharp objects, such as fish bones and toothpicks, are unlikely to be visualized on plain x-ray, and a high suspicion for ingestion of a sharp object warrants immediate referral for endoscopy. Once a sharp object has passed through the pylorus, discussion with a pediatric specialist is warranted to determine the need for immediate referral vs close follow-up.

- Large blunt objects: Objects larger than 5 cm have a high likelihood of impaction either at the level of the gastric outlet, duodenal sweep, or ileocecal valve.⁵ Any child with concern for intestinal obstruction or those found to have a large foreign body in the stomach should be referred to an appropriate facility for urgent removal. A large object that has passed into the small intestine may be managed by serial radiographs to follow its progression. Patients being discharged with close follow-up should receive anticipatory guidance on the signs of intestinal obstruction and perforation.
- Esophageal food impaction: Though food debris is the most common esophageal foreign body reported in adults, it is uncommon in children in the absence of underlying esophageal pathology.⁵ Food impaction usually presents as acute dysphagia while eating. These patients should be referred to an appropriate facility for a barium swallow esopho-

gram and endoscopic removal of the impacted food, if indicated.

- Superabsorbent materials: Items such as disposable diapers and feminine hygiene products pose a high risk for obstruction if ingested, with the capacity to expand up to 30 to 60 times their original size as they pass through the gastrointestinal tract.⁵ Radiographs are of little use in identifying these objects because they are radiolucent. Any patient with a suspicion for ingestion of these substances should be referred for possible exploratory endoscopy, direct observation, and surgical consultation as needed.
- Esophageal radiolucent objects: Any partially obstructing esophageal foreign body should be considered for removal, especially if it has been lodged in the esophagus for >24 hours. With the exception of batteries and magnets, small blunt objects that pass through to the stomach usually progress without any complications. Parents should be instructed to examine the stool for passage, and subsequent radiographs can be obtained if needed. If an object fails to progress over a period of 4 weeks, or the child develops symptoms of concern (eg, abdominal pain, vomiting, gastrointestinal bleeding) surgical intervention for removal may be indicated.⁴

Case Resolution

Biplane radiographs of this 2-year-old patient show a round object lodged in the upper esophagus. A "doublehalo" sign can be seen on the anteroposterior view, and there is a visible "'step-off" sign on the lateral view that are characteristic of a disk battery. It is common for children to mistake button batteries for coins, and in this case the battery had been dislodged from the hearing aid of a visiting grandparent. The patient was sent by EMS to the nearest hospital, where an airway specialty team escorted the patient to the operating room where the battery was endoscopically removed under anesthesia.

Summary

The majority of foreign body ingestions occur in children under the age of 3 years, making it difficult to obtain an accurate history. Once ingested, most objects pass through the gastrointestinal tract without incident, though the potential for serious complications does exist, particularly with certain objects and in certain locations. Successful management of suspected pediatric foreign body ingestions in an urgent care setting depends on a timely and accurate recognition of highrisk ingestions. Rapid referral for removal of an ingested

Swallowed Foreign Body?

- What is Most Common
 - Coins
 - Plastic toys
- What You Don't Want to Miss
 - Button battery
 - Multiple magnets
 - Radiolucent sharp objects

• What Needs Intervention:

- Object lodged at cricoid notch
- Button battery in the esophagus
- Food impaction in the esophagus
- Sharp object in the esophagus
- Multiple magnets
- What Needs Close Observation
 - Button battery in stomach
 - Large object in the stomach
 - Sharp object in the stomach

foreign body is indicated in the following situations:

- Signs of airway compromise (wheezing, stridor)
- Signs of esophageal obstruction (inability to handle oral secretions)
- A disk battery lodged in the esophagus
- Ingestion of a large, high-powered magnet or multiple magnets
- A sharp or large (>5 cm long or >2 cm wide) object in the esophagus or stomach
- Concern for intestinal obstruction or perforation (abdominal pain, vomiting)

For asymptomatic patients with low-risk ingestions, discharge is recommended with coordinated follow-up care and anticipatory guidance for signs of complications.

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ABSTRACTS IN URGENT CARE

- New Rapid Flu Tests
- PCI in Patients with Angina, Stenosis
- New Herpes Vaccine Recommendation
- Trimethoprim-Sulfamethoxazole in Skin Abscesses
- Low-Dose Corticosteroid for Sore Throat
- Preventing Disease in Organized Sports
- Contraindicated Drops Common in Conjunctivitis

GLENN HARNETT, MD

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

Innovative Rapid Tests Show Promise in Influenza

Key point: Novel DIAs and rapid NAATs had markedly higher sensitivities for influenza A and B in both children and adults than did traditional RIDTs, with equally high specificities.

Citation: Merckx J, Wali R, Schiller I et al. Diagnostic accuracy of novel and traditional rapid tests for influenza infection compared with reverse transcriptase polymerase chain reaction: a systematic review and meta-analysis. *Ann Intern Med*. 2017;167(6):394-409.

This meta-analysis of 162 studies summarized and compared accuracy of traditional rapid influenza diagnostic tests (RIDTs), digital immunoassays (DIAs), and rapid nucleic acid amplification tests (NAATs) in children and adults with suspected influenza. Pooled sensitivities for detecting influenza A from Bayesian bivariate random-effects models were 54.4% for RIDTs, 80.0% for DIAs, and 91.6% for NAATs. Those for detecting influenza B were 53.2% for RIDTs, 76.8% for DIAs, and 95.4% for NAATs. Pooled specificities were uniformly high (>98%) for all three types of testing. Of note, few NAAT studies reported adult-specific data, and none evaluated point-of-care testing. The data in this analysis are important, as sometimes appropriate antiviral therapy is withheld due to uncertainty in the diagnosis of influenza. This same uncertainty in diagnosis leads to higher usage of antibiotics. An



Glenn Harnett, MD is principal of the No Resistance Consulting Group in Mountain Brook, AL; a board member of the College of Urgent Care Medicine and the Urgent Care Foundation; and sits on the *JUCM* editorial board. editorial accompanying the article pointed out that the superiority of the newer rapid tests seems clear, and that their use in replacement of traditional tests is warranted. The authors went on to note that the rapid NAATs are more expensive than the other tests, and cost would need to be brought down to encourage wider use. They closed stating that the use of rapid NAATs may allow us to rationally increase the use of antivirals and decrease the unnecessary use of antibiotics.

No Improved Exercise Time with PCI vs Sham Procedure

Key point: Percutaneous coronary intervention (PCI) didn't improve exercise time relative to a sham procedure in patients with stable angina and coronary stenosis.

Citation: Al-Lamee R, Thompson D, Dehbi H-M, et al. Percutaneous coronary intervention in stable angina (ORBITA): a double-blind, randomized controlled trial. *Lancet*. 2017;6736 (17)32714-32719.

This double-blind, randomized controlled trial studied 230 patients with stable angina who had at least one significant lesion (70% blockage or more) in a single vessel. The results published in *Lancet* were presented at the 2017 Transcatheter Cardiovascular Therapeutics conference. All patients received 6 weeks of optimized antianginal medication prior to intervention. They also underwent treadmill exercise testing until they developed limiting symptoms, heart rhythm or blood pressure abnormalities, or significant ST-segment deviations. Patients were then randomized to undergo PCI with drug-eluting stents, or to receive a sham procedure in which they were sedated for at least 15 minutes and had their coronary catheter withdrawn

"Analysis suggests a single low-dose corticosteroid can relieve sore throat, with no increase in serious adverse effects."

without intervention.

Six weeks after PCI or sham, patients repeated the treadmill test. Patients had similar improvements in exercise time (28.4 more seconds with PCI vs 11.8 more seconds with placebo, P=0.200). The bulk of other endpoints yielded no differences between groups, either. The results show that even with severe coronary stenosis, exercise capacity and symptoms are not improved significantly compared with a placebo intervention vs PCI. PCI's sole significant advantage was the greater improvement of a patient's dobutamine stress echocardiography (DSE) peak stress wall motion score index (-0.08 vs +0.02, P=0.0011). This small study questions some key assumptions about the benefit of PCI in patients with stable angina. The researchers did emphasize that this study has no bearing on the treatment of acute coronary syndrome, for which PCI has been proven effective. However, an accompanying editorial urged that, based on these data, medical societies revise all cardiology guidelines to downgrade the recommendation for PCI in patients with angina despite use of medical therapy. The study also provokes questions about the need to evaluate interventions and devices with sham controls.

ACIP Weighs in on Herpes Zoster Vaccines

Key point: CDC immunization practice committee recommends new herpes zoster vaccine in a close vote.

Citation: Meeting of the Advisory Committee on Immunization Practices (ACIP), Centers for Disease Control and Prevention, October 25-26, 2017, Atlanta, GA.

The CDC's Advisory Committee on Immunization Practices (ACIP) voted in November to recommend use of a newly approved herpes zoster vaccine, called Shingrix (GlaxoSmithK-line). This vaccine, an inactivated, recombinant subunit, is given in two doses. The committee recommended its use for adults aged 50 years and older, after a 12-1 vote in its favor. In comparison, Zostavax, the other shingles vaccine currently available, is only recommended for patients 60 and older. A second vote on whether or not they should recommend Shingrix over Zostavax narrowly passed 8-7. The recommendations came after the committee reviewed data that showed Shingrix was more efficacious than Zostavax, particularly for older adults. Shingrix had 97% efficacy in those aged 50–69 and 91% efficacy in older adults and, importantly, efficacy was at least 85%

at 4 years postvaccination in those patients aged 70 and older. Dissenters expressed concerns about supply, unknown long-term safety issues, and lack of head-to-head comparisons. The committee also voted to recommend Shingrix for patients who had previously received Zostavax, with at least 8 weeks between vaccines. The number of patients in their 60s who would need to be vaccinated in order to prevent one zoster case was only 11.

Improved Outcomes in Skin Abscesses with Trimethoprim-Sulfamethoxazole

Key point: Treatment of skin abscesses with trimethoprim-sulfamethoxazole was associated with improved outcomes regardless of lesion size or guideline antibiotic criteria.

Citation: Talan DA, Moran GJ, Krishnadasan A, et al. Subgroup analysis of antibiotic treatment for skin abscesses. *Ann Emerg Med.* October 5, 2017. [Epub ahead of publication].

This article provided a subgroup analysis of a double-blind randomized trial performed at 5 U.S. emergency departments that recently demonstrated efficacy of methicillin-resistant Staphylococcus aureus (MRSA)-active antibiotics for drained skin abscesses. Among the 1,057 mostly adult participants, median abscess cavity and erythema diameters were 2.5 cm and 6.5 cm, respectively; 44.3% grew MRSA. Overall, for the trimethoprim-sulfamethoxazole and placebo groups, clinical cure rates at 7 to 14 days were 92.9% and 85.7%, respectively. The data were analyzed by subgroup across a variety of characteristics, including abscess cavity dimension <5 cm, erythema dimension <5 cm, past MRSA infection, fever, diabetes, or a major comorbidity. Trimethoprim-sulfamethoxazole was associated with improved outcomes across lesion sizes and among subgroups, including those who did and did not meet guideline antibiotic criteria. The treatment effect was greatest in patients with a history of MRSA infection, fever, or a positive MRSA culture.

New Trials on Corticosteroids in Sore Throat

Key point: A single dose of a corticosteroids improved pain relief in patients with acute sore throat.

Citation: Sadeghirad B, Siemieniuk RAC, Brignardello-Peterson R, et al. Corticosteroids for treatment of sore throat: systematic review and meta-analysis of randomised trials. *BMJ*. 2017;358:j3887.

This meta-analysis examined 10 trials that compared corticosteroids with standard care or placebo in about 1,400 patients (age 5 years and older) presenting with clinical signs of acute tonsillitis, pharyngitis, or the clinical syndrome of sore throat to either the emergency department or a primary care office. Single-dose oral dexamethasone (10 mg for adults, 0.6 mg/kg for children) was the most common steroid intervention. The stan-

ABSTRACTS IN URGENT CARE

dard of care frequently involved antibiotics, analgesics, or both. Complete resolution of pain at 24 hours was more common with than without corticosteroids (22% vs 10% of patients, relative risk 2.2, 95% confidence interval). Results were similar at a 48hour interval (61% vs 43%). The mean time to onset of pain relief in patients treated with corticosteroids was 4.8 hours earlier, and the mean time to complete resolution of pain was 11.1 hours earlier than in those treated with placebo. The absolute pain reduction at 24 hours was greater in patients treated with corticosteroids. Adverse events were uncommon and did not differ between groups. This analysis suggests that a single low-dose corticosteroid can provide pain relief in patients with sore throat, with no increase in serious adverse effects.

Inhibiting Infectious Disease in Organized Sports

Key point: The American Academy of Pediatrics (AAP) offers new guidance on preventing spread of infectious diseases associated with organized sports.

Citation: Davies HD, Jackson MA, Rice SG. Infectious diseases associated with organized sports and outbreak control. *Pediatrics*. 2017;140(4):e20172477;2017-2477.

In a recently published article in *Pediatrics*, the AAP has offered guidance on preventing and managing various infections associated with organized sports and details the types, treatments, and risk factors of infection, which are especially prevalent in close-contact sports such as football and wrestling. Infectious pathogens include those spread by skin contact, by contaminated food or water, by respiratory droplet, and by airborne particles and includes discussion of methicillin-resistant *Staphylococcus* aureus (MRSA), group A streptococcus, herpes simplex virus, tinea capitis, tinea pedis, scabies, and lice. About 10% to 15% of injuries that force college-level athletes to take time off from playing a sport are due to infectious disease, according to the AAP. Although biologically plausible, there have been no validated reports of infections from transmission of bloodborne pathogens, including hepatitis B, hepatitis C, or HIV during athletic competitions.

The clinical report says that pediatricians can help identify skin conditions and other infections during the preparticipation physical required for some athletes. They can also use the physical to educate student athletes about the importance of proper hygiene and of not sharing items like water bottles or razors. Besides showering and washing hands, athletes should also be discouraged from sharing their water bottles, towels, mouth guards, and other personal items.

They recommend routinely screening athletes for skin infections before and after competitions and during practices, and also state that coaches and trainers should develop a plan for proper cleaning and maintenance of all sporting facilities and equipment. They also point out that student athletes should "Patients were more likely to fill antibiotic prescriptions if they were first diagnosed by an optometrist, urgent care physician, internist, pediatrician, or family practitioner, vs ophthalmologist."

be up to date on their vaccinations. The article includes guidelines on return-to-practice and competition for infected athletes, which gives providers suggestions specific to each type of infection.

Contraindicated Drops Used Often in Acute Conjunctivitis

Key point: One out of every five patients who was diagnosed with acute conjunctivitis in this retrospective study filled prescriptions for antibiotic-corticosteroid combination drops, which are contraindicated for this condition.

Citation: Shekhawat NS, Shtein RM, Blachley TS, Stein JD. Antibiotic prescription fills for acute conjunctivitis among enrollees in a large United States managed care network. *Ophthalmology*. 2017;124(8):1099-1107.

Antibiotics are seldom necessary to treat acute conjunctivitis, but are very widely prescribed. This retrospective, observational cohort study examined a total of 340,372 enrollees in a large nationwide United States managed care network with newly diagnosed acute conjunctivitis, from 2001 through 2014. They identified patients diagnosed with acute conjunctivitis and calculated the proportion filling one or more topical antibiotic prescriptions. They also assessed sociodemographic, medical, and other factors associated with antibiotic prescription fills in acute conjunctivitis. Geographic variation in prescription fills also was studied. Of the 340,372 enrollees with acute conjunctivitis, 58% filled ≥ 1 topical antibiotic prescriptions. Of note, one out of every five antibiotic users filled prescriptions for antibiotic-corticosteroids, which are contraindicated for acute conjunctivitis. Also of note, patients had considerably higher odds of antibiotic prescription fills if they were first diagnosed by an optometrist, urgent care physician, internist, pediatrician, or family practitioner, compared with first diagnosis by an ophthalmologist. Antibiotic prescription fills did not differ for persons with risk factors vs without risk factors for development of serious infections. such as contact-lens wearers or patients with human immunodeficiency virus infection or AIDS. Filling antibiotic prescriptions was driven more by sociodemographic factors and type of provider diagnosing the enrollee than by medical indication.

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Boerhaave Syndrome in a 41-Year-Old Female

Urgent message: While Boerhaave syndrome is a rare finding, a relatively high number of cases may present in the urgent care setting. As such, awareness of and vigilance for related symptoms are essential to taking a proper history and, ultimately, early diagnosis of acute, subacute, or chronic Boerhaave syndrome.

JOHN SHUFELDT, MD, MBA, JD, FACEP, AMBER HAWKINS, and CARLI NICHTA, MS4

Introduction

Doerhaave syndrome is a spontaneous esophageal rupture indicated in some cases by Mackler's triad: subcutaneous emphysema, vomiting, and lower chest pain. Early diagnosis is critical for positive patient outcome, as this rare syndrome has a morbidity and mortality rate of 20%.¹ With half the cases of esophageal ruptures being iatrogenic, the second most common cause being spontaneous perforation, history is an important part of diagnosis.

Acute awareness of this rare syndrome and careful evaluation of patients with related signs and symptoms will help prevent missed diagnoses.

Case Presentation

A 41-year-old previously healthy female presents to the urgent care 12 hours after feeling like she had a piece of meat "stuck." She states she initially gagged and then vomited x 1. She denies that the meat was expelled, however after the event she felt better.

Subsequently, she developed midback pain that feels like a muscle strain and shoulder pain described as "achy."

- ROS is only positive for the back and shoulder pain.
- Past medical history is significant for hypertension, fibromyalgia, and obesity. She is status post lapband procedure.
- On her physical exam, her vitals are stable. She is



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afebrile. Other than her mild distress, her exam is normal. She has no abdominal tenderness, nor can you appreciate any abnormal heart or lung sounds.

 Chest x-ray is normal and the patient reports feeling better after a GI cocktail.

Introduction

The first historical record of spontaneous transmural

John Shufeldt, MD, MBA, JD, FACEP is the Interim Chief Medical Officer at San Carlos Healthcare Center in Peridot AZ and an Adjunct Professor at Creighton University School of Medicine. Amber Hawkins is a graduate of the University of Arizona and a care coordinator with MeMD. Carli Nichta, MS4, is a medical student at Creighton University School of Medicine. The authors have no relevant financial relationships with any commercial interests. esophageal rupture was documented by Dr. Herman Boerhaave regarding his patient Baron Jan Gerrit van Wassenaer.² Following a large 3-day feast, Admiral van Wassenaer developed an upset stomach after a ride on his horse. He attempted to relieve his pain with an emetic, but while vomiting his pain suddenly increased exponentially and he reported that he felt as if something had ruptured. His pain would last 16 hours before he died of septicemia, and Dr. Boerhaave found the patient's perforated esophagus on autopsy.

Boerhaave syndrome refers to a spontaneous transmural esophageal rupture from increased

intra-esophageal pressure, specifically secondary to vomiting or straining.

Presentation

The classic presentation of Boerhaave syndrome is severe retrosternal chest and upper abdominal pain coupled with a history of significant retching or vomiting.³ These classic symptoms may be accompanied by a crunching, rasping sound occurring in synchrony with the heartbeat on auscultation, also known as Hamman's sign.

Hamman's sign represents the presence of subcutaneous emphysema: when air from the ruptured esophagus infiltrates mediastinal tissues, the pressure of myocardial contraction creates a sound described by some as the "snap, crackle, pop" of Rice Krispies cereal.

These three findings: evidence of subcutaneous emphysema, history of vomiting, and chest pain make up Mackler's triad and are indicative of Boerhaave syndrome. Mackler's triad, however, is only present in about half of the patients with esophageal perforation.^{4,5} Thus, despite the recognition of clinical findings specific to Boerhaave syndrome, the absence of Mackler's triad is not evidence to rule out esophageal perforation.

At initial evaluation, Boerhaave syndrome may be overshadowed by more prevalent options on the differential diagnosis. Chest pain at initial presentation is always concerning for a myocardial infarction and will often warrant a thorough cardiac workup. It is important, however, to maintain a high index of suspicion for



esophageal perforation, especially when the chest pain localizes retrosternally with radiation to the back or left shoulder, or in the presence of a negative cardiac workup. One case report describes an esophageal perforation with complicated mediastinal involvement that presented with ECG changes of ST elevation in leads I, II, and a VL.⁶

Another potential convoluting factor is the association of nausea and vomiting with both myocardial infarction and esophageal perforation. Therefore, it is important to focus on obtaining a detailed, chronological history of symptom presentation, and assessment of risk factors.

A common misconception regarding life-threatening conditions is their presentation as acute, obvious, and easily identifiable. Many cases of Boerhaave syndrome will present in an urgent care environment. Furthermore, Boerhaave syndrome cases may present as acute, subacute, or chronic:

- Acute Boerhaave syndrome is defined as the development and presentation with symptoms within 24 hours of esophageal rupture.
- Subacute presentation occurs between 24 hours and 2 weeks following esophageal rupture.
- Chronic Boerhaave syndrome presents with subtle development of symptoms weeks to months after rupture.

Diagnosis of subacute and chronic Boerhaave syndrome is further complicated by the challenge of ascertaining an accurate history. To the typical patient there stands a significant disjunction between vomiting and the development of chest pain. Additionally, the more time passes between an initial vomiting event and the onset of symptoms secondary to esophageal perforation, the less related the two seem—certainly to the patient, and potentially to the evaluating provider.

Patients presenting with subacute and chronic cases of Boer-

haave syndrome, as well as elderly patients, have both been shown to be less likely to report a history of vomiting at diagnosis of Boerhaave syndrome. In the face of the nonspecific symptoms and elusive diagnostic findings, often history plays a key role in diagnosing esophageal perforation. Early damage occurs within the first 6 hours, with the most damage being at around 12 hours.⁷

Other presentations include pleural effusion (not uncommon presentation), duodenal ulcer perforation, tension pneumothorax, hydrothorax, pneumomediastinum, and collapse of the lung.

Risk Factors

Risk factors for Boerhaave syndrome are intimately linked to its pathogenesis of severe vomiting. Vomiting severe enough to cause esophageal perforation is most often seen with alcohol abuse and bulimia, though any event of sustained or single emesis has the potential to precipitate Boerhaave syndrome. In addition, men between the ages of 50 and 70 years are the most likely candidates for esophageal perforation. Often, the patients present with sepsis.⁷

Interestingly, the most common cause of esophageal perforation is iatrogenic, generally implicated during intubation procedures; however, 6.8% of esophageal perforations are spontaneous, and can be life-threatening if unrecognized and untreated.⁸ Other known cases are due to weight lifting, labor, epileptic episodes, straining for bowel movements, use of the Heimlich maneuver, external trauma, perforating trauma, and ingestion of caustic substances.^{1,9}

A related condition, Mallory Weiss syndrome, is also an esophageal pathology. Mallory Weiss syndrome, however is a longitudinal esophageal tear that does not extend beyond the mucosa, whereas Boerhaave is a full thickness perforation. Mallory Weiss syndrome is always associated with hematemesis, a strong distinction from Boerhaave

"Nonsurgical treatment involves the patient being restricted to NPO and given IV fluid, antibiotics, protein pump inhibitors, and pain treatment."

syndrome, which rarely has associated hematemesis.¹⁰

Evaluation

Evaluation of esophageal perforation begins with a chest x-ray. Despite its availability and popularity, plain film radiographs are unreliable for diagnosis or rule-out of Boerhaave syndrome. When present on chest x-ray, pneumomediastinum, or free air in the mediastinum, gives a fairly

limited differential diagnosis of esophageal rupture, asthma or alveolar rupture, bowel perforation, or *Mycoplasma pneumoniae* pneumonia. A detailed history would identify the diagnosis of Boerhaave syndrome in the presence of pneumomediastinum.

A leak can sometimes be identified if the chest x-ray can include a water-soluble contrast solution instead of barium, due to additional inflammation risk. In some cases, patients are unable to swallow, so a CT scan can also be used to reveal an esophageal perforation and potentially provide more information about its location. However, one study showed a false-negative rate of 15% to 25% using a CT scan or esophagogram with water-soluble contrast.¹⁰

Recently, the Pittsburgh group researched and published a decision-making protocol for evaluating esophageal perforations: the perforation severity score (PSS). Based on preexisting esophageal pathology and clinical presentation, three distinct groups were determined: low-, intermediate-, and high-severity perforation. The PSS was developed to guide decision-making in areas with different morbidities and outcome strata. The PSS evaluates age, tachycardia, leukocytosis, pleural effusion, noncontained leak, respiratory compromise, and time to diagnosis >24 hours and guides decision-making mainly with regard to proceeding with operative vs conservative management. While both useful and successful, the PSS assumes a known diagnosis of esophageal perforations.

Treatment

Early diagnosis and proper care are critical for survival of patients with Boerhaave syndrome. In some cases, nonsurgical treatment is best. Patients should be transferred to the ICU and/or surgery for further evaluation and treatment. Nonsurgical treatment involves the patient being restricted to NPO and given IV fluid, antibiotics, protein pump inhibitors, and pain treatment; in some

Summary

- Classic presentation of Boerhaave syndrome is severe retrosternal chest and upper abdominal pain coupled with a history of significant retching or vomiting, which may be accompanied by a crunching, rasping sound in synchrony with the heartbeat on auscultation (ie, Hamman's sign).
- Boerhaave syndrome is sometimes characterized by Mackler's triad (ie, subcutaneous emphysema, vomiting, and lower chest pain).
- Vomiting severe enough to cause esophageal perforation is most often seen with alcohol abuse and bulimia; however, any event of sustained or single emesis has the potential to precipitate Boerhaave syndrome.
- Mallory Weiss syndrome is a longitudinal esophageal tear that does not extend beyond the mucosa, whereas Boerhaave is a full thickness perforation.
- The perforation severity score (PSS) developed by the Pittsburgh group identified three groups, based on pre-existing esophageal pathology and clinical presentation: low-, intermediate-, and high-severity perforation. While both useful and successful, the PSS assumes a known diagnosis of esophageal perforations.

cases, a T-tube oesophagostomy is appropriate for reinforcement and to allow the damaged tissue to heal.¹

After the patient has stabilized, another treatment option, depending on severity, is surgical repair and close follow-up. Spontaneous rupture leads to a complicated and challenging surgery. Surgical treatment can be risky and, in the case of spontaneous perforation, the mortality rate is high and a function of length of time since onset. Surgery within <24 hours has a mortality rate of 36%; >24 hours, this number increases to 64% according to one study.¹¹ In all cases, the sooner the diagnosis and treatment onset, the better the patient outcome.

Case Resolution

In the present case, the chest x-ray performed in the urgent care was negative for mediastinal air. Because the provider had a high index of suspicion, the patient was transferred to the ED. At the hospital, the esophagogram was negative for both mediastinal air or extravasation. The CT of her chest, however, was positive for air in her mediastinum. She was admitted to the ICU after under-

going operative repair. Because of the early diagnosis, the patient made an uneventful recovery. ■

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HEALTH LAW AND COMPLIANCE

What HIPAA Is and What It's Not

ALAN A. AYERS, MBA, MACC

Urgent message: While many people perceive HIPAA as a law governing patient privacy, protection and standards for personal health information is only one aspect of this law, which was originally intended to regulate health insurance.

Introduction

A sk anyone—even the owner of an urgent care center—what HIPAA is, and they'll most likely tell you it's all about patient privacy. While the Health Insurance Portability and Accountability Act did establish national standards for the protection of individuals' medical records and other personal health information,¹ there are other aspects of the law—and many misconceptions that have created confusion for those in the healthcare industry.

This article will examine the true purposes of the law and what this historic legislation—as much concerned with insurance as privacy—entails, and why understanding HIPAA is important for urgent care center owners.

HIPAA—Not What You Think It Is

HIPAA was signed into law on August 21 ,1996, with a stated purpose to:

"...improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes."²

Note that the first part of the statement is to provide "portability and accountability of health insurance coverage for employees between jobs."³ Because of this mandate, the industry



Alan A. Ayers, MBA, MAcc is Vice President of Strategic Initiatives for Practice Velocity, LLC and is Practice Management Editor of *The Journal of Urgent Care Medicine*. simplified the administration of health insurance, which encouraged the digitization of patient health records. Computerization of patients' medical records, in turn, made it necessary to safeguard the security of that data in digital format.⁴

The other objectives of the Act were to promote the use of medical savings accounts (MSAs) by introducing tax breaks, provide coverage for employees with preexisting medical conditions, and simplify health insurance administration.⁴

Focus on Insurance

A primary concern addressed in HIPAA was ensuring that individuals would be able to maintain their health insurance between jobs. The relatively straightforward health insurance portability portion of the Act has been implemented successfully.⁵

For example, HIPAA precludes a group health plan insurer from enforcing an exclusion of preexisting medical conditions.⁵ One U.S. circuit court has explained that the effect of HIPAA in that situation is to increase the relative cost of the plan by compelling continued healthcare coverage for employees who are likely to incur greater-than-average healthcare expenses.⁶

A Louisiana federal district court held that to avoid a break in insurance coverage, an employee must apply to the state HIPAA pool within 63 days of the day group coverage ended. The court went on to explain that HIPAA requires that when an employee moves to a new job, her subsequent employer or health plan must give her "credit" for having held that prior continuous coverage.⁷ If an employee was provided insurance coverage by the previous employer or health plan for the requisite period of time with no gap in coverage of more than 63 days, the employee must be eligible for insurance from the new employer, regardless of any preexisting condition.⁷

Likewise, HIPAA prohibits group health plans and insurers offering coverage through group health plans from charging different premiums or contributions to "similarly situated individuals on account of any health status-related factor in relation to the individual[s]...."⁸

Application to Urgent Care Operators

It's important for urgent care operators to remember that

HIPAA is not a general medical privacy law. While complicated and confusing in some aspects, the Act provides protections to individuals in certain contexts—primarily where protected health information (PHI) originates with or flows through a HIPAA "covered entity," such as a healthcare provider or urgent care center. It applies to certain entities in certain situations only for certain information. Of these, patient consent is one of the areas most misconstrued by urgent care facilities

TPO Purposes in HIPAA. HIPAA provides for patient consent by assumption for certain categories of use and disclosure. The "assumption" is that there are certain kinds of uses and disclosures of patient information that are essential to the operation of the healthcare system. Collectively, these are known as TPO (Treatment, Payment for healthcare services, and healthcare Operations or administration).

The uses and disclosures that fit under TPO require no action. These disclosures make up a vast majority of the information use in the healthcare system.

Public Priority Purposes. These categories of disclosures make patient consent, in effect, irrelevant and unnecessary. These include public health disclosures, enforcement investigations, certain research, law enforcement, judicial and administrative proceedings, and several other purposes where there's a public goal served by the disclosure—independent of patient consent.⁹ These disclosures can be made without patient consent.

Patient Authorization. Aside from TPO and public priority purposes, disclosure can only be made with patient authorization, which is a specifically defined document executed by a patient in a particular situation.¹⁰ With this, a patient can "authorize" any use or disclosure of his information.

In addition to these notions of consent, the "minimum necessary" principle provides a blanket for most uses and disclosures. This means that an entity subject to HIPAA—even when a use or disclosure is permitted—is to disclose the "minimum necessary" information needed to perform the particular function.¹² It must make "reasonable efforts" to limit the use, disclosure, or request of protected health information to what's minimally necessary.¹¹

Experts say that this isn't a hard-and-fast rule, so urgent care center owners need not spend an inordinate amount of time and effort analyzing each disclosure. However, an owner should draft a set of general principles concerning how an urgent care determines what the "minimum necessary" information to be disclosed actually is. Employees will then need to be trained on these principles.

The HIPAA Privacy Rule. Under this rule, there's a requirement to develop specific administrative procedures to ensure compliance with HIPAA. To make this feasible, the U.S. Department of Health and Human Services developed a "flexible" approach to compliance by making the requirements "scalable" based on the characteristics of an organization.¹²

"Urgent care centers will provide better care by applying the true prerequisites and not using valuable resources based on fallacies and misunderstandings of HIPAA."

Misconceptions

With all the rules created by HIPAA, there are some broad and overreaching misconceptions that have confused and hampered urgent care business owners in the effective operation of their centers in attempting to comply with the Act. Here are four common inaccuracies:

- Unnecessary Business Associate Agreements. HIPAA requires urgent care centers to have written agreements called business associate agreements (BAAs) with other entities that receive or work with their PHI. The agreements say that the business associates will appropriately safeguard the information.¹³ However, some facilities take unneeded precautions with BAAs and have everyone sign a BAA though there's no need to make your cleaning service sign a BAA, for one, because they don't fall into the definition of a business associate. They're not interacting with PHI.
- Unnecessary Patient Authorizations. Many urgent care centers require a patient authorization prior to transferring patient information to another provider for treatment purposes. Although it's important to comply with HIPAA's requirements concerning access to PHI—because it's covered under TPO purposes¹⁴—there's no need to get authorization. This misunderstanding results in delays and confusion, as well as added stress between the patient and the provider. Again, if access is specifically necessary for treatment purposes, an urgent care center doesn't need a patient authorization.
- HIPAA Cancels Out All Other State and Federal Privacy Laws. This is not accurate. There are many other patient laws that apply to the privacy of medical data for HIV, mental health, substance abuse, sexual assault, domestic abuse, and the medical treatment of minors. Although HIPAA's privacy rules supersede many of the laws that are on the books in specific states, some state laws are still important in specific scenarios. Remember that HIPAA covers only *digital* medical information—not PHI that's oral or written. A state's medical privacy laws would most likely still cover PHI in hard copy. In addition, there are some state medical privacy laws that are more stringent than HIPAA, so those

HEALTH LAW AND COMPLIANCE

rules must also be consulted to get a full picture of medical privacy laws in a specific state.

HIPAA's Privacy Laws Apply to Industries Outside of Healthcare. While many industries are heavily regulated, HIPAA isn't applicable to hotels, retail stores, airlines, or veterinary clinics. None of these fit the HIPAA definition of a "covered entity." Remember, HIPAA's Privacy Rule covers health plans, healthcare clearinghouses, and healthcare providers.¹⁵

Conclusion

Contrary to some beliefs, HIPAA hasn't created a momentous change in the way healthcare is provided in the U.S.

Although it's complex, the law has been fashioned to meet the reality of medical practice. Compliance with its requirements is aided greatly by understanding what the Act truly means and separating fact from fiction. Urgent care centers will provide better care to their patients by applying the true prerequisites and not using valuable resources based on fallacies and misunderstandings of the law.

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CLINICAL CHALLENGE: CASE 1

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A 42-Year-Old Man with Thumb Pain After a Fall



Case

A 42-year-old man arrived at your urgent care center complaining of thumb pain a day after taking a fall while skiing. You find that the pain is worse with movement in any direction; in addition, he exhibits limited ability to grip anything using his thumb.

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

Figure 1.

INSIGHTS IN IMAGES: CLINICAL CHALLENGE

THE RESOLUTION



Figure 2.

Differential Diagnosis

- Avulsion fracture at the ulnar collateral ligament attachment
- Distal metacarpal fracture
- Extensor tendon rupture
- Metacarpophalangeal joint dislocation
- Proximal phalanx fracture

Diagnosis

There is a small defect at the ulnar corner base of proximal phalanx, seen on the AP view secondary to an avulsion fracture at the ulnar collateral ligament attachment.

Learnings

- Historically known as gamekeeper's thumb, this injury more currently is also referred to as skier's thumb because of the frequency with which it's associated with skiing accidents where the thumb is bent back by the ski pole
- This injury is often seen only on a good AP view of the thumb, and may not be visible on a standard hand x-ray exam

Pearls for Urgent Care Management and Consideration for Transfer

- Initial treatment is aimed at reducing swelling and pain, and immobilization of the affected joint
- Conservative treatment is possible for nondisplaced fractures.
- For displaced fractures, refer for surgical consideration. Patients are most likely to require surgical repair if the ligament injury is complete or displaced



An 82-Year-Old Man with Palpitations



Figure 1.

Case

An 82-year-old man presents with complaints of palpitations. He denies chest pain, shortness of breath, dizziness, fever, vomiting, or confusion.

Upon exam, you find:

- General: Alert and oriented
- Lungs: CTAB

- Cardiovascular: Regular and tachycardic without murmur, rub, or gallop
- Abdomen: Soft and nontender without rigidity, rebound, or guarding

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

THE RESOLUTION



ECG courtesy of Nicholas Patchett, MD.

Differential Diagnosis

- Sinus tachycardia
- AV block second degree—Mobitz I (Wenckebach)
- Multifocal atrial tachycardia
- Atrial fibrillation
- Third-degree AV block

Diagnosis

This patient has a Mobitz I (Wenckebach) second-degree AV block, revealed in the ECG by progressive lengthening of the PR interval until there is a nonconducted P wave. The first two arrows above show the PR interval lengthening; the last arrows a nonconducted P wave.

Learnings

- There is a progressive lengthening of the PR interval, until there is a nonconducted P wave (see arrows above)
- The P-P interval is typically constant

- Medical conditions which may cause Wenkebach include myocardial infarction, myocarditis, electrolyte abnormalities, and postcardiac surgery
- Medications include beta-blockers, calcium channel blockers, and digoxin

Pearls for urgent care management and considerations for transfer:

- Compare to previous ECG, if available
- Patients without identifiable cause after history do not require further testing
- Patients who are asymptomatic without an identifiable cause do not require treatment
- Patients who are symptomatic with tachycardia, hypotension, chest pain, shortness of breath, or altered consciousness should be transferred
- Distinguish from Mobitz II second-degree AV block and thirddegree AV block, which are not benign rhythms



INSIGHTS IN IMAGES CLINICAL CHALLENGE: CASE 3

A 22-Year-Old Man with an Itchy Patch of Skin



Case

A 22-year-old man presents to urgent care with a round, hyperpigmented patch on his arm. He reports that it's "itchy," and that it appeared soon after taking a second dose of a sulfonamide he's taking for a persistent sinus infection.

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

INSIGHTS IN IMAGES: CLINICAL CHALLENGE

THE RESOLUTION



Differential Diagnosis

- Contact dermatitis
- Drug-induced phototoxic reaction
- Fixed drug eruption
- Lichen planus

Diagnosis

This patient was diagnosed with a fixed drug eruption (FDE), a cutaneous drug reaction marked by sharply demarcated, typically round red patches that recur at the same body site each time an affected individual is re-exposed to the culprit drug.

Learnings

Red patches associated with FDE may vary from 0.5 cm to several centimeters in size. Though usually asymptomatic, they may be associated with burning, pain, or pruritus.

- Any cutaneous surface may be affected, but the oral and anogenital mucosa are involved most frequently.
- Treatment consists of eliminating the causative drug, if possible. First-generation antihistamines, mild topical steroids, and moisturizing lotions may be helpful in reducing symptoms.
- Drug classes most commonly associated with FDE include antibiotics (especially sulfonamides, trimethoprim, fluoro-quinolones, and tetracyclines), nonsteroidal anti-inflammatory medications (including naproxen, ibuprofen, and celecoxib), and barbiturates. Other specific implicated drugs include amoxicillin, erythromycin, metronidazole, fluconazole, paracetamol (acetaminophen), cetirizine, hydroxyzine, methylphenidate, oral contraceptives, quinine, and phenolphthalein. A nonpigmenting variant is seen with pseudoephedrine.



Understanding Case-Rate Reimbursement

DAVID E. STERN, MD, CPC

What is case-rate reimbursement, and how does it work in the urgent care sector?

A. *Case rate,* sometimes called *flat rate,* describes a reimbursement structure in which providers receive a flat reimbursement rate for every patient visit, no matter what service they provide.

Case-rate reimbursement means that the urgent care is contracted with the payor to receive the same reimbursement regardless of the acuity of care, whether it's the treatment of a hangnail or a complex laceration repair.

Will the simplification of case-rate reimbursement mean that my center will save a lot of the costs of revenue cycle management?

Although the initial coding and charge entry is somewhat simpler, case rate has many of the same complexities of fee-for-service reimbursement and actually *adds* complexity. Billing under a case rate is not as simple as billing the payor, and in 3-4 weeks the payor remits the full amount. Generally, even under a case rate, the patient is still responsible for any copays, coinsurance, or amount put toward the deductible; thus, much of the other work of revenue cycle management is essentially unchanged. In addition, any claim billed initially as a case rate and subsequently billed to a secondary payor under a fee-for-service contract is quite complex, and is different for every payor.

A fee-for-service model involves billing (often multiple) CPT and HCPCS codes under a contracted fee schedule for those codes. With fee-for-service, higher-acuity cases typically involve billing codes with higher reimbursement, and often billing multiple additional codes specific to the complexity of the case. On the other hand, with a case rate, acuity has no bearing on reimbursement.



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, LIC (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. "Case-rate contracts can be financially detrimental for urgent care centers that handle a high percentage of higher-acuity cases."

Although fee-for-service has been the longstanding reimbursement model in ambulatory care, many payors—such as Aetna/Coventry, Cigna, and UnitedHealthcare—no longer offer fee-for-service contracts for urgent care. However, even for these specific payors, this may vary from state to state, and by individual contract negotiations.

Many urgent care providers think a fee-for-service contract is more advantageous because they get paid for the level of care provided, but that's not always the case. Case-rate contracts can be more beneficial for urgent care centers that primarily handle low-acuity cases. Case-rate contracts, however, can be financially detrimental for urgent care centers that handle a higher percentage of moderate and higher-acuity cases. It's a matter of the cost of providing care vs the rate of reimbursement.

It is a good practice to understand what your fee-for-service contracts pay per visit. For a year (or another specific time frame), take your total dollars from adjudicated claims from a payor and divide by the number of visits. In some cases, you may be surprised to discover that your fee-for-service contracts may actually pay less, on average, than a given case rate. Yes, you may be paid a lesser amount on a specific complex case, but, overall, your average collections per visit will be more under the case rate.

If a case-rate reimbursement methodology is offered by a payor, some urgent care owners follow up with a request for a fee-for-service proposal. However, payors have generally developed specific policies for urgent care, and very few payors offer both options for urgent care centers.

REVENUE CYCLE MANAGEMENT Q&A

"Detailed coding information for claims billed with a single case-rate code can be useful when planning to renegotiate with a specific payor."

Is the HCPCS S9083 always the correct code to bill under a case-rate agreement?

A HCPCS code S9083 is the case-rate code "global fee urgent care centers." Some payors request to have caserate claims billed with code S9083 instead of billing the specific CPT codes for the services rendered. However, other payors request that you continue to bill with CPT codes despite the fact that they are reimbursing you at a flat rate.

In some instances, payors require urgent care centers to bill the CPT codes for all services rendered, and the payors then adjust everything in the back end to pay the urgent care centers the contracted case rate. Sometimes the payor wants the dollars billed for each CPT code to show on the claim, but other payors expect the additional codes to be billed at \$0. The reason that some payors may prefer to have providers submit the actual CPT codes is that a blanket case-rate code also does not provide any detailed utilization information, and the payor is unable to determine the levels of care that are being provided in the urgent care. For example, in recent months, BlueCross BlueShield of New Jersey has issued a directive to its case-rate clinics to bill all claims with CPT codes instead of S9083, which was what they used previously.

If a center is planning to renegotiate with a specific payor that is contracted under a case rate, it can be very useful to have detailed coding information for claims that were billed with a single case-rate code. If a center maintains this documentation, it can be useful to show that the center is performing substantial numbers of complex services, such as complex laceration repairs, intravenous hydration, casting, and other more complex services. This can provide documentation to argue effectively that the center is offering much more than minimal care and should receive higher reimbursement under a case rate.

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DEVELOPING DATA

How Patients Find a Healthcare Professional

very business—universally, in every field—survives on its ability to draw the right customers. For healthcare professionals, that means patients. In this age of on-demand service and walk-in appointments, more than at any other time, providers are also called upon to be astute marketers who know how to help patients find them when they need care.

Making the effort doesn't always assure success, however. So, it may be helpful to know that there are new, independent data giving us some idea of how the patient chooses healthcare providers. The 2017 Patient Access Journey Report from Kyruus reflects the views of 1,000 patients who reported searching for a healthcare provider within the past 2 years. Consider what it reveals when strategizing how to bring more new patients into your urgent care center. It's interesting to note there are disparities between what respondents reported as their preferred methods and how they actually ended up fining a provider.



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