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UCA URGENT CARE
ASSOCIATION

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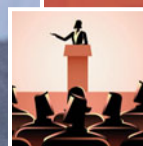
Getting to the
Heart of Post-Op
Complaints Now

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Edged Sword



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Urgent Care in the Hospital System—*One and Done, or Done and Won?*

■ JOSEPH TOSCANO, MD

Over the past couple of decades, urgent care has secured its place in healthcare and become a household name, sought after by patients seeking care, providers seeking careers, entrepreneurs seeking opportunity, and investors seeking returns. In the mix since close to the beginning, hospitals and healthcare systems are now increasingly viewing the specialty and business model as a viable, profitable, and even necessary part of their missions. Further, on a process basis, logistics can be simplified when the urgent care center is owned by the hospital if patients need to access multiple points of care.

The advantages include a relatively efficient means of geographic expansion and ready mechanism to increase market share and referrals back to the hospital system. Depending on their philosophy and goals, some systems may not strive to optimize their urgent care practices and business, seeing more value just from the increases in advanced imaging and surgeries for those patients first seen in urgent care. As medicine continues to evolve, however, the most successful healthcare systems will deploy urgent care in the most elegant and adaptable ways. Of course, the business concerns of budgets and finance, avoiding market saturation, and finding a suitable location and qualified staff will always be essential, but careful consideration of scope-of-services and overall health system integration needs to be at the core of any vision for urgent care in a larger system of healthcare.

As a discipline, urgent care specializes in the care of acute illness and injury in those who are healthy at baseline, as well as those who have chronic illnesses. As advances in other specialties allow patients to live longer with increasing multimorbidity, urgent care clinicians must be capable of navigating that burgeoning complexity—treating acute conditions superimposed on an increasing number of chronic diseases, as well

as acute disease related to exacerbations of those underlying conditions. Such evolution of practice is inevitable if the “urgentcarist” is to thrive and serve patients and systems.

Hospitals have plenty of experience with emergency medicine, but this urgent care “cousin” differs enough in capability, capacity, cost, and efficiency that applying an EM or ED paradigm to UC can misguide expectations and derail business and even patient-care outcomes. As a discipline, urgent care is unique in its flexibility.

Current UC practice capacities range from those that care for patients using plain radiography and a few basic lab tests (and still providing valuable care to many, many patients) to “mini-ERs” with intravenous therapy and CT and ultrasound imaging. Where and how any UC practice along that scope continuum fits into an overall health system model will depend on the role it needs to serve—and it can serve any of them.

Major challenges predicted for hospitals and healthcare systems in the future revolve around momentum away from fee-for-service reimbursement. In addition to preventing and best managing chronic disease, cornerstones of population health success must involve caring for patients’ illnesses and injuries (what we do now) as economically as possible, safely sparing higher-cost hospital admission (daily outpatient re-evaluations and treatment for appropriate conditions) and, when possible, intervening to prevent readmissions (assessing patients after hospital-based treatment for any worsening as soon as possible). Who better to do this than those whose expertise, involves most efficiently evaluating and treating those with acute illness and injury?

Systems that are successful in terms of health outcomes and profitability will have to place urgent care prominently alongside primary care, hospitalist, and emergency medicine; that will require making diagnoses and caring for all those patients which it can, deciding on the location of best care, and helping fill the gaps left by the fragmentation within every system. Rather than “one and done,” we may need to be poised to provide a more comprehensive “done and won.” That win will be for healthcare systems, our patients, and our specialty. ■



Joseph Toscano, MD is chief, emergency medicine and medical director, occupational medicine at San Ramon Regional Medical Center. He also sits on the Board of Certification in Urgent Care Medicine, and is a longstanding member of the JUCM Editorial Advisory Board.

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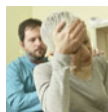
11 Postoperative Complications in the Urgent Care Setting

Patients don't go to an urgent care center to have surgery, but many do present when they're concerned about possible complications from a recent procedure. Whether their concern is lingering pain, bleeding, or possible infection, they expect answers when they come to see you.

Tracy Quail Davidoff, MD

CASE REPORT

19 Shortness of Breath in a Postprocedural Pneumothorax



The patient history is an essential part of every encounter. However, it's important to not let it—or your patient's assurance that they know what's wrong with them—color your judgment about what ails the patient today.

Katlin F. Mattson, M3 and Shailendra Saxena, MD

PRACTICE MANAGEMENT

27 When the 'Inner Entrepreneur' Needs to Step Aside



A hard-charging, risk-ready personality can be a great benefit when you're starting an urgent care business. When that business is up and running, though... not so much. The transition from visionary entrepreneur to responsible business leader can be trickier than it seems.

Alan A. Ayers, MBA, MAcc

OCCUPATIONAL MEDICINE

31 Keeping Occ Med Clients Happy—While Keeping Patients Safe



Congratulations, you've secured a new occ med client! Now all you have to do is make sure the client is satisfied with your service while also providing excellent, ethical care for every patient.

Max Lebow, MD, MPH, FACEP, FACPM

HEALTH LAW AND COMPLIANCE

34 The Finer Points of Video Surveillance in an Urgent Care Center



Advances in technology have made video surveillance a more accessible medium for keeping your urgent care center secure. However, it's important to understand the legalities and limits of utilizing such a system before having one installed.

Alan A. Ayers, MBA, MAcc

IN THE NEXT ISSUE OF JUCM

Preexposure prophylaxis (PrEP) has been hailed as a vital tool in preventing the spread of HIV. Simultaneously, more and more patients seek testing and treatment for all manner of sexually transmitted infections in the urgent care setting. And yet, relatively few urgent care centers offer PrEP services, possibly losing out on an opportunity to both beef up their patient visits and make a real difference in public health. On those bases alone, it seems likely PrEP will find a home in urgent care operations. Find out what you need to know before offering this service in the March issue of JUCM.

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Mission Statement

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

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

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Things don't always go according to plan in life, and clearly the practice of medicine is no exception. Patients can have surgical procedures, whether "routine" or complex, that go perfectly smoothly but still face serious complications after the fact. They're not prepared for it, most likely, but you have to be because if they have a high fever, unusual bleeding, or trouble at the site of a surgical wound on Sunday afternoon they're probably coming to see you.

Essentially, that's the scenario addressed in this month's cover article, Postoperative Complications in the Urgent Care Setting (page 11). In it, author **Tracey Quail Davidoff, MD** alerts us to some of the more common post-op complaints patients can have and, at least equally importantly, how you can prepare to care for them.

Dr. Davidoff is an attending physician at Rochester Regional Health Immediatecare in Rochester, NY, as well as a member of the JUCM Editorial Board.



Complications of a different sort are covered in the case report that begins on page 19. In Shortness of Breath in a Postprocedural Pneumothorax, by **Katlin F. Mattson, M3** and **Shailendra Saxena, MD** we learn that sometimes the "complications" can have just as much to do with a patient's perspective as it does with whatever is wrong with them physically.

Ms. Mattson is a third-year medical student at Creighton University Medical School, where Dr. Saxena serves as a professor. He also sits on the JUCM Editorial Board.

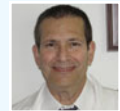
Things on the business side of urgent care can get a bit complicated, too—even if you started the enterprise. As **Alan Ayers, MBA, MAcc** explains in When the "Inner Entrepreneur" Needs to Step Aside (page 27), the fighting spirit that fuels someone to start a successful urgent care operation isn't necessarily the right stuff to run the show on an ongoing basis. Where being the player-coach may have been a necessity in order to get the business off the ground, once your team has settled into their own roles it can be hard to hand them the ball and let them run with it. However, your long-term success depends on doing just that.

Mr. Ayers, who is chief executive officer of Velocity Urgent Care and practice management editor of JUCM, also alerts us to the potential pitfalls of employing a video surveillance system in an urgent care center. While it *can* be an effective security measure, it can also land you in hot water if you don't understand the risks and restrictions that exist for patient and employee safety and privacy. Read The Finer Points of Video



Surveillance in an Urgent Care Center, which starts on page 34, and you'll see what we mean.

One situation in which you're the one being watched, figuratively, is when you start working with a new occupational medicine client. Once that first patient walks in the door, you'll be evaluated by how well you're able to serve two masters: the patient and the client. Fail to do so effectively and you could lose the business—and the opportunity to provide excellent care. **Max Lebow, MD, MPH, FACEP, FACPM** explains an approach to do it gracefully and ethically in Keeping Occ Med Clients Happy—While Keeping Patients Safe (page 31). Dr. Lebow is president and medical director of Reliant Immediate Care Medical Group.



Another thing to consider to ensure your business is a healthy one: Make sure your providers are credentialed properly, or you could be missing out on revenue. **David Stern, MD, CPC** answers a reader question about that in Revenue Cycle Management on page 44. Dr. Stern is CEO of Practice Velocity, LLC, NMN Consultants, and PV Billing.

Finally, in Abstract's in Urgent Care, **Joshua Russell, MD, MSc, FAEEM, FACEP** explains the most salient, urgent care-relevant points of new articles on topics ranging from proper temperature-taking to the power of sitting down when you're with a patient. Abstracts in Urgent Care begins on page 23.

One other note: If you flipped through the first few pages of the issue to land on this one, you may have noticed something new. This month, we launch Urgent Perspectives, in which thought-leading clinicians, business leaders, and industry stakeholders share their thoughts on the state of urgent care. We're pleased that **Joseph Toscano, MD** accepted our invitation to author the first entry, on the (very busy) intersection between urgent care and hospitals. As chief, emergency medicine and medical director, occupational medicine at San Ramon Regional Medical Center and a member of our Editorial Board, he's the perfect person to lead the discussion.

Thanks to Our Peer Reviewers

We rely on the urgent care professionals who volunteer to serve as peer reviewers to ensure we bring you relevant, unbiased, and relevant articles every month. This month, we thank:

- **A. David Matian, DO**
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Expiration Date: January 31, 2020

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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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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.

Postoperative Complications in the Urgent Care Setting (p. 11)

1. Acute postoperative complications would include which of the following?

- a. Side effects of anesthesia
- b. Bleeding
- c. Side effects of pain medications
- d. Nausea and vomiting
- e. All of the above

2. Subacute postoperative complications are those that would occur:

- a. At any time after the patient has been discharged from surgery
- b. Several days post-op
- c. Because the patient didn't follow postdischarge instructions
- d. New injury to the surgical site
- e. Respiratory distress

3. The main risk factor for postoperative seroma is:

- a. Infection at the incision site
- b. Allergic reaction to anesthesia
- c. Obesity
- d. Poor wound care
- e. None of the above

Shortness of Breath in a Postprocedural Pneumothorax (p. 19)

1. Symptoms of a tension pneumothorax include:

- a. Hypotension
- b. Shortness of breath
- c. Rapid heart rate
- d. Neck vein distension
- e. All of the above

2. Needle decompression should be performed in the second intercostal space, over the rib, in the presence of:

- a. Hemodynamic instability, as evidenced by hypotension
- b. Altered level of consciousness
- c. Significant tachypnea

d. All of the above

e. None of the above; patients with these finding should be referred

3. Patients with which of the following may have a heightened predisposition to pneumothorax?

- a. History of COPD
- b. Recent history of urinary tract infection
- c. Acute myocardial infarction
- d. Post cataract surgery
- e. Gastritis

When the 'Inner Entrepreneur' Needs to Step Aside (p. 27)

1. Executive hubris is characterized by:

- a. Impulsive risk-taking
- b. Indecisiveness
- c. Perfectionism
- d. Conflict avoidance
- e. All of the above

2. Doubt can be used as a decision-making tool:

- a. In order to envision what could go wrong in various scenarios
- b. When a leader wants to delegate a decision to a subordinate
- c. Both of the above
- d. Never

3. Transitioning from entrepreneur to a leader who encourages teamwork requires:

- a. Being open to others' ideas
- b. Allowing others to speak, while making sure they understand "who's the boss"
- c. Fostering a culture where diversity of thought is accepted as an asset
- d. All of the above except "b"
- e. None of the above

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UCA 2019 Annual Convention & Expo—*Reinvented. Elevated. Unprecedented.*

■ LAUREL STOIMENOFF, PT, CHC

In the last quarter of 2018, UCA announced its intent to move from two annual conferences to a single mega-event—the 2019 Annual Convention & Expo, “*Oceans of Opportunity*” will take place in West Palm Beach, FL, April 7–10. This event also marks UCA’s 15th anniversary, as we celebrate our past and map our future. Whether you are a single center operator, a clinician, CMO, or CEO, there is valuable educational content coupled with opportunities to network with your peers and rub elbows with a faculty sought out by not only those in the urgent care and on-demand industry, but the entire healthcare sector.

This year’s event is replete with activities, upgraded educational sessions, and elevated faculty. The experience includes:

Additional General Sessions: Owing to the unique nature of this year’s faculty, there are additional unopposed sessions. Presenters or panelists include **Chet Robson, DO, MHCDS, FAAFP**, medical director, clinical programs & quality for **Walgreens**; **Jeff Alter**, the former CEO at **United Healthcare**; **Paul Smolke**, senior director of worldwide health, **Microsoft Corporation**; and **Mitch Perry**, CFO, **BCBS of NC**, just to name a few. Discussion of their envisioned future, including opportunities and potential perils, will be worthy of your attendance.

Skills to Scale Track: This track is for anyone wanting to make the leap from operating a few centers to overseeing a region and more. Just as there must be a leap in sophistication for any organization entering the multisite and/or multistate stage of its evolution, the same need for new skills and expertise exists for the operators who run them.

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

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Postoperative Complications in the Urgent Care Setting

Urgent message: Patients who have had recent surgical procedures may present to urgent care centers for reasons ranging from seeking reassurance to presentation of life-threatening complications.

TRACEY QUAIL DAVIDOFF, MD

Introduction

Patients often experience complications—or, at least as often, fear they're experiencing complications—after a surgical procedure. While the surgeon is often the best person for them to consult, this may not be possible for a variety of reasons. Outpatient surgical centers are opening almost at the same rate as urgent care centers,¹ but may not be well prepared to handle complications after hours. Patients in rural areas may need to travel to distant facilities for cosmetic or specialized procedures, making bedside reassessment with the surgeon difficult. Medical tourism, where patients travel outside the country for procedures, also makes follow-up with the actual surgeon impractical if not impossible. Patients who have just been discharged from the hospital may not wish to return if they have a complication, fearing long emergency room wait times and large bills, opting instead to present to urgent care.

Surgical complications likely to present to an urgent care center can be divided into acute, subacute, and late.

Acute Complications

Complications defined as *acute* occur as a direct result of the surgery itself, side effects of anesthesia, bleeding, or side effects of the medications prescribed, such as pain medications and antibiotics. These may include:

- **Injury to anatomic structures or expected post-surgical effects.** Some concerns may be condition-specific (eg, hematuria from lithotripsy, inability to void after prostatectomy, or vaginal bleeding after gynecologic procedures). Patients who have had



laparoscopy may complain of abdominal pain or bloating or even shoulder pain from the insufflated gas. These concerns need to be addressed on a case-by-case basis, with consultation with the surgeon or referral to the ED if the concern cannot be addressed by the urgent care provider.

- **Postoperative pain.** This is one of the major reasons a patient will seek urgent care following surgery. In the current climate of narcotic abuse,

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Table 1. Causes of Postoperative Fever

Acuity	Immediate	Acute	Subacute	Late
Time span	Within hours of surgery	Within 1 week of surgery	1-4 weeks following surgery	>1 month after surgery
Condition/ complication	Medications	Nosocomial infections	Surgical-site infection	Recurrent infection
	Blood products	Infections obtained prior to surgery	Central venous catheter infection	Postpericardiotomy syndrome (if open heart surgery)
	Infections obtained prior to surgery	Early surgical-site infections (GAS, <i>Clostridium perfringens</i>)	Antibiotic-associated diarrhea (<i>Clostridium difficile</i>)	Viral infections related to blood products
	Inflammation due to surgery itself	Vascular access-related infections	Febrile drug reaction (β -lactam antibiotics, sulfa-containing medications)	Surgical-site infections due to indolent organisms (Coagulase-negative <i>Staphylococcus</i>)
	Malignant hyperthermia (rare but deadly)	<ul style="list-style-type: none"> • Aspiration • Ventilator-acquired pneumonia (VAP) • Catheter-related UTI • Pancreatitis • Myocardial infarction • Pulmonary embolus • Thrombophlebitis • Alcohol withdrawal • Acute gout 	<ul style="list-style-type: none"> • Thrombophlebitis, especially if patient is less mobile • Post-CU-related infections 	

surgeons rely less on postoperative narcotics and more on local blocks for postoperative pain control. These blocks generally lose their effectiveness after 16-18 hours. If NSAIDs are not strong enough or contraindicated, the patient does not wish to take the narcotics, or they were not prescribed, the patient may present seeking pain control. If the patient contacted the surgeon and he or she refused to prescribe narcotics, the urgent care provider should be cautious about dispensing them. If narcotics are prescribed, no more than a 5-day supply should be offered. Be sure to follow your state regulations when prescribing narcotics.

- **Postoperative fever** is most commonly an acute complication but can occur at any point in the postoperative period. Fever is defined as temperature higher than 38°C or 100.4°F. See **Table 1** for differential diagnoses.

Subacute and Late Complications

Subacute complications present several days postoperatively. “Late” complications can occur anytime after that in the post-op period, and are discussed here accordingly.

- **Allergic reactions** should prompt a careful review of any medications given intra- or postoperatively as well as latex and glue or tape allergies from bandages. Antibiotic ointments may also cause contact dermatitis and allergy. Dressings should be removed and the area inspected. Betadine may not have been washed off, causing itching. Some patients may also have a contact reaction from tincture of benzoin used to adhere surgical tape and bandages.
- **Dystonic reactions** may occur from medications prescribed for nausea and vomiting, presenting with muscle spasms including fixed upward gaze, neck twisting, grimacing, clenched jaw, and difficulty speaking. It is usually painful and frightening. Treatment with parenteral diphenhydramine, diazepam, or benzotropine is usually curative.
- **Spinal or postdural puncture headaches** occur as a complication of accidental puncture of the dura during epidural anesthesia or failure of the puncture to seal following spinal anesthesia. Patients will complain of headache that is positional; worse when upright and better when lying flat. The

Figure 1. Surgical-site infection.

(Photo courtesy of medicalimages.com)

headache may be accompanied by neck stiffness, photophobia, nausea, tinnitus, or phonophobia. Risk factors include female sex, young but not pediatric age, pregnancy, history of prior headaches, and a low BMI.² Mild symptoms may be treated with fluids, caffeine, bed rest and analgesia. Severe cases may require an epidural blood patch, which will likely require transfer to the ED and consultation with an anesthesiologist.

- **Nausea and vomiting** may occur immediately after surgery or several days post-op. Early vomiting is usually due to the aftermath of anesthesia, though it can also be caused by narcotic pain medications including codeine, morphine, and oxycodone; or antibiotics. The patient should be evaluated for dehydration, and if necessary, fluids should be replaced. Antiemetics such as ondansetron, metoclopramide, promethazine, or prochlorperazine can be given or prescribed for outpatient use. Changing from one narcotic to another may alleviate vomiting. Other structural causes may include ileus or obstruction. With significant pain or vomiting, or consideration of severe dehydration, intractable emesis, or an organic cause, emergent evaluation in the ED is advisable.

One frequent cause of nausea and vomiting, as well as diarrhea, is antibiotics. Vomiting may present as an early side effect, and diarrhea as a late effect. Most diarrhea from antibiotics is self-limited and will resolve when the antibiotic is discontinued, but if the diarrhea is severe, associated with abdominal pain, fever, or marked cramping, consider *Clostridium difficile*. Antibiotics may also cause yeast infections in the form of thrush or vaginitis in females.

Figure 2. Hematoma 1 week after right inguinal hernia repair.

(Photo courtesy of medicalimages.com)

Figure 3. Seroma following a hernia repair.

(Photo courtesy of Tracey Quail Davidoff, MD.)

- **Constipation** is common following abdominal procedures. Etiologies may include medications, bowel inactivity, decreased postoperative activity, and dietary changes. Treatment with suppositories or enemas may be trialed first, and if limited results, oral agents such as granular bulking agents or citrate of magnesium can be tried. Granular bulking agents should be avoided if bariatric or bowel surgery has been performed as they may cause obstruction. Severe cases may require manual disimpaction of stool from the rectum. Before making a diagnosis of constipation, consider consultation with the surgeon, as constipation may be a symptom of obstruction.

Sore throats are common following endotracheal intubation for general anesthesia. Evaluate for stridor and drooling. If stable, a careful exam of the oral cavity to inspect for trauma, swelling, and injury to the teeth should be performed to rule out

any serious complications. If these are not present, the patient should be reassured. With persistent or significant symptoms, the patient may need referral to an otolaryngologist for an endoscopic procedure to detect occult injury.

- **Cough** is also common following general anesthesia; this may be self-limited but may indicate more serious concerns such as pneumonia, aspiration, and atelectasis. Assess for fever, elevated respiratory rate, tachycardia, hypoxia, and abnormal breath sounds. A chest radiograph may be indicated for abnormal findings.
- **Chest pain** is worrisome in the postoperative patient. Pulmonary embolus (PE) and deep venous thrombosis (DVT) may follow major procedures, lower extremity procedures, and patients who have had inpatient surgery. Patients who have had a personal or family history of venous thromboembolic disease, obese patients, and cancer patients also have an elevated risk. Patients should be referred to the ED with consideration of DVT or PE.

Myocardial infarction may occur in the postoperative period; these patients should be evaluated in the ED.

- **Urinary symptoms.** Patients who have had gynecologic, urologic, or other surgeries requiring a Foley catheter may present with urinary symptoms such as dysuria, urgency, or frequency. Side effects of anesthetics, narcotics, antiemetics, and antihistamines may also cause urinary retention. Patients may also develop candida vaginitis as a result of antibiotics that may cause urinary symptoms. Unless there are urologic complicating factors, treatment is often the same as non-postoperative patients. Contacting the patient's gynecologist or urologist may be advised for further direction in complicated cases.
- **Bleeding or drainage** from the wound may be distressing for patients, prompting them to seek urgent care. Although medical personnel are accustomed to seeing blood or serous fluid soaking through bandages, patients may see this as a potential complication. Removing the bandage and inspecting the area, with reassurance and a bandage change may be all that is required, but the patient should be evaluated for hematoma, seroma, or infection.

A *hematoma* is a collection of blood, in this case beneath a surgical incision. It is due to the failure of primary homeostasis to be achieved during the

time of the procedure, or a failure of the clotting mechanism of the patient due to a bleeding diathesis, causing pain, swelling and oozing from the suture line, which can then predispose to separation of the wound and infection.

A *seroma* is a collection of serum beneath the surgical incision. A seroma forms due to dead space remaining between the skin and the deep tissues at the time of wound closure. This allows the accumulation of serous fluid to form in the dead space. This can be site-specific or due to failure of the surgeon to adequately close the dead space. Obesity is the main risk factor and can be mitigated by drain placement. Higher-risk surgical sites include breast and abdominal wall surgeries, especially ventral hernia repairs. Seromas cause swelling and oozing from the suture line, but compared to a hematoma, are usually painless. They rarely become infected but add to wound healing time.³ The drainage can be quite copious and distressing.

The diagnosis of either is by inspection and palpation of the wound. If the diagnosis is in question, ultrasound or CT scan may be useful to delineate the extent of the area or distinguish between hematoma, seroma, infection, and the dreaded complication of necrotizing fasciitis. Small hematomas and seromas can safely be observed, but large ones should be drained. The wound may be opened partially along the suture or staple line after consultation with the surgeon. If a seroma is suspected, needle aspiration may be all that is required.⁴ The wound should be packed until granulation tissue is present at the base allowing healing by secondary intention. If there is any suspicion of infection or if it appears that deeper tissues are exposed or disrupted, the patient should be evaluated urgently by a surgeon.

- **Fascial dehiscence** may occur when the incision breaks down due to tissue breakdown, suture failure, or knot failure. This may occur early or late in the course of healing. The wound may dehisce partially or completely.⁵ Abdominal wounds are at risk for evisceration. Fascial dehiscence that is not repaired may result in hernia formation.

Suspect dehiscence if the patient complains of a serosanguinous drainage from the wound. There may be an incisional bulge which is exacerbated by a Valsalva maneuver. Most fascial dehiscence occurs 4-14 days after the surgical procedure. The diagnosis is clinical. Complete fascial dehiscence is a sur-

gical emergency for which mortality and morbidity may be significant. If the bowel is exposed the wound should be gently covered with saline-soaked gauze and the patient transferred to the ED.

- **Surgical-site infection (SSI)** occurs in 4% of all clean surgical wounds and 35% of grossly contaminated wounds (characterized as being grossly purulent, with a retained foreign body [trauma], devitalized tissue, or fecal contamination).⁶ Risk factors include obesity, immunosuppression, cardiovascular disease, smoking, cancer, previous surgery at the same site, malnutrition, and prior irradiation in the field of surgery. The diagnosis is clinical, with erythema, induration, warmth, pain, and purulent wound drainage present. Separation of the incision may occur, as well as fever, and leukocytosis. Deep tissue infection extending to the fascia, or necrotizing fasciitis, is a surgical emergency. These patients will have copious, dishwater-like drainage from the wound and the skin will be dusky with pale and devitalized, even necrotic tissue beneath. The surrounding tissue will be friable. Treatment is emergent surgery.

SSIs with cellulitis can be treated with oral antibiotics or, in select patients, topical mupirocin. Topical antibacterial preparations such as povidone-iodine, sodium hypochlorite, and hydrogen peroxide should be avoided as they are toxic to fibroblasts and impede wound healing. Cleaning with soap and water may be done daily. Swabs of the wound are often polymicrobial and cannot distinguish colonization from active infection and are not helpful. Antibiotics should cover gram-positive cocci from skin (eg, cephalexin). If a methicillin-resistant staph aureus (MRSA) abscess is a consideration, incision and drainage should be performed with possible prescription of antibiotics which cover the MRSA (such as trimethoprim-sulfamethoxazole).

Infected wounds with fluctuance and evidence of abscess formation should be opened, explored, drained, and irrigated with sterile normal saline. If fascial disruption is suspected or discovered the procedure should be done in an operating room under sterile conditions. Mechanical debridement with forceps, scissors, or scalpel and removal of all foreign bodies should be done.⁷ Superficial wounds can be covered with sterile dressings; deeper wounds should be packed with wet, saline-soaked gauze and changed twice daily until a bed of healthy granulation tissue is present. There are many commercial

Figure 4. Dehiscence of a laparoscopy incision.



Note the ruptured sutures in the wound bed.

(Photo courtesy of Tracey Quail Davidoff, MD.)

dressings available, one should be selected that allows for maintenance of warmth and moisture and encouragement of granulation tissue.⁸ Antibiotics are not required if the wound is open and draining and the patient has no signs of systemic infection. The patient should be referred back to the surgeon if possible; if not, a wound center.

- **Drains and sutures.** Patients may present to the urgent care center for removal of drains or sutures. Drains are generally removed when there has been no fluid output for 24 hours. Any suture should be removed first. The tubing should be “milked” from the skin to the bulb until as much liquid as possible is collected from the tube. The drain should then be removed in a continuous unidirectional pull. A dressing to collect any further drainage should be applied. Patients should be warned that some drainage from the opening is to be expected.

A late presentation postsurgery may be for suture removal if the patient has had their procedure in a distal location. Before removing any sutures, the wound should appear to be well healed, similar to a laceration, and “ready” to have the sutures removed. If in doubt, a few or every other suture can be removed and reassessed before removing all the sutures. If it appears more time is needed, surgical tape strips can be applied to maintain approximation.

Abdominal wounds require longer healing periods to prevent dehiscence, especially in the obese. Some cases require 2-3 weeks or more. Early removal can contribute to dehiscence, hypertrophic scarring, and hernia by increasing the tension on the underlying deep sutures. If there is any question as to the timing of removal, a surgeon, preferably the one who did the procedure should be consulted prior

Figure 5. Incisional midline hernia.

(Photo courtesy of medicalimages.com)

to removal of any sutures or staples.

- **Itching** is common following any surgical wound and is a normal part of the healing processes. Inspect the wound for any evidence of infection or rash. Contact dermatitis from bandages or topical ointments is common. Ask the patient what they are putting on the wound. If no evidence of rash or infection is present, the patient can be reassured that itching is normal. Petroleum jelly can be used to provide barrier protection and alleviate itch. If the wound is completely closed, topical scar creams, Vitamin E oil, or cocoa butter can be used.
- **Neuropathic symptoms.** Cutaneous nerves are frequently disrupted during surgery and may result in neuropathic symptoms such as numbness, burning, itching or paresthesia in and around the wound. These symptoms may partially resolve over time but are frequently permanent. They can be quite distressing for the patient. Deeper nerve injuries may cause pain, numbness, weakness, and ultimately neuroma.⁹ If reassurance is not sufficient the patient should be referred back to the surgeon and in some cases a pain and symptom management specialist.
- **Keloids and hypertrophic scars** can occur from any injury to the skin in susceptible persons. Topical silicone sheets or gel may be helpful if used for 3-6 months in new and established scars.^{10,11} Other treatments such as steroid injection, laser therapy, and resection are best left to a dermatologist or plastic surgeon. Treatment of these complications is often less than satisfactory.¹¹
- **Hernias** occur when the abdominal wall tension overcomes the suture or knot strength of the fascial layer of an abdominal wound. It may be partial or complete and occur in any abdominal incision including laparoscopic sites. This may occur at any

point in the healing process. It is more likely to occur in males, obese patients, patients with chronic coughs, wound infections, patients on chronic glucocorticoids, and patients with poor nutritional status. Following abdominal surgeries patients should avoid heavy lifting of >13 pounds from the floor for 4 to 6 weeks following the procedure.¹² Once the hernia has occurred, the only option is surgical repair. Hernia belts or abdominal compressive garments may minimize symptoms but are not curative. Patients should be evaluated for incarceration, and if present, should be sent to ED for evaluation. If incarceration is not present, outpatient referral for surgical evaluation and potential repair is recommended. Patients should be warned about the signs of incarceration such as significant pain, vomiting, or fever. Larger hernias are less likely to become incarcerated than smaller as the abdominal contents flows freely from the hernia sack to the abdomen.

Conclusion

Postoperative complications are common, and it is not always possible for the patient to be evaluated by the operating surgeon. As patients are more and more looking for immediate solutions to their medical concerns, they may seek care for these complications in your urgent care center. A thorough evaluation is key in determining if an emergency condition exists and if transfer to the hospital is required. Consultation with the performing surgeon should be accomplished if possible. Frequently, gentle reassurance and patient education is all that is required. ■

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Shortness of Breath in a Postprocedural Pneumothorax

Urgent message: Patient histories can be helpful in guiding the examination and raising red flags for possible diagnosis. However, it is essential to resist the urge to accept a patient's self-diagnosis at face value.

KATLIN F. MATTSON, M3 and SHAILENDRA SAXENA, MD

Case Presentation

A 65-year-old female with a history of metastatic endometrial cancer, COPD, and asthma presented with increasing shortness of breath. Four days prior, the patient had undergone a chest wall port placement for chemotherapy. The patient believed her symptoms were attributable to COPD exacerbation.

Physical Examination

The physical exam revealed the following:

- Weight: 147 lbs
- O₂ sat: 96%
- RR: 16
- BP: 114/72
- Pulse: 98 bpm

General appearance: Patient is alert and oriented. Slightly tachypneic

HEENT: PERRLA, oropharynx non-erythematous, conjunctivae pink with no scleral jaundice, normal mucosa and nasal septum

Neck: Supple with no cervical or supraclavicular lymphadenopathy

Heart: Tachycardic, S1 and S2 normal, no murmurs

Lungs: Diminished breath sounds on left, expiratory wheeze evident

Extremities: No peripheral edema or pain

A chest x-ray was obtained and depicted a large left pneumothorax with associated pleural effusion and a mild rightward mediastinal shift. These findings reflected a tension pneumothorax as visualized in **Figure 1**. The patient was transferred to the emergency room

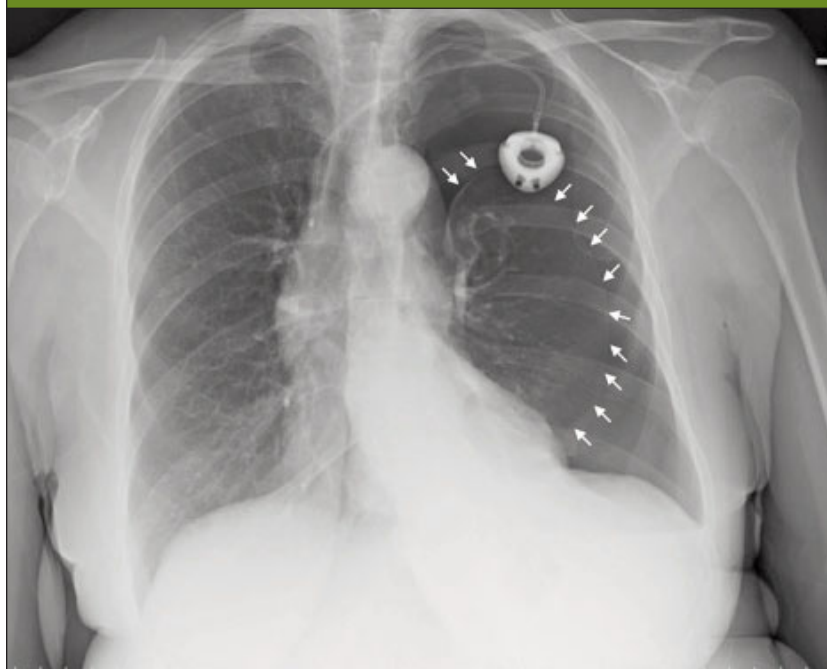


and underwent needle decompression followed by a tube thoracostomy. She was successfully stabilized and has obtained a full recovery as demonstrated by the image in **Figure 2**.

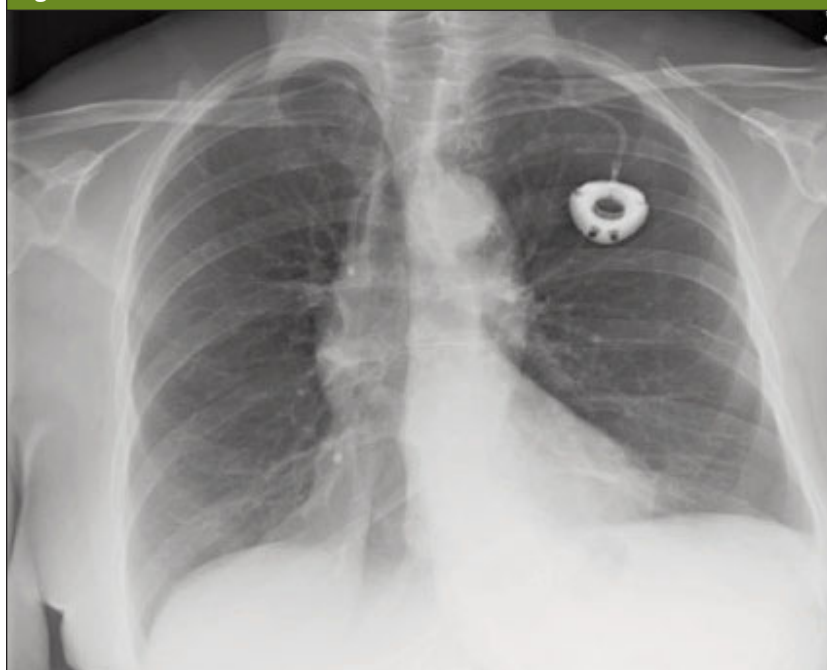
Discussion

Tension pneumothoraxes develop with the accumulation of air in the pleural space and compression of the lung under the resulting pressure. Typical symptoms and signs of a tension pneumothorax include hypotension, short-

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Figure 1.

Large left pneumothorax. White arrows demarcate the lining of the left lung. Left-sided infusion port and mild rightward mediastinal shift also evident in the image.

Figure 2.

Cardiac silhouette and pulmonary vasculature are stable. Interval re-expansion of the left lung.

ness of breath, rapid heart rate, rapid breathing, neck vein distension, dyspnea, and pleuritic chest pain.^{1,2} Physical findings involve hyper-resonance to percussion, decreased breath sounds on the affected side, and tracheal deviation.^{1,2} A chest x-ray visualizing radiolucent air and the absence of lung markings is suggestive of a pneumothorax, but tracheal deviation is suggestive of a tension pneumothorax.^{1,2}

With hemodynamic instability as evidenced by hypotension, altered level of consciousness, significant tachypnea or tachycardia, a needle decompression in the second intercostal space, over the rib, should be performed.^{1,3}

Our patient exhibited the majority of these symptoms upon entering the clinic and provides an excellent example of a postprocedural tension pneumothorax, again as seen in **Figure 1**.

Four days prior, our patient had undergone a subcutaneous port placement for treatment of endometrial cancer that had metastasized to the lungs. The use of central venous catheter (CVC) insertions over the last decade has increased due to a simultaneous increase in disease severity, age, and comorbidities of patients.

The overall complication rate of CVC placement is 15% (ranging from 5% 19%) and includes infection, thrombosis, occlusion, hemothorax, pneumothorax, arterial-venous fistula, nerve injury, thoracic duct injury, intraluminal dissection, and aortic puncture.⁴⁻⁸

Development of a pneumothorax is one of the most frequent mechanical complications associated with long-term vascular access and reportedly represents up to 30% of all mechanical adverse events of CVC insertion.⁴ General incidence rates for pneumothorax typically vary between 1% and 6.6%, but likelihood of such an event is largely dependent upon the nature of the underlying disease, presence of a

comorbidity (pulmonary emphysema, COPD, coagulopathy), congenital anomalies, previous catheterizations, and catheter type.^{4,9}

Mechanical complication rates also vary according to the site of central vascular access. Using the internal jugular vein has a rate of pneumothorax of <0.2% while the subclavian vein has a rate of 0.45-3.1%.⁴ If an ultrasound is used to guide the internal jugular vein access, rate of pneumothorax decreases to <0.1%.⁴

Primary care physicians must be actively aware of the potential for postprocedural pneumothoraxes, particularly with patients who complain of dyspnea or shortness of breath. Patients with a history of COPD, bronchiectasis, cystic fibrosis, malignant disease, interstitial lung disease, pneumonia, tuberculosis, Marfan's, and Ehlers-Danlos, some of which apply to the patient described here, have a heightened predisposition to pneumothorax and must be monitored more extensively for the condition. Providers must secondarily be aware of the possibility of being led astray by patient self-diagnosis and delve further into patient-proclaimed conditions.

Conclusion

Urgent care and primary care physicians are the first line for many acute conditions, and so must be vigilant for life-threatening diagnoses regardless of the presenting complaint. Tension pneumothorax is one such diagnosis with potentially dire consequences. The provider must understand the circumstances in which a pneumothorax can arise, the symptoms involved, and the techniques available to diagnose pneumothorax. Further, urgent care providers must keep in mind that while the patient history can be helpful in guiding the examination and possible diagnoses, we must not accept a patient's self "diagnosis" at face value but explore other possibilities for common symptoms. ■

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“Urgent care physicians are on the first line for many acute conditions, and so must be vigilant for life-threatening diagnoses regardless of the presenting complaint.”

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Summary

- Tension pneumothoraxes develop with the accumulation of air in the pleural space and compression of the lung under the resulting pressure.
- Typical symptoms and signs of a tension pneumothorax include:
 - Hypotension
 - Shortness of breath
 - Rapid heart rate
 - Rapid breathing
 - Neck vein distension
 - Dyspnea
 - Pleuritic chest pain
- Physical findings involve hyper-resonance to percussion, decreased breath sounds on the affected side, and tracheal deviation.
- Chest x-ray visualizing radiolucent air and the absence of lung markings is suggestive of a pneumothorax, but tracheal deviation is suggestive of a tension pneumothorax.
- With hemodynamic instability as evidenced by hypotension, altered level of consciousness, significant tachypnea or tachycardia, a needle decompression in the second intercostal space, over the rib, should be performed.
- Patients with a history of COPD, bronchiectasis, cystic fibrosis, malignant disease, interstitial lung disease, pneumonia, tuberculosis, Marfan's, and Ehlers-Danlos have a heightened predisposition to pneumothorax and must be monitored accordingly.

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

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





ABSTRACTS IN URGENT CARE

- Taking Temps
- Probiotics + Antibiotics = ?
- Radiography in Kids with Bronchiolitis
- Lead the Way with Hand Sanitizer
- Questioning Positive Viral Tests
- Time to Sit Down

■ JOSHUA RUSSELL, MD, MSC, FAAEM, FACEP

Check the Temps: A Timely Throwback

Key points: Peripheral temperatures (ie, temporal, tympanic, oral, and axillary) are inaccurate and cannot reliably exclude the presence of fever. If absolute certainty regarding febrile status is critical (eg, neonates, immunosuppressed patients), a (gentle) rectal temperature is the preferred method of temperature acquisition in the urgent care setting. For all others, a tympanic temperature reading $<37.5^{\circ}\text{C}$ appears to best exclude true fever with reasonable certainty. Finally, all this comes with the important caveat that recent use of an antipyretic must also be considered when evaluating for fever.

Citations: Bijur PE, Shah PD, Esses D. Temperature measurement in the adult emergency department: oral, tympanic membrane and temporal artery temperatures versus rectal temperature. *Emerg Med J*. 2016;33(12):843-847.

Niven DJ, Gaudet JE, Laupland KB, et al. Accuracy of peripheral thermometers for estimating temperature: a systematic review and meta-analysis. *Ann Intern Med*. 2015;163(10):768-77.

Coughing, sneezing, sniffing. These sounds likely haunt you for hours after every shift. In fact, chances are you've got many of these very symptoms yourself right now—some days, maybe even more than your patients. As we find ourselves headlong into cold and flu season, upper respiratory infections and related concerns are probably dominating your clinical life.

In the assessment of both adult and pediatric patients with URI symptoms, one of the most important data points in our evaluative algorithms is the presence or absence of fever. So,

how do we actually know if the patient in front of us is febrile? Obviously, we check their temperature. But *how*? And does method of measuring matter?

There are a myriad of techniques to measure body temperature—temporally, orally, axillary, tympanically, and dare I say, rectally. The practicality and ease of temperature acquisition varies based on the patient's age and situation. And most patients certainly have a preference, as well. Consider the difference between getting a rectal temperature in a 10-month-old vs a 10-year-old. But are all methods equally accurate?

In my role supervising dozens of urgent care advanced practice providers, I don't often hear much discussion about how temperatures are acquired. However, an accurate temperature is crucial in urgent care, where we have very little objective data and only a short time to evaluate each patient—especially because presence of a fever will often significantly alter our management.

I wanted to begin Abstracts in Urgent Care this month with two “greatest hits” papers from the last decade that probably flew under your radar, as they address this very issue.

In the first paper, a 2015 meta-analysis, the authors compiled the data from 75 studies involving over 8,000 patients. They specifically compared the accuracy of peripheral thermometers to nonperipheral thermometers in identifying temperatures $\pm 0.5^{\circ}\text{C}$ from the normal range. For the purposes of this analysis, peripheral thermometers included oral, tympanic, axillary, and tympanic readings. Nonperipheral referred to rectal recordings as well as other more invasive techniques (eg, bladder and esophageal).

The authors found that peripheral temperatures were highly specific (96%) for identifying fevers, but had poor sensitivity (64%). In other words, an elevated peripheral temperature virtually guarantees that the patient is truly febrile, whereas a normal peripheral temperature is highly unreliable in excluding the



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presence of fever. Based on this finding, they concluded that “peripheral thermometers do not have clinically acceptable accuracy and should not be used when accurate measurement of body temperature will influence clinical decisions.”

Measuring temperatures in urgent care

While a reliable temperature measurement is a priority, checking a rectal temperature on every patient with a runny nose would be an impractical (and unpopular) way to practice. Which leads to the next logical question: If we must choose between peripheral methods of temperature recording, which should we choose? The second paper addresses exactly this issue.

In this 2016 article, the researchers took nearly 1,000 emergency patients and evaluated the accuracy of oral, temporal, and tympanic temperatures compared with core temperature readings. Similar to the meta-analysis, the investigators found a high specificity and low sensitivity of all peripheral thermometers. Interestingly, oral temperatures were both the most specific and the least sensitive (possibly due to recent PO intake) for the presence fever using a cut-point of 38°C. These authors reached the same conclusion as those of the 2015 meta-analysis: peripheral thermometers are not reliably sensitive enough to be used to exclude the presence of fever.

However, in a clever subanalysis, the authors changed the cut-point for defining a fever to 37.5°C. With this revised definition of fever, they found that the sensitivity of peripheral thermometers improved significantly. The best performing method, using the lower cutoff, was tympanic temperature acquisition with a sensitivity and specificity both >90% for identifying patients with a core temperature >38°C.

And with that, let’s get on to this month’s review of recent abstracts in UC. ■

Let Them Fight it Out

Key point: *Probiotics co-prescribed with antibiotics are a low-risk strategy to mitigate risk of C difficile colitis.*

Citation: Goldenberg JZ, Mertz D, Johnston BC. Probiotics to prevent *Clostridium difficile* infection in patients receiving antibiotics. *JAMA*. 2018;320(5):499-500.

Antibiotics are the most commonly prescribed class of medications in urgent care. Recent evidence has suggested that many of these prescriptions are unnecessary, and antibiotics have multiple known risks. Most frequent among these adverse reactions is intestinal dysbiosis and diarrhea, including that related to *Clostridium difficile* infection, which can be life-threatening. Probiotics have been increasingly used as a strategy to address this gut dysbiosis. If *C diff* strikes when the antibiotics wipe out too many of the “good guys,” maybe we can prevent this by giving the patient back some normal flora, the thinking goes.

These authors from *JAMA* reviewed the clinical evidence for

co-prescribing a probiotic with an antibiotic as a means of reducing the risk of *C diff*. In creating this “Clinical Evidence Synopsis,” the authors reviewed nearly 40 RCTs which included both adult and pediatric patients. They found that there was “moderate” quality evidence present across these studies in support of this practice. Based on the pooled analysis of the trials, the authors found a number needed-to-treat (NNT) of about 40 probiotic prescriptions required to prevent one case of antibiotic associated *C diff* colitis. Unfortunately, there are literally thousands of nonstandardized probiotic products on the market containing a multitude of strains and concentrations of different “good” microorganisms. So which product, which strains, which dose, and what duration of therapy to recommend remains anybody’s guess. ■

Taking the Lead from Our Ped Colleagues on Chest X-Rays

Key point: *Pediatric emergency clinicians ordered less than half as many chest x-rays as nonpediatric emergency specialists did for children <2 years of age with bronchiolitis.*

Citation: Burstein B, Plint AC, Papenburg J. Use of radiography in patients diagnosed as having acute bronchiolitis in US emergency departments, 2007-2015. *JAMA*. 2018; Oct 16; 320:1598.

When parents bring in an infant with fever, cough, and wheezing, the elephant in the room is generally pneumonia. Because most urgent care centers have x-ray capability, there is often unspoken (and sometimes not so unspoken) pressure from families to just get the chest x-ray “to make sure” the cause of the child’s symptoms isn’t pneumonia. However, in children <2 years with rhinorrhea and bilateral rhonchi and wheezing, the diagnosis is almost certainly bronchiolitis. In these cases, a chest x-ray usually doesn’t help make this diagnosis, but can lead to increased antibiotic and radiation exposure without improving outcomes. For these reasons, the American Academy of Pediatrics has actually made a formal recommendation *against* routine chest x-ray in cases of suspected bronchiolitis.

In this retrospective database analysis, researchers identified that children seen in pediatric EDs and diagnosed with bronchiolitis had chest radiographs ordered 25% of the time vs 53% of the time in nonspecialized EDs with similar rates of admission. This was felt to be attributed to increased familiarity with guidelines and comfort with evaluation of pediatric patients with respiratory complaints among pediatric specialists.

The bottom line is that bronchiolitis is a self-limited lower respiratory tract viral syndrome. While it might make parents and children miserable for a while, the vast majority of otherwise healthy children will recover relatively quickly and uneventfully. Treatment and disposition should be based on the clinical assessment for work of breathing and dehydration rather than radiographic findings. ■

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“Hand hygiene isn’t necessarily the most compelling topic to discuss, but it remains the most impactful strategy for preventing the spread of disease.”

When It Comes to Kids, Hand Sanitizer Wins

Key point: Providing hand sanitizer and teaching children to use it effectively reduces the incidence of URIs in the daycare setting.

Citation: Azor-Martinez E, Yui-Hifume R, Muñoz-Vico FJ, et al. Effectiveness of a hand hygiene program at child care centers: A cluster randomized trial. *Pediatrics*. October 8, 2018 [e-pub ahead of print].

There is no more reliable question to determine whether a child has had sick contacts than simply asking if he or she attends daycare. Children who attend daycare get sick more often, leading to higher rates of antibiotic use and healthcare utilization, which in turn means more illness, clinic visits, and missed work for their parents too.

It doesn’t take long working in urgent care before clinicians can identify the well-appearing, febrile child who needs nothing—and whose caregiver needs nothing more than reassurance. But perhaps this is the exact moment where we can provide not only some meaningful teaching for our patient, but a useful service for the good of public health, as well. Hand hygiene isn’t necessarily the most compelling topic to discuss. However, as our infectious disease colleagues keep reminding us, it remains the most impactful strategy for preventing the spread of disease. The question is, which type of hygiene? Hand washing has long been considered the gold standard; however, getting a toddler to participate with appropriate vigilance so as to make the practice effective is improbable at best.

This group of researchers from Spain performed a cluster randomized control trial involving 911 children across 24 daycare centers. Each center was randomized to either a hand-washing with soap and water intervention, hand sanitizer intervention, or no intervention (control). The authors found that there was a nearly 25% decrease in both URIs and antibiotic prescriptions among the centers using hand sanitizer compared with no intervention. Children attending centers using hand sanitizer had significantly fewer missed days due to respiratory illness compared with children attending centers in the other two groups. ■

Never Trust a Febrile Neonate—Even with a Positive Viral Test

Key point: In infants <60 days of age, a positive viral test (eg, influenza) decreases but does not eliminate the possibility of

concurrent serious bacterial infection (SBI).

Citation: Mahajan P, Browne LR, Levine DA, et al. Risk of bacterial coinfections in febrile infants 60 days old and younger with documented viral infections. *J Pediatr*. 2018; Dec;203:86-91.

Young infants are notoriously difficult to evaluate clinically. While the majority will end up having a viral infection as the sole etiology of a fever, a nontrivial proportion will have invasive bacterial diseases. Rapid viral assays are among the most common tests available in urgent care centers. These viral assays tend to have high specificities and are valuable when the aim is to confirm infections such as influenza or respiratory syncytial virus.

When parents bring in a <60-day infant with fever, therefore, the natural temptation can be to run a viral assay with the hopes that a positive test will obviate the need for ED referral and more invasive testing. According to this research, we must resist this temptation.

In this observational study, investigators prospectively followed 1,200 infants <60 days old with fever and positive viral tests and 1,745 with negative viral tests. They found that the rate of SBI was 3.7% in the group with positive viral studies vs 12.7% in the group with negative viral studies. As expected, a positive viral study does decrease the likelihood of SBI somewhat, but not to a safely negligible level. Based on these findings, running viral assays on such patients does not seem to be of value in the urgent care setting because it will not change immediate management, and should not deter urgent care clinicians from referring these potentially ill patients to the ED for further evaluation. ■

Practice of Urgent Care: Have a Seat

Key point: Patients perceive that providers who sit down during interactions spend significantly more time with them.

Citations: Young RA, Burge SK, Kumar KA, et al. A time-motion study of primary care physicians’ work in the electronic health record era. *Fam Med*. 2018;50(2):91-99.

Johnson RL, Sadosty AT, Weaver AL, Goyal DG. To sit or not to sit? *Ann Emerg Med*. 2008;51(2):188-193.

Time flies when we’re having fun, but drags when we are stuck in line at the bank. Abundant human psychology research has demonstrated that our perception of the passage of time is highly variable based on a number of external factors.

As urgent care clinicians, we often face competing pressures related to delivering quick and efficient care while simultaneously providing excellent patient experience. Both patients and clinicians highly value time spent together; yet, ironically, with each passing year, the amount of time healthcare providers spend with their patients decreases.

Because of the pressures in urgent care to see many patients quickly without causing any of them to feel shortchanged for

our time and attention, a strategy which creates the sense of time with the provider expanding would be something of a Holy Grail. And it turns out it's been right under our noses all along: It's that stool sitting in corner.

Perhaps some of you already practice the habit of sitting when speaking to every patient, but there is certainly an ever-present temptation, especially when in a hurry, to remain standing. However, if our goal is for our patients to feel we are present and that they have more of our time than we actually have to give them, it's worthwhile to make sitting a standard practice with each patient.

In this study from 2008, researchers surveyed 224 ED patients who were seen by various types of providers (APPs, residents, and attending physicians). Providers were assigned to a standing or sitting position for the majority of the interaction. The providers spent an average of 8.6 minutes with patients. There was no statistical difference between the amount of time the providers in each group actually spent with the patients.

"A strategy which creates the sense of time with the provider expanding would be something of a Holy Grail—and it turns out it's been right under our noses all along."

Remarkably, the patients who were seen by standing providers mistakenly felt that the provider spent significantly less time with them, whereas patients who were seen by a provider who sat misperceived that the provider actually spent more time interacting with them. The relative difference was 1.9 minutes in perceived time between the two positions. In other words, patients felt that providers who sat spent an extra 22% more time with them relative to providers who stood.

So, while sitting doesn't really give us more physical time with our patients, it does make them feel like they are getting more of it. And, in urgent care, that may actually be a more desirable solution. ■

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When the ‘Inner Entrepreneur’ Needs to Step Aside

Urgent message: Being an aggressive founder who is willing to take risks is invaluable when it comes to starting and growing a business. However, after that business becomes established, it’s essential to transition into a new role as a leader so those same traits that helped start the business don’t also ruin it.

ALAN A. AYERS, MBA, MACC

Leaving behind the relative safety of working as a physician in a hospital or private practice to start your own business can be scary. For those who aren’t a physician-entrepreneur, the risks and rewards of opening an urgent care center can be alluring. The thrill of owning and running your own business entices many to take the plunge and form a start-up. Traits like creative vision and risk-taking contribute to the success of any new business. A start-up must be carefully nurtured and steered in the right direction while financial, emotional, and reputational risks are necessary to increase its growth.

On the other hand, an established business relies on teamwork and openness to continue thriving and growing. Unfortunately, many start-up entrepreneurs have difficulty transitioning into this role and breaking out of the risk-taking mindset of starting a business. Those who cannot display a dangerous trait known as “executive hubris.”

What Is Executive Hubris?

Executive hubris is how academics describe a CEO or business owner who displays extreme self-confidence, even over-confidence—in themselves and in their businesses. This leads to increased risk-taking, decreased cohesiveness among team members, and a demoralizing and demeaning company culture. It stems from two main sources: extensive power and the inability to let go of the thrill of start-up culture. Perhaps the owner-entrepreneur is on top of a company doing extremely



well and rolling in profits. He or she may be more likely to take business risks, like a poorly timed acquisition or expansion, that may ultimately hurt the business. If the leader is stuck in the start-up mindset, he or she will likely take those same risks and, in addition, refuse to listen to the opinions or visions of others.

Regardless of where it stems from, executive hubris is extremely damaging to both companies and employees.

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

hu-bris	
(h)yoo-br s/ noun: hubris synonyms:	1. excessive pride or self-confidence. arrogance, conceit, haughtiness, hauteur, pride, self-importance, egotism, pomposity, superciliousness, superiority; More informal: big-headedness, cockiness “the hubris among economists was shaken”
antonyms:	humility • (in Greek tragedy) excessive pride toward or defiance of the gods, leading to nemesis.
Source: Google	

“Once a business becomes established, the owner must transition into the role of team member rather than one-man show. Other professionals will step up to help run the business.”

And it's more common than you may think.

Nearly one in five CEOs say they never doubt themselves, according to a study by the University of Oxford.¹ While it's good to have confidence, this rash overconfidence of “never doubting oneself” is extremely dangerous when it belongs to the individual in charge of running a business. Whether you run a small urgent care center or a growing portfolio of multiple centers, identifying and understanding how executive hubris can be a danger is not only practical, but essential.

From an outsider's perspective, it's easy to see that running a start-up and running a successfully established business are not the same. However, for the physician-entrepreneur starting an urgent care center, the differences may not be so obvious. Growing the business from an idea into something viable and then something successful is a taxing process that leaves the owner very involved in a hands-on way. However, once a business becomes established, the owner must partially step back and transition into the role of “team member” rather

than “one-man show.” Other professionals will step up to help run the business while the owner becomes the visionary and strategist, setting the future direction of the business. This transition is very difficult to make, leaving owners who still have an entrepreneurial mindset stuck in a pattern of thinking that results in executive hubris.

Transitioning from Founder to Executive

Massive ride-sharing company Uber has made the news recently in light of scandals like secretly tracking its customers and having a company culture of unchecked sexual harassment. In part, this was due to founder and CEO Travis Kalanick having too much power and not running the business as part of an ethical and supportive team.² Ultimately, this led to his removal as CEO and the appointment of new executives to run the company. This example from one of the fastest-growing companies in America shows urgent care owners the importance of taking practical steps to avoid executive hubris.

Use Doubt to Your Advantage

Although doubt may seem like a negative in a business world where confidence is rewarded, doubt can also be one of the most powerful tools a leader possesses. Although 20% of CEOs said they don't doubt themselves, fortunately, the other 71% said that they use their doubt as a decision-making tool. Strategies like scenario-planning and thinking about the bad things that may occur help successful CEOs manage the company's risks. Although thinking about everything that could go wrong may not be as fun as envisioning boundless success, identifying the doubts that relate to a plan or idea leads to much better decision-making than unchecked confidence.

Culture, Culture, Culture

Practically any conference or seminar on business leadership will mention company culture in some way—because it is essential to creating and growing a successful company. Often, start-up companies have a very adventurous, daring, and risk-taking culture. This can resonate well or poorly with employees, depending on the mindset and philosophies of the founder. However, in time, it will lead to talented workers leaving and general unhappiness among those who remain. One of the most difficult things to do for a founder transitioning into a leadership/CEO role is to foster a culture that creates openness, collegiality, and diversity of thought among team members.

As discussed earlier, being a CEO or leader of a business, specifically an urgent care center, requires tremendous teamwork and openness. If a physician opens an urgent care center, they should surround themselves with talented and intelligent individuals who will help run the company and make it stronger. This can only happen if the leader at the top provides a culture in which to do so. Team members should feel comfortable and motivated to provide opinions, even if they are not in line with the CEO's vision. In addition, the leader should take these opinions seriously and reflect on them. Many people in many different positions can have great ideas, and it is the responsibility of the leader to hear these ideas and use them to guide the company in the right direction. At the same time, he or she should facilitate a company culture that promotes respect and achievement for all team members and the business as a whole.

Recognize Individual and Team Hubris Early

Physicians understand the benefits of "early detection" when it applies to catching a disease early. Whether it's by the patient at home or in a regular screening, detecting a problem early in its course almost always leads to a better or simpler outcome. The same goes for recognizing hubris in a business. Looking out for signs of executive hubris, like the following, in leaders and in executive boards/teams lets action be taken early to keep it from becoming a bigger problem:

- Obsession with personal image
- Reckless or impulsive risk-taking
- Refusal to listen to others' ideas repeatedly
- Excessive self-confidence and a strong dislike of criticism

Happily Accepting Criticism

A strong dislike of criticism is listed as one of the signs of hubris. So, it only makes sense that learning to accept criticism and then consciously taking steps to better the object of the critique is an effective countermeasure. By allowing themselves to be critiqued, and in fact encouraging it, CEOs and business leaders can stay in touch with reality and help avoid executive hubris.

An Essential Transition

For urgent care owner-operators, being an aggressive

"Physicians understand the benefits of early detection when it applies to catching a disease. The same goes for recognizing hubris in a business."

founder who is willing to take risks is important when it comes to growing a business. However, after that business becomes established, it is essential to transition into a new role as a leader so those same traits that helped found the business don't harm it. Avoiding the trap of executive hubris that happens during this time of transition is something all owner-operators

must be aware of and actively work on avoiding while simultaneously developing traits like teamwork and openness to better run the established company. ■

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Suggested Further Reading

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Summary

- The dangers of executive hubris include unreasonable risk-taking, poor cohesiveness among team members, and a company culture that can be demoralizing and demeaning.
- While 20% of CEOs say they don't doubt themselves, 71% acknowledge they do—and that they use their doubt as a decision-making tool.
- Strategies like scenario-planning and recognizing the possibility of a poor business outcome may help successful CEOs manage a company's risks. In this way, identifying doubts that relate to a plan or idea leads to better decision-making than unchecked confidence.
- One of the most difficult things to do for a founder transitioning into a leadership/CEO role is to foster a culture that creates openness, collegiality, and diversity of thought among team members.

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■ MAX LEBOW, MD, MPH, FACEP, FACPM

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To make sure the first visit is a productive one—and that the first impression of your clinic is a favorable one—you have to lay the groundwork before the first patient arrives.

The first step is to build a client profile for the business. This will be the roadmap for every subsequent visit when employees are sent to the clinic for workplace injuries.

Much of this information can be obtained from the employer by your marketing and administrative staff, but it's advisable to invite the employer for a clinic tour and arrange a meeting with your medical director. The goal of this meeting is not only for the important players to meet, but also to obtain and confirm important information that will make your relationship smooth and productive from the start.

At a minimum, the client profile should include:

- The name, email, and phone number of your key contacts. This will often be the head of human resources, the safety manager, or even the chief operating officer (or any combination of persons at the business). Whoever it is, there

must be an open line of communication at all times.

- The necessary insurance information, including carrier name, policy numbers, and billing addresses. It's important to know to what degree a business is self-insured, for example. Along with billing information, you should also understand who must be notified of a new injury and what preauthorization is required for subsequent visits or referrals, such as to physical therapy.
- Information about job duties and history and types of injuries that are sustained by their workforce. This helps the provider accurately assess whether an injury was viably "within the scope of employment."
- Availability and attitude of the business toward transitional/modified duty. Understanding the availability of modified work, and the accommodations the business can make, will help keep injured employees at work and avoid temporary disability. Modified duty may fall under a union contract, so it is important to understand these variables.
- For the client, important information about your clinic, including your hours, capabilities, and referral processes. Make sure the company representatives know all your services so if the need arises, they will come to you first for things like on-site flu shots, health fairs, wellness checks and education, and all things medical.
- Companies that are self-insured should be aware that your urgent care services can help keep their employees out of the emergency room and help drive down their general medical costs.



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The Patient Visit and Client Communication

The most common reason an urgent care center loses occupa-

tional medicine clients is dissatisfaction with patient/employee care. Conversely, loyalty is built when employer and patient needs are handled so well that your clients never think about using another provider. Marketing can bring a client through the door, but only good medical care with excellent communication can keep them as a client for the long term.

It's important to understand that the bulk of this task will be done by the medical provider. There is no substitute for your clients hearing good things about your care directly from their own employees. However, the provider should also be communicating directly with the business. At minimum:

- The provider must call the employer on 100% of all new injuries. This call needs to be made after the patient is seen, but before final disposition. A two-way communication might include information about the mechanism of injury and condition of the patient. The employer can provide information about the injured employee's job duties, availability of transitional/modified duty, and additional information that may have a secondary effect on the injury and its prognosis.
- The provider must call the employer whenever there is an unexpected change in the condition of the patient or treatment plan. This can include failure of the patient to progress, no-shows for rechecks, or unforeseen delays to discharge, beyond the expected time suggested by American College of Occupational and Environmental Medicine guidelines.
- The provider should contact the employer if there is a conflict during the patient visit. It is vitally important that the provider calls the employer to report when the patient leaves the clinic expressing dissatisfaction with their visit.

A number of other elements of the patient visit, besides those related to physician/client communications, must be performed. For starters, follow the company guidance, obtained in the new client onboarding process, as closely as possible. Failure to follow company policy can be a quick path to losing the company as a client. The services being performed, and the notifications and authorizations required, should be printed out and made available to every member of the clinic team upon arrival of the company's employee.

Be mindful that employers are concerned about managing their Workers' Comp insurance premiums, which like all insurance are based on an employer's "risk." That's why you often see signs at businesses like "XX many days since last injury." All providers seeing employees injured at the worksite must understand the concept of recordable injuries, the inclusion and exclusion criteria for OSHA First Aid classification, and determination of work-related vs non-work-related injury. This starts with every provider knowing the OSHA First Aid requirements. Taking the time to obtain a good history that may also

"The most common reason an urgent care center loses occupational medicine clients is dissatisfaction with patient/employee care."

reveal a non-work-related causation for the injury will always be appreciated by your clients.

In general, when conducting a patient visit, it is advisable to:

- Avoid prescribing opiates and instead seek other modalities for controlling pain, including acupuncture and massage therapy. Most employers are sophisticated enough to understand that Workers' Comp and opioids are usually a bad mix.
- Be mindful of unnecessary referrals. Referrals to imaging centers and specialists, including orthopedic surgeons for soft-tissue injuries, increase the total cost of claim without improving medical outcomes.
- Respect employers' time. All patients should be seen in a timely way, and large delays must be avoided. For work injury follow-up care appointments, the patient should be seen as close to the scheduled time as possible. Employers expect the patients to be seen at the time of their appointment and be back to work quickly.

Additional communication about the patient should occur in a number of other circumstances:

- The employer should be notified every time an employee misses a clinic appointment or physical therapy session. Noncompliance with the treatment protocol can mean either the patient is feeling better and does not want to continue treatment, or the patient is noncompliant, which will result in a delay in resolving the case. In either situation, the employer needs to know.
- The employer must be able to communicate with the clinic in an efficient way. Establishing a separate occupational medicine client phone line is one way to avoid having your clients get caught up with general questions such as directions or hours of operation. Having a skilled person from your clinic at the other end ready to answer such questions as the employee status, prospects for full duty or modified duty, the time of the next appointment, or other information is essential. You can be sure that if your client spends more than a short time on hold, you will hear about it quickly.
- For large employers, assign a single contact person within your organization. It's a great comfort to your clients to

be able to know an individual in your organization on whom they can depend to get the information they want in a timely and friendly way.

Finally, understanding the services and accommodations the employer needs is the first step toward fulfilling those needs. Such insights can help you to:

- Set appropriate clinic hours of operation. If your plan is to obtain contracts for businesses that work late shifts or are 24/7, clinic hours and an on-call schedule must be established so that these clients never have a need to look elsewhere for care outside the normal hours of the clinic.
- Offer DOT exams. Many transportation companies need an occupational clinic that can turn around their DOT exams quickly. Be prepared to train your staff and have physicians and other providers who are DOT-certified. If needed quickly, the clinic may need to pay for the training and certification process for their providers.
- Work to be a one-stop shop. Additional services such as physical therapy, a broad range of drug testing, and on-

“Understanding the services and accommodations the employer needs is the first step toward fulfilling those needs.”

site specialists such as orthopedists will be appreciated by clients who need those services—and discourage them from looking for another occupational medicine clinic.

We’ve discussed a number of ways clinics can serve their clients so these businesses never have a need to look elsewhere for occupational medicine services. As each clinic matures in occupational medicine, these will become second nature and part of a comprehensive program that stresses client satisfaction, resulting in business partnerships that are beneficial to both sides for years to come. ■

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- **January 2017:** Ralph Mohty, MD, MPH and Michael Esmay, MD submit an article on a real-life patient for consideration in our Case Report department
- **May 2018:** Drs. Mohty and Esmay are bestowed with a Silver Award in the American Society of Healthcare Publication Editors 2018 Awards Competition—the 15th time *JUCM* has taken home a prize in our history

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The Finer Points of Video Surveillance in an Urgent Care Center

Urgent message: The increasing use of video surveillance in urgent care requires an awareness of the risks and restrictions of such systems used for patient and employee safety.

■ ALAN A. AYERS, MBA, MAcc

Security is one of the most significant concerns in the operation of an urgent care facility. In this instance, it's not data security or HIPAA compliance, but rather the physical security and safety of employees and patients that leads some operators to install surveillance systems. In doing so, it's essential to recognize both the benefits and the potential risks involved.

Benefits

A digital video surveillance system can capture images and videos stored or delivered offsite via a communication network.¹ Typically, these systems allow for recording via a digital video recorder (DVR) for archiving and the review of specific time frames and incidents. Plus, now with smart technology, many video surveillance systems have the ability to live "stream" footage and to be managed from a mobile device.

A digital video surveillance system can be used to safeguard employees and patients, and to deter theft or other unwanted or illegal behavior.

Urgent care centers in larger communities may have issues with unwelcome solicitors, vagrants, or potential criminals.² Whether by a simple IP (internet protocol) camera network or a more elaborate CCTV (closed circuit television) set-up, an urgent care center will see the benefits in employee and patient safety.

A digital video surveillance system gives an urgent care operator the ability to remotely monitor a center and provide evidence for investigations into crimes and safety incidents. In addition,

there is an operational benefit of implementing a system, as managers and owners can monitor customer service flow and wait times, as well as employee productivity and behavior.³

Legal Considerations

There are special considerations that exist for the use of video surveillance in healthcare settings when compared to another retail property or service environments. The primary legal concern is *patient privacy*. For example, a California healthcare facility may have violated HIPAA when it released video surveillance footage to an attorney. In that case, the hospital placed *hidden* cameras in the operating room. Neither the staff nor the patients were notified of surveillance cameras in use to record surgical procedures.⁴ Although the administration installed the cameras in an attempt to thwart drug theft by doctors and staff, the surreptitious way in which the hospital used the surveillance system resulted in legal problems, both in terms of civil liability and state and federal agency investigation.^{5,6} Such conduct may result in the imposition of sanctions by the Health and Human Services Office of Civil Rights for HIPAA infractions.

The laws of California, New York, and Rhode Island prohibit hidden video cameras in locations where individuals expect complete privacy, and Connecticut and Delaware statutes require businesses to notify employees and customers of video cameras in bathrooms and changing rooms.⁷

Other privacy concerns

Beyond HIPAA, patients who visit an urgent care center have a reasonable expectation of privacy in a public place.

Likewise, staff members also have privacy rights. Surveillance cameras should be placed only in common or public areas, such as the facility lobby, hallways, and other public spaces like en-



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trances and parking lots. Cameras should not be placed in treatment rooms, offices, conference rooms, and break areas.

While video surveillance may be helpful in monitoring staff behavior, owners should recognize that employees still have privacy expectations at work. To that end, cameras at the entrance may be permitted to monitor employees on smoke breaks or at the reception area to observe their interactions with the public, but surveillance cameras in treatment rooms, break areas, and bathrooms will certainly run afoul of state law.

Using a surveillance system that records audio may also be considered eavesdropping or wiretapping, depending on the circumstances of the conversation.⁸ Many states make a distinction between audio and video recordings, requiring “dual consent,” or permission from the person being recorded, before audio recording is permitted.

Another concern for owners of urgent care facilities is whether there is a requirement for signage where video surveillance is being used. Typically, video surveillance systems that are used by businesses are coupled with a video surveillance notice (for example, a sign saying “All activities monitored by video surveillance”). However, there is little guidance from state and federal governments on the issue of notification.⁹ Currently, a business owner is not legally required to post these signs for public area surveillance.¹⁰ But note that posting signs will not excuse an urgent care owner from liability for installing cameras or video recording in areas or circumstances where it’s prohibited by law.

Risks of Video Surveillance

There are several risks with implementing a video surveillance system in an urgent care facility. Owners and operators should recognize these and plan their security programs accordingly.

Access to the footage should be limited to key personnel, such as the owner, HR manager, and operations director. As with electronic medical records and other health and business information, access should be based on a demonstrated need, and only to the specific footage needed to address a patient, safety, or compliance concern. Access should be via a company device on a secured network. Any other personal access to either the live stream or archived footage should be restricted. Access privileges assigned to one individual may not be delegated to anyone else, and dual presence should be considered when reviewing archived footage.

Video surveillance can be a critical component of an urgent care’s security plan; however, it should not be a substitute for physical security on the premises. Owners run the risk of an overreliance on technology, and they shouldn’t be tempted to eliminate other security policies and procedures in place, ranging from physical locks to hired security guards.

Other technological issues may be concerns. They include people tampering with security cameras—repositioning camera

“While video surveillance may be helpful in monitoring staff behavior, owners should recognize that employees still have privacy expectations at work.”

angles, erasing stored footage, and damage to the systems hard drive and other components. Urgent care owners should take steps to physically safeguard the system to be certain of an uninterrupted signal.

Finally, circuitry, the internet, and smart technology all are susceptible to bugs, power outages, software glitches, and other anomalies. A back-up system and redundancies can help an urgent care center maintain uninterrupted monitoring and recording of its operations.

Takeaway

While there are some laws concerning video surveillance, much of its use centers upon common sense and reasonable privacy expectations for urgent care employees and patients.

An urgent care center may consider creating a written policy and informing its employees about the existence of cameras. Frequently, this type of notice will defeat an invasion of privacy claim, as employees are less apt to pursue such an action if they’ve been warned. ■

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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 10-Year-Old Girl with Foot Pain After Falling from a Tree

Figure 1.



Figure 2.



Case

A 10-year-old girl presents with pain after falling from a tree, landing on her right foot. On examination, the pain emanates from the second through fifth metatarsals and proximal phalanges.

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

THE RESOLUTION

Figure 1.



Mediastinal
air

Differential Diagnosis

- Fracture of the distal fourth metatarsal
- Plantar plate disruption
- Sesamoiditis
- Turf toe

Diagnosis

Angulation of the distal fourth metatarsal metaphyseal cortex and hairline lucency consistent with fracture.

Learnings/What to Look for

- Proximal metatarsal fractures are most often caused by crushing or direct blows
- In athletes, an axial load placed on a plantar-flexed foot should raise suspicion of a Lisfranc injury

Pearls for Urgent Care Management and Considerations for Transfer

- Emergent transfer should be considered with associated neurologic deficit, compartment syndrome, open fracture, or vascular compromise
- Referral to an orthopedist is warranted in the case of an intra-articular fracture, or with Lisfranc ligament injury or tenderness over the Lisfranc ligament

Acknowledgment: Images courtesy of Teleradiology Associates.



A 55-Year-Old Man with 3 Hours of Epigastric Pain

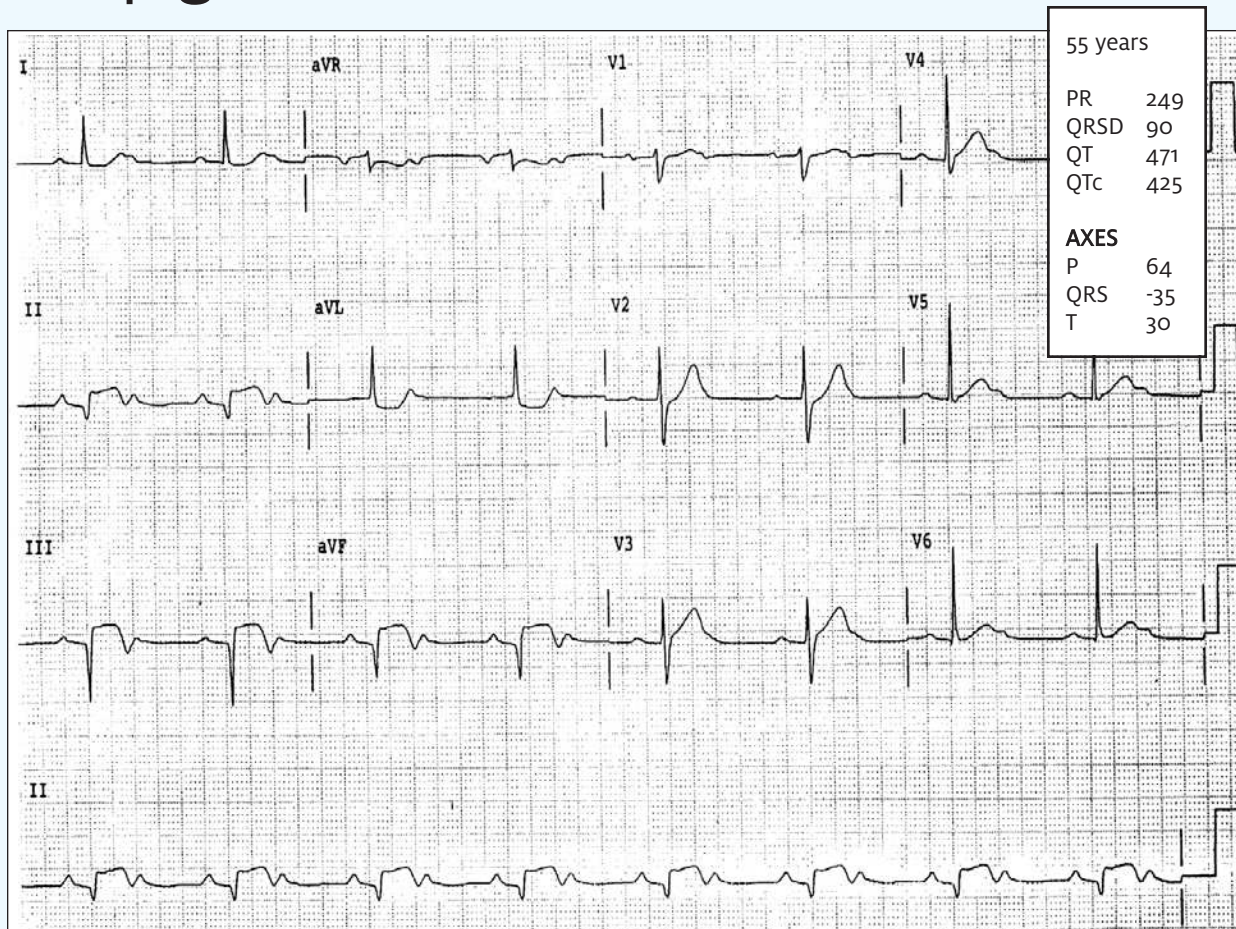


Figure 1.

Case

A 55-year-old man presents to urgent care with 3 hours of epigastric pain which began gradually and is constant. He has associated diaphoresis and minimal dyspnea. There is family history of hypertension and high cholesterol. Personal medical history is significant for diabetes mellitus and hypertension. The patient reports that he stopped smoking 2 years ago.

Upon exam, you find:

- **General:** Alert, breathing comfortable, skin clammy
- **Lungs:** CTAB

- **Cardiovascular:** RRR, without m,r,g
- **Abdomen:** Soft and NT, no distention, without r/t/g, 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

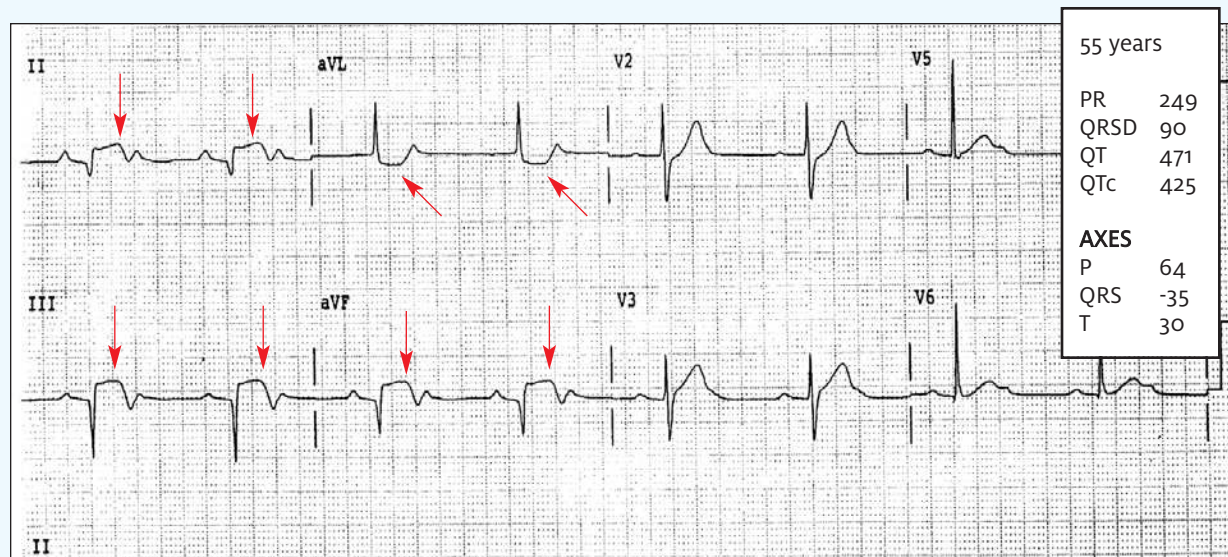


Figure 2. The downward facing arrows show the ST elevation indicating an inferior STEMI. The upward facing arrows highlight the reciprocal changes in lead aVL.

Differential Diagnosis

- Atrial fibrillation
- Multifocal atrial tachycardia
- Third-degree AV block
- Inferior STEMI
- Wolff-Parkinson-White syndrome (WPW)

Diagnosis

This patient has an inferior STEMI.

This ECG is normal sinus rhythm, with a P wave preceding each QRS. The normal PR interval is 120-200 ms; this PR is prolonged at 249, consistent with first-degree AV block, a generally benign finding. But that is only an incidental notation on this ECG, as there are major abnormalities in the ST segments inferiorly.

The inferior leads, II, III, and aVF, are limb leads which reflect changes at the inferior aspect of the heart, typically with blood supply from the right coronary artery. Further confirming the diagnosis is ST depression in lead aVL, called a reciprocal change, increasing the concern for inferior STEMI.

Atrial fibrillation is an irregularly irregular rhythm without defined p waves, not present on this ECG. Multifocal atrial tachycardia is often present in patients with COPD, and though irregular and fast, there is a p wave preceding each QRS. Third-degree AV block is confirmed with P waves which are not associated with the QRS complex, usually with a rate in the 30s. WPW is defined by a short PR segment (not present here) and

a delta wave which is a gradual upsloping of the initial reflection of the QRS complex, often seen in the lateral precordial leads such as leads V5 and V6.

This ECG shows an inferior STEMI with reciprocal changes as well as first-degree AV block.

Learnings/What to Look for

- Patients with inferior ischemia or STEMI may present with epigastric pain, as opposed to chest pain
- In patients with epigastric pain, inquire about associated symptoms of ischemia/infarction such as diaphoresis, dyspnea, radiation, exertional discomfort, or vomiting
- Reciprocal changes will help to confirm the diagnosis of STEMI, but lack of reciprocal changes does not exclude the diagnosis of STEMI

Pearls for Urgent Care Management and Considerations for Transfer

- All patients presenting to the urgent care with STEMI will need emergent transfer to an ED with capability to perform percutaneous coronary intervention
- Inform EMS that the patient has a STEMI to facilitate rapid arrival
- While awaiting transfer the patient should be monitored, ACD at bedside (if available), and 1-2 IVs placed
- Provider-to-provider contact should optimally occur with the receiving facility and a copy of the ECG sent



A 2-Year-Old with a Nodule on His Face— and Other Concerning Symptoms

Figure 1.



Case

A mother and father bring their 2-year-old son to your urgent care center because of a smooth nodule on his face, which they noticed the previous day. They also reveal they noticed a small lump on his testicle about a week ago, and that they've been going through diapers faster than usual because he seems to be urinating more frequently over the past few days.

View the photo taken, 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**

- Neuroblastoma
- Merkel cell carcinoma
- Rhabdomyosarcoma
- Epidermoid cyst

Diagnosis

This boy has a rhabdomyosarcoma (RMS), a malignant mesenchymal tumor of skeletal muscle derivation. Though rare in adults, it is the most common soft tissue carcinoma in children and adolescents.

Learnings

- Primary cutaneous RMS most often occurs due to invasion from deeper structure or a frank metastatic event; secondary cutaneous RMS represents advanced disease with a poor prognosis

- RMS can occur anywhere in the body, but is more likely to originate in the head and neck; the urinary system (including the bladder); the reproductive system; or the arms and legs
- Genetic syndromes and maternal factors associated with childhood RMS include parental cocaine and marijuana use, Li-Fraumeni syndrome, neurofibromatosis type 1, Beckwith-Wiedemann syndrome, and Costello syndrome

Pearls for Urgent Care Management and Considerations for Transfer

- Emergent transfer is not necessary, but immediate referral to the child's pediatrician is advisable. Ultimately, the child should be seen by a pediatric oncologist as soon as possible

Acknowledgment: Images courtesy of VisualDx.



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Navigating the Credentialing Process to Maximize Revenue and Minimize Denials

■ DAVID E. STERN, MD, CPC

Q. What is the best way to get my practitioners credentialed with various insurance companies and networks? It is frustrating to try and navigate this convoluted process. I am asked by each insurance company to complete a mound of paperwork and collect a stack of supporting documents for each practitioner. Then I wait *months* for approval notifications and effective dates. As a result, we end up losing some patients because they want to be treated at medical offices where their in-network benefits will apply. If we do treat patients with an out-of-network provider, claims will be either denied or paid at a reduced rate. We can't afford a loss in revenue and we can't afford to lose patients!

A. Credentialing can be a frustrating experience if you are not familiar with the process, especially with provider turnover in the urgent care setting. It is not just physicians (MDs and DOs) that must be credentialed in most cases. Depending on specific insurance company or network (payer) requirements, you might also need to credential advanced care practitioners (ACPs), chiropractors, and therapists including behavior health specialists. The National Committee for Quality Assurance (NCQA), an organization that manages provider and facility credentialing bylaws, states that an insurance company or network can require credentialing for any "...licensed practitioner certified or registered by the state to practice independently and provide care to members...." Alternately, the payer may, to your benefit, allow credentialing for your facility where all providers are covered under the contractual arrangement—generally not requiring a separate application process

for your individual practitioners. It is advisable to verify the specific process with each payer entity.

Documentation

The paperwork required for credentialing practitioners can be overwhelming, as the list of documents seems almost endless. Listed below is just a small sampling of the supplemental documents required to accompany a practitioner credentialing application before submitting to a payer:

- Copies of diplomas
- Curriculum vitae
- Copy of medical and Dangerous Substances certificates
- Work history
- Proof of professional liability insurance
- Negative actions (including investigation, charges, limitations, sanctions, etc.) against the provider's license or regarding DEA, board status, hospital privileges, medical society, faculty status, professional association, applicable narcotic registration, etc.
- Copies of current NPDB and HIPDB results
- Exclusions from Medicare and/or Medicaid
- Full description of clinical services that will be performed
- Accreditations and certifications
- Clinical Laboratory Information Act (CLIA) certificate

State- and Payer-Specific Requirements

Each state and payer has its own specific requirements that you need to know and understand. Caveat: Be prepared for the requirements to change, as the insurance companies have the right to change the process at will. Most changes occur without notification to the facility. Generally, you will discover a change in process when you try to credential your next new practitioner.

Medicare requires an online submittal process via the Medicare Provider Enrollment Chain and Ownership System (PECOS). Other payers may also offer similar systems or web



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“Insurance companies have the right to change the process at will. Most changes occur without notification to the facility, and you will discover a change in process when you try to credential your next new practitioner.”

portals for submitting credentialing applications, but most will require paper applications to be submitted via regular mail.

Once the credentialing application and required supplemental documentation have been received by the payer, the initial aggregation process will begin to ensure that all forms have been properly completed by the practitioner. This process usually takes place 30–45 days from the date the payer receives the credentialing application. However, if a discrepancy is discovered, usually meaning that supporting documents are missing or the application is incomplete, the payer has the right to (and in many cases will) return the application with all supplemental documents back to the provider to start the application process from scratch.

On average, the entire credentialing process will take anywhere from 3 to 6 months. Payer processing timeframes are regulated by NCQA, which allows 180 days to fully process a submitted and completed credentialing application and send the application off to a credentialing committee for approval or denial into the payer’s provider network. Once the application is approved by the insurance company’s credentialing committee, the provider becomes eligible for in-network reimbursement from the payer. However, payers are not diligent in notifying providers of their effective dates. NCQA requires insurance companies or payers to notify providers of the committee’s decision no more than 60 calendar days as of the date a credentialing committee decision has been made. It is quite *rare* for an effective date or approval date to be retroactive, as that would result in back payment on claims for dates of service prior to the credentialing approval date. It is more likely that the effective date or approval date will be 30 days out from the credentialing approval date, but this varies greatly by payer.

Credentialing Denials

Keep in mind that not all practitioners receive approvals from the payer’s credentialing committee. Once in a while you will get a denial, which also means the provider is a nonparticipating provider for an undetermined period of time. Any

claims submitted under that practitioner’s name will be denied. Common reasons for denials include:

- Payer credentialing verifications that do not match what was documented and submitted on the provider application
- Provider failing to release sanctions, limitations, or adverse actions
- Payer unable to verify completion of training program
- Medical malpractice cases showing a trend in clinical negligence
- On occasion there is a misunderstanding and the payer denies a practitioner by mistake

A knowledgeable credentialing professional will go beyond just filing the letter and accepting the denial. Know your provider’s rights and each payer’s appeals process. If the denial remains, the provider may be able to reapply in 1–3 years to be reconsidered into the payer’s network.

Recredentialing

Medicare requires credentialing every 5 years. Most insurance companies and networks require credentialing every 2 years. NCQA requires insurance companies and networks to reevaluate a provider’s credentials every 36 months at the very least. Credentials can be reevaluated sooner, but never later according to the NCQA bylaws; otherwise, payers can lose their NCQA accreditation. Some insurance companies will provide a recredentialing date in the approval letter, through other correspondence, or orally. The majority of insurance companies will not release recredentialing dates, and will require you to keep a look out for a notification email or letter to prompt the completion of the recredentialing process. If you do not respond to the payer’s request for recredentialing in the required timeframe, the provider’s credentialing file will eventually be terminated and claims will start processing as out-of-network until you complete the credentialing process again from scratch.

Storing Credentials

In addition to completing a payer-specific credentialing application, some insurance companies also require providers to

“Having a competent urgent care credentialing specialist handle the process will allow your practice to minimize delays, increase revenue, and raise customer satisfaction.”

maintain and store credentials in the Council for Affordable Quality Healthcare (CAQH) online data collection solution. The provider's uploaded credentials are then pulled by the insurance company to supplement any payer-specific forms that are required. If the credentials are not up to date, providers will be penalized by the payers and their participation will be terminated or suspended. CAQH requires provider information to be updated on a quarterly basis.

Utilizing Uncredentialed Providers

There are some ways you can utilize providers who are awaiting credentialing approvals. Educate your front desk staff on the importance of reviewing patient insurance information and knowing where each provider is in the credentialing process. Most credentialing companies will provide frequent reports detailing updates. If your urgent care center has more than one provider concurrently working in the clinic, then the staff can use this information to match noncredentialed providers with patients who are:

- Members of plans where the provider is credentialed
- Self-pay patients
- Occupational medicine clients

- Members of insurance plans that do not require an approval process prior to treating patients

Regardless of credentialing status, always be upfront with the patient. Depending on your situation, you could offer to work out a payment plan or some other option for those patients being seen by a noncredentialed provider. However, ensure the payer allows this type of arrangement and immediately notify your biller.

Have an In-House Expert

With the headaches, losses in revenue, and patient dissatisfaction at stake, it is highly recommended that you partner with a credentialing expert who can navigate this process. You will want someone who is familiar with the nuances of each payer, has personal contacts with each insurance company to solve problems quickly, and understands NCQA bylaws and provider rights. The alternative is to hire an employee dedicated to credentialing and ongoing recredentialing for your group of practitioners. Having a competent urgent care credentialing specialist handle the process will allow your practice to minimize delays, increase revenue, and raise customer satisfaction. ■

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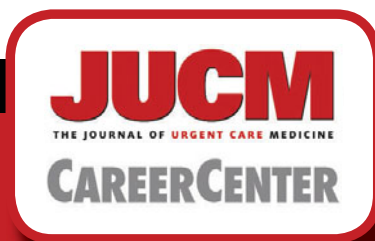



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Can Urgent Care and Advanced Practice Providers Fill the Void as PCP Numbers Dwindle?

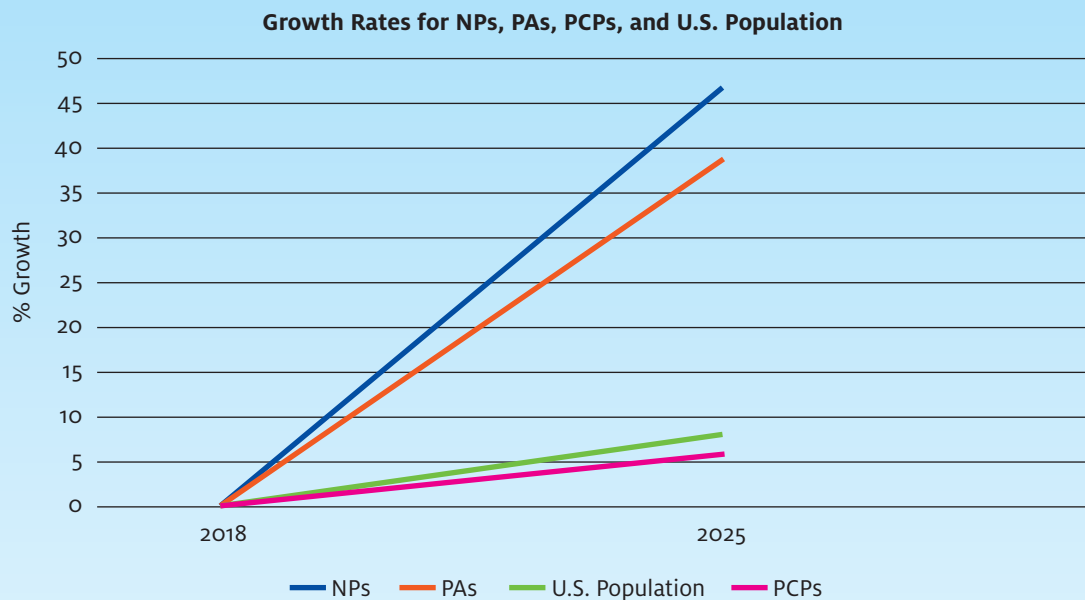
The much-discussed shortage in primary care physicians isn't going to get any better over the coming decades. In fact, it's probably going to get a lot worse—and urgent care is likely to play a significant role in mitigating the risk for the U.S. population, according to a new report from UnitedHealthGroup.¹

The problem isn't that fewer physicians are committing to primary care as a career choice; their ranks are actually expected to grow by 6% between now and 2025. However, the U.S. population is growing at a faster rate so the shortfall that exists today (18,000 too few PCPs) is expected to widen

to 49,000. If those figures hold true, a PCP with a typical patient panel would have to offer preventive, chronic, and acute care for 17.4 hours every day to meet demand.²

The answer, according to UHG, lies in the continued growth of “innovative delivery models” (defined by UHG as urgent care, retail clinics, and in-home clinical visits), in which advanced practice providers—primarily nurse practitioners and physician assistants when it comes to urgent care—will play an increasingly vital role. Fortunately, their growth is expected to outpace that of the patient population substantially (see below). ■

KEEPING PACE WITH PATIENT POPULATION NEEDS



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1. UnitedHealthGroup. Addressing the Nation's Primary Care Shortage: Advanced Practice Clinicians and Innovative Care Delivery Models. Available at: <https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2018/UHG-Primary-Care-Report-2018.pdf>. Accessed January 10, 2019.
2. Bodenheimer T, Pham HH. Primary care; current problems and proposed solutions. *Health Aff.* 2010;29(5):799-805.

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