

# JUCM<sup>®</sup>

THE JOURNAL OF **URGENT CARE** MEDICINE<sup>®</sup>

SEPTEMBER 2018  
VOLUME 12, NUMBER 11

**UCA** URGENT CARE  
ASSOCIATION

 COLLEGE OF  
URGENT CARE  
MEDICINE

www.jucm.com

The Official Publication of the UCA and CUCM

CLINICAL **cme**

## Looking Past the Complaint to Make a Life-Saving Discovery

### ALSO IN THIS ISSUE

#### 24 **Health Law and Compliance**

Sharing Workers' Comp Details  
without Violating HIPAA's Privacy  
Rule

#### 30 **Occupational Medicine**

You Get Just One Shot to Get the  
History Right

**cme**

#### 33 **Case Report**

When Healthy Patients Have a  
Potentially Deadly Condition

#### 43 **Revenue Cycle Management**

New ICD-10-CM Codes: Don't Leave  
Money on the Table



**cme**

#### **Practice Management**

Run an Ethical Business—  
Your Practice is Riding on It

# Serenity Now!

Cough? Congestion? Fever? Times three? That's right!



A weary mom and her three restless and very fussy children just checked in to your clinic. Not surprisingly, your other patients and staff are growing weary and restless too.

No sweat, because there's a better way to test for Flu and RSV. With Sofia® Influenza A+B FIA, Sofia® RSV FIA and the Sofia 2 platform with Advance Result Technology, you can quickly and accurately test the whole family. Giving mom, her kids, your patients and your staff the right result at the right time — restoring Serenity Now!

**Sofia 2 with Advance Result Technology**  
*Delivering accurate, objective and automated  
results in as few as three minutes!*



For information on how you can have results for Influenza A+B and RSV in as few as three minutes, call your Quidel account manager at **800.874.1517**, or visit us online at **quidel.com**.



**Sofia<sup>2</sup>**  
**Influenza A+B FIA**  
**RSV FIA**



## LETTER FROM THE EDITOR-IN-CHIEF

# Urgent Care and Antibiotics: Advancing Care and Stewardship



**A**ntimicrobial stewardship is defined as a coordinated program that promotes the appropriate use of antimicrobials, improves patient outcomes, reduces microbial resistance, and decreases the spread of infections caused by multidrug-resistant organisms.

Stewardship initiatives in hospitals are paving the way for the rest of healthcare through education campaigns, monitoring, and restrictions. Outpatient practice is beginning to catch up as the stories of resistance grow and the lines between nosocomial and community-acquired infections blur.

We all have a role to play in stewardship, and with education and careful communication, we can make a difference. Urgent cares can do a better job in this regard. As you have heard me say before, we practice in a unique setting with increased risks and challenges. Our lack of continuity relationships makes it difficult to build trust and ensure patients are progressing as expected.

All the while, we have a primary obligation to remain vigilant for serious bacterial illness and concerning complications.

In the end, I believe this issue is all about balance. Balancing risk, trust, and time is uniquely difficult in urgent care. Here are a few thoughts for you to consider as you build your own approach to this tricky subject:

- You can't win every battle, but you can make a dent in the armor.
  - Sometimes a back-up prescription is a useful tool to build trust so you can begin to chip away at some of the myths of antibiotics and their efficacy. E-prescription programs are even creating special "wait and see" prescriptions that are only filled upon patient request.
  - Referring those with recurrent URIs like "sinusitis" and "bronchitis" to a specialist for a better evaluation and treatment plan can be helpful for breaking the cycle of misuse. Demonstrate genuine concern for the patient and they will show appreciation.
- You'd be surprised what a little sensitivity can do. If you don't make people feel silly for coming in and if you don't downplay the severity of their symptoms, they are more likely to follow your guidance and appreciate your care.
  - I often will remind patients that many viral illnesses are far worse than bacterial infections. The degree

of illness does not determine need for antibiotics. Show empathy, and never say, "It's just a virus!"

- When antibiotics are indicated, use the narrowest-spectrum choice for the treatment of the infection. Follow IDSA guidelines if in doubt.
- Use your best judgement and don't ignore atypical courses of disease.
  - If a patient is getting worse after a period of getting better, strongly consider a bacterial superinfection like pneumonia.
  - Remember that early in an illness like pneumonia, infiltrates might not be seen. If you think a patient clinically has pneumonia, do not hesitate to treat it as such.
  - Those with cardiopulmonary disease; immunosuppression and other immunologic disease; cancer; and other comorbidities should be managed more aggressively. These are not the patients to stand on a stewardship soapbox for.
- For pharyngitis, only treat with antibiotics when testing is positive for strep (rapid test or culture).
- Children with a diagnosis of URI, bronchitis or serous otitis media should *not* receive antibiotics.
  - Most parents understand the need to avoid antibiotics for viral illness.
  - Most parents do not realize that bronchitis is a viral illness, but are happy to learn.

As noted in a separate column by Jasmeet Bhogal, MD and Laurel Stoimenoff, PT, CHC, (page 9), the Urgent Care Association and the College of Urgent Care Medicine are actively engaged in a campaign to improve antibiotic stewardship in the urgent care setting. With a collective effort, we can demonstrate our industry's commitment to this important issue and reduce unnecessary antibiotic use. ■

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



# Need an ECG or Spirometer?

**VECTRACOR**

*Diagnosing Better Care*



**Over 20 Years of Developing  
ECG & Spirometry Devices**

PC - USB Based  
3 Year Warranty  
Free Tech Support  
EMR - Email Compatible  
Reimbursable

***Be Accurate. Be Efficient. Be Smart.***

Ask about our **NEW SMART ECG TECHNOLOGY - VectraplexECG -**

- Detects ECG changes suggestive of a heart attack with patented Cardiac Electrical Biomaker (CEB)
- Derives a 15-Lead ECG using only 5 electrodes (V2 & Limbs)

**Call today +1 (973) 904 -0444 Ext. 2**

VectraCor.com

**Free Laptop**

with Vectraplex ECG purchase (\*V100001)

## *Awards*

- *New Product Innovation Leadership Award - Cardiac Monitoring*
- *Recipient of the EMS World Top Innovation Award*
- *The Society of Critical Care Medicine Scientific Award*

**VECTRACOR**  
*Diagnosing Better Care*





## CLINICAL

### 11 The Approach to the Hypertensive Patient in the Urgent Care Setting

Patients don't usually go to an urgent care center to manage their hypertension. Patients who are first diagnosed with hypertension in an urgent care center are another matter, however—and often, it's when they've presented with unrelated complaints.

*Taylor Fischer MMS, PA-C and Rebecca L. McClough, MPAS PA-C*

## PRACTICE MANAGEMENT

### 19 Building Ethical Organizations and Teams



Workplace ethics don't apply just to your clinical staff—and they're essential to building loyalty among workers and patients alike.

*Alan A. Ayers, MBA, MAcc*

## HEALTH LAW AND COMPLIANCE

### 24 HIPAA-Compliant Disclosure in Workers' Compensation



Figuring out what details of a workers' compensation case can be shared with the patient's employer—your client—can be tricky. Say too little and you risk losing the business; say too much and you'll wind up with a HIPAA violation.

*Alan A. Ayers, MBA, MAcc*

## OCCUPATIONAL MEDICINE

### 30 Taking the Occupational Medicine History



A thorough, occupational medicine-specific history is essential to identifying and resolving work-related injuries quickly and safely—for the benefit of the patient and the employer.

*Max Lebow, MD, MPH, FACEP, FACPM*

## CASE REPORT

### 33 Rhabdomyolysis in a Previously Healthy 33-Year-Old Man



Young, healthy patients with unexplained, noncardiac pain would probably never suspect they could have a life-threatening condition. The index of suspicion has to be much higher for clinicians, however.

*John Shufeldt, MD, JD, MBA, FACEP and Zana Alattar, MS3*

## IN THE NEXT ISSUE OF JUCM

The tide of sexually transmitted disease in the United States is turning—and not necessarily in a positive way. Take syphilis, for example; prevalence has been on the decline compared with other STDs in recent years, but occurrence is going up all of a sudden. It doesn't discriminate among potential hosts, either. There's no "typical" patient. The trick is to use your best history-taking skills to tease out red flags from patients. Once you do recognize patients at risk, diagnostic testing and treatment can be relatively simple. Learn more in the October issue of JUCM.

## DEPARTMENTS

- 6 Continuing Medical Education
- 9 From the UCA
- 27 Abstracts in Urgent Care
- 37 Insights in Images
- 43 Revenue Cycle Management Q&A
- 48 Developing Data

## CLASSIFIEDS

- 45 Career Opportunities

## TO SUBMIT AN ARTICLE:

JUCM utilizes the content management platform Scholastica for article submissions and peer review. Please visit our website for instructions at <http://www.jucm.com/submit-an-article>

## JUCM EDITOR-IN-CHIEF

### Lee A. Resnick, MD, FAAFP

Chief Medical and Operating Officer,  
WellStreet Urgent Care  
Assistant Clinical Professor, Case Western  
Reserve University,  
Department of Family Medicine

## JUCM EDITORIAL BOARD

### Alan A. Ayers, MBA, MAcc

CEO, Velocity Urgent Care

### Jasmeet Singh Bhogal, MD

Medical Director, VirtuaExpress Urgent Care  
President, College of Urgent Care Medicine

### Tom Charland

CEO, Merchant Medicine LLC

### Jeffrey P. Collins, MD, MA

Chief Medical Officer,  
MD Now Urgent Care  
Part-Time Instructor, Harvard Medical School

### Tracey Quail Davidoff, MD

Rochester Regional Health/  
Immediate Care  
Senior Clinical Instructor,  
Dept. of Emergency Medicine,  
Rochester General Hospital

### Thomas E. Gibbons, MD, MBA, FACEP

President-Elect, Columbia Medical Society

### William Gluckman, DO, MBA, FACEP, CPE

CEO, FastER Urgent Care

### David Gollogly, MBChB, FCUCP (New Zealand)

Chair, Royal New Zealand College of  
Urgent Care

### Glenn Harnett, MD

Principal, No Resistance Consulting Group  
Trustee, UCA Urgent Care Foundation

### Toni Hogencamp, MD

Regional Medical Director, PM Pediatrics  
Founding Member, Society for Pediatric Urgent  
Care

### Sean M. McNeeley, MD

Network Medical Director, University  
Hospitals Urgent Care  
Clinical Instructor, Case Western Reserve  
University School of Medicine  
UCA President

### Shailendra K. Saxena, MD, PhD

Professor, Creighton University  
Medical School

### Elisabeth L. Scheufele, MD, MS, FAAP

Physician, Massachusetts General Hospital  
Chelsea Urgent Care  
Physician Informaticist

### Laurel Stoimenoff, PT, CHC

CEO, Urgent Care Association of America

### Joseph Toscano, MD

Chief, Emergency Medicine  
Medical Director, Occupational Medicine  
San Ramon Regional Medical Center  
Board Member, Board of Certification in  
Urgent Care Medicine

### Janet Williams, MD, FACEP

Medical Director, Rochester Regional Health  
Immediate Care  
Clinical Faculty, Rochester Institute of  
Technology

## JUCM ADVISORY BOARD

### Kenneth V. Iserson, MD, MBA, FACEP, FAAEM

The University of Arizona

### Peter Rosen, MD

Harvard Medical School

### Martin A. Samuels, MD, DSc (hon), FAAN, MACP

Harvard Medical School

### Kurt C. Stange, MD, PhD

Case Western Reserve University

### Robin M. Weinick, PhD

RTI International

## UCA BOARD OF DIRECTORS

### Sean McNeeley, MD

President

### Pamela C. Sullivan, MD, MBA, FACP, PT

Immediate Past President

### Richard Park, MD, BS

President-Elect

### Shaun Ginter, MBA, FACHE

Treasurer

### Lou Ellen Horwitz, MA

Secretary

### Joe Chow, MD, MBA

Director

### Mike Dalton, MBA, CPA

Director

### Max Lebow, MD, MPH

Director

### Damaris Medina, Esq

Director

### Armando Samaniego, MD, MBA

Director

### Jeanne Zucker

Director

### Laurel Stoimenoff, PT, CHC

CEO



## EDITOR-IN-CHIEF

### Lee A. Resnick, MD, FAAFP

editor@jucm.com

## MANAGING EDITOR

### Harris Fleming

hfleming@jucm.com

## ASSOCIATE EDITOR, PRACTICE MANAGEMENT

### Alan A. Ayers, MBA, MAcc

## ASSOCIATE EDITOR, CLINICAL

### Michael B. Weinstock, MD

## CONTRIBUTING EDITORS

### Glenn Harnett, MD

### David E. Stern, MD, CPC

## ART DIRECTOR

### Tom DePrenda

tdeprenda@jucm.com



185 State Route 17, Mahwah, NJ 07430

## PUBLISHER AND ADVERTISING SALES

### Stuart Williams

swilliams@jucm.com • (201) 529-4004

## CLASSIFIED AND RECRUITMENT ADVERTISING

### Joseph Petit

Joseph.petit@communitybrands.com • (727) 497-6565 x3706

## Mission Statement

JUCM The Journal of Urgent Care Medicine (ISSN 19380011) supports the evolution of urgent care medicine by creating content that addresses both the clinical practice of urgent care medicine and the practice management challenges of keeping pace with an ever-changing healthcare marketplace. As the Official Publication of the Urgent Care Association and the College of Urgent Care Medicine, JUCM seeks to provide a forum for the exchange of ideas regarding the clinical and business best-practices for running an urgent care center.

## Journal Ethics

JUCM® expects the highest ethical standards from its authors, reviewers, and editors when conducting research, submitting papers, and throughout the peer-review process. JUCM® has applied to be a member of the Committee on Publishing Ethics (COPE) and follows its recommendations on publication ethics and standards. For additional information on COPE, please visit <http://publicationethics.org/>.

## Allegations of Editorial Misconduct, Complaints, or Appeals

To report any allegations of editorial misconduct or complaints, or to appeal any article, email the publisher, Stuart Williams, directly at [swilliams@jucm.com](mailto:swilliams@jucm.com).

## Affiliations

JUCM The Journal of Urgent Care Medicine ([www.jucm.com](http://www.jucm.com)) is published by agreement between Braveheart Group, LLC and the Urgent Care Association ([www.ucaoa.org](http://www.ucaoa.org)) and the College of Urgent Care Medicine ([www.uccop.org](http://www.uccop.org)).

## Disclaimer

JUCM The Journal of Urgent Care Medicine (JUCM) makes every effort to select authors who are knowledgeable in their fields. However, JUCM does not warrant the expertise of any author in a particular field, nor is it responsible for any statements by such authors. The opinions expressed in the articles and columns are those of the authors, do not imply endorsement of advertised products, and do not necessarily reflect the opinions or recommendations of Braveheart Publishing or the editors and staff of JUCM. Any procedures, medications, or other courses of diagnosis or treatment discussed or suggested by authors should not be used by clinicians without evaluation of their patients' conditions and possible contraindications or dangers in use, review of any applicable manufacturer's product information, and comparison with the recommendations of other authorities.

## Advertising Policy

Advertising must be easily distinguishable from editorial content, relevant to our audience, and come from a verifiable and reputable source. The Publisher reserves the right to reject any advertising that is not in keeping with the publication's standards. Advertisers and advertising agencies recognize, accept, and assume liability for all content (including text, representations, illustrations, opinions, and facts) of advertisements printed, and assume responsibility for any claims made against the Publisher arising from or related to such advertisements. In the event that legal action or a claim is made against the Publisher arising from or related to such advertisements, advertiser and advertising agency agree to fully defend, indemnify, and hold harmless the Publisher and to pay any judgment, expenses, and legal fees incurred by the Publisher as a result of said legal action or claim.

## Copyright and Licensing

© Copyright 2018 by Braveheart Group, LLC. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording, or any information storage and retrieval system, without written permission from the Publisher. For information on reprints or commercial licensing of content, please contact the Publisher.

## Address Changes

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



**M**any patients probably approach a visit to the urgent care center with a fair amount of certainty, bordering on an affirmed self-diagnosis. How many times have you or a colleague heard, *It's a sinus infection, I just came in so you can prescribe an antibiotic?*

One of the challenges for the provider, of course, is to listen to what the patient has to say but not be bound by it. Often, there are things going on they may have no idea about—things that could prove to have severe consequences if they're not addressed.

High on the list of those previously unknown diagnoses: hypertension. There's a reason it's called "the silent killer"; for many, it has no obvious symptoms until there's a crisis. Urgent care clinicians are positioned perfectly to discover high blood pressure in patients who might otherwise never have a chance to take corrective action. And that's the subject of this week's cover article.



The Approach to the Hypertensive Patient in the Urgent Care Setting (page 11), by **Taylor Fischer, MMS, PA-C** and **Rebecca L. McClough,**

**MPAS, PA-C** looks at the cases of four patients who visited an urgent care center for reasons completely unrelated to concerns about their blood pressure. Close attention to the vital signs prompted the examining physicians to look further than the presenting complaint to make a crucial diagnosis.

Mr. Fischer is an assistant professor at Wingate University, Hendersonville Campus and a medical provider at Mission Health System. Ms. McClough is director of Clinical Education and an assistant professor in the Harris Department of PA Studies at Wingate.

Then there are patients who think because they take excellent care of themselves, eating right and exercising, that whatever ails them couldn't be anything serious. The consequences of this could be just as dire as undiagnosed hypertension. *Rhabdomyolysis in a Previously Healthy 33-Year-Old Man*, by **John Shufeldt, MD, JD, MBA, FACEP** and **Zana Alattar, MS3** tells the story of one such patient. It starts on page 33.

Dr. Shufeldt is the interim chief medical officer at San Carlos Apache Healthcare Center and chief executive officer of US Careways. Ms. Alattar is an MD candidate in the University of Arizona College of Medicine – Phoenix, Class of 2020.

In all patient presentations, in all settings, clinicians are expected to uphold the highest ethical standards. When it comes to nonclinical staff, however, the rules are less official. It's up to each operation to make sure employees know what's

expected of them. As **Alan Ayers, MBA, MAcc**, CEO of Velocity Urgent Care and the practice management editor of *JUCM*, explains in *Building Ethical Organizations and Teams*, an ethical workplace culture is a required element of any successful practice.



The article starts on page 19.

Different standards come into play when working with occupational medicine patients. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has strict rules as to what patient information can be shared with whom. The details of how to do balance the client's needs with the patient's can be tricky. Fortunately, Mr. Ayers' second article in this issue has some answers on how to pull it off. HIPAA-Compliant Disclosure in Workers' Compensation begins on page 24.

Treating occupational medicine patients, in general, has distinct similarities and differences compared with "typical" urgent care patients. That starts with the history, as explained by **Max Lebow, MD, MPH, FACEP, FACPM** in *Taking the Occupational Medicine History* on page 30. A regular *JUCM* contributor on the topic of occupational medicine, Dr. Lebow is president and medical director of Reliant Immediate Care Medical Group.



## Also in this issue:

**Glenn Harnett, MD** reviews new articles on upcoming changes to fluoroquinolone labels, AAP's thoughts on the upcoming flu season, and more. Abstracts in Urgent Care starts on page 27. Dr. Harnett is principal, No Resistance Consulting Group.

Finally, in Revenue Cycle Management Q&A (page 43), **David Stern, MD, CPC** provides highlights of changes by the International Classification of Disease, 10<sup>th</sup> Revision. This information is essential information for every urgent care coder. Dr. Stern is the CEO of Practice Velocity; Urgent Care Consultants; and PV Billing.

## Thanks to Our Peer Reviewers

Our aim at *JUCM* is to provide content that is relevant, practical, and of high interest to urgent care clinicians and operators. We are aided tremendously in those efforts by industry leaders who volunteer their time to read and comment on key articles in every issue. This month, we want to thank the following:

**Barbara Chambers**

**Kent Erickson, MD**

**David Pick, MD**

**John Reilly, DO ■**







# CONTINUING MEDICAL EDUCATION

**Release Date:** September 1, 2018

**Expiration Date:** August 31, 2019

## Target Audience

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

## Learning Objectives

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

## Accreditation Statement



SCHOOL OF MEDICINE  
CASE WESTERN RESERVE  
UNIVERSITY

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Case Western Reserve University School of Medicine and the Institute of Urgent Care Medicine. Case Western Reserve University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

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

## Planning Committee

### • Lee A. Resnick, MD, FAAPF

*Member reported no financial interest relevant to this activity.*

### • Michael B. Weinstock, MD

*Member reported no financial interest relevant to this activity.*

### • Alan A. Ayers, MBA, MAcc

*Member reported no financial interest relevant to this activity.*

## Disclosure Statement

The policy of Case Western Reserve University School of Medicine CME Program (CWRU CME) requires that the Activity Director, planning committee members, and all activity faculty (that is, anyone in a position to control the content of the educational activity) disclose to the activity participants all relevant financial relationships with

commercial interests. Where disclosures have been made, conflicts of interest, real or apparent, must be resolved. Disclosure will be made to activity participants prior to the commencement of the activity. CWRU CME also requires that faculty make clinical recommendations based on the best available scientific evidence and that faculty identify any discussion of "off-label" or investigational use of pharmaceutical products or medical devices.

## Instructions

To receive a statement of credit for up to 1.0 *AMA PRA Category 1 Credit™* per article, you must:

1. Review the information on this page.
2. Read the journal article.
3. Successfully answer all post-test questions.
4. Complete the evaluation.

Your credits will be recorded by the CWRU CME Program and made a part of your cumulative transcript.

## Estimated Time to Complete This Educational Activity

This activity is expected to take 3 hours to complete.

## Fee

There is an annual subscription fee of \$145.00 for this program, which includes up to 33 *AMA PRA Category 1 Credits™*.

## Email inquiries to [info@jucmcme.com](mailto:info@jucmcme.com)

## Medical Disclaimer

As new research and clinical experience broaden our knowledge, changes in treatment and drug therapy are required. The authors have checked with sources believed to be reliable in their efforts to provide information that is complete and generally in accord with the standards accepted at the time of publication.

Although every effort is made to ensure that this material is accurate and up-to-date, it is provided for the convenience of the user and should not be considered definitive. Since medicine is an ever-changing science, neither the authors nor Case Western Reserve School of Medicine nor any other party who has been involved in the preparation or publication of this work warrants that the information contained herein is in every respect accurate or complete, and they are not responsible for any errors or omissions or for the results obtained from the use of such information.

Readers are encouraged to confirm the information contained herein with other sources. This information should not be construed as personal medical advice and is not intended to replace medical advice offered by physicians. Case Western Reserve University School of Medicine will not be liable for any direct, indirect, consequential, special, exemplary, or other damages arising therefrom.





## CONTINUING MEDICAL EDUCATION

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

### The Approach to the Hypertensive Patient in the Urgent Care Setting (p. 11)

**1. Hypertension is a significant risk factor for:**

- a. Myocardial infarction
- b. Chronic heart failure
- c. Kidney disease
- d. Stroke
- e. All of the above

**2. All of the following medications may increase blood pressure, except:**

- a. Naproxen
- b. Methylphenidate
- c. Amoxicillin
- d. Pseudoephedrine
- e. Ortho Evra

**3. Hypertension is the most common cardiovascular risk factor in the United States and accounts for an estimated 41% of cardiovascular disease (CVD) related deaths**

- a. True
- b. False

### Building Ethical Organizations and Teams (p. 19)

**1. Which of the following would be considered common ethical dilemmas likely to be faced in the urgent care environment?**

- a. Covering for a colleague who is impaired due to drug or alcohol use, or illness
- b. Misuse of the prescription pad
- c. Failing to exercise proper hygiene and sanitization standards and protocols
- d. None of the above
- e. All of the above

**2. More than 40% of employees in the U.S. have witnessed illegal or unethical activity at work.**

- a. True
- b. False

**3. The foundation for building an ethical workplace culture starts:**

- a. At the top
- b. At the front desk, since that's the patient's first point of contact
- c. With the clinical staff
- d. With billing and coding

### Rhabdomyolysis in a Previously Healthy 33-Year-Old Man (p. 33)

**1. What is the classic triad of rhabdomyolysis?**

- a. Fever, weakness, cough
- b. Muscle pain, weakness, and tea-colored urine
- c. Muscle pain, fever, confusion
- d. Hypotension, dysuria, flank pain

**2. All of the following are helpful lab tests to evaluate for rhabdomyolysis except:**

- a. Serum myoglobin levels
- b. Creatinine
- c. Electrolytes
- d. Urine screen for myoglobinuria
- e. Rapid strep test

**3. A normal physical exam excludes the diagnosis of rhabdomyolysis**

- a. True
- b. False

# New Frontiers

## 2018 Urgent Care Fall Conference

OCTOBER 12-14 • HOUSTON, TEXAS • MARRIOTT MARQUIS

### Awaken your inner adventurer and launch into New Frontiers

Explore ingenious strategies, gain unique perspectives and receive smart advice to approach the practice of urgent care differently, defy current limitations and endeavor long-term success.

Visit the website for information on how you will be able to "create your own adventure" for the first time ever at this year's conference. We will not only inspire you to do better, but be better - it's the *New Frontier!*

Register at [ucaoa.org/2018fall](http://ucaoa.org/2018fall) or call 877-698-2262

FOLLOW US / #UCA18HOUSTON [f](#) [in](#) [t](#) [v](#)



COLLEGE OF  
URGENT CARE  
MEDICINE



**More than 600 UCA Accredited Centers  
have *raised the bar* and it's getting noticed!  
Don't get left behind - join them today**

### Steps to accreditation:

- Complete application
- Study the Standards and Prep Manual to prepare for your survey
- Schedule your on-site visit
- Complete your survey
- Need help? We have consultants available to help you prepare through the Urgent Care Services Corporation

**Learn more and apply today  
at [ucaoa.org/AUC](http://ucaoa.org/AUC)**

Ensure that your organization is providing the highest level of safety measures, quality of care and scope of services to your patients by getting accredited today!



# Our Finest Hour

■ JASMEET BHOGAL, MD and LAUREL STOIMENOFF, PT, CHC

As you are most likely aware, the Centers for Disease Control and Prevention published a retrospective analysis of antibiotic prescribing, comparing urgent care centers, retail clinics, emergency departments, and other practice settings. Using 4-year-old data, the CDC assigned the site where a prescription originated using only place-of-service codes, and determined the appropriateness of a pharmacy-dispensed antibiotic based on the ICD-9 code. The study indicated that urgent care centers were prescribing inappropriately at a higher percentage than the other three sectors.

The publication was released the same day representatives of the College of Urgent Care Medicine, the Urgent Care Association, urgent care clinical and operational stakeholders, EHR leadership, and payer representatives were attending a summit cosponsored by UCA, the CDC, and the Antibiotic Resistance Action Center (ARAC).

The story was picked up by a number of media outlets, with “urgent care” prominent in the headlines. But let’s look at the numbers more closely in order to maintain some perspective. Even if the prescribing percentage is a true reflection of the actual rate, based on a limited set of diagnoses urgent care centers would have been responsible for 201,000 unnecessary prescriptions compared to 1.6 million in the remaining groups.

While concerns were expressed about the methodology, all industry representatives agreed that urgent care medicine has an opportunity to be part of the solution and take a leadership role in appropriate antibiotic prescribing.

## A Serious Threat

Since their initial use in the 1940s, antibiotics have alleviated tremendous suffering and have saved millions of lives. Many organizations, including the CDC and the World Health Organization, agree that antibiotic resistance has become an increasing problem over the ensuing decades. On the Antibiotic/ Antimicrobial Re-

*“We must continue to provide the highest quality care...while helping providers and patients improve antibiotic prescribing and utilization.”*

sistance page of its website, the CDC estimates that at least 2 million people become infected with bacteria that are resistant to antibiotics each year in the United States, and that at least 23,000 people die each year as a direct result of these infections.

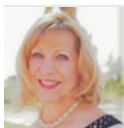
## Our Finest Hour

As we head to Houston for the UCA Fall Conference, it is appropriate that we remember the words of Apollo 13 Flight Director Gene Kranz. Overhearing others lamenting the likely fate of the mission, he rallies his team by saying “With all due respect sir, I believe this is going to be *our finest hour*.”

We have a responsibility to make this our finest hour. We need to each take responsibility in our area of influence to effect change. CUCM has created an Antibiotic Stewardship Toolkit, available on UCA’s website. The CDC also has a plethora of resources and training programs, and has committed to ongoing public education. UCA, the Urgent Care Foundation, and CUCM will apply additional energies toward educational and stewardship resources. We must continue to pursue the overarching goal of providing the highest quality care to our patients, while helping providers and patients in positively improving antibiotic prescribing and utilization practices.

The Foundation will cohost a stewardship summit in Houston immediately following our Fall Conference. During that summit, we will work toward clearly articulated, solution-focused deliverables.

Many organizations have made a stewardship commitment. They have demonstrated success and are willing to share how they brought about change. Collectively, we can and will make a difference. We will report back to the media and it will be our finest hour. In the interim, continue to make a difference providing exceptional healthcare to your communities. UCA will persevere to ensure that message remains at the forefront. See you in Houston! ■



**Jasmeet Bhogal, MD** is President of the Board of the College of Urgent Care Medicine. **Laurel Stoimenoff, PT, CHC** is Chief Executive Officer of the Urgent Care Association.



# WHO'S YOUR **READER?**



I AM DAVID COHEN,  
**BOARD CERTIFIED  
RADIOLOGIST.**

I TRAINED AT THE  
UNIVERSITY OF  
MIAMI AND HAVE  
**20 YEARS  
RADIOLOGY  
EXPERIENCE.**

I DEMAND A  
**PERFECT  
OVER READ  
ACCURACY RATE.**

**DR. COHEN IS ONE OF 90+ U.S. BASED, BOARD CERTIFIED  
RADIOLOGISTS PARTNERED WITH TELERADIOLOGY SPECIALISTS.**

Let our network of radiologists come work for you! With a 99.97% accuracy rate and a TAT of thirty minutes or less, your patients will get an accurate diagnosis quickly. #WhosYourReader

**Call for your free quote. 888-779-9738 | [teleradiologyspecialists.com](http://teleradiologyspecialists.com)**



# The Approach to the Hypertensive Patient in the Urgent Care Setting

**Urgent message:** Previously undiagnosed hypertension is common among ambulatory patients, and urgent care providers are often the first to recognize and diagnose this condition. Initiating treatment, testing, and providing patient education and follow-up are well within the scope of urgent care practice and help ensure positive outcomes. Being attentive to the presentation and care of hypertensive emergencies is also paramount.

TAYLOR FISCHER MMS, PA-C AND REBECCA L. MCCLOUGH, MPAS PA-C

Hypertension (HTN) affects approximately 29% of American adults, according to the latest report released from the Centers for Disease Control.<sup>1</sup> While typically this disease process is diagnosed and managed by the patient's primary care provider, there may be times that a patient presents to the urgent care center with either high blood pressure (BP) as a secondary finding or with symptoms that are sequelae of high BP. The task for an urgent care provider includes defining and managing HTN, determining the need for testing, and recommending appropriate follow-up.

In this article, we first examine the process for identifying patients with "simple" elevated BP—those who might likely be categorized as prehypertensive or hypertensive—and then patients who may be in hypertensive crisis or hypertensive emergency.

## Patients with Elevated Blood Pressure

The following patients represent two common presentations to the urgent care center:

- A 40-year-old female complains of right ankle pain after twisting it. She appears to be in a substantial amount of pain and has to be helped from her vehicle into the clinic. She denies any known medical problems, takes no medications, and does not smoke. She took two 200 mg of ibuprofen without relief. On exam, her right ankle is swollen over the lateral malleolus with ecchymosis. Her blood pressure upon



©fotolia.com

**Taylor Fischer MMS, PA-C** is Assistant Professor, Wingate University, Hendersonville Campus and a medical provider at Mission Health System. **Rebecca L. McClough, MPAS PA-C** is Director of Clinical Education/Assistant Professor, Wingate University: Harris Department of PA Studies. The authors have no relevant financial relationships with any commercial interests.

two readings in the office is 148/90 and 152/96.

- A 52-year-old male presents for a pre-employment physical examination. He does not have a primary care provider. He smokes one pack of cigarettes per day. He has no current complaints, and specifically denies chest pain, shortness of breath, and headaches. His blood pressure readings in the office are 158/92 and 160/92. Both cases represent significant challenges.

### Definitions

HTN can either be classified as primary (essential) or secondary.

- *Primary HTN* accounts for an estimated 95% of all HTN cases. It does not have a well-defined cause, but rather has been linked to predisposing factors including, but not limited to, family history, diet, lack of exercise, and obesity.
- *Secondary HTN* refers to elevated BP caused by another medical condition. Commonly associated causes of secondary HTN are conditions that affect a patient's kidneys or cardiovascular or endocrine systems.<sup>3</sup>

The newest Joint National Committee (JNC 8) Hypertension Guideline place more emphasis on age, race, and comorbidities to determine the appropriate systolic blood pressure (SBP) and diastolic blood pressure (DBP) than do previous recommendations. These guidelines are utilized specifically for guiding hypertensive treatment. Most organizations utilize the following parameters for staging HTN:

- Normal blood pressure:  $\leq 120/80$
- Stage 1 HTN: SBP/DBP of  $\geq 140/90$  mmHg
- Stage 2 HTN: SBP/DBP of  $\geq 160/100$  mmHg<sup>2</sup>

There is a linear relationship between SBP as low as 115 mmHg and cardiovascular risks. Based on these data, it is recommended that BP readings of 120-139/80-89 mmHg be treated as *prehypertensive* because half of these patients will go on to develop HTN in the next 4 years.<sup>3</sup>

A person is *hypertensive* at a systolic blood pressure of  $\geq 140/90$ .<sup>2</sup> At this level, there is increased risk of kidney disease, intracranial hemorrhage, myocardial infarction, heart failure, and a host of other life-threatening problems. Furthermore, there is a linear relationship between increasing blood pressure and mortality from cardiovascular disease and between increasing BP and mortality from

*“Half of those with HTN are uncontrolled or may not be aware of the diagnosis; the urgent care provider may be the first to diagnose it.”*

ischemic stroke.

*Hypertensive crises* are designated as BP readings of  $\geq 180/120$  mmHg,<sup>4</sup> with a *hypertensive emergency* defined as elevated blood pressure with signs of end organ damage. These will be discussed in greater detail later.

### Consequences and Related Disease Processes

Hypertension is the most common cardiovascular risk factor in the United States, accounting for an estimated 41% of cardiovascular disease (CVD)-related deaths.<sup>9,10</sup> It is also considered a significant risk factor for myocardial infarction (MI), chronic heart failure (HF), and stroke. Seven out of 10 people having their first heart attack also have HTN, as do eight of 10 people who suffer from a stroke.<sup>10,11</sup>

In 2013, more than 360,000 deaths in the American adult population included HTN as a primary or contributing cause of death.<sup>11</sup> By lowering blood pressure 10 mmHg, lifetime risk for CVD- and stroke-related death decreases by 25% – 45%.<sup>2</sup> Aside from CVD, MI, chronic HF, and stroke, there is also the risk of developing chronic kidney disease (CKD) and dementia later in life.<sup>9</sup>

HTN presents a unique challenge in that it affects many patients who are likely to visit an urgent care center. Half of those with HTN are uncontrolled or may not even be aware of the diagnosis.<sup>12</sup> The urgent care provider may be the first clinician to identify HTN.

### Presentation

The evaluation of patients presenting with high blood pressure in the urgent care center is a multifocal process that begins with a thorough history and physical examination. The vast majority of patients will most likely be asymptomatic, without symptoms of target organ damage.

BP measurements are often taken incorrectly with a cuff too large or too small, leading to abnormally low or high blood pressure readings, respectively. Patients may be lying down, standing, or the measurement might be performed over top of clothing. Repeating the measurement should focus on proper technique. This means:

- A seated patient with the arm at the level of the heart
- An appropriately sized cuff
  - Length = 80% of arm circumference
  - Width = 40% of arm circumference
- A patient who has been relaxing for at least 10 minutes



Table 1. Medications Which May Increase Blood Pressure				
NSAIDs	Stimulants	Oral Birth Control	Decongestants	Antidepressants
Naproxen Ibuprofen Meloxicam Celecoxib Indomethacin	Methylphenidate Dextroamphetamine Lisdexamfetamine	Ortho Evra Ortho-Tri Cyclen Yaz Yasmin	Pseudoephedrine Phenylephrine	Sertraline Citalopram Fluoxetine Paroxetine Escitalopram Fluvoxamine Paroxetine

- Avoidance of automatic blood pressure machines if repeat reading<sup>13</sup>

Once elevated blood pressure is established, the chronicity of the disease, as well as any possible comorbidities and disease sequelae, should be determined. The patient should be asked about headaches, chest pain, shortness of breath, swelling in the legs, abdominal pain, nausea, vomiting, or any focal neurosensory changes, as these all reflect target organ damage.

If symptoms related to target organ damage are absent, the BP may be elevated due to pain. Pain leads to activation of the sympathetic nervous system; as detailed with our first case scenario above, a patient who presents for a sprained ankle may have an elevated BP in the urgent care center, despite not having hypertension.<sup>1</sup>

Though an isolated increased blood pressure is not diagnostic of hypertension, a significant number of these patients will have acute illnesses that lead to dehydration or tachycardia; even loss of sleep can increase BP. So, the patient diagnosed with influenza may also have high blood pressure unrelated to underlying vascular disease.

### Past Medical History

Many patients will have either a documented history of hypertension, or will have had sporadic high blood pressure readings in the primary care office. Exploration of concomitant risk factors including diabetes mellitus (DM) and CKD will help with long-term risk stratification according to the JNC 8 guidelines.<sup>2</sup> Commonly used medications such as nonsteroidal anti-inflammatory medications (NSAIDs) and stimulants are known to elevate blood pressure (Table 1).

### Physical Examination

Concerning cardiac findings may include murmurs, extra heart sounds, arterial bruits, or abnormal heart rate and rhythm.

The pulmonary examination may reveal crackles rep-

resenting right-sided failure and pulmonary edema. An abdominal exam should explore for tenderness, ascites, and aortic bruits, which could be indicative of an abdominal arterial aneurysm or renal artery stenosis.

Examine the extremities for edema and asymmetry.

A neurological exam may reveal subtle abnormalities from early hypertensive encephalopathy. Funduscopic exam may reveal flame hemorrhages, cotton wool spots, and papilledema.

Routinely ordering lab work, electrocardiograms, or chest x-rays for the hypertensive patient without target organ damage is not recommended.<sup>1</sup>

### Management

Although the primary application of the Framingham Heart Study is to estimate long-term risk of cardiovascular disease, in the urgent care setting it can be a helpful tool for making decisions about discharging patients with medication and an easy way to deem individuals as high-risk or low-risk. This decision should be made carefully and with specific considerations in mind:

- Ultimately, hypertension is a problem best managed by primary care with access to regular follow-up.
- Patients who do not have access to primary care should be evaluated in a reasonable period, 1 to 2 weeks, to recheck blood pressure, confirm adherence, and monitor for side effects. In patients on diuretics, heart rate and potassium levels may be checked at this time, as well.
- Angiotensin-converting enzyme inhibitors (ACEI) and angiotensin II receptor blockers (ARB) are known teratogens; although popular choices for first-line HTN management, they should be avoided in this group.<sup>16</sup>
- One of the few labs that should be considered is a basic metabolic panel evaluating the patient's renal function and potassium level. Although there is no

guideline for this, the decision to obtain labs should be based on comorbid conditions like diabetes, current medications, and age. The provider may be more inclined to obtain lab studies on the 52-year-old male smoker than the 40-year-old female who has no medical problems and takes no medications.

In most cases, treatment should begin with a calcium channel blocker, an ACEI, an ARB, or a thiazide diuretic. In the African-American population, calcium channel blockers or diuretics are preferred.

If the patient is already taking a medication, consider increasing the dosage or adding a second medication.

### Follow-Up: What Happened with Our Two Patients?

- **40-year-old female with severe right ankle pain.** She has no medical problems, takes no medications, and does not smoke. She took 400 mg of ibuprofen last night. Her right ankle is swollen over the lateral malleolus, tender, and ecchymotic. Her blood pressure readings in the office after multiple attempts are 148/90 and 152/96.

- More than likely, this patient's elevated blood pressure is a direct result of her ankle injury. Prescription of medication should be deferred, but the patient should be informed of her blood pressure reading and the importance of outpatient follow-up with her primary care provider. Once her pain is better controlled, she should also check her blood pressure at home or a pharmacy and keep a log of her readings

- **52-year-old male needing a pre-employment physical exam.** He does not have a primary care provider. He has 27 pack-years of smoking. He does not exercise and he generally eats a poor diet. He specifically denies any chest pain, shortness of breath, and headaches. His blood pressures in the office after multiple attempts are 158/92 and 160/92.
- There is a strong likelihood that this patient has longstanding hypertension. Using the patient's current vital signs, history of smoking, and age, the patient is also likely at very high risk of cardiovascular disease based on the Framingham study. With no primary care provider, it would be reasonable to obtain initial labs including a basic metabolic panel, and to treat this patient with a blood pressure-lowering medication such as hydrochlorothiazide or lisinopril. He should follow up with primary care and check his blood pressure.

Hypertension is seen primarily as a disease best dealt with in the primary care setting. The unfortunate reality,

however, is that a great many patients either have hypertension or have elevated blood pressure without adequate diagnosis or management. These facts necessitate that providers not only be familiar with HTN, but be comfortable addressing it with the patient and possibly treating it with appropriate medications. Next, we will address the appropriate evaluation and management of asymptomatic hypertensive crisis from the urgent care perspective.

### Patients Who May Be in Hypertensive Crisis or Hypertensive Emergency

Where previously we discussed the routine diagnosis and management of HTN from the urgent care perspective, we now turn our attention to patients suspected of hypertensive crisis or emergency, problems that add complexity to the already difficult task of managing elevated blood pressure.

As a reminder, HTN affects an estimated 75 million people in the United States.<sup>1</sup> It is, therefore, something that almost every urgent care provider will encounter. Making the appropriate decisions regarding blood pressure elevation, especially in the face of a potentially life-threatening diagnosis, is a critical task.

The following cases represent patients who present to urgent care in potential hypertensive crisis:

- A 62-year-old, obese (body mass index [BMI] of 35) man presents complaining of elevated BP after self-administering a reading using an automated device in a grocery store an hour ago. When the machine showed a reading of 180/110, he became worried and decided to get "checked out." He appears well in the clinic, and denies chest pain, shortness of breath, blurry vision, syncope, or any other symptoms for that matter. His physical exam is within normal limits to include normal cardiac and pulmonary exams. He mentions a 30 pack-year history of smoking. His current blood pressure is 190/125, higher than the grocery store reading.
- A 72-year-old female patient presents complaining of elevated blood pressure. She has a history of HTN and takes lisinopril 20 mg daily. She checks her blood pressure occasionally if she doesn't feel well, and says she checked it today because she has been very tired. After her BP machine showed a reading of 200/110, she decided to come in to the clinic to be evaluated. She denies chest pains, blurry vision, or syncope, but does note increasing shortness of breath (SOB) over the past few days, progressing from only when she walks her dog to SOB at rest. Her BP in the clinic is 196/120, and although her

**Table 2. Signs of Potential Organ Damage**

Symptom	Potential Source
Chest pain	Myocardial infarction, aortic dissection
Shortness of breath	Pulmonary edema, pulmonary embolism, myocardial infarction
Vision loss or disturbances	Stroke, increased intracranial pressure
Lower back pain	Heart failure
Nausea/vomiting	Increased intracranial pressure
Weakness	Stroke, aortic dissection
Numbness/tingling	Stroke, aortic dissection
Seizures/change in mental status	Increased intracranial pressure
Headache	Subarachnoid hemorrhage
Pregnancy*	Preeclampsia/eclampsia
*Pregnancy is not a symptom, but it is worth noting here because of how it affects the differential diagnosis	

pulmonary examination is normal, she has distant heart sounds, and is tachycardic with a rate of 130 beats per minute.

### Background

*Hypertensive crisis* can be a nebulous term. It is used to describe elevated blood pressure, usually  $\geq 180/120$  without associated target organ damage, acute kidney injury, myocardial infarction, etc. Conversely, *hypertensive emergency* involves elevated BP with one or more of the aforementioned problems. (Older terminology such as *malignant hypertension* and *hypertensive urgency* are falling out of favor.)

With this in mind, and recalling that 180/120 mmHg is considered crisis level, one can understand why the BP of the patient in the first scenario is so concerning. Consider his risk factors, as well. As a smoker, he likely has underlying atherosclerosis and coronary artery disease. If this is put into the Framingham Heart Study CVD prediction calculator, his 10-year cardiovascular risk is 46.4%.<sup>17</sup> Most urgent care providers can relate to the feeling of uneasiness that accompanies these types of patients. No one wants to be the last link in a broken chain, but what is the appropriate response to such significant risk of mortality? The answer is to begin with the basics: an appropriate history and physical examination, understanding that from the urgent care perspective, the goal is to identify individuals at risk of hypertensive crisis, not to treat the crisis itself.

### History and Physical Exam

With patients at risk for hypertensive crisis or hypertensive

emergency, the examination should always begin with obtaining vital signs. Given that this has already been done, the next step is to repeat the blood pressure, obtaining readings in both arms using appropriate technique as discussed previously. Confirm that the BP is still elevated and that it corroborates the value described by the patient. Confirm, also, that there is not a discrepancy  $>10$  mmHg between BPs in the upper extremities, as this can be indicative of an aortic dissection. Confirm that the patient has no chest pain, shortness of breath, vision changes, lower back pain, nausea, vomiting, weakness of the face or extremities, alterations in mental status, headache, or numbness and tingling anywhere. These are all signs of potential organ damage and should increase the provider's suspicion of true hypertensive emergency. They are listed in the **Table 2**, along with their potential source.<sup>18</sup> (This list is not all inclusive.)

An important caveat to taking the patient history is the presence of headache, which is often mentioned by patients with elevated BP. Although there has been no causal relationship demonstrated between elevated BP and mild headache,<sup>17</sup> subarachnoid hemorrhage, which can present as a headache, should be ruled out with further questioning. Specifically, if the hypertensive patient complains of a headache, the clinician should confirm that it was not sudden in onset, maximal at onset, and is not worse than previous headaches. If any of these questions are answered in the affirmative, a subarachnoid hemorrhage cannot be ruled out and should be moved to the top of the list of differential diagnoses.

The physical exam should be directed by the history. That being said, if the history is void of concerning symp-



**Table 3. Noteworthy Signs<sup>18</sup>**

Symptom	Potential Source
New diastolic murmur	Aortic dissection
Neurologic deficits, change in mental status	Stroke, increased intracranial pressure, subarachnoid hemorrhage
Papilledema, flame hemorrhages on fundoscopic exam	Hypertensive encephalopathy
Abdominal bruit	Acute renal failure
Unequal blood pressures in upper extremities	Aortic dissection
Cotton wool spots, retinal hemorrhages	Hypertensive retinopathy
Diaphoresis, tachycardia	Myocardial infarction, pulmonary embolism
Pulmonary edema	Acute heart failure

toms, the physical exam should still include, at minimum, the evaluation of the heart, lungs, cranial nerves, abdomen, and eyes to include a fundoscopic exam. The remainder of the vital signs should have been obtained previously and need to be scrutinized, as well. Tachycardia, fever, or low oxygen saturation, for example, can all indicate infection or even pulmonary embolism, two potential causes of hypertensive emergency.

Signs and potential sources are noted in **Table 3**.

If both the history and physical exam are unremarkable, the practitioner should consider letting the patient rest in a quiet, dark room for about 30 minutes.<sup>19</sup> The clinician should resist the urge to order labs or other ancillary testing on asymptomatic patients with normal physical exams. The most recent guidance from the American College of Emergency Physicians reveals that there is very little useful information gained by performing ancillary studies in patients with no signs or symptoms of target organ damage.<sup>20</sup> This means that there is no need to order routine labs, a chest radiograph, or even an ECG. This is counterintuitive, given the level of potential risk associated with these patients.

A few caveats to this recommendation may include patients with known history of aortic or cerebral aneurysm, previous MI, or known decreased renal function. These individuals are at greater risk for asymptomatic hypertension transitioning into symptomatic hypertension; thusly, a reasonable approach may be to include basic labs plus the appropriate imaging study or ECG based on the level of concern. In most cases, this would include a urinalysis, a complete metabolic panel (CMP), and an ECG.

### Diagnosis and Treatment

Any patient who has a concerning historical or physical finding should be referred to the ED for the appropriate

diagnostic work-up. For example, review the case of the 72-year-old female with shortness of breath. Regardless of the remainder of her exam, her primary complaint, when combined with a BP >180/120, represents an increased probability of true hypertensive emergency—elevated BP with end organ damage. In her case, she may be experiencing an MI or a pulmonary embolism. Neither of these potential diagnoses can be ruled out from the urgent care center.

While the severity of a particular case may necessitate resuscitative efforts such as IV fluid or oxygen in clinic, the ultimate goal in the ED remains the same: a thorough evaluation that may include advanced imaging, laboratory studies, and an ECG. The aim of diagnosis and treatment in the urgent care center, therefore, is to tease out those individuals who need a higher level of care from those individuals who may be released home with or without medication. Patients who have no positive historical or physical findings associated with target organ damage have likely had an elevated BP for quite some time. ED evaluation in these patients is not necessary.

It is imperative to note here that the practice of giving medications to rapidly lower the blood pressure in clinic is neither safe nor indicated. There is no improvement in morbidity or mortality when asymptomatic individuals are treated with antihypertensive medications.<sup>21</sup> Furthermore, medications like clonidine, a longtime staple of urgent care medicine, work against the body's autoregulatory mechanisms, used to balance the increased pressure with adequate perfusion of the vital organs. As such, acute lowering of the BP could lead to an ischemic stroke or a MI.<sup>22,23</sup>

To summarize:

- Most patients who are asymptomatic and do not have signs of target organ damage do not need to have their blood pressure rapidly lowered. In fact,

doing so can cause an ischemic event (MI or stroke) by counteracting the normal autoregulatory mechanisms of the body.

- Most patients who are asymptomatic and do not have signs of target organ damage also do not need ancillary testing such as CBC, CMP, ECG, or chest radiography.
- A thorough history and physical exam that encompasses symptoms of target organ damage is a sufficient evaluation.
- Patients at high risk for an event—those who have had an MI previously or have an aortic aneurysm, cerebral aneurysm, or active renal disease—should be evaluated more thoroughly with the appropriate ancillary studies.
- If the decision is made to start a blood pressure medication, JNC 8 should be consulted to determine which medication is most appropriate. The patient's renal function and potassium need to be evaluated prior to starting any medication.

#### Follow-Up: What Happened with Our Two Patients Evaluated for Hypertensive Crisis?

- **62-year-old male with blood pressure of 190/125 and no signs of target organ damage.** This patient was discharged because he was determined *not* to be in hypertensive crisis. His condition did not warrant emergent attention or further work-up, and he was advised to follow up with a primary care provider.
- **72-year-old female with blood pressure of 196/120, shortness of breath, and tachycardia.** This woman was transported emergently to the ED for further evaluation and care.

With hypertension being one of the most common diagnoses in medicine, urgent care providers must be able to identify situations that require immediate, higher-acuity care as well as patients who can be discharged safely. The patients described here illustrate that making the distinction need not be difficult if the patients are viewed through the appropriate lens and approached logically and with confidence. ■

*“The aim of diagnosis and treatment in the urgent care center is to tease out individuals who need a higher level of care from those who may be released with or without medication.”*

#### References

1. Merai R, Siegel C, Rakotz M, et al. CDC Grand Rounds: a public health approach to detect and control hypertension. *MMWR Morb Mortal Wkly Rep*. 2016;65(45):1261-1264.
2. Kjeldsen S, Feldman RD, Lisheng L, et al. Updated national and international hypertension guidelines: a review of current recommendations. *Drugs*. 2014;74(17):2033-2051.
3. Sutters M. Systemic Hypertension. In: Papadakis MA, McPhee SJ, Rabow MW, eds. *Current Medical Diagnosis & Treatment* 2018. New York, NY: McGraw-Hill Education; 2018:447-478.
4. Salkic S, Brkic S, Batic-Mujanovic O, et al. Emergency room treatment of hypertensive crises. *Med Arch*. 2015;69(5):302-306.
5. Pearson T. Treating hypertension – losing sight of the forest for the trees? *Clin Advisor*. 2015;18(7):55-60.
6. Rosendorff C, Lackland D, Allison M, et al. Treatment of hypertension in patients with coronary artery disease. *Hypertension*. 2015;65(6):1372-1407.
7. Ibrahim H, Manohar P. Systemic arterial hypertension and antihypertensive drugs. In: Elmoselhi A, ed. *Cardiology: An Integrated Approach*. New York, NY: McGraw-Hill; 2018:201-214.
8. McCance K, Huether S. Alterations of cardiovascular function. In: Brashers VL, eds. *Pathophysiology: The Biology Basis for Disease in Adults and Children*. 7<sup>th</sup> ed. St. Louis, MO: Elsevier Mosby; 2014:1132-1140.
9. Peterson E, Gaziano M, Greenland P. Recommendations for treating hypertension: what are the right goals and purposes? *JAMA*. 2014;311(5):474-476.
10. Kovell L, Ahmed H, Misra S, et al. US hypertension management guidelines: a review of the recent past and recommendations for the future. *J Am Heart Assoc*. 2015;4:e002315.
11. Mozaffarian D, Benjamin EJ, Go AS, et al. Heart disease and stroke statistics—2015 update: a report from the American Heart Association. *Circulation*. 2015;e29-322.
12. Nwankwo T, Yoon SS, Burt V, Gu Q. Hypertension among adults in the United States: national health and nutrition examination survey, 2011–2012. NCHS Data Brief. Available at: <https://www.cdc.gov/nchs/data/databriefs/db133.pdf>. Accessed July 18, 2018.
13. O'Gara PT, Loscalzo J. Physical examination of the cardiovascular system. In: Kasper D, Fauci A, Hauser S, et al, eds. *Harrison's Principles of Internal Medicine*. 19<sup>th</sup> ed. New York, NY: McGraw-Hill; 2014:267.
14. Fagius J, Karhuvaara S, Sundlöf G. The cold pressor test: effects on sympathetic nerve activity in human muscle and skin nerve fascicles. *Acta Physiol Scand*.
15. ACEP Clinical Policy Review: Evaluation and Management of Adult Patients in the ED with Asymptomatic Elevated BP. ACEP Now. Available at: [www.acepnow.com/article/acep-clinical-policy-review-evaluation-management-adult-patients-ed-asymptomatic-elevated-bp/](http://www.acepnow.com/article/acep-clinical-policy-review-evaluation-management-adult-patients-ed-asymptomatic-elevated-bp/). Accessed January 16, 2018.
16. Postmarketing surveillance for angiotensin-converting enzyme inhibitor use during the first trimester of pregnancy—United States, Canada, and Israel, 1987-1995. *JAMA*. 1997;277(15):1193-1194.
17. Cardiovascular Disease (10-Year Risk). Available at: <https://www.framinghamheartstudy.org/fhs-risk-functions/cardiovascular-disease-10-year-risk/>. Accessed February 28, 2018.
18. Baumann BM. Systemic hypertension. In: Tintinalli JE, Stapczynski J, Ma O, et al, eds. *Tintinalli's Emergency Medicine: A Comprehensive Study Guide*. 8<sup>th</sup> ed. New York, NY: McGraw-Hill Education; 2016: Chapter 57.
19. Grassi D, O'Flaherty M, Pellizzari M, et al. Hypertensive urgencies in the emergency department: evaluating blood pressure response to rest and to antihypertensive drugs with different profiles. *J Clin Hyperten*. 2008;10(9):662-667.
20. Wolf SJ. ACEP Clinical Policy Review: Evaluation and Management of Adult Patients in the ED with Asymptomatic Elevated BP. October 1, 2013. Available at: [www.acepnow.com/article/acep-clinical-policy-review-evaluation-management-adult-patients-ed-asymptomatic-elevated-bp/](http://www.acepnow.com/article/acep-clinical-policy-review-evaluation-management-adult-patients-ed-asymptomatic-elevated-bp/). Accessed July 18, 2018.
21. Perez M, Musini V. Pharmacological interventions for hypertensive emergencies. *Cochrane Database of Systematic Reviews*. 2007. doi:10.1002/14651858.cd003653.pub2.
22. Omalla JJ. Nifedipine-associated myocardial ischemia or infarction in the treatment of hypertensive urgencies. *Ann Intern Med*. 1987;107(2):185-186.
23. Grossman E, Messerli FH, Grodzicki T, Kowey P. Should a moratorium be placed on sublingual nifedipine capsules given for hypertensive emergencies and pseudoemergencies? *JAMA*. 1996;276(16):1328-1331.

Recommend MUCINEX®

# #1 doctor recommended cough & cold brand\*

Maximum strength MUCINEX® 12-hour products help thin and loosen mucus in patients with upper respiratory infections



Use as directed.

## Recommend other leading brands from the RB portfolio

**Delsym®** reduces the uncontrollable urge to cough—at the source—and lasts up to 12 hours†

**Cepacol® INSTAMAX™** delivers the power of 2 maximum strength pain relievers for sore throat‡

**Children's Mucinex® Chest Congestion** helps keep the mucus moving for children ages 4 to under 12§



Use as directed.

Give your patients what they need, when they need it!  
For more information on how to sell these over-the-counter products  
at your urgent care center, please contact:  
Ellen Rendle: [ellen.rendle@rb.com](mailto:ellen.rendle@rb.com) / (859) 462-2245

\*MUCINEX® is the #1 Recommended Brand in the Adult Cough/Cold category in the US among the Universe of Physicians (IQVIA ProVoice Survey). MAT 52 weeks through December 2017.

†Delsym® is the #1 Recommended product in the Adult Cough/Cold category with a 12-hour Cough Suppressant in the US among the Universe of Physicians (AlphaImpactRx). MAT 52 weeks through May 2017.

‡Cepacol® is the #1 Recommended product in the Sore Throat Lozenges category in the US among the Universe of Physicians (AlphaImpactRx). Period from June 1, 2016 to May 31, 2017.

§Children's Mucinex is the #1 Pediatrician Recommended non-antihistamine, multi-symptom brand in the Children's Cough/Cold category among the Universe of Pediatricians (IQVIA ProVoice Survey). MAT 52 weeks through February 2018.





# Building Ethical Organizations and Teams

**Urgent message:** As consumers pay closer attention to the ethical behaviors of the companies they do business with, the topic of workplace ethics has garnered renewed interest. Hence, the urgent care operator who makes a concerted effort to build an ethical workplace culture lays the groundwork for patient loyalty, motivated and productive employees, and financial success.

ALAN A. AYERS, MBA, MACC

Thanks to what seems like a steady stream of headline-grabbing corporate scandals, misconduct accusations, and fraud investigations, the business ethics of organizations big and small remain under intense scrutiny. With each new tale of misdeed or impropriety, the media pounces, consumer confidence in once-trusted brands erodes, and embattled CEOs caught in the spotlight's glare commence frantic damage control.

For sure, companies' ethical cultures, including urgent care organizations, permeate every level of the business, and can be a critical factor in whether those businesses flourish or flounder. Author and global leadership expert Jeremy Tozer, in his 2012 book *Leading Through Leaders: Driving Strategy, Execution and Change*, sums up the essence of ethics in business this way:<sup>1</sup> "A business perceived to lack integrity or to operate in an unethical, immoral, or irresponsible manner soon loses the support of customers, suppliers and the community at large."

More than ever, consumers—simultaneously numb and fed up with what they deem betrayals of their trust—are voting with their wallets and forgoing businesses that fail to maintain the high ethical standards they expect. Not to mention a growing workforce of employees and top talent who increasingly place a premium on their companies' ethical cultures, to the point where they're prioritizing ethics ahead of benefits, perks, and even salary.

## Why an Ethical Culture is Important

As it turns out, *good ethics* means more than simply



©Fotolia.com

doing the right thing for honesty's sake; it makes good business sense. This is evidenced further by the fact that most of *Fortune* magazine's "The 100 Best Companies to Work For" also find themselves on the "Most Popular Consumer Brands" list. In fact, it perfectly underscores the notion that companies that treat their employees well and maintain a strong workplace culture will naturally realize that trickle-down effect through their employees treating customers with same high regard.

So, when considering an urgent care environment, what are some common ethical dilemmas care teams, physicians, and managers might be forced to confront?

---

**Alan A. Ayers, MBA, MACC** is Chief Executive Officer of Velocity Urgent Care and is Practice Management Editor of *The Journal of Urgent Care Medicine*. The author has no relevant financial relationships with any commercial interests.



Here are a few examples, gathered through anonymous surveys of healthcare workers courtesy of Medscape:

- Prescribing antibiotics to patients who don't need them, yet are arguing for them
- Choosing to not reveal a minor mistake in treatment or diagnosis of a patient simply because it will not cause harm
- Covering for a colleague who is impaired due to drug or alcohol use, or illness
- Discussing a patient's information with a colleague in a way that violates the patient's privacy
- Accepting inappropriate gifts and perks from suppliers and/or vendors
- Witnessing a coworker behave rudely towards a patient and wrestling with whether to report the incident to supervisors
- Witnessing a team member stealing medical and/or office supplies
- Overstating a patient's condition in order to submit a false claim or prior authorization
- Showing favoritism towards certain team members or colleagues (eg, vacation, scheduling, breaks, duties, shift preferences, leniency)
- Hiring or promoting individuals with lesser qualifications than more qualified candidates based on race, gender, age, nepotism, etc.
- Failing to consistently exercise proper hygiene and sanitization standards and protocols
- Misuse of the prescription pad

Not an exhaustive list certainly, but it does a good job of spotlighting where typical ethical lapses can occur in urgent care. And such lapses probably occur more often than you'd think: According to the Ethic's Resource Center's 2013 National Business Ethics Survey, more than 40% of employees in the U.S. witnessed illegal or unethical activity at work.<sup>2</sup> Worse, troubling encounters such as these are not without secondary consequences: When employees witness colleagues violating ethical rules and norms without reprimand or punishment, they may decide that ethics aren't important and join in themselves or become disillusioned and depart the company altogether. Not the hallmarks of a strong workplace culture, nor a formula for success.

Combined with the additional pressure that the rise of social media has placed upon companies to be ethical and transparent—or risk online exposure to an audience of millions—it's clearer than ever that an all-out emphasis on ensuring an ethical workplace culture is critical. Additionally, studies show that unethical cultures invariably

ably lead to lowered morale, loss of customer, community, and vendor support, and are a breeding ground for lawsuits. In short, workplaces that tolerate or turn a blind eye to misconduct will suffer higher turnover, diminished employee engagement, and a lowered reputation, whereas organizations that build and nurture ethical workplace cultures see increased profits, a workforce that is engaged and productive, and happier customers.

### What an Ethical Culture Looks Like

How do you define an ethical culture? There are few hard and fast rules as to what constitutes an “ethical” culture, given that each workplace environment has its own unique objectives and dynamics. However, most ethical cultures share an overarching theme: A workplace where the entire staff, starting with ownership down to the managers and team members, believe in, support, and practice legal and moral business practices. Further, ethical workplace cultures encourage, spotlight, and reward ethical behavior, while discouraging and punishing ethical lapses.

Observe enough workplace cultures, though, and you'll discover a wide variety of ethical standards that aren't necessarily laid out clearly in manuals or contracts. Rather, the attitudes and behaviors that comprise a company's culture are mostly inferred – even unspoken in some cases – depending on the nature of the business or the organization in general. Regardless, companies that boast stellar ethical cultures rarely develop them by accident; ethical cultures flourish only when there is a clear commitment to building and maintaining them, by leaders who understand how important ethics are to the livelihood of the organization. With that in mind, the following sections will examine such factors as behavioral “nudges” to influence ethical workplace behavior, how an ethical culture can help guide decision making in the absence of specific training, and the consensus best practices for building an ethical workplace culture.

### How ‘Nudges’ Support and Reinforce Ethical Behavior

Behavioral nudges can be loosely defined as suggestions, reminders, and gentle proddings toward doing what's healthy, moral, responsible, and ethical. The concept of workplace nudges originated in the government public policy sector, where it was developed by American behavioral economist Richard Thaler, who in 2008 authored a seminal work on nudges. This led to Thaler being awarded the 2017 Nobel Prize for economics

based largely on his work in nudge theory dynamics.

The concept behind nudges is a straightforward one: People are not as rational or reasonable as they like to believe; thus, strategic nudges can help direct them toward desired behaviors. Thaler, when asked to summarize his theory, was able to do so in just three words: “Make it easy.”<sup>3</sup> Indeed, nudge theory presumes that people resist change when it requires expenditure of mental energy, so by “making it easy” to perform the desired change, compliance rates, ethical decisions, and healthy, responsible choices skyrocket.

Nudges are also based on what Thaler calls “choice architecture.”<sup>4</sup> Meaning, the way a nudge is presented and communicated plays a huge role in how effective it is. With nudges, the theory goes, the practice is most successful when the nudge strikes a perfect balance between articulating benefits, and making people feel like performing the desired behavior was really their choice. Explicit demands or veiled threats, on the other hand, have shown to be much less effective than strategic prodding, and are if fact likely to backfire. Basically, the employee must feel like they made the right decision on their own, even if the nudge helped steered their choice.

One example of a successful nudge Thaler documented that has practical implications for urgent care was a nudge within a food processing plant. In the case study, a researcher and his team were able to increase compliance rates for hand washing by 63% with a deceptively simple nudge: an ink handstamp reminding team members to...wash their hands. *Make it easy*. When considering the many times throughout an urgent care shift that routine activities such as hand washing, applying latex gloves, and sanitizing surfaces and instruments should occur but might not, a similar nudge could help boost compliance rates towards maintaining a clean and sanitized workplace environment, which is indeed an ethical consideration in a medical practice.<sup>5,6</sup>

### How an Ethical Culture Helps ‘Fill in the Gaps’

Another benefit of building and maintaining an ethical culture is that its foundational principles can serve as guideposts for handling situations that employees and team members haven’t been specifically trained for. Given that a typical urgent care is a fast-paced clinical environment with walk-in patient flow and varied patient presentations, unpredictable situations can unfold in a moment’s notice. Thus, when a strong ethical culture is ingrained in the center’s staff, team members are empowered to do the right thing for patients and staff members.

If an urgent care center holds values of “compassionate care,” “treating patients like honored guests,” and “going above and beyond,” for instance, then those ethical principles will “fill in the gaps” between what team members were specifically trained for and the unusual situations that may arise. In one real-life anecdotal example, a passerby wandered into an urgent care confused about his explanation of insurance benefits he received from a different medical provider. Rather than dismiss the nonpatient and direct him back to his PCP, the urgent care office manager, falling back on the center’s values, instead invited the passerby back to her office where she called the insurance company herself and got the man the clarification he needed.

Was the office manager, obviously a busy professional, obligated to do that? Of course not. But “going above and beyond” is one of the center’s values, so it not only served as a guidepost as for what to do, but it freed her to be the compassionate, caring individual she is at her core. The passerby was naturally elated and promised to reward the center with his patronage when the need arose, as well as sharing the story of his wonderful encounter with family and friends.

It’s stories like this one, repeated often, that work in tandem with managerial edicts to really help form the kind of ethical culture that every urgent care should strive for.<sup>7</sup>

### Best Practices for Building an Ethical Workplace Culture

When it comes to building an ethical workplace culture, at least one fact is in near consensus among experts: it starts at the top. This assertion is widely supported by research studies, including one conducted by highly regarded Stanford psychologist Al Bandura, which showed that people are predisposed to follow the behavior of others they admire or view as leaders. So for urgent care operators, the task is remaining ever cognizant that their behavior sets the tone, their words and actions are being closely observed, and that they must lead by example at all times.

To that end, here are several foundational principles espoused by Tozer, Thaler, and other HR experts that any urgent care organization can embrace towards building, maintaining, and nurturing an ethical culture:<sup>8,9</sup>

- **Communicate ethical expectations.** An employee handbook that clearly outlines the center’s ethical values should be read and signed by each team member. In addition, the walls and bulletin boards should be adorned with placards, posters, and framed pictures declaring the center’s guiding principles as

both a nudge to desired behaviors and an ever-present reminder to patients and employees.

- **Model the ethical behavior you expect.** When ethical dilemmas inevitably arise, forgo expediency and convenience, and let others witness you take ethical action – even if it’s costly or inconvenient. For example, always demonstrate impartiality, flexibility, and compassion to your team members and patients. This lets everyone know that the center’s values are not simply lip service, but guiding principles that you believe in, and expect everyone to follow.
- **Talk about ethics often.** Repeat stories and anecdotes often that involved ethical decision making. Provide corrective feedback when an inadvertent ethical lapse occurs. Bring up ethical dilemmas in meetings and huddles and solicit feedback and input from your team. Above all, keep the topic of ethics top-of-mind so team members remain vigilant against ethical lapses.
- **Provide ethics training.** Go beyond manuals and contracts, and augment your ethics training with workshops, seminars, and online programs. The training should help develop effective ethical decision making and teach the proper way to navigate ethical dilemmas. Moreover, research shows that when ethics training is dynamic and interactive as opposed to rote and dull, the ethical principles and values are assimilated better, further ingrained, and acted upon more frequently.
- **Make reporting ethical violations safe.** Ensure that mechanisms are in place that allow team members to report ethics violations safely and in confidence without fear of retribution. Leave no doubt to employees that their ethical concerns are important and will be taken seriously no matter their role or seniority.
- **Manage performance expectations.** If the KPIs and metrics you task your team members with exceeding are unreasonable, they may be tempted to cut corners and take shortcuts, undermining the center’s ethical values and compromising the patient experience. Thus, ensure that performance objectives and goals are attainable, processes are in place to support them, and team members are empowered to speak up when they’re not.

*“The onus is on leaders to ensure that their workplace meets or exceeds ethical expectations.”*

■ **Praise and reward ethical behavior.** By placing a spotlight on your team members’ exemplary ethical choices, decisions, and behaviors, you’re communicating to everyone how important and valued their adherence to those principles is. By the same token, ethical lapses and viola-

tions must be addressed immediately and decisively to discourage future incidents. Remember, ethical lapses tend to snowball when they go unchecked, others are watching and taking cues based on how leaders respond, and the livelihood of the center, in a very real way, is at stake.

### Conclusion

As organizations realize that both consumers and employees are placing heightened importance on ethical cultures, the onus is on leaders to ensure that their workplace meets or exceeds ethical expectations. It’s clear that strong ethical cultures help reduce misbehavior, and doing the right thing—even when it’s inconvenient to do so—signals to everyone that the organization is truly committed.

Hence, it’s up to urgent care leaders to promote ethics in their workplaces by talking about ethics often, making accountability simple, nudging where appropriate, and giving team members tools and safeguards that make the ethical choice the easy one. The rewards to patients, employees, and the health of the organization are certainly worth it. ■

### References

1. Nguyen S. Creating an ethical organizational culture. *Workplace Psychology*. February 14, 2011. Available at: <https://workplacepsychology.net/2011/02/14/creating-an-ethical-organizational-culture/>. Accessed July 2, 2018.
2. Ethics & Compliance Initiative. National Business Ethics Survey 2013. Available at: <http://www.ethics.org/ecihome/research/nbes/nbes-reports/nbes-2013>. Accessed July 2, 2018.
3. Lovallo D, Webb A. Nudging the world toward smarter public policy: an interview with Richard Thaler. *McKinsey Quarterly*. June 2011. Available at: <https://www.mckinsey.com/industries/public-sector/our-insights/nudging-the-world-toward-smarter-public-policy-an-interview-with-richard-thaler>. Accessed July 2, 2018.
4. Thaler R, Sunstein C. *Nudge: Improving Decisions about Health, Wealth, and Happiness*. New York, NY: Penguin Books; 2008.
5. Gray R. To nudge or not to nudge? *HR*. Available at: <http://www.hrmagazine.co.uk/article-details/to-nudge-or-not-to-nudge>. Accessed July 2, 2018.
6. Palmquist M. Want more ethical employees? Given ‘em a nudge. *Strategy-Business*. Available at: <https://www.strategy-business.com/blog/Want-More-Ethical-Employees-Give-Em-a-Nudge?gko=gdb79>. Accessed July 2, 2018.
7. Ayers A. Culture fills in the gaps. Available at: [http://www.alanayersurgentcare.com/Linked\\_Files/2014\\_Articles/Ayers\\_UCAOA\\_Blog\\_Culture\\_June\\_2014.pdf](http://www.alanayersurgentcare.com/Linked_Files/2014_Articles/Ayers_UCAOA_Blog_Culture_June_2014.pdf). Accessed July 2, 2018.
8. Tucker K. What is cultivating ethical culture at a workplace? *Career Trend*. Available at: <https://careertrend.com/cultivating-ethical-culture-workplace-29009.html>. Accessed July 2, 2018.
9. Miller CB. Science-tested tips to be a better person. *Wall Street Journal*. January 5, 2018. Available at: <https://www.wsj.com/articles/science-tested-tips-to-be-a-better-person-1515169638?mod=searchresults&page=1&pos=5>. Accessed July 2, 2018.

**It's simple.  
Read an article.  
Take a quiz.  
Earn your credits.**

JUCM has partnered with the Institute of Urgent Care Medicine<sup>SM</sup> and Case Western Reserve University to bring journal-based CME credits to Urgent Care!

Earn up to three CME credit hours per issue, simply by reading about the diagnoses and treatment of common conditions seen in urgent care, as well as practice management best practices.

The annual JUCM CME subscription of \$145 includes a print copy of the journal, and up to 33 hours of CME credits.

Yes, it's that simple!

---

**Learn more at [JUCM.com/CME](http://JUCM.com/CME)**



sponsored by:

SCHOOL OF MEDICINE  
CASE WESTERN RESERVE  
UNIVERSITY

presented by:



This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Case Western Reserve University School of Medicine and the Institute of Urgent Care Medicine. Case Western Reserve University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians. Accreditation Statement

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





# HIPAA-Compliant Disclosure in Workers' Compensation

■ ALAN A. AYERS, MBA, MAcc

**Urgent message:** While a workers' compensation carrier may want to see a patient's entire medical record, claiming that such is compliant with HIPAA as the "minimum necessary information to get paid," urgent care providers should reasonably limit the health information released to the "minimum necessary to accomplish the workers' compensation purpose."

### Introduction

The HIPAA Privacy Rule dictates how a covered healthcare provider, such as an urgent care center, shares an employee's protected health information with an employer. The Rule sets parameters on the use and release of health records, and establishes appropriate safeguards that healthcare providers and others must satisfy to protect the privacy of health information.<sup>1</sup>

While many assume that the law provides a blanket protection, HIPAA's Privacy Rule does not protect employment records, even if the information in those records is health-related.<sup>2</sup> In fact, the Department of Health and Human Services states that in most cases, the Privacy Rule doesn't apply to the actions of an employer.<sup>2</sup> The HHS states that if you work for a health plan or a covered healthcare provider, HIPAA's Privacy Rule doesn't apply to your employment records. However, the rule does protect your medical or health plan records if you're a patient of the provider or a member of the health plan (as it would for any other employer).<sup>3</sup>

But what happens when the worlds of healthcare and employment collide, as in the area of workers' compensation? The question as it applies in the urgent care setting is, how much of a patient's medical history can (and should) be shared with an employer?



**Alan A. Ayers, MBA, MAcc** is Chief Executive Officer of Velocity Urgent Care and is Practice Management Editor of *The Journal of Urgent Care Medicine*.

### Business Scenario

In a hypothetical case, Dr. White is treating employee John Smith, who is complaining of wrist pain. Smith shares that he had surgery on his wrist 3 years ago after a non-work-related accident.

Dr. White acknowledges that our providers can and should be providing more details about how the injury occurred and further personal medical history related to Smith's injury. In fact, the workers' compensation carrier is seeking *all* of the patient's history—including psychological, sexual, drugs, everything. Dr. White is of the mindset that information not pertaining to the incident at hand would not be shared. However, the workers' compensation carrier states that our competitors share the patient's full medical history.

The key point here is that the law provides that covered entities are required to reasonably limit the amount of protected health information disclosed to the *minimum necessary* to accomplish the workers' compensation purpose. Dr. White appears to be correct in that medical information not germane to Smith's injury (eg, psychological treatment, sexual history, and medications) should not be disclosed. Disclosure of that PHI would be in violation of the HIPAA Privacy Rule. Also, the competition is in violation of HIPAA's Privacy Rule.

Here, we discuss this issue at length, with focus on the responsibilities of urgent care centers, which are frequently used by employers, workers' compensation insurance carriers, and third-party administrators to treat the work-related injuries of employees.

### Workers' Compensation

As a general rule, an employer can request that an employee provide a doctor's note or other health information if they re-



# CHOOSING THE RIGHT

*contracting and  
credentialing*

# CAN MAKE OR BREAK YOUR URGENT CARE

Leverage the expertise at Urgent Care Consultants to avoid common urgent care startup mistakes. We have over a century of combined industry experience, and have helped hundreds of urgent care startups just like you! Schedule a free consult.

888-779-0543 | [urgentcareconsultants.com](http://urgentcareconsultants.com)

**Urgent Care  
Consultants<sup>SM</sup>**



*You may only have...*

8 chances to hit the  
links this season.

How many moments are you going to miss

*because of your EMR?*

Make every moment! When you use the only EMR built specifically for urgent care, by urgent care doctors, you can run a successful business and still have time to experience all of life's moments. Let our award-winning EMR and practice management software help increase profits and run your center more efficiently than ever before.

#HowManyMoments

Schedule a free demo today.



**PRACTICE V VELOCITY®**  
*Urgent Care Solutions®*

888-779-0542 | [practicevelocity.com](http://practicevelocity.com)



# WHAT DOES POOR RCM **REALLY** COST?

---

**INFLATED DAYS IN AR**  
**CODING ERRORS**  
**POOR REIMBURSEMENT RATES**  
**NEGATIVE NPS**  
**UNHAPPY PATIENTS**  
**DECREASE IN PATIENT VOLUMES**  
**POOR COMPLIANCE**  
**EMPLOYEE SATISFACTION/RETENTION**  
**DECREASED CASH FLOW**  
**DELAYS IN REVENUE**

---

**Poor billing solutions can cause lots of damage.**

We're not down with that.

Call 888-779-0542 now for a FREE demo.



[practicevelocity.com](http://practicevelocity.com)

*“Urgent care operators should understand that all covered entities are required by law to reasonably limit the amount of protected health information disclosed.”*

quire the information for sick leave, workers’ compensation, wellness programs, or health insurance.<sup>2</sup> But if the employer requests information about the employee *directly* from the healthcare provider, the provider cannot give the employer the information without employee authorization unless other laws require them to do so.<sup>2</sup>

However, in workers’ compensation, it’s important to note that the HIPAA Privacy Rule doesn’t apply to entities that are either workers’ compensation insurers, workers’ compensation administrative agencies, or employers, except to the extent they may otherwise be covered entities.<sup>3</sup> These entities require access to the health information of individuals who are injured on the job or who have a work-related illness to process or adjudicate claims, or to coordinate care under workers’ compensation systems. This health information is typically obtained from healthcare providers who treat these individuals and who may be covered by the Privacy Rule, such as urgent care facilities.

With that in mind, the HIPAA Privacy Rule recognizes *the legitimate need* of insurers and other entities involved in the workers’ compensation systems to have access to individuals’ health information as authorized by law.<sup>3</sup> The question remains, to what extent can personal health information (PHI) be disclosed?

#### *Disclosures with and without individual authorization*

The HIPAA Privacy Rule allows covered entities to disclose protected health information to workers’ compensation insurers, state administrators, employers, and other persons or entities involved in workers’ compensation systems, without the individual’s authorization in specific circumstances:

- As authorized by and to the extent necessary to comply with laws relating to workers’ compensation or similar programs established by law that provide benefits for work-related injuries or illness without regard to fault.<sup>4</sup>
- To the extent the disclosure is required by law, and the disclosure must comply with and be limited to what the law requires.<sup>4</sup>
- For purposes of obtaining payment for any healthcare provided to the injured or ill worker.<sup>4</sup>

Covered entities *may* disclose PHI to workers’ compensation insurers and others involved in workers’ compensation systems where the individual has given his or her authorization for the release of the information to the entity.<sup>3</sup>

#### What Can Be Safely Reported?

When reporting a patient’s medical history or status to a workers’ compensation insurance carrier, third-party administrator, or directly to an employer, the following information is generally considered “pertinent” to the injury:

1. Date of injury
2. Mechanism of injury
3. Quality, intensity, and location of pain
4. Treatments tried and success of same treatments
5. Your diagnosis and treatment plan
6. Date of follow-up visit (unless you are sending the patient back to full duty, workers’ compensation cases must be seen in follow-up)
7. Specialty referral if necessary – Panel or open referral
8. Document on return-to-work forms what restrictions are appropriate for the patient. Allowing the workplace to determine if they have a position that can accommodate the restrictions
9. Prior medical history pertaining specifically to the injury

#### *Minimum necessary*

Urgent care operators should understand that all covered entities are required by law to *reasonably limit* the amount of protected health information disclosed under 45 CFR § 164.512(l) to the minimum necessary to accomplish the workers’ compensation purpose.<sup>3</sup> This means that an employee’s PHI may be shared for such purposes to the full extent authorized by law—but that covered entities must reasonably to limit the amount of PHI disclosed for payment purposes to the *minimum necessary*.<sup>5</sup> However, the Privacy Rule’s requirements for minimum necessary are designed to be “sufficiently flexible to accommodate the various circumstances of any covered entity.”<sup>5</sup>

The Department of Health and Human Services states that covered entities are permitted to disclose the *amount and types of protected health information that are necessary to obtain payment for healthcare provided to an injured or ill worker*. Further, it’s important to note that where a covered entity such as an urgent care center routinely makes disclosures for workers’ compensation purposes under federal regulation or for payment purposes, it may develop standard protocols as part of its minimum necessary policies and procedures that address the type and amount of protected health information to be disclosed for such purposes.<sup>4</sup>

In addition, the HHS explains that where PHI is requested by a state workers’ compensation or other public official, an urgent care center or other covered entity is permitted to reasonably rely on the official’s representations that the information requested is the minimum necessary for the intended

*“Disclosure of medical information not germane to a patient's injury (eg, psychological treatment, sexual history, medications) would be in violation of the HIPAA Privacy Rule.”*

purpose.<sup>6</sup> Covered entities aren't required to make a minimum necessary determination when disclosing protected health information as required by state or other law, or pursuant to the individual's authorization.<sup>7</sup>

#### Takeaway

Urgent care center owners should be certain that safeguards, procedures, and training are in place to ensure that when complying with workers' compensation claims that disclosure of PHI is reasonably limited to the *minimum necessary* to accomplish the workers' compensation purpose.

The penalties for HIPAA noncompliance with the Privacy Rule can range from \$100 to \$50,000 per violation.<sup>8</sup> The maximum penalty of an identical provision is \$1.5 million per year of violations. In addition, a person who knowingly obtains or discloses individually identifiable health information in violation of the Privacy Rule may face a criminal penalty of up to \$50,000 and up to 1-year imprisonment.<sup>8</sup> ■

#### References

1. HHS.gov. Health Information Privacy. *What does the HIPAA Privacy Rule do?* Available at: <https://www.hhs.gov/hipaa/for-individuals/faq/187/what-does-the-hipaa-privacy-rule-do/index.html?language=es>. Accessed July 21, 2018.
2. HHS.gov. Health Information Privacy. *Employers and health information in the workplace*. Available at: <https://www.hhs.gov/hipaa/for-individuals/employers-health-information-workplace/index.html>. Accessed July 21, 2018.
3. HHS.gov. Health Information Privacy. *Disclosures for Workers' Compensation purposes*. Available at: <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-workers-compensation/index.html>. Accessed July 21, 2018.
4. 45 CFR § 164.512.
5. CFR § 164.502(a)(1)(ii).
6. HHS.gov. Health Information Privacy. *Minimum necessary requirement*. Available at: <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/minimum-necessary-requirement/index.html>. Accessed July 21, 2018.
7. 45 CFR § 164.514(d)(3)(iii)(A).
8. HHS.gov. Health Information Privacy. *Summary of the HIPAA Privacy Rule*. Available at: <https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html>. Accessed July 21, 2018.



# VisualDx is your trusted second opinion.

#### Features include:

- ✓ Fast access to insights from the best specialists
- ✓ Handle complex cases directly
- ✓ Engage patients with our handouts

**20% OFF**  
for JUCM readers  
[visualdx.com/jucm](http://visualdx.com/jucm)



## ABSTRACTS IN URGENT CARE

- Too Soon to Talk About ICD-11?
- Boxers or Briefs (Clinically Speaking)?
- Fluoroquinolone Label Changes Ahead
- Speech Recognition Software May Not Be Ready for Prime Time
- Study Suggests Anticonvulsants Unsuitable for Back Pain
- AAP Weighs in on Nasal Flu Vaccine

■ GLENN HARNETT, MD

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

### WHO Announces ICD-11 Is on the Way

*Key point: New set will reflect current terminologies and classifications, integrate more smoothly with new technologies.*

Citation: World Health Organization. WHO Releases New International Classification of Diseases (ICD 11). June 18, 2018. Available at: [http://www.who.int/news-room/detail/18-06-2018-who-releases-new-international-classification-of-diseases-\(icd-11\)](http://www.who.int/news-room/detail/18-06-2018-who-releases-new-international-classification-of-diseases-(icd-11)). Accessed August 14, 2018.

ICD-10 was released in 2015, but according to the World Health Organization (WHO) we can already expect the next revision, ICD-11, sometime early in the next decade. ICD-11 is supposed to contain updates to key clinical elements and allow the coding process to integrate more smoothly with new electronic records technology. The hope is that it will allow for better interoperability and coding consistency across different platforms. ICD-11 will be presented for adoption at the World Health Assembly in May 2019 and will become effective in 2022. According to the WHO, the new ICD includes several new chapters, including one on traditional medicine and another one on sexual health that brings together conditions that were previously categorized in other ways (eg, gender incongruence was listed under mental health conditions) or described differently. Gaming disorder was added to the section on addictive disorders. The WHO has promised significant improvements over ICD-10, stating that for the

first time, it will be completely electronic and also claiming that ICD-11 will be more user-friendly than ICD-10. It took 23 years for the U.S. to agree to ICD-10, but healthcare experts expect ICD-11 to be adopted much quicker this time around. ■

### It's Official: Boxers Over Briefs for Optimal Male Fertility

*Key Point: Boxers are better than briefs when it comes to sperm counts and mobility.*

Citation: Mínguez-Alarcón L, Gaskins AJ, Chiu YH, et al. Type of underwear worn and markers of testicular function among men attending a fertility center. *Hum Reprod*. August 8, 2018. [Epub ahead of print]

A recently published study in *Human Reproduction* confirmed earlier research regarding underwear types and their potential effects on male fertility. Researchers questioned almost 650 men attending an infertility clinic to determine what kind of underwear they customarily wore. Answer choices included boxers, jockeys, bikinis, briefs, or "other" (a category that included boxer-briefs or mixtures of underwear types). Semen and blood samples were collected from each participant. The men were then divided into two groups according to their underwear type: those primarily wearing looser-fitting boxers and those mainly wearing tighter-fit underwear. The results revealed that a preference for boxers was associated with higher sperm counts and concentrations, and higher numbers of motile sperm. It was also associated with lower serum levels of follicle-stimulating hormone. Sperm counts were, on average, 17% lower in those who wore briefs than in men who wear boxers. The authors postulated that tight underwear elevates scrotal



**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.



temperatures, thus leading to lower sperm production. They also noted that even though the average sperm count was lower in men who wore tight-fitting underwear instead of boxers, this value was still well within healthy levels, suggesting the difference between underwear types shouldn't be exaggerated. Skeptics noted that the type of pants typically worn by each patient, such as tight-fitting jeans, could outweigh any benefits derived from wearing loose boxers, and may have confounded results. ■

## FDA Calls for Fluoroquinolones Label Changes

**Key point:** *Warnings regarding hypoglycemia, mental health will be stronger.*

**Citation:** U.S. Food and Drug Administration. FDA updates warnings for fluoroquinolone antibiotics on risks of mental health and low blood sugar adverse reactions. July 10, 2018. Available at: <https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm612995.htm>. Accessed August 14, 2018.

The FDA called for even more label changes to fluoroquinolones to strengthen warnings that the antibiotics could cause severe hypoglycemia or mental health issues. The first label change requires that all fluoroquinolone labels must now explicitly warn of the potential risk for coma due to hypoglycemia. The second label change regards mental health side effects, which include agitation, attention disturbances, delirium, disorientation, memory impairment, and nervousness. These mental health side effects must now be listed separately from adverse reactions to the central nervous system. The FDA noted that mental health side effects have been reported after just one dose of a fluoroquinolone. These new warnings are in addition to numerous other prior fluoroquinolone warnings, including boxed warnings about risks for tendinitis and tendon rupture, as well as worsening muscle weakness in patients with myasthenia gravis. The changes are in response to an agency review of adverse event and case reports. ■

## Speech Recognition Software Needs More Work

**Key point:** *Speech recognition software leads to higher error rates in patient documentation.*

**Citation:** Zhou L, Blackley SV, Kowalski L. Analysis of errors in dictated clinical documents assisted by speech recognition software and professional transcriptionists. *JAMA Network Open*. Available at: <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2687052>. Accessed August 14, 2018.

Speech recognition software (for dictation) is being increasingly used to document clinical encounters in electronic health records.

Proponents of the software note that the software decreases the time providers spend on documenting patient notes and procedures. However, a study published in *JAMA Network Open* suggests that it yields errors in up to 7% of dictated words. The author's analysis included about 220 documents (office notes) that were dictated using one speech recognition system at two U.S. healthcare organizations. Researchers had human transcriptionists transcribe each original recording to use as the reference standard. They compared the error rate in the note solely created by the speech recognition software, then compared it to the error rate after the transcriptionist review and physician sign-off. The error rate was 7 per 100 words in the notes created by the speech recognition software, falling to below 1 per 100 after transcriptionist review and physician sign-off. They also noted that when it came to clinically significant errors, 64% of the speech-recognition notes had such errors, which fell to 8% after review and sign-off. The researchers concluded that their study "highlights the crucial role of manual editing and review" when using speech recognition software. ■

## Are Anticonvulsants a Suitable Alternative for Low Back Pain?

**Key point:** *Studied anticonvulsant drugs are ineffective for treating low back pain, and may even be harmful.*

**Citation:** Enke O, New HA, New CH, et al. Gabapentinoids ineffective in treatment of low back pain or lumbar radicular pain. *CMAJ*. 2018;190(3):E786-E793.

Prescriptions for anticonvulsant drugs have increased sharply in recent years, presumably as alternatives to opioid pain medication. Lyrica (pregabalin) and Neurontin (gabapentin) are primarily used for treating nerve pain and fibromyalgia, but are increasingly being prescribed off-label to treat lower back and neck pain. In a meta-analysis published in the *Canadian Medical Association Journal*, researchers examined nine studies of chronic low back pain or lumbar radicular pain that included 859 unique patients and compared topiramate, gabapentin, or pregabalin to placebo. Results revealed that these medications do not appear to improve low back pain. In fact, the gabapentinoids did not have any effect on low back pain or disability and topiramate appeared to have only a small effect on pain, and then only in the short term. Neither treatment had any effect on lumbar radicular pain. Researches also pointed out that gabapentinoids were associated with significantly increased risk for adverse events relative to placebo, including drowsiness, dizziness, and nausea. The authors concluded that the evidence does not support the use of anticonvulsants for treatment of either chronic low back pain or lumbar radicular pain. This was based on the high quality of evidence suggesting no treatment benefit for pain and disability, and high-level evidence supporting the risk of harms. ■

*“The AAP...states that the nasal spray should be a last resort for children who would not otherwise receive a flu vaccine.”*

### Stick with Needles for the Upcoming Flu Season

**Key point:** AAP recommends against nasal spray for upcoming flu season.

**Citation:** American Academy of Pediatrics. American Academy of Pediatrics advises parents to choose the flu shot for 2018-2019 flu season. Available at: <https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAP-Advises-Parents-to-Choose-the-Flu-Shot-For-2018-2019-Flu-Season.aspx>. Accessed August 14, 2018.

The American Academy of Pediatrics will advise families to choose the inactivated influenza vaccine (the flu shot) when they vaccinate their children this fall. The decision was made by the AAP Board of Directors after reviewing data on the effectiveness of this season's flu shot compared with the nasal spray flu vaccine, which has not worked as well in recent flu seasons. Even though the CDC's Advisory Committee on Immunization Practices gave a weak endorsement of the live attenuated nasal flu vaccine (Flumist) for the 2018–2019 flu season, AAP clearly recommends the injectable influenza vaccine over the nasal spray for youth this year. They will publish their formal policy statement on flu prevention in September. In the previous 2 years, neither the AAP nor the CDC recommended the live attenuated vaccine (nasal spray) because evidence showed it had poor efficacy against H1N1 and other strains. The AAP did not endorse this season's influenza nasal spray vaccine (still citing poor efficacy), stating that the nasal spray should only be used in children who would otherwise go unvaccinated. In an AAP press release, a member of the AAP Committee on Infectious Diseases said, “If you get the nasal spray vaccine, just be aware that there might be a chance you will not be fully protected against H1N1 strains of flu.” In summary, the AAP does not recommend the nasal spray for routine influenza vaccination in children (they instead recommend the injectable version) and state that the spray should be a last resort for children who would not otherwise receive a flu vaccine. ■



**Committed to  
providing you  
*the best*  
financial health!**

Small business loans up to  
\$5 million approved in days

Experienced & knowledgeable  
in the Urgent Care Industry

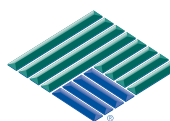
Quick-Close with a streamlined  
low-doc closing process

Extraordinary personal service,  
no automated system



Call Jeremy Goltz or Tom Ethen today!

**1.888.320.2899**



**STEARNS  
BANK** N.A.  
*We get the job done!*

Follow us     [StearnsBank.com](https://www.StearnsBank.com)

Member FDIC



## Taking the Occupational Medicine History

■ MAX LEBOW, MD, MPH, FACEP, FACPM

**Urgent message:** A thorough, occupational medicine-specific history is essential to identifying and resolving work-related injuries and illnesses quickly and safely—for the benefit of the patient and the employer.

Like any medical history, the occupational medicine history is meant to guide the clinician to the proper diagnosis and treatment for the patient. However, it is set apart from the “typical” history in that several other goals must be achieved in the process. Not only are the duties and responsibilities of the occupational primary treating physician often mandated by law, gathering the proper historical information at the beginning of the case will lead to a timely resolution and rapid return to work for the injured worker, help avoid an adversarial relationship between the employer and the employee, and identify any red flags to assure that the subjective complaints and description of the injury match the objective findings of the physical exam. Finally, healthy, respectful skepticism is helpful in determining if the claimed injury or illness occurred out of and in the course of employment vs the result of off-duty activities. (Note: The specific words “arising out of and in the course of” are often used to make the determination of on-duty vs off-duty injury)

Here, we discuss some of the key requirements and nuances of obtaining an occupational medicine history in the urgent care setting.

### Understand Your Patient’s Job Duties

Injured employees often present with paperwork that identifies their job title. What does that actually mean, though? Job

### Goals of Occupational History

- Establish the precise onset of symptoms
- Understand the patient’s job duties
- Obtain detailed mechanism of injury
- Determine if the illness/injury is work-related
- Determine if case meets OSHA first aid requirements
- Determine work status: full vs modified duty, or TTD
- Determine treatment options
- Estimate time to Maximum Medical Improvement
- Identify any “red flags”

titles can be ambiguous, and often do not describe what the employee—your patient—actually *does*. Questions such as the amount of time spent standing vs sitting; lifting requirements of the job, including how much and how often; and description of any particularly awkward motions such as cleaning behind sinks help define the worker’s actual duties.

This information is obtained in three different ways.

First, ask specific questions during your history. For example, if someone is claiming a knee injury, it is important to know whether most of their time is spent sitting or standing, and if they are carrying heavy loads.

The second way is to talk to your client company. The examining physician should talk to the company contact to obtain job duty information, or better yet, obtain a copy of the defined job duties, which will generally describe the percentage of time spent sitting vs standing, the usual loads that the employee is expected to lift during the day, and other important information about the physical demands of the job.

Finally, I have found that scheduling a visit to the job site provides invaluable information about the work environment and insights into the daily activities of the workers. It’s also an opportunity to meet the supervisors, safety officers, and those I will communicate with in the future to facilitate better relations.

Of special importance is the determination of whether the



**Max Lebow, MD, MPH, FACEP, FACPM** Is Board Certified in Emergency Medicine and Preventive/Occupational Medicine, and is President and Medical Director of Reliant Immediate Care Medical Group.

job is “safety sensitive.” Does the employee drive, operate machinery, work around toxic materials? The answers to these questions not only help reveal the mechanisms of some injuries, but also help the occupational medicine provider create a modified duty program that can keep the injured employee at work and active during the recovery period.

All this information can illuminate how the injury or illness occurred, and help the occupational medicine provider formulate a treatment plan to optimize recovery and return to full duty at preinjury levels as quickly and safely as possible.

#### **Length of Time with Current Employer and at Current Position**

The length of time the patient has been on the job can be a predictive indicator for how quickly recovery will progress. For example, an employee claiming an overuse injury in the first few weeks of employment represents the need for strengthening, rather than treatment for repetitive strain injury. An injury shortly after hiring may also be a red flag for possible workers’ compensation fraud.

The length of time a worker has been performing a task may also offer more subtle clues that the root of the complaint may not be physical. For example, long-term employees who have had a recent change in their job function, or a shift change, may be dissatisfied with the change and more likely to claim a work-related injury. Only close attention to the details of the mechanism of injury and the subjective complaints and objective findings can make these important differentiations.

#### *Full or part-time employment?*

One factor that may be overlooked by the occupational medicine provider is that many people now may hold two or three part-time jobs simultaneously. This is a common reason for delay in recovery from musculoskeletal injuries. Patients who have jobs outside of the one related to their treatment may be unable to rest adequately between shifts, have frequent missed appointments or missed physical therapy treatments, or be nonadherent with self-treatment, such as stretching and home exercise.

*“An overuse injury in the first few weeks of employment represents the need for strengthening, rather than treatment for repetitive strain injury.”*

*“Gradual vs sudden onset can help differentiate repetitive stress injury from acute musculoskeletal strain.”*

#### **History of the Current Illness or Injury**

Understanding precisely when the injury began is an important part of the occupational medicine history. Gradual vs sudden onset can help differentiate repetitive stress injury from acute musculoskeletal strain, and help predict the timeline and outcome of the case.

Delay in reporting may represent a red flag for deception or secondary gain associated with the injury. Most serious injuries are reported immediately, and treatment can begin quickly. If there is no obvious reason for a delay in the injured worker presenting to the clinic, probe for a reasonable explanation. One method of probing for issues such as workplace dissatisfaction is to ask: “What is it like to work for company ABC?” An open-ended question is less likely to elicit a defensive response, and more likely to give an unvarnished answer.

#### *Is this injury new, or a recurrence?*

A good description of any previous injuries, especially in the previous 36 months, can help differentiate a new injury from a recurrence of an old injury (and, therefore, help direct treatment decisions). The differentiation can be difficult, but a reasonable decision can be made with patient questioning and a review of thorough records.

#### **Obtain a Detailed Mechanism of Injury**

For an urgent care patient, it is adequate to document that the patient experienced “back pain after lifting,” or “hurt ankle climbing steps.” In a typical urgent care setting, there is little riding on where or when an injury occurred. By contrast, the workplace injury should be described in greater detail, to assure that the mechanism can reasonably explain the patient’s injury claim. For example, understanding the approximate weight of an object can help determine whether this injury occurred during routine job activities, was an unusual event, or occurred in an activity unrelated to the job. This information can also help determine work modifications at discharge.

#### **Document a Thorough List of Subjective Complaints**

In urgent care or emergency medicine, the provider will perform a clinical triaging to distinguish serious injuries from



minor injuries that may not need immediate attention. By contrast, in occupational medicine all subjective complaints and injured body parts and locations should be recorded. One way to accomplish this, and help organize your eventual treatment plan, is to ask the patient to list areas of pain, from worst to least troublesome. It is important to ask this question again at every subsequent visit to help monitor recovery, or identify more persistent areas of pain that may need special attention. Also, a great deal of inconsistency may be a red flag to identify exaggeration of the injury.

Finally, when this process is completed, the occupational medicine provider should document "No other injuries present." This statement is intended to assure that no non-work-related illness or injuries are later injected into the case.

### Past Occupational History

Similar to a past medical history, the goal of the past *occupational* history is to identify previous injuries, both work-related and non-work-related, that may interfere with the patient's timely recovery.

Akin to this, consider whether the patient is being treated for any other work injury currently; has any disabilities caused by a previous work injury; or has any current restrictions or accommodations in the workplace. It should be remembered that an injured worker could have multiple workers' compensation cases running at the same time. Multiple previous or concurrent workplace claims may be a clue that the patient is trying to manipulate the work comp system.

### Conclusion

While this may seem like a lot of information to gather, once the provider becomes familiar with the process and understands the rationale of the occupational medicine history, it takes only a few minutes to get the relevant facts. Because the occupational medicine physician has many administrative (as well as medical) decisions to make, having all the information together at the beginning of the case will facilitate correct diagnosis and proper treatment of work-related injuries, while also assuring that the injured worker and the employer are both treated fairly. ■

Is it viral or bacterial?  
Urgent or routine?

Take the guess work out  
of urgent care with  
HORIBA Medical!

HORIBA's hematology and chemistry analyzers provide:

- Fast and accurate results allowing you to deliver more decisive patient care
- Reduce patient anxiety by eliminating the wait time for test results
- Lower the cost of health care by minimizing repeat visits to the urgent care

Now you can have immediate results and a complete picture of the patient's wellness while you treat them.

**HORIBA**  
Medical

Micros ES 60 Hematology System  
3-part diff



Advanced technology  
in a small footprint  
HORIBA Part # 5360600241

Pentra 60C+ Hematology System  
5-part diff



Compact  
5-part diff system  
HORIBA Part # 5300001398

Pentra C400 Chemistry Analyzer



Compact benchtop  
from routine to  
special testing  
HORIBA Part # 5300001388



# Rhabdomyolysis in a Previously Healthy 33-Year-Old Man

**Urgent message:** Life-threatening degrees of rhabdomyolysis can be seen in young, healthy patients with stable presentation and nearly normal examination findings.

JOHN SHUFELDT, MD, JD, MBA, FACEP and ZANA ALATTAR, MS3

## Introduction

This case demonstrates the importance of considering and ruling out rhabdomyolysis in patients with myalgia. We describe a case illustrating the management and work-up of myalgia in a young, healthy individual to identify the underlying cause. As with many illnesses, the linchpin to make the diagnosis is often found in the history.

## Case Presentation

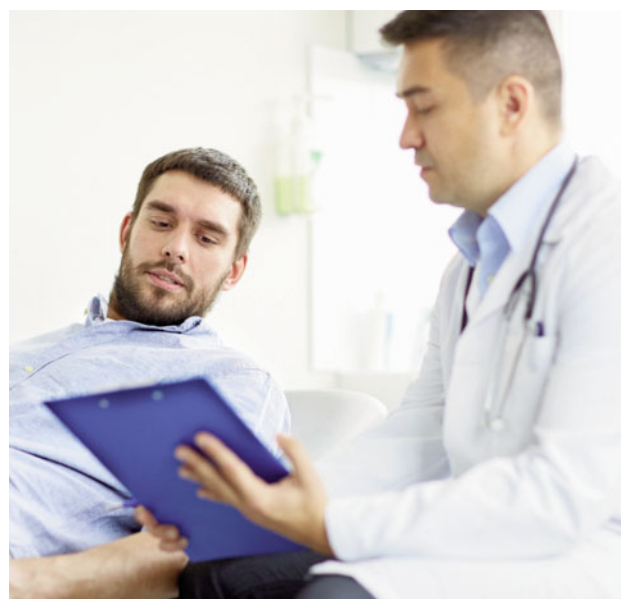
A 33-year-old healthy male presented to urgent care reporting diffuse muscle pain and soreness since the previous evening, with associated weakness, headache, and discoloration of his urine. He presented to the urgent care center concerned for dehydration. The patient exercises regularly and most recently lifted weights yesterday. He denies strenuous exercise or excessive exertion, outside of his usual regimen. Patient denies alcohol, drug, or supplement use.

## Physical Examination

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

- Temperature PO: 36.2° C
- Heart rate: 79 bpm
- Blood pressure: 144/95 mmHg
- Respiratory rate: 20 breaths/min
- O<sub>2</sub> sat: 100% on room air

The patient's lungs were clear to auscultation bilaterally, respirations were nonlabored, and breath sounds were equal. The cardiovascular examination revealed normal peripheral perfusion and a regular heart



©Fotolia.com

rate and rhythm without murmur. Extremities showed no sign of edema, swelling, tenderness, or ecchymosis. The abdomen and back were nontender. The neurologic examination showed no focal neurologic deficit; cranial nerves II through XII were intact; and normal sensory, motor, speech, and coordination findings.

## Diagnostic Results

An electrocardiogram showed no acute changes. A urine sample was collected and demonstrated dark, tea-colored urine. Urine dipstick showed heme-positive urine. An IV was started; the patient received a 1 L fluid

John Shufeldt, MD, JD, MBA, FACEP is Principal at Shufeldt Consulting in Scottsdale, AZ. Zana Alattar is a third-year medical student at the University of Arizona College of Medicine–Phoenix.

Complete Metabolic Profile		
Albumin	3.4 g/dL	Low
BUN	12 mg/dL	Normal
Calcium	8.1 mg/dL	Low
CO <sub>2</sub>	22 mmol/L	Normal
Chloride	110 mmol/L	Normal
Creatinine	0.91 mg/dL	Normal
Glucose	88 mg/dL	Normal
Potassium	4.2 mmol/L	Normal
Sodium	139 mmol/L	Normal
Protein, total	6.7 mg/dL	Normal
Bilirubin, total	0.4 mg/dL	Normal
ALT	382 Units/L	High
AST	1,253 Units/L	High
Alk phos	76 units/L	Normal
Further lab studies showed a severely elevated creatine kinase (CK) of 102,650 units/L (reference: 60-400 units/L), consistent with diagnosis of acute rhabdomyolysis.		

bolus. He was then transferred to the ED.

Upon arrival to the ED, the patient immediately received a 2 L bolus of normal saline. The patient was then able to produce enough urine for a formal urinalysis and urine myoglobin levels, which revealed the positive dipstick was secondary to myoglobin in the urine.

Complete metabolic profile (CMP) was concerning for hypocalcemia, hypoalbuminemia, and elevated aminotransferases.

### Diagnosis

The patient was diagnosed with acute rhabdomyolysis.

### Overview

Rhabdomyolysis is a potentially life-threatening condition of skeletal muscle breakdown, which results in the release of intracellular muscle contents—such as myoglobin, creatine kinase, aldolase, lactate dehydrogenase, alanine aminotransferase, aspartate aminotransferase, and electrolytes—into the bloodstream.<sup>1</sup> This condition should be suspected in patients with the classic triad of muscle pain, weakness, and tea-colored urine, especially in the setting of myoglobinuria. Myoglobinuria is seen only in cases of rhabdomyolysis and presents as a positive result for blood on urine dipstick, in the absence of RBCs on urine

*“Initial management and treatment of rhabdomyolysis can be accomplished in most urgent care settings.”*

sedimentation. While this presentation raises suspicion for the disease, the gold standard for definitive diagnosis of rhabdomyolysis is measurement of the serum CK. Diagnosis is confirmed with concentrations 5-10 times the upper limit of normal (<100 units/L), typically in the range of 500–1,000 units/L.

Of note, urine discoloration secondary to myoglobinuria is only seen in half of cases and therefore, is also not the primary indicator of the illness. In addition, routine lab tests can vary significantly depending on the underlying cause of the rhabdomyolysis and should not be relied on for diagnosis.<sup>2</sup> On physical exam, muscle tenderness and swelling may be seen; however, the swelling usually develops, if it occurs, with volume repletion. Therefore, a normal physical exam also does not exclude the diagnosis of rhabdomyolysis.

Thus, the duty falls on the physician to obtain a CK level on patients with high suspicion for rhabdomyolysis. Patients who present with the aforementioned triad of symptoms in the setting of one of the causes of rhabdomyolysis are prime candidates for evaluation of CK level. Common causes of acute rhabdomyolysis include mechanical injury from trauma or excessive muscle activity, alcohol or drug abuse, toxins, lying in one position (for example, when a patient gives a history of passing out after excessive use of alcohol for a prolonged period), medications, or infection. In patients with extreme physical exertion, risk increases with conditions causing dehydration, including severe heat or humidity and the abuse of diuretics, as seen in some athletes.

Once diagnosed, the severity of rhabdomyolysis varies and is strongly correlated with the extent of enzyme elevation. Regardless of severity, initial management and treatment of rhabdomyolysis can be managed in most urgent care settings. Early fluid resuscitation is key to treatment and prevention of further complications. However, it is the severity of the syndrome and presence or absence of complications upon patient presentation that dictates next-steps for the patient.

While in the urgent care center, if the patient's urine is tea-colored and heme-positive, the author would err

on providing IV fluid boluses and referring the patient to the emergency department for further testing as described above. Additionally, if the patient cannot tolerate PO fluid intake or is unable to recognize the potential seriousness of their diagnosis, transfer to the ED and potential admission is warranted to ensure adequate hydration. Complete evaluation of patients with suspected severe rhabdomyolysis should include serum myoglobin levels, creatinine, electrolytes, uric acid, and liver function tests, as well as urinalysis and urine screen for myoglobinuria.<sup>3,4</sup> If, however, the patient is only trace positive, is tolerating PO fluids, is amenable to increasing their PO fluid consumption, another course of action would be to discharge home with close follow-up and expectant observation.

### Additional indications for ED transfer

**Rhabdomyolysis-induced acute kidney injury.** Acute kidney injury (AKI) is a common, potentially life-threatening complication of severe rhabdomyolysis. This is seen in 15%–33% of cases of rhabdomyolysis and is most common in cases due to alcohol, drugs, or trauma.<sup>5</sup> Risk of AKI is higher in patients with CK level >5,000 units/L.<sup>2</sup> Therefore, close monitoring of renal function, in addition to serial CK levels, is suggested in these patients. As such, patients with CK levels >5,000 units/L should be considered for transfer to the ED for more aggressive fluid resuscitation, renoprotective management, and admission. Physicians caring for such patients should be aware that CK level elevation peaks 1–3 days after initial muscle injury and will decline 3–5 days after cessation of the muscle injury.

**Rhabdomyolysis-induced electrolyte abnormalities or cardiac arrhythmias.** Fatal complications from severe rhabdomyolysis include cardiac arrest and respiratory failure. Therefore, patients with severe rhabdomyolysis should receive an immediate ECG to assess for cardiac arrhythmias due to electrolyte imbalances. Upon admission, the patient should be placed on continuous cardiac monitoring.

### Take-Home Points

This case of rhabdomyolysis could have resulted in severe complications if left undiagnosed and untreated. It was prudent that the clinician at the UC use her clinical judgement and refer the patient to the ED at the appropriate time. The patient's early volume resuscitation was critical in preventing permanent renal damage. It is important to consider rhabdomyolysis in

### Summary

- The “classic triad” of rhabdomyolysis includes muscle pain, weakness, and tea-colored urine.
- Initial management and treatment of rhabdomyolysis can be accomplished in most urgent care settings.
- Common causes of acute rhabdomyolysis include mechanical injury from trauma or excessive muscle activity, alcohol or drug abuse, toxins, lying in one position (eg, a patient who admits passing out after excessive use of alcohol for a prolonged period), medications, or infection.
- In patients with extreme physical exertion, risk increases with conditions causing dehydration, such as severe heat or humidity and abuse of diuretics.
- Complete evaluation of patients with suspected severe rhabdomyolysis should include:
  - Serum myoglobin levels
  - Creatinine
  - Electrolytes
  - Uric acid
  - Liver function tests
  - Urinalysis and urine screen for myoglobinuria
- Rhabdomyolysis is a potentially life-threatening condition of skeletal muscle breakdown, resulting in the release of intracellular muscle contents (eg, myoglobin, creatine kinase, aldolase, lactate dehydrogenase, alanine aminotransferase, aspartate aminotransferase, and electrolytes) into the bloodstream.

patients with the triad of myalgia, weakness, and urine discoloration. In patients whose cause of rhabdomyolysis is mechanical injury, patients may not realize that they exerted themselves to such a significant level. A thorough history should be taken to exclude co-risk factors such as dehydration, medication use, and recent illness. Moreover, a serum CK level must be attained to assess severity of rhabdomyolysis in order to identify appropriate treatment for individual patients. ■

### References

1. Bosch X, Poch E, Grau JM. Rhabdomyolysis and acute kidney injury. *N Engl J Med*. 2009 Jul 2;361(1):62-72, correction can be found in *N Engl J Med* 2011 May 19;364(20):1982, commentary can be found in *N Engl J Med* 2009 Oct 1;361(14):1411.
2. Brown CV, Rhee P, Chan L, et al. Preventing renal failure in patients with rhabdomyolysis: do bicarbonate and mannitol make a difference? *J Trauma*. 2004;56(6):1191-1196.
3. Dimitriu A, Lupescu O, Ciurea N, et al. Markers of inflammation in crushing trauma of the lower limbs. *Therapeutics, Pharmacology & Clinical Toxicology*. 2016;20(1):20-24.
4. Gabow PA, Kaehny WD, Kelleher SP. The spectrum of rhabdomyolysis. *Medicine (Baltimore)* 1982; 61:141.
5. Melli G, Chaudhry V, Cornblath DR. Rhabdomyolysis: an evaluation of 475 hospitalized patients. *Medicine*. 2005;84(6):377-385.

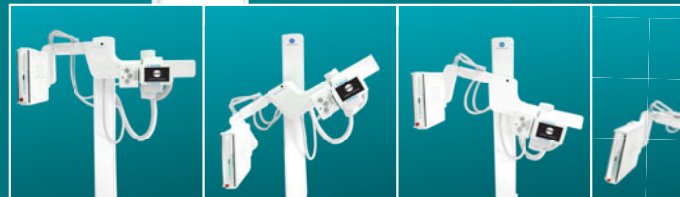


Fits your space.  
Fits your cases.  
Fits your workflow.  
Fits your needs.



## The KDR™ Advanced U-Arm.

The KDR™ AU System delivers state of the art digital X-ray technology in a compact, highly versatile design. With innovative features that optimize workflow, increase staff efficiency and help drive improved outcomes, the system is made to support **better decisions sooner** in any clinical setting.



©2017 Konica Minolta Healthcare Americas, Inc.

### Optimized Workflow

Swiveling into place across an extended range of motion, the system literally revolves around the patient. And advanced automation allows you to complete each scan faster. The result: Simplified workflow, increased efficiency, and more satisfied patients.

### Superior Image Quality

High resolution images with excellent bone and soft tissue visualization from a single exposure provide the clarity you need to reach confident diagnoses sooner.

### Compact and Versatile

Designed with small spaces in mind, the quality of imaging and workflow efficiencies of the system make it an excellent choice in facilities of any size.

### Intuitive Controls

With all vital information front and center in a highly intuitive interface, operators work more efficiently and make more confident decisions.

For more information visit:  
<http://www.konicaminolta.com/medicalusa/landing/kdr-advanced>



KONICA MINOLTA



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

If you would like to submit a case for consideration, please email the relevant materials and presenting information to [editor@jucm.com](mailto:editor@jucm.com).

## A Runner with a History of Foot Pain

Figure 1.



### Case

The patient is a 27-year-old male who presents to urgent care with foot pain, for which he says there is no explanation. With probing, he reveals that he is a “fanatic” about running, and that the pain has persisted for close to 7 months.

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

Figure 2.



## THE RESOLUTION



Mediastinal  
air

### Differential Diagnosis

- Capsulitis
- Freiberg disease
- Metatarsal stress fracture
- Metatarsalgia
- Tendinitis

### Diagnosis

The patient was diagnosed with Freiberg disease/avascular necrosis/osteochondritis of the second metatarsal head.

### Learnings

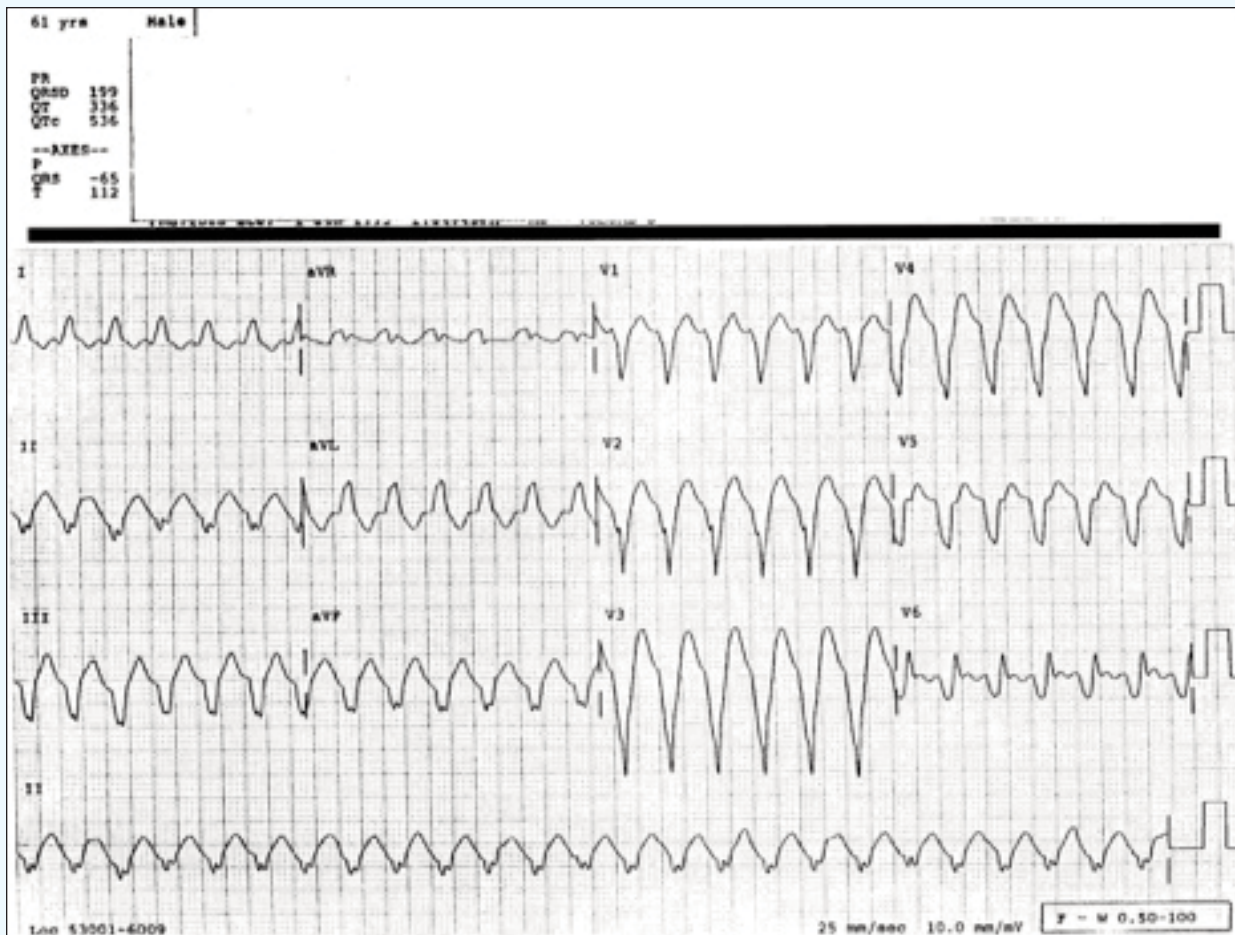
- This diagnosis occurs most often in patients from adolescence into the second decade of life
- The triggering event is trauma or repetitive trauma leading to metaphyseal microfractures, compromised vascular supply, and avascular necrosis
- Typically, head regions of the second or third metatarsal bones are involved

### Pearls for Urgent Care Management and Consideration for Transfer

- The radiographic findings are those of avascular necrosis. Findings include flattened, collapsed head region of the metatarsal bone, fragmentation of the metatarsal head, loose bodies in the MP joint, zone of demarcation, sclerosis, and deformed sclerotic head upon healing
- Diagnosis is based on plain radiograph or MRI showing an avascular necrosis
- Treatment consists of rest, modification of physical activities, immobilization, and surgery if necessary

**Acknowledgment:** Images courtesy of Teleradiology Specialists.

# A 61-Year-Old Man Who Is Lightheaded and Dizzy



**Figure 1.**

## Case

The patient is a 61-year-old man who presents to the urgent care center with lightheaded dizziness, which he says started several hours prior to arrival. He denies chest pain, syncope, and shortness of breath but says he feels “clammy.” He is not taking any medications on a regular basis and has no history of myocardial infarction, but he had a stent placed 8 years ago.

Upon exam, you find:

**General:** Alert and oriented X 3, mildly tachypneic, skin color good but slightly moist

**Lungs:** CTAB

**Cardiovascular:** Tachycardic and regular without murmur, rub, or gallop

**Abdomen:** Soft and NT, no pulsatile mass

**Ext:** No peripheral edema, pulses are 2+ and equal in all extremities

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



## THE RESOLUTION

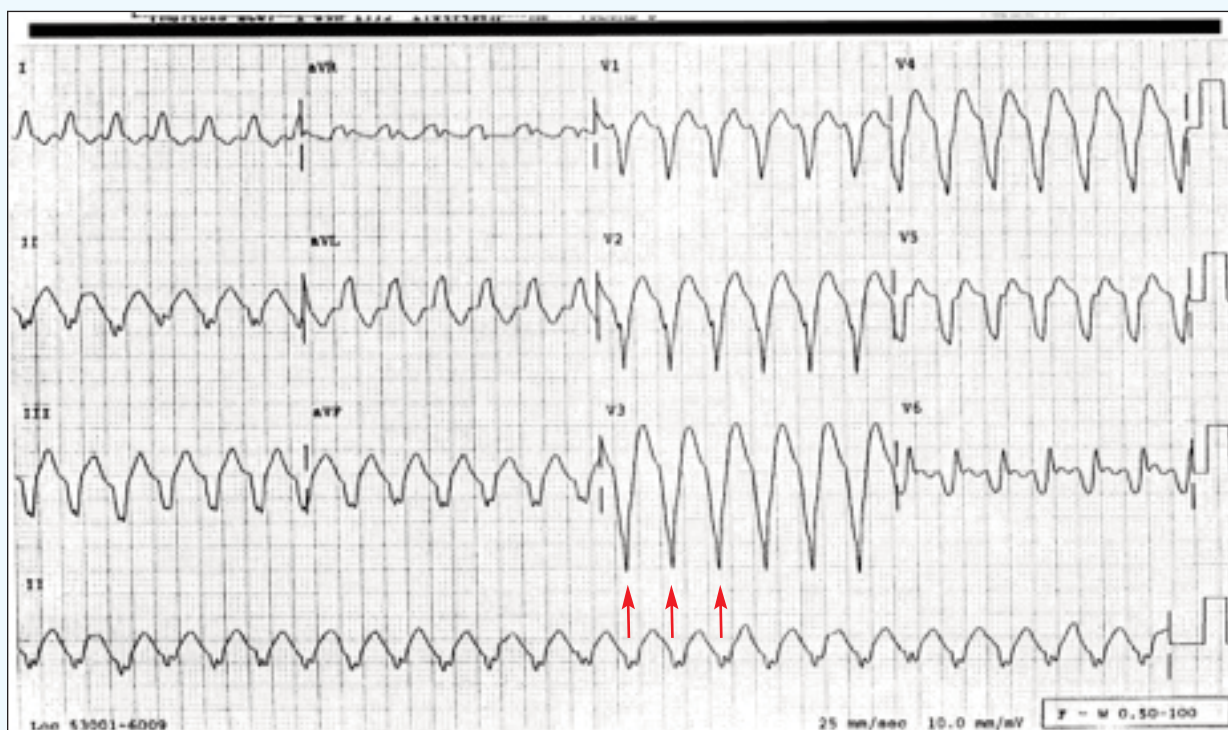


Figure 2.

**Differential Diagnosis**

- Anterior STEMI
- Grouped premature ventricular contractions
- Ventricular tachycardia
- Atrial flutter
- Atrial fibrillation with preexcitation

**Diagnosis**

This patient was diagnosed with ventricular tachycardia (VT).

The ECG reveals a regular rhythm which is tachycardic, with a rate just above 150 bpm. There are no defined ST elevations across the anterior precordium, V3 and V4, so anterior STEMI is unlikely.

Grouped premature ventricular contractions (PVC) would be seen as a ventricular complex which occurs intermittently with sinus rhythm. Focusing on lead II (on the bottom of the ECG), we see that all the complexes here are the same, making a PVC or grouped PVCs unlikely.

Atrial flutter should show a sawtooth pattern, best seen in leads V1 and V2, and though the rate is close to 150 (commonly seen with atrial flutter), there are no “flutter” waves.

Atrial fibrillation is an irregularly irregular rhythm, but our

patient’s rhythm is regular, so Afib is not occurring.

The ECG shows a wide complex, regular tachycardia without preceding P waves; this is VT.

**Learnings/What to Look for**

- VT is a wide complex tachycardia originating in the ventricles
- Monomorphic VT has complexes which originate from the same ventricular focus and are identical in appearance
- VT patients may be stable, as was our patient, or profoundly hemodynamically unstable

**Pearls for Urgent Care Management and Considerations for Transfer**

- Inquire about signs of ischemia such as chest discomfort, shortness of breath, diaphoresis, or dizziness
- Assess for hemodynamic instability such as hypotension, dizziness, or confusion
- VT is a true cardiac emergency and EMS should be emergently activated. While waiting, place the patient on a monitor and attempt to establish IV access
- Unstable patients require emergent cardioversion



## A 28-Year-Old Man Complaining of Tiredness, Myalgia, and Sore Throat

Figure 1.



### Case

The patient is a 28-year-old man who presents to urgent care with a fever and complaints of tiredness, myalgia, and sore throat. You note that he has pink, scaly papules on his palms and soles. He also has patchy alopecia developing on his scalp, which he says is a very recent development.

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

## THE RESOLUTION

Figure 2.

**Differential Diagnosis**

- Alopecia areata
- Pityriasis rosea
- Reactive arthritis
- Secondary syphilis

**Diagnosis**

This patient was diagnosed with secondary syphilis, the second stage of the infection caused by spirochete, which has spread throughout the entire body. Typically, it occurs 1–3 months after the appearance of the primary syphilitic chancre.

**Learnings**

- Secondary syphilis is characterized by hematogenous and lymphatic dissemination
- Patchy alopecia is distinctive of secondary syphilis

- Other symptoms could include weight loss and lymphadenopathy
- Malignant syphilis, or lues maligna, is a rare, noduloulcerative manifestation of secondary syphilis. Most contemporary cases have been reported in the setting of underlying human immunodeficiency virus infection

**Pearls for Urgent Care Management and Considerations for Transfer**

- The lesions of secondary syphilis heal in 2–10 weeks, with or without treatment. If left untreated, up to 25% of patients will relapse within the first 2 years
- Ocular screening (eg, slit lamp examination) is advised for patients with suspected or proven syphilis

**Acknowledgment:** Images courtesy of VisualDx.



# 2019 International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Codes

■ DAVID E. STERN, MD, CPC

October 1, 2018 will bring 279 new codes to ICD-10-CM. Combined with 51 deactivated codes (and 143 revised codes), that brings the total number of ICD-10-CM codes to 71,932. We identified a few examples that are especially important for urgent care coders to be aware of; a complete list of ICD-10-CM changes can be found on the CMS website at <https://www.cms.gov/Medicare/Coding/ICD10/2019-ICD-10-CM.html>.

### Chapter 2: Neoplasms (C00-D49)

*Melanoma and other malignant neoplasms of the skin*

The codes addressing carcinoma, melanoma, and neoplasm of the eyelid have been split into separate codes to indicate upper and lower eyelid. For example:

- C43.11, "Malignant melanoma of right eyelid, including canthus" has been deactivated
- C43.111, "Malignant melanoma of right upper eyelid, including canthus" has been added
- C43.112, "Malignant melanoma of right lower eyelid, including canthus" has been added

### Chapter 4: Endocrine, Nutritional and Metabolic Diseases (E00-E89)

*Metabolic disorders*

In addition to a couple of deactivations, new characters have been added to two codes (E72 and E78), allowing greater specificity:

- E72.8, "Other specified disorders of amino-acid metabolism" has been deactivated

- E72.81, "Disorders of gamma aminobutyric acid metabolism" has been added
- E72.89, "Other specified disorders of amino-acid metabolism" has been added
- E78.4, "Other hyperlipidemia" has been deactivated
- E78.41, "Elevated lipoprotein(a)" has been added
- E78.489, "Other hyperlipidemia" has been added

### Chapter 5: Mental, Behavioral and Neurodevelopmental Disorders (F01-F99)

*Mental and behavioral disorders due to psychoactive substance use*

Additional codes were added to report cannabis use with withdrawal:

- F12.23, "Cannabis dependence with withdrawal"
- F12.93, "Cannabis use, unspecified with withdrawal"

### Chapter 6: Diseases of the Nervous System (G00-G99)

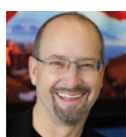
*Diseases of myoneural junction and muscle*

The more generic code G71.0, "Muscular dystrophy" was deactivated to make room for more specific codes:

- G71.00, "Muscular dystrophy, unspecified"
- G71.01, "Duchenne or Becker muscular dystrophy"
- G71.02, "Facioscapulohumeral muscular dystrophy"
- G71.09, "Other specified muscular dystrophies"

### Chapter 7: Diseases of the Eye and Adnexa (H00-H59)

Options to code blepharitis of upper and lower eyelids have been created so that one code will cover the condition of both the upper and lower eyelid. For example, code H01.00A, "Unspecified blepharitis right eye, upper and lower eyelids" can be assigned now, whereas before, the coder would assign a code for blepharitis of the right upper eyelid and another code for blepharitis of the right lower eyelid. Code subcategory H02.151 through H02.159 was added in order to diagnose par-



**David E. Stern, MD, CPC**, is a certified professional coder and is board-certified in internal medicine. He was a director on the founding board of UCAOA and has received the organization's Lifetime Membership Award. He is CEO of Practice Velocity, LLC ([www.practicevelocity.com](http://www.practicevelocity.com)), NMN Consultants ([www.urgentcareconsultants.com](http://www.urgentcareconsultants.com)), and PV Billing ([www.practicevelocity.com/urgent-care-billing/](http://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.



alytic ectropion of the eyelid. Subcategory H10.8, "Other conjunctivitis" was added in order to code rosacea conjunctivitis. The new codes are:

- H10.821, "Rosacea conjunctivitis, right eye"
- H10.822, "Rosacea conjunctivitis, left eye"
- H10.823, "Rosacea conjunctivitis, bilateral"
- H10.829, "Rosacea conjunctivitis, unspecified eye"

### Chapter 11: Diseases of the Digestive System (K00-K95)

#### *Diseases of appendix*

Some changes were made to codes for acute appendicitis with peritonitis. Codes K35.2, "Acute appendicitis with generalized peritonitis" and K35.89, "Other acute appendicitis" have been deactivated. Several new codes can be found in category K35. Some examples are:

- K35.20, "Acute appendicitis with generalized peritonitis, without abscess"
- K35.30, "Acute appendicitis with localized peritonitis, without perforation or gangrene"
- K35.890, "Other acute appendicitis without perforation or gangrene"
- K35.891, "Other acute appendicitis without perforation, with gangrene"

### Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)

#### *Other and unspecified soft tissue disorders not elsewhere classified*

The code for myalgia, M79.1, has been deactivated and four new codes have been added:

- M79.10, "Myalgia, unspecified site"
- M79.11, "Myalgia of mastication muscle"
- M79.12, "Myalgia of auxiliary muscles, head and neck"
- M79.18, "Myalgia, other site"

### Chapter 14: Diseases of the Genitourinary System (N00-N99)

#### *Other diseases of the urinary system*

Code N35.8, "Other urethral structure" was deactivated and the subcategory expanded in order to specify codes for male and female. You will now see codes such as these in this section:

- N35.819, "Other urethral stricture, male, unspecified site"
- N35.82, "Other urethral stricture, female"

### Chapter 18: Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00-R99)

#### *Abnormal findings on examination of urine, without diagnosis*

Code R82.99, "Other abnormal findings in urine" was deactivated and the code expanded to six digits, where the following codes were added:

- R82.991, "Hypocitraturia"

- R82.992, "Hyperoxaluria"
- R82.993, "Hyperuricosuria"
- R82.994, "Hypercalciuria"
- R82.998, "Other abnormal findings in urine"

### Chapter 19: Injury, Poisoning, and Certain Other Consequences of External Causes (S00-T88)

(As an unfortunate result of hospitals seeing an increase in human trafficking cases, the majority of new codes added are codes describing exploitation of children and adults.)

#### *Other and unspecified effects of external causes*

To help differentiate human trafficking victims from other abuse victims, the codes in categories T74 and T76 were expanded, making room for 24 new codes, such as:

- T74.51XA, "Adult forced sexual exploitation, confirmed, initial encounter"
- T76.662XA "Child forced labor exploitation, suspected, initial encounter"

In addition, code subcategory T43.64 has been expanded to allow 12 new codes to identify when the drug ecstasy was used, and the circumstance, such as T43.641A, "Poisoning by ecstasy, accidental (unintentional), initial encounter."

Subcategory T81.4 was expanded to incorporate 18 new codes that help identify postprocedural infection and sepsis. For example, T81.41XA, "Infection following a procedure, superficial incisional surgical site, initial encounter" is among one of those new code choices.

The seventh character options, A (initial), B (subsequent), and D (sequela) apply to all the codes in this section.

### Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

#### *Persons encountering health services for examination*

Examination code Z04.8, "Encounter for examination and observation for other reasons" was deactivated to make room for exploitation codes:

- Z04.81, "Encounter for exam and observation of victim following forced sex exploitation"
- Z04.82, "Encounter for exam and observation of victim following forced labor exploitation"
- Z04.89, "Encounter for examination and observation for other reasons"

Subcategory Z13.3 was created so that more specific screening codes could be assigned. A few of those are:

- Z13.31, "Encounter for screening for depression"
- Z13.32, "Encounter for screening for maternal depression"
- Z13.41, "Encounter for autism screening"

ICD-10 codes are updated annually, and are effective from October 1 through September 30. ■

### Patient First

## Physician Founded. Patient Focused.

**With an outstanding staff, Patient First supports you in providing excellent care.**



**We are looking for full- and part-time physicians.**

With over 70 locations throughout greater Washington, D.C., Maryland, Virginia, Pennsylvania, and New Jersey, Patient First physicians have been providing urgent and primary care for over 35 years. In addition to flexible schedules and career advancement opportunities, we offer a comprehensive compensation package that includes:

- Excellent salary
- Loan assistance
- Licensure and certification assistance and reimbursement
- Relocation package
- Outstanding malpractice insurance
- Health, dental, vision, life, and disability insurance, plus more.

To learn more, contact  
Recruitment Coordinator Eleanor Hertzler  
at 804-822-4478 or [eleanor.hertzler@patientfirst.com](mailto:eleanor.hertzler@patientfirst.com),  
or visit [www.patientfirst.com/PatientFirstCareers](http://www.patientfirst.com/PatientFirstCareers)



The Peak of Good Health

### Urgent Care Physician

**Summit Urgent Care seeks a Nurse Practitioner or Physician Assistant to join their expanding team of Urgent Care physicians and Advance Practice Providers**

- Full time
- Flexible Shifts
- 2 Urgent Care Facilities located in Chambersburg and Shippensburg
- 1 New Urgent Care Facility located in Greencastle, PA opening 2018

**Benefits**

- Highly competitive salary
- Health, life and disability insurance
- Generous allowances for CME, Dues
- Loan Repayment
- PTO
- Retirement savings plan with employer automatic contribution and match after 1200 work hours
- Relocation Expenses
- Medical malpractice insurance and tail coverage

**Summit Health**, Franklin County's largest healthcare provider, is headquartered in Chambersburg. As a non-profit organization, Summit Health works to improve the health of the community through leading-edge medical technology, skilled physicians, caring staff, and convenient locations.

**The Community**

Chambersburg, PA is in the heart of South Central Pennsylvania where you'll find mountains, lakes, and a picturesque countryside coupled with theater, music, skiing, fishing, and much more. Franklin County merges the best of small town friendliness with easy access to metropolitan areas. We're only 90 minutes from Baltimore and Washington, D.C., and only 3 hours away from Philadelphia and Pittsburgh.

For immediate confidential consideration or to learn more please contact:

**Tammie Chute - Physician Recruiter**

**[tchute@summithealth.org](mailto:tchute@summithealth.org)**

**717-267-7780**



### Urgent Care

Call This "Top 10" Community Home

McFarland Clinic is seeking a BE/BC Family Medicine or Emergency Medicine physician to join our extraordinary Urgent Care team and provide

exceptional care within Iowa's largest multidisciplinary clinic. Consistently ranked in the top 10 "Best Places to Live" by Money Magazine and CNNMoney.com, this thriving town has been ranked in the top 3 cities in the country for job growth.

- Full or part-time
- Epic EMR System
- Physician-owned and governed
- Large, established referral network
- One of the least litigious states in the country
- "#1 Best State to Practice Medicine" - WalletHub



Ames, Iowa is a family friendly town that offers top quality education with the best school district in the state. Home to Iowa State University, this Big 12 city has been voted the "Best College Town" by Livability.com. Our proud community boasts the cultural, recreational, and entertainment amenities of a big city while maintaining the charm that you have come to expect from small-town living. Become part of Ames, a place that will quickly become your hometown.

EOE/AA Employer/Protected Vet/Disabled

**Contact Doug Kenner**

866-670-0334 or [dkenner@mountainmed.net](mailto:dkenner@mountainmed.net)



**McFarland Clinic**

**Extraordinary Care, Every Day**

## Advertise Your Urgent Care Opportunity With Us

Get your urgent care job opportunity in front of the most qualified candidates in the industry.

Advertise in *The Journal of Urgent Care Medicine* and on the JUCM Career Center.



**JUCM**  
THE JOURNAL OF URGENT CARE MEDICINE  
**CAREERCENTER**

**FIND THE RIGHT JOB**  
[www.UrgentCareCareerCenter.com](http://www.UrgentCareCareerCenter.com)

## CAREERS



### *I am a* **PERMANENTE PHYSICIAN.**

While every physician at the **Southern California Permanente Medical Group** has their own personal and professional ambitions, they all share a common vision: to transform the practice of medicine. Every day, they work hand in hand—with each other and their patients—to achieve outcomes that elevate the level of care across our organization and, ultimately, our nation.

### **FULL-TIME URGENT CARE PHYSICIANS**

Opportunities throughout Southern California

**\*\*Ask about our Advance on Pay Bonus\*\***

Our physicians benefit from:

- Alternate Work Schedule
- No Patient Panel
- Diverse Patient Population
- No Overnights
- Procedure Driven

**SCPMG is proud to offer its physicians:**

- **An organization that has served the communities of Southern California for more than 60 years**
- **A physician-led practice that equally emphasizes professional autonomy and cross-specialty collaboration**
- **Comprehensive administrative support**
- **An environment that promotes excellent service to patients**
- **A fully implemented electronic medical record system**
- **An excellent salary, comprehensive benefits and partnership eligibility after 3 years**

At SCPMG, you'll enjoy the amazing recreational activities, spectacular natural scenery and exceptional climate our area is known for, along with stability in today's rapidly changing health care environment.

If you believe in pursuing dreams, creating hope and driving progress, then you're the very definition of a Permanente Physician. For consideration or to apply, please visit our website at <http://scpmgphysiciancareers.com>. For additional information about these opportunities, contact Virginia Albert at [Virginia.L.Albert@kp.org](mailto:Virginia.L.Albert@kp.org) or call **877-824-8284**. We are an AAP/EEO employer.



**KAISER PERMANENTE.**

Southern California Permanente Medical Group

The **Answer**  
to Health Care  
in America.

## MARKET PLACE

### MEDICAL EQUIPMENT/SUPPLIES



*X-Ray Systems – new or used*  
*Economy CR/DR options*  
*Nationwide Installation*

*imaging solutions for your clinic & budget*

**CALL FOR MORE INFO!**

**1.800.727.7290 x1209**

**BlueRidgeXray.com**



**JUCM**  
THE JOURNAL OF URGENT CARE MEDICINE

**CAREERCENTER**

**FIND THE RIGHT JOB**  
**[www.UrgentCareCareerCenter.com](http://www.UrgentCareCareerCenter.com)**





# Warning: The Future of Patient Engagement May Require Straying Beyond Your Comfort Zone

Urgent care has faced many challenges since its inception—starting with trying to get healthcare consumers and insurers to understand what it has to offer that's different from a traditional primary care practice or the emergency room. Through true market evolution—we're talking Darwin, here—that hurdle has helped separate the wannabes from the real innovators. The latter came to grasp that a patient-friendly approach would be one obvious attribute that could keep waiting rooms full and good word-of-mouth buzzing. Many who failed to grasp that also failed to stay in business.

So, the results of a new study by the marketing consulting firm Prophet can be viewed as confirmation that urgent care has flourished at least partly because its founders were on the right track all along. The data plainly spell out that all healthcare environments would be well advised to adopt a more patient-friendly (ie, retail-like) approach to the patient experience. Organizational leaders across various practice settings seem to be getting the message—though the data below also seem to suggest that even those who are thinking outside the box might be too nervous to step outside it. ■

### WHAT WE THINK VS WHAT WE WOULD DO



say the most important innovations come from digital companies



would be comfortable partnering with a digital company



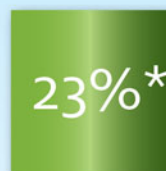
would consider bringing in leaders from consumer-centric industries



expect leaders to have a medical or clinical background



measure specific *experience* metrics (eg, appointment satisfaction)



measure *relationship* metrics

\*Among healthcare providers surveyed.

Data source: Prophet. The Healthcare Shift: The Transformation to Consumer Centricity. 2018.

# Corporate Support Partners

Thank you to our Corporate Support Partners for their ongoing support in helping the association achieve its mission and vision.

## DIAMOND PARTNERS



## PLATINUM PARTNER



## GOLD PARTNERS



## SILVER PARTNERS



## BRONZE PARTNERS



# 100.00 PERCENT

**Uptime the last 60 days.**

How is your EMR doing?

Call 888-779-0542 now for a FREE demo.

---

[practicevelocity.com](http://practicevelocity.com)

