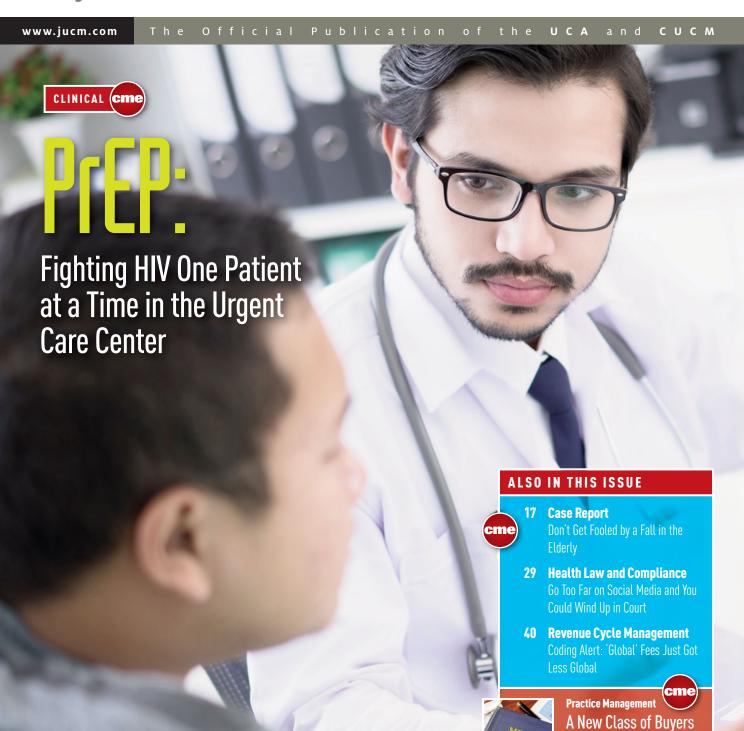


MARCH 2019 VOLUME 13, NUMBER 6





Is Shaking Up the Acquisition Market





Sofia 2 Lyme FIA: **CLIA-waived Results in minutes**, not days.

With the incidence of Lyme disease on the rise and children among those most commonly affected, parents want answers – fast. It doesn't help that current testing options may take hours or days for results. Not anymore! Sofia 2 Lyme FIA uses a finger-stick whole blood sample to provide accurate, objective and automated results in as few as 3 minutes, getting doctor and patient on a path to treatment much sooner.

Sofia 2 Lyme FIA is the only rapid, near-patient testing solution that provides IgM and IgG differentiated results in a single test. It has demonstrated accuracy comparable to laboratory testing – all with less than 1 minute hands-on-time. And with the power of Virena, you will have near real time prevalence data and incidence mapping for your area providing greater information and allowing for better healthcare decisions.

To find out how to get ready for Lyme Season with our **CLIA-waived Sofia 2 Lyme FIA**, contact Quidel Inside Sales at 858.431.5814









Sofia2Lyme.com



LETTER FROM THE EDITOR-IN-CHIEF

I'm Not a Lawyer, But I Play One...

■ LEE A. RESNICK, MD, FAAFP

ike many of you, the fear of a medical malpractice claim casts a wide shadow over everything I do. Like most of you, my intent is always to do no harm and provide the best care possible for every patient despite significant challenges. And like all of you, I wonder how we got to a place where any level of inaccuracy or misjudgment became a breach of the standard of care. While some reforms have been enacted to reduce the burden and exposure of medical liability, we still practice in an environment that expects near perfection despite the fact that this goal is unachievable. We are still judged and punished on our imperfections regardless of intent or any objective definition of negligence. This is a shame.

So, when is a mistake in judgment, an error of omission, or miscalculation considered to be negligent, and why? How does the law define "negligence" and "standard of care," and when should a mistake be "acceptable" vs punished? Let's start with some legal definitions:

Standard of care: The standard of care is linked to the legal concept of "custom." It is most easily described as a customary way of doing things safely. "Customary" practice has also been defined as "reasonable" or "expected" relative to other providers with similar experience and training.

Negligence: Negligence and liability are a little bit different. Negligence requires four legal elements be met: duty, breach of duty, harm, and causation. Duty is aligned with the standard of care; breach is falling below that standard; harm is "injury" or consequence; and causation relates to the connection between the breach and the harm.

While these definitions may all seem reasonable, there are many inherent problems. First, there is little agreement and even less consistent application of the term of "customary." Is this a "minimal" standard, a reasonable standard, or a usual standard? Who decides? If two experts disagree about the standard (which, in the course of litigation, they always do), who



Lee A. Resnick, MD, FAAFP is chief medical officer, WellStreet Urgent Care; assistant clinical professor, Department of Family Medicine, Case Western Reserve University; and editor-in-chief of *JUCM*.

"The system should focus more on cases of alleged misconduct than trying to adjudicate standards of care."

breaks the tie? Well, in practical terms, it's the jury that decides (or in the case of settlement negotiations, the *threat* of a jury decision). And how do juries decide you may ask? Well, based on which expert they believe and what they think the standard *should* be. Of course, all this is a very flawed, and profoundly unfair way to confer negligence and apply punishment.

Consider this example: Most physicians would agree that a patient with a chief complaint of chest pain should have an EKG. And most would agree an EKG is standard when the chief complaint is shortness of breath and chest pain is identified in the review of systems.

But what if the chief complaint is cough and chest pain is associated? This example is less clear. If the provider diagnosed pneumonia and the patient died of a myocardial infarction, does the failure to order an EKG breach the standard of care? The jury will hear this from plaintiff's counsel: An EKG is such a simple and inexpensive test and would have more likely than not identified the patient's heart attack. And since the patient presented with chest pain, why not rule out the most threatening cause? The defense expert can only counter with lectures on pretest probability and the risk of false positives that lead to unnecessary testing and complications. Of course, the jury already knows the outcome, and the emotional plea is always more compelling than statistics.

It seems to me that the system should focus more on cases of alleged misconduct (eg, practicing while impaired) than trying to adjudicate standards of care. An insurance pool could exist to compensate patients for mistakes and misjudgments and these cases should be heard by a panel of unconflicted experts rather than juries. We should limit the trauma of jury trial and punitive damages to more obvious neglect of duty. This would reflect true reform and remove an unfair burden from the thousands of dedicated, well-ntentioned and "imperfect" providers.

AC400

General Radiographic Systems

Compact & configurable design • Full featured & DR compatible Economical & low cost of ownership • Industry leading warranty







FRS | Floor Rail System

Multi-purpose Radiographic System

Minimal space requirement – ideal for Ambulatory Care environments

Configurable to meet facility needs • Ease of use – optimize workflow & productivity

Broad examination capability • Industry leading warranty



The Official Publication of the UCA and CUCM

March 2019 | VOLUME 13, NUMBER 6



CLINICAL

11 Initiating PrEP Services in Urgent Care

Offering preexposure prophylaxis (PrEP) against HIV is a relative rarity in urgent care. As such, clinicians may lack experience with it, as well as an informed perspective on why it can be an ideal setting—for the patient, the public, and the operator.

Yeow Chye Ng, PhD, FNP-BC, NP-C, CPC, AAHIVE, Jack J. Mayeux, MSN, APRN, NP-C, and Thuy Lynch, PhD, RN

CASE REPORT

17 Infection Masquerading as a Fall in the Elderly



It's not uncommon for elderly patients to experience falls. Chalking it up to "just one of those things" without sufficient consideration of underlying etiologies can put patients at risk, however.

Kamilah Kelly, MD, MS

PRACTICE MANAGEMENT

25 End Users and Consolidators: The Next Possible Wave of Transactions in Urgent Care



First there were the urgent care entrepreneurs, forging a new trail through the wilderness of primary care. Then private equity caught onto the idea that urgent care could be a great investment. Who are the latest buyers to want to get in on the action?

Corey Palasota, CFA and Emily Schmidt, CFA

HEALTH LAW AND COMPLIANCE

What is the Liability for an Urgent Care Slandering a Competitor on Social Media?



Social media can seem like a battleground, even for urgent care owners and operators. Going overboard with negative comments about a competitor can be not only off-putting to potential patients, but downright dangerous if those comments are viewed as slander.

Alan A. Ayers, MBA, MAcc

IN THE NEXT ISSUE OF JUCM

Two patients—one an infant and one a teenager—present to urgent care separately with symptoms that could be attributable to pertussis. The course of disease is vastly different between the two. The younger the patient, the greater the risk of severe complications. Older children (and adults, for that matter) who have been previously immunized may have a milder illness, but one that is characterized by the classic "whoop." Assessment and treatment follow suit. Each will be discussed in detail in the April issue of JUCM.

DEPARTMENTS

- 6 Continuing Medical Education
- 9 From the UCA
- 21 Abstracts in Urgent Care
- 33 Insights in Images
- 40 Revenue Cycle Management Q&A
- 44 Developing Data

CLASSIFIEDS

42 Career Opportunities

TO SUBMIT AN ARTICLE:

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

JUCM EDITOR-IN-CHIEF

Lee A. Resnick, MD, FAAFP

Chief Medical and Operating Officer, WellStreet Urgent Care Assistant Clinical Professor, Case Western Reserve University.

Department of Family Medicine

JUCM EDITORIAL BOARD

Alan A. Ayers, MBA, MAcc

CEO, Velocity Urgent Care

Jasmeet Singh Bhogal, MD

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

Tom Charland

CEO, Merchant Medicine LLC

Jeffrey P. Collins, MD, MA

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

Tracey Quail Davidoff, MD

Attending Physician Rochester (NY) Regional Health Immediate Care

Thomas E. Gibbons, MD, MBA, FACEP

Lexington Medical Center Urgent Care President-Elect, Columbia Medical Society

William Gluckman, DO, MBA, FACEP, CPE, CPE, FCUCM

CEO, FastER Urgent Care

David Gollogly, MBChB, FCUCP (New Zealand)

Chair, Royal New Zealand College of Urgent Care

Glenn Harnett, MD

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

Toni Hogencamp, MD

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

Sean M. McNeeley, MD, MD, FCUCM

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

Shailendra K. Saxena, MD, PhD

Professor, Creighton University Medical School

Elisabeth L. Scheufele, MD, MS, FAAP

Physician, Massachusetts General Hospital Chelsea Urgent Care Physician Informaticist

Laurel Stoimenoff, PT, CHC

CEO. Urgent Care Association

Joseph Toscano, MD

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

Janet Williams, MD, FACEP

Medical Director, Rochester Regional Health Clinical Faculty, Rochester Institute of

JUCM ADVISORY BOARD

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

The University of Arizona

Peter Rosen, MD

Harvard Medical School

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

Harvard Medical School

Kurt C. Stange, MD, PhD

Case Western Reserve University

Robin M. Weinick, PhD

RTI International

UCA BOARD OF DIRECTORS

Sean McNeeley, MD

President

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

Immediate Past President

Richard Park, MD, BS

President-Elect

Shaun Ginter, MBA, FACHE

Treasurer

Lou Ellen Horwitz, MA

Secretary

Joe Chow, MD, MBA

Director

Mike Dalton, MBA, CPA

Director

Max Lebow, MD, MPH

Director

Damaris Medina, Esq

Armando Samaniego, MD, MBA

Director

Jeanne Zucker

Director

Laurel Stoimenoff, PT, CHC



EDITOR-IN-CHIEF

Lee A. Resnick, MD, FAAFP

editor@jucm.com

MANAGING EDITOR

Harris Fleming

hfleming@jucm.com

ASSOCIATE EDITOR, PRACTICE MANAGEMENT

Alan A. Ayers, MBA, MAcc

ASSOCIATE EDITOR, CLINICAL

Michael B. Weinstock, MD

CONTRIBUTING EDITORS

Joshua Russell, MD, MSc, FAAEM, FACEP

David E. Stern, MD, CPC

ART DIRECTOR Tom DePrenda

tdeprenda@jucm.com

BRAVEHEART

PUBLISHING

185 State Route 17, Mahwah, NJ 07430

PUBLISHER AND ADVERTISING SALES

Stuart Williams

swilliams@jucm.com • (201) 529-4004

CLASSIFIED AND RECRUITMENT ADVERTISING Samantha Rentz

samantha.rentz@communitybrands.com • (727) 497-6565 x3322

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.

Publication Ethics & Allegations of Misconduct, Complaints, or Appeals JUCM® expects authors, reviewers, and editors to uphold the highest ethical standards

when conducting research, submitting papers, and throughout the peer-review process. JUCM supports the Committee on Publishing Ethics (COPE) and follows its recommendations on publication ethics and standards (please visit http://publicationethics.org). IUCM further draws upon the ethical guidelines set forth by the World Association of Medical Editors (WAME) on its website, www.wame.org. To report any allegations of editorial misconduct or complaints, or to appeal the decision regarding any article, email the Publisher, Stuart Williams, directly at swilliams@jucm.com

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

Advertising Policy

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

Copyright and Licensing

© Copyright 2019 by Braveheart Group, LLC. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording, or any information storage and retrieval system, without written permission from the Publisher. For information on reprints or commercial licensing of content, please contact the Publisher.

Address Changes

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



JUCM CONTRIBUTORS

sk any urgent care professional if they would like to offer a service that has the potential to be lifesaving while also constituting a public health service and there's no doubt that you would receive a resounding Yes! Now explain that doing so means running a battery of tests to check for possible contraindications, and committing to intensive patient counseling about the dose regimen. Oh, and the coding is a little tricky, too.

Now you might see a few people mulling it over a little more—and you will certainly understand why preexposure prophylaxis (PrEP) services for HIV is a topic worthy of coverage in this month's issue. Read Initiating PrEP Services in Urgent Care and you'll see there's no need to be intimidated. Understanding the steps involved could unlock the door to new revenue streams and offer yet another chance to prove the value of urgent care.

The article by Yeow Chye Ng, PhD, FNP-BC, NP-C, CPC, AAHIVE; Jack J. Mayeux, MSN, APRN, NP-C; and Thuy Lynch, PhD, RN begins





on page 11. The authors all hail from the University of Alabama at Huntsville. Drs. Ng and Lynch are assistant professors and Mr. Mayeux is a DNP student who also practices as a family nurse practitioner at Coastal Urgent Care in Baton Rouge, LA.



Another somewhat tricky topic is the basis of this month's case report. In it, you'll hear about any elderly woman with a history of recent falls. As the title of the article implies, attributing the

events to potential balance problems or dizziness would be a grave mistake. Infection Masquerading as a Fall in the Elderly begins on page 17. We appreciate author Kamilah Kelly, MD, MS, an emergency physician in Elkridge, MD bringing the case to light so we could share it with you.

If you've been in urgent care for any length of time, you know the picture of a "typical" owner is constantly evolving. Whether you're a clinician or on the business side, knowing what's likely to come next is important to your career. End Users and Consolidators: The Next Possible Wave of Transactions in Urgent Care (page 25) by Corey Palasota, CFA and Emily Schmidt, CFA is essential





reading in this regard. Mr. Palasota is director of healthcare transactions and advisory services for VMG Health in Dallas, TX, where Ms. Schmidt is manager of business valuation.

The idea of "what comes next" could be downright perilous if you get involved in a social media beef with a competitor. In What is the Liability for an Urgent Care Slandering a Competitor on



Social Media? (page 29), Alan A. Ayers, MBA, MAcc explains where competitive claims cross the line and become defamatory statements. Mr. Ayers is the chief executive officer of Velocity Urgent Care and the practice management editor of JUCM.





We're also pleased to publish a contribution from Swetha Gogu, **OMSII** of Kansas City University of Medicine and Biosciences and Sud-

hir R. Gogu, DO, PhD, MBA, of Stone Oak Urgent Care and Family Practice and a clinical assistant professor at TTHSC/ UNTHSC/UTHS/UIWSOM in Texas. The pair had a case they thought would be a good ECG-based item for Insights in Images. We agreed; you can read it starting on page 35. (If you'd like to contribute a case, describe it in an email to editor@jucm.com.)

As always, we're also happy to bring you overviews of relevant content in other journals. In this month's Abstracts in Urgent Care (page 21), Joshua Russell, MD, MSc, FAAEM, FACEP



looks at articles concerning the dangers of decision fatigue, whether we really need to treat syncope and near-syncope differently, and more subjects relevant to urgent care.



Finally, in recognition of the fact that staying in business is contingent upon getting reimbursed for the services you provide, **David Stern**, MD, CPC shares news that one of the country's

major insurers is discontinuing a couple of commonly used codes. Make sure you're up to speed by reading Revenue Cycle Management (page 40).

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:

- David Pick, MD
- John Reilly, DO

If you'd like to support the journal—and your colleagues by reviewing articles, please send an email with your CV to editor@jucm.com.



CONTINUING MEDICAL EDUCATION

Release Date: March 1, 2019 Expiration Date: February 29, 2020

Target Audience

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

Learning Objectives

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

Accreditation Statement



This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Urgent Care

Association and the Institute of Urgent Care Medicine. The Urgent Care Association is accredited by the ACCME to provide continuing medical education for physicians.

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

Planning Committee

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

Disclosure Statement

The policy of the Urgent Care Association CME Program (UCA CME) requires that the Activity Director, planning committee members, and all activity faculty (that is, anyone in a position to control the content of the educational activity) disclose to the activity participants all relevant financial relationships with commercial interests. Where disclosures have been made, conflicts of interest, real or apparent, must be resolved. Disclosure will be

made to activity participants prior to the commencement of the activity. UCA CME also requires that faculty make clinical recommendations based on the best available scientific evidence and that faculty identify any discussion of "off-label" or investigational use of pharmaceutical products or medical devices.

Instructions

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

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

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

Estimated Time to Complete This Educational Activity This activity is expected to take 3 hours to complete.

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

Email inquiries to info@jucmcme.com

Medical Disclaimer

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

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

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



CONTINUING MEDICAL EDUCATION

JUCM CME subscribers can submit responses for CME credit at www.jucm.com/cme/. 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.

Initiating PrEP Services in Urgent Care (p. 11)

- 1. PrEP can reduce the risk of contracting the HIV infection by up to:
 - a. 50%
 - b. 75%
 - c. 80%
 - d. 90%
 - e. 99%
- 2. Approved dosing for PrEP is:
 - a. Once daily
 - b. Twice daily
 - c. Dependent on the patient's weight
 - d. Dependent on the patient's age
- 3. Contraindications for PrEP medication use include:
 - a. Positive HIV test
 - b. Concerns for medical adherence (eg, due to mental health issues)
 - c. eCrCl <60 mL/min
 - d All of the above
 - e. Answers a and c

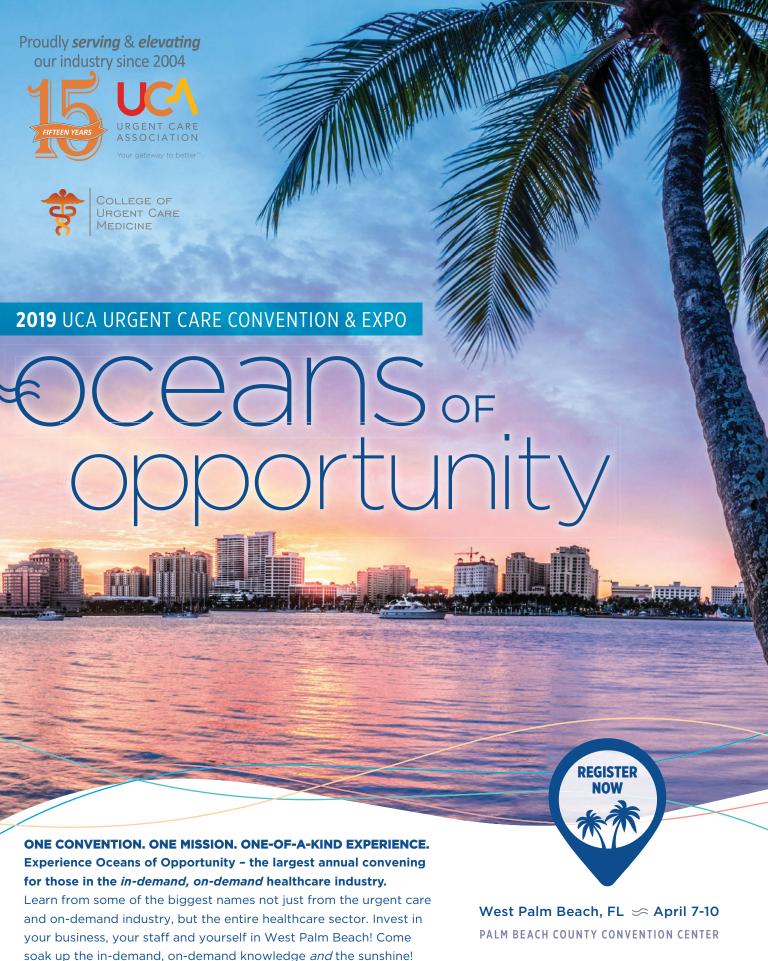
Infection Masquerading as a Fall in the Elderly (p. 17)

- 1. In 2014, what percentage of older adults reported falling?
 - a. 5%
 - b. 29%
 - c. 75%
 - d. 90%
- 2. Which aspects of the evaluation should be performed in elderly patients who have fallen?
 - a. Visual acuity and depth perception
 - b. Look for signs of failure to thrive
 - c. Evaluate the patient for injury and the etiology of the fall
 - d. Assess balance and stability
 - e. All of the above

- 3. Per a study out of Massachusetts General Hospital, which is the most commonly diagnosed systemic infection that coexists in a patient who presented due to a fall?
 - a. Bacteremia
 - b. Lower respiratory tract infection
 - c. Sepsis
 - d. Sinusitis
 - e. Urinary tract infection

End Users and Consolidators: The Next Possible Wave of Transactions in Urgent Care (p. 25)

- 1. Private equity firms tend to operate under investment "time horizons" that typically last:
 - a. 1 or 2 years
 - b. 3-6 years
 - c. 5-10 years
 - d. 10+ years
 - e. An indeterminate period of time, depending on business conditions
- 2. With significant growth opportunity:
 - a. Buyers seek to leverage the existing platform to achieve that growth
 - b. Buyers are generally less concerned with how operations "look" today
 - c. Valuations are directionally higher
 - d. All of the above
 - e. None of the above
- 3. Which of the following is *not* considered a typical motivation for acquiring an urgent care operation?
 - a. Potential level of future earnings
 - b. Future possible "exit" value
 - c. Ability to expand the footprint of the business
 - d. Bringing a self-contained operation into an existing system
 - e. All of the above are considered motivations for acquiring an urgent care operation





FROM THE UCA CEO

The UCA Benchmarking Survey Told Us What Keeps You Up at **Night**

■ LAUREL STOIMENOFF, PT, CHC

The Urgent Care Association's primary responsibility is to support member success, so we elected to formally ask participants in our most recent Benchmarking Survey to rank their top 10 pain points. Not surprisingly, the responses were dominated by reimbursement issues and the associated administrative challenges around credentialing and timely payment.

As on-demand medicine evolves, the scope of care in an urgent care center would logically respond by continuing to distinguish itself from the retail clinics and preparing to offload appropriate patients from the emergency department. This may mean elevating the in-house lab from waived to moderate, preparing to perform more complex procedures, and maintaining an inventory of supplies and medications that support an expanded scope.

Payers tell us this is where they see urgent care providing the greatest value; yet, we hear of increasing global (fixed) reimbursement and other payment options that create a disincentive to expanding the scope of care.

We are also fielding calls about narrowing networks, new centers being denied in-network status, and restrictive contractual clauses that mandate specific staffing models or limit follow-up care. The prohibitions on follow-up care defy logic when considering the substantial percentage of patients seeking care in an urgent care setting who are unaffiliated with a primary care physician (PCP) or traveling and geographically displaced from their PCP. Where, then, are they to go if followup is needed?

The scope of care an urgent care operator elects to provide should be the decision of the operator. Yet those who see a



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

need within their community to add or modify services frequently find themselves facing contractual barriers to stepping into new areas that fall outside the episodic care silo.

We are seeing the industry respond to many of these pressures by lowering its dependence on commercial payers. Operators have done so by offering more cash payment options such as travel medicine, expanding into occupational medicine, and targeting baby boomers now covered by Medicare. UCA recently announced the Gateway2Better Network, a member benefit whereby we shall pursue direct-to-employer contracting through healthcare industry partnerships and other nontraditional pathways.

Let's Look at the Bright Side—Chaos

We actually need some discomfort and chaos in order to continue to innovate and evolve. The late author Michael Crichton always inspired me with his creativity and intellect. In *The Lost* World he wrote about how systems on the edge of chaos innovate to keep the system vibrant, yet stable. But if that system moves too close or too far away from the edge, the result is extinction. It goes on to state "only at the edge of chaos can complex systems flourish." No one can deny that many days, if not most, we feel as though we're on the edge of chaos. We know you're responding to new payment models and forces, and we ask that you reach out and tell us about them. UCA has always sought out opportunities to dialogue with payers. UCA staff, along with our Health & Public Policy and Payer Relations Committees, are committed to elevating our voice in 2019 as a strategic objective.

Join us next month at our Annual Convention & Expo to network with your peers, speak with staff, and hear from a highlevel payer panel. The future of the industry depends on us collectively harnessing chaos. For more information, go to www.ucaoa.org/expo. And learn about UCA's recently released Benchmarking Report at www.ucaoa.org/benchmarking.

IN ALL 50 STATES

QUALITY RADIOLOGY REPORTS

Teleradiology Specialists is licensed to provide urgent care over reads in all 50 states. With our network of more than 90 Board Certified, U.S. Based radiologists, 99.97% accuracy rate and industry leading turnaround times, you will receive an accurate diagnosis to serve your patients quickly.

If you're looking for a new teleradiology partner, we can have you up and running with training and cases tested in 7 days or less. Contact us today to get your free quote and to get started.



info.teleradiologyspecialists.com/covered | 888-779-0544



Initiating PrEP Services in Urgent Care

Urgent message: Urgent care centers may offer opportunities to provide preexposure prophylaxis (PrEP) services for HIV due to large numbers of patients seeking testing and treatment for sexually transmitted infection. In the same sense, the urgent care center may also serve as an important ally in providing referrals for patients not currently linked to primary care services.

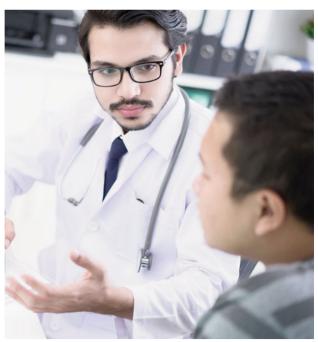
YEOW CHYE NG, PhD, FNP-BC, NP-C, CPC, AAHIVE, JACK J. MAYEUX, MSN, APRN, NP-C, and THUY LYNCH, PhD, RN

Introduction

reexposure prophylaxis (PrEP) services for HIV are not currently offered in a majority of urgent care settings in the United States. Common reasons include the complexity of the treatment protocols and concern about providers being reimbursed for the time spent providing these services. Here, we describe a process for initiating PrEP services and offer a list of service codes providers can use when offering services.

The concept of PrEP was first approved by the U.S. Food and Drug Administration as a medication option to reduce HIV infection. 1,2 Since that time, many primary care clinicians have begun offering PrEP services.³ PrEP is a once-a-day medication regimen recommended for people not currently infected by HIV and who participate in risky sexual behavior. PrEP can reduce the risk of contracting the HIV infection up to 99% if the patient adheres to a strict medication regimen.⁴⁻⁷ Behavioral and lifestyle changes determine the duration of continuum for PrEP care.

Not everyone is considered a likely candidate due to lab testing requirements prior to the initiation of PrEP. Lab tests include screening all prospective patients for sexual transmitted infections (STI); HIV; and hepatitis B and C; and checking for renal insufficiency. It is advisable to ensure that testing for STIs be conducted in a uniform fashion—ie, testing for the same STIs in the same fashion for each patient as indicated. If any of these tests are recorded as positive, the patient will not be able to begin PrEP.8 From 2012 through 2015, it was estimated



that 79,000 people in the U.S. received PrEP services.⁹ PrEP treatment is a vital part of HIV prevention. This

prevention treatment process mirrors other chronic disease management plans in which patients are required to seek follow-up care services, lab evaluations, and medication refills. Guidelines for clinicians who initiate PrEP are widely available from several government agency websites. 8,10,11 Unfortunately, a large percentage of med-

Yeow Chye Ng, PhD, FNP-BC, NP-C, CPC, AAHIVE is an Assistant Professor at the University of Alabama in Huntsville. Jack J. Mayeux, MSN, APRN, NP-C is a DNP student from the University of Alabama in Huntsville. Thuy Lynch, PhD, RN, is an Assistant Professor at the University of Alabama in Huntsville. The authors have no relevant financial relationships with any commercial interests.

Table 1. Suggested Process for PrEP Initiating in an Urgent Care Setting					
	Initial	3-month	6-month	9-month	12-month
HIV test	✓	✓	✓	✓	✓
STI symptom assessment	✓	✓	✓	✓	✓
STI test	✓		✓		✓
Check for side effects	✓	✓	✓	✓	✓
Pregnancy testing	✓	✓	✓	✓	✓
Renal function, CrCL >6omL/min	✓		✓		✓
Prescribe 90-day supply of PrEP	✓	✓	✓	✓	✓
Assess the need to continue PrEP					✓

Source: Up-to-date guidelines for PrEP management, resource management for clinicians, and patient education material. Available at: http://nccc.ucsf.edu/clinicalresources/prep-guidelines-and-resources/. Accessed February 12, 2019.

ical providers (approximately 34%) are not aware of the PrEP treatment process. 12

Due to busy schedules and time constraints, patients are constantly seeking more convenient hours to initiate their medical or follow-up care. For urgent care facilities that operate 7 days a week and have access to in-house lab testing, same-day PrEP services are certainly a feasible option. For facilities that do not offer in-house lab testing, PrEP services can also be considered with scheduled follow-up visits upon verification of lab results.

Studies have revealed a 2.5-fold increase in overall urgent care utilization between 2010 and 2014.13 Within the same clinical setting, researchers reported an increase in requested services for STI testing. STI is considered one of the major risk factors for patients contracting HIV. Treatment and services were sought by patients with an average age of 30 years. This age group also is the third-highest age group to be newly diagnosed with HIV, as presented by a surveillance report from the Centers for Disease Control and Prevention. 14

What You Need to Know Before Offering and Initiating PrEP Services

Know your local community HIV/STD resources

Providers in the urgent care center should establish a collaborative partnership with the local community HIV prevention and treatment facility. Many of these facilities are pioneers in managing HIV and preventive care. They also have resources that could assist the urgent care center in expanding PrEP services. By offering PrEP services, the urgent care setting can meet important community and patient needs. The urgent care facility can accept and accommodate these walk-in patients during off hours.

PrEP treatment protocol

Embracing the current PrEP treatment protocol will provide a seamless transition for patients regardless of which treatment facility they choose to initiate their follow-up care. A majority of HIV prevention centers have adopted the same treatment guidelines from the CDC. Table 1 provides a summary of the recommended laboratory testing prior to initiating PrEP services.

Screening for STIs, initiating PrEP, follow-up testing

Current CDC treatment guidelines and PrEP protocol begin with screening for acute HIV infection and HIV laboratory testing. Additional testing includes screening for STIs and hepatitis B and C, pregnancy testing, and assessment of renal function being at eCrCl >60 mL/min.8

Once PrEP has been initiated, laboratory testing and screening for medication side effects should take place at 1 month with subsequent follow-up and testing being accomplished every 3 months. Testing for STI and assessment of renal function can be delayed for every 6 months, unless otherwise needed. PrEP refills should be limited to no more than 90 days.8

PrEP medications

Currently, within the U.S., the only medication proven safe and effective is a fixed-dosed combination medication containing tenofovir disoproxil fumarate (TDF) 300 mg and emtricitabine (FTC) 200 mg.8 This medication is a once-daily dose recommended for men who have sex with men (MSM), heterosexually active men and women, and people who inject drugs (PWID). While this combination medication is preferred, TDF alone has been proven effective and can be used in PWID and het-

Table 2. Indications, Contraindications, and Adverse Reactions to PrEP Medication Use ^{8,17}					
Indications	Contraindications	Adverse Reactions			
Men who have sex with men (MSM) Uninfected individual with an HIV infected partner Heterosexual individual with multiple sexual partners People who inject drugs (PWID)	 Positive HIV test eCrCl <60 mL/min Concerns for medication adherence like mental health disease or substance abuse Infection with hepatitis B and C should be discussed with specialist before initiation or discontinuation 	Short-term Nausea Abdominal cramping Vomiting Dizziness Headache Weight loss Fatigue Long-term Reduced renal function Reduced bone mineral density			

erosexually active men and women. Only once-daily dosing should be used for PrEP, and no other antiretroviral medications should be used in place of or in addition to TDF/FTC. PrEP should not be provided to any individual who has not undergone necessary testing and is not under the provider's care.

PrEP medication drug interactions

While the effects of PrEP medications, TDF/FTC, have not been studied in combination against other drugs, they have been evaluated individually. 15,16 In studies of TDF, no significant effect or dose adjustment was found necessary when taken with buprenorphine, methadone, and oral contraceptives.

The serum concentrations of TDF and/or the following drugs may be increased, requiring monitoring for dose-related renal toxicities: antivirals, aminoglycosides, high-dose NSAIDs, or other drugs that reduce renal function. Additionally, ledipasvir/sofosbuvir may increase TDF concentrations and will require monitoring for toxicity. FTC currently has no data on any of the medications listed, with the exception of ledipasvir/sofosbuvir, which has no significant side effect.

Side effects of PrEP

- Short-term: Some of the short-term side effects include nausea, abdominal cramping, vomiting, dizziness, headache, weight loss, and fatigue.¹⁷ Many of these side effects present within the first 2 weeks of taking the medication and often resolve within a few weeks.
- Long-term: The two most common concerns with long-term use include changes in renal function and bone mineral density (BMD); however, the actual effect of PrEP on renal function and BMD is unclear and difficult to assess.8,17 Many candidates for PrEP

carry risk factors (eg, substance abuse and lack of exercise) or conditions (eg, diabetes) which can affect their bodily systems aside from PrEP use. Additionally, while antiretroviral medication containing TDF/FTC has been observed to decrease BMD in HIV-infected individuals, it is unclear if this decline would have been observed in HIV-negative individuals and those taking fewer antiretrovirals.8

While many studies have measured the effect of TDF/FTC on renal function, the results are varied concerning the medications' impact. There is a risk of kidney damage, but PrEP trials have shown low rates of creatinine elevations.¹⁷ Due to the risk of kidney damage, the need to monitor renal function throughout the course of PrEP treatment remains vital.

PrEP is not for everyone

Not all patients are candidates for PrEP. This is especially true when medication adherence is a major concern. Occasionally, a provider may also encounter patients who may benefit from mental health services or substance abuse services. In this situation, the provider will need to document in the medical records valid reasons for not offering the patient PrEP. This should be followed by a documented referral made by the medical provider for the patient.

Coding and billing

From a business and professional perspective, the mechanism of reimbursement plays a significant role in how a business entity may choose to offer any medical services. PrEP services are no different. Providers will need to collaborate with their billing department to understand the complexity of lab testing requirements for initiating PrEP. It is also vital to establish a standard template that considers patient work flow and includes the point-of-care lab testing services that are available in the clinic. Detailed documentation is critical to match with services performed.

Commonly used service codes that may be helpful for urgent care providers include:

- Evaluation and management (E/M) coding: New patients: 99203-99205; Established patients: 99213-99214
- Preventive medicine Current Procedural Terminology (CPT) codes: Some patients may benefit from
 - having one-on-one preventive medicine counseling sessions prior to receiving a prescription for PrEP. In such a scenario, the provider may use CPT codes 99401-99404. This is based on the amount of time providers spend with the patient
- Suggested PrEP counseling ICD-10 codes: Z20.2 Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission; Z11.4 Encounter for screening for human immunodeficiency virus [HIV]; Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission
- Prolonged non face-to-face care: In some situations, medical providers may use CPT 99358-99359. This usually occurs when providers receive a reactive test of lab results that require additional time to review and coordinate care for the patient. Such coordination does not require the patient to be present

NASTAD, formerly known as the National Alliance of State and Territorial AIDS Directors, which represents public health officials who administer HIV and hepatitis programs in the U.S. and around the world, has a billing and coding guide for HIV prevention on its website. Providers are encouraged to visit and learn the suggested coding guide (https://www.nastad.org/resource/billingcoding-guide-hiv-prevention).

Patient education

PrEP is a powerful HIV prevention tool. However, PrEP does not protect against other sexually transmitted infections; therefore, patient education should be deliv-

"Entrusted with an important role in HIV prevention, urgent care providers may find both clinically important and profitable opportunities in providing PrEP services."

ered as part of the clinical visit protocol.

Conclusion

Entrusted with an important role in HIV prevention—and due to the large numbers of patients seeking STI testing and treatment in urgent care—providers may find both clinically important and profitable opportunities in providing PrEP services. By the same token, urgent care may also serve as an important ally in providing referrals for patients not currently linked to primary care services. Fostering PrEP

services in the urgent care environment can provide an alternative solution to prevent any missed opportunities for safe and effective HIV prevention.

References

- U.S. Food and Drug Administration. FDA approves first drug for reducing the risk of sexually acquired HIV infection. Silver Spring, Maryland: US Food and Drug Administration; 2012.
- 2. Holmes D. FDA paves the way for pre-exposure HIV prophylaxis. *Lancet*. 2012;380 (9839):325.
- 3. Smith DK, Mendoza MC, Stryker JE, Rose CE. PrEP Awareness and Attitudes in a National Survey of Primary Care Clinicians in the United States, 2009-2015. *PLoS One*. 2016;11(6):e0156592.
- 4. Choopanya K, Martin M, Suntharasamai P, et al. Antiretroviral prophylaxis for HIV infection in injecting drug users in Bangkok, Thailand (the Bangkok Tenofovir Study): a randomised, double-blind, placebo-controlled phase 3 trial. *Lancet*. 2013;381(9883): 2083-2090.
- 5. Baeten JM, Donnell D, Ndase P, et al. Antiretroviral prophylaxis for HIV prevention in heterosexual men and women. *New Engl J Med.* 2012;367(5):399-410.
- 6. Thigpen MC, Kebaabetswe PM, Paxton LA, et al. Antiretroviral preexposure prophylaxis for heterosexual HIV transmission in Botswana. *New Engl J Med.* 2012;367(5):423-434. 7. Grant RM, Lama JR, Anderson PL, et al. Preexposure chemoprophylaxis for HIV prevention in men who have sex with men. *New Engl J Med.* 2010;363(27):2587-2599.
- 8. Centers for Disease Control and Prevention. Preexposure Prophylaxis for the Prevention of HIV Infection in the United States 2017 Update: Clinical Practice Guideline. 2017; https://www.cdc.gov/hiv/pdf/guidelines/cdc-hiv-prep-guidelines-2017.pdf.
- 9. Mera R, McCallister S, Palmer B, et al. FTC/TDF (Truvada) for HIV pre-exposure prophylaxis (PrEP) utilization in the United States: 2013-2015. 21st International AIDS Conference; 2016; Durban, South Africa.
- 10. World Health Organization. Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. In: Organization WH, ed. Geneva; 2015.
- 11. Centers for Disease Control and Prevention. Preexposure Prophylaxis for the Prevention of HIV Infection in the United States 2014 Clinical Practice Guideline. 2014.
- 12. Smith DK, Mendoza MCB, Stryker JE, Rose CE. PrEP awareness and attitudes in a national survey of primary care clinicians in the United States, 2009–2015. *PLOS ONE*. 2016;11(6):e0156592.
- 13. Pearson WS, Tao G, Kroeger K, Peterman TA. Increase in urgent care center visits for sexually transmitted infections, United States, 2010–2014. Emerg Infect Dis. 2017;23(2):367-369. 4. Centers for Disease Control and Prevention. HIV Surveillance Report, 2015. Vol 272016. 15. Gilead Sciences. Highlights of Prescribing Information: Truvada. 2018.
- 16. Hall AM, Hendry BM, Nitsch D, Connolly JO. Tenofovir-associated kidney toxicity in HIV-infected patients: a review of the evidence. *Am J Kidney Dis*. 2011;57(5):773-780.
- Mascolini M. Weighing risks of TDF/FTC side effects in people without HIV. Winter 2012. Available at: http://www.thebodypro.com/content/72567/ weighing-risks-of-tdfftc-prepside-effects-in-peop.html. Accessed February 12, 2019.



Identify your patients today and link them to care





Simple

Rapid antibody test results in 20 minutes

Accurate

- HCV: >98% accuracy; clinical performance equivalent to lab EIA
- HIV: >99% sensitivity and specificity

Versatile

Ideal for clinical and non-clinical settings



OraQuick® HCV Rapid Antibody Test

 Description
 Item No.

 25/Box
 1001-0181

 100/Box
 1001-0180

 Control
 1001-0182

OraQuick *ADVANCE®* HIV-1/2 Rapid Antibody Test

 Description
 Item No.

 25/Box
 1001-0079

 100/Box
 1001-0078

 Control
 1001-0077



220 East First Street Bethlehem, PA 18015 1-800-672-7873 www.OraSure.com

IFD0054 (rev. 03/17) © 2017- 2011 OraSure Technologies, Inc. OraQuick® and OraQuick ADVANCE® are registered trademarks of OraSure Technologies, Inc.



Syndromic respiratory infection testing now CLIA-waived

The BioFire® FilmArray® Respiratory Panel (RP) EZ uses a molecular syndromic approach to accurately detect and identify a wide range of pathogens—not just Flu A and B. As a healthcare provider, this means your patients can receive the right treatment the first time, potentially leading to higher patient satisfaction and lower costs. And as the name implies, it's easy and can be performed right in your office or clinic.1 1 test. 14 respiratory pathogens. All in about an hour.



BioFire RP EZ Pathogens

Viruses Adenovirus Coronavirus Human Metapneumovirus Human Rhinovirus/Enterovirus Influenza A

Influenza A/H1 Influenza A/H1-2009 Influenza A/H3 Influenza B Parainfluenza Virus Respiratory Syncytial Virus Mycoplasma pneumoniae

Bacteria Bordetella pertussis Chlamydophila pneumoniae

¹ CLIA Certificate of Waiver required to perform testing.

For more information contact +1 801-736-6354 ext. 1947







Infection Masquerading as a Fall in the Elderly

Urgent message: Falls in the elderly may be mechanical or due to an underlying etiology, making the urgent care evaluation tricky. The provider will need to evaluate the sequelae of the fall as well as searching for the hidden cause.

KAMILAH KELLY, MD, MS

Introduction

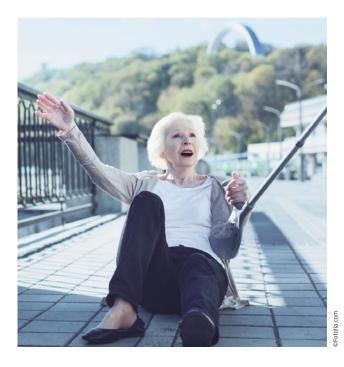
dedical complaints from the elderly population will pose more of a challenge when the chief complaint is *fall*. The source can range from a neurologic etiology, a cardiac abnormality, or a metabolic or endocrine source.

Presentation

BS, an 83-year-old woman, presented with her daughter reporting a 2-week history of falls. She admits to intermittent fatigue, dizziness, and loss of balance, but denies syncope. The daughter reports the last episode occurred at home 3 days ago.

BS denied any numbness or focal weakness, headache, loss of vision, loss of hearing, chest pain, difficulty breathing, nausea, vomiting, diarrhea, fever, cough, abdominal pain, or urinary symptoms.

- PMH: HTN, DM type 2, hypercholesterolemia
- Medications included vitamin D, glipizide, metformin, simvastatin, telmisartan
- Allergies included sulfa
- Social history: No tobacco, alcohol or drug use
- Physical examination:
 - Vital signs: BP 157/78, HR 74, temp 97.7, O₂ sat 97%, resp 12
 - General: A&O, NAD
 - HEENT: NC/AT. PERRL. Neck with painless ROM
 - CVS: Heart sounds normal. No murmurs
 - Resp: mildly decreased breath sounds in the right lung base posteriorly
 - Abdomen: no visible injury. Nontender. Bowel sounds normal. No masses



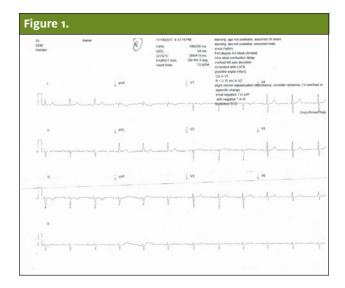
• Skin: Skin intact

- Extremities: Normal inspection. Extremities atraumatic. Normal gait
- Neuro: Oriented x3. No motor or sensory deficit

The following tests were performed:

■ ECG: Normal sinus rhythm. Normal P waves. Normal PRI. Normal QRS complex. Normal axis. Normal QT. T wave inversion in lead III. Prior ECG unavailable for review. (See Figure 1).

Kamilah Kelly, MD, MS is an emergency medicine physician in Elkridge, MD. The author has no relevant financial relationships with any commercial interests.



- **Bedside tests:** Urine dipstick: trace leukocytes; nitrite negative; protein negative; glucose normal; ketones negative; urobilinogen normal; bilirubin negative; trace blood.
- Chest X-ray, PA and lateral: Infiltrate present along the retrocardiac view consistent with pneumonia. (See Figures 2a and 2b).

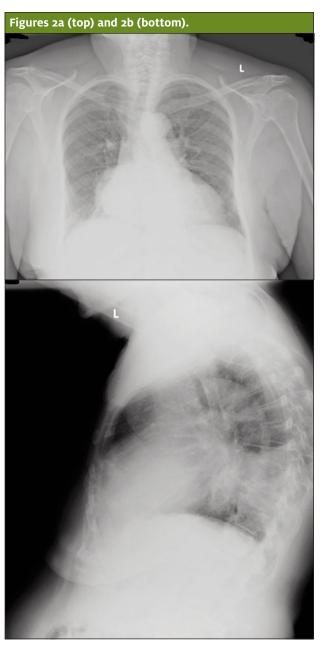
Course and Treatment

The ECG showed T wave inversion only without reciprocal changes; without a prior ECG on file, it was unclear if this was consistent with chronic ECG changes. Due to the lobar appearance of the infiltrate found on chest x-ray, BS was transferred by private vehicle with her daughter to a local emergency room for further evaluation and diagnostic testing.

Discussion

A fall is defined as a person having an accident where he/she comes into contact with the ground or another lower level. A person can strike another object prior to making ultimate contact with the ground, leading to two potential sources of harm; the provider needs to evaluate the patient for injury from the fall, as well as the etiology of the fall.

As the United States population continues to age, medical facilities will evaluate patients in greater numbers over the age of 65. Falls are the leading cause of injury-related visits to emergency departments in the United States² and the primary etiology of accidental deaths in persons over the age of 65 years.³ It is reported that in 2014, 28.7% of older adults reported falling.⁴ Eld-



erly patients, in particular, need a thorough evaluation as related causes of falls broaden when considering both extrinsic and intrinsic factors.

Extrinsic factors include environmental factors such as walking on a surface needing greater postural control and mobility. 1 This also includes when an environment is unfamiliar (ie, a new neighborhood).

Intrinsic factors signify a decline in mobility because of one's age, muscle tone, and balance. Age-related

"Diagnosis can be more challenging due to the fact that the elderly may present later in the course of illness than younger patients."

changes can alter methods involved in maintaining balance and stability while walking, standing, or sitting, and can increase the risk of falls. The elderly can also face impairments with visual acuity and depth perception. Contrast sensitivity and the ability to adapt to darker surroundings decline as one ages. Changes in muscle activation patterns and the inability to produce sufficient muscle power may hinder the elderly's ability to maintain or recover balance in response to uneven surfaces or an object in their footpath.

As urgent care clinicians, our duty is to maintain a high level of suspicion as to why the patient fell, as a fall is often a symptom of serious underlying pathology (eg, infection, electrolyte imbalance, stroke, or cardiac etiology, even when the patient reports a history of a mechanical fall).5 In the urgent care setting, many of us may be limited in our resources for a full diagnostic evaluation in such a patient. Making the diagnosis even more challenging, elderly patients may present later in the course of their acute illness than younger patients.

Table 1 highlights data from a retrospective review completed by Massachusetts General Hospital in Boston, drawn from electronic health records of 161 patients admitted from January 1, 2000 to December 31, 2014. Patients presented with a chief complaint revolving around a fall, were hospitalized, and found to have a coexisting systemic infection (CSI) which may have served as a possible contributing factor.⁶

Of the patients presenting with a fall and CSI during the study period, 85 (52.8%) were female, with a mean age of 76 years (range 35-102).

The researchers noted that CSI in patients presenting with a chief complaint revolving around a fall is commonly associated with bacteremia, is often not clinically suspected, and is associated with a significant in-hospital mortality.6

Findings in other literature support that elderly present to healthcare institutions later in their illness. This factor, along with a low index of suspicion from the clinician and the lack of classic clinical symptoms of infec-

Table 1: Coexisting Systemic Infections Found from Retrospective Review				
Infection	No. (%) of patients			
Urinary tract infections	71 (44)			
Bacteremia	64 (39.7)			
Lower respiratory tract infections (ie, pneumonia)	37 (22.9)			
Sepsis of an unclear source	34 (21.1)			

tion, lead to delayed recognition of severe illness in the elderly.⁷

Summary

Our patient's presentation could have resulted in nothing more than an evaluation for possible injuries from the fall, but a good history and exam were able to localize an infiltrate which was likely the underlying cause of the fall. UTI, as well as infection in the upper and lower respiratory tracts, can be readily diagnosed, leading to at least one source for the infection that can lead to quicker treatment and recovery. This case highlights the importance of our ability as urgent care clinicians to use the resources available to assist in the care of the elderly presenting to us with a chief complaint of a fall.

Take-Home Pearls

- Falls may be a nonspecific presenting sign of an acute illness in patients over 65 years old.
- If the presentation is suggestive of an infection, consider obtaining a urinalysis and/or chest x-ray to rule out infectious sources of falls.
- More than one etiology is often the cause of a fall in the elderly.
- Assess the sequelae of the fall (fracture, strain, contusion), as well as the etiology of the fall (vertigo, imbalance, infection). ■

References

- 1. Rubenstein LZ. Falls in the elderly. Merck Manual Professional Edition. Merck & Co., Inc. Kenilworth, NJ.
- 2. National Hospital Discharge Survey. Vital Health Stat. 1998;13:1-76.
- 3. Xu J, Murphy SL, Kochanek KD, et al. Deaths: final data for 2016. Natl Vital Stat Rep. 2018;67(5):1-76.
- 4. Bergen G, Stevens MR, Burns ER. Falls and fall injuries among adults aged >65 years—United States, 2014. MMWR Morb Mortal Wkly Rep. 2016;65(37):993-998.
- 5. Blickendorf R. Urgent care management of geriatric fall. J Urgent Care Med. Available at: https://www.jucm.com/urgent-care-management-of-geriatric-falls/. Accessed February 10, 2019.
- 6. Durkin M. A new cause to consider in falls: Infections. ACP Hospitalist. 2016 May. 7. Brito V, Niederman MS. Predicting morality in the elderly with community-acquired pneumonia: should we design a new car of set a new 'speed limit'? Thorax. 2010;65(11):944-945.

Recommend MUCINEX®

doctor recommended cough & cold brand*

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





Recommend other leading brands from the RB portfolio

DELSYM® reduces the uncontrollable urge to cough—at the source—and lasts up to 12 hours[†]

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

MUCINEX® Children's Chest Congestion helps keep the mucus moving for children ages 4 to under 12^s



Use as directed.

Give your patients what they need, when they need it!

For more information on how to sell these over-the-counter products at your urgent care center, please contact

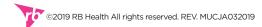
Christina Cuccia: Christina.Cuccia@rb.com/(404) 434-6005

MUCINEX is the #1 Recommended Brand in the Adult Cough/Cold category in the US among the Universe of Physicians (IQVIA ProVoice Survey). MAT 52 weeks through December 2018.

DELSYM* is the #1 physician recommended OTC product in the Adult Cough/Cold category with a 12-hour cough suppressant in the US among the Universe of Physicians (IQVIA, ProVoice Survey). MAT 52 weeks through October 31, 2018.

¹Cepacol* is the #1 Recommended product in the Sore Throat Lozenges category in the US among the Universe of Physicians (IQVIA, ProVoice Survey). Period from June 1, 2017 to May 31, 2018.

⁹MUCINEX* Children's 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

- Decision Fatigue vs Antibiotic Stewardship
- Rethinking Syncope and Near-Syncope
- Blunt Abdominal Trauma in Kids
- JOSHUA RUSSELL, MD, MSC, FAAEM, FACEP

- Is Too Much Made of Biphasic Anaphylaxis?
- Relief for the Retching
- Exacerbations of Asthma in Children

Practice of Urgent Care: More Patients, More **Decisions, More Fatigue**

Key point: We should be aware, as clinicians, that as we progress through our shifts, decision fatigue mounts. One manifestation of decision fatigue is an incremental decline in antibiotic stewardship. It is also important to understand that taking breaks seems to combat the harmful effects of decision fatique.

Citations: Linder JA, Doctor JN, Friedberg MW, et al. Time of day and the decision to prescribe antibiotics. JAMA Intern Med. 2014;174(12):2029-2031. Pignatiello GA, Martin RJ, Hickman RL Jr. Decision fatigue: a conceptual analysis. J Health Psychol. March 1, 2018. [Epub ahead of print]

As we grind our way toward the tail end of another cold and flu season, patient volumes at most urgent care centers remain high. And the more patients we see, the more decisions we have

One study estimated that the average American makes as many as 35,000 decisions every day. And in urgent care, we almost certainly are forced to make even more choices than the average person. Think about your last shift and the multitude of decisions you faced at every step, with every patient. Thousands and thousands of decisions—ranging from mundane to critical—requiring thoughtful consideration throughout the day. Follow-up with primary care or ENT? In 2 days or 3? Or 5? Splint or brace? Order a chest x-ray for this patient with cough or not?

The result of this seemingly endless stream of choices is what cognitive psychologists call decision fatigue: the notion that we (ie, humans) have limited capacity to regulate our behavior and that that capacity wanes each day with every decision we make. Because this is a universally relevant concept to all professions, decision fatigue has been getting an increasing amount of press in recent years. And even if you haven't heard the term, you've certainly experienced its effects. Those moments where you find that your resolve to do the right thing for the patient has been replaced with the temptation to just do the easy thing. That's decision fatigue.

And nowhere in acute care is this temptation greater than when we are faced with the choice of whether or not to prescribe antibiotics for respiratory illnesses. In this 2014 paper, Linder, et al reviewed nearly 22,000 primary care visits for URI symptoms involving 204 different providers. Importantly, they excluded patients with significant chronic disease.

The investigators found that there was a linear increase in the likelihood of a provider prescribing an antibiotic in a situation where antibiotics were "sometimes indicated" and "never indicated" with each passing hour of the work day. By the end of an 8-hour shift, the odds of an inappropriate antibiotic prescription from this group of providers was 26% higher than at the beginning of the work day.

Importantly, antibiotic stewardship did improve somewhat after the providers' lunch break. This suggests that breaks can reduce the harmful effects of decision fatigue (although even after their break, inappropriate antibiotic prescriptions were doled out at a significantly higher rate than at the beginning of the work day).

Treat Patients Who Get Dizzy and Pass Out the Same

Key point: Most clinicians think of near-syncope as a lower risk complaint than syncope. However, patients presenting with syncope and near-syncope have similar rates of short-term morbidity and mortality.



Joshua Russell, MD, MSc, FAAEM, FACEP practices emergency and urgent care medicine, and manages quality and provider education for Legacy/GoHealth Urgent Care. Follow him on Twitter: @UCPracticeTips.

"Avoidance of unnecessary ED referrals and diagnostic radiation in children is an important objective for pediatric patient safety."

Citation: Bastani A, Su E, Adler DH, et al. Comparison of 30-day serious adverse clinical events for elderly patients presenting to the emergency department with near-syncope versus syncope. *Ann Emerg Med.* December 7, 2018. [Epub ahead of print]

Dizziness is among the more challenging complaints to evaluate in urgent care. Patients can feel dizzy for a litany of reasons ranging from the trivial to the life-threatening. However, there is a common tendency among clinicians to treat true syncope more seriously than "simple" lightheadedness. This study should prompt us to rethink that notion.

In this cohort study, the researchers enrolled 3,581 adult patients over age 60 presenting to 11 different EDs over a 3-year period with either near-syncope/lightheadedness or syncope. They then followed these patients to determine the rates of 30-day adverse outcomes between the two groups. There were similar rates of both death (0.9 vs 1.4%) and serious clinical events, such as ACS/MI, arrhythmia, CVA, PE etc. (18.7% vs 18.2%) for both groups in the 30 days following presentation. Based on these results, the authors conclude that the acute care clinician should use the same clinical approach for patients presenting with near-syncope and syncope.

Blunt Abdominal Trauma in Kids? There's a Clinical Prediction Rule for That

Key point: Clinically important intraabdominal injuries (CIIAI) in children, thankfully, are rare. The PECARN prediction rule for children with blunt abdominal trauma (BAT) was 99% sensitive for excluding CIIAIs in this validation study. This decision tool appears to be "ready for primetime."

Citation: Springer E, Frazier SB, Arnold DH, Vukovic AA. External validation of a clinical prediction rule for very low risk pediatric blunt abdominal trauma. *Am J Emerg Med*. November 23, 2018. [Epub ahead of print]

Parents frequently bring children to urgent care centers with all manner of injuries. Excluding intraabdominal injury is challenging without advanced imaging. However, most urgent care centers do not have ready access to CT. Additionally, avoidance of unnecessary ED referrals and diagnostic radiation in children is an important objective for pediatric patient safety.

In 2013, the PECARN group published a prospective study

of more than 12,000 children with BAT. In doing so, they derived a seven-item clinical prediction rule that excluded CIIAI with 97% sensitivity. This more recent external validation study found that the PECARN very-low-risk criteria for children with BAT performed with similarly high sensitivity in this second large group of children with abdominal injuries.

The prediction rule for very-low-risk BAT consists of the *absence* of the following criteria:

- Evidence of abdominal wall trauma or seatbelt sign
- Glasgow Coma Scale score <15</p>
- Abdominal tenderness
- Evidence of thoracic wall trauma
- Complaints of abdominal pain
- Abnormal breath sounds
- Any vomiting

This study included all children 18 years and younger except those with a penetrating mechanism of injury, known pregnancy, and/or preexisting neurologic disorder. Based on these data, if all seven criteria were met, CIIAI was excluded with 99% sensitivity. In such very-low-risk patients, ED referral is unnecessary. Applying the prediction rule for pediatric BAT can prevent unwarranted expense and diagnostic radiation exposure, although few children will actually meet all seven low-risk criteria.

Is Biphasic Anaphylaxis the Boogie Man After All?

Key point: Recurrence of anaphylaxis after the resolution of symptoms appears to be exceedingly rare. When allergic symptoms do recur, cutaneous findings seem to be most common. In this series of patients, airway/respiratory compromise and shock did not occur in the few cases of possible biphasic allergy. Citation: Højlund S1, Søe-Jensen P, Perner A, et al. Low Incidence of biphasic allergic reactions in patients admitted to intensive care after anaphylaxis. Anesthesiology. 2019;130(2): 284-291.

During my emergency medicine training I remember being scolded by one of my gruffer and grayer-haired attendings during a night shift as I was discharging a young woman with resolved anaphylaxis. He was upset that I hadn't warned her that, because of the risk of recurrent anaphylaxis, she needed to have 911 dialed on her phone, ready to send, and an Epi-Pen unsheathed, ready to inject. Historically, this sort of paranoia among clinicians regarding the possibility of anaphylaxis recurring suddenly and unpredictably has been common.

Despite incidences reported as high as 23%, though, I've never seen a case of recurrent, or so-called, "biphasic" anaphylaxis (nor do I know anyone who has). Still, with a concern for such high-risk complications, I've made it a habit to sternly warn all my patients with moderate-to-severe allergic reactions about this phenomenon when I discharge them.

With so much at risk, is your only option.

When it comes to your urgent care endeavor, success is the only option. Why risk that success when you can partner with Urgent Care Consultants for all of your startup or enhancement needs? #WhyRiskIt

Urgent Care Consultants

888-779-0543 | urgentcareconsultants.com/whyriskit



extraordinary

Gus was injured on the job...

Because his employer referred him to an urgent care with Employer Portal, a tool I helped implement, customized business protocols were already in place. Within 25 minutes, Gus received clearance and his employer was automatically informed of his results. I'm proud I played a part in getting Gus back to work.

Kristina, Product Owner

This is one of the many ways Practice Velocity powers extraordinary healthcare experiences. Hear more about this story – and others – at practicevelocity.com/powerextraordinary.

#PowerExtraordinary

Our Solutions

YOUR SUCCESS

Leverage our lending partners to fund your new urgent care.

Why risk funding when Urgent Care Consultants' financial pro forma projects your first seven years of operations? We have solutions for all your startup or enhancement needs. #WhyRiskIt



888-779-0543 | urgentcareconsultants.com/whyriskit

"Prolonged observation periods and ED referrals/admissions for patients whose [anaphylaxis] symptoms have resolved is likely overkill."

This paper has forced me to rethink that practice.

In this retrospective Danish chart review study, 83 patients with severe anaphylaxis requiring ICU admission were identified and followed during a 3-year study period. Of those 83 patients, 4.8% presented again with possible allergic reactions.

All reactions consisted of isolated skin findings. Only one case (1.2%) of possible recurrence was thought most likely due to biphasic allergy rather than another cause. None of the patients died or required rehospitalization.

It is worth noting that 96% of patients in this study were treated with corticosteroids, which are believed to reduce the risk of recurrent allergic symptoms. Based on these data, it's probably still worth mentioning the small possibility of shortterm recurrence of allergic symptoms, but prolonged observation periods and ED referrals/admissions for patients whose symptoms have resolved is likely overkill.

Ohhh, That Smell!

Key point: Inhaled isopropyl alcohol, or "aromatherapy," effectively and quickly controls acute nausea.

Citation: April MD, Oliver JJ, Davis WT, et al. Aromatherapy versus oral ondansetron for antiemetic therapy among adult emergency department patients: a randomized controlled trial. Ann Emerg Med. 2018;72(2):184-193.

Imagine the last patient you had who simply couldn't stop retching. They probably couldn't even talk to you, much less take a pill. All they could do was hold their head down and moan. These patients are not uncommon in urgent care. And while many therapeutic options exist to control nausea and vomiting, for rapid effects, most drugs require parenteral administration and cause significant side effects such as sedation and akathisia.

Over recent decades, ondansetron oral dissolving tablets have emerged as a relatively safe, relatively quick option for mitigating nausea in the acute care setting. However, even ondansetron requires staff to administer the medication and the patient to be able to hold the tablet in their mouth.

Borrowing an established treatment from the anesthesiology literature, isopropyl alcohol has gained increasing attention as an adjunctive treatment for acute nausea in recent years. In this randomized controlled trial, the investigators compared the effects of isopropyl alcohol with ondansetron to isopropyl alcohol with placebo on subjective nausea in 120 adult ED patients. The study included patients with nausea from all causes; however, the vast majority of patients were vomiting due to food poisoning or gastroenteritis.

The researchers measured the patients' nausea on a visual analog scale (VAS) before receiving the treatment they were randomized to and then again at 30 minutes post-treatment. Patients receiving isopropyl alcohol with ondansetron and placebo had roughly equivalent, significant reductions in subjective nausea (30 and 32/100 respectively). Interestingly, there did not appear to be an added benefit of ondansetron above placebo when added to inhaled isopropyl alcohol. There were no adverse reactions reported to inhaled isopropyl alcohol.

Think again about your last miserable patient who was retching uncontrollably. Now imagine simply handing them an alcohol wipe to sniff rather than trying to get them to keep a tablet under their tongue. This strategy appears to be a safe and effective initial treatment for such patients in the urgent care setting and offers a quick fix solution if they arrive while there's a wait

Greatest Hit of the Month: Treating Acute **Exacerbations of Asthma in Children**

Key point: Single-dose oral dexamethasone is not inferior to 3 days of oral prednisolone for children with mild-to-moderate acute asthma exacerbations.

Citations: A randomized trial of single-dose oral dexamethasone versus multidose prednisolone for acute exacerbations of asthma in children who attend the emergency department. Cronin JJ, McCoy S, Kennedy U, et al. Ann Emerg Med. 2016; 67(5):593-601.

Toledo A, Amato CS, Clarke N, et al. Injectable dexamethasone sodium phosphate administered orally? A pharmacokinetic analysis of a common emergency department practice. J Pediatr Pharmacol Ther. 2015;20(2): 105-111.

Increasingly, urgent care is the destination of choice for parents when their child's asthma flares up. Asthma treatment is straightforward and, unless severe, doesn't require many resources. The mainstay of treatment for acute asthma exacerbations, in addition to inhaled, short-acting bronchodilators, has long been systemic corticosteroids.

In children, oral steroids are preferred to minimize the traumatic experience of an injection; however, the horrendous taste of most orally administered glucocorticoids makes the experience only slightly less abhorrent for children. Because of their unpalatability, completion of a full course of oral steroid solution is a challenge even for the most well-intentioned parents. Additionally, multiday dosing of corticosteroids requires the caregivers to fill a prescription, which presents an often-under-

ABSTRACTS IN URGENT CARE

estimated logistical challenge while simultaneously caring for a sick child. If only there were an easier way.

Well, turns out, there is. In a 2016 study, researchers enrolled 226 pediatric patients 2-16 years of age who presented to an Irish ED with mild-to-moderate asthma exacerbations. Children were randomized to receive prednisolone oral solution (1 mg/kg q day, max daily dose 40 mg) for 3 days or dexamethasone oral solution (0.3 mg/kg once, max dose 12 mg).

Between the prednisolone 3-day course and dexamethasone single-dose therapy, there was no difference between the groups for the primary outcome of interest, which was respiratory assessment (PRAM score) at post-ED visit day 4. Additionally, there was no difference in need for repeat ED/clinic visits or hospitalizations between the groups.

Single-dose dexamethasone appears to be an effective and attractive alternative to multiday prednisolone for acute asthma exacerbations in children. Additional evidence suggests that while oral bioavailability of injectable dexamethasone (dexamethasone sodium phosphate) is slightly less than that of orally formulated dexamethasone, it has similar clinical efficacy. Addi-

"Evidence suggests that while oral bioavailability of injectable dexamethasone is slightly less than that of orally formulated dexamethasone, it has similar clinical efficacy."

tionally, injectable dexamethasone has the practical advantage of being a smaller volume for an equivalent dose and is generally felt to be less unpleasant tasting. Furthermore, many urgent care centers do not carry both oral and injectable formulations of dexamethasone and, in such cases, dosing children one time orally with the injectable formulation of dexamethasone is a reasonable practice as complete steroid therapy for children with acute asthma exacerbations.

24 JUCM The Journal of Urgent Care Medicine | March 2019

www.jucm.com



EB-5 Financing Now Available for Your New Construction Medical Project!

Are you planning to build a medical project?

Do you need a construction loan or equity?

☑ Minimum Loan Amount: \$2,000,000

☑ Maximum Loan Amount: None

Over \$100 million raised from 200+ EB-5 investors since 2012



Steve Smith, President (206) 214-8882 steve@EB5CoastToCoast.com

EB5 Coast to Coast LLC www.EB5CoastToCoast.com

Call us today for details!



End Users and Consolidators: The Next Possible Wave of Transactions in Urgent Care

Urgent message: The idea of a "typical" urgent care operation buyer is evolving along with the industry. While private equity has been an essential player in market growth, healthcare organizations with longer-term vision are now more commonly involved in acquisitions.

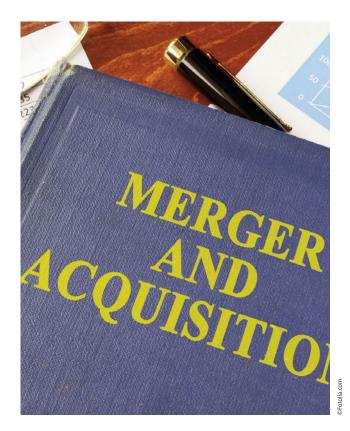
COREY PALASOTA, CFA and EMILY SCHMIDT, CFA

t's no secret private equity (PE) has a played a paramount role in the design, development, and growth of the urgent care industry. Collectively, these firms have invested billions of dollars to create the level of awareness, acceptance, and reliability that is enjoyed by patients across the country.

In the industry's pioneer period, urgent care chain transactions among private equity companies were commonplace. Since PE firms typically operate under 3- to 6-year investment time horizons, it is inevitable that many of these urgent care chains have and will continue to be sold. Today, we find evidence that urgent care chains are increasingly acquired by health systems, managed care organizations, and existing PE-backed portfolio companies (ie, market consolidators). These new buyers are expected to have possibly longer investment horizons and varying transaction motivations.

Table 1 illustrates the evolving nature of urgent care transactions. Earlier in the decade, PE firms generally held their investments for 3-6 years and sought 20%-30% annual investment returns that were largely achieved by expanding the size, scale, and penetration of their urgent care chain. While not all-inclusive, there are currently seven urgent care chains held by a PE firm that could be for sale in the short-term based on this average historical hold period.

As the industry matures, achieving above-average investment gains by opening new clinics can be difficult. Already some markets are highly competitive and appear to be oversaturated with urgent care centers. In



these areas, market participants have complained that de novo (ie, new clinic) volumes are not ramping up as expected, and volumes in established clinics are declining. One market participant in a large city recently com-

Corey Palasota, CFA is Director of Healthcare Transactions and Advisory Services for VMG Health in Dallas, TX. Emily Schmidt, CFA, is Manager of

Business Valuation for VMG Health in Dallas, TX. The authors have no relevant financial relationships with any commercial interest.

Table 1. The Evolving Nature of Urgent Care Chain Investments, 2010—Present ¹⁻⁴					
Year	Target	Locations	Buyer	Holding period	
2010	NextCare Urgent Care	75	Enhanced Equity	8.5 years	
2010	MedExpress	42	General Atlantic	4.5 years	
2010	Urgent Cares of America/FastMed	9	Comvest Partners	4.5 years	
2011	MedSpring	4	Summit Partners	3.5 years	
2011	WellStreet Urgent Care	12	FFL Partners	Current—7+ years	
2012	Urgent Team	5	SV Life Sciences	5.2 years	
2012	MD Now	6	Brockway Moran & Partners	6.3 years	
2012	Hometown	25	Ridgemont Equity Partners	2.2 years	
2012	Physicians Immediate Care	20	LLR Partners/WellPoint	Current—6+ years	
2013	PhysicianOne Urgent Care	14	Pulse Equity	Current—5+ years	
2014	Little Spurs Pediatric Urgent Care	9	Striker Partners	Current—4+ years	
2014	CityMD	8	Summit Partners	3.3 years	
2014	GoHealth Urgent Care	17	Texas Pacific Group	Current—4+ years	
2014	Zoom+Care	23	Endeavor Capital	4.5 years	
2015	Concentra	141	Welsh Anderson Carson Stowe	Current—3.5+ years	
2015	FastMed	14	ABRY Partners	Current—3.5+ years	
2015	CRH Healthcare, LLC	10	MSouth Equity Partners	Current—3+ years	
2016	Med First Immediate Care	13	Sverica Capital Management	Current—2+ years	
2016	Fast Pace Urgent Care	14	Revelstoke Capital Partners	Current—2+ years	
2017	Urgent Team	68	Crestline Investors	Current—1.5+ years	
2017	CityMD	216	Warburg Pincus	Current—<1.5+ year	
2018	Hulin Health	4	Shore Capital Partners	Current—<1 year	
2018	vybe Urgent Care	32	NewSpring Capital	Current—<1 year	
2018	MD Now	27	Brentwood Associates	Current—<1 year	

Sources: Irving Levin Associates – Quarterly Healthcare Merger & Acquisition Reports; Capital IQ announcements; VMG proprietary research through involvement in the transaction; company press releases.

mented, "This market is at a shake-out point." This has led some PE firms to shift their investment strategy, whereby more reliance is placed on acquisitions or consolidations to expand an existing footprint. Table 2 outlines major transactions where urgent care chains were acquired by existing PE-backed urgent care chains.

The introduction of payers and providers as a new buyer class ("end users") accelerated in the latter half of the decade. Previously, payers and providers were monitoring the industry to determine whether urgent care would prove to be a viable new care delivery model. Many health systems started to recognize urgent care as an important access point for patients and a way to gain more integrated exposure to the market. The number of transactions involving this group increased from three major transactions prior to 2014 to eight major transactions after 2014.

Figure 1 summarizes urgent care chain transactions by buyer type. While PE buyers are expected to remain active in the market, clearly there has been a shift toward market consolidators, health systems, and payers.

Of particular note to current owners of urgent care operators, the introduction of a new emerging buyer class (namely, payer/providers and market consolidators) may have valuation implications. When there is significant growth opportunity, valuations are direction-

Table 2. Expansion of Current Footprint or Consolidation: 2010–Present ¹⁻⁴					
Year	Target	Locations	Buyer	Holding period	
2012	Doctors Express	49	The Ensign Group – Immediate Clinic	1.1 year holding period	
2013	Doctors Express	49	American Family Care	Platform expansion	
2013	PrimaCare	11	NextCare Urgent Care	Platform expansion	
2017	U.S. HealthWorks	172	Concentra	Current holding—1+ year (JV)	
2018	STAT Health	8	CityMD	Platform expansion	
2018	MEDcare Urgent Care	7	Urgent Care Group	Platform expansion	
2018	NextCare Urgent Care	251	FastMed Urgent Care	Platform expansion	

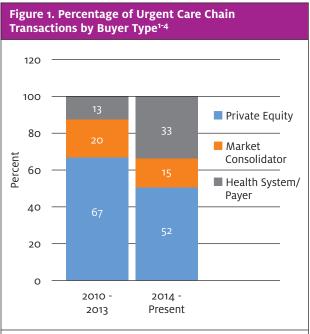
Sources: Irving Levin Associates - Quarterly Healthcare Merger & Acquisition Reports; Capital IQ announcements; VMG proprietary research through involvement in the transaction; company press releases

Table 3. Typical Motivations by Buyer Type			
Market Developer Considerations	End-User Considerations		
Prospective growth/ability to expand footprint	Current existing footprint Current level of earnings		
Potential level of earnings tomorrow	today • Focused on cash flow into		
Focused on future possible "exit" value of business	perpetuity		
Self-contained operations	 Integration with rest of system 		
• "Buy" then expand	• "Build" vs "buy" decision		

ally higher; the buyer is less concerned with how the operations look today (ie, less focus on current profits or operating risks) and more concerned with what the company could become (ie, the ability to leverage the existing platform to achieve growth). If an investment horizon approaches before expected profits are realized, the seller seeks another growth-focused buyer who will appreciate and continue to invest in the company's growth story. This has historically been the "market developer" or PE-to-PE transaction narrative.

Alternatively, when there is less perceived opportunity for growth, valuations are directionally lower. The buyer becomes more concerned with what the organization looks like today (ie, current profits, operating risks, and integration) and less concerned with the ability to leverage the existing platform. End users typically match this buyer profile.

Real differences between urgent care chains and investment strategies are starting to emerge, where some chains have noticeably better prospects than others. As the urgent care industry matures, competition and mar-



Sources: Irving Levin Associates – Quarterly Healthcare Merger & Acquisition Reports; Capital IQ announcements; VMG proprietary research through involvement in the transaction; company press releases

ket saturation may limit the opportunity for de novo growth to fuel expansion. Existing portfolio chains may be pursuing expansion via consolidation or acquisition in certain markets. At the same time, health systems and payers that have been behind the curve are becoming a more represented buyer at auction. Substantially different offers for the same urgent care chains have already been observed, depending on the buyer. For these reasons, the next possible wave of urgent care transactions will likely be diverse mix of buyers with different motivations and outlooks for the same enterprises.

POWEr Extraordinary

Occupational Medicine Portal

- Streamline communications with employers
- Provide accessibility to review and track visits
- Reduce admin time spent responding to inquiries



We #PowerExtraordinary healthcare experiences.

practicevelocity.com/employer-portal | 888-779-0542



HEALTH LAW AND COMPLIANCE

What is the Liability for an Urgent Care Slandering a Competitor on Social Media?

Urgent message: While competition for patients among urgent care operators can be intense, speaking negatively of a competitor online can lead to unwanted liability.

ALAN A. AYERS, MBA, MACC

ompetition between businesses can be intense. In some instances, comparisons between one company and another can lead to disparaging and inaccurate claims. This can result in unneeded liability for an urgent care owner. Here, we examine how the law of defamation in social media applies to urgent care centers and the rights and responsibilities of their owners.

In 2017, the owner of a St. Louis urgent care was sued by a rival urgent care provider for defaming the company on Facebook.¹ The fight between the two centers started innocently with a customer tagging the defendant urgent care in a Facebook post, commenting that they recommended their services. The owner of that urgent care responded with "Thank you. And by the way, we accept Medicaid and we don't CT scan people unnecessarily."

Even though the other urgent care went unnamed, the plaintiff had its attorney send a letter demanding that the defendant delete the posts. That set off the fireworks, and the defendant named its competitor in subsequent inflammatory online statements. The plaintiff obtained a temporary restraining order, and the posts were removed. But the fight escalated, with the plaintiff urgent care bringing an action alleging defamation and tortious interference, and seeking an injunction to bar further posts by the competitor.¹ The plaintiff claimed that its reputation was impacted negatively by the social media posts and sought an un-

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*.

specified amount of damages, attorney's fees, and other costs.²

In addition to a possible defamation claim, urgent care owners may need to defend claims of tortious interference with existing contracts and prospective business relations, unfair competition, and false advertising.

Social Media and Defamation in General

There are two primary kinds of defamation—libel, which is written defamation, and slander, which is oral defamation. When an alleged defamatory statement is made online or through social media—Facebook, Twitter, LinkedIn, Yelp, or another application—it involves the written word. As such, it's libel.³

As opposed to a libelous statement in a newspaper, a social media post creates a bit more complexity because the law depends on several factors:

- The state in which the victim resides
- The state in which the alleged defamer resides
- The "contacts" the defamer has had with the victim's state, if any

The concern here is whether an urgent care owner can sue in his local jurisdiction. If the competitor is a national chain with its headquarters on the other side of the country, it may make it more difficult—but not impossible. A qualified attorney can help you with the best strategies and outcome.⁴

The Legalities

Although each state's laws can be different, basically defamation is a false statement that is public and injurious to the victim's reputation. To prevail in a defamation lawsuit, a victim must be able to prove that the statement was *false* (the truth is a complete de-

HEALTH LAW AND COMPLIANCE

Law Review

- Although state laws may differ, defamation is generally a false statement that is public and injurious to the victim's reputation. There are two primary kinds of defamation:
 - *Libel* is written defamation
 - Slander is oral defamation
- The statement is *public* when the content is posted on the webpage.
- "Injurious" in the business sense can mean loss of business or profits, but also damage to reputation. Regarding the latter, ask yourself whether a statement would cause the person's peers to think less of him.
- Defamatory statements made online or through social media (eg, Facebook, Twitter, Yelp) constitute libel because they involve the written word.
- An alleged victim must be able to prove that a statement was false in order to prevail in a defamation lawsuit; the truth is a complete defense.
- Alleged defamatory statements must be presented as fact, not a subjective opinion.
- Social media posts create a bit more complexity because the law depends on several factors:
 - The state in which the victim resides
 - The state in which the alleged defamer resides
 - The "contacts" the defamer has had with the victim's state, if any

fense). The alleged defamatory statement must be presented as a fact and not as an opinion. ⁶⁻⁸ The statement is *public* when the content is posted on the webpage. It doesn't matter if the website is read by a dozen people or it's on a Kardashian's Twitter feed seen by millions.

Finally, it's critical that the victim show specific damages. In the business setting, this is usually accomplished by providing evidence that the victim's reputation has been damaged, such as with a loss of business or lost profits.6-8

Untrue statements

On the other hand, some statements are so inherently injurious that a victim may not be required to prove actual damages. 9 This is known as *per se* defamation. Some examples are statements that charge an individual or entity with an infamous crime or tend to subject it to "hatred, distrust, ridicule, contempt, or disgrace."10 Other examples include claims of being incompetent in the profession, of certain sexual conduct, or of having a "loathsome" disease.11-13 These statements would likely be considered defamatory regardless of their veracity.14

Similarly, if an employee posts information that's partially true and partially false, she can be found liable for defamation. Perhaps the competition doesn't take military insurance: it would be dangerous to state that that the urgent care didn't care about the military and refused to treat them.

A good rule of thumb in judging if a person's reputation has

been damaged is if the statement would cause the person's peers to think less of him.

The Protections

You can protect your urgent care from a competitor's defamation lawsuit by posting only factually accurate statements. If you want to post something, be certain it's true before you post. 15 Check your facts.

Even if a statement's true about a competitor, it still may not be the wisest thing to make it known. Consider your own company's reputation as you potentially tarnish another's. Just like words, images can also be defamatory.16 Don't alter photos or create memes to make another urgent care look bad.

Ask yourself: What does it say about your urgent care if you knock down the competition? Perhaps it's better to take the high road. Ethical marketing may produce tangible benefits for your urgent care business. There's a lot to be said for a provider that exhibits integrity. New clients will appreciate this, and your business will develop loyalty and increased customer retention. Referrals for your upstanding urgent care will also grow.¹⁷

Medical Ethics

In addition to the legal parameters of social media statements, healthcare owners and operators must also be bound by medical ethics that have traditionally discouraged disparaging competitors and acting in an unprofessional manner.

The 1969 AMA Judicial Council Opinions and Reports states that "[t]he practice of medicine should not be commercialized nor treated as a commodity of trade."¹⁸ Healthcare professionals have an ethical and legal responsibility to maintain their patients' confidentiality.19

With this in mind, urgent care owners, operators, and employees must understand their ethical responsibilities to their patients. More than a few Millennials and other young people will be working at your urgent care center. This means that their main mode of communication may be via smartphone and apps where stream-of-consciousness entries are the norm. Emphasize the importance of patient confidentiality, as well as their responsibility in representing the company in all comments, blogs, posts, and online communications in the best possible light and with the highest standards.20,21

Takeaway

It may sound too easy, but common sense is a good gauge of how you should act or react to a social media post that mentions your urgent care. The Golden Rule is a good yardstick, as well.

If you or an employee is blogging or writing on a Facebook page or submitting comments on a competitor's website, review site, or other social media site, be certain that you have all your facts absolutely correct before posting your statement. Again, think about it ethically and consider whether to send the

HEALTH LAW AND COMPLIANCE

statement at all.

When submitting posts or comments on social media, use extreme caution and avoid making any "gray area" statements that could be construed as defamation. While a statement may, in the end, not be judged to be defamatory, your business doesn't need the trouble and expense of defending a lawsuit to find out.

If you believe that your business has been defamed online, contact a qualified attorney to discuss your legal options and the wisest course of action. A retraction and an online apology may end the matter quickly and to your satisfaction. If the statements are more severe and are causing damage, your legal counsel may suggest more aggressive action.

When considering posting something about a competitor, remember Abraham Lincoln. When Abe wanted to fire off a nastygram, he'd compose what he called a "hot letter." He'd get all of his anger and hostilities out into a letter—then put it in his desk drawer until he cooled down. Then he'd write on the top of it: "Never sent. Never signed."²²

References

- 1. Fenske S. St. Louis doctor sued after blasting a fellow urgent care provider on Facebook. St. Louis Riverfront Times. October 11, 2017.
- 2. Liss S. Urgent care competitors in St. Louis County court over defamation claims. St. Louis Post-Dispatch. October 9, 2017.
- 3. Social Media and Online Defamation. Nolo. Available at: https://www.nolo.com/legal-encyclopedia/social-media-online-defamation.html. Accessed February 8, 2019.

- 4. Defamatory Social Media Posts—Can I Sue Someone for Bashing Me Online? HR.org. Available at: https://www.hg.org/legal-articles/defamatory-social-media-posts-can-i-sue-someone-for-bashing-me-online-34430. Accessed February 9, 2019.
- 5. Bedford v Spassoff. 520 S.W.3d 901, 904 (Tex. 2017).
- 6. Dallas Morning News, Inc. v Tatum. 554 S.W.3d 614, 626 (Tex. 2018).
- 7. Lubin v Kunin. 117 Nev. 107, 112, 17 P.3d 422, 426 (Nev. 2001)
- 8. Yeager v Local Union 20, Teamsters, Chauffeurs, Warehousemen & Helpers of Am. 6 Ohio St.3d 369, 372, 453 N.E.2d 666 (Ohio 1983).
- 9. Paulson v Cosmetic Dermatology, Inc., Civil Action No. 17-20094-Civ-Scola, 2017 U.S. Dist. LEXIS 88031, at *7 (S.D. Fla. June 8, 2017).
- 10. Scobie v Taylor, No. 13-60457-Civ, 2013 U.S. Dist. LEXIS 99786, at *6 (S.D. Fla. July 17, 2013). 11. Gordon v Boyles, 99 P.3d 75, 79 (Colo. App. 2004).
- 12. Metropolis Co. v Croasdell, 145 Fla. 455, 199 So. 568, 569 (Fla. 1941).
- 13. Fun Spot of Fla. v Magical Midway of Cent. Fla., Ltd., 242 F. Supp. 2d 1183, 1197 (M.D. Fla. 2002).
- 14. MacLeod v Tribune Publishing Co., 52 Cal.2d 536, 549 (Cal. 1959), quoting Cal. Civ. Code § 45a.
- 15. Awad R. 3 social media mistakes that could get you sued! Incomediary.com. Available at: https://www.incomediary.com/social-media-mistakes. Accessed February 8, 2019. 16. Hinson v Yates, No. 1:17-cv-639, 2018 U.S. Dist. LEXIS 127919, at *13 (W.D. Mich. July 9, 2018)
- 17. Anderson B. Badmouthing the competition is a losing proposition. *Think Advisor*. Available at: https://www.thinkadvisor.com/2015/09/09/badmouthing-the-competition-is-a-losing-propositio/?slreturn=20181115222012.
- 18. Veatch RM. Ethical dilemmas of for-profit enterprise in health care. *Institute of Medicine*. Available at: https://www.ncbi.nlm.nih.gov/books/NBK216766/. Accessed February 8, 2019.
- 19. Mansfield SJ, Morrison SG, Stephens HO, et al. Social media and the medical profession. Med J Aust. 2011;194:642–644.
- 20. The American Medical Association (AMA) opposes the publication of inaccurate, unreliable, or meaningless healthcare data, and advocates that physicians be allowed to review any information before its online publication.
- 21. Azu MC, Lilley EJ, Kolli AH. Social media, surgeons, and the internet: an era or an error? Am Surg. 2012;78(5):555-558.
- 22. Konnikov M. The lost art of the unsent angry letter. *The New York Times*. March 22, 2014.

www.jucm.com

JUCM The Journal of Urgent Care Medicine | March 2019 31

Call for Authors

JUCM, The Journal of Urgent Care Medicine has built a reputation as the voice of the urgent care community by engaging urgent care professionals at every level.

In fact, we thrive on contributions from the urgent care community. The process tends to work out pretty well for our authors at times, too. For example:

- 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

Might you be next?

If you have an idea, or even a completed article, email it to us at editor@jucm.com.

Help us continue to present excellent, timely content that informs the urgent care industry!



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



When better answers are everything.

optimize workflow, increase staff efficiency and help drive improved outcomes, the system is made to support better decisions sooner

Optimized Workflow

in any clinical setting.

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

Come see us at AAOS booth #3113,

Superior Image Quality

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

Compact and Versatile

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

Intuitive Controls

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

March 12-16 in Las Vegas, NV.





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 47-Year-Old Woman with Hip Pain After Exercise

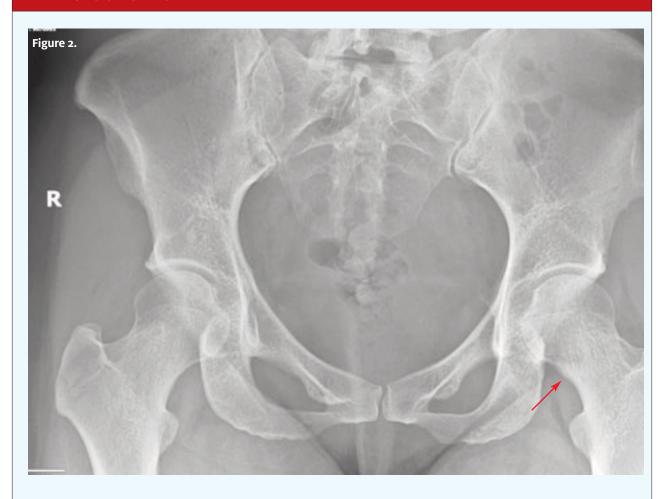


The patient is a 47-year-old woman who presents with left hip pain that worsens when she is working out on her elliptical machine, and improves with rest.

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

INSIGHTS IN IMAGES: CLINICAL CHALLENGE

THE RESOLUTION



Differential Diagnosis

- Femoral head avascular necrosis
- Hip tendinitis and bursitis
- Subcapital hip fracture
- Snapping hip syndrome
- Cortical thickening due to stress reaction or impending stress fracture

Diagnosis

The image shows focal cortical thickening along the medial wall of the femoral neck. This could be due to a stress reaction and be the precursor to a stress fracture. There is no evidence of lucent fracture line.

Learnings/What to Look for

Causes of focal cortical thickening may include osteoid osteoma, chronic infection, and stress fracture—all of which may appear similar on radiographs. As such, more advanced imaging is required

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

■ This patient should undergo an MRI. If one is not available on site, she should be referred

Acknowledgment: Images and case provided by Teleradiology Specialists, www.teleradiologyspecialists.com.

A 55-Year-Old Man with a 2-Day History of Respiratory Symptoms, Palpitations, and Dizziness

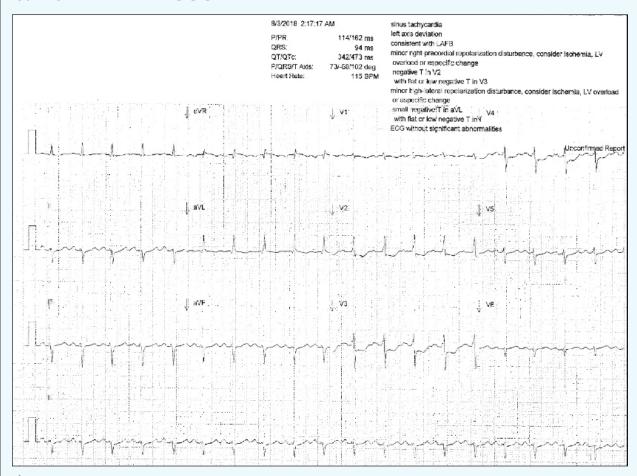


Figure 1.

Case

A 55-year-old male presented to urgent care with a chief complaint of coughing, shortness of breath, wheezing, chest palpitations, and dizziness for the past 2 days. The patient denied chest pain. He has a significant past medical history of diabetes mellitus II and takes metformin 500 mg once a day.

The patient's blood pressure is 88/60 mmHg, heart rate is 115, O2 sat 98%, weight 275 pounds, BMI 50.3. In addition:

■ General: alert and oriented X3

- Lungs: CTAB
- Cardiovascular: tachycardic and regular without murmur, rub,
- **Abdomen:** soft and non-tender, no pulsatile mass
- **Ext:** 1+ pitting edema bilaterally in shins and ankles, pulses are equal and 2+ in all extremities

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

INSIGHTS IN IMAGES: CLINICAL CHALLENGE

THE RESOLUTION

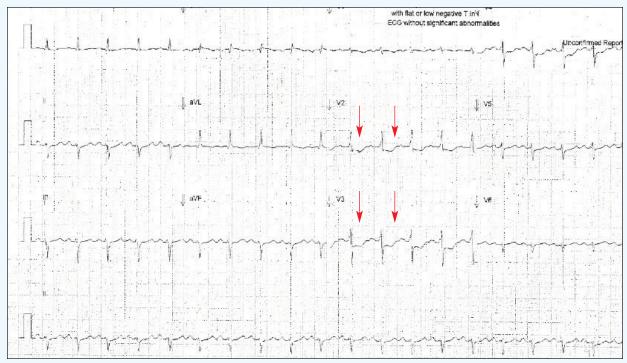


Figure 2.

Differential Diagnosis

- Anterior myocardial infarction
- Subendocardial ischemia
- Posterior mvocardial Infarction
- Left anterior fascicular block
- Supraventricular tachycardia

Diagnosis

The ECG shows marked ST depression in chest leads V2, V3, and V4. This patient had a posterior myocardial infarction. Immediately he received oral fluids, aspirin, and albuterol nebulizer treatments but showed no significant improvement. Nitroglycerin 0.4 mg was not given due to low blood pressure because of the likelihood of having right heart myocardial infarction. ECG was repeated after 15 minutes and showed no improvement.

The patient was transferred and admitted to the hospital for further evaluation and treatment. There, catherization showed four vessels blocked, leading to open heart surgery.

Learnings/What to Look for

- Be alert for ST-depression in the anterior leads of V1-V3 since these leads directly face the posterior wall of the left ventricle
- Other signs include:

- Large R-waves in leads V1-V2
- R:S >1 in either V1 or V2
- Often, there will be large and upright anterior T waves
- There may be subtle signs of inferior or lateral MI; look for ST elevation in other corresponding leads

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

- Probe for signs of MI, including chest discomfort, shortness of breath, diaphoresis, and dizziness, as well as hemodynamic instability (eg, hypotension, dizziness, confusion)
- If symptomatic in the urgent care, give oxygen support, aspirin, o.4 mg sublingual nitroglycerin, and morphine if chest pain continues
- Do a mirror image challenge and look at leads V1-V4 by turning the ECG readings 180° and putting the readings up to the light. The tall anterior R-waves become deep posterior Qwaves, the ST-depression becomes ST-elevation, and upright T-wave becomes terminal T-wave inversion
- Do not give nitroglycerin to patients who are hypotensive
- All patients presenting to the urgent care with a posterior MI will need emergent transfer to a cardiac catherization lab

Acknowledgment: Case submitted by Sudhir R. Gogu, DO, PhD, MBA.



An 18-Month-Old with an Itchy Rash and Wheezing



The patient is an 18-month-old girl brought to your urgent care center by her parents. They report that she has been scratching her abdomen. When they lifted her shirt, they found multiple hyperpigmented macules widespread across the front and back of her trunk. She also has 1 hour of wheezing.

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

INSIGHTS IN IMAGES: CLINICAL CHALLENGE

THE RESOLUTION



Differential Diagnosis

- Urticaria pigmentosa
- Bullous impetigo
- Atopic dermatitis
- Psoriasis

Diagnosis

This patient was diagnosed with urticaria pigmentosa, a form of cutaneous mastocytosis in which mast cells accumulate in the skin, causing the characteristic skin lesions seen here.

Learnings

- Urticaria pigmentosa presents within the first week-tomonths of life, though involution can occur in early childhood or last until puberty
- Bronchospasm, as well as flushing, diarrhea, and syncope can all occur

Unlike adult forms of mastocytosis, there is rarely internal organ involvement in children

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

- There is no "cure," per se, for urticaria pigmentosa, though antihistamines can relieve itching and flushing. Other treatments include:
 - Topical corticosteroids
 - Hydrocolloid dressings
 - Fluocinolone acetenoide
- Parents of younger children should try to discourage scratching or rubbing of itchy skin, as doing so could spur a stronger reaction

Acknowledgment: Images courtesy of VisualDx.



Simplify workflow, results and patient management.

The CLIA-Waived **BD Veritor™ Plus System for Rapid Detection of Flu A+B** simplifies workflow and provides clear and quick results for appropriate patient management within the same visit.

- One button functionality, easy to use and implement
- Unambiguous digital flu result in under 11 minutes*
- Demonstrated performance compared to molecular tests¹
- Low cost of ownership

Simply the right POC test for influenza, Group A Strep and RSV.⁺

Request a demo today at go.bd.com/VeritorJUCM

*Results after 10-minute incubation period for Flu A+B and RSV; after 5-minute incubation period for Group A Strep †RSV- Respiratory Syncytial Virus

References: 1. BD Veritor System for Rapid Detection of Flu A+B, CLIA-waived kit package insert, 8087667 (14) 2018-06. BD Veritor System for Rapid Detection of Flu A+B, laboratory kit package insert, 8087666 (11) 2017-10.







REVENUE CYCLE MANAGEMENT Q&A

What You Need to Know About UnitedHealthcare Cuts

■ DAVID E. STERN, MD, CPC

eginning April 1, 2019 UnitedHealthcare will discontinue reimbursement for HCPCS code S9083, "Global fee urgent care Centers" in some states (see **Table 1**). The change affects UnitedHealthcare commercial plans, UnitedHealthcare Oxford, and UnitedHealthcare Community Plan policies. Additionally, UnitedHealthcare Community Plan will no longer reimburse HCPCS code S9088, "Services provided in an urgent care center." Providers should report the Evaluation and Management (E/M), and/or procedure code(s) that specifically describes the services provided, consistent with the Current Procedural Terminology (CPT) manual.

Are the 2019 telehealth Healthcare Common Procedure Coding System (HCPCS) codes G2010 and G2012 approved by Medicare restricted to Rural Health Care (RHC) or Federally Qualified Health Care (FQHC) centers?

No, these codes are not restricted to RHC or FQHC centers. As of January 1, 2019, providers who can bill an evaluation and management (E/M) service can bill these codes when appropriate, as published in the final rule for the 2019 Physician Fee Schedule (PFS) (https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24170.pdf). The Centers for Medicare and Medicaid Services (CMS) will allow separate payment for brief check-in services and remote evaluation of recorded video and/or images that do not result in an office visit, or are not part or a prior officevisit, as follows:

■ G2010, "Remote evaluation of recorded video and/or images submitted by an established patient (eg, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous

1			E	
Q	-	下分	Γ	
	1			

David E. Stern, MD, CPC, is a certified professional coder and is board-certified in internal medicine. He was a director on the founding board of UCAOA and has received the organization's Lifetime Membership Award. He is CEO of Practice Velocity, LLC (www.practicevelocity.com), NMN Consultants (www.urgentcare consultants.com), and PV Billing (www.practicevelocity.com/ urgent-care-billing/), providers of software, billing, and urgent care consulting services. Dr. Stern welcomes your questions about urgent care in general and about coding issues in particular.

Table 1. States Affected by UHC Policy Changes					
State	UnitedHealthcare Commercial & Oxford (S9083)	UnitedHealthcare Commercial & Oxford (S9088)			
Connecticut	X	_			
Maine	X	_			
Massachusetts	X	X			
New Hampshire	Х	_			
Rhode Island	Х	Х			
Vermont	Х	_			

7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment"

- National average reimbursement is \$12.61
- G2012, "Brief communication technology-based service, eg, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion"
 - National average reimbursement is \$14.78

Both can be billed for established patient visits only and a copay is required. An "established patient" is one who has received professional services from the physician or qualified healthcare professional or another physician or qualified healthcare professional of the same specialty and subspecialty in the same group practice within the past 3 years.

Patient consent must be obtained and documented for each visit of this type. Consent may be oral or written, including electronic confirmation, and must be documented in the medical record for each billed service. CMS has not given a limit to the number of times these services can be billed, but will monitor utilization to determine whether limitation should be re-

REVENUE CYCLE MANAGEMENT

guired in the future. CMS also reminds us that the services must be medically reasonable and necessary to be reimbursed.

These codes are valid for providers only, and cannot be billed by clinical or nursing staff who are not eligible to bill for E/M services. While reimbursement may seem low, CMS believes that it accurately reflects the resources involved in furnishing the service, and provides a valuable service to patients.

HCPCS code G2010, defined as remote evaluation of prerecorded patient information, can only be billed when the patient has submitted a still or video image via asynchronous telemedicine technology. Once the provider has reviewed and interpreted the image(s), a follow-up response must take place within 24 hours. The follow-up can be made with a phone call, audio/video communication, secure text messaging, email, or patient portal communication. For example, an established patient emails a picture of a rash on his arm and explains that he came across poison ivy while doing yard work. The provider reviews the image and documents that the rash is consistent with poison ivy, and recommends an over-the-counter oint-

ment, also advising that he should contact the urgent care center again if there is no improvement. This information is relayed to the patient via secure email. The patient does not require an office visit, nor does he come to the clinic in the next 24 hours, so it is appropriate to bill HCPCS code G2010 for the service.

HCPCS code G2012, defined as virtual check-in, requires direct interaction between the provider and the established patient, whether through audio only, real-time telephone interactions or synchronous, two-way audio interactions enhanced with video or other data transmission. CMS was not explicit in describing the technology, so as not to have to update policies frequently. There are no service-specific documentation requirements aside from documenting patient

These new codes exemplify CMS's renewed vision to bring Medicare into the future of virtual care services and encourage providers to use new technologies to deliver medical care.

www.jucm.com

JUCM The Journal of Urgent Care Medicine | March 2019 41



Features include:



Fast access to insights from the best specialists



Handle complex cases directly



Engage patients with our handouts

20% OFF for JUCM readers visualdx.com/jucm



CAREERS

PHYSICIANS WANTED

Urgent Care Physicians **HEAL. TEACH. LEAD.**

At HealthPartners, we are focused on health as it could be, affordability as it must be, and relationships built on trust. Recognized once again in Minnesota Physician Publishing's 100 Influential Health Care Leaders, we are proud of our extraordinary physicians and their contribution to the care and service of the people of the Minneapolis/St. Paul area and beyond.

As an Urgent Care Physician with HealthPartners, you'll enjoy:

- Being part of a large, integrated organization that includes many specialties; if you have a question, simply pick up the phone and speak directly with a specialty physician
- Flexibility to suit your lifestyle that includes expanded day and evening hours, full day options providing more hours for FTE and less days on service
- An updated competitive salary and benefits package, including paid malpractice

HealthPartners Medical Group continues to receive nationally recognized clinical performance and quality awards. Find an exciting, rewarding practice to complement all the passions in your life. Apply online at healthpartners.com/careers or contact Diane at 952-883-5453 or diane.m.collins@ healthpartners.com. EOE





Advertise Your Urgent Care Opportunity With Us

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



727-497-6565 x3328

JUCMprint@CommunityBrands.com

Patient First

Physician Founded. Patient Focused.

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

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

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

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

To learn more, contact Recruitment Coordinator Eleanor Hertzler at 804-822-4478 or eleanor.hertzler@patientfirst.com, or visit www.patientfirst.com/PatientFirstCareers

MARKET PLACE

MEDICAL EQUIPMENT/SUPPLIES



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

imaging solutions for your clinic & budget

CALL FOR MORE INFO!

1.800.727.7290 x1209

BlueRidgeXray.com

Advertise Your Urgent Care Opportunity With Us

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



727-497-6565 x3328

JUCMprint@CommunityBrands.com



DEVELOPING DATA

Proof: Availability of Urgent Care Lowers ED Traffic—and Could Save Up to \$1 Billion

t has always seemed self-evident that urgent care centers, offering a lower-cost and usually faster experience that is also on par clinically for nonemergent complaints, should help draw patients away from overcrowded emergency rooms. Just as obviously, that would mean more efficient use of the ED for patients who truly need to be there, and less of a financial burden on the healthcare system.

One problem has been a lack of conclusive data to back up those contentions. Until now.

A new study by the National Bureau of Economic Research, reflecting roughly 2.4 million visits, shows that nonemergent use of the ED goes up when local urgent care centers are closed. In other words, more patients choose urgent care for nonemergent complaints when that's an option.

With a trip to the ED costing \$414 more than a trip to the urgent care center for the same complaint, on average, the difference in the cost of care is dramatic. See the graphic below for a glimpse of the full effect. ■

URGENT CARE REDUCES NONEMERGENT ED VISITS—AND SPENDING

When urgent care centers close, nonemergent trips to the ED go up...



Percent of ED visits that are nonemergent when urgent care is open After urgent care closes

Percent of ED visits that are nonemergent after urgent care closes

...and so does the cost

2.4 million ED visits x \$414 higher cost/visit vs urgent care = \$993.6 million in higher cost when urgent care is closed

Source: Allen L, Cummings JR, Hockenberry J. Urgent care centers and the demand for non-emergent emergency department visits. National Bureau of Economic Research. January 2019.



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

DIAMOND PARTNERS









GOLD PARTNERS







SILVER PARTNERS











BRONZE PARTNERS

















































I power extraordinary

Your patients should focus on feeling better...

I understand the relationship between a patient and doctor is sacred, and the integrity of that relationship depends on privacy and trust. I'm happy to spend my day focusing on the safety of your medical data, so you don't have to.

-Blake, Manager of Security and Compliance



This is one of the many ways Practice Velocity powers extraordinary healthcare experiences. Hear more about this story – and others – at practicevelocity.com/powerextraordinary.

#PowerExtraordinary