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URGENT CARE ASSOCIATION

COLLEGE OF URGENT CARE MEDICINE

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CLINICAL cme

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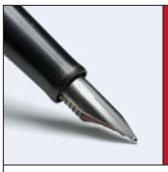


LETTER FROM THE EDITOR-IN-CHIEF

Narcan or Narcan't: An Ethical Dilemma for a Modern Scourge

With opiate abuse and overdose rates at epidemic levels, the campaign for easing access to the potentially life-saving reversal agent Narcan (naloxone) has gained significant momentum. It began with EMS and law enforcement, but has since expanded to schools, community centers, and public spaces; now it is available over the counter in most every state.

Some experts and law enforcement agencies have declared this a well-intentioned mistake. Increasing access, they say, is a "moral hazard," characterized by its potential for encouraging more high-risk behaviors by abusers.

In fact, several studies demonstrate increased rates of abuse and increased risk taking when access to naloxone expands. Users tend toward higher doses and the use of more potent drugs like Fentanyl when the risk of death is decreased.

In addition, studies have found that broadening access leads to more opioid-related emergency room visits and crime without a reduction in mortality.

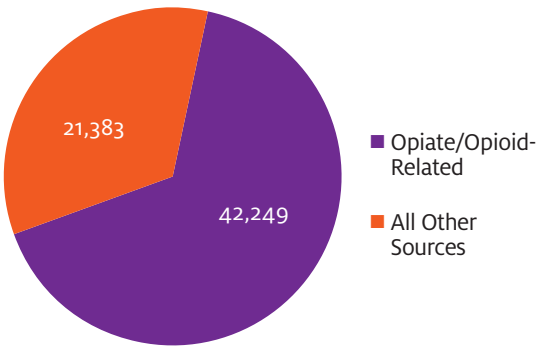
The findings are a gut-punch to a public health crisis searching for solutions. And it creates a terrible burden on the first responders and healthcare providers who frequently revive patients from certain death only to be called back to rescue the same person later in the day.

There is room for ethical debate, however, and the scientific, healthcare, and law enforcement communities are not of one voice on the subject.

Personally, I am torn. But I am very self-aware of my biases and perspective. I can't help but feel a weighty guilt on behalf of my profession for the role that physicians played in fueling the epidemic in the first place. We are in no position to declare the moral high ground here, so I am careful not to be too righteous. I am also of the belief that one life saved is one more person who might just eventually find help and a way out. Others have. And many of them are now leading productive lives, yet were once thought to be hopeless and too addicted to recover.

As a physician, I feel an obligation to give everyone a chance for a healthy life and I try not to make "worthiness" distinctions between organic diseases, mental illness, and substance-use disorders. There will always be people in this world who take advantage of the generosity and kindness of others, but one life saved is more important than the cost of perpetuating an already ruined life.

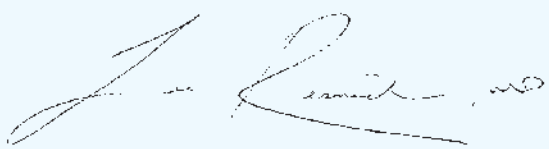
U.S. Overdose Deaths, 2016 (N=63,632)



Source: Centers for Disease Control and Prevention

"Some experts...say [over-the-counter access to naloxone] encourages more high-risk behaviors by abusers."

I strongly believe that we will prevail over this crisis, eventually. We have made a palpable shift in how we treat pain, limit unwarranted access to opiates, track prescribers, and share information. And while we have a ways to go on addiction treatment, we are taking some important baby steps there, as well. These advances are all-too recent to determine their long-term impact, but I am confident we are going to make progress and eventually overcome. And I am in favor of giving every addict a chance at life until we do. ■



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CLINICAL

IN THE NEXT ISSUE OF *JUCM*

This month, we featured a discussion on how to prevent influenza while also preparing for the first wave of patients presenting with flu symptoms, from the science behind the vaccine to the nuances of testing. In the next issue, we turn our attention to how to treat patients who have *the flu. While they will appreciate any help you can offer for their symptoms, the fact is that in some patients vigilance for possible complications can truly be lifesaving. Read the second article in this two-part series to assure you know what to look for—and what to do about patients who may be facing the poorest of outcomes.*

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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 CONTRIBUTORS

"It's just the flu." Patients may be able to get away with saying that, but they'll be in even worse stead if their healthcare providers are not fully aware of just how dangerous influenza can be.

We're sure you understand it can kill, and that it has cost our economy millions of dollars in care provided, missed work, and lost productivity. What you may not be as aware of is why you need to start preparing to treat patients long before they walk through the door, or even what all that preparation should entail. Hint: It's about much more than ensuring you have enough vaccine on hand.

In An Urgent Care Approach to Influenza—Before Onset, **Brent Arnold, DO** walks us through the most relevant chapters in the history of influenza. That's just the set-up for a more detailed discussion of the science behind influenza immunization (and why that matters to you and your patients).

Dr. Arnold is an emergency medicine resident with Adena Health System. (And by the way, his article is the first in a two-part series that concludes next month with an overview of steps you can take once patients who actually have the flu present—with the key objective being to prevent catastrophic complications and get them back on their feet as quickly and safely as possible.)

Few patients would make the mistake of downplaying the seriousness of an orthopedic injury incurred while playing a sport—if for no other reason that they're likely to be in serious pain. However, in their zeal to heal they may be inclined to rush the process. Or, sometimes they make mistakes inadvertently. Either way the consequences of going too far with cryotherapy were inflicted on the patient at the center of this month's Case Report, offered for your edification by **Amitesh Kumar, MD**. Post Sports Injury Burn Due to Inappropriate Use of Cryotherapy begins on page 17.

Dr. Kumar brings a welcome international flavor to *JUCM*; he's a general practitioner at Bakerfield Medical and Urgent Care in Manukau, Auckland, New Zealand.

Regardless of the patient's presentation, every urgent care center needs to ensure the staff is up to the task. If you feel strongly that only the best will do for your operation and your patients, you've got to have the best talent. That can be easier said than done sometimes—like now, for instance, when there's a particularly tight job market. It's not necessarily about offering top dollar, either. Learn what you need to do to have the best candidates knocking on your door, and to keep your most valuable workers in-house by reading Becoming the Employer of Choice for the Emerging Urgent Care Workforce, by **Alan A. Ayers, MBA**, MAcc, on page 26.

Mr. Ayers is the chief executive officer of Velocity Urgent Care, as well as the practice management editor of *JUCM*.

One perk likely to be coveted by applicants for upper-tier positions is a company car. It would be a mistake to think of that, or even of an automobile allowance or mileage reimbursement, as something you can consider lightly. Besides the obvious expense to your operation, there are a number of legal considerations that would likely never occur to you unless you're a lawyer or a finance wiz. If you're neither of those, we suggest reading The Tax, Legal, and Business Implications of Providing a Company Vehicle, Vehicle Allowance, or Mileage Reimbursement, which starts on page 20. It's written by Mr. Ayers, as well.

Also in this issue, **David Stern, MD, CPC** delivers a critical analysis of changes in the Centers for Medicare and Medicaid Services reimbursement structure for Medicare evaluation and management. It's all part of CMS's Patients Over Paperwork initiative. Miss it and you'll be the poorer for it (literally, in this case). Dr. Stern is the CEO of Practice Velocity, LLC and PV Billing.

Finally, in Abstracts in Urgent Care (page 23), we look at new articles published elsewhere from an urgent care perspective. This month, you can read about changing patterns of hepatitis A transmissions; essential information to consider when transporting patients who've had a stroke; how often patients are readmitted to the hospital after experiencing episodes of syncope (sometimes after presenting first to urgent care); options for symptoms of irritable bowel syndrome; and an algorithm for choosing the right treatment for staph bacteremia.

Peer Reviewers

We appreciate the time and efforts of the urgent care professionals who volunteer to serve as peer reviewers for *JUCM*. Their considered opinions are indispensable in our mission to present urgent care-specific content that is unbiased and relevant every month. This month, we thank:

- **Alex Ambroz, MD, MPH**
- **Rajesh K. Davit, MD**
- **Luis de la Prida**
- **Lou Ellen Horwitz**
- **Adrian Scipione**

If you would like to support the growth of urgent care-specific literature, consider volunteering to review content for future issues of *JUCM*. Send a brief email expressing your interest to editor@jucm.com and we'll be in touch in the very near future. ■

CONTINUING MEDICAL EDUCATION

Release Date: November 1, 2018
Expiration Date: October 31, 2019

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

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

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The Urgent Care Association designates this journal-based CME activity for a maximum of 3 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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- **Lee A. Resnick, MD, FAAFP**
  Member reported no financial interest relevant to this activity.
- **Michael B. Weinstock, MD**
  Member reported no financial interest relevant to this activity.
- **Alan A. Ayers, MBA, MAcc**
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CONTINUING MEDICAL EDUCATION

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

An Urgent Care Approach to Influenza—Before Onset (p. 11)

1. **The H1N1 strain of influenza "surprised" the CDC in 2009 because:**
   a. It was a combination of flu genes that had never been seen before
   b. It was believed to have been eradicated in the 1970s
   c. It was a combination of four separate influenza sources
   d. Both a and c
   e. All of the above

2. **At what point is it possible for adults who have influenza to infect others?**
   a. 2 days after exposure
   b. 24 hours before symptoms develop, and up to a week after becoming sick
   c. Up to 1 month after resolution of symptoms
   d. As soon as they're exposed to someone who has influenza
   e. There are no data suggesting a timeframe

3. **Rapid nucleic acid amplification tests and digital immunoassays are effective in assessing patients with symptoms of influenza because:**
   a. They have higher sensitivities for both influenza A and B while maintaining equally high specificities when compared to traditional point-of-care testing
   b. They're inexpensive to administer
   c. They take less time than other point-of-care tests
   d. These tests cover the greatest number of strains of influenza
   e. These tests are not effective in assessing patients with symptoms of influenza

Post Sports Injury Burn Due to Inappropriate Use of Cryotherapy (p. 17)

1. **Which of the following is a means of administering cryotherapy?**
   a. Ice cubes
   b. Ice packs
   c. Ice massage
   d. Ethyl chloride
   e. All of the above can be used to administer cryotherapy

2. **Injuries attributed to cryotherapy are most likely the result of:**
   a. Prolonged application and direct contact of ice on skin
   b. Using mechanical devices
   c. Poor placement of the cold source by the provider
   d. Choosing a cold source that is cold but above freezing

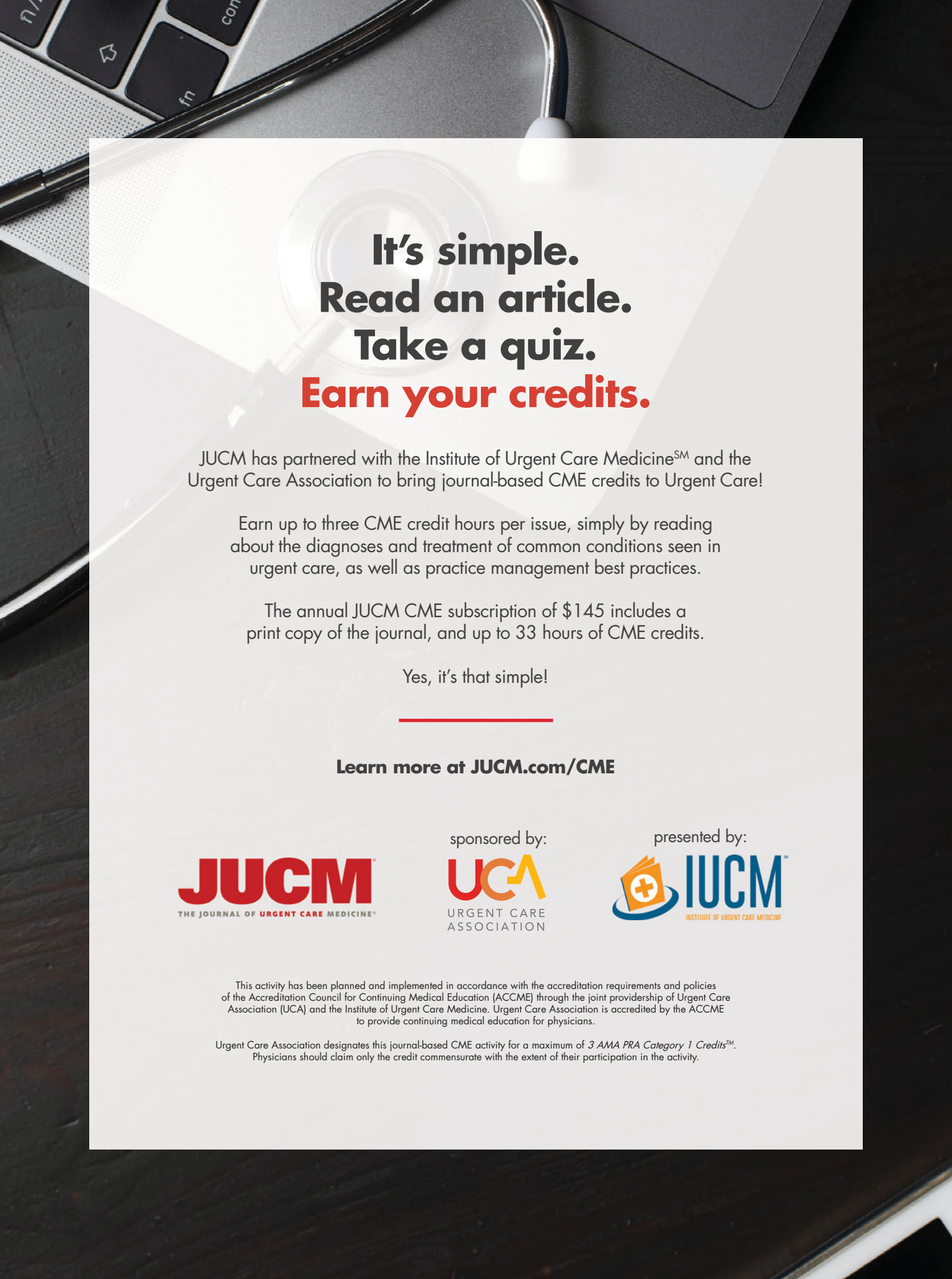
3. **A systemic review of 22 RCTs found:**
   a. No benefit of cryotherapy after soft tissue injuries
   b. Marginal benefit of cryotherapy after soft tissue injuries
   c. Significant benefit of cryotherapy after soft tissue injuries
   d. A long-lasting benefit of cryotherapy after soft tissue injuries

Becoming the Employer of Choice for the Emerging Urgent Care Workforce (p. 26)

1. **The term *new economy* reflects:**
   a. Wider acceptance of virtual currency
   b. That patients are more concerned with healthcare costs than ever before
   c. The U.S. has entered an era of lower unemployment, so more patients have employer-sponsored health plans
   d. The economic transition from manufacturing-based to service-oriented
   e. None of the above

2. **In a "tight" labor market, employers need to:**
   a. Re-engineer their workplaces to make them more attractive
   b. Rethink compensation structures
   c. Evaluate their own employee engagement strategies
   d. None of the above
   e. All of the above

3. **Studies have shown a number of benefits for companies that offer an employee stock ownership plan (ESOP). Which of the following has not been found among those benefits?**
   a. Increases in productivity of up to 5% in the first year the ESOP is offered
   b. Job growth that is 25% higher vs companies with conventional ownership models over a 10-year period
   c. 33% more income from wages as a result of accompanying increases in productivity, compared with conventional ownership models
   d. Lower incidence of on-the-job injury



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It's November. It's the Midterms. Let's Get PAC(K)ing!

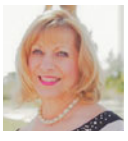
LAUREL STOIMENOFF, PT, CHC

You've probably heard the adage, "If you're not at the table, you're probably on the menu." It seemed that for years I always questioned if the urgent care industry should use being seemingly invisible for good or evil. It was inconceivable to me that the obvious value urgent care could provide to so many healthcare industry challenges went largely unnoticed.

Fast forward to 2018. You have been noticed. In recent weeks we have had promising conversations with the Medicare Payment Advisory Commission (MedPAC), as well as state and federal disaster preparedness organizations who have identified urgent care as a prospective partner to enhance disaster response. During a recent call with MedPAC that included a handful of urgent care industry stakeholders, the MedPAC representative stated, "This is the first time we've looked specifically at urgent care." There is proposed legislation in Louisiana to allow EMS personnel to triage Medicaid patients to urgent care centers, as well as other alternatives to the emergency room. Additionally, the Centers for Medicare and Medicaid Services responded favorably to comments made by the Urgent Care Association (UCA) and the College of Urgent Care Medicine (CUCM) with a proposed urgent care quality measure specialty set for 2019 Merit-based Incentive Payment Systems participants.

Be Careful What You Wish For: Urgent Care Under Siege

But with the benefits we've seen with this newfound visibility, there is also risk. Massachusetts legislators recently proposed an 8.75% tax on commercially billed urgent care charges (yes, that's charges, not collections) and New Jersey is following with a bill that would prevent urgent care centers from discriminating based on "ability to pay," while also prohibiting urgent care centers from providing care for anyone under the age of 18 unless it's an emergency. This despite a 2018 Fair Health evaluation of claims that concluded 23% of claim lines[1] in an urgent care environment were related to this age group. If successful, this New Jersey legislation would represent a devastating and unprecedented blow to urgent care providers. Urgent care operators have also found themselves the target of byzantine certificate of need and licensure regulations which stifle growth due to administrative and cost hurdles.



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

"We have our seat at the table. Now, we need to be able to pay for the meal."

UCA Board Approves the Formation of UCA-PAC

The UCA Board has approved the formation of a Political Action Committee (PAC) after determining that our strategy must be to get ahead of pernicious regulations. Having our seat at the table means we must identify and support candidates who recognize the value proposition made by urgent care centers across the country. We need to exploit the opportunities and squelch the threats.

To do so, we need data, dollars, and determination. In working with our chapters and individuals in the states under siege, we've seen plenty of grit and commitment, but most are growing weary of playing defense. A PAC Advisory Board has been convened, and we will be seeking others to provide input. The PAC was introduced at last month's fall conference in Houston. You can expect to hear more soon.

Flying under the radar was peaceful, but urgent care has been elevated. We have our seat at the table. Now, we need to be able to pay for the meal.

You can make a donation to the PAC today by texting "UCAPAC" to 91999. ■

1. *Fair Health*. FH Healthcare Indictors and FH Medical Price Index: a new view of place of service trends and medical pricing. March 2018.

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An Urgent Care Approach to Influenza—Before Onset

Urgent message: The urgent care clinician must have a thorough understanding of different influenza types and strains, disease course, and preventive measures—including, but not limited to, vaccination—at the outset of flu season.

Brent Arnold, DO

Introduction

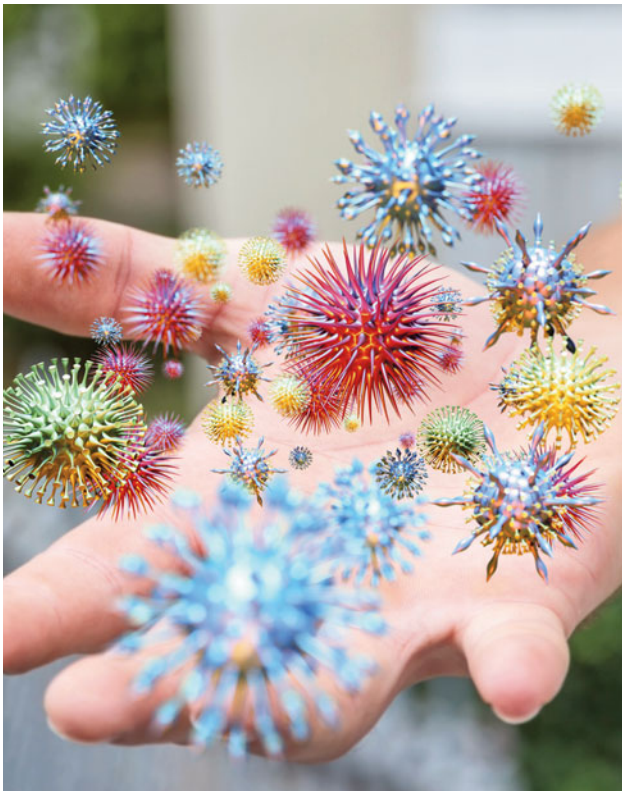
Influenza is most deadly in the very young, very old, and those with comorbid conditions. Typically, onset is rapid and seasonal, though patients may initially present with few or nonspecific symptoms. Complicating things further, there are many different strains of the flu. Spread can occur from the host even before the onset of symptoms, and current treatments may be only marginally effective.

Flu Types and Strains

The Centers for Disease Control and Prevention has adopted an international naming convention for influenza based on the antigenic type (A-D), origin, and strain number. Seasonal flu epidemics are caused by the two main human influenza virus types: A and B. Type C generally does not cause true epidemics and is self-limited to mild respiratory illnesses. Type D influenza affects cattle and has no known effect on humans.[1]

Influenza A has two different subtypes which are defined as the hemagglutinin (H) and the neuraminidase (N) protein markers. There are different subtypes which can correspond to influenza A (H1-18) and (N1-11), respectively. Perhaps one of the most well-known influenza subtypes is influenza A (H1N1), which has been known to cause disease in humans for many years but in 2009 changed and caused the first pandemic influenza outbreak in more than 40 years.[1]

This strain of influenza surprised the CDC because it was a combination of flu genes that had never been seen before in animals or humans, being a combination from four separate influenza sources. In just 2 months, it became a true pandemic, with CDC estimates of infection in over 1 million people.[2] Though large, that does not compare with the 1918 influenza pandemic which affected 500 million people and had death tolls



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Brent Arnold, DO, is an Emergency Medicine Resident with Adena Health System. The author has no relevant financial relationships with any commercial interests.

upwards of 50 million. This pandemic caused the average life expectancy in the U.S. to fall by 12 years. It was termed the Spanish flu, as Spain was one of the few countries that remained neutral during WW I and they reported the influenza news around the world.[3]

Influenza B is not divided into subtypes, but rather has different strains and lineages: Yamagata and Victoria.

There are key differences, both biological and clinical, between the flu virus types. About 75% of influenza infections are caused by influenza A, with influenza B making up the other 25%.[4] Influenza A infections are associated with more serious complications, such as pneumonia and deaths in children and the elderly. Influenza B tends to be more prevalent later in the season and does not cause pandemics. It causes symptoms similar to influenza A, but they are milder and rarely cause the life-threatening complications seen with influenza A.

The Changing Nature of Influenza

Influenza viruses change periodically by a process call antigenic drift, which is a slow but continuous change resulting in a new strain that is not recognized by the host's immune system. This is a more abrupt, sudden, and complete change which produces a completely new subtype with new H/N that leaves patients without antibody protection.[5] A prime example of this "antigenic shift" is the 2009 H1N1 virus that combined genes in a new way to affect humans and resulted in the 2009 influenza A pandemic. When these shifts happen, most people have very little immunity against the newly formed virus because the change happened so suddenly.[6]

Time from Exposure to Onset

Influenza is highly contagious. Symptoms start, on average, 2 days after exposure to the virus. Adults can start to spread the infection 24 hours before symptoms develop and up to a week after becoming sick. Children can spread the virus for more than 1 week.

Influenza is spread through respiratory droplets such as a cough or sneeze and can be spread up to 6 feet. The virus can be transmitted onto surfaces, as well, then transmitted to a person who touches the surface and then their own mucosal surfaces (mouth/nose).

"Influenza is spread through respiratory droplets such as a cough or sneeze and can be spread up to 6 feet. It can also be transmitted via contact with tainted surfaces."

Clinical Course

The abrupt onset of fever, cough, malaise, myalgia, nasal congestion, and sore throat is characteristic of influenza. In immunocompetent patients, symptoms should start resolving within 1 week, but cough and malaise may last up to 2 weeks.

Signs/Symptoms/Duration

Sensitivity and specificity

Several studies have attempted to isolate or help predict the most likely symptoms associated with influenza illness. A study out of Taiwan in 2015 suggested that the combination of fever and cough had the best sensitivity (86%), and fever, cough, and sneezing had the best specificity at 77%.[7] Another study out of Kenya also showed fever and cough as the most sensitive.[8]

What clinical findings are most reliable?

There are several symptoms associated with influenza illness. They generally include fever, myalgias, sore throat, cough, headaches, fatigue, chills, and runny/ stuffy nose. Some strains of influenza also can cause nausea, vomiting, and/or diarrhea. It is possible to have influenza and not have a fever.[9]

Many of these symptoms are also associated with other viral illnesses, so it would be beneficial to know which symptoms are most suggestive of influenza. In 2000, Monto, et al looked at 3,700 patients suspected to have the flu, noting:[10]

- 93% had cough
- 91% had nasal congestion
- 68% had fever
- Cough + fever during flu season had a positive predictive value of 79%

Symptoms of influenza are similar to the symptoms of other viral respiratory infections, making a definitive clinical diagnosis difficult. Establishing a pretest probability and assessing the importance of a definitive diagnosis (such as in the elderly, pregnant, or immunosuppressed) will aid in the decision to pursue further testing.

Testing

Indications

Early season

Influenza testing early in the season may be useful to establish when the virus is starting to increase in prevalence. It can also be used to help further characterize what symptoms or subtleties of this season's virus is producing.

Late season

Testing later in the season is less useful if the patient fits into the pre-established risk group and may benefit from treatment.

Diagnosis

Diagnostic testing is not always necessary, as the diagnosis can often be suspected on a clinical basis. This is especially true during "flu season" when the virus is more prevalent.

The virus is spread through respiratory droplets and can be found in nasal, oral, or respiratory mucosa. Testing in the urgent care center occurs with a nasal swab. These tests may use molecular assays such as rapid molecular assays, reverse transcription polymerase chain reactions (RT-PCR), nucleic acid amplification tests, and antigen detection (rapid influence diagnostic tests [RIDTs] or immunofluorescence assays).

- *Rapid molecular assays* detect influenza-specific nucleic acids from an upper respiratory sample. Sensitivity is 90%-95%, with results within 30 minutes.
- *RT-PCR* recognizes influenza RNA or nucleic acids (again, in a respiratory sample) with high sensitivity and specificity. The tests can isolate whether the virus is influenza A or B. Some tests can even identify specific subtypes, such as influenza A (H1N1). These tests take a little longer (from 45 minutes to several hours), which is seen as an acceptable compromise due to the increased sensitivity/specificity.
- *Rapid influenza diagnostic* tests are antigen tests specific to influenza, and produce results within 15 minutes with 50%-70% sensitivity and high specificity (90%). Some tests can have up to 80% sensitivity.[11] A limitation is that these tests don't differentiate between viable and nonviable infections or ongoing infections. Another key consideration is that influenza A subtypes cannot be obtained from the RIDTs.
- *Immunofluorescence assays* also use antigen detection but, as the name implies, require the use of a fluorescent microscope to provide results. This does take longer (2-4 hours) and produces moderate sensitivity and high specificity. These types of tests can differentiate between influenza A and B, but cannot further differentiate different influenza A subtypes.
- *Viral cultures* are not timely enough to effect clinical management, as they can take anywhere from 3 to 10 days. The strength of these cultures is that one can characterize the antigenic and genetic makeup of the specific influenza virus causing the patients infection. These are generally, at least in part, used to determine the following year's influenza vaccine.

"The key to ordering and proper clinical use of these tests requires knowledge of the reliability and timing of the tests."

The key to ordering and proper clinical use of these tests requires knowledge of the reliability and timing of the tests. For example, RDITs have moderate sensitivities, meaning that false-negative results are common, but high sensitivity of 90%-95%, which means false-positives are uncommon. This makes it useful for confirming an influenza infection, but not in ruling it out. This is in contrast to viral cultures, which have a 90%-95% specificity—false-positive are uncommon.[12,13]

To sum up, the rapid nucleic acid amplifications tests and digital immunoassays have higher sensitivities for both influenza A and B while maintaining equally high specificities when compared to traditional point-of-care testing.[13]

Prevention of Spread

Other than getting the yearly flu vaccine, the best ways to avoid getting the flu include the following:[14]

- Avoid close contact with people who are ill
- Stay at home when you are sick
- Minimize the spread of respiratory droplets by covering the mouth and nose when sneezing or coughing
- Do not touch the face (eyes, nose, mouth)

- Disinfect commonly touched surfaces
- Wash hands frequently

A 2007 meta-analysis in the *American Journal of Public Health* showed a 21% reduction in the transmission of respiratory illness just by hand hygiene alone.[15]

The Flu Vaccine

There are over 100 national influenza centers in over 100 countries.[16] These centers conduct year-round research on influenza by analyzing thousands of virus samples. In the U.S., the Food and Drug Administration has the final approval for vaccines to be produced and sold here. This takes place in February each year for the upcoming flu season. The CDC generally chooses a vaccine to protect against three or four influenza viruses based on these research center data. Now, the vaccine always includes influenza A (H1N1), A (H3N2), and one or two flu B viruses.[1]

These vaccination choices are based on the influenza centers' predictions of which viruses have been and will be circulating during the upcoming season. The ideal vaccine would contain viruses that are easily isolated and can be grown, which occurs in chicken eggs. Additionally, the vaccine virus must have enough similarity to the circulating viruses to provide immunity and also have adequate time to be tested and produced.[16]

The influenza vaccine takes about 7 months to become available after the virus vaccine combination is chosen. One complication from this long time frame is that the influenza virus can change between the time the vaccine was chosen and when it became available. A perfect example of this, again, is the 2009 H1N1 pandemic that became one of the worst influenza pandemics since the 1918 Spanish flu. Generally, if these viruses are not antigenically significant, it won't cause an issue. However, if they do become different, the vaccination may not allow the patient's immune system to detect these changes and the patient would get the flu. Currently, work is being done to shorten production time to help reduce this effect.

Who should get the influenza vaccine?

Anyone can get the influenza vaccine, but certain groups are at much higher risk, including:

- The elderly (>65 years of age)
- Those with neurological, heart, lung, liver, renal, endocrine, blood, or metabolic diseases
- Very young children (<2 years of age)
- Pregnant women

Also, less commonly thought of but of clinical importance to note, are Alaska Natives and Native American, as these populations are more susceptible to significant flu complications.

"Patients with significant illness and a fever should wait until they are over their current illness prior to being vaccinated."

Patients with significant illness and a fever should wait until they are over their current illness prior to being vaccinated. The thought process behind this recommendation is that if the patient were to develop a fever immediately following vaccine administration, it would be difficult, if not impossible, to tell if the fever was due to the preceding illness or a reaction to the vaccine.

If it is a reaction to the vaccine, this would cause the patient to be unable to get the vaccine in the future. Another common reason is more speculative and based on physiology that during an active illness, the body is already developing an immune response to another bug and may not achieve a maximal immune response to influenza when compared to the patient being healthy and receiving the vaccine.[17] Additionally, patients with a history of Guillain-Barre syndrome after receiving the influenza vaccine in the past and who are not currently at risk for severe illness from the flu should not receive the vaccine.[18]

New Nasal Indication (What's Different vs Old Nasal Vaccine)

Previously, the nasal live attenuated influenza vaccine (LAIV) was indicated for all nonpregnant patients 2-years-old through 49-years-old without significant comorbidities. Those with certain diseases and comorbidities should not receive this form of the vaccine because safety and effectiveness in these people have not been established. Additionally, a key difference between this route of administration and the injection is that the

LAIV can be shed for up to 2 weeks. However, according to the 2017-2018 and current recommendations, the LAIV is not recommended for use.[19]

Does the flu vaccine decrease mortality?

During the 2016-2017 season alone, the CDC estimated that the influenza vaccination "prevented an estimated 5.29 million illnesses, 2.64 million medical visits, and 84,700 hospitalizations."[1]

To calculate this, the expected outcome of people at risk was compared with the expected outcome if no one was vaccinated. Then, the averted outcomes (assumed to be from vaccination) were calculated by the difference between outcomes in the hypothesized unvaccinated and vaccinated populations.[1] The data are generated from studies conducted by the U.S. Influenza Vaccine Effectiveness Network, a group of academic institutions.[20]

The problem with these data, however, is multifactorial. First, flu-related deaths of people over the age of 18 are not required to be reported. Second, flu-related deaths often occur weeks after the initial illness due to deadly secondary infections (eg, pneumonia) or exacerbated chronic respiratory illnesses such as COPD or CHF. Further complicating this scenario is that by the time a life-threatening diagnosis is made, the virus can no longer be detected in respiratory samples. Finally, "influenza" is rarely listed as a cause of death on death certificates, making it difficult to track.[21] ■

[This article is the first in a two-part series. In next month's JUCM*, we will examine how urgent care providers and operators can prepare for the influx of patients with influenza—including treatment, patient education, and vigilance for patients who may be prone to complications and poor outcomes.]*

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Summary

- Influenza can be spread from the host 24 hours before symptoms develop, and up to a week after the host becomes sick.
- Influenza A infections are associated with more serious complications, such as pneumonia and death in children and the elderly.
- Early-season testing may be useful in establishing when the virus is starting to increase in prevalence. Conversely, late-season testing is less useful if the patient fits into a pre-established risk group.
- Because rapid nucleic acid amplification tests and digital immunoassays have higher sensitivities for both influenza A and B while maintaining equally high specificities compared with traditional point-of-care testing, they are effective in assessing patients with symptoms of influenza.

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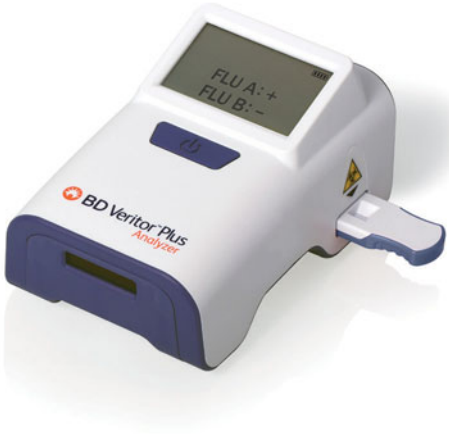

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See **CME Quiz Questions** on page 7.

Post Sports Injury Burn Due to Inappropriate Use of Cryotherapy

Urgent message: PRICE (protection, rest, ice, compression, and elevation) treatment is often advised to patients as part of sports soft tissue injuries; however, incorrect use of cryotherapy may lead to complications.

AMITESH KUMAR, MD

Introduction

Cryotherapy involves application of ice on acute soft tissue injuries in the form of ice cubes, ice packs, ice towels, ice massage, frozen gel packs, ethyl chloride, and other chemical devices. The goal is temperature reduction of 10-15° C[1] to decrease pain and swelling, accomplished by localized inhibition of nerve conduction and vasoconstriction with reduced metabolic need. Cryotherapy burns are uncommon,[2,3] with most occurring due to prolonged exposure to cold or a thin barrier covering the ice or cool packs.

Case Discussion

A 55-year-old male was playing soccer, and after a sudden burst felt pain on the back of his right calf. He was limping and had difficulty in weight bearing. There was tender medial head of gastrocnemius with normal Achilles tendon. He had no drug allergies, and significant past medical history included ischemic heart disease, psoriasis, rosacea, and colon polyps. Regular medications consisted of atorvastatin, aspirin, ACE inhibitor, metoprolol, hydrocortisone ointment, and moisturizers. He was treated for a gastrocnemius sprain with PRICE, diclofenac, physiotherapy, and advised to follow up later in the week.

He returned to the clinic the next day with superficial blisters up to 6 x 6 cm surrounded by dark pigmentation on the right calf, thought to be due to direct application of ice for about 4 hours. (See **Figure 1**.)

Education on cryotherapy treatment was provided and he was advised to return in 2 days for a wound check, at which time his limping had worsened and the blister size increased to 10 x 11 cm with fluid collection. The bullous lesion was drained, yielding 180 mL of serous fluid.

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The wound was cleaned with normal saline and dressed with sterile dressing. Regular dressing changes and follow-up were advised. (See **Figure 2**.)

After a week of alternate day dressing in the clinic, he improved considerably, with only a residual small distal blister on his calf. He has been walking without a limp but some pain.

During the second week of injury, the superficial burn site increased to 17 x 10 cm, but there was no sign of infection and hence dressing continued. (See **Figure 3**).

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Figure 1. Day 2 of cryotherapy burn, formation of a blister.

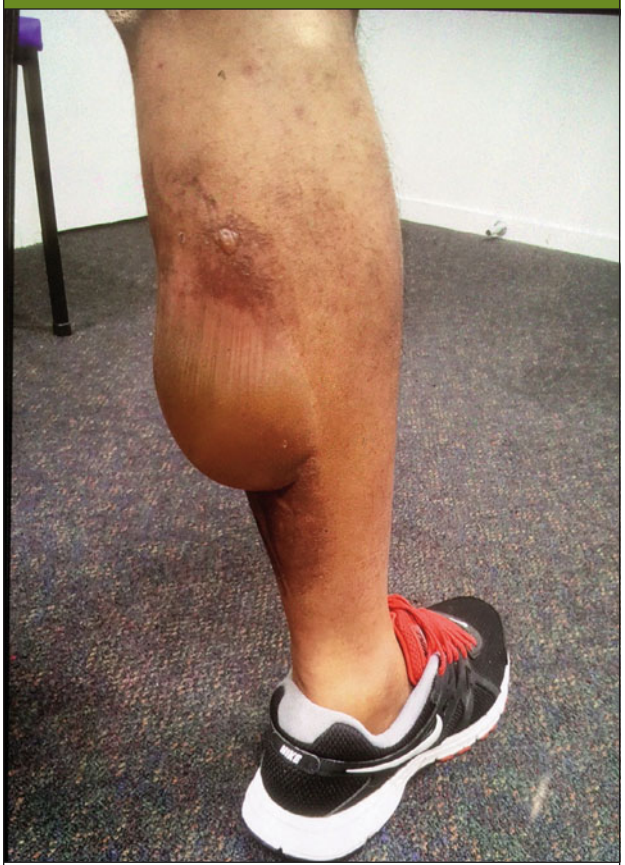

Photo courtesy of Dr. Amitesh Kumar.

Figure 2. Day 2 burn, post blister aspiration.

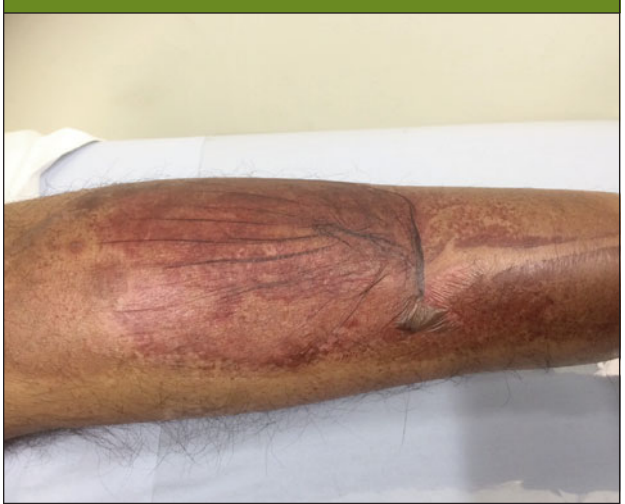

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Figure 3. Two weeks after burn (second-degree burn).

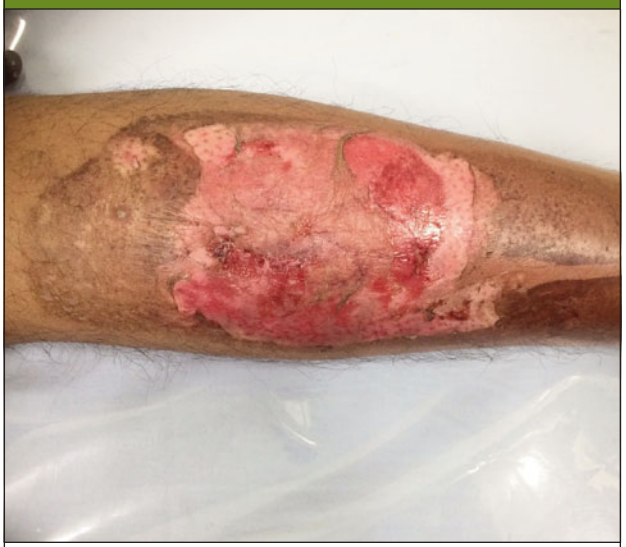
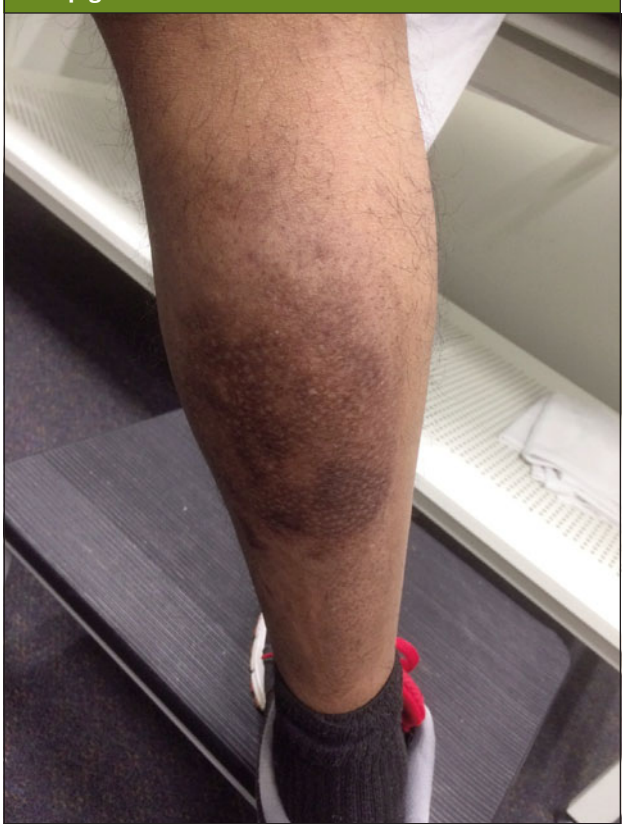


Photo courtesy of Dr. Amitesh Kumar.

Figure 4. Five weeks after burn; skin healing well with dark pigmentation.



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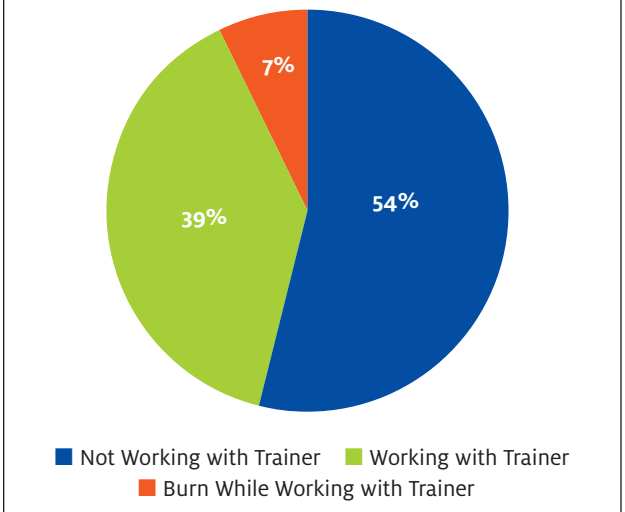
When do complications from chryotherapy occur?



He improved within the next 2 weeks and continued his physiotherapy for calf strain. (See **Figure 4**.)

Discussion

Cryotherapy is common and widely accepted with orthopedic injuries. Though cryotherapy injuries may occur from home use, 42% of the complications occur in patients working with athletic trainers, of which 18% are burn related.[4]

Prolonged application and direct contact of ice on the skin are detrimental and could lead to burns, which further delays the rehabilitation of the injured soft tissue. Scenarios could be more challenging if burns occur on joints, which can lead to contractures and further hinder rehabilitation of the injured soft tissue. Cryotherapy leads to reduced blood flow and metabolism and prolonged exposure causes tissue necrosis and resultant burn.

Effectiveness of Cryotherapy

Though it is commonly practiced, a systemic review of 22 randomized controlled trials found marginal benefit of cryotherapy after soft tissue injuries.[5,6] Few of those studies had good methodology, and further well-controlled trials are necessary for better guidelines on cryotherapy with various types of injuries. Cryokinetics, which is cryotherapy plus exercise, has been gaining momentum. It has shown to be more effective than cryotherapy alone in treating soft tissue injuries.

There are various cryotherapy guidelines,[7] generally recommending use in acute setting for 3-10 days. Commercial ice packs are available. If using homemade ice packs, they should be well wrapped to avoid direct contact on skin. Recommended use is for 10-20 minutes, 3-4 times per day.[8]

Burns from such a common treatment modality signify that better education and awareness of PRICE and cryotherapy are needed. In busy urgent care clinics, face-to-face counseling can be further emphasized with written information.

Take-Home Points

Proper use and application of cryotherapy should be explained to patients as to minimize the risks of adverse events like burns. ■

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Summary

- When employing PRICE treatment for a sports injury, cryotherapy may be administered via ice cubes, ice packs, ice towels, ice massage, frozen gel packs, ethyl chloride, and other chemical devices.
- The goal of cryotherapy is to reduce site temperature by 10–15° C to decrease pain and swelling.
- While use of cryotherapy in orthopedic injuries is common, cryotherapy burns are uncommon. Most occur due to prolonged exposure to cold or because a barrier covering the ice or cool packs is too thin.
- Cryotherapy leads to reduced blood flow and metabolism; prolonged exposure causes tissue necrosis.
- A review of 22 randomized controlled trials revealed marginal benefit of cryotherapy after soft tissue injuries, though few of those trials had good methodology.

The Tax, Legal, and Business Implications of Providing a Company Vehicle, Vehicle Allowance, or Mileage Reimbursement

ALAN A. AYERS, MBA, MAcc

Urgent message: The nature of a multisite urgent care business entails operations and clinical leadership travelling among various sites, so a sensible, easily administered, and cost-effective policy for paying employee vehicle must be established to assure tax and legal compliance.

Company vehicles can be an attractive perk for urgent care administrators or providers and can provide several benefits to the urgent care entity. These benefits can include out-of-home advertising in a wrapped vehicle, an enhanced brand image transporting employees and prospects in a newer model car, and increased visibility of leaders in the centers, as well as administrative convenience and time savings. Vehicle allowances or mileage reimbursements are also appealing perks for staff, and can give the company a financial benefit.

However, there are important implications to consider before deciding to provide a company car, a vehicle allowance, or a mileage reimbursement to employees. Providing a vehicle has tax, legal, and business consequences, while, generally, vehicle allowance and mileage reimbursement are concerns for employers only when it comes to taxes.

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Tax Implications

Company car

A company car is one that is purchased, financed, or leased by the company. The company can deduct all business use costs and expenses for the vehicle, such as gas, oil, and maintenance. However, the employer must be aware of any personal use of the company vehicle by the employee and exclude this from its deductions. The IRS stipulates that personal use of a company vehicle is a noncash fringe benefit. Companies that provide a company car must comply with the IRS rules to determine the compensation value and withhold the appropriate amount in income tax, Social Security tax, and federal unemployment tax.

The value of a company car as a fringe benefit is based on the amount an employee would pay to lease a vehicle of equivalent value, otherwise known as fair market value (FMV).[1] Employers must calculate the FMV at least once a year for tax purposes.[2]

Regardless of who's driving a car or who owns it, only the business use of that car is deductible as a business expense. As a result, the driver must keep meticulous records of driving for business use, and the business event must be recorded the day it happened, with details of the purpose, date, and location or mileage.[3]

Car allowance

The vehicle in this scenario is financed or leased by the employee, but the company car allowance contributes toward the payment. The allowance is a predetermined sum paid to the

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"The employee is required to maintain a mileage log that includes odometer readings, as well as the purpose and destination of each business trip. (Commuting to and from work doesn't qualify.)"

employee as compensation for driving their own vehicle for business reasons. A car allowance is designed to cover expenses like wear-and-tear on the employee's car, gas costs, and regular repairs.[4]

Car allowances are generally used by employers to minimize accounting costs. When an employee is given a car allowance, the amount is added to their paycheck.[5] The IRS has stated that if the employee's deductible business expenses are fully reimbursed under an accountable plan, the reimbursements shouldn't be included in the wages on a Form W-2. As a result, the employee shouldn't deduct the expenses.[6]

To qualify as an accountable plan, the employer's reimbursement or allowance arrangement must include all three of the following rules:

- The employee must have paid or incurred expenses that are deductible while performing services as an employee
- The employee must adequately account to the employer for these expenses within a reasonable time period
- The employee must return any excess reimbursement or allowance within a reasonable time period[7]

However, if the employer's reimbursement scheme doesn't meet all three requirements, the arrangement is deemed to be a nonaccountable plan, and the reimbursements are includable in employee wages. The employer must combine the amount of any reimbursement or other expense allowance paid to the employee under a nonaccountable plan with wages, salary, or other compensation and report the total on a Form W-2.[6] The employee can deduct employee business expenses as an itemized deduction.[2]

Vehicle expense may be calculated using a per-mile rate, which is set by the IRS (although a lesser rate could be used), or by calculating the actual car expense, which includes items such as lease payments, depreciation on a purchased asset, collision insurance, and maintenance, including oil changes, car washes, and gasoline. Both methods require that a detailed mileage log be kept to determine the business, commuting, and personal use. However, if detailed expenses are tracked in lieu of a per-mile allowance, receipts for all car-related expenses must also be maintained.

Commuting Mileage

Commuting mileage—the distance between the employee's home and regularly scheduled place of business (ie, the address where they would anticipate working for 1 year or longer)—is not considered a business use, even if the employee is working during the commute (ie, conversing on their cell phone or transporting supplies) and even if the employee is "self-employed." Mileage from home to temporary working locations and mileage from the office to other work locations is considered "business use." Because the IRS categorizes mileage from home to work as "commuting," which is taxable, the easiest way to minimize the impact of commuting mileage is to establish a "home office" as a base of operation, but that invokes other requirements and tax implications.Commuting mileage must be accounted for and segregated from business and personal use miles in the mileage log. Otherwise the employer may need to make an assumption as to commuting mileage and deduct the miles of the regular daily commute from the business use, either increasing the tax liability of a company car or car reimbursement, or decreasing the tax-free mileage reimbursement. Adapted from: IRS Commuting Rule: Mileage Rules & Commute Definition. Available at: https://www.mileiq.com/blog/irs-commuting-rule-definition/. Accessed October 1, 2018.

Mileage reimbursement

Here, the vehicle is purchased, financed, or leased by the employee. The employer reimburses the employer for the miles driven for work-related travel.

The IRS has specific limitations and documentation requirements that apply to company mileage reimbursements.[9-11]

If an employee uses their personal vehicle in business, and it's used only for that purpose, they may deduct its entire cost (with some restrictions). However, if the car is used for both business and personal purposes, an employee can deduct only the cost of its business use.[8]

The employee is required to maintain a mileage log that includes odometer readings, as well as the purpose and destination of each business trip. Commuting to and from work doesn't qualify. Since mileage reimbursements are not taxable income, an employee may wind up with more money compared to the after-tax amount of a car allowance.[5]

Mileage reimbursement at the IRS rate is typically the most cost-effective option for employers while employees can often make a

"Employers are liable for the negligent actions or nonactions of their employers while working in the scope of their employment."

tax-free profit if they manage their car expenses appropriately. The downside is the necessity to keep detailed recordkeeping of each trip by the employee and regular processing of expense reports by the employer.

Legal Implications

Employees traveling for company business lends itself to potential legal issues. In the majority of instances, an employer will be responsible for the actions of its employees under the doctrine of respondeat superior or vicarious liability. Under this theory, employers are liable for the negligent actions or nonactions of their employers while working in the scope of their employment. This would include a motor vehicle accident, a moving violation, or other offense. The employer is typically liable because the employee was acting within the scope of their duties and wasn't committing any crimes. The critical factor is determining whether the employee was acting within the scope of their duties.

Take, for example, an employee who is cited for driving under the influence in a company vehicle. This isn't within the scope of an employee's duties. Even if the employee was at a business lunch with a client, they will likely be found personally liable and won't be covered by vicarious liability.

Likewise, an employee who runs personal errands while on company time and is involved an auto accident may also not be protected from personal liability. It's irrelevant whether this is on company time or not—the employee is acting in his or her own personal capacity and not at the employer's direction. As a result, typically, the employer isn't legally required to pay for damages or injuries caused by the employee in a nonwork sanctioned activity while using a company vehicle.[12]

Business Implications

Another important consideration in this area is the type of insurance policy the employer carries. Many companies have collision coverage which extends to their employees. Businesses with company vehicles need to make certain that their coverage is sufficient and that the policy covers all work-related activities. Employers should consult with their automobile insurance carriers and legal counsel to be certain that the proper coverages are in place to cover potential liability arising out of the use of a company vehicle by any person allowed to use it.[11]

Company policies and employee handbooks should detail the use of company vehicles and the scope of employee reponsibilities.[13,14]

Takeaway

In each of the three scenarios discussed above, specific considerations must be given to comply with IRS rules, maximize the benefit to the company, and provide the greatest benefits to employees.

It's important for the employee and/or the company to maintain diligent records on business and personal use of company vehicles. There are numerous tax, business, and legal implications that a business must be aware of and address.

In addition, detailed vehicle records are necessary to reimburse employee driving expenses, to deduct depreciation expenses, and to prove business use so that an employer doesn't have to include this portion of the car's value in employee pay.

Company insurance policies should be reviewed for scope and sufficiency of coverage.

Finally, employers should include the parameters of the use of company vehicles and the scope of employee duties in company policies and employee handbooks. ■

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ABSTRACTS IN URGENT CARE

- Changing Patterns of Hep A Transmissions
- Transporting Stroke Patients
- Readmission Rates for Syncope
- Weighing Options for IBS Symptoms
- An Algorithm for Antibiotic Choice in Staph Bacteremia

REVIEWED BY 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.

From ID Week: Outbreak-Related Hep A Infections Are on the Rise

Key point: Hepatitis A infection may be evolving from common-source exposure to outbreak exposure. Urgent care clinicians can influence this phenomenon by recommending that at-risk adults receive immunization.

Citation: Foster M, Hofmeister M, Yin S, et al. Changing epidemiology of hepatitis A virus infections—United States, 2009–2017. Oral Abstract Session. ID Week 2018. Available at: https://idsa.confex.com/idsa/2018/webprogram/Paper74176.html. Accessed October 8, 2018.

Between 2007 and 2017, the incidence of hepatitis A attributed to outbreaks, as opposed to common-source exposure, increased steadily—so much so that by 2017 43% of hep A infections were associated with outbreaks. For context, only 5% were associated with outbreaks between 2007 and 2011. Previously, large community outbreaks were most likely to be associated with asymptomatic children who would pass the virus on to adults, who would then proceed to infect other adults. That dynamic started to change when the Centers for Disease Control and Prevention issued a recommendation that all children receive the hep A vaccine. Given the timing of the CDC recommendation, and the fact that it was specific to children, there is a relatively large population of adults who are not immune to hepatitis A. In a presentation at ID Week, Monique Foster, MD, of the CDC in Atlanta, noted that high-risk adults (eg, travelers, men who have sex with men, and persons who use illicit drugs) have been slow to get the vaccine. In fact, there is still no universal recommendation that adults be immunized against hepatitis A infection. Foster, et al stressed the importance of "decreasing the susceptible population through adherence to childhood vaccination recommendations and targeted vaccination of recommended at-risk groups" in order to "prevent future hepatitis A outbreaks of any transmission pattern." ■

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Considerations When Transporting Patients with Suspected Acute Ischemic Stroke

Key point: Distance to a facility and that facility's capability to administer thrombolysis quickly are both essential considerations when transferring patients presenting with suspected acute ischemic stroke.

Citation: Holodinsky JK, Williamson TS, Demchuk AM, et al. Modeling stroke patient transport for all patients with suspected large-vessel occlusion. *JAMA Neurol*. September 4, 2018. [Epub ahead of publication]

When patients present to urgent care with symptoms that could be attributed to acute ischemic stroke, time is of the essence. It may be necessary to weigh the relative merits of transferring the patient to one facility vs another. The authors of this study set out to answer a basic but essential question: In suspected acute ischemic stroke with large-vessel occlusion, should thrombolysis-capable stroke centers be bypassed in favor of direct transfer to endovascular-capable stroke centers? In weighing those options, they determined that the "correct" answer depended on several factors, chief among them the patient's distance from a location and the speed with which the destina-

tion would be prepared to provide the right care. "If treatment times are slow at the thrombolysis center, bypass should be considered when the centers are 60 minutes or less apart; with greater transport times between centers, bypass is not always favorable," they wrote. Using a theoretical, conditional probability model employing existing data from clinical trials of stroke treatment, they determined that travel time from both thrombolysis and endovascular therapy centers; speed of treatment; and positive predictive value of the screening tool affect whether the "drip-and-ship" or "mothership" strategy would effect the best outcomes. Both options could facilitate similar outcomes within the optimal treatment window, which they deemed as follows:

- Door-to-needle time: 30 minutes
- Door-in-door-out time: 50 minutes
- Door-to-groin-puncture time: 60 minutes (mothership) or 30 minutes (drip and ship)

They found that outcomes would be similar if the centers are ≤60 minutes apart. However, at 90–120 minutes apart, drip-and-ship would be favored "if the patient would have to travel past the thrombolysis center to reach the endovascular therapy center or if the patient would arrive outside the alteplase treatment time window in the mothership scenario." All things considered, the study suggests that decision is context-specific, and that delivery of treatment should be regionally centralized in order to have the greatest chance for positive outcomes. When transferring a patient with symptoms of acute stroke, urgent care providers should alert EMS that they should go to a stroke center for consideration of thrombolysis, and not just to the closest ED. ■

Red Flags for Readmission of Patients with Syncope

Key point: Vigilance for characteristics common among syncope patients who have been readmitted to the hospital may help urgent care clinicians prevent further rehospitalization.

Citation: Kadri AN, Abuamsha H, Nusairat L, et al. Characteristics associated with causes and predictors of 30-day readmission in patients with syncope/collapse: a nationwide cohort study. *J Am Heart Assoc*. 2018;7:e009746. Available at: https://www.ahajournals.org/doi/pdf/10.1161/JAHA.118.009746. Accessed October 8, 2018.

Syncope accounts for 3% of all emergency room visits and up to 1.5% of hospitalizations in the United States annually. The 30-day readmission rate, however, was 9.3% in this study of 323,250 encounters with a primary diagnosis of syncope/collapse in the 2013–2014 Nationwide Readmissions Database. While the most common cause of readmission was a repeat episode of syncope/collapse, certain other characteristics were more easily identifiable and, therefore, could alert the clinician that recurrence and readmission may be more likely among some patients. Characteristics most often associated with 30-day readmissions were:

1. Age ≥65 years (odds ratio [OR] 0.7)
2. Female sex (OR 0.9)
3. Congestive heart failure (OR 1.5)
4. Atrial fibrillation/flutter (OR 1.3)
5. Diabetes mellitus (OR 1.2)
6. Coronary artery disease (OR 1.2)
7. Anemia (OR 1.4)
8. Chronic obstructive pulmonary disease (OR 1.4)
9. Sent home with home healthcare disposition (OR 1.5)
10. Leaving against medical advice (OR 1.7)
11. Length of stay 3–5 days (OR 1.5) or >5 days (OR 2)
12. Having private insurance (OR 0.6)

Antidepressants and Psychological Therapies for IBS Symptoms

Key point: Centrally acting drugs such as antidepressants and psychological therapy can be effective in alleviating symptoms of irritable bowel syndrome.

Citation: Ford AC, Lacy BE, Harris LA, et al. Effect of antidepressants and psychological therapies in irritable bowel syndrome: an updated systematic review and meta-analysis. *Am J Gastroenterol*. September 3, 2018. [Epub ahead of print]

The authors conducted a meta-analysis of 53 randomized controlled trials comparing antidepressants with placebo (17 studies); psychological therapies vs control therapies or "usual management" (35 studies); and one study that compared both psychological therapy and antidepressants with placebo for management of symptoms of irritable bowel syndrome (IBS). They concluded that antidepressants are efficacious, as is psychological therapy—though results of studies looking into the latter may have overestimated the treatment effects due to limitations in the quality of the evidence. Minimum duration of treatment in either case was 7 days. In patients taking antidepressants to aid in managing symptoms of IBS, tricyclic antidepressants and selective serotonin reuptake inhibitors showed similar results (except for stomach pain, for which SSRIs were not effective). Psychological interventions included cognitive behavioral therapy; hypnotherapy; relaxation training; dynamic psychotherapy; mindfulness meditation; stress management; and emotional awareness training. IBS symptoms failed to improve in 52% of subjects receiving psychological therapies. Directed psychological treatment (eg, cognitive behavioral therapy, relaxation therapy, multicomponent psychotherapy, and hypnotherapy) were more likely to produce symptoms reduction than self-administered methods like mindfulness meditation training. One limitation of the study was that few trials were at higher risk for bias because they could not be blinded. ■

"With antibiotic stewardship being a critical consideration for clinicians, more guidance on appropriate choices...would likely be beneficial in preventing resistance."

Algorithm-Guided Antibiotic Choices for Staphylococcal Bacteremia

Key point: *Treatment of staphylococcal bacteremia guided by algorithm was noninferior to usual care, but did not affect the rate of serious adverse events. Thus, the appropriate duration of antibiotic treatment remains unknown.*

Citation: Holland TL, Raad I, Boucher HW, et al for the Staphylococcal Bacteremia Investigators. Effect of algorithm-based therapy vs usual care on clinical success and serious adverse events in patients with staphylococcal bacteremia. *JAMA*. 2018;320(12):1249-1258.

With antibiotic stewardship being a critical consideration for clinicians, more guidance on appropriate choices, including duration of treatment for specific indications, would likely be beneficial in preventing resistance. Researchers conducted a randomized trial that included 509 adults to determine if an algorithm to guide antibiotic choice and duration of treatment could be one such tool. They found that use of the algorithm compared with usual care resulted in a nearly identical clinical success rate (82.0% vs 81.5%, respectively), and only a marginal difference in occurrence of serious adverse events (32.5% vs 28.3%). Subjects were adults with staphylococcal bacteremia at 15 academic medical centers in the United States and one in Spain between April 2011 and March 2017. Patients were followed up for 42 days beyond end of therapy for those with *Staphylococcus* aureus and 28 days for those with coagulase-negative staphylococcal bacteremia. They were randomized to algorithm-based therapy (n=255) or usual practice (n=254). Coprimary outcomes were 1) clinical success, as determined by a blinded adjudication committee and tested for noninferiority within a 15% margin, and 2) serious adverse event rates in the intention-to-treat population. The prespecified secondary outcome measure, tested for superiority, was antibiotic days among per-protocol patients with simple or uncomplicated bacteremia. Given the very narrow disparity between the groups, the authors concluded that further research is needed to assess the utility of the algorithm. ■

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

Becoming the Employer of Choice for the Emerging Urgent Care Workforce

Urgent message: A tight labor market combined with stagnant real wage growth and shifting worker expectations has placed the onus on employers to rethink their approaches to attracting, engaging, and retaining talent. Thus, the challenge for talent-hungry industries such as healthcare is to fully reimagine their workplaces such that they become the "employer of choice" for the modern, millennial-dominated workforce.

ALAN A. AYERS, MBA, MACC

As a nation, the U.S. is well into what experts have dubbed the "new economy"—a buzzword denoting the economic transition from manufacturing-based to service-oriented. And without question, the most pressing issue facing today's urgent care employers and business leaders across this new service- and information-focused economic landscape is this: How can we attract, develop, engage, and retain the talent necessary to remain competitive?

Indeed, workers with the education, training, and skills to assume new and evolving roles in the technology-driven, digital workplace of today (a vast departure from the traditional, manufacturing-dominant economy of the past) are at a premium for companies. Attracting and retaining coveted "knowledge" workers has been a struggle, however, for reasons ranging from noncompetitive wages to lack of employee engagement and buy-in.

Healthcare in particular—although it's among the sectors forecast to add the most jobs (2.4 million through 2024 according to the Bureau of Labor Statistics[1] (BLS))—is struggling with this impending talent crunch. In fact, a study conducted last year by the Association of American Medical Colleges asserts that the industry will experience a shortage of nearly 105,000 physicians by 2030.[2] This is in addition to the looming shortage of nurses—half of whom are projected to retire by 2020,

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Healthcare, like many major industries, is facing a talent gap, and will need to devise creative solutions for hiring and engaging skilled talent for their workforces.

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according to the BLS—and the ongoing dearth of specialists, support staff, and trained technicians needed to support the healthcare infrastructure.

In short, a tight labor market with more jobs than workers demands that today's employers not only re-engineer their workplaces to make them more attractive to talented workers, but rethink their compensation structures, training and learning models, company branding, and employee engagement strategies for capturing the best and brightest from the limited pool of candidates.

To that end, we'll explore several potential areas of focus that can help companies transform into more engaging, better paying, and supportive workplaces towards becoming the "employer of choice" for the emerging workforce: The new "blue-collar" job of the future, the embrace of fair-pay principles, accommodating millennials, and the Net Promoter management philosophy.

The New "Blue-Collar" Job of the Future

The manufacturing-based blue-collar job of the past provided by large companies such as Chrysler and GM is slowly becoming a thing of the past. Performed on factory floors across America for decades, these jobs were once the backbone of the nation's economy, and offered the kind of living wages, health/retirement benefits, and job security that workers could build a life upon. As with so many modern industries, however, technology is rapidly reshaping the traditional blue-collar workplace such that human labor is being replaced by robots, and many erstwhile human tasks have become automated via machines and computers. Naturally, this has resulted in diminished employment opportunities and lowered wages in most traditional blue-collar sectors. So, as the economy shifts from manufacturer-based to service-oriented, the new "blue-collar" jobs won't be found in large numbers in manufacturing plants, but in the service industry.

Sectors like healthcare, therefore, will become the new venue for the blue-collar job of the future. The healthcare industry, for example, has a growing need for not only physicians and nurses, but technicians, medical assistants, facilities staff, and other support personnel. Unlike the manufacturing jobs of the past though, blue collar service-based jobs of today—due to a multitude of shifting economic factors—won't necessarily feature the same great wages, benefits, and job security that past generations relied upon.

In the absence of those traditional wages and benefits, the challenge for blue-collar employers of today is to

Engaging Millennials in The Workforce

According to Pew Research statistics, Millennials have edged the Baby Boomer cohort to become the largest segment of the labor force. Millennials, defined as workers between the ages of 21–36 as of 2018, are 53 million strong, with their numbers on the rise. As Millennials increasingly assume workplace leadership positions, their unique characteristics as a generation will exert a growing influence on their organizations' business strategies, attitudes, and values.[5]

With that in mind, here are several of the most noteworthy characteristics of Millennials as they relate to the workplace, along with the way organizations can engage them to make the most of their unique worldviews and specific talents:

- Millennials favor technology platforms as their preferred method of communication. As a generation that has never known life without the internet, millennials are tech-savvy digital natives. They thrive when texting, email, teleconferencing, and social media are the dominant communication tools—and balk at an excess of face-to-face meetings and lengthy telephone conversations. Organizations, therefore, should embrace newer communication platforms to leverage the strengths and tendencies of millennials who are adept with these technology tools, and can wield them expertly to increase their workplace efficiency and productivity.
- Millennials embrace variation and novelty in the workplace. They thrive on challenge, learning experiences, and goal-setting/attainment. Conversely, they can quickly become bored and disengaged with a lack of stimulation, monotonous routines, and the status quo. This means leaders should ensure that Millennials are given opportunities to cross-train, learn and develop new skills, and interact with colleagues in various capacities across organizations.
- Millennials place great importance on relationship building, teamwork, and transparency. While they love collaborating with colleagues and leaders regardless of position, they bristle under the constraints of rigid, hierarchal leadership structures. Hence, organizations should offer ample opportunity for team projects and collaborative initiatives, where feedback and sharing of opinions and insights—even with upper management and executives—is encouraged and solicited.
- Millennials are in search of greater meaning in their day-to-day careers. Eager to fulfill personal and social goals through their work, Millennials will often turn down higher-paying positions and advancement if the work is not fulfilling or gratifying. So, it's important that workplaces allow Millennials to take part in the creative process and ensure that their core values as people are represented in organizational objectives. Additionally, encourage Millennials to lead the way as change agents, especially when those initiatives help the company better serve the community and impact people's lives.

Net Promoter: From 'Score' to 'Service Philosophy'

Nearly every service industry uses the popular customer service measurement tool Net Promoter Score (NPS), created in 2003 by business strategist Frederick F. Reichheld and now in its 15th year of usage, which measures customer satisfaction beginning with the asking of a simple question: How likely is it that you would recommend "X" to a friend or colleague?

Today, Net Promoter has grown from being a simple customer satisfaction metric into an entire company philosophy built around tapping into an innate human desire to make other people happy. Indeed, the satisfaction derived from making a customer's experience wonderful, NPS experts found, can be molded into a system with repeatable methodologies that lead to predictable, measurable results. When implemented, reinforced, and fine-tuned, the NPS allows employees to derive a deep sense of satisfaction in delighting customers—and consequently, places the responsibility squarely on customer-facing teams to do just that.

Hence, the NPS philosophy is a great tool for increasing employee engagement, as it frees and empowers your most valuable employees to put in discretionary effort, exercise judgement, and give customers rich experiences. To that end, here are the six conditions Reichheld and NPS philosophy partner Rob Markey say companies must ensure are in place to implement an NPS system:[6]

1. **Consistently reliable metrics** – In order to trust that NPS scores are reliable, there must be an established system for accurately collecting and measuring feedback.
2. **Clear links between NPS scores and strategic outcomes** – Incentivized compensations and rewards must be clear to all participants as they work to achieve strategic targets.
3. **Tools and processes that aid in understanding root causes** – Only when employees and leaders consistently understand the factors that both delight and anger customers can they take meaningful action, address the root causes, and implement changes.
4. **Organized learning** – Employees must learn from each others' successes and missteps, and how their service delivery impacts scores in order to progress and fine-tune their methods.
5. **Constant communication** – There should always be regular reminders of the goals and benchmarks of any incentive plan, and the way employees can achieve improved compensation while adhering to the rules of the system.
6. **Strong antigaming deterrents** – There should be direct consequences for in any way attempting to manipulate scores, tamper with the collection process, or beg customers for favorable feedback. These rules help keep scores and feedback authentic, which allows it to be tracked, measured, and improved accurately.

reimagine their workplaces toward filling those gaps in innovative ways while still providing a quality employment opportunity. An article in the January 2018 issue of the *Harvard Business Review* tackled this very issue of blue-collar jobs in the new economy, with the authors arriving at several insightful and instructive conclusions.[3]

First, to attract and retain a talented and engaged workforce, employers must increasingly offer employees a direct stake in the company's performance—through profit-sharing, stock options, or a combination of both.

Second, there must be opportunities for transferable learning and skill development, such that employees retain the marketability to find work during economic downturns.

Third, for maximum employee engagement, workers must be encouraged and trained to think like owners, understand the economics of the business, and be taught to track and improve key performance metrics.

Bear in mind, as well, that an employee's wages constitute just one component of total compensation. Robust benefits packages that include a 401K and/or profit-sharing plan may offer operators the option of granting employees a sense of ownership and investment.

Then again, some companies may find it advantageous to offer its employees true ownership. Practice Velocity, LLC, a software and billing solutions company servicing the urgent care industry, surprised their 240 employees by announcing that it was rolling out an employee stock ownership plan (ESOP), in effect transforming its entire workforce into part-owners.

While the Practice Velocity ESOP was conceived as a show of appreciation for its dedicated employees and a long-term investment in its most valuable resource (ie, its people) the plan had solid economic grounding, as well. ESOPs have been studied in detail by academics and HR experts alike, with the research documenting numerous positive economic benefits for companies, including:

- Increases in productivity of up to 5% during the first year of implementation
- 25% greater job growth over a 10-year period compared to companies with conventional ownership models
- A median household wealth 92% greater than that of comparable employees absent a similar ESOP plan
- 33% more income from wages as a result of the accompanying increases in productivity compared to conventional ownership models

The lesson for companies? Given full transparency into the company's economics and the sharing of key

financial metrics with employees, ESOPs can help create an unrivaled culture of ownership and employee engagement. While ESOPs may not be accessible to all urgent care operations (such as small practices or those whose earnings are not robust enough), many blue-collar companies unable to pay above market rates will gain a competitive advantage when employees become "owners"—figuratively and literally.

Embrace of Fair-Pay Principles

In the new economy, technology has evolved to the point where it has irrevocably altered the traditional workplace. Now more than ever, companies need employees with the specialized skills and training to use, develop, and service the tech-driven tools, systems, and platforms that have become workplace fixtures. But due to the aforementioned tight labor markets, employers are having difficulty filling these roles. PriceWaterhouseCoopers for example, in their 20th CEO survey, found that nearly 80% of CEOs declared a scarcity of key skills as the greatest detriment to their businesses' growth.[4] And despite their efforts to attract and retain talent—including making the workforce more millennial-friendly, recruiting from high schools and universities, and offering apprenticeships—they're still struggling to fill key positions.

Nevertheless, more companies are taking a more straightforward approach to attracting and retaining talent: the adoption of fair-pay principles. When companies talk about fair-pay principles, they're referring to workplace policies specifically designed to guide them when it comes to matters of total compensation and remuneration for their employees. Fair-pay principles usually pertain to providing employees a livable wage, equal pay for equal work regardless of race or gender, and company-wide transparency as it relates to compensation and benefits. Transparency in particular is a hot-button issue these days, with it oftentimes being a deciding factor when people decide whether to apply for work with a particular company. If a perception exists that a company is not offering competitive wages comparable to their industry counterparts, for instance, studies have shown that in-demand talent is far less likely to consider that opportunity. Additionally, it's far more difficult to keep current employees from defecting to competitors when they feel they're unfairly compensated.

And beyond the competitive edge it lends in the war for talent, fair-pay principles help companies take the lead in combating stagnant real wage growth, which has been an economic dilemma for decades.

Of course, adopting fair-pay principles has cost implications for companies, especially upfront. But to flourish in the new economy, employers are realizing that above all, their talent is their greatest asset, and is well worth the long-term investment of ensuring competitive wages.

In sum, businesses leaders at the forefront on fair wages are the best positioned to attract, retain, and nurture the valuable human capital that remains key to driving their businesses. And as the spotlight around fairness principles—in the workplace and in larger society—grows brighter, it's not an issue that businesses can afford to ignore.

Conclusion

With the advancement of workplace technology and the decline of manufacturing jobs, the growing importance of fair-pay principles and employee engagement, along with the ascendancy of the Millennials in the workforce, the traditional workplace is undergoing a dramatic transformation. Employers are increasingly realizing that to attract, retain, and engage the talented and skilled workers necessary to drive their businesses in the new economy, they must reimagine their workplaces toward becoming the "employer of choice" that talented candidates in a tight labor market will choose. Hence, ESOPs, service-based blue-collar jobs, transparency around fair pay and compensation, the impact of Millennials, and brand differentiation through NPS philosophies will become central in the new service-oriented economy—and of paramount importance for industries seeking a competitive edge in their markets. ■

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INSIGHTS IN IMAGES

CLINICAL CHALLENGE: CASE 1

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

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

A 12-Year-Old Football Player with Sudden Hip Pain

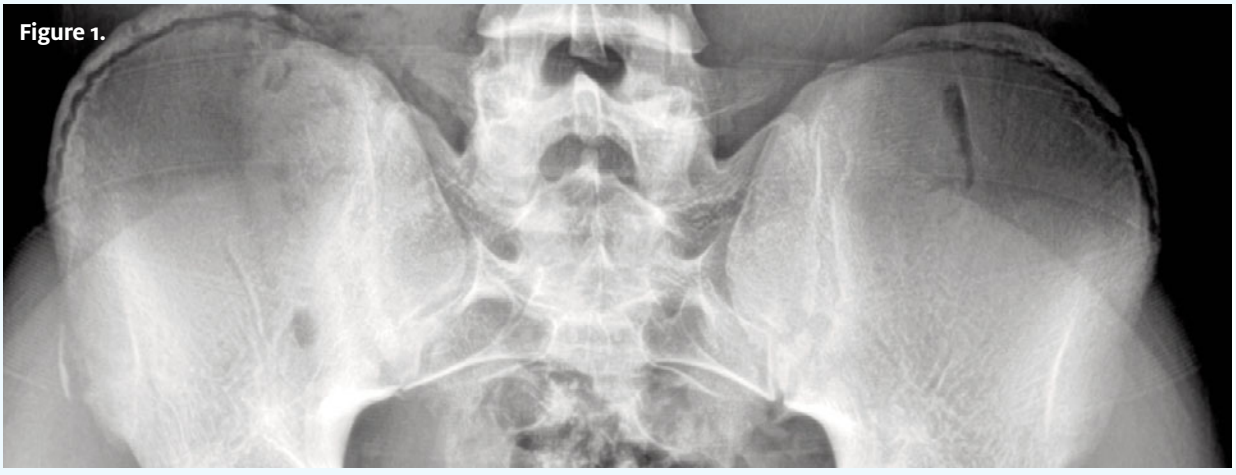


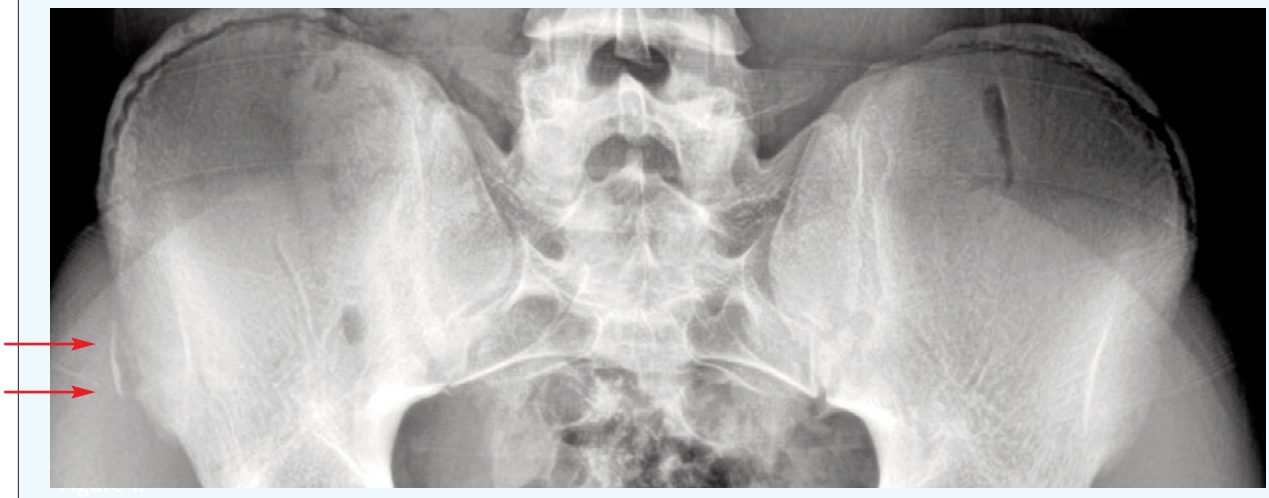
Figure 1.

Case

The patient is a 12-year-old boy who presents with sudden hip pain that started simultaneously with a "popping feeling" in the same hip. He reports that it started in the middle of his football game earlier in the day.

View the image 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 anterior superior iliac spine
- Genitourinary abnormalities
- Intra-abdominal pathology
- Snapping hip syndrome
- Stress fracture

Diagnosis

This patient was diagnosed with an avulsion fracture of the anterior superior iliac spine (ASIS), an injury that occurs most often in young athletes. It results from sudden, forceful contraction of sartorius and tensor fascia lata.

Learnings/What to Look for

- ASIS fractures occur as acute-onset injuries (though chronic stress fractures can be a predisposing factor)
- These injuries result from sudden, vigorous contractions (or repetitive contraction) of the sartorius and tensor fasciae latae muscles

Pearls for Urgent Care Management and Considerations for Transfer

- Treatment is usually conservative, including rest, analgesia, anti-inflammatory medications, and partial weightbearing supported by crutches. Referral to an orthopedist is warranted
- Fracture fragments displaced by more than 3 cm may require surgery
- Early diagnosis and prompt initiation of treatment are important to prevent ASIS injuries from becoming chronic

Acknowledgment: *Images courtesy of Teleradiology Specialists.*

CLINICAL CHALLENGE: CASE 2

A 52-Year-Old Man Who Is Lightheaded and Dizzy

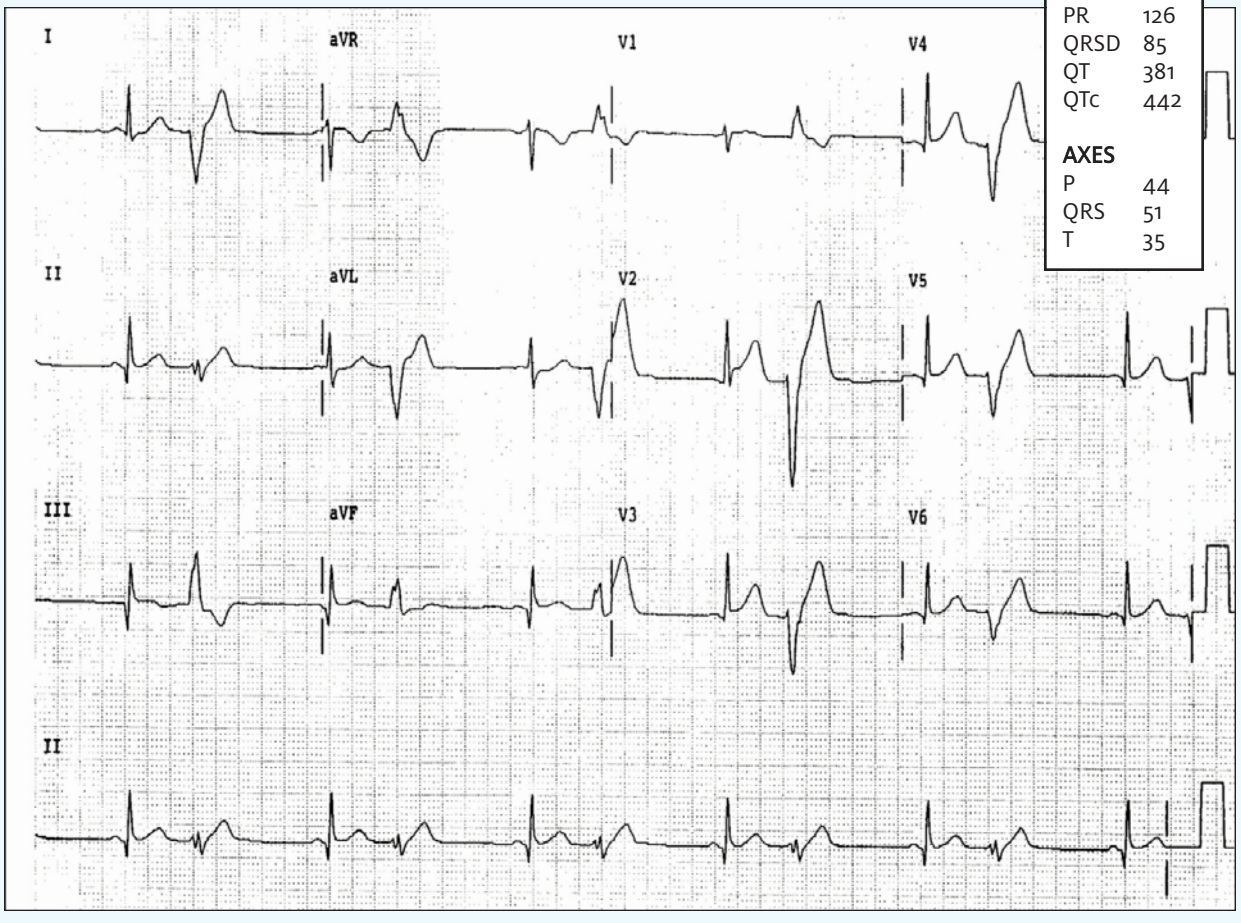


Figure 1.

Case

The patient is a 52-year-old man who presents to your urgent care center with lightheaded dizziness, which he says has been present for the past 3 days. It is worse with standing. He reports that he has been spending a lot of time in the sun lately. He denies chest pain, shortness of breath, abdominal pain, or paresthesias. He does not take any medications. His personal medical history includes untreated hypertension, and there is a family history of heart disease. Upon examination, you find:

- **General:** Alert and oriented, NAD, WNWD
- **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

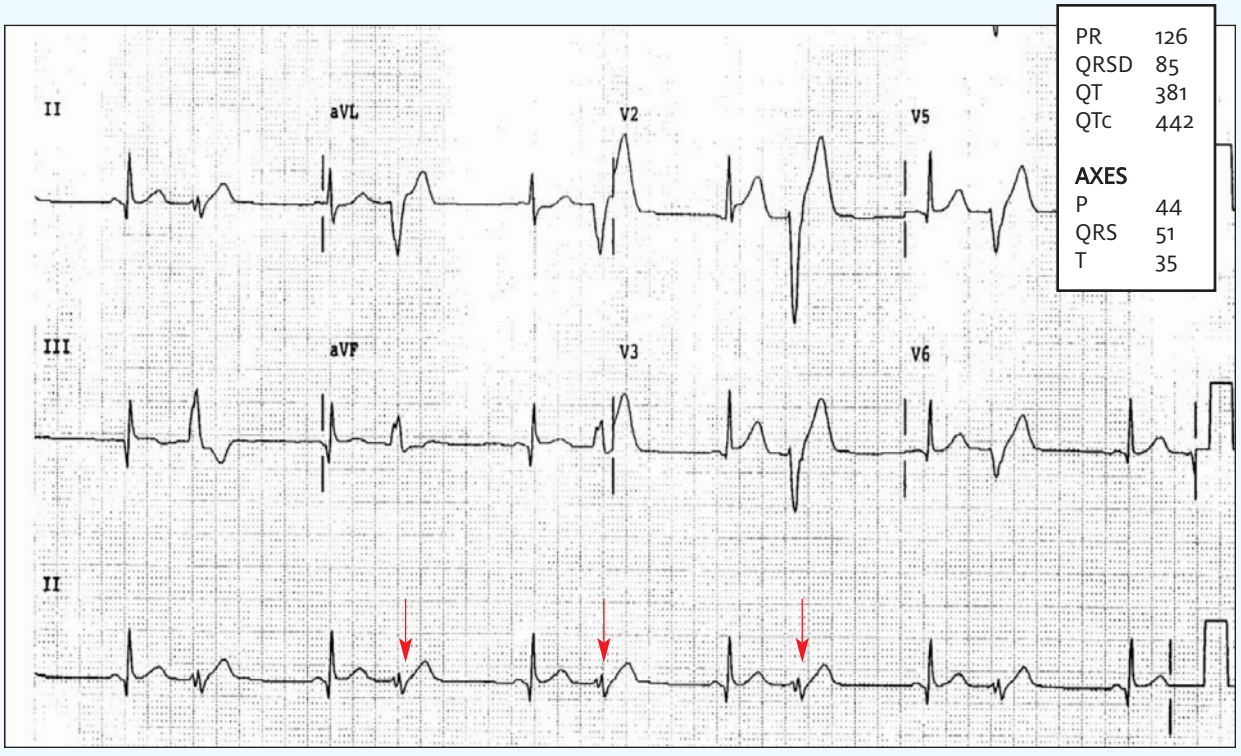


Figure 2.

Differential Diagnosis

- First-degree AB block
- Atrial flutter
- Mobitz type 2
- Ventricular bigeminy
- Ventricular trigeminy

Diagnosis

This patient was diagnosed with ventricular bigeminy.

The ECG reveals a regular rate. There are P waves with a PR interval of 126, with normal being 120-200 so this is not first-degree AV block. The rhythm is regular, and there are no flutter (saw tooth) waves, so this is not atrial flutter. 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. Mobitz type 2 is an intermittently dropped QRS segment (without the gradual lengthening of the PR interval), but this is not occurring on this ECG, either. Ventricular bigeminy is a ventricular beat occurring every other beat; this rhythm is present on this ECG. Ventricular trigeminy is a ventricular beat every third beat.

Learnings/what to look for:

- Ventricular bigeminy is diagnosed when there is a ventricular depolarization occurring every other beat
- The ventricular beat is a wide QRS complex (appearance similar/identical to a PVC)
- These beats may occur from a sympathomimetic stimulus (eg, meds, caffeine, cocaine), alcohol, beta agonists, theophylline, electrolyte abnormality, acidosis, or ischemia

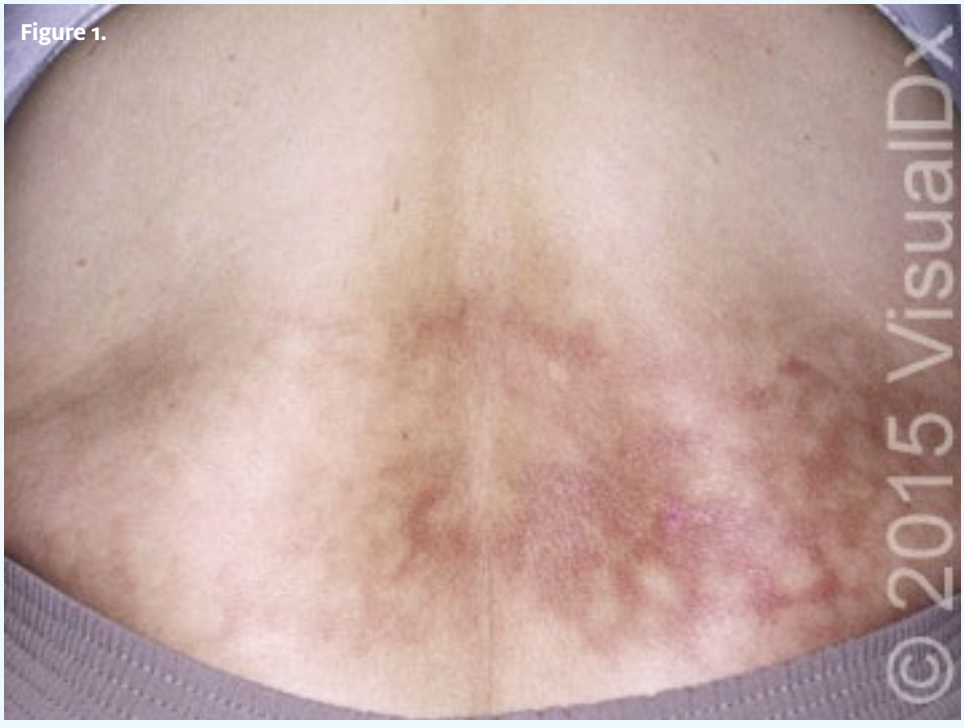
Pearls for Urgent Care Management and Considerations for Transfer

- Inquire about signs of acute coronary syndrome, such as chest discomfort, shortness of breath, diaphoresis, weakness, or dizziness, as well as hemodynamic instability such as tachycardia, hypotension, dizziness, or confusion
- Compare to an old ECG
- Consider checking electrolytes in patients who are at risk for abnormalities, such as patients on diuretics, or those with dehydration, prolonged vomiting/diarrhea, or with renal failure. Review the med list for antiarrhythmics, as many may also have a proarrhythmic potential
- If there is concern for ischemia, transfer to the ED for emergent evaluation

CLINICAL CHALLENGE: CASE 3

A 45-Year-Old Woman with Suddenly Discolored Skin

Figure 1.



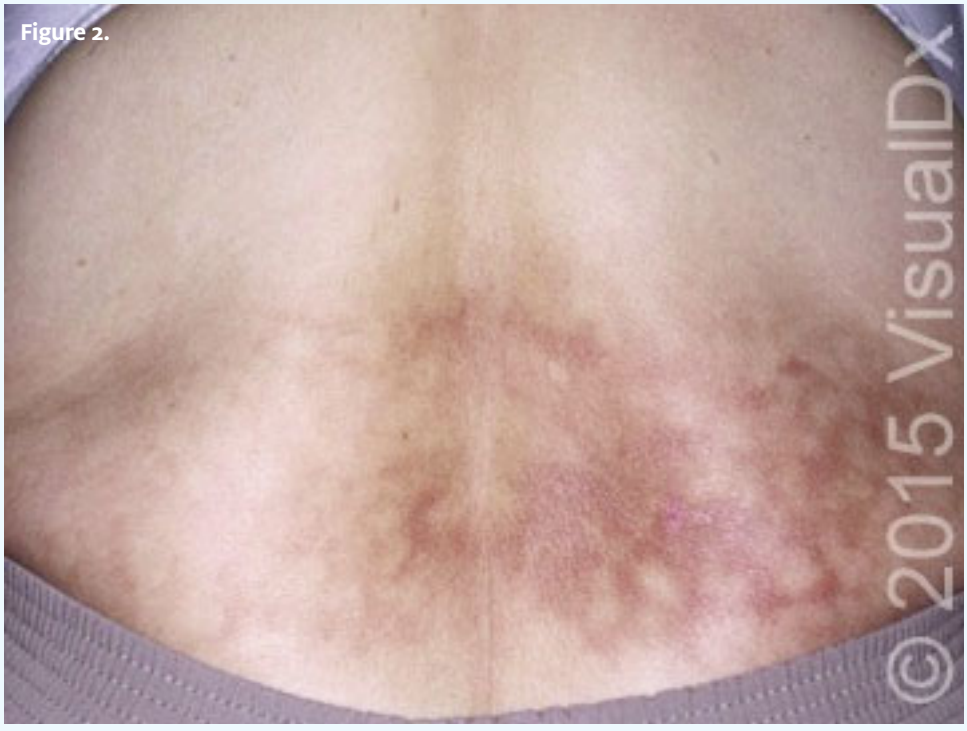
Case

A 45-year-old woman presents with a complaint of "a brown spot" on her back. Upon examination, you confirm there is a reticular hyperpigmented patch of skin, which she says she noticed after using a heating pad to relieve myalgia after working in her garden. She confesses that she fell asleep with the heating pad on the area, she thinks for several hours.

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

- Livedo reticularis
- Cholesterol emboli
- Erythema ab igne
- Systemic lupus erythematosus

Diagnosis

This patient was diagnosed with erythema ab igne (literally, in Latin, redness from fire), a hyperpigmentation disorder caused by long-term exposure to heat. The most common sources include hot water bottles, electric blankets, and even laptop computers.

Learnings

- Although actual burns do not occur from the heat source in erythema ab igne, the skin develops a course pigmentation that appears as patches that are pink, purple, and eventually brown
- Pruritus or mild burning paresthesias may occur
- Resultant pigmentation changes can be permanent; there is no effective treatment

Pearls for Urgent Care Management and Considerations for Transfer

- Caution the patient to avoid prolonged exposure to the heat source
- Follow-up with a dermatologist is warranted to establish a new "baseline" against which future changes in pigmentation can be measured, in the interest of vigilance for cutaneous malignancies

Acknowledgment: *Images courtesy of VisualDx.*

Big Changes in Medicare Evaluation and Management Reimbursement

DAVID E. STERN, MD, CPC

The Centers for Medicare and Medicaid Services (CMS) has published the proposed changes for the Calendar Year (CY) 2019 Physician Fee Schedule (PFS).[1] Probably the most controversial of these proposed changes is the Patients Over Paperwork initiative, which streamlines documentation requirements and reimbursement for Evaluation and Management (E/M) services in the office and outpatient setting, affecting Current Procedural Terminology (CPT) codes 99201 through 99215.

CMS has announced that it plans to eliminate differential payments for most E/M codes on January 1, 2019. For the E/M codes only, Medicare will pay one rate for all new patient visits at levels 2 through 5 E/M code range and a different single rate for all established patient visits at levels 2 through 5 E/M code range.

The primary goal is to reduce administrative burden so clinicians can spend more time on patient care and less time on documentation and determining what level of service to bill for the visit. Clinicians billing these office visit CPT codes to Medicare, Medicare Advantage plans, and Medicare Railroad in 2019 will have the option to document by continuing to use the 1995 and 1997 guidelines, by Medical Decision Making (MDM), or by total time.

The proposed minimum documentation requirement to bill an E/M service based on MDM can be compared to current level 2 visit guidelines where a straightforward MDM is measured by minimal problems, minimal data reviewed, and minimal risk. CMS has also proposed that the history and exam for established patients need only be updated as to what has changed since the last visit, rather than redocumenting the same information in order to count "points" toward a specific level for each component.

This also means that clinicians can indicate in the medical record that they have reviewed the history of present illness entered by ancillary staff, rather than having to redocument the same information.

The other proposed alternative for determining the level of service is to document based on time. Currently, you can only count time if more than 50% of the face-to-face time is spent counseling and/or on care coordination for the patient. The proposal is that the clinician should document the medical necessity of the visit and show the total amount of time spent by the billing clinician face-to-face with the patient. The typical times in current CPT guidelines for each level of service would still apply.

CMS is also proposing new prolonged care add-on code GPRO1, "Prolonged evaluation and management or psychotherapy service(s) beyond the typical service time of the primary procedure in the office or other outpatient setting requiring direct patient contact beyond the usual service; 30 minutes." The minimal time spent and documented would need only to meet the threshold of 16 minutes in order to bill for it instead of the 31 minutes required in order to bill prolonged service CPT codes 99354 (first hour) and 99355 (each additional 30 minutes).

Also proposed are add-on G-codes to help make up costs incurred by those specialties who treat patients with more complex problems. Code GCGoX, "Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, or interventional pain management-centered care" and GPC1X, "Visit complexity inherent to evaluation and management as-

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Table 1. Proposed Payment Schedule for New Evaluation and Management Structure

Level	Current Payment* (established patient)	Proposed Payment†	Level	Current Payment* (new patient)	Proposed Payment†
1	$22	$24	1	$45	$44
2	$45		2	$76	
3	$74	$93	3	$110	$135
4	$109		4	$167	
5	$148		5	$211	

*Current payment for CY 2018
†Proposed payment based on the CY 2019 proposed relative value units and the CY 2018 payment rate

"Since CMS is reducing the burden of documentation, you can probably guess that they are reducing the reimbursement, as well."

sociated with primary medical care services that serve as the continuing focal point for all needed health care services." The codes are intended to be used with current E/M codes 99201 through 99215. CMS believes that code GPC1X will be used predominantly by family practice or pediatrics.

Unfortunately, there were no proposed auditing guidelines to determine how much documentation would be needed in order to base the E/M level on MDM or even time, making the auditor's job very difficult beginning in 2019. During a CMS panel discussion on E/M Coding Reform,[2] Dr. Kate Goodrich, CMS chief medical officer and director of the Center for Clinical Standards and Quality (CCSQ), stated that when adopting the proposed documentation guidelines, it will be imperative to have a clear, written policy in place for what is required when updating medical records.

Since CMS is reducing the burden of documentation, you can probably guess that they are reducing the reimbursement, as well. The proposal is to streamline payment for E/M codes that fall in the visit level 2 through 5 range, or CPT codes 99202 through 99205 and 99212 through 99215. **Table 1** shows the proposed payment schedule for the new E/M structure.

During the question-and-answer portion of the August 22, 2018 listening session on the Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics, hosted by the CMS Medicare Learning Network (MLN) events team, CMS confirmed that the 15% reduction rate for reimbursement for services provided by nonphysician practitioners will still apply with this new payment rule.

CMS has also proposed assigning Multiple Procedure Status 2 to codes 99201 through 99215, which means that when these codes are billed with other procedures, the most expensive code will be reimbursed at 100% and the least expensive procedure on the same visit will be reduced by 50%. This includes situations where modifier -25, "Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service" is appended to the E/M code.

Another, additional proposed change that will impact urgent care providers is that ancillary staff will be allowed to obtain and enter the History of Present Illness (HPI) as long as the record clearly indicates that the HPI has been reviewed by the provider. Currently, CMS has determined that the provider must personally obtain the HPI directly from the patient.

CMS states the reason for the Patients Over Paperwork initiative and E/M reform is that across America, the number-one complaint among clinicians was that current documentation requirements were extremely cumbersome and took away from actual patient care. They estimate a savings of 51 hours per year, per clinician if the proposed documentation requirements are implemented.

Keep in mind that these proposed changes are only for claims billed to Medicare, Medicare Advantage plans, and Medicare Railroad. CMS states that private payors were not consulted on the proposed changes, but the expectation is that they will eventually follow suit. CMS plans to continue to solicit comment on how documentation guidelines can be improved in subsequent years.

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PHYSICIANS WANTED

MARKET PLACE

MEDICAL EQUIPMENT/SUPPLIES

DEVELOPING DATA

If You Want Your Providers to Get a Flu Shot, Make It a Requirement

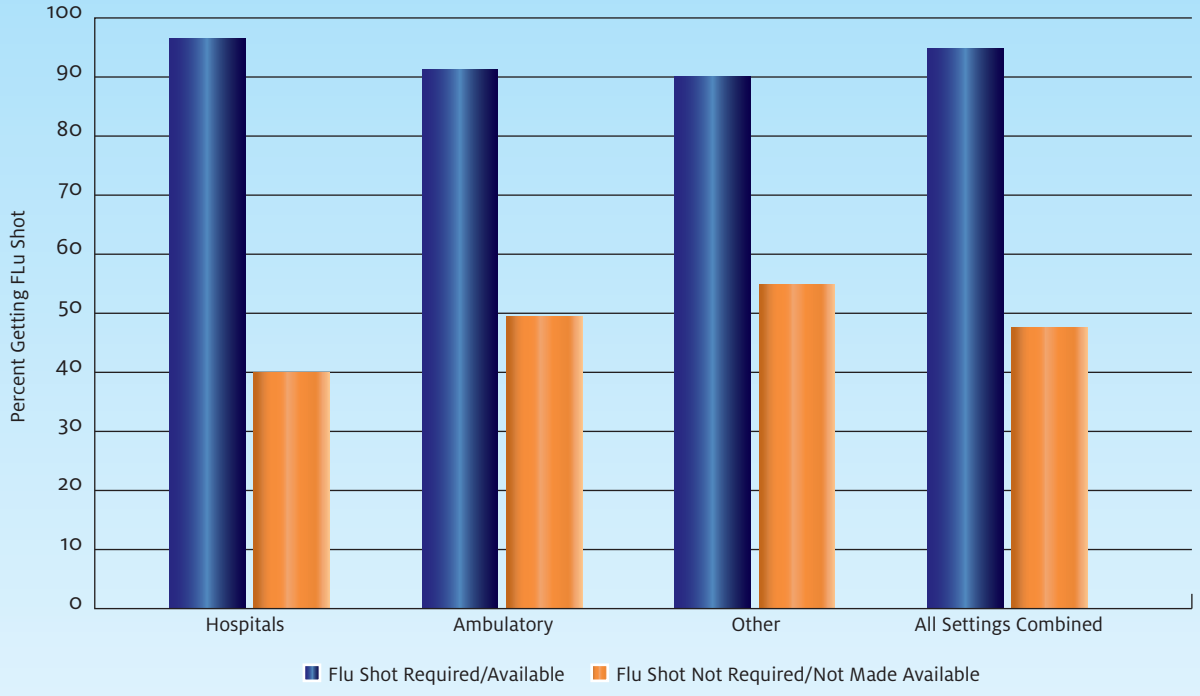
The Centers for Disease Control and Prevention has spelled out the best way to ensure providers who work in your urgent care center heed the advice they're supposed to be giving patients (in short, *Get a flu shot*). It's a simple one: Tell them they have to, and make it easy for them to do so.

The CDC just released data for last year's flu season on the influence of employer-imposed requirements to receive an influenza vaccination among healthcare personnel in hospitals, ambulatory care settings (which includes urgent care centers, in the CDC's organizing of settings), and other settings (including, but not limited to, retail clinics and public health settings).

In every setting, compliance approached 100% when the provider's employer imposed a rule saying all healthcare personnel had to get a flu shot and made it available on site for at least 1 day; the rate fell to roughly half that without the requirement and ready availability across the board, as seen here.

If you expect patients to get a flu shot, it makes sense to encourage providers to follow the philosophy of "physician, heal thyself" instead of "do as I say, not as I do." ■

INFLUENZA VACCINATION AMONG U.S. HEALTHCARE PERSONNEL, 2017–2018 FLU SEASON



Adapted from: *MMWR*. Influenza vaccination coverage among health care personnel—United States, 2017–18 influenza season. 2018;67(38):1050-1054.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