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

OCTOBER 2018  
VOLUME 13, NUMBER 1

UCA URGENT CARE ASSOCIATION

COLLEGE OF URGENT CARE MEDICINE

www.jucm.com

The Official Publication of the UCA and CUCM

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## Uncovering Syphilis

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# Taking a QI Approach to Antibiotic Stewardship



In my previous column, I introduced why antibiotic stewardship is important to urgent care practice and presented some practical solutions to common scenarios that can lead to overprescribing of antibiotics. This month, let's look at some efforts underway to promote stewardship through education and performance improvement initiatives.

Quality improvement (QI) programs have several key components that apply very well to antibiotic stewardship initiatives; these can serve as a guide as you prepare your own plan of action. The nice thing about QI projects is that the interventions you make are not prescriptive. You can tailor your plan to what works best for you and your patients. The key components include the following: identify, intervene, measure, report, change.

- Identify: What is the problem and what are you trying to achieve?
  - Antibiotic overuse
  - Reduce unnecessary antibiotic use
- Intervene: What are you proposing to do?
  - Patient and provider education
  - Back-up antibiotic policy and procedure
  - MIPS quality measure implementation
- Measure:
  - Pre- and postintervention measures
  - Audits
  - Surveys
- Report:
  - Monthly performance reports to providers
  - MIPS reporting
  - Benchmarking
- Change:
  - Intervention
  - Implementation
  - Repeat QI assessment

For a QI initiative to be successful, data collection and reporting are key. Working with your EMR vendor to develop simple reports can go a long way in this regard. Even if you aren't planning to formally participate in MIPS, many EMRs are already capable of collecting data to match some of these measures. Here are some examples:

*“Urgent care can have a dramatic impact on unnecessary antibiotic use...without impacting patient satisfaction.”*

- MIPS Measure #65: Appropriate treatment for children with upper respiratory infection
- MIPS Measure #66: Appropriate testing for children with pharyngitis
- MIPS Measure #91: Acute otitis media externa topical therapy
- MIPS Measure #116: Avoidance of antibiotic treatment in adults with acute bronchitis

Even if your EMR vendor does not participate in MIPS, they should be able to run simple reports for you to yield similar results. One example would be to match the diagnosis codes for upper respiratory infection and bronchitis with antibiotic prescriptions to determine the rate of antibiotic prescribing for these nonindicated conditions.

Patient and provider education is another important intervention that should be part of any stewardship program. There are a lot of materials available, but I encourage you to review the Antibiotic Stewardship Toolkit compiled by the Urgent Care Association. You can access the toolkit at [www.ucaoa.org/antibioticsteward](http://www.ucaoa.org/antibioticsteward).

With proper training, scripting, and patient education tools, urgent care providers can have a dramatic impact on unnecessary antibiotic use in the communities we serve *without* impacting patient satisfaction. Still in doubt? Consider implementing any of the initiatives described above over 1-2 months and simultaneously measure performance and patient satisfaction. I am confident that you will be surprised by the results. ■

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

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**CLINICAL**

## 11 Syphilis in the Urgent Care Center

Sexually transmitted diseases are on the rise in the U.S.—and syphilis is spreading fastest of all. Diagnosis and initiating treatment often require looking beyond the presenting complaint, as many infected patients may not even know they have it.

*Brandon Godfrey, MD; Haylie Wiesner, BS; and John Shufeldt, MD, JD, MBA, FACEP*

**PRACTICE MANAGEMENT**

## 17 How Urgent Care is the Antidote to Traditional Doctors' Offices



Patients just aren't happy with the "same old, same old" healthcare experience—that's why they're flocking to urgent care centers in greater numbers. But what exactly are they seeking?

*Alan A. Ayers, MBA, MAcc*

**CASE REPORT**

## 20 A 32-Year-Old Male with Unsteady Gait



You're unlikely to see patients who complain they have symptoms of multiple sclerosis. The onus is on the provider to recognize red flags, take a thorough history, and initiate a focused examination.

*Waqas Memon, MD; Zonaira Shabbir, OMS IV; and Muhammad Akhtar, MD, FACP*

**HEALTH LAW AND COMPLIANCE**

## 23 Animals Used for Medical and Support Assistance in the Urgent Care Setting



Do you know the difference between an actual service animal and one a patient relies on for emotional comfort and support—and what your obligations under the law are for each?

*Alan A. Ayers, MBA, MAcc*

**CLINICAL**

## 26 Employing the Parental Papoose Technique in Treating Young Children



Even usually calm, cooperative children can be difficult to treat if they're frightened or in pain.

Knowing how to keep them still, with a parent's help, is the best way to make sure minor procedures go smoothly and safely.

*Oscar D. Almeida, Jr., MD, FACOG, FACS*

**IN THE NEXT ISSUE OF JUCM**

*By next month, you're likely to see patient visits due to symptoms of influenza start climbing—and if the Centers for Disease Control and Prevention's predictions are correct, they're likely to climb high, fairly quickly. Your patients' best preparation, as you know, is to get a flu shot. Your best preparation is to read our two-part series on influenza. Part I will offer background on matching the vaccine to the strains most likely to dominate, who does (and doesn't) need a flu test in your urgent care center, and trying to minimize the effects of flu in patients who do become infected.*

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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.

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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)



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Patients usually do their best to tell their clinician all the information they can about what brought them to the urgent care center. Sometimes, however, they may be hesitant to share details they may find embarrassing. In other situations, they might leave out things they simply haven't noticed or that they don't think are relevant. That's why it's so important to look beyond the stated history, and to ask the right questions to uncover the details you need to make the right diagnosis—and to start treatment as soon as possible.

In Syphilis in the Urgent Care Center (page 11), we're introduced to a woman with a plethora of acute and chronic health concerns. As far as she knows, though, none of them has anything to do with having a sexually transmitted disease. Her case is the basis of a deeper discussion about diagnosing and treating syphilis, which is one of the fastest-growing STDs in the United States. We're grateful to **Capt. Brandon Godfrey, MD, USAF, MC, FS**; **Haylie Wiesner, BS**; and **John Shufeldt, MD, JD, MBA, FACEP** for presenting this article.



Dr. Godfrey is an active-duty member of the United States Air Force; Ms. Wiesner is chief medical scribe at Children's Hospital of Wisconsin in Milwaukee; and Dr. Shufeldt is the interim chief medical officer at San Carlos Apache Healthcare Center and chief executive officer of US Careways.



Patients would also be hard pressed (and certainly hesitant) to attribute new symptoms to a serious condition like multiple sclerosis.



One such patient presented to an urgent care center and, thankfully, was seen by a clinician who dug deep to hasten the diagnosis of MS so the patient could get started on the right course of treatment soon thereafter, likely improving his odds for the best outcome possible. **Waqas Memon, MD, Zonaira Shabbir, OMS IV, and Muhammad Akhtar, MD, FACP** crafted a case report, *A 32-Year-Old Male with Unsteady Gait that begins on page 20*.

Dr. Memon is a third-year Internal Medicine Resident at the University of Illinois-Urbana Champaign; Ms. Shabbir is a student at the Kentucky College of Osteopathic Medicine; and Dr. Akhtar is a neurologist with Adena Regional Medical Center.

The youngest patients who come to your urgent care center are the most dependent on you, and on their parents, to make sure diagnoses are reached and care is administered as quickly and comfortably as possible. Sometimes, especially with children who are anxious or going through an uncomfortable



procedure, providers and parents need to work together to keep the child still. One method is the parental papoose technique. It's described by **Oscar D. Almeida, Jr., MD, FACOG, FACS**, a staff physician at Stopwatch Urgent Care LLC in Auburn, AL in *Employing the Parental Papoose Technique in Treating Young Children* (page 26).

Regardless of the patient's reason for needing to see a provider, they choose urgent care over other settings for particular reasons. One way or another, they perceive urgent care to be the solution to their problem. **Alan A. Ayers, MBA, MAcc** looks at that dynamic on a much broader scale in *How Urgent Care is the Antidote to Traditional Doctors' Offices* (page 17), examining how changing consumer expectations have been critical in fueling the growth of our industry—and how primary care practices will need to adapt if they want to keep up. Mr. Ayers is chief executive officer of Velocity Urgent Care and Practice Management Editor of *The Journal of Urgent Care Medicine*.



Mr. Ayers also shares his expertise in successful management of an urgent care practice in this month's *Health Law and Compliance* feature. *Reading Animals Used for Medical and Support Assistance in the Urgent Care Setting* (page 23) will help you ensure you're up to speed on the rights of patients to bring service animals into a healthcare setting—as well as the limitations of those rights.

Finally, in *Revenue Cycle Q&A*, David Stern, MD, CPC provides literally valuable insights into how to ensure you're getting the reimbursements you deserve for incision and drainage procedures. *Small Errors Could Cost Big Bucks When Billing for I&D starts on page 41*. Dr. Stern is the CEO of Practice Velocity; Urgent Care Consultants; and PV Billing.

## Thanks to Our Peer Reviewers

In addition to the industry professionals who create the articles you read, we appreciate the insights shared by the following peer reviewers:

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

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# CONTINUING MEDICAL EDUCATION

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## Syphilis in the Urgent Care Center (p. 11)

### 1. How is syphilis transmitted?

- a. Aerosolized droplets
- b. Contact with a syphilitic chancre through oral, vaginal, or anal sex
- c. Intact skin to skin contact
- d. Urinary or fecal particles
- e. Sweat

### 2. Which of the following characterizes secondary syphilis?

- a. A chancre which is often unnoticed
- b. Ocular abnormalities including optic neuritis
- c. Headaches, confusion, stiff neck without fever
- d. No noticeable symptoms
- e. A diffuse rash often including the palms and soles

### 3. What is the first-line medication recommended to treat syphilis?

- a. Levofloxacin
- b. Ceftriaxone
- c. Penicillin
- d. Cephalexin
- e. Azithromycin

## How Urgent Care is the Antidote to Traditional Doctors' Offices (p. 17)

### 1. Besides the rise of urgent care, factors that may contribute to the struggles of traditional doctors' office include:

- a. Long waits for appointments
- b. Lack of digital engagement
- c. An uninspiring physical plant
- d. All of the above

### 2. Traditional doctors' offices would be wise to embrace retail principles and adopt a "disruptive" approach that has worked well for companies like Amazon and Starbucks.

- a. True
- b. False

### 3. Patients are likely to feel more welcome upon arrival to a practice if your staff does which of the following?

- a. Offers them a complimentary beverage
- b. Introduces themselves and offers a firm handshake
- c. Greets the patient by name
- d. Gives the patient a coupon book for nearby businesses

## A 32-Year-Old Male with Unsteady Gait (p. 20)

### 1. Which of the following may occur in multiple sclerosis?

- a. Numbness in different parts of body (most common initial symptom), paresthesia
- b. Gait disturbances
- c. Unilateral vision loss (optic neuritis), diplopia
- d. Weakness, focal as well as generalized, leading to paralysis
- e. All of the above

### 2. Which is the most reliable imaging modality when evaluating for MS?

- a. CXR
- b. CT scan
- c. Magnetic resonance imaging (MRI)
- d. Ultrasound

### 3. Treatments for MS are aimed toward managing symptoms and modifying the disease course.

- a. True
- b. False



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# Urgent Care in the Crosshairs

■ CAMILLE BONTA, MHS

Healthcare will be a defining issue for many voters this year, on the basis that many Republicans in Congress still want to repeal the Affordable Care Act (ACA). Yet, on many healthcare issues, there is little daylight between Republicans and Democrats, and healthcare providers commonly find allies in both parties.

Elections provide a tremendous opportunity to educate candidates, including incumbents, because they are more interested in what you have to say before election day than after. Take the threat to urgent care in Massachusetts, for example.

This summer, Massachusetts state lawmakers proposed to impose new regulations on urgent care centers and to levy an 8.75% tax on center charges. Passage of the legislation would have been a terminal event for urgent care in Massachusetts and would have established an alarming model for other states to replicate. The North East Regional Urgent Care Association and the Urgent Care Association teamed up, and urgent care center operators from Massachusetts were called into action. We are pleased to report that the bill failed to advance before the close of the legislative session. From the experience, we learned that many lawmakers don't understand urgent care and that advocacy efforts would have been aided by pre-established relationships among urgent care center operators, their providers, and state lawmakers. It is a certainty that urgent care centers in Massachusetts and other states will be under threat again next year. Urgent care centers need to position themselves and should use the elections as a platform.

At the Urgent Care Convention and Expo in Las Vegas last May, I provided perspective on 10 ways the healthcare landscape had changed since the start of 2017. I highlighted actions by Congress and the Trump administration that are contributing to this reshaping, which occurred largely as an after-effect of Congress's failure to repeal the ACA.

Other events, including continued healthcare consolidation



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*“UCA is engaged nationally with a seat at important tables, but urgent care center owners, operators, and providers are the foot soldiers.”*

and rising healthcare premiums that force Americans into high-deductible plans, also have profound effects on the healthcare landscape, creating challenges—but also opportunities.

And a new level of acknowledgement by policymakers that not all healthcare regulations lead to better care has spawned federal initiatives like Patients Over Paperwork, Meaningful Measures, and Red Tape Relief.

The urgent care community must lend some critical thinking to how it can take advantage of a shifting healthcare landscape, which includes engaging with policymakers.

In Washington, a bipartisan group of senators is interested in improving the transparency of healthcare cost and quality. The Medicare Payment Advisory Commission, charged with making recommendations to Congress, is examining the role of urgent care in delivering care to Medicare beneficiaries. Dramatic changes to the way Medicare pays for evaluation and management services are being considered. And, the Centers for Medicare and Medicaid Services has acknowledged the uniqueness of urgent care by creating an urgent care medicine specialty measure set for quality reporting.

The attention on urgent care has never been greater, and UCA is engaged nationally with a seat at important tables, but urgent care center owners, operators, and providers are the foot soldiers. Advocacy involvement at the local, state, and federal levels needs to become part of the business model for urgent care centers. For those who have disregarded the importance of engaging with elected officials and other policymakers, this is a paradigm shift—and a necessary one. ■

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# Syphilis in the Urgent Care Center

**Urgent message:** Seeking information beyond the stated history can prompt important information that informs the true diagnosis. This is especially true in patients with a complicated or potentially embarrassing history.

BRANDON GODFREY, MD; HAYLIE WIESNER, BS; and JOHN SHUFELDT, MD, JD, MBA, FACEP

## Case Presentation

A 59-year-old female with a past medical history of type 2 diabetes and hypertension presents to an urgent care facility with complaints of abdominal pain. She is well known to the urgent care staff. She is consistently noncompliant with medical care. Her hypertension and diabetes are both uncontrolled. She has a right below-knee amputation and is wheelchair-bound. She has been flagged in the past for drug-seeking behavior, often requesting opiates or loperamide (Imodium). She was recently treated for a urinary tract infection. She has had multiple urinary tract infections over the course of the past year. On the initial examination, she does not endorse any additional complaints but does request pain medication for her chief complaint of abdominal pain.

Her physical exam reveals a rash on her right leg but was otherwise normal. Evaluation of the right inguinal area, right thigh, and labia majora demonstrate a well-circumscribed ulceration on the right labia majora, another ulceration in the right groin, and erythematous and inflamed skin on the medial right thigh. This prompts questions about her recent sexual history. She notes a recent isolated, unwanted sexual encounter with a man. She denied any other sexual encounters. She noted that the one sexual encounter she had was approximately one month prior to her presentation to the urgent care facility. She denied any drug or alcohol use. Lab testing came back positive for syphilis without any co-infections. She is treated with a single dose of IM benzathine penicillin G.

On subsequent follow-up, her repeat titers show resolution of the disease burden.

## Introduction/Epidemiology

Syphilis is a sexually transmitted disease caused by the



*Treponema pallidum* bacterium, and poses serious health risks if not treated properly. It is transmitted through intimate contact, typically by direct contact with a syphilitic chancre through oral, vaginal, or anal sex. The occurrence has been steadily increasing across the U.S. over the past several years.

According to the Centers for Disease Control and Prevention, syphilis reached its nadir in 2015, increasing by 19% from 2014 and by 27% in women, regardless of sexual orientation.<sup>1</sup> The U.S. saw an increase in primary and secondary syphilis, from 7.4 cases per 100,000 people in 2015 to 8.7 cases per 100,000 people in 2016.<sup>2</sup> The Western region of the country reported the highest levels of

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primary and secondary syphilis, with 11.4 cases per 100,000 people.<sup>2</sup> Overall, this is the highest reported incidence of syphilis since historic lows in 2000 and 2001.

The age group most susceptible to infection is 20-24 (men and women, though men have a higher incidence of infection than women).<sup>2</sup> Of all men who contract syphilis, men who have sex with men comprise 83% of reported cases of primary and secondary syphilis.<sup>2</sup> There has been an increase in the number of early and late latent syphilis cases. The rate of early latent syphilis rose by 19.7% and late latent syphilis rose by 17.2%. This indicates more people overall are going untreated.<sup>2</sup>

### Stages of Syphilis

Syphilis progresses through four stages: primary, secondary, latent, and tertiary. The progression of each stage can last for weeks or years at a time. The major characteristics of each stage are described here:

- **Primary:** The primary stage is marked by a chancre which is often unnoticed and heals regardless of treatment. It occurs at the site of inoculation and can range in size from 0.3 mm to 3 cm. This ulcer is generally painless and often resolves without treatment. If the patient presents to an urgent care center with a painless ulcer in the genital area, the diagnosis becomes more straightforward; they should be tested and treated at that time. The incubation period can last from 3 to 90 days prior to the appearance of the chancre, but usually lasts 21 days.<sup>3</sup> The disease transitions to the secondary stage as the initial ulceration heals.
- **Secondary:** During the secondary stage, a diffuse rash can develop. This stage of syphilis is often called “the great imitator” because it can easily be misdiagnosed as psoriasis, eczema, or a viral exanthem. The rash can be macular to maculopapular and occasionally pustular. A palmar rash is a distinctive feature of secondary syphilis. In untreated patients, the rash will heal after several weeks. Other symptoms include low-grade fever, headache, general malaise, sore throat, nausea, gen-

eralized lymphadenopathy, condyloma lata, alopecia, and occasional vomiting. These symptoms can easily be mistaken for other common illnesses.<sup>4</sup>

- **Latent:** The latent stage has no noticeable symptoms and can last for many years; 60%-85% of people will remain asymptomatic for years without any treatment.<sup>3</sup> During the latent phase, the symptoms from the secondary stage disappear until treatment is received or the symptoms manifest into the tertiary stage. The latent stage lasts 1 to 2 years in most people, but may last longer.<sup>4</sup>
- **Tertiary:** The tertiary stage affects multiple organ systems and is often fatal if left untreated.<sup>5</sup> Symptoms vary depending on the organ system affected. Cardiovascular syphilis often occurs 10-30 years after the initial infection and can cause aortic aneurysms and heart failure. The tertiary phase can also manifest as neurosyphilis where cerebrospinal fluid undergoes invasion by the *T pallidum* bacteria. Clinical findings may include headaches, confusion, stiff neck without fever, and ocular abnormalities including optic neuritis. As these symptoms progress, they are sometimes misdiagnosed as dementia or a psychiatric illness.<sup>4</sup>

*“Accurate and honest histories play a vital role in capturing these patients because the disease burden isn’t always obvious.”*

### History and Examination

The history involves directed questions about sexual orientation, the most recent sexual encounter, alcohol use, and drug use. This is in addition to questions about the chief complaint (if unrelated) and associated symptoms. Patients at high risk for infection should be questioned about their sexual and social history at every urgent care visit. The provider needs to question the patient about prior syphilis infections if it is suspected and the patient will be getting tested for syphilis. Some laboratory tests will return positive results if the patient has ever had syphilis, even if they were treated appropriately. Accurate and honest histories play a vital role in capturing these patients because the disease burden isn’t always obvious.

The physical exam is directed to finding a painless chancre in patients with primary syphilis, a rash with secondary syphilis, and neurologic or cardiac symptoms with tertiary syphilis. Symptoms, like fever and malaise, may be indicators of secondary syphilis and should

prompt further questioning of the patient's sexual and social history.

When syphilis is suspected in the differential diagnosis, a thorough skin exam needs to be performed. Evaluation for a chancre should not be limited to the genitalia because chancres can arise in the mouth, around the anus, or within the vaginal canal (among other sites). The chancre simply develops at the site of inoculation. Multiple chancres may also be present, and should immediately prompt the provider to test for HIV co-infection.

Secondary syphilis most classically presents with a rash. However, 20% of patients with secondary syphilis may not even notice their symptoms.<sup>6</sup> Again, a thorough skin exam is warranted in the evaluation of secondary syphilis. Because secondary syphilis can affect multiple organ systems, a full physical exam is warranted.

The evaluation for tertiary syphilis should include thorough neurologic and cardiac exams. Auscultation of the heart may reveal a murmur. General paresis or tabes dorsalis are two ways that neurosyphilis can present. The physical exam will include a detailed neurologic exam looking at pupillary response, sensation, motor function, gait, and reflexes.<sup>6</sup>

### Laboratory Testing

If the history and physical examination do not reveal a definitive diagnosis, the fol-

lowing higher risk groups may be candidates for testing: men who have sex with men, patients with high-risk sexual activity, HIV-infected individuals, and patients with a sexual partner who tested positive for syphilis.<sup>6</sup>

Nontreponemal and direct treponemal testing are used to detect the presence of *T pallidum*. Typically, a combination of both types of tests is used in the diagnosis of syphilis. The nontreponemal tests include the RPR and VDRL tests. These measure the amount of antibodies (IgM and IgG) present in the serum to a cardiolipin-cholesterol-lecithin antigen and not directly to a treponemal protein.<sup>6</sup> These tests are generally reported as titers (eg, 1:32, etc.).<sup>6</sup> The sensitivity of the RPR test is 92.7% and the VDRL is 72.5%.<sup>6</sup> Seroconversion typically occurs around 3 weeks, but can take up to 6 weeks,

which contributes to the false negative rate.<sup>7</sup> The titers can also wane over time without treatment of syphilis.<sup>1,6</sup> A decrease in the level of the titers is used to determine response to treatment (eg, from 1:64 to 1:8).

The treponemal tests have typically been used as a confirmatory test when the nontreponemal tests are positive.<sup>6</sup> The available tests include the fluorescent treponemal antibody absorption test (FTA-ABS), microhemagglutination test for antibodies to *T pallidum* (MHA-TP), *T pallidum* particle agglutination assay (TPPA), *T pallidum* enzyme immunoassay (TP-EIA), and the chemiluminescence immunoassay (CIA).<sup>6</sup> The tests detect antibodies to specific treponemal antigens.<sup>6</sup> The FTA-ABS test is the most sensitive test in diagnosing primary syphilis, with a sensitivity of 98.2%. The TP-EIA

has nearly the same sensitivity for primary syphilis as the FTA-ABS and has become the favored test in labs.<sup>6</sup> Using the treponemal tests as the initial screening modality is affected by the prevalence in the population. These tests have a good negative predictive value in the general population. However, in high-risk populations such as patients with HIV, the positive predictive value of the treponemal tests rises significantly. Lately, there has been a trend toward "reverse screening" where the treponemal tests are being used as the initial screening test for syphilis.<sup>6,7</sup> This is a

result of these tests becoming more automated and easier to use. However, these tests are resultated as reactive or nonreactive and once positive will remain positive for life.<sup>6</sup> The treponemal tests are qualitative, which still leaves a role for the nontreponemal tests in monitoring response to treatment.

There are also direct detection methods for syphilis and some point-of-care (POC) tests including PCR, direct fluorescent antibody testing, and dark field microscopy.<sup>7</sup> Use of these tests is limited by their cost and complexity. The newer PCR technique may be viable in the future, but is not recommended as a screening test due to its lower sensitivity in blood and CSF samples compared with specimens collected from mucosal sites.<sup>6</sup> POC testing is currently approved for use under an FDA waiver. The

*"If history and physical examination do not reveal a definitive diagnosis, high-risk groups (men who have sex with men, patients with high-risk sexual activity, HIV-infected individuals, and patients with a sexual partner who has syphilis) may be candidates for testing."*

sensitivities of these POC tests are ranging from approximately 75% to 90%; the specificities range from 92% to 100%.<sup>6</sup> There still needs to be further evaluation of the POC testing but, if approved, this could streamline testing in the urgent care.

After initial laboratory testing, providers should ensure appropriate follow-up for repeat serologic testing. If the initial serology is negative, but the suspicion remains high, empirically treat and repeat the serology 1 week after treatment.<sup>3</sup> Ideally, patients with primary or secondary syphilis will be re-examined at 1 week to ensure symptom improvement and undergo repeat titers at 6 and 12 months. A fourfold decrease in titers is considered significant and should be seen between 6 and 12 months for HIV-negative patients and 12-24 months for HIV-positive patients.<sup>3</sup>

For HIV-positive patients, titers should also be repeated more frequently at 3, 6, 9, 12, and 24 months. HIV-negative patients with latent syphilis should have repeat titers at 6, 12, and 24 months, while HIV-positive patients with latent syphilis should get repeat titers at 6, 12, 18, and 24 months.<sup>3</sup> Pregnant patients with syphilis should have titers at 28 and 32 weeks of gestation and at the delivery of the child; high-risk patients can even have monthly titers drawn.<sup>3</sup> Most women will deliver before the appropriate serologic response can be detected.

### Treatment

After diagnosing syphilis, benzathine penicillin G is given as a long-acting dose of 2.4 million units administered intramuscularly. This treatment will eradicate the bacteria while in the primary, secondary, or early latent stages. During the late latent or tertiary stages, the patient should receive benzathine penicillin G on a weekly basis for 3 weeks. The optimal interval between doses is 7-9 days, and the maximum allowable interval between doses of benzathine penicillin G is 14 days.<sup>3</sup> While this treatment will cure the disease, it cannot reverse any previous damage.<sup>8</sup> To date, there has been no reported resistance to penicillin, but there are cases of treatment failure.<sup>9</sup> Cases of treatment failure likely stem from immunocompro-

mised states, treatment with alternative agents, and undiagnosed neurosyphilis.<sup>9</sup> If the patient is found to have neurosyphilis, the treatment becomes IV penicillin G.<sup>3</sup>

Reported penicillin allergies are commonly encountered in urgent care centers. While 10% of the U.S. population reports a penicillin allergy, <1% of the population is truly allergic.<sup>10</sup> Patients without a true penicillin allergy should be treated with benzathine penicillin G. Patients with a reported delayed hypersensitivity reaction (ie, rash) can be challenged with penicillin or sent for allergy skin testing.<sup>9</sup> Lastly, patients with immediate hypersensitivity reactions should be treated with an alternative regimen or undergo desensitization therapy.<sup>9</sup> For patients with an immediate hypersensitivity reaction and early syphilis, use doxycycline, ceftriaxone, or tetracycline for the initial treatment. However, data to support the use of these alternatives are limited and patients need to be monitored closely for clinical response. If they fail treatment with one of the alternative medications, are pregnant, or have neurosyphilis and/or symptoms of cardiovascular syphilis they should be tested for penicillin allergy and desensitized if required.<sup>9</sup>

Penicillin is the only acceptable treatment for syphilis during pregnancy because the other medications are either contraindicated, don't cross the placenta, or lack efficacy data.<sup>11</sup> If the woman has a doc-

umented penicillin allergy, then desensitization therapy should be undertaken. Desensitization therapy entails treatment in an inpatient setting. Oral desensitization therapy is the preferred method as it is safer and simpler than IV desensitization therapy.<sup>11</sup> It typically takes 4 hours to complete, and most adverse reactions can be managed without discontinuing the treatment.<sup>11</sup>

Another reason to make quick and accurate diagnoses of syphilis is that, if left untreated, it can be transmitted from pregnant mother to fetus in the form of congenital syphilis. Congenital syphilis can be transmitted during intrauterine development or at the time of birth.<sup>11, 12</sup> Symptoms include fever, failure to thrive, and diffuse rash. More serious complications include blindness, deafness, and facial deformities. Treatment for congenital syphilis is also benzathine penicillin G and can be given

*“Penicillin is the only acceptable treatment for syphilis during pregnancy because the other medications are either contraindicated, don't cross the placenta, or lack efficacy data.”*

to the mother before birth and to the infant after birth. Treatment before birth decreases the chances of a stillbirth; however, it is not a guaranteed cure.<sup>13</sup>

The Jarisch-Herxheimer reaction is an acute febrile reaction that usually occurs in the first 2–8 hours after the administration of benzathine penicillin G, but can occur up to 24 hours later; it can include symptoms of headache, myalgias, and rash and is most commonly seen in primary and secondary syphilis.<sup>3</sup> The provider should not confuse this with a penicillin allergy. If systemic symptoms are present in addition to a rash, the Jarisch-Herxheimer reaction should be considered the more likely diagnosis over a penicillin allergy.

While penicillin is affordable through most insurance companies, due to the current national shortage, the price for patients without insurance can be high. It should also be taken into consideration that in late stages, at least three intramuscular injections are generally required for adequate treatment. This may not always be the most practical option for the patient in an urgent care setting, so appropriate follow-up must be stressed to the patient, and the provider should make every attempt to ensure follow-up. The way arrangements are made will of course vary depending on the site. Providers should ensure the first follow-up is scheduled in 7 days from the initial treatment.

Ideally, follow-up should occur with the patient's primary care physician. However, it can also take place at the same urgent care facility in which they were originally seen, at local STI clinics, if available, or anywhere else that ultimately gives the best chance for follow-up and completing the treatment course.

### Conclusion

Although recognition of syphilis can be complicated depending on when the patient presents, diagnostic testing and treatment are fairly simple. Providers in the urgent care setting should be direct in their questioning with patients and aware that syphilis is becoming a more

prevalent sexually transmitted disease. As was seen in the initial case presentation, the patient may not be coming in because of their chancre or rash. Patients may not even realize that they have a chancre or rash characteristic of primary or secondary syphilis. Providers should be aware of the prevalence of this disease in the area they work and know what high-risk groups require further investigation in an effort to capture and treat all patients that present with this infection. Careful consideration should also be given to the course of treatment that will be best for the patient when considering medication availability, cost, and follow-up. With cases of syphilis continuing to increase, providers in primary care clinics, urgent care clinics, and emergency departments need to be thorough and effective in their attempts to diagnose and treat the reemergence of this disease. ■

*“Providers in the urgent care setting should be direct in their questioning with patients and aware that syphilis is becoming a more prevalent sexually transmitted disease.”*

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# How Urgent Care is the Antidote to Traditional Doctors' Offices

**Urgent message:** Changing consumer expectations have led experts to question the future viability of “traditional” doctors’ offices, but urgent care provides a model for shifting from “caregiver-focused” to “patient-centric” care.

ALAN A. AYERS, MBA, MACC

In the not-so-distant future of healthcare, the familiar query *Is the doctor in?* could very well be met with a resounding *No!* when it comes to the traditional doctor’s office setting.

Indeed, independent primary care offices—once the backbone of America’s healthcare system—remain under siege from a variety of market forces, and, as a result, are being slowly pushed toward extinction. No longer the frontline of medicine due mostly to healthcare consumerism ushering in more care choices than ever, traditional doctors’ offices have been slow to keep up with the modern consumer’s expectations for service. This has allowed new players and market entrants to enter the fray, establish a foothold with consumer-friendly platforms and models, and fiercely compete for the modern patient’s healthcare dollar.

## Traditional Doctors’ Offices Struggle

According to insurance data analyzed by the Health Care Cost Institute, visits to primary care offices fell 18% from 2012 to 2016, and continue to trend downward.<sup>1</sup> Contrast that with the explosive growth of urgent care: private insurance claims originating from urgent care visits between 2007 and 2016 increased by 1,725% according to FAIR Health, a data collection agency.<sup>2</sup>

Clearly, urgent care’s emphasis on on-demand, fast, low-cost, and convenient care is resonating with consumers far more than traditional doctors’ offices are. Beyond the rise of urgent care, though, are additional factors contributing to doctor office struggles, including:

- **Limited office hours** – Traditionally, medical offices have adhered to a “business hours”-type schedule: 9 AM-5 PM in many cases, with little to no



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availability during late evening hours and weekends. This has always been problematic for patients who have 9-to-5 jobs and don’t want to miss work for a doctor’s visit or need to have a sick child seen by a doctor outside of normal hours.

- **Long waits for an appointment** – A major contributing factor to the rise of urgent care (and convenient care in general) has been the weeks-long waits to get an appointment to see a traditional primary care physician. The long wait to see a doctor has long been a major grievance of consumers who need an appointment right way but can’t be seen by their PCP.

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- **Lack of digital engagement** – Global IT innovator NTT DATA Services recently conducted a survey that confirms what much of the healthcare market already understands about the modern consumer: 78% of respondents stated that digital tools in healthcare—such as online scheduling, text reminders, lab updates, provider messages, and patient surveys—are severely lacking. This deficiency is acutely felt in traditional physician offices, which collectively have been notoriously slow to embrace digital innovations in patient care.<sup>3</sup>
- **Poor patient throughput due to location** – Many traditional medical offices are tucked away in sprawling office parks, or medical buildings with lots of floors, which can be inconvenient to access and out of the way of patients' normal driving and shopping routes.
- **Boring, uninspiring physical plant** – If you've been to one primary care office, you've been to them all. There's a counter, usually behind a wall of plexiglass where you check-in with a front desk person before being assigned a stack of forms attached to a clipboard. There may be Wi-Fi available and a TV on the wall, but it also probably has the typical old magazines and cold, sterile exam rooms found in most medical offices.
- **Inefficient workflows** – Independent physicians trained in clinical medicine often lack the time and expertise to efficiently manage the administrative side of the business. Hence, in the absence of a trained office manager or digital productivity tools, this can result in inefficient workflows (often built upon broken processes), which can lead to micro-managing staff and poor delegation of tasks. These factors, when they're out of balance, negatively impact patient wait times, lower employee productivity, and lead to burnout.

### The New Consumer Expectations

These struggling independent doctors' offices are not only competing with urgent care for patients, but with large hospital systems, retail clinics, and telemedicine providers, among others. Thus, when factoring in the deficiencies that plague a traditional doctor's office, the outlook is bleak that the status quo model has a future in the new healthcare landscape. So, can traditional doctors' offices find a way to survive as consumer expectations and healthcare options continue to grow? Yes, but it will require a complete paradigm shift in how they do business.

Indeed, there must be a reckoning that the modern patient has options and will no longer accept the status

quo. They've come to expect convenience, digital channels, competitive and transparent pricing, great customer service, and a retail-like experience from every company and brand they do business with—including their healthcare providers. So, there is an opportunity for physician offices to remake themselves and integrate what they excel at—patient provider relationships and continuity of care—with the success principles of strong consumer brands that have mastered the capabilities that allow consumers to experience exceptional service delivery.

### Shift from Caregiver-Focused to Patient-Centric Care

The paradigm shift that a doctor's offices must undergo to thrive must begin with their fundamental approach to delivering care. It requires a shift from the traditional, caregiver-focused model, to being patient-centric in everything they do. The old, ineffective way of delivering healthcare in an inconvenient, impersonal, commoditized manner must give way to a fully differentiated patient experience that delights patients and engenders brand loyalty. Thus, it's time to start reimagining your practice model from the perspective of the brands with the strongest customer loyalty.

In other words, you must think like innovators and disrupters such as Amazon, Apple, Tesla, and Starbucks rather than the old guard of Chevrolet and Sears when evaluating your practice. To win and retain patients today, your practice must embody, embrace, and integrate retail principles and digital experiences, and deliver them in the most consumer-friendly way possible. To that end, here are several principles that should form the bedrock of your differentiation strategy to delight patients and build loyalty:

- **Improved access** – Traditional doctors' offices, in order to compete with urgent care, retail clinics, and telemedicine providers, must offer some level of on-demand, same-day service. This may require a radical restructuring of the practice model, but it's a necessity for patients who won't wait a week to be seen in your office when they can pop in at the local urgent care and be in and out in under an hour. Also, practices should offer evening and weekend hours more in line with the urgent care and retail clinics vying for the same patients.
- **Inviting waiting room.** Taking a cue from urgent care, your waiting room should be a pleasant place to wait. Wi-Fi is standard nowadays, but there should also be at the very least a free coffee machine, complimentary bottled water, and light snacks. Additionally, the waiting area should be redesigned to remove unnecessary physical barriers in favor of a

more inviting and modern open concept.

- **Digital check-in.** Clipboards with paper forms must become a thing of the past. They should be replaced with digital check-in capabilities, either from an in-office kiosk or through online apps. Digital check-ins will help to alleviate much of your staff's administrative burden, freeing them up to focus more time on patient care.
- **Opportune locations.** Doctors' offices should leave the sprawling office parks and six-story office buildings for more prime locations. Urgent care rightly builds centers in high-traffic areas where big box retailers, grocery stores, banks, and the McDonalds are. These are the places patients frequent, so you want to make it easy for them to meet you where they are.
- **Premium, responsive website.** If your current website is clunky, poorly organized, and full of text, it's overdue for an overhaul. The vast majority of internet users search online to locate local businesses, so you want visitors to your website to have a seamless and streamlined experience. Ensure that your web designer utilizes hi-res images that showcase your office, highlights your amenities, and lists your providers (with their portraits) and their education and clinical backgrounds. In addition, include a section or page with online reviews and/or patient testimonials for social proof.
- **Online scheduling.** The last thing a patient inquiring about your services wants to do is navigate a complicated phone tree. By offering online scheduling, patients have a no-friction way to set an appointment day and time that fits their schedule. As an added bonus, online scheduling flattens demand, and frees up your staff to handle fewer administrative tasks.
- **Text/email communication.** Modern consumers expect text messages from the brands they do business with. For a medical office, this will likely require upgrading to a software system that facilitates and manages the text messaging system. Medical offices should therefore send patients text messages with appointment and payment reminders, lab results, provider messages, and patient surveys. The patient survey should take place right after the office visit, however, so that if the patient provides negative feedback, the office staff can attempt to remedy the situation right away.
- **Self-pay pricing.** Especially for those patients who are paying out of pocket, there should be a clear and easy-to-read menu of prices for services posted

in the lobby of the office. Affordable and transparent pricing—a hallmark of urgent care centers—builds trust with patients, such that it's a convenience every doctor's office should offer.

- **A welcoming, cheerful staff.** When you think through your lifetime of doctor's visits, aren't you more likely to recall harried and impersonal staffers rather than charming brand ambassadors? Indeed, the demeanor of your staff is a huge differentiator and can be the difference in whether your patient returns to your office or seeks out another provider. Your care team should be trained to be cheerful, greet patients by name, explain each step of the process, and to intervene if there is a wait of longer than 5 minutes at any point of the visit. In short, they should take on the role of concierges of your practice, and really make an impression on your patients.

### Conclusion

To compete for patients and thrive in the new health-care landscape, traditional doctors' offices would have to evolve to accommodate the modern patient. No longer willing to deal with inconveniences and unresponsiveness, the consumer of today has learned to expect the same speedy, digitally based, low-cost, and friendly service they receive from Starbucks and Amazon. These power brands have engendered consumer loyalty through differentiation, personality, and the experience they deliver, which is the same route doctors' offices must take to achieve similar results.

The path to this differentiation is to adopt patient-centric principles—fast service, convenient locations, digital tools, and affordable prices—and meld them with primary care core competencies of provider-patient relationships and continuity of care. Only then would traditional medical offices thrive once again and become the modern patient's provider of choice. ■

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# A 32-Year-Old Male with Unsteady Gait

**Urgent message:** Early diagnosis and management of multiple sclerosis are crucial for long-term prognosis. Urgent care providers must be vigilant with proper history taking and thorough physical examination when looking for signs and symptoms of early MS.

WAQAS MEMON, MD, ZONAIRA SHABBIR, OMS IV, and MUHAMMAD AKHTAR, MD, FACP

## Introduction

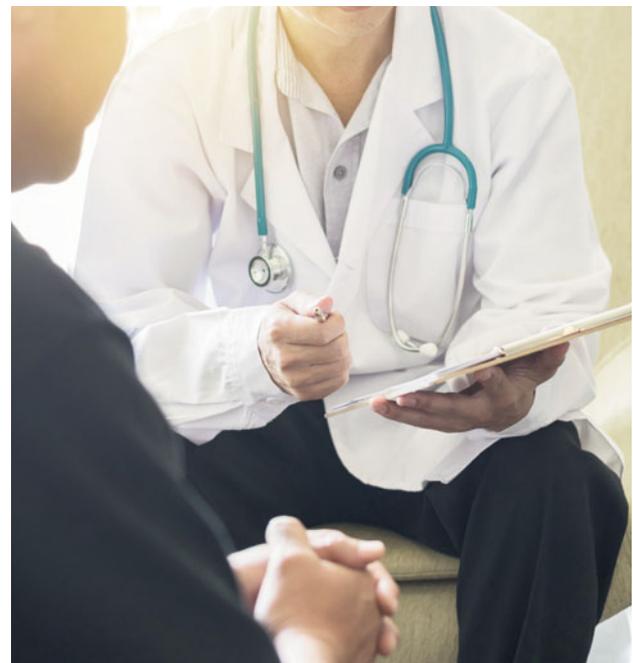
In the early course of multiple sclerosis (MS), the initial symptoms are nonspecific and intermittent, which makes the diagnosis challenging.<sup>1</sup> Focusing on common symptoms and considering the diagnosis will direct the evaluation. Common symptoms include coordination abnormalities, weakness and/or numbness of the extremities, loss of bladder control, and visual disturbances.

Assessing the nervous system requires more directed questioning. Asking about head trauma/injury, loss of consciousness, unsteady gait, vision loss, double vision and headaches, syncope, vertigo, dysphagia, speech, coordination disturbances, numbness or tingling, and weakness or paresthesia is important to making the diagnosis.

## Case Presentation

A 32-year-old male presented with right ankle pain after falling out of a truck. He rated the pain a 4 out of 10 in intensity and the pain was worse with range of motion. Further questioning revealed that the patient had been feeling unsteady for 3 months prior to his visit, with loss of balance and recurrent falls. In addition to the unsteady gait, the patient had 60 pounds of unintentional weight loss. He denied numbness or weakness in his extremities; slurred speech; facial droop; confusion; and head/neck chest, abdomen, or back pain. He denied having any fever, blurred vision, rhinorrhea, cough, hematuria, melena, bruising, rashes, lower extremity pain, or tenderness.

Further exploration of the past history revealed that



he had presented to an emergency department 3 weeks previously for similar complaints and was discharged after CT scan of the head did not show any intracranial pathology. The patient had no other significant past medical history. Surgical history included titanium hip replacement. Family history was noncontributory and social history included daily use of marijuana and occasional alcohol use.

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On examination, the patient was well appearing, awake, and alert x 4. The initial blood pressure was 148/64 mmHg, heart rate 51 beats/min, and a temperature of 97.8°F. The eye exam revealed PERRLA, EOMI, without scleral icterus. Neck was supple without rigidity or lymphadenopathy. The cardiovascular exam revealed regular rate and rhythm without murmurs, rubs, or gallops. Neurological exam revealed cranial nerves II-XII intact. Sensation intact. Strength was 5/5 for flexion and extension in all four extremities. Deep patellar tendon reflexes are equal and intact. Finger-to-nose testing is equal and normal bilaterally. The laboratory was all within normal limits.

### Differential Diagnosis and Medical Decision-Making

The secondary complaints of unsteady gait and 3 months of unintentional weight loss raised the provider's concern for:

- brain neoplasm
- myelopathy
- stroke
- vertebrobasilar insufficiency
- vestibular disorders
- multiple sclerosis
- encephalitis
- acute disseminated encephalomyelitis
- transverse myelitis
- sarcoidosis
- Wernicke's encephalitis
- subacute combined degeneration of the spinal cord
- megaloblastic anemia

At an outside hospital, a CT scan of the brain was performed but was inconclusive for any acute intracranial pathology, making a large mass unlikely. Primary or metastatic malignancy typically presents with focal neurological deficits, but our patient did not have these findings, making the diagnosis of neoplasm unlikely. The patient did have a laboratory work-up later which did not reveal leukocytosis and the erythrocytes sedimentation rate and C-reactive protein were within normal range. Measurement of vitamin B12, folate, thiamine, and vitamin D level was also within normal limits. He was afebrile.

With these findings, we can further rule out many of the inflammatory, infectious, or nutritional etiologies listed previously. For this reason, a lumbar puncture was not performed. Since the patient previously had multiple falls which caused him significant disability, an MRI was performed to look for intracranial pathology, including sarcoidosis and multiple sclerosis.

### Clinical Pearls

1. Multiple sclerosis can have varying and confusing presentations, with symptoms and signs including coordination abnormalities, weakness and/or numbness of the extremities, loss of bladder control, and visual disturbances.
2. An MRI has a diagnostic sensitivity of 94%, with a specificity of 83%.
3. Multiple treatment options are available; early diagnosis and intervention increases chances for a favorable outcome.

### Case Resolution

Though the initial presentation was an ankle sprain, the elicited history of imbalance and weight loss were concerning. The MRI showed moderately extensive periventricular white matter changes and mild deep gray matter changes suggesting demyelination. The patient was admitted for further evaluation for possible MS.

### Discussion of Multiple Sclerosis

Multiple sclerosis is the most common immune-mediated demyelinating disease of the central nervous system and a major cause of disability in young individuals, both physically and cognitively. The demyelination causes inflammation to the white matter, damaging the nerve sheath. This results in axonal degeneration and miscommunication between the central nervous system and the peripheral nervous system.

MS causes a range of signs and symptoms, including physical, cognitive, and behavioral. The common features in order of highest incidence are:

- Numbness in different parts of body (most common initial symptom), paresthesia
- Gait disturbances
- Unilateral vision loss (optic neuritis), diplopia
- Weakness, focal as well as generalized, leading to paralysis
- Cognitive symptoms
- Generalized pain
- Urinary symptoms, bladder bowl incontinence

The physical signs of MS are nonspecific. A longitudinal study was performed looking at the first 10 years of relapsing/remitting multiple sclerosis (RRMS), specifically at memory, information processing, and executive functions. Even with no impact on physical disability, patients show an increase in frequency and severity of cognitive impairment in the first ten years.<sup>3</sup>

In a patient presenting with possible MS, an early diagnosis facilitates the best management. The most reliable imaging is a magnetic resonance imaging (MRI),<sup>4</sup> as was

Prevalence of Multiple Sclerosis by Age and Sex in the United States				
	Female	Male	Overall	
Age group (yrs)	Rate/100,000 (95% CI)	Rate/100,000 (95% CI)	Rate/100,000 (95% CI)	Female:Male ratio
0-4	0.2	0.2	0.2	1.04
5-9	1.3	0.9	1.1	1.40
10-14	3.4	1.2	2.3	2.77
15-19	22.3	7.2	14.6	3.11
20-24	59.7	21.2	40.1	2.82
25-29	193.0	65.3	130.7	2.95
30-34	294.3	95.6	198.6	3.08
35-39	415.2	126.7	275.4	3.28
40-44	428.2	134.9	286.2	3.17
45-49	455.6	139.7	303.5	3.26
50-54	388.7	130.6	265.1	2.59
55-59	295.9	103.9	204.2	2.85
60-64	151.0	59.1	107.4	2.55
65-69	106.8	45.6	75.7	2.34
70-74	81.7	35.1	60.0	2.32
75-79	53.4	26.0	40.2	2.05
80-84	16.3	8.4	13.1	1.93
≥85	na	na	na	na
Overall	224.2	71.6	149.2	3.13

CI, confidence interval; na, not applicable  
 Data source: Dilokthornsakul P, et al. Multiple sclerosis prevalence in the United States commercially insured population. *Neurology*. 2016;86(11):1014-1021.

done in this case. The sensitivity of diagnosing MS within the first year after a single attack is 94%, with a specificity of 83%.<sup>5</sup> Sometimes, an abnormal MRI requires confirmation with CSF analysis like oligoclonal IgG bands, and other immune markers like IgG. Diagnosis at times can be difficult, usually requiring an MRI and CSF analysis.

Treatments for MS are aimed toward managing symptoms and modifying the disease course.<sup>7</sup> For an acute exacerbation, the mainstay for MS is corticosteroids to help reduce the inflammation.<sup>8</sup> Disease-modifying therapies have been shown to reduce inflammation and relapses, and slow the accumulation of brain lesions on MRI, thus slowing down the overall progression of the disease. Injectable intramuscular and subcutaneous therapies include interferon beta and glatiramer acetate. The most common side effects of interferons include injection-site reactions, flu-like symptoms, anemia, leukopenia, and depression. Potential for hepatotoxicity exists, but it is rare.

### Case Summary

It would have been easy for the provider to simply focus on the ankle pain, interpret imaging, then splint and discharge with symptomatic management, but the deeper dive into the reason for the strain was what unmasked symptoms which were eventually found to be due to MS. This diagnosis facilitated earlier therapy, likely improving the ultimate outcome. ■

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## Animals Used for Medical and Support Assistance in the Urgent Care Setting

■ ALAN A. AYERS, MBA, MAcc

**Urgent message:** Urgent care providers must be prepared to address the increasing presence of dogs and other animals used for either support or comfort by patients and/or employees.

### Introduction

Animals used for medical and emotional support assistance are commonly seen in the workplace. This includes dogs that assist those who are visually impaired, service dogs for medical conditions,<sup>1</sup> and emotional support dogs for individuals such as military combat veterans.<sup>2</sup> The American Humane Association reports that there are 20,000 service dogs working in the United States.<sup>3</sup> However, there have been many recently reported cases of fraud with support animals.<sup>4,5</sup>

This article examines issues concerning employees—and, especially, patients—who want or need to bring service animals onto the premises of an urgent care center. To that end, what legal protections does the patient or employee have to require an employer to allow their animal, and what protections must be provided for the urgent care center and patient safety?

### Challenges

There are numerous challenges in the urgent care environment that pertain to the presence of a service animal. Of course, chief among them is creating and maintaining a clean environment to keep employees, animals, visitors, and family members safe from biohazards that enter an urgent care setting. There is also additional liability for an animal's behavior if it were to bite an

employee, a patient, or a visitor.

### Discussion

Initially, it is imperative to recognize that federal law makes a drastic distinction between *service animals* and those that provide *emotional support/comfort*. Under the Americans with Disabilities Act (ADA),<sup>6</sup> a service animal is defined as a *dog* that has been “individually trained to do work or perform tasks for an individual with a disability.”<sup>7</sup> The task(s) performed by the dog must be *directly related* to the person's disability. These dogs are permitted under federal law to accompany their disabled handler into *non-sterile, public areas*. This means that service dogs are allowed in hospitals, doctor's offices, patient rooms, and other healthcare facilities, provided their presence does not pose a threat or danger to standard medical practices and does not impede operations of fundamental services and functions.<sup>8</sup>

The federal regulation states, “[i]ndividuals with disabilities shall be permitted to be accompanied by their service animals in all areas of a public entity's facilities where members of the public, participants in services, programs or activities, or invitees, as relevant, are allowed to go.”<sup>7</sup> Typically, the service animal can accompany an urgent care patient to all areas where the public is normally allowed to access. In an urgent care center, this includes treatment rooms and exam rooms.<sup>1</sup> However, service animals need not be allowed into areas if their presence would *fundamentally alter* the nature of a service. In a healthcare setting, this would mean settings where an animal would compromise a sterile environment—like an operating room. In other words, the presence of the service dog cannot violate the standards that are in place for patient or staff safety and are medically necessary.

The vast majority of positions in urgent care entail direct patient care on the clinic floor. As a result, the specific regulations discussed in this article would apply. For support functions such as billing, human resources, and accounting—if located off-



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site—this would be determined by the standard ADA rules and regulations for service animals in the workplace.

### Emotional Support Animals

To reiterate, dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.<sup>9</sup> These animals are also known as therapy, comfort, or companion animals.

An emotional support animal does not need to be professionally trained because they provide support just by being around the patient—the animal's *mere presence* provides comfort. Again, an emotional support animal is not protected by the ADA governing service animals. Service dogs are allowed access to all public places. In contrast, emotional support animals are allowed access only to apartments (including those with no-pet policies) and on airplanes.

However, if a public place is pet-friendly, that means it's open to both emotional support animals and regular pets; examples would include a pet store or some coffee shops. An urgent care facility may impose a "no pets" policy similar to any restaurant, grocery store, schools, or retail establishment. Again, emotional support animals do not need to be accommodated.

Note that the ADA makes a distinction between *psychiatric service animals* and emotional support animals. If the dog has been trained to sense that an anxiety attack is about to occur and take a specific action to help avoid such an attack or lessen its impact, it would qualify as a service animal. But if the dog's *mere presence* provides comfort, the animal would not be considered a service animal under the ADA.<sup>1</sup>

### Urgent Care Center Policies

It's critical that urgent care operations have policies that comply with the ADA when addressing patients' service animals and address how to handle emotional support animals.

When a patient arrives at an urgent care facility with an animal, staff should first determine whether it is a service animal. As discussed above, a service animal is a dog that is individually trained to perform a task/work for an individual with a disability that is directly related to that individual's disability. Any other animal is not a service animal and *does not* need to be accommodated under the ADA.<sup>10</sup>

In making this initial determination, it's important to understand that federal regulation mandates that a public entity *cannot* inquire about the nature or extent of a person's disability.<sup>7</sup> However, it may make two inquiries to determine whether an animal qualifies as a service animal. They can ask whether the animal is required because of a disability, and what work or task the animal has been trained to perform.

Also, an urgent care center cannot require documentation (eg, records or other proof that the animal has been certified, trained, or licensed as a service animal).<sup>1</sup> Along with this, staff

may not ask that the animal wear any special harness or vest or request that the animal demonstrate its task or work.<sup>7</sup>

Federal law states that these inquiries about a service animal cannot generally be made when it's readily apparent that an animal is trained to do work or perform tasks for an individual with a disability, such as the dog is seen guiding the patient who is blind, pulling a person's wheelchair, or providing assistance with stability or balance to an individual with an obvious mobility disability.

If a patient at an urgent care center answers that the animal is required for a disability and explains the task/work that the animal performs, the facility must accommodate the animal.<sup>7</sup> However, a public entity may ask an individual with a disability to remove a service animal from the premises if either the animal is out of control, and the animal's handler doesn't take effective action to control it; or the animal isn't housebroken.<sup>7</sup> (One final note: A public entity can't ask or require an individual with a disability to pay a fee or a deposit for the dog's presence, such as for potential damage caused by the service animal.<sup>7</sup>)

### Takeaway

Urgent care centers must accommodate service animals (dogs) pursuant to the ADA, and should fashion policies that reflect the restrictions concerning inquiries into a patient's disability and a service animal's training and work.

Animals that provide only comfort or emotional support through companionship are not service animals; these animals do not need to be accommodated under federal law. However, an individual urgent care owner may pursue a policy permitting emotional support animals in an effort to be more sensitive to their patients' needs and well-being. ■

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# Employing the Parental Papoose Technique in Treating Young Children

**Urgent message:** Children presenting to the urgent care center are often in a state of distress and agitation—to the extent that they may be difficult to treat when it comes to certain procedures. The parental papoose technique may help soothe the patient—and the parent—making effective treatment more accessible.

OSCAR D. ALMEIDA, JR., MD, FACOG, FACS

It is common for a young child to enter our urgent care center calmly—while being held by a parent, only to start crying uncontrollably when separated from that parent in order to be restrained by conventional methods prior to having a nebulizer treatment, sutures applied or removed, or other procedures performed.

With implementation of the novel parental papoose technique, a child may experience an added level of comfort, and be more cooperative due to the close proximity of their parent with whom they have a close bond.

The mutual emotional and psychological closeness between a parent and their child forms the foundation for the success of this innovative technique, allowing the urgent care provider to administer care more efficiently while lowering the stress levels of both the patient and their parent.

Criteria for a successful intervention include:

- 1) simple
- 2) practical
- 3) easy to use and
- 4) affordable

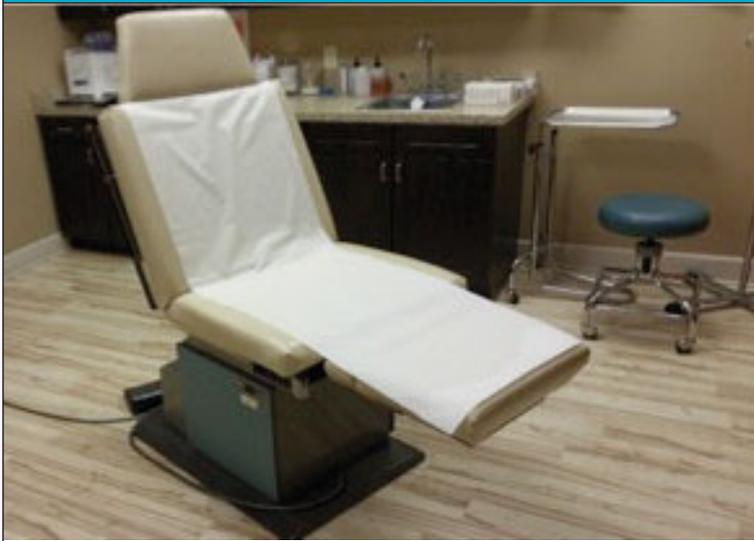
The parental papoose technique meets all of these criteria. Implementation does not require any equipment for immobilizing the child. Further, the parental papoose technique cultivates a more child-friendly environment while the urgent care provider performs a given procedure. Although the papoose board remains



useful for select pediatric medicine and dental cases, it remains a controversial tool in certain settings. The papoose board is banned and its use considered a serious breach of ethics in the United Kingdom.<sup>1</sup> The State of Colorado passed a law forbidding its use for pediatric dental patients unless a dentist has documented that they have exhausted all other options for controlling a child's behavior.<sup>2</sup>

Oscar D. Almeida, Jr., MD, FACOG, FACS is a staff physician at Stopwatch Urgent Care LLC in Auburn, AL and a former adjunct professor of obstetrics and gynecology at the University of South Alabama College of Medicine.

**Figure 1.**



Procedure power table in the semi-Fowler position.  
(Image courtesy of Oscar D. Almeida, Jr., MD, FACOG, FACS.)

Head and neck wounds account for 60%-81% of pediatric lacerations.<sup>3-5</sup> While some clinicians find the papoose technique to be beneficial during laceration repair in children, others believe it is better employed when giving nebulizer treatments; removing sutures (especially in the absence of anesthetics); nasal foreign body removal; and phlebotomy in younger toddlers.

Unfortunately, many urgent care providers are uncomfortable providing some of these services in younger patients primarily because of the lack of restraining methods available for the injured, uncooperative child.

A recent study in the *Rhode Island Medical Journal* reported that some urgent care providers send pediatric patients with facial lacerations from their facility to the emergency room for suturing.<sup>6</sup> Unlike more mature patients, it is reasonable to expect a child with a facial laceration to have difficulty laying still while the urgent care provider sutures their laceration. Utilizing the parental papoose technique may help ameliorate this obstacle. With the parent's active participation, the desired goal of decreasing sudden, uncontrolled movements of the child which could impede repair of their laceration can be achieved. Furthermore, a child will feel more secure if they observe that their parent is comfortable and trusts the urgent care provider.

Further, some physicians find it is best to use the parental papoose technique only in certain situations, with patients of specific ages. For example, it is generally not effective in children 6 years of age and up, as they may be too big to sit comfortably and securely in their parents' lap. In the author's experience, repair of forehead or chin lacerations can be enhanced with the technique; others find it cumbersome in such patients, but have noted its benefits in children with nasal lac-

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erations—all dependent on the relative positioning of the clinician relative to the child.

**Technique**

The first step involves counseling the child's parent on the proposed procedure and emphasizing the impor-

tance of their role in keeping the child from making any sudden uncontrolled movements. Cooperation of the child is further enhanced by using a "vocal local",<sup>7</sup> an anesthesia technique giving verbal reassurance to the child by the parent and urgent care provider. Ideally, the participating parent should be counseled outside the presence of the child, and understand their role and task. Reassure the child that their parent will be with them the entire time.

The parent then lays supine on the procedure power table (**Figure 1**) with the head of the table at approximately 30-45 degrees (semi-Fowler position). With reassurance from the parent, the child is then placed on the parent's lap. The parent's arms are then wrapped around the child's arms, and their hands placed over the child's hands. The parent's legs are then positioned over the child's legs. This forms the parental papoose, immobilizing the child (**Figure 2**). The medical assistant then gently supports the child's head at an appropriate angle for the procedure (**Figure 3**).

If a patient is coming in with a prearranged appointment, recommend to the parent bringing a favorite

stuffed animal or toy (**Figure 4**). This will preoccupy the child while you administer care.

### Contraindications

Contraindications include lacerations that are very jagged, many layers deep, located over a joint, or potential for nerve damage. Children who are combative and uncooperative before the procedure begins are not good candidates and should be referred to the emergency room. For a procedure to be successful, full parental cooperation is essential. If the parent is hesitant or uncooperative during the preprocedure counseling, transfer should be considered. Finally, if the urgent care provider is inexperienced in repairing traumatic facial lacerations using the small caliber sutures utilized for repair of facial lacerations in children, then the child should be referred to the emergency room.

### Conclusion

Urgent care centers are often the preferred venues of choice for parents to take their children for treatment

of sudden complaints, some of which may require some form of restraint. Proper selection of the “right” situations for employing the parental papoose technique, based on the provider’s experience and comfort level, as well as the nature of the presentation, will allow for many procedures that might otherwise require transfer to be managed in the urgent care center.

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## ABSTRACTS IN URGENT CARE

- Prepare for Drug-Resistant Gonorrhea
- Opioid Prescribing Increases Throughout the Day
- Overcrowded Pediatric Emergency Rooms
- New CDC Guidelines on mTBI in Children
- Two Studies Consider Risks with Syncope Patients

■ GLENN HARNETT, MD and MICHAEL B. WEINSTOCK, 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.

### New Data Show ‘Steep and Sustained’ Increase in STD Occurrence—Especially Syphilis

*Key point: Over the past 5 years, rates of syphilis, gonorrhea, and chlamydia have all increased in the United States, with syphilis cases almost doubling and cases of antibiotic-resistant gonorrhea rising.*

Citation: Centers for Disease Control and Prevention. 2018 STD Prevention Conference. New CDC Analysis Shows Steep and Sustained Increases in STDs. August 28, 2018. Available at: <https://www.cdc.gov/nchstp/newsroom/2018/2018-std-prevention-conference.html#Graphics>. Accessed September 7, 2018.

Every other year, the Centers for Disease Control and Prevention hosts a gathering of top experts and stakeholders in the field of sexually transmitted diseases to discuss the current state of affairs, review the latest research, and make projections about emerging trends (and what to do about them). This year’s conference, held in August, included the grim news that rates of syphilis, gonorrhea, and chlamydia have all increased over the past 5 years, with syphilis nearly doubling in that time period. Gonorrhea is up 67%, as well, and chlamydia is more common than at any other time. Total cases of those three infections combined are up 31%, from 1.8 million in 2013 to 2.3 million in 2017.



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Despite its dramatic growth, syphilis is still the third leading STD by total number of diagnoses. While chlamydia is the most common (1.7 million cases) the biggest threat may prove to be from gonorrhea. There were 555,605 confirmed cases of gonorrhea in 2017, but urgent care providers should be aware that the worst news is the CDC is seeing signs that resistance is on the rise—so the threat of untreatable gonorrhea is increasing along with the number of cases. ■

### Check Yourself if You’re Thinking of Prescribing an Opioid Toward the End of Your Shift

*Key Point: Physicians are more likely to prescribe an opioid product in the fourth hour of a clinical session than they are in the first hour.*

Citation: Philpot LM, Khokhar BA, Roellinger DL, et al. Time of day is associated with opioid prescribing for low back pain in primary care. *J Gen Intern Med.* July 2, 2018. [Epub ahead of print]

“Decision fatigue” may lead physicians to be more willing to prescribe an opioid pain medication than they’d be at the start of a shift, according to new data published in the *Journal of General Internal Medicine*. While their research centered on patients with low back pain seen by primary care physicians, it echoes the findings of a 2014 study showing that the likelihood of prescribing an antibiotic inappropriately was greater as the clinical day progressed. This newer paper reflects 2,772 visits for low back pain at the Mayo Clinic in Rochester, MN. Overall, 19.8% of patients received a prescription for an opioid in spite of the fact that there’s little evidence that opioids are effective

*“Greater access to physicians outside of ‘normal’ office hours would likely reduce unnecessary trips to pediatric EDs and improve the quality of care.”*

with low back pain long-term. The doctors in the study were 60% more likely to prescribe an opioid in the fourth hour of a clinical session compared with the first hour of that same session. ■

### High Volume Diminishes Quality of Care in Pediatric Emergency Rooms

**Key point:** “Inappropriate” visits (ie, for relatively low-acuity complaints) to the ED are largely to blame for overcrowding and resultant lower quality of care.

**Citation:** Haasz M, Ostro D, Scolnik D. Examining the appropriateness and motivations behind low-acuity pediatric emergency department visits. *Pediatr Emerg Care.* 2018;34(9):647-649.

Most children who show up in the pediatric emergency department (PED) have a “regular” pediatrician or primary care physician—but not necessarily access to those physicians at times their parents deem it necessary for the child to see someone immediately, say the authors of a new article published in the journal *Pediatric Emergency Care*. This leads to overcrowding in PEDs and, ultimately, diminished quality of care. Out of 635 patients with a Paediatric Canadian Triage and Acuity Score of 4 or 5, only 25% were found to need truly emergent care at the time of their PED visit. Perceived expertise at the tertiary care hospital and ease of getting test results were the most common reasons (93% and 81%, respectively) for the children to have been brought in. The authors concluded that greater access to physicians outside of “normal” office hours, including testing capabilities, would likely reduce unnecessary trips to PEDs and, as a result, improve the quality of care for all. Though urgent care was not included in the discussion, one can only imagine

how the growth of the pediatric urgent care center market in the U.S.—which by its very nature will increase access as described by the authors—might impact future studies of a similar nature. ■

### CDC: Less Imaging, More Symptom Scales and Counseling for Kids with mTBI

**Key point:** New guidelines on assessing and treating children with suspected mild traumatic brain injury apply to providers in all practice settings—including urgent care.

**Citation:** Lumba-Brown A, Yeates KO, Sarmiento K. Centers for Disease Control and Prevention Guideline on the Diagnosis and Management of Mild Traumatic Brain Injury Among Children. *JAMA Pediatr.* Available at: <https://jamanetwork.com/journals/jamapediatrics/fullarticle/2698456>. Accessed September 9, 2018.

The Centers for Disease Control and Prevention considered 25 years of research into pediatric patients with mild traumatic brain injury (mTBI) in formulating its new set of guidelines on assessing and treating children who’ve experience a blow to the head. Ultimately, the CDC team came up with 19 distinct guidelines, which they boiled down into five broad recommendations:

- Do not routinely image patients to diagnose mTBI.
- Use validated, age-appropriate symptom scales to diagnose mTBI.
- Assess evidence-based risk factors for prolonged recovery.
- Provide patients with instructions on return-to-activity customized to their symptoms.
- Counsel patients to return gradually to nonsports activities after no more than 2–3 days of rest.

Perhaps with a nod to the diverse and evolving nature of today’s healthcare landscape, the authors emphasize that the evidence-based rules “cover diagnosis, prognosis, and management and treatment...in all practice settings.” They also note that there’s been a “marked” increase in the number of emergency room visits for mTBI in the past 10 years, with more than 800,000 children presenting to the ED with mTBI annually. ■

### Be Vigilant for PE and Arrhythmias in Patients with Syncope

**Key point:** A pair of studies describe incidence and considerations for cardiac arrhythmias and pulmonary embolism in patients who present with syncope.

**Citations:** 1. Costantino G, Ruwald MH, Quinn J, et al. Prevalence of pulmonary embolism in patients with syncope. *JAMA Intern Med.* 2018;178(3):356-362. 2. Nishijima DK, Lin AL, Weiss RE, et al. ECG predictors of cardiac arrhythmias in older adults with syncope. *Ann Emerg Med.* 2018;71(4):452-461.

*“It is helpful for the urgent care provider to understand that syncope can be a bellwether for near-future, potentially life-threatening events.”*

Patients who present to the urgent care center with a complaint of syncope are often at a loss to explain whether they experienced any other symptoms. As such, the process of narrowing down the possible causes—and eliminating the most threatening—can be a challenge. Two recent articles published in *JAMA Internal Medicine* and the *Annals of Emergency Medicine* provide clues that it is wise to be vigilant for cardiac arrhythmias, and that the incidence of pulmonary embolism is lower than reported in recent studies.

In considering the prevalence of PE in syncopal patients, Costantino, et al looked at the cases of nearly 1.7 million adults who presented to emergency rooms across four countries with syncope. Prevalence of PE at the time of the ED visit ranged from 0.06% to 0.55% for all patients and 0.15%–2.1% for patients who were hospitalized. Follow-up assessment at 90 days postvisit showed higher rates for both groups (a range of 0.3%–1.37% for nonhospitalized patients and 0.75% to 3.86% for patients who were hospitalized).

In the *Annals* article, researchers sought to identify specific abnormalities in the ECGs of patients ≥60 years of age who presented to 11 emergency rooms with syncope or near syncope. Approximately 3% received a diagnosis of a “serious cardiac arrhythmia not recognized on initial ED evaluation” within 30 days of their ED visit. More specifically, the authors found “the presence of nonsinus rhythm, multiple premature ventricular conduction, short PR interval, first-degree atrioventricular block, complete left bundle branch block, and Q wave/T wave/ST-segment abnormalities consistent with acute or chronic ischemia on the initial ED ECG increased the risk for a 30-day serious cardiac arrhythmia.”

Both studies point to the need for the urgent care provider to understand that syncope can be a bellwether for near-future, potentially life-threatening events. This can inform interaction with patients, both in terms of taking a history but also educating patients as to their risk for those events. ■



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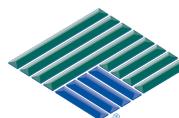
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## A 16-Year-Old with Severe Pain and Immobility After a Basketball Mishap



### Case

The patient is a high school athlete who is brought to your urgent care center with severe pain in the area of his right foot and ankle. He reports that he jumped for a rebound, landing hard on another player's foot with his full weight on his right foot.

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

THE RESOLUTION



**Differential Diagnosis**

- Avulsion fracture of the proximal 5th metatarsal
- Chopart fracture/dislocation
- Jones fracture
- Chopart fracture/dislocation and Jones fracture
- Iselin disease

**Diagnosis**

This patient suffered a Chopart fracture/dislocation and a Jones fracture.

**Chopart fracture:** There is widening and asymmetry of the talonavicular and calcaneocuboid joints that are compatible with dislocation. Fractures of the medial aspect of the navicular and medial cuneiform are noted.

**Jones fracture:** In this case, there is fracture of the proximal aspect of the fifth metatarsal in the region of the metadiaphyseal junction. Asymmetric thickening of the lateral aspect of the fifth metatarsal cortex suggests prior injury and refracture.

**Learnings**

- Chopart fracture/dislocation
  - This relatively uncommon injury involves the midtarsal joints (talonavicular and calcaneocuboid joints). There are frequently associated fractures of the calcaneus, cuboid, and navicular
  - Typically caused by falls from a height, motor vehicle accidents, and severe twisting injuries such as can occur in basketball players who land on a plantar-flexed and inverted foot
- Jones fracture
  - Jones fractures are located at the metadiaphyseal junction, approximately 2 cm (1.5-3 cm) from the tip of the 5th metatarsal
  - This area receives less blood and is therefore more prone to difficulties in healing, with rates of nonunion as high as 30%—50%
  - Typically caused by forced inversion of plantarflexed foot

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



# A 62-Year-Old Woman with Palpitations

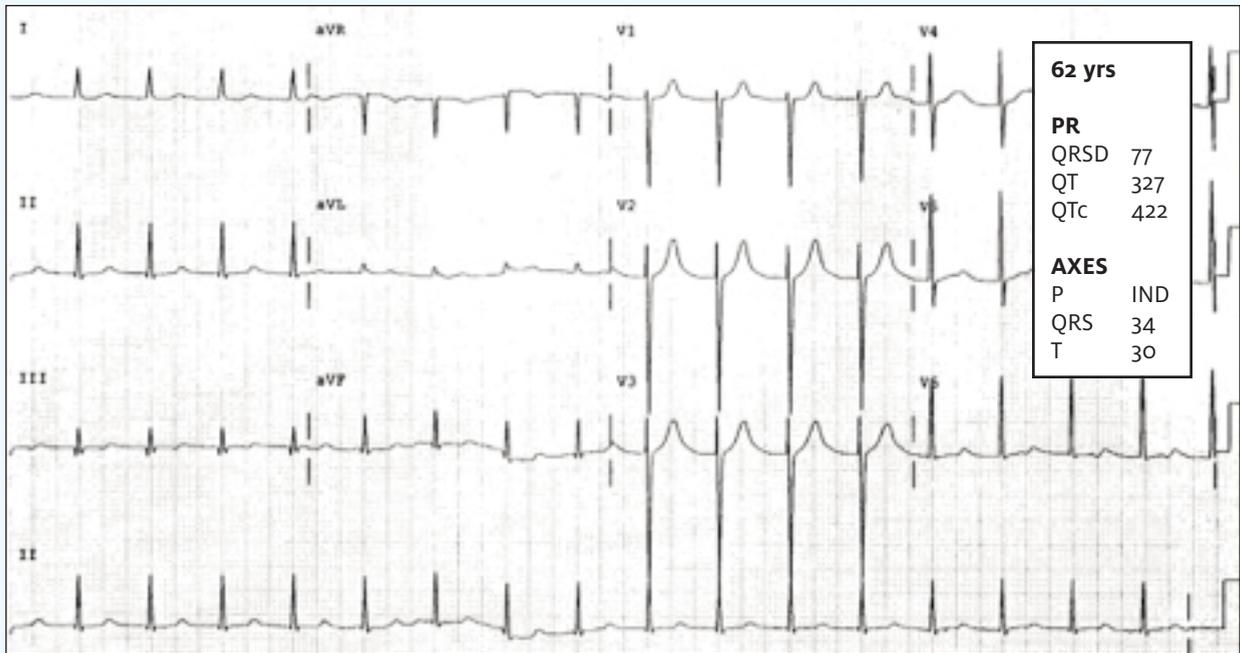


Figure 1.

## Case

The patient is a 62-year-old woman who presents to your urgent care center with a feeling of palpitations, which began the previous evening. She has no chest pain or shortness of breath, but does feel “clammy.” She takes no medications. Her history includes MI and CABG 5 years ago. Upon exam, you find:

- **General:** Alert and oriented X 3, skin color good but clammy
- **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

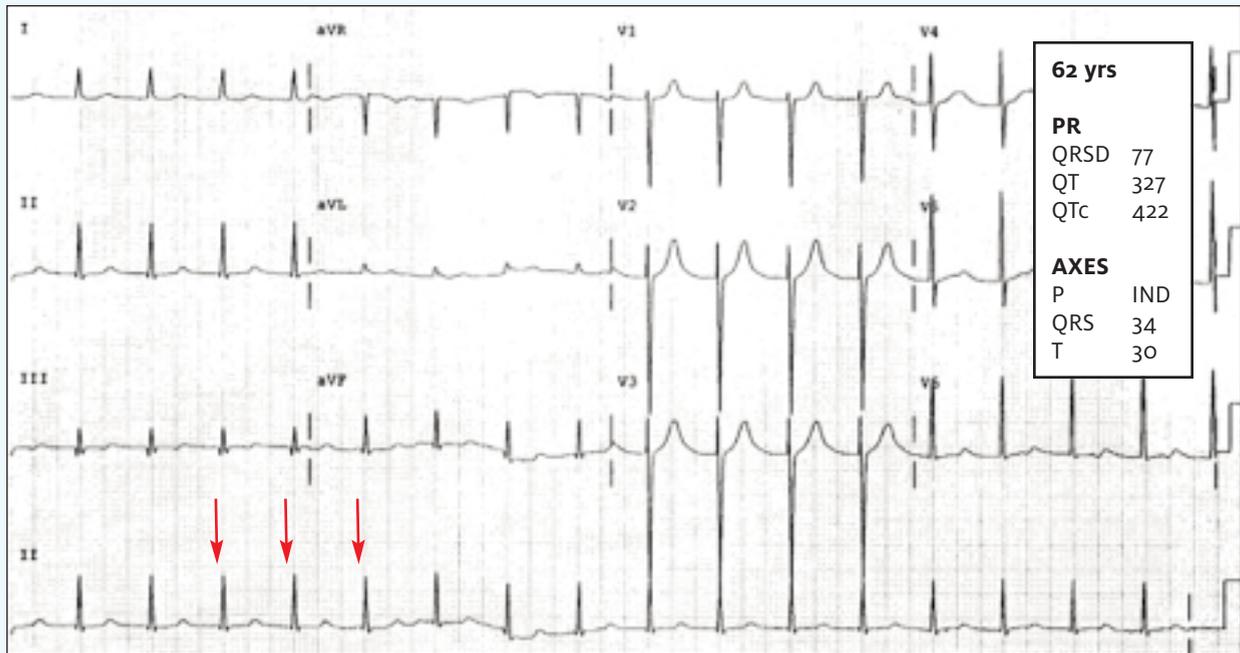


Figure 2.

**Differential Diagnosis**

- First-degree AV block
- Normal sinus rhythm
- Atrial flutter
- Junctional rhythm
- Wenckebach type 1

**Diagnosis**

This patient was diagnosed with junctional rhythm. The ECG reveals a regular rate. There are no P waves, making first-degree AV block impossible. The rhythm is regular, so this is not atrial fibrillation. Wenckebach type 1 has a gradual lengthening of the PR interval until there is a dropped beat (a P without a QRS following) and is not occurring in this ECG. Normal sinus rhythm would require a P wave before each QRS. There are no P waves evident on the tracing; this ECG shows a junctional rhythm.

**Learnings/What to Look for**

- Junctional rhythm has the depolarization initiated at the cardiac junction, at the AV node; as there is no atrial depolarization, there are no P waves
- The rate is typically slow, between 40 and 60 beats per minute. As the depolarization is initiated above the ventricles, it results in a narrow QRS complex

- Junctional rhythms may occur in patients with sick sinus syndrome (SSS) or simply with significant bradycardia
- Patients with junctional rhythm do not have an increased morbidity or mortality (unless the underlying cause, such as SSS, would result in a changed morbidity or mortality)

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

- Inquire about signs of ischemia such as chest discomfort, shortness of breath, diaphoresis, or dizziness, as well as hemodynamic instability such as hypotension, dizziness, or confusion
- Compare to an old ECG to see if the rhythm is new or an incidental finding
- Consider checking electrolytes in patients who may have abnormalities, such as patients on diuretics or those with renal failure
- If the patient is asymptomatic and the rhythm is found incidentally, inform the patient of the rhythm, but no further urgent care management is necessary, and the patient may follow up as an outpatient with primary care



## A 72-Year-Old Man with Black Skin Lesions



### Case

A 72-year-old man brought his wife into the urgent care center because she woke up with a raw throat and fever. However, he also asks to see a clinician to ask about multiple black skin lesions on his cheeks and eyelids. Once in the exam room, he notes that he spent more than 40 years in the landscaping business, getting considerable sun exposure. He knows that put him at risk for skin cancer. In addition, he recently quit smoking after 48 years.

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**

- Acne vulgaris
- Colloid milium
- Favre-Racouchot disease
- Sebaceous hyperplasia
- Syringomas

**Diagnosis**

This patient was diagnosed with Favre-Racouchot disease (FRD), also known as solar or senile comedones.

**Learnings**

- FRD is a disorder of the skin, resulting from chronic exposure to the sun and culminating with small cysts and large blackheads that form on the face and neck. It is also more common in patients with a heavy smoking history, in males, and in whites.

- Unlike the comedones in acne vulgaris, FRD comedones do not become inflamed
- The lesions are most commonly seen on the face (in particular on the temples, cheeks, and periorbital area) of elderly adults

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

- Because FRD is benign, any treatment, other than advising the patient to use sun-protection measures, would be for cosmetic purposes only

*Acknowledgment: Images courtesy of VisualDx.*



## Small Errors Could Cost Big Bucks When Billing for I&D

■ DAVID E. STERN, MD, CPC

**Q.** While reviewing charts where incision and drainage (I&D) procedures were being performed, I came across instances where *Current Procedural Terminology* (CPT) code 10060, “Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single” was billed for treatment of an abscess on the finger. I believe this is an error, since this procedure involved an abscess of the finger pad and not just paronychia. Can you explain the different I&D procedures please?

**A.** If the procedure documentation in your scenario above supports code 26010, “Drainage of finger abscess; simple,” this is an error, and a costly one at that. For example, there is a considerable difference in reimbursement between CPT codes 10060 and 26010. According to the Medicare Physician Fee Schedule (MPFS), average reimbursement for code 10060 is \$121.68, while the average reimbursement for code 26010 is \$272.88.

Billing code 10060 instead of code 26010 once a week results in a loss of \$7,862.40 a year.

Treatment for paronychia using a simple incision just below the skin’s surface (and documented as such) would be billed correctly using CPT code 10060. However, if the patient had an abscess on the finger requiring a deeper incision into the superficial subcutaneous tissue of the finger, then the documentation should reflect that, and the biller should use CPT code 26010 on the claim.

Key points to correct coding I&D procedures in general depend on the site, identifying the abscess, cyst, hematoma, or seroma, and whether the procedure is simple or complicated. The last part of the definition, *simple or complicated*, is probably

**Table 1**

CPT Code	Description	MPFS Average Reimbursement
10080	Incision and drainage of pilonidal cyst; simple	\$184.32
10081	Incision and drainage of pilonidal cyst; complicated	\$276.48
21501	Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax	\$465.83
23930	Incision and drainage, upper arm or elbow area; deep abscess or hematoma	\$369.72
25028	Incision and drainage, forearm and/or wrist; deep abscess or hematoma	\$543.59
26010	Drainage of finger abscess; simple	\$272.88
26011	Drainage of finger abscess; complicated (eg, felon)	\$402.48
26990	Incision and drainage, pelvis or hip joint area; deep abscess or hematoma	\$649.43
27301	Incision and drainage, deep abscess, bursa, or hematoma, thigh or knee region	\$696.23
27603	Incision and drainage, leg or ankle; deep abscess or hematoma	\$545.75
42700	Incision and drainage abscess; peritonsillar	\$194.04
54700	Incision and drainage of epididymis, testis and/or scrotal space (eg, abscess or hematoma)	\$222.84
56405	Incision and drainage of vulva or perineal abscess	\$111.60
56420	Incision and drainage of Bartholin’s gland abscess	\$124.9
67000	Blepharotomy, drainage of abscess, eyelid	\$276.48
69000	Drainage external ear, abscess or hematoma; simple	\$190.80
69005	Drainage external ear, abscess or hematoma; complicated	\$217.08
69020	Drainage external auditory canal, abscess	\$234.36



**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.

the most difficult to determine since the CPT descriptions are somewhat vague.

A simple I&D includes drainage of the pus or purulence

from the cyst or abscess. The incision is left open to drain on its own, allowing for healing with normal wound care. A complex I&D is generally defined as an abscess requiring placement of a drainage tube, allowing continuous drainage, or packing to facilitate healing.

As a physician, it is important that you document precisely, notating the simplicity or complexity of the procedure, as well as how deep the incision(s) is. For example, a patient presents with a large but superficial abscess on the arm that is easy to reach. After the patient was appropriately prepped and anesthetized, an incision was made just under the skin and the pus drained. Packing was placed in the wound, and the patient instructed to return in 2 days for repacking.

In this case, the correct code is 10061, "Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple" because packing the wound adds complexity.

**Table 1** addresses I&D procedures with average reimbursement rates that are worthy of discussion with fellow physicians to demonstrate how imperative it is for the documentation to reflect the procedure exactly as it was performed, and with coders so that they are aware of the numerous I&D codes available.

The procedures above require that documentation indicates the abscess, hematoma, or seroma is deep in order to bill for the procedure. The site of the affected area, method of incision, as well as the depth, width, and length of the incision will direct

Table 1 (continued)		
CPT Code	Description	MPFS Average Reimbursement
<b>Bursa</b>		
23931	Incision and drainage, upper arm or elbow area; bursa	\$298.08
25031	Incision and drainage, forearm and/or wrist; bursa	\$364.3
26991	Incision and drainage, pelvis or hip joint area; infected bursa	\$731.51
27301	Incision and drainage, deep abscess, bursa, or hematoma, thigh or knee region	\$696.23
27604	Incision and drainage, leg or ankle; infected bursa	\$493.91
28001	Incision and drainage, bursa, foot	\$286.20

the coder to the correct code. When the problem is more superficial, the following procedures might be more appropriate:

- 10140, "Incision and drainage of hematoma, seroma or fluid collection" — \$168.84
- 10160, "Puncture aspiration of abscess, hematoma, bulla, or cyst" — \$133.56

As you can see, the correct documentation can make a huge difference in your reimbursement. Continue to review the documentation and claims billed in order to ensure you are coding appropriately for the work that is being performed. ■



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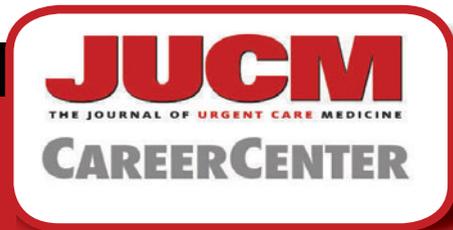
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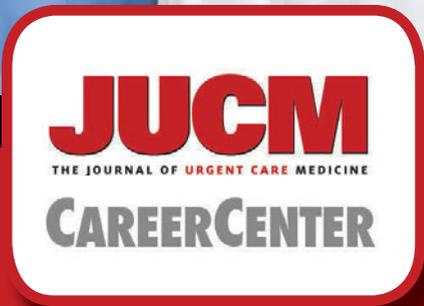
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## Urgent Care Visits Go Up (and Up) While Costs Remain Low vs the ED

The key question posed by the authors of an article published last month in *JAMA Internal Medicine*: How have patterns of care for low-acuity patients with acute conditions changed over time among a commercially insured population? The answer is, quite a lot—due largely (and much to the benefit of) urgent care. Working from 2008–2015 claims data supplied by Aetna, the researchers looked at utilization, inflation-adjusted price, and spending associated with approximately 20 million acute care visits per study year for acute respiratory infections, urinary tract infections, rashes, and musculoskeletal strains.

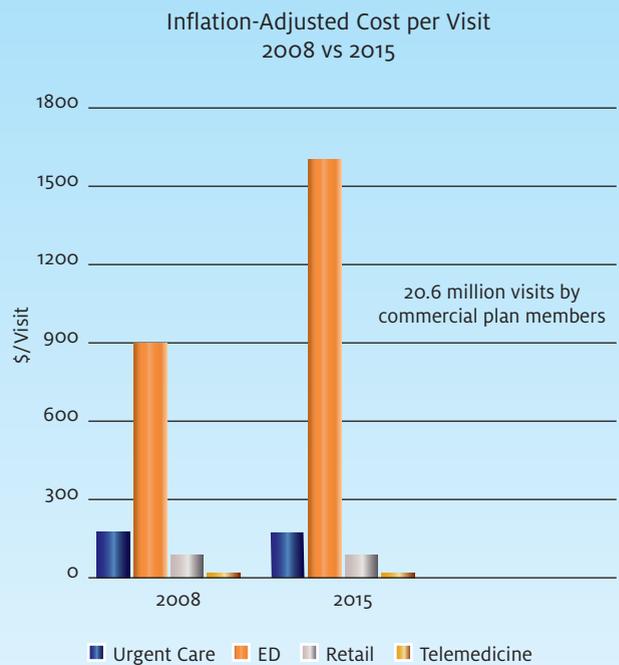
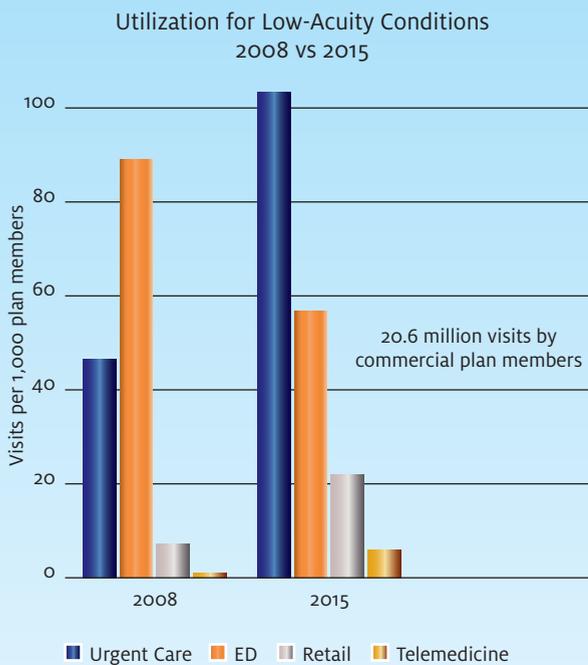
Considering all treatment venues (the ED, urgent care, retail clinics, and telemedicine), treatment of those low-acuity conditions

increased 31% over the study period; however, visits to the non-ED acute care setting jumped 140%, with urgent care getting the biggest bump. In what may be the key understatement of the year, the authors concluded that “these findings suggest that patients are more likely to visit urgent care centers than EDs for the treatment of low-acuity conditions.”

Meanwhile, the cost of a trip to ED rose 79% over the study period, while the average cost of a visit to other nonacute settings is stable.

The particulars (including cost data), illustrated below, paint an even more promising picture for urgent care. ■

### UTILIZATION AND COST FOR LOW-ACUITY CONDITIONS IN ACUTE CARE SETTINGS



Data source: Poon SJ, Schuur JD, Mehrotra A. Trends in visits to acute care venues for treatment of low-acuity conditions in the United States from 2008 to 2015. *JAMA Intern Med.* September 4, 2018. [Epub ahead of print]



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