

**JUNE 2019** VOLUME 13, NUMBER 9





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## URGENT PERSPECTIVES

## Point–Counterpoint: Is Telemedicine Ready for Prime Time?

■ STANFORD COLEMAN, MD, MBA, FAAP and WILLIAM GLUCKMAN, DO, MBA, FACEP

UCM invited two longstanding industry leaders to share their perspectives on the viability of telehealth in the urgent care setting. Stanford Coleman, MD, MBA, FAAP, Vice President and Chief Networking Officer for Medical Affairs and Community Relations for Righttime Medical Care in Maryland is a proponent of the use of telehealth in urgent care. He treats patients virtually through the company's RighttimeNow telemedicine service. William Gluckman, DO, MBA, FACEP, President and CEO of FastER Urgent Care in Morris Plains, NJ; Clinical Assistant Professor of Emergency Medicine at Rutgers New Jersey Medical School; and a member of the JUCM Editorial Board, is skeptical about telehealth's place in urgent care. Here's what they had to say.

**WG:** I have concerns about telehealth in urgent care in a number of areas, but the most significant are from a quality perspective and from a liability perspective. The quality piece has a couple of components to it: One is the ability to perform an appropriate, complete evaluation from a hands-on perspective, meaning the inability to do a real palpation of the abdomen, to auscultate the lungs, or test for instability in an orthopedic issue.

**SC:** Telemedicine can be and *is* being practiced multiple ways in urgent care today. A number of urgent cares do telemedicine for load-balancing and have a "virtual room" on-site staffed by medical assistants using electronic peripheral instruments such as a telestethoscope for heart and breath sounds, otoscope for examination of the ears and throat, as well as an ophthalmoscope, and video/still camera systems—all directed by the remote provider. We need to do a survey and get data, but





Stanford Coleman, MD, MBA, FAAP, is Vice President and Chief Networking Officer for Medical Affairs and Community Relations, Righttime Medical Care in Maryland. William Gluckman,

**DO, MBA, FACEP,** is President and CEO of FastER Urgent Care in Morris Plains, NJ; Clinical Assistant Professor of Emergency Medicine at Rutgers New Jersey Medical School; and a member of the *JUCM Editorial Board*.

there is anecdotal evidence to support this.

Further, the remote provider can direct the patient in self-examination, with self-palpation of the abdomen or heel tap that can provide information about abdominal pain, or observe the patient's breathing pattern, cough, and voice quality, etc.

The real issue is having providers and assistants properly trained in doing these kinds of remote physical examinations. Not every provider can be a telemedicine provider in urgent care. They should be selected based, in some sense, on how telegenic they are, how enthusiastic they are about doing telemedicine visits, and what kind of relationship they can build with a patient remotely. They clearly have to be a clinically experienced provider who can make appropriate decisions in this setting and trained to best practices.

Quality and liability in any clinical setting rest on proper documentation of clinical decision-making supported by an adequate follow-up plan. The follow-up plan is essential. Having an adequate "safety net" for follow-up is most important. At Righttime we schedule follow-up visits and call every patient after every telemedicine visit.

**WG:** My concern is that many other telemedicine providers operate without the diagnostic tools and POC testing you described. This is the major issue I have. If all telemedicine visits have advanced diagnostics associated with them, I would have less opposition. And about the ability to do point-of-care testing, such as for sore throat? Standard practice is to do a rapid strep test. If it's positive, great, you know it's strep, you give them antibiotics, and all is good. But if the rapid strep is negative, the general procedure is not to provide antibiotics. You may choose to do a throat culture and only if that's positive do you treat. I think it's almost a given that a patient calling in through a telemedicine visit is looking for an antibiotic. The easy thing to do is, *Well, it's a sore throat, we'll give you antibiotics.* And that goes against the current push toward antibiotic stewardship.

**SC:** Most patients want advice, a diagnosis, and relief from discomfort. You'd be surprised how many patients listen when

## URGENT PERSPECTIVES

you sincerely educate them when antibiotics would be inappropriate for them. Let me describe our process at Righttime, using sore throat as an example.

When patients call in to our call center for a visit, they're given the opportunity to have what we call a RighttimeNow visit, a telemedicine visit. We have an intermediary company that has created the ability to connect the patient to the provider through a HIPPA-compliant secure channel by using Facetime or Skype. When the visit is scheduled, I have the patient's chart. I know everything about every visit they've ever had to Righttime. If they're a new patient, I start a new chart. Either way, I can decide whether this is an appropriate telemedicine visit. If it is not, I can immediately schedule them for a face-to-face visit and get them into one of our sites.

When our call center schedules a patient for me, we ask the patient to take their temp, have a flashlight or be sitting in good lighting. I'm going to look in their eyes, their nose, and their throat and I'm going to teach them how to do a self-exam for their cervical lymph nodes. If they've had no fever, if their sore throat just began today, if no one else in the household has a sore throat, or has been diagnosed with strep, I'm not going to put them on antibiotics. There are criteria called the Centor criteria we utilize; if they don't have a temperature of 38.5° C, don't have tender lymph nodes, no exposure to strep, they don't have any exudative pharyngitis, I'm not going to put them on an antibiotic.

We are very aware of proper antibiotic stewardship at Righttime and have kept our antibiotic prescribing rate well below national averages for urgent care and will do the same for telemedicine.

**WG:** Clearly that's a better approach than what my perception from other providers is. If you're very comfortable that they don't meet Centor criteria or other evidence-based guidelines for use of antibiotics and you're firm with it, and you explain why they're not getting an antibiotic, that's a win-win. But beyond the testing issue, aren't the tangible benefits of face-to-face contact and a hands-on approach lost in a telemedicine visit?

**SC:** I'd rather look at what is *gained* for patients in terms of access, convenience, and timeliness in a telemedicine visit rather than what could be lost in not seeing them in person. I see it as an opportunity to see and satisfy more patients and to connect them to our urgent care and our values. The face-to-face interaction, eye-to-eye is still there. The patients I see are very excited, and curious about doing a videoconference visit. And they know right up front there are limitations, but they all respond positively when there is an expression of warmth, concern, and commitment to finding a solution to their medical problem.

**WG:** Do the patients who are excited about it tend to be the

younger generation that are tech-savvy? How many seniors do you really get doing this?

**SC:** I would have thought it would be the young, tech-savvy people but I've had a number of elderly patients. I think it's because our system is really easy as long as they know how to use their cell phone or they know how to use their tablet or laptop. Overall, our mission is to simplify access to trustworthy medical care. So this is just another modality for us in simplifying access and providing trustworthiness.

**WG:** There's no doubt it can improve access, but I would still have reluctance about certain conditions. I don't know how even the best clinician would be comfortable dealing with a young female of childbearing years with a chief complaint of abdominal pain. That could be anything, from gas to an ectopic to appendicitis. Without having a pregnancy test, without having a urinalysis, without pushing on her belly, I would be reluctant to say anything other than, *Please come in and be seen by a provider*. In which case, what's the satisfaction of a patient who has a telemedicine visit and is then told, I think you need to be seen by a provider? *Hey, I thought I was getting on-demand care here and all you do is tell me to come in*?

**SC:** It comes down to clinical judgment. For the childbearing age female with abdominal pain, I'm going to take a very careful history to understand the quality, location, duration, and associations of the pain, her last normal menstrual period, etc., the same history that I would acquire in an in-person visit. More than likely this patient would be sent to a site for further evaluation and lab work. She and the next provider would have the benefit of my evaluation in her chart and the relationship I would have already built. She would not be charged for two visits, and I'm certain she'd realize how important she is to us and that we will not abandon her.

**WG:** We don't hear a lot about horrible medical-legal cases—yet—with telemedicine but I look at that as a different standard of care. Say you thought a patient had bronchitis but they ultimately turned out to have either a lung mass or maybe pneumonia. For whatever reason, they go on to decompensate and have a bad outcome. They could certainly try to challenge: *Dr. Coleman, you didn't even listen to his lungs. How could you possibly have missed this?* We haven't heard that yet, but my hairs go up thinking that's coming down the pike.

**SC:** You can be still be sued for missing a lung mass even when you treat a patient for bronchitis in person. What it comes down to is what kind of advice did you give the patient about follow-up, what to watch for, how soon to follow up and how well did you document the visit.

## URGENT PERSPECTIVES

We provide diagnosis information handouts in an email to the patient, and they have access to the Righttime patient portal if they need further detailed information. So the followup plan is the same as if I were seeing that patient in person.

**WG:** By the way, I don't think there's *no* utility for telemedicine. I could see where you'd suture a wound and want to do a telemedicine visit in 2 days just to do a wound check, for example. Or you're following a skin lesion to see if it's getting worse. But I'm still having a hard time with many of the acute scenarios for first-time visits.

**SC:** As you've detected, I'm very enthusiastic about this. But I try to be very disciplined about it. That's one of the tenets a telemedicine provider has to sign on to, that he or she is going to fight that temptation to write a prescription just to make the patient happy, but to educate patients very carefully and take the time to explain things. That's why I have them bring a pencil and paper to the visit—because I'm going to give them many things to do. Educating patients on elements oself-care is critical to antibiotic stewardship in urgent care and in telemedicine.

**WG:** Hearing all this from you certainly gives me food for thought. I'm going to sit back in the wings and watch a little bit more to see what happens, though.

**SC:** Developing evidence-based guidelines should help. That's the next step for me in terms of growing our program. And I would love to run those past you to see if I can convert you.

**WG:** I think you should do some real research, write it up, and publish it in *JUCM*.

**SC:** That's a good point. All the innovations in medicine we practice today, that we have confidence in, have gone this way. Telemedicine has its place. But it also has its risks and therefore has to be done very carefully and thoughtfully. It is an opportunity to provide further access, convenience, and patient satisfaction. Just like urgent care.

(The views expressed by Drs. Coleman and Gluckman reflect their experiences and perspectives, and are not meant to speak for the industry as a whole.)

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JUCM, The Journal of Urgent Care Medicine is known as the voice of the urgent care community, thanks to the contributions of urgent care professionals just like you.

Whether you're a physician, nurse practitioner, a physician assistant—or an owner, manager, billing and coding specialist, lawyer, or anyone else with expertise that could benefit our readers—you're qualified to submit an article.

So, if you've ever had a situation arise in your urgent care center and thought somebody should write an article about this, maybe you should be that "somebody." Describe it in an email to editor@jucm.com and we'll help you get started.

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Our content works for the urgent care community because it comes from the urgent care community. And we aim to keep it that way.

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## CLINICAL

## Top 5 Wilderness Medicine Presentations for the Urgent Care Provider

As summer approaches, the nature of wilderness-related complaints will change from frostbite and hypothermia to tick-borne illness, skin conditions resulting from contact with various "poison" leaves, and more. Locking in on the exact cause requires expert history-taking and an awareness of regional environs. Stewart Harsant, MMS, PA-C

## PRACTICE MANAGEMENT

## Are Those Teambuilding Activities Really Worth It?



Urgent care staff need to function as a tight unit in order to perform at their peak. In other fields, shutting down for a one-day retreat may be the perfect opportunity to build camaraderie, share experiences, and develop mutual trust. What are you supposed to do when your business operates 7 days a week, 12 hours a day, and is depended on for the very well-being of your community, though?

Amy Lafko, MSPT, MBA

## HEALTH LAW AND COMPLIANCE

## How Best to Manage an 'At-Will' Termination



In most states, you have the legal right to terminate an employee literally *at will*—but that doesn't mean doing so is a good idea, or that there won't be potential legal ramifications.

Alan A. Ayers, MBA, MAcc

## CASE REPORT

## 32 A 9-Year-Old Girl with Sudden-Onset Sore Throat After a Meal



It's been assumed forever, and proven in studies over the past few years: sore throat is likely to be the most common presenting complaint in your urgent care center. The cause is usually infectious—but you have to be aware of the noninfectious causes that could bring serious consequences.

Linu Samuel, MD

## IN THE NEXT ISSUE OF JUCM

Clinicians know it. Parents know it. Children are prone to vomiting. There are a range of disorders that can cause vomiting, however, from mild and self-limiting to life-threatening conditions. Numerous organ systems can be involved. Understanding the pathophysiology can be invaluable in formulating an appropriate differential diagnosis. Read what red flags to look out for in the July–August issue of JUCM.

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Alan A. Ayers, MBA, MAcc

## ASSOCIATE EDITOR, CLINICAL

Michael B. Weinstock, MD

## **CONTRIBUTING EDITORS**

Joshua Russell, MD, MSc, FAAEM, FACEP

David E. Stern, MD

## 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

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ilderness medicine" sounds like something that would be practiced in the far reaches of civilization. However, anyone out for a pleasant hike in a local park stands the chance of running into ticks fully capable of passing along disease, walking through any number of plants that can cause dermatological issues, and stopping for a quick drink from a stream literally swimming with infectious organisms.

Reading our lead clinical article this month, Top 5 Wilderness Presentations for the Urgent Care Provider (page 15) will help you prepare for such cases. It's a subject that author Stewart Harsant,



MMS, PA-C is well prepared to address. In addition to treating patients as a physician assistant at Physicians Immediate Care in Chicago and teaching clinicians as adjunct faculty at the Rush University PA Program, he's a Fellowship candidate in the Academy of Wilderness Medicine.

Warmer weather also means people are back to firing up their grills at dinner time. Usually we think of grilling as a healthy way to prepare food, but this month's case report illustrates there are associated risks beyond that undercooked chicken breast. In fact, if the author of the article didn't take such a thorough history of the patient, the source of her discomfort could have gone undetected long enough to cause life-threatening damage.



You can read A 9-Year-Old Girl with Sudden-Onset Sore Throat After a Meal on page 32. The author, **Linu Samuel, MD** is a senior staff physician with Baylor Scott and White Health – Killeen (TX).

At the time he treated the patient that's the subject of this case report, he was completing his Fellowship in urgent care medicine at The University of Illinois College of Medicine in Rockford.

The importance of taking a thorough history is self-evident in the two articles described above. It's always been important. What's changing





among some urgent care operators is how exams are conducted. Take telemedicine, for example. On the surface, its key selling points sound tailor-made for urgent care—terms like convenience and cost savings inevitably come up when discussing the possibilities. However, it's been slow to catch on amid concerns about process, billing, and infrastructure. And what about establishing a relationship with the patient, or being able to palpate a patient's belly? We're excited to have two urgent care leaders debating these very points in this month's Urgent Perspectives column. If you got to this page without reading it, we suggest you go back to page 1 and see what Stanford Coleman, MD, MBA, FAAP and Will Gluckman, DO, MBA, FACEP have to say.

Dr. Coleman is vice president and chief networking officer for medical affairs and community relations for Righttime Medical

Care in Maryland. Dr. Gluckman is president and CEO of FastER Urgent Care in Morris Plains, NJ; clinical assistant professor of emergency medicine at Rutgers New Jersey Medical School; and a member of the JUCM Editorial Board.

On the practice management side, you're probably aware that running an urgent care center holds certain challenges that set the business apart from, say, an accounting firm. Take teambuilding, for



example. Many companies close the office for a day so the staff can share motivational bonding experiences. That wouldn't work so well for urgent care, where patients are counting on you to be available for their own and loved ones' wellbeing every day. So how do you go about building that sense of unity? Amy Lafko, MSPT, MBA offers some great points in her article, Are Those Teambuilding Activities Really Worth It? (page 26). Ms. Lafko is owner and principal of Cairn Consulting Solutions.

Of course, no matter what you do to build a healthy workplace, there will always be hires that just don't work out. In most states, employment is at will—meaning, in theory, that you can let an employee go at any moment when the need arises, without being legally bound to provide a reason. It's not necessarily the best move to make, though. In How Best to Manage an 'At-Will' Termination (page 29), **Alan Ayers, MBA, MAcc** explains the key considerations to ponder before terminating a staff member. Mr. Ayers is chief executive officer of Velocity Urgent Care, LLC and practice management editor of JUCM.

In this month's Abstracts in Urgent Care (page 23), **Joshua** Russell, MD, MSc, FAAEM, FACEP reviews urgent care-relevant literature concerning concussion management, assessing nonspecific head and back pain, and how best to put infant safety first.

Finally, in Revenue Cycle Management, **David Stern, MD** offers a preview of the latest changes in E/M guidelines (page 43). If you want to ensure you're being compensated fairly for the services you provide, it's a must-read.

## **Thanks to Our Peer Reviewers**

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

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Visit ucaoa.org/workshop for more details and to register.



## FROM THE UCA CEO

## Accreditation—Part of Urgent Care's Offensive Line

■ LAUREL STOIMENOFF, PT, CHC

e've all heard the adage, The best defense is a strong offense. Whether entering a battle, participating in sports, or in life itself, the premise is to mount actions that distract the opposition and therefore curtail or abate the enemy's attack. It's time we start thinking about our strategy to protect the services we provide to millions of grateful patients.

Accreditation is an offensive play and a proactive measure to defend your organization—and urgent care medicine as a whole.

Thanks to a growing number of urgent care operators playing offense, the Urgent Care Association (UCA) achieved a major milestone in early 2019 when it accredited its 1,000<sup>th</sup> center. Five years after the launch of its program, UCA now accredits more urgent care centers than any other accrediting body.

UCA established its accreditation program in response to industry stakeholders' pursuit of a recognition program that would be affordable and customized to the uniqueness of urgent care medicine. As the program matured, UCA sought feedback from the field on its merits. Here is a sampling of what we heard:

- It added *credibility* to the organization's commitment to quality. Todd Martin, chief operating officer (COO) at Emergency One, stated, "It assisted us in communicating our position in the overall healthcare delivery system and the value we bring to our patients and their families. It not only provided a mechanism for self-assessment on best practices internally, but it served as an acknowledgement to the community, patients, insurance companies, and all other healthcare stakeholders that our urgent care centers meet the highest standards."
- Steven Hull, COO of Integrity Urgent Care expressed, "UCA accreditation challenged our organization on every



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

"Accreditation may just be one page in the playbook, but it's a solid one that's being embraced by urgent care owners and operators across the country."

aspect of what we were doing and left us considerably stronger. In short, the UCA has helped legitimize our organization as a true urgent care." Todd Martin agreed, stating, "It has become increasingly important in our State (New York) as lawmakers struggle to understand the definition of urgent care amid mixed messaging from the hospital association and other competitors about our relevance in the delivery system and the governance that exists in our practices to ensure the safety of the patient when receiving care in our facilities."

Perhaps one of the most compelling reasons that we've heard from accredited organizations relates to how the process creates a culture of quality and pride within the organization, manifesting in improved retention of talented providers and valued staff members. Accreditation is one way leadership can emphatically demonstrate to internal and external customers that the organization is on a mission to excel.

In today's climate, it is important that the industry clearly demonstrates that it's serious about good medicine and continuous improvement. Accreditation may just be one page in that playbook, but it's a solid one that's being embraced by urgent care owners and operators across the country.

UCA is hosting two Accreditation Workshops this year; attend and receive access to accreditation experts and a simulated survey experience, and earn credits toward the Certified Urgent Care Management Professional (CUCMP) designation. Seventy-five percent of the attendees from the 2018 AUC workshop are now successfully accredited! Learn more and register at https://www.ucaoa.org/Education/Events/Accreditation-Workshop.



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

## **Learning Objectives**

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

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- 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.

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## Top 5 Wilderness Medicine Presentations for the Urgent Care Provider (p. 15)

- 1. Which of the following is not considered among of the top five wilderness-related presentations to the urgent care center?
  - a. Diarrhea
  - b. Dermatitis
  - c. Hypothermia
  - d. Injuries related to falls on outstretched hands (FOOSH)
  - e. Rocky Mountain spotted fever
- 2. Following exposure to cold temperature, blisters filled with clear, milky fluid surrounded by erythema and edema are indicative of:
  - a. First-degree frostbite
  - b. Second-degree frostbite
  - c. Third-degree frostbite
  - d. Fourth-degree frostbite
- 3. Lyme disease is characterized by which of the following?
  - a. Linear vesicles
  - b. Appearance of a fine pink rash
  - c. Generalized petechial rash
  - d. Flu-like symptoms
  - e. All of the above

## Are Those Teambuilding Activities Really Worth It? (p. 26)

- 1. Teambuilding exercises should accomplish which of the following in order to be considered successful?
  - a. Greater trust among team members
  - b. Positive peer pressure to perform
  - c. Improved patient satisfaction
  - d. All of the above
  - e. All of the above except "b"
- 2. According to data from Gallup, disengaged employees cost their organizations:
  - a. 34% of their salary
  - b. 17.2% of their salary
  - c. 3% of the operation's annual revenue, per disengaged worker
  - d. None of the above
  - e. The cost is impossible to assess

- 3. Which of the following is not one of the core components to building a sustainable, cohesive culture?
  - a. Cultural ambassadors
  - b. Incentive
  - c. Behavioral norms
  - d. Strategic approach
  - e. Each of these is among the core components to building a sustainable, cohesive culture

## A 9-Year-Old Girl with Sudden-Onset Sore Throat After a Meal (p. 32)

- 1. How should a patient with respiratory distress following foreign body aspiration be transported to the emergency department?
  - a. Private car
  - b. EMS
  - c. Ambulate
  - d. No need to go to the ED
  - e. All of the above
- 2. Commonly ingested foreign bodies include:
  - a. Bones
  - b. Coins
  - c. Magnets
  - d. Safety pins
  - e. All of the above
- 3. Foreign bodies in the esophagus may present as which of the following?
  - a. Drooling
  - b. Dysphagia
  - c. Refusal to eat
  - d. All of the above

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## Top 5 Wilderness Medicine Presentations for the Urgent Care Provider

**Urgent message:** "Wilderness" medicine is less exotic than one would think. Patients with complaints that began during or after an outdoor outing in any season are likely to present to urgent care, making wilderness medical knowledge of paramount importance.

STEWART HARSANT, MMS, PA-C

## Introduction

very season holds its own unique appeal to those who love the great outdoors. Similarly, every season has its own distinct set of risks, ranging from gastrointestinal symptoms, dermatological conditions, and infection from insect bites to external and internal damage from exposure to frigid temperatures. Here, we focus on the proper urgent care management—and pitfalls—of relatively common wilderness-related presentations.

## 1. Infectious Diarrhea

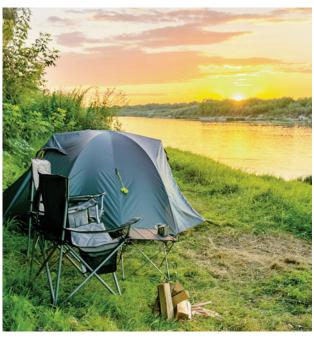
Infectious diarrhea is one of the most common presentations of the wilderness traveler. A common microbe is *Giardia*, though there are plenty of other culprits. As such, all patients presenting with infectious diarrhea should have a full abdominal exam.

The history should include fever, blood in stool, and weight loss, as well as a detailed travel history including timeline of symptom onset, water source, water treatment, and sick contacts. The exam will often be normal, but consider red flags of surgical illness including severe localized pain, peritonitis, hypotension, or altered consciousness.

Differential diagnosis depends on the geographic region of travel, but often includes *Giardia*, enterotoxic *E coli*, enterohemorrhagic *E coli*, *Cryptosporidium*, *Cyclospora*, and viruses. Diagnosis can either be clinical or by testing (eg, stool culture, antigen testing, or testing for ova and parasites).

## Management

Most traveler's diarrhea is self-limiting and requires only



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supportive therapy such as hydration. Antidiarrheal medication may be used for nonbloody diarrhea. *Giardia* is treated with metronidazole 2 g PO as a single dose or, alternatively, 500 mg PO twice daily 7 days or tinidazole 2 g PO as a single dose with food. The use of antimicrobials to treat other forms of traveler's diarrhea should be guided by severity: mild, moderate, and severe.

Mild diarrhea is tolerable and does not interfere with planned activities. Treatment should entail

**Stewart Harsant, MMS, PA-C** is a physician assistant at Physicians Immediate Care in Chicago; adjunct faculty at the Rush University PA Program; and a Fellowship candidate in the Academy of Wilderness Medicine. The author has no relevant financial relationships with any commercial interests.





oral rehydration, loperamide, and bismuth salicylate (BSS). Antimicrobial agents are not recommended. Sports drinks may be used if diluted to half strength with clean water. World Health Organization and the U.S. Public Health Service both have oral rehydration formulas whose recipes are available to the pubic online.

- Moderate diarrhea is distressing, interferes with planned activities, and may be treated with antimicrobials.<sup>2</sup> Empiric antibiotics used to treat infectious diarrhea include azithromycin, ciprofloxacin, and rifaximin. Caution should be used when prescribing fluoroquinolones due to increasing resistance worldwide and side effects such as tendinopathy, aortic rupture, and neuropathy.
- Severe diarrhea is incapacitating, prevents planned activities, and should be treated with antibiotics.
   Strongly consider ED transfer if associated with hypotension and/or intractable vomiting.



## Prevention

Infectious diarrhea can be prevented through proper water treatment or drinking bottled water only. As for water treatment modalities, one may disinfect water using heat, filter, chemical, and UV methods. Heat disinfects the most adequately, though other modalities are effective when used properly. If traveling in a developing country, drinking bottled water is advised. Avoid eating fresh fruits and vegetables that may have been washed with contaminated water. Daily BSS is an effective prophylaxis.<sup>2</sup>

Recent wilderness travel does not exclude a noninfectious or life-threatening cause of diarrhea. As with urban patients, the wilderness traveler can also develop appendicitis, cholecystitis, pancreatitis, bowel obstruction, etc. Patients suspected of having such conditions should be transferred to the ED.

## 2. Contact Dermatitis Due to Exposure to Plants

Common plants that cause dermatitis include poison oak, poison ivy, and poison sumac (Figures 1, 2, and 3). Poison oak and poison ivy are three-leaved plants and can be difficult to distinguish from other nonpoisonous plants, which gives rise to the saying "leaves of three, let it be." Poison sumac is a shrub or bush with two rows of seven to 13 leaflets. The causative agent for each is urushiol, which is an adherent, heat-stable, and persistent resin found on the leaf surface that can cause a type IV hypersensitivity reaction on the skin of an unsuspecting wilderness traveler. Due to the heat stability of urushiol, brush fires can cause serious respiratory distress. Even if recent wilderness travel is not reported, exposure can happen from urushiol-exposed pets, garden gloves, land-scaping equipment, and shoes, with plant dermatitis

occurring up to 3 weeks after exposure.3 Differential diagnosis can also include irritant contact dermatitis, impetigo, photocontact dermatitis, and viral exanthem, though diagnosis is largely clinical.

## Management

Management depends on severity of reaction. All areas of contact should be rinsed with soap and cold water, as should other possible contacts such as clothes, gear, and pets. Cold water is recommended in order to keep pores closed to minimize urushiol skin penetration.

- Mild reactions can be treated with topical steroids and an oral antihistamine. Calamine lotion and oatmeal baths can offer relief to some patients. Patients should be advised to not scratch the area in order to prevent secondary bacterial infection.
- Moderate reactions involve a significant amount of body surface area or regions that cause particular discomfort. If not contraindicated, consideration should be given to a steroid taper, with a duration of 14-21 days, which may help preclude rebound dermatitis. <sup>1</sup> Initial IM or IV steroid can be given in the urgent care setting followed by adequate outpatient steroid taper. Note that the fluid in the vesicles is sterile and does not contain urushiol, so a ruptured vesicle does not cause spread of contagion.
- Severe reactions involve respiratory distress. Strongly consider ED transfer.

## 3. Tick-Borne Illness

Tick-borne illness should be suspected in any symptomatic patient who is a resident of, or who has traveled recently to endemic areas. Symptoms range from simply dermatologic to constitutional, musculoskeletal, cardiac, and neurological.

Differential diagnosis of tick-borne illness should include Lyme disease, Rocky Mountain spotted fever (RMSF), ehrlichiosis, southern tick-associated rash illness, babesiosis, and tularemia; we will focus on RMSF and Lyme disease.

Blacklegged ticks (commonly referred to as deer ticks) are known vectors for Borrelia burgdorferi, which causes Lyme disease. Dog ticks and wood ticks are known vec-

"Patients with PTLDS may complain of nonspecific symptoms such as fatigue, headaches, joint and muscle aches, and pain, most of which are difficult to discern from normal aches and pains of daily living."

tors for Rickettsia rickettsii, which causes RMSF.

■ Lyme is characterized as primary (erythema migrans), with flu-like symptoms developing shortly after onset; secondary (constitutional, AV block, pericarditis, myocarditis, arthralgia, myalgia, cranial nerve palsy, meningitis, encephalitis); and tertiary (large joint arthritis, neurological symptoms of secondary Lyme). ELISA and Western blot antibody testing for Lyme serological antibody testing may be used to aid in diagnosis but should not delay treatment or rule out need for

treatment in patients with clinically suspected Lyme disease. The CDC advises to not delay the empirical treatment of suspected Lyme disease.4

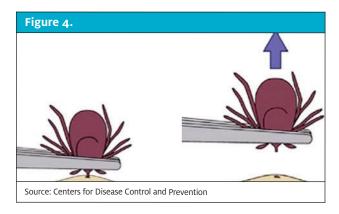
RMSF presents with onset of fever, chills, sweats, body aches, rash, and headache with the appearance by days 4-7 of a fine pink rash. Just as with Lyme disease, ELISA and Western blot antibody testing for Rickettsia serological antibody testing may be used to aid in diagnosis but should not delay treatment or rule out need for treatment in patients with clinically suspected RMSF. Even with treatment, mortality is 4%. Children have higher rates of mortality than adults.<sup>5</sup> The CDC advises to not delay the empirical treatment of suspected RMSF.4,6

## Management

Doxycycline 100 mg PO BID x 14-21 days is the treatment of choice to treat both Lyme and RMSF.

- For RMSF, doxycycline is the recommended treatment, regardless of age.<sup>7,8</sup>
- For Lyme disease, in children <8 years of age and for doxycycline-allergic patients, effective alternatives include amoxicillin, cefuroxime, and ceftriax-
- Providers may be hesitant to prescribe doxycycline to children <8 due to staining of teeth, though a 2017 study "failed to demonstrate dental staining, enamel hypoplasia, or tooth color differences among children who received short-term courses of doxycycline at <8 years of age."

Tick removal is an unnecessarily daunting task for the



urgent care provider. If the tick is still attached to patient, remove the tick by grasping its mouth with tweezers and pulling perpendicular to the attachment point. (See **Figure 4**.) Do not twist the tick, apply petroleum jelly, or touch the tick with a match. Do not attempt to remove retained tick body parts.

There is controversy regarding chronic Lyme disease; ie, whether persistent Lyme symptoms after treatment are due to ongoing infection or from treated Lyme disease. Prolonged antibiotic treatment in such patients showed no clinical benefit.<sup>9</sup> The CDC recommends using the term *post-treatment Lyme disease syndrome* (PTLDS) as opposed to "chronic Lyme disease".<sup>10</sup>

Patients with PTLDS may complain of nonspecific symptoms such as fatigue, headaches, joint and muscle aches, and pain, most of which are difficult to discern from normal aches and pains of daily living. Patients complaining of such concerns should be treated with respect, taken seriously, and referred to their PCP for proper management of such chronic ailments. Further research and evidence are needed to more definitively understand this phenomenon. Patients with confirmed PTLDS should be referred to an infectious disease specialist.

## 4. Frostbite

Frostbite is the freezing of the skin and deeper tissues and can happen in an urban or backcountry environment. The most commonly affected areas are fingers, toes, nose, ears, and cheeks due to vasoconstriction away from the periphery in attempts to maintain adequate core body temperature. Pathophysiology is divided into four overlapping stages:<sup>8</sup>

- 1. Pre-freeze: Vasoconstriction occurs though no ice crystals have formed yet.
- Freeze-thaw: Both intracellular and extracellular ice crystal formation lead to cell death. After the rewarming and during the thawing process, dam-

- age can continue with ischemia-reperfusion injury and ischemia.
- 3. Vascular stasis: Small vessel thrombosis and plasma leakage occur.
- 4. Late ischemia. Ischemia occurs due to progressive tissue ischemia and infarction from inflammatory cascade of thromboxane and prostaglandin, intermittent vasoconstriction, showers of emboli in microvessels, and thrombus formation in larger vessels. Destruction of the microvasculature is the root of continued cell death.

Frostbite is classified as *superficial* (first- and second-degree), and *deep* (third- and fourth-degree).

- First-degree presents with numbness and erythema; raised white, yellow plaque at the site of injury; and, commonly, mild edema.
- Second-degree results in blisters filled with clear, milky fluid surrounded by erythema and edema.
- Third-degree frostbite produces hemorrhagic blisters, which are indicative of penetration to the reticular dermis, surrounded by erythema and edema.
- Fourth-degree leads to complete penetration through the dermis, resulting in necrosis of deeper structures.

Deep injuries should be referred immediately to the ED. Superficial frostbite victims may be treated safely and effectively in the urgent care setting.

## Management

Remove patient from causative cold environment into a controlled, warm environment. Prior to any rewarming intervention, ensure there is no chance of refreezing, as this can lead to more severe injury. The injury should be warmed with warm, gently circulated water (98.6° -102.2° F, roughly "hot tub temperature") for at least 15 to 30 minutes or until skin regains pliability and its color returns to normal, red, or purple. You can use a water basin as your warming bath, consistently monitoring temperature. If the water is too hot, it can cause burn injury; if it is too cool, it can delay thawing. Thawing of a body part is very painful, sometimes requiring an opioid analgesic, though NSAIDs are recommended as sole analgesic or in conjunction with opioid to help inhibit the prostaglandin and thromboxane inflammatory cascade, which leads to worsening ischemia and necrosis.<sup>8,11</sup> Prior to thawing, it can be difficult to accurately gauge the extent of the injury. As such, if an initially suspected superficial injury demonstrates deep characteristics after rewarming, the patient must be transferred

Table 1. Staging and Treating Accidental Hypothermia			
Stage	Clinical symptoms	Typical core temperature	Treatment
Mild (HT I)	Conscious, shivering	35-32° C	Warm environment and clothing, warm sweet drinks, active movement (if possible)     HT I patients with significant trauma or comorbidities or those suspected of secondary hypothermia should receive HT II treatment
Moderate (HT II)	Impaired consciousness* (may or may not be shivering)	<32-28° C	Active external and minimally invasive rewarming techniques (warm environment; chemical, electrical, or forced air heating packs or blankets; warm parenteral fluids)     Cardiac and core temperature monitoring     Minimal and cautious movements to avoid arrhythmias     Full-body insulation, horizontal position, and immobilization
Severe (HT III)	Unconscious*; vital signs present	<28° C	HT II management plus:  • Airway management as required  • Preferences to treat in an ECMO/CPB center, if available, due to high risk of cardiac arrest  • Consider ECMO/CPB in cases with cardiac instability that is refractory to medical management  • Consider ECMO/CPB for comorbid patients who are unlikely to tolerate the low cardiac output associated with HT III
Profound (HT IV)	Vital signs absent	Cardiac arrest possible below 32° C; risk increases substantially below 28° C and continues to increase with ongoing cooling	CPR and up to three doses of epinephrine and defibrillation (further dosing guided by clinical response)     Airway management     Transport to ECMO/CPB†     Prevent further heat loss (insulation, warm environment, do not apply heat to head)     Active external and minimally invasive rewarming (see HT II) during transport is recommended but controversial; do not apply heat to head

CPB, cardiopulmonary bypass; ECMO, extracorporeal membrane oxygenation; HT, hypothermia

Adapted from: Tintinalli's Emergency Medicine: A Comprehensive Study Guide. 8th ed. New York, NY: McGraw-Hill Education; 2016.

to a higher level of care.

Do not:

- Rub or massage the area in attempt to thaw.
- Attempt rewarming with dry heat (eg, fire or a heater)

because this temperature is not controlled. Frostbitten skin with decreased sensation can be prone to burn injury without the patient being aware. If too cool, it can delay thawing.

<sup>\*</sup> Consciousness may be impaired by comorbid illness (eg. trauma, CNS pathology, toxic ingestion) independent of core temperature.

<sup>†</sup> Transferring an HT IV patient to an ECMO/CPB center may reduce mortality by 40%–90% (number needed to treat ~2); if ECMO/CPB is not available within a few hours of transport, consider on-site rewarming with hot packs or forced-air blankets, warm IV fluid, +/- warm bladder lavage, and +/- warm peritoneal lavage; do not apply heat to

 Debride blisters, especially hemorrhagic blisters, as this will increase risk of infection.

After the rewarming process has been completed and it is clear that the injury is superficial, apply topical aloe vera ointment and wrap in gauze every 6 hours; like NSAIDs, this helps to decrease the inflammatory cascade after rewarming to prevent further injury. Rest and elevate the affected body part. If injuries are on toes or feet, avoid weightbear-

"Heat is lost from the body through the mechanisms of conduction (body to object), convection (body to air or liquid), radiation (electromagnetic wave), and evaporation (sweat, respiration)." of which correlates to lower core body temperatures. 12 Patient presentation may range from being cold, shivering, and nonhypothermic to profoundly hypothermic, in cardiac arrest, and coma.

Diagnosis is made by measuring the core body temperature. Hypothermia is defined as having a core body temperature <35° C and is classified as mild, moderate, severe, and profound.

Mild hypothermia temperatures are 35° C to 32° C

- Moderate, 32° C to 28° C
- Severe, 28° C to 24° C
- Profound <24° C<sup>8,13</sup>

ing until completely healed. Update tetanus vaccine if needed. Prophylactic antibiotics are not recommended. One can expect tissue loss with deep injuries, and no tissue loss with superficial injuries. Concurrent hypothermia may also be present in frostbite victims and should be treated accordingly. Patients with superficial frostbite that you have treated in your urgent care should be reevaluated the next day.

## Prevention

Frostbite can be prevented by adequate preparation, including proper gear and clothing, being aware of the weather forecast, and having an evacuation plan that you decide on prior to leaving for wilderness activity. It is said that "cotton kills" because it absorbs moisture, including sweat, and accelerates body heat loss, increasing vasoconstriction, ultimately increasing risk of frostbite. Layering with moisture-wicking performance material or wool clothing is recommended.

## 5. Hypothermia Due to Exposure

Hypothermia is a serious and life-threatening condition that can happen in any season, even in temperate and tropical climates. Additional risk factors include alcohol ingestion and overexertion (eg, running a marathon) leading to fatigue, sweating, and dehydration. Heat is lost from the body through the mechanisms of conduction (body to object), convection (body to air or liquid), radiation (electromagnetic wave), and evaporation (sweat, respiration).

The pathophysiology of hypothermia is due to tissue cooling which results in a decreased resting metabolism and an impairment of neurologic function, the severity The best means to obtain an accurate core temperature in the urgent care setting is by using a rectal thermometer. Oral, infrared tympanic, and temporal thermometers should be avoided due to inaccuracy of measurements. Oral thermometers may be used only to rule out hypothermia.

- Mild: Patients in mild hypothermia will manifest uncontrollable shivering and have varying levels of alertness and hemodynamic stability. Vital sign abnormalities such as tachypnea, tachycardia, and hypertension may be present. Urinary frequency is common due to increased renal blood flow from vasoconstriction. Shivering increases metabolism, cardiac output, ventilation, and mean arterial pressure. Shivering is triggered at core body temperature of approximately 37° C and starts to decrease at 32° C. Patients will lose their ability to shiver at <30° C, which is an ominous sign.
- Moderate: Patients in moderate hypothermia will have a minimal to completely absent capability of shivering. Depressed vital signs are common, and include hypotension, decreased heart rate, and decreased respirations. Mental status will be altered, and patients may have dilated pupils with muscle rigidity. Cardiac arrhythmias are common at such core body temperatures, and can be precipitated by even the slightest of stimulation of the periphery such as taking one's wet clothes off.
- Severe: Severely hypothermic patients will be in a

coma with dilated pupils and muscular rigidity. Pulse may be barely palpable as the heart rate drops to as low as 10-20 beats per minute. Lifethreatening cardiac arrhythmias, such as ventricular fibrillation, are common at such temperatures and tend to be recalcitrant to chemical or electrical conversion until rewarming is accomplished.

Profound: Profound hypothermia is defined as <24° C, at which point the

patient has a high likelihood of cardiac arrest and death.

## Management

The degree of hypothermia guides management (see Table 1).

The patient with mild hypothermia who is shivering, has no altered mental status, has no concurrent trauma or comorbidities, and is hemodynamically stable may be safely treated in the clinic. Such patients should be kept horizontal, as standing can lead to a drop in BP and hemodynamic instability. Wet clothing should be removed by cutting, taking care to minimize peripheral stimulation, which may precipitate cardiac arrhythmia. Rewarming methods should include insulating patient with blankets, towels, sleeping bag, dry clothes, etc. Warming equipment such as warm water bottles or warming pads may be placed in the axillae and groin. Always place a barrier between warming equipment and the patient's skin to avoid causing burn.

Once the patient has been rewarmed to 37° C, is hemodynamically stable and unaltered, and has been horizontal for at least 30 minutes, they may attempt to stand. At this point they may be seated upright and given warm liquids and foods rich in carbohydrates to meet the elevated metabolic demand. 12 These patients should have next-day follow-up visits and should be given strict ED precautions. They should remain indoors, warm, and insulated from the outside environment.

All other hypothermia patients should be referred to the ED. While waiting on EMS transfer for the hypothermic patient, warming methods should be initiated. Remove wet clothing by cutting. Keep the patient hor-

"The patient with mild hypothermia who is shivering, has no altered mental status, has no concurrent trauma or comorbidities, and is hemodynamically stable may be safely treated in the clinic "

izontal and insulated. Be prepared to perform CPR and have the AED ready if neces-

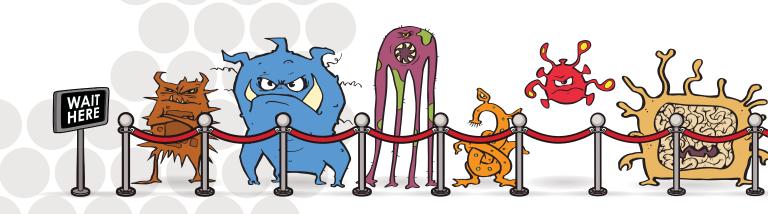
## Prevention

Hypothermia can be prevented by wearing proper clothing, staying dry, taking shelter as needed, and having an evacuation plan.

## **Teaching Points**

- Doxycycline is the recommended treatment for RMSF, regardless of age.
- A prolonged steroid taper of 14-21 days is the preferred treatment for poison ivy.
- Azithromycin, not ciprofloxacin, is the first-line empiric antimicrobial choice for infectious trav-
- Hypothermia can happen in any season, even in temperate and tropical climates. ■

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## **ABSTRACTS IN URGENT CARE**

- Multitasking—A Receipt for Failure?
- Rethinking Concussion Management
- The Missing Link in Nonspecific Head, Back Pain
- JOSHUA RUSSELL, MD, MSC, FAAEM, FACEP

- Putting Infant Safety First
- Overtreatment of Asymptomatic Bacteriuria

## Practice of Urgent Care: The Illusion of Multitasking and the Cost of Interruptions

Key point: True multitasking is not possible. Rather, when we attempt to multitask, our brains are actually rapidly switching focus. Task-switching and interruptions negatively impact our ability to complete tasks accurately and effectively. Minimizing task-switching reduces the likelihood of cognitive errors and, consequently, adverse patient outcomes.

Citation: Skaugset LM, Farrell S, Carney M, et al. Can you multitask? Evidence and limitations of task switching and multitasking in emergency medicine. Ann Emerg Med. 2016;68(2): 189-195

As a younger physician, I ardently sought to multitask more efficiently, thinking it to be the most assured path to clinical expertise. In fact, I believed multitasking to be the only way to manage the multiple patients I was caring for simultaneously. Unfortunately, abundant studies on human cognition have demonstrated that our attention simply cannot be divided this way. Multitasking, while alluring in concept, is sadly not possible.

When we attempt to "multitask" we are actually rapidly taskswitching. And it turns out, task-switching carries with it a heavy cost in terms of performance. Pausing a task leads to a dramatic increase in rates of error and likelihood of task incompletion. It naturally stands to reason, therefore, that we should strive to reduce the number of times we switch tasks.

However, in acute care, interruptions occur with alarming frequency. ED studies have demonstrated that clinicians are interrupted about once every 6 minutes. And while there have never been such studies performed in urgent care, rates of interruption in our clinical environment are likely comparable. And with increasing numbers of interruptions comes increasing risk for cognitive error.

The authors of this review article suggest that the insidious danger of interruptions must first be appreciated. We as urgent care clinicians need to divorce ourselves from the notion that multitasking is possible and acquiesce to its superhuman unattainability. Secondly, these authors recommend taking actions to minimize the quantity of interruptions, especially during critical tasks. There are some simple steps we can take ourselves to achieve this, such as turning off push notifications on our smartphones and diverting calls while engaged in procedures. However, more challengingly, we also need to change the behaviors of our staff to discourage unnecessary interruptions and work toward a culture in urgent care where interruptions are recognized for the patient safety hazards they create.

## A Gamechanger for Sport-Related Concussion

Key point: Light aerobic activity may allow adolescents with concussion to recover more quickly.

Citation: Leddy JJ, Haider MN, Ellis MJ, et al. Early subthreshold aerobic exercise for sport-related concussion: a randomized clinical trial. JAMA Pediatr. February 4, 2019. [Epub ahead of print]

Recommendations for the management of concussion in adolescents have long been a moving target. While there is no consensus across professional societies, recent guidelines have advised strict physical rest, especially for athletes, until entirely asymptomatic. However, there is also extensive observational data suggesting a role for physical activity in being helpful for



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.

## ABSTRACTS URGENT CARE

"Thanks to the advent of clinical decision rules for pediatric head injury (eg, PECARN), we can clear the vast majority of head-injured children without imaging and discharge them directly from urgent care. However, the next obvious question often is: So, when will these symptoms go away?"

the brain and preventing neurodegenerative disease.

With this backdrop, these investigators performed a randomized controlled trial of 103 adolescents who sustained a sports-related concussion in the prior 10 days. Participants were randomized to perform either gentle stretching or aerobic exercise (below the threshold to exacerbate concussion symptoms) for 20 minutes per day. Their symptoms were subsequently evaluated each day.

Remarkably, the patients in the aerobic exercise group recovered dramatically faster (13 vs 17 days). While this was a single RCT, the results are compelling and suggest that it may be reasonable to prescribe gentle aerobic exercise (below symptom threshold) to patients after sports-related concussion. Of course, this should also include a caveat that this must be noncontact physical activity.

## Taking the Guesswork out of Concussion Recovery

Key point: Concussion recovery takes time, and is slower in adolescents than in younger children. These data can be helpful in setting realistic expectations for recovery and return to play. Citation: Ledoux AA, Tang K, Yeates KO, et al. Natural progression of symptom change and recover from concussion in a pediatric population. JAMA Pediatr. November 5, 2018. [Epub ahead of print]

Concussion is a common diagnosis in urgent care, especially at this time of year. Thanks to the advent of clinical decision rules for pediatric head injury (eg, PECARN), we can clear the vast majority of head-injured children without imaging and discharge them directly from urgent care. In athletes particularly, however, the next obvious question after the diagnosis of concussion often is: So, when will these symptoms go away?

In a large, prospective, secondary analysis of a multicenter RCT, this group of Canadian researchers analyzed data on concussion symptom progression in over 2,700 children ranging from 5 to 18 years of age. They found that younger children (57 years) recovered significantly more quickly than older children (8-12 years) and adolescents (13-18 years), with approximately 75% of children <8 years fully recovered within 4 weeks. Children aged 8-18 years recovered more slowly, with most children requiring at least 2 weeks to even begin to notice symptom improvement. Adolescent females recovered most slowly, with many not fully recovered even by week 12.

While the pace of concussion recovery was quite variable, these data do allow urgent care providers to disabuse parents of the common, wishful thinking that their concussed teenager can safely play in next week's football game. Informing patients and caregivers that concussion recovery (especially in adolescents) is better measured in months than in weeks can help establish realistic expectations for recovery and return to play.

## What Are We Missing when We Diagnose Nonspecific Headache and Back pain?

Key point: The vast majority of ED patients discharged with nonspecific back pain and headache will not go on to have serious short-term adverse outcomes. Among the few patients with headache or back pain who do have short-term adverse outcomes, thankfully most will have obvious risk factors. Citation: Dubosh NM, Edlow JA, Goto T, et al. Missed serious neurologic conditions in emergency department patients discharged with nonspecific diagnoses of headache or back pain.

Ann Emerg Med. February 20, 2019. [Epub ahead of print]

We assign benign diagnoses to the vast majority of patients presenting with acute back pain and headache. In the ED setting, and certainly even more so in the urgent care setting, patients with these complaints tend to undergo little, if any, diagnostic workup. Rather, clinicians generally rely on the patient's history and exam to exclude dangerous causes of headache and back pain. At the same time, however, multiple life-threatening conditions can present with these symptoms.

The investigators in this study sought to answer the question, how often are dangerous etiologies of back pain and headache missed by acute care providers on an index visit? They retrospectively analyzed a truly massive number of ED visits (over 1 million ED visits for each complaint) occurring in

"When it comes to preventing sudden unexplained infant death, nothing is more important than attention to a safe sleep environment. In fact, 82% of cases of SUID are attributable to suffocation while sleeping."

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## "Asymptomatic bacteriuria should only be tested for (and, if identified, treated) in pregnant women. It's really that simple."

six different states from 2006 to 2012. They created a composite primary outcome of interest, which included a return visit with hospitalization for an issue related to their back pain or headache and/or diagnosis of a "serious neurological condition" or death within 30 days of ED visit.

Overall, the results were reassuring. A negative composite outcome occurred in only 0.5% of headache patients and 0.2% of back pain patients. The most common adverse outcomes were CVA/stroke in headache patients and spinal infection in back pain patients. Predictors of serious outcomes were not surprising and included advanced age, male gender, immunosuppression, HIV/AIDS, and comorbid malignancy.

An important limitation in this study when considering its generalizability for the urgent care setting is that it included only ED patients. These patients were likely sicker, which may suggest a lower risk for urgent care patients; however, ED clinicians often also have immediate access to advanced imaging, as well, which can provide more certainty in excluding dangerous conditions. Data on the exact use of imaging by ED providers to exclude serious pathologies were not included.

## **What Really Matters for Infant Safety**

Key point: The majority of accidental deaths in infants occur due to suffocation in bed. Reminding new parents about the importance of laying infants on their backs, avoiding soft/loose bedding, and not allowing babies to sleep in adult beds can be lifesaving.

Citation: Erck Lambert AB, Parks SE, Cottengim C, et al. Sleep-related infant suffocation deaths attributable to soft bedding, overlay, and wedging. *Pediatrics*. 2016;174:84-90.

Parents of newborns worry about a lot—about rashes, spitting up, and, of course, the frequency, consistency, and color of their baby's stool. When distraught and sleep-deprived caregivers present with these concerns, they usually require nothing more than reassurance. However, the challenge in raising infants lies not only in avoiding excessive worry about the things that don't matter, but more importantly, in paying close attention to the few things that really do matter.

When it comes to preventing sudden unexplained infant death (SUID), nothing is more important than attention to a safe sleep environment. In fact, 82% of cases of SUID are attributable to suffocation while sleeping. The authors of this paper

reviewed all cases of SUID in the CDC registry from 2011 to 2014. They found that the majority of suffocation deaths (69%) were caused by soft sheets and bedding, followed by accidental overlay/crushing by a parent (19%). Further examination revealed that most of the cases of suffocation were due to the child being in an adult bed, laying prone, and being accidentally overlaid by the mother.

New parents are basically all sleep-deprived and can easily fall asleep accidentally with their newborn in their bed. So, take a moment when discharging new parents and make sure that they are aware that, while that minor diaper rash won't kill them, an inappropriate sleeping position or environment actually could.

## **Stop Treating Asymptomatic Bacteriuria in Almost Everyone**

Key point: The best and most recent evidence suggests that we should only be screening for and treating asymptomatic bacteriuria in pregnant patients.

Citation: Nicolle LE, Gupta K, Bradley SF, et al. Clinical practice guideline for the management of asymptomatic bacteriuria: 2019 update by the Infectious Diseases Society of America. *Clin Infect Dis.* March 21, 2019. [E-pub ahead of print]

Nearly 15 years have passed since the Infectious Disease Society of America's (IDSA) last update on guidelines for screening and treatment for asymptomatic bacteriuria. In that time span, rates of antibiotic resistance among urinary pathogens have increased substantially. Unsurprisingly, in response the IDSA has tightened their recommendations on who should be tested and treated for asymptomatic bacteriuria.

In summary, asymptomatic bacteriuria should only be tested for (and, if identified, treated) in pregnant women. It's really that simple. The authors recommend a treatment duration of 4 to 7 days in this population. Notably, they recommend against screening in infants, the elderly, and individuals with diabetes, chronic kidney disease, and immunosuppression. These recommendations, while easy to recall, importantly should only be applied to asymptomatic patients.

## **Tips on Twitter: Peds Pearls**

- Up to 40% of toddler fractures (spiral tibial fractures) are not evident on initial radiographs. If they are painful/tender on the tibia and can't bear weight, put them in a long leg splint. Thanks Ilene Claudius and @mizspangler for sharing.
- If you are going to document two things on every pediatric fever case they should be vaccination status and a description of the reassuring behavior you are witnessing.

(Follow Dr. Russell on Twitter: @UCPracticeTips.)



## Are Those Teambuilding Activities Really Worth It?

**Urgent message:** High-profile teambuilding extravaganzas may get your crew pumped up—once or twice a year, assuming you can shut down your operation for the day. In the 7-day-a-week culture of urgent care, however, you may get better results by making it a day-to-day commitment.

AMY LAFKO, MSPT, MBA

## What will you find in this article?

- ROI of teambuilding
- Clues on assessing the current state of your team
- Tools to foster teamwork in a sustainable way

There are hundreds of articles about teambuilding activities like ziplining, ropes courses, and escape rooms. While these activities can jumpstart more effective teams, you're thinking to yourself, We are open 7 days a week, 12 hours a day. When exactly can we take the time to go to an escape room?!

And what is the goal of all of this "teambuilding" anyway? According to Oxford Living Dictionaries, teambuilding is the action or process of causing a group of people to work together effectively as a team, especially by means of activities and events designed to increase motivation and promote cooperation. Well, that certainly sounds good but again, where do we find the time? I want to reframe the thinking about teambuilding activities from once-aquarter events to daily habits.

## **ROI of Teambuilding**

In order to calculate the ROI of teambuilding, we need to first establish what teambuilding is actually meant to accomplish:

- 1. Trust among team members
- 2. Increased productivity: efficiently working together
- 3. Effective group communication
- 4. Understanding team member strengths and interests



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- 5. Healthy conflict leading to better decisions
- 6. Alignment toward the same goals
- 7. Positive peer pressure to perform
- 8. Engage people to give their discretionary effort
- 9. Increased patient satisfaction
- 10. Team-oriented culture that promotes retention

Gallup found that an actively disengaged employee costs their organization \$3,400 for every \$10,000 in

Amy Lafko, MSPT, MBA is the founder and principal of Cairn Consulting Solutions. The author has no relevant financial relationships with any commercial interests.

salary (34% of salary). This cost reflects lost productivity, poor communication or decision-making, etc. Gallup predicts that in any given organization, 17.2% of employees are disengaged. Now, you know your team and hopefully you are measuring engagement so use your numbers if you have them.

## Table 1. Cost of Disengaged Employee

Number of employees x .172= number of disengaged employees eg, 15 X .172 = 2.58

Combined salaries of disengaged employees x 34% eg, using MAs at \$14/hour 2.58 x (\$14 x 2080hrs) =

\$75,130

\$75,130 X .34 = \$25,544

eg, using 1 NP's

\$100,000 Salary \$100,000 X .34= \$34,000

That is only one calculation we need to do. Another key calculation is the cost of turnover. According to Bureau of Labor statistics, at a minimum, every time you replace a position it costs your company 33% of salary and benefits. This 33% includes recruitment cost, time lost to interviewing and onboarding, plus new hire not at full productivity. So looking at the same salaries with 20% benefit load:

## Table 2. Cost of Turnover

MA \$34,944 X 33% =**\$11,532** NP \$120,000 X 33% = **\$39,600** 

An even more grim calculation comes from the Society of Human Resource Management (SHRM), which estimates 6-9 months of salary per lost employee. These are some scary numbers and they don't even take into account the lost productivity caused by poor communication, lack of decision-making, conflicts, etc.

## **Assess the Current State of Your Team**

To assess the current state of your team, there are several data points for you to consider. As we saw in the previous calculation, turnover costs money and you need data points about turnover and retention rates. Examine overall turnover rate and then break the rate down by position and location. Track your retention rates by tenure, as well as by position.

Unless you have a small practice, you need to measure employee engagement. Many places choose not to do these surveys because they say they won't get "real" information. Depending on how you present the concept, that may be true, but with the right foundation a survey can provide incredibly valuable data.

Think of it like the value of taking vital signs as part of a visit; if you don't take them correctly, they are useless. These surveys don't have to be complex or time-consuming. With most of my clients, we ask no more than a handful of questions that truly get to the heart of engagement. The best thing about successfully measuring employee engagement is that it will give you the roadmap to improvement specific to your organization.

Some elements of teamwork and engagement that you may not automatically consider include things like worker's comp claims. Take a look at your quality outcomes and how many patient safety events occur. Are people being lax in safety and quality because they don't communicate well or just don't care? A significant indicator is patient satisfaction. I will never forget the time I took a role in an urgent care facility and on day 3 someone told me, "We will never care about these people until management cares about us."

## **Tools to Foster Teamwork in a Sustainable Way**

Many of you might feel compelled to combat turnover and other issues with team dynamics by simply throwing money at the problem (or at your employees). You might want to rethink that in light of a *Harvard Business Review* article on a meta-analysis of 92 quantitative studies that found "the association between salary and job satisfaction is very weak. The reported correlation indicates that there is less than 2% overlap between pay and satisfaction levels."<sup>2</sup>

You might also decide that based on the calculations noted previously, a teambuilding event is certainly cheaper than turnover. That's true, but one or two events a year won't transform a negative culture into a teamwork-oriented culture. In order to create a sustainable, cohesive culture, you need to address six core components. To get a better understanding of those six components, let's compare them to a teambuilding activity in an escape room.

1. Purpose. In an escape room, there is a clear purpose with priorities delineated. We want to get out of the room. In your organization, you also need a clearly defined purpose with established priorities. If your mission, vision, and values statement are in a binder or hanging behind a door, then I don't con-

## Table 3. Core Components to Building a Sustainable, Cohesive Culture

- 1. Purpose
- 2. Strategic approach
- 3. Leadership
- 4. Behavioral norms
- 5. Cultural ambassadors
- 6. Incentives

sider those *purpose*. If your team can reference them and how they impact their work each day, then yes—your mission statement is your purpose. More often than not, purpose is actually the unspoken activities that are encouraged, or statements made by senior leaders. If you don't have a purpose that is motivating and compelling to the frontline team members, then creating that is priority #1. An organization I work with has added several marketing components to their performance review, things like the number of favorable Yelp reviews and number of community events; this has left the employees feeling like their role is similar to a car salesperson instead of a healthcare professional.

- **2. Strategic approach.** If you want to get out of the escape room, you have to do it in a step-by-step manner. You have to solve the first clue to get the second clue. Similarly, if you want to make progress with your culture, you need to have a plan that is well thought out. Use the data you have collected as a starting point. After getting the results of an employee engagement survey, one of the first things I do with clients is create a strategic plan for the year based on action items and milestones that will affect the feedback we received. Determine which step will have the greatest impact and move in that direction. What elements must be in place before you can roll out the next phase? By creating a strategic approach, you will be more likely to achieve the goal.
- 3. Leadership. A strategic approach only works if you have leaders who are skilled at carrying it out. They need to be able to communicate the purpose, create dialogue, and build trust. We talk about methods of communication all the time, yet people forget the most common route of communication from corporate to frontline is through the clinic manager. It's important to remember professional development as part of your strategic approach. Train people in conflict resolution, providing feedback,

- holding other accountable, etc. In-person development workshops bring huge value, but there are also online video resources that support ongoing leadership development.
- 4. Behavioral norms. Aristotle told us, "We are what we repeatedly do." In an escape room, we see people step up to take charge, while others gravitate to their strengths and some people get frustrated or simply stop doing their part. What are the "stories" that are told to new people about "how we do things around here"? Are there behavioral norms you are pretending don't negatively impact your culture? What behavioral norms are you encouraging and positively reinforcing? It is important that you help build stories and behaviors that align with the culture you want.
- 5. Cultural ambassadors. These are the cheerleaders in the escape room. They may be the ones on the sidelines cheering or they may be the ones in the thick of getting to the goal. In your organization, you have these ambassadors at every location. Get to know who they are and support them.
- 6. Incentives. In an escape room, the aim is to succeed in getting out. That sole purpose is ample incentive to motivate people. Now think about how motivating your purpose is. As we saw in the research, money isn't the motivator. Yes, it has an impact but if you are paying a fair wage and have decent benefits, people will stay for a great team. Your incentive plans have to align with the hearts and minds of your people. Get creative with incentives. What do they really want and need?

Back to our original question: Are those teambuilding activities really worth it? I'm not suggesting these activities aren't useful. After all, when you are getting out of an escape room people have a common purpose, strengths are exposed, leaders emerge, and communication has to be effective for the team to succeed. Taking the team offsite can help refresh people, build camaraderie, and be fun. I am suggesting that successful teambuilding does not take place during a twice-a-year teambuilding experience. Your culture exists every day and if you want a strong team, those habits and behaviors need to be reinforced on a daily basis.

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## HEALTH LAW AND COMPLIANCE

## How Best to Manage an 'At-Will' **Termination**

**Urgent message:** In most states, employment is at will—meaning that an employer can fire or terminate an employee at any time, for any reason that is not against the law. Even so, the employment at-will doctrine isn't a license for an employer to fire employees at the drop of a hat. There are still critical considerations for urgent care operators to heed when terminating a provider or staff member.

ALAN A. AYERS, MBA, MACC

## What is Employment At Will?

n short, if you're employed at will, an employer doesn't need good cause to fire you. 1-3 The employer can terminate an employee at any time, for any reason, with or without notice. That comes as a surprise to many employees (and some employers).

It may be a bit far-fetched for an employer to tell an at-will employee, "I don't like that you're a rabid Green Bay Packers fan—you're fired," but it's generally not against the law to do so. An employee in that situation has few, if any, remedies, unless the employer did something to violate the employee's rights or violated state or federal law.<sup>4,5</sup>

All states—except for Montana—have enacted laws that protect the employer in an at-will situation. Unless you signed an employment agreement that states you can't be terminated without good cause, it is assumed in all other states and jurisdictions that you're an at-will employee.<sup>6,7</sup>

In many situations, employers will explicitly state that a worker is an at-will employee in the onboarding process. However, as discussed below, some employees have won lawsuits where their employers told them they could only be fired for good cause.8-10 Even statements as lighthearted as, "You'll always have a place here, as long as you keep up the great



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.

work," have been found to create a contractual relationship for employment.11,12

## **Employment Contracts**

An employment contract is a signed agreement between the employer and the employee that outlines the basic details of the position. This contract sets out the specific parameters of the employment situation. Provided the employee signs the employment contract, it is binding. An employment contract may include a detailed description of the terms under which the employee will work for the employer. This typically includes salary and health benefit eligibility after working a specific amount of time, as well as vacation, retirement, and personnel procedures.13

## Implied contracts

In some circumstances where there is no written contract, an agreement will be implied through a verbal understanding or by the actions of the employer and the employee.<sup>6</sup> Again, while employment is presumed to be at-will,14 typically, the "at-will presumption can be rebutted by a showing that the parties entered into an express or implied agreement which prohibited the employer from discharging the employee without just cause."15

In the private employment context, an express or implied agreement between the employer and employee may provide the terms of the employment contract. Courts frequently examine language of employee handbooks to determine terms of an employment contract and whether they provide that an

## HEALTH LAW AND COMPLIANCE

"The three common-law exceptions accepted by most courts are public policy, implied contract, and implied covenant of good faith. The most commonly recognized exception: An at-will employee has a cause of action for wrongful termination if termination of the at-will employee is retaliatory in violation of a clear mandate of public policy."

employee may be discharged only for cause. 16,17 Some courts have held that personnel rules can form the terms of the employment contract. 18 Thus, an implied employment contract may in some instances be inferred from comments made during an interview or job promotion, or from provisions of a training manual or handbook. 19

Although implied contracts are difficult for an employee to prove, they have been held to be binding.<sup>19</sup> Courts will look at factors such as these to determine if an implied contract existed:

- The length of employment
- Evidence of the employee's performance on the job, such as performance evaluations
- The employee's performance recommendations by the employer
- The history of discussions between the employer and the employee, to see if statements were made to ensure the future employment of the employee
- The employment handbook, to see whether the employer violated any actions in properly terminating the employee
- The employer's hiring and firing practices
- The timing of the employee's qualifications for benefits like medical coverage
- A comparison of similar industries as to whether written or implied contracts are the norm<sup>13</sup>

## **Exceptions to the At-Will Presumption**

Courts have created exceptions to the at-will presumption in an attempt to in some way equitably mitigate the doctrine's sometimes severe consequences.

The three common-law exceptions accepted by most courts are public policy, implied contract, and implied covenant of good faith.<sup>20</sup> Courts that have recognized good-faith-and-fair-dealing exceptions have found either covenants implied in-fact

or covenants implied in-law.21-23

Covenants implied in-fact have been found in "objective manifestations." <sup>24</sup> This includes actions by the employer such as repeated promotions and pay increases that might reasonably give an employee reason to think that they have job security and will be treated justly. <sup>25</sup> When determining if such a covenant should be inferred, a court will examine factors such as whether the company properly followed its stated personnel policies, the tenure of the individual's employment, any job security assurances that may have been given, a presence or lack of prior criticism of performance, and basic concepts of fairness. <sup>26</sup>

The most commonly recognized exception to the at-will presumption protects employees against adverse employment actions that violate a public interest or public policy.<sup>27</sup> Specifically, under the public policy exception to the at-will employment doctrine, South Carolina courts have held that an at-will employee has a cause of action in tort for wrongful termination where there is "a retaliatory termination of the at-will employee in violation of a clear mandate of public policy."<sup>28,29</sup>

The South Carolina Supreme Court found that the public policy exception clearly applies in cases in which either: 1) the employer requires the employee to violate the law; or 2) the reason for the employee's termination itself is a violation of criminal law.<sup>30</sup>

Note that those states that accept the public policy exception differ to various degrees in its application. Most states accept only public policy that is provided in state constitutions and statutes, but there are a few states that permit additional sources such as administrative regulations, professional codes of ethics, and notions of public good and civic duty.<sup>31</sup>

## **Takeaways**

It's essential for urgent care operators and owners to understand and appreciate that while employment relationships are presumed to be "at-will" in all states except Montana, unlawful termination lawsuits can arise.

The common-law and statutory exceptions to the at-will rule are litigated with some frequency to determine whether the specific facts of a case constitute an exception or an implied contract. Generally, courts uphold the presumption of at-will employment, and a plaintiff's cause of action is difficult to prove.

While, in many cases, an employer may believe that he can terminate an employee "at will," there is some protection that can be taken to prevent a potential lawsuit. A severance agreement can be offered to the employee at termination. The employer can ask the employee to sign the agreement which provides them with a certain amount of salary (eg, 2 weeks for every year of employment) in exchange for full release of claims and a promise of confidentiality or nondisclosure.

The employment "at-will" doctrine does not give the employer a license to do whatever it pleases—there are still

#### HEALTH LAW AND COMPLIANCE

very important issues to examine any time an employee is terminated. Always, discuss your employment issues with a qualified employment law attorney.

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## A 9-Year-Old Girl with Sudden-Onset Sore Throat After a Meal

Urgent message: Sore throat and throat pain are common complaints in the urgent care setting. While infectious causes are the most common and the likely cause of the patient's complaint, it is important to consider other causes.

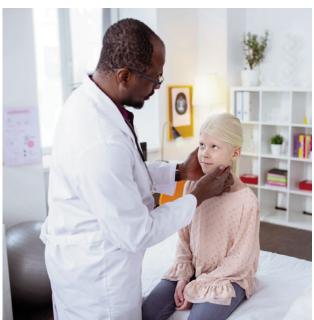
LINU SAMUEL. MD

#### Introduction

Ore throat and throat pain are common chief complaints across all ages in the urgent care setting. As cli-Unicians who likely see these complaints multiple times a day, our differential diagnosis when walking into the patient room probably consists of only the most common causes of pharyngitis, which are the infectious causes (viral pharyngitis, allergic pharyngitis, and streptococcal pharyngitis). While it is easy to consider sore throat and throat pain to be "just pharyngitis" and rely on decision criteria and/or point-of-care testing to make or confirm our diagnosis, it is always important to obtain a thorough history and physical exam, and use our clinical gestalt when the typical infectious history and exam findings are not present. At times, it may be important to revisit the physical exam and ask more questions when history, exam, and our differential do not match. In addition to the viral, allergic, and streptococcal pharyngitis, it is important to remember that a complete differential for pharyngitis also includes gonococcal pharyngitis, infectious mononucleosis, sinusitis, postnasal drainage, herpangina, gastroesophageal reflux disease, smoking, thyroiditis, and foreign body ingestion.<sup>1,2</sup>

#### **Case Presentation**

A 9-year-old female presented to urgent care with the chief complaint of sore throat for the past 2 to 3 hours. She states her throat started to hurt after eating dinner, which consisted of a hamburger, French fries, and corn. She and her parents described the pain as moderate to



severe and right-sided. She felt the pain improved minimally after eating yogurt and drinking cold water. The parents did give her Tylenol at the time the pain started, but it had yet to resolve the pain. They described her voice as "hoarse," but otherwise there were no other symptoms. She denied fever, chills, recent or current URI symptoms, ear pain, drooling, shortness of breath, stridor, chest pain, and abdominal pain. She and her parents denied any recent exposure to strep throat, infectious mononucleosis, or any sick contacts in general.

Linu Samuel, MD is a senior staff physician at the Baylor Scott and White Health Convenient Care Clinic - Belton (TX). The author has no relevant financial relationships with any commercial interests.





The patient's medical history and her family history were unremarkable.

#### **Physical Examination**

Vital signs were within normal limits and included:



■ Temperature: 98.6° F ■ Respiratory rate: 18

■ Heart rate: 97

■ Oxygen saturation: 98%

"Foreign body ingestion should be on a clinician's differential when the history and physical exam do not point toward the more common causes of sore throat."

Physical exam revealed the child was well but did have discomfort in the area of her throat/neck. She was active, and able to carry a conversation. No obvious stridor was noted. Her oropharynx was unremarkable. There was no erythema, tonsillar swelling, tonsillar exudate, or soft-tissue swelling. Palpation of her neck revealed no enlarged or tender lymph nodes. There was an area of the right anterior neck that with light palpation was able to recreate the patient's moderate-to-severe sharp throat pain.

At that time, further history was obtained; it was noted the patient's pain started while eating the hamburger her father cooked on their home grill. At this point the patient was given a combination of Mylanta and viscous lidocaine, and imaging of the neck soft tissue was obtained. Her pain resolved with treatment.

#### Diagnosis, Course, and Treatment

Imaging of the neck (**Figure 1**) was concerning for a thin linear radiopaque density in the area of the vallecula anterior to the epiglottis. When the imaging results were reviewed with the father and the patient, the father remembered that he had cleaned the grill with a metal bristled brush before cooking. As the patient had a likely foreign body ingestion, with the foreign body most likely a sharp-pointed metallic body, the case was discussed with an ED attending who agreed transfer to the ED for further evaluation and management was advisable.

While in the ED the patient had a noncontrast CT of the neck soft tissue, which confirmed there was a linear foreign body anterior to the epiglottis in the area of the vallecula, approximately 9.5 x 1 mm in size (**Figure 2** and **Figure 3**). The patient went to the OR for direct laryngoscopy under general anesthesia. A metallic linear foreign body was found imbedded in the vallecula and was removed. Final diagnosis: metal foreign body

of the throat, consistent with metal wire.

#### **Discussion**

While there are many more common causes for throat pain, foreign body ingestion should be on a clinician's differential when the history and physical exam do not point toward the more common causes.

Foreign body ingestion can occur at any age but is more common between the ages of 3 and 6 years and in patients with developmental delay and behavioral problems. While morbidity is low (<1% of all patients), death from foreign body ingestion can occur—and does, in approximately 1,500 deaths a year.<sup>3,4</sup> Commonly ingested foreign bodies include coins, button batteries, toys, toy parts, magnets, safety pins, screws, marbles, bones, and large amounts of food.

Foreign body ingestion presentations show great variation between symptomatic and asymptomatic. While approximately 50% of children with witnessed or reported foreign body ingestion are asymptomatic, respiratory distress along with initial suspicion and choking attack while eating have been found to have strong indicators for foreign body aspiration.<sup>5</sup> Patients in respiratory distress who are referred for emergent care should be transported to the ED by private car if feasible. Another study found that 40%-50% of individuals with foreign body ingestion are not witnessed, and in many cases the patient has no symptoms.3 A case series of 325 children with foreign body ingestion found approximately half of the children were symptomatic at the time of ingestion. Those symptoms included retrosternal pain cyanosis, cyanosis, and dysphagia.<sup>6</sup>

Symptoms of foreign body ingestion are typically dependent on the location of the foreign body. Foreign body in the esophagus may cause refusal to eat, dysphagia, drooling, or respiratory symptoms, or the patient may be asymptomatic. Older children may be able to localize the pain. If the foreign body is in the stomach or intestines, the patient is typically asymptomatic but may have vomiting or refuse to eat. It has also been found that 20%–50% of children with confirmed ingestion are asymptomatic of foreign body ingestion and have possibly been treated for other diagnoses for a month before the diagnosis of foreign body ingestion is made.<sup>3,6</sup>

With these variations in presentation and symptoms, it is important to have a high index of suspicion for foreign body ingestion when the history and physical exam do not correlate, as seen with our case.

When there is suspicion of foreign body ingestion,

plain radiographs of the neck, chest, and abdomen should be obtained. It is important to note that approximately 64% of ingested foreign bodies are radiopaque.<sup>6</sup> If radiographs do not reveal a foreign body, advanced imaging can be obtained (depending on patient presentation and the suspected foreign body); this is especially helpful when the suspect body is radiolucent.<sup>3,4,7</sup>

#### Management

Management of foreign body ingestion breaks down into two categories-urgent vs expectant management—depending on the location of the foreign body and the specific foreign body. Urgent management, emergency endoscopy, is required if:

- The patient shows symptoms of airway compromise
- There is near to complete esophageal compromise
- The object is sharp, long, or a superabsorbent polymer in the esophagus or stomach
- The object is a high-powered magnet or multiple magnets
- The object is a button battery
- There are signs/symptoms of inflammation or intestinal obstruction such as fever, abdominal pain, or vomiting

Any object in the esophagus for more than 24 hours should be removed emergently so as to decrease the risk of transmural erosion, perforation, or fistula. Patients who do not meet the criteria for urgent management can be observed for 12 to 24 hours, as spontaneous passage is likely.<sup>3,4,7</sup>

Exceptions to the urgent vs expectant management occur when the foreign body is in the esophagus or the patient is symptomatic and the foreign body is in the stomach or duodenal bulb. Symptoms include fever, nausea, vomiting, or abdominal pain/tenderness. In these situations, urgent endoscopy, within 24 hours, is recommended. In addition, if a foreign body is in the stomach for more than 4 weeks it is unlikely to pass beyond the pylorus and should be removed endoscopically as well.<sup>3,4,7,8</sup>

Looking specifically at sharp-pointed foreign body ingestion, as with our patient, if there is suspicion of ingestion it is important to determine location of the foreign body. Sharp-pointed objects lodged in the esophagus are at high risk for perforating the esophagus; this is a medical emergency requiring urgent endoscopy for removal. As many ingested sharp objects are radiolucent (eg, fish bones and wooden toothpicks), endoscopy should be performed if there is a high level of suspicion or witnessed ingestion. If the patient is "Any object in the esophagus for more than 24 hours should be removed emergently so as to decrease the risk of transmural erosion, perforation, or fistula."

asymptomatic and ingestion is not definite or not recent, CT or other advanced imaging can be considered with subsequent removal or observation and/or close follow-up.<sup>7,8</sup>

If the sharp-pointed foreign body is in the stomach or proximal duodenum, removal is required due to risk of perforation of the gastrointestinal tract. If the object is found in the small intestine it can be monitored with serial imaging if the patient is asymptomatic. Surgical intervention is required if the object fails to progress after 3 days or if the patient is symptomatic of obstruction or perforation (abdominal pain, fever, vomiting, hematemesis, or melena).<sup>3,4,7</sup>

With the rising number of foreign body ingestion secondary to the use of wire grill brushes, a high index of suspicion is needed to consider and make the diagnosis of foreign body ingestion in most cases.<sup>7,9-11</sup>■

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## A Construction Worker with Sudden Foot Pain After Stepping Into a Hole



#### Case

The patient is a 45-year-old male construction worker who felt pain immediately after stepping down from a truck into a pothole.

View the images 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**

- Foot dislocation
- Metatarsal fracture
- Plantar plate disruption
- Soft tissue ankle injury
- Lisfranc fracture dislocation

#### **Diagnosis**

This patient has fractures of the metatarsal bases of digits 2 and 3, and likely 4, as noted. Metatarsal malalignment is diagnostic for Lisfranc fracture dislocation.

#### Learnings/What to Look for

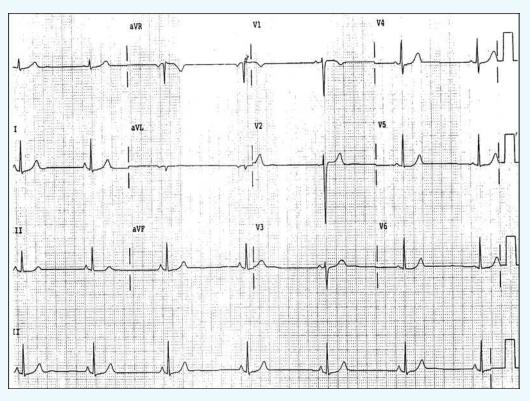
- Mechanism of injury is direct crush injury, or an indirect load onto a plantar flexed foot
- Disability will occur if the injury is untreated

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

■ Internal fixation is the most common treatment

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

# A 27-Year-Old Marathon Runner with Epigastric Pain



PR QRSD QT QTc	155 80 455 362
AXES P QRS T	81 72 51

Figure 1.

#### Case

A 27-year-old woman who has been training for a marathon presents to the urgent care center with epigastric pain. She states the pain is worse after she consumes tomato sauce or orange juice, and wonders if she may have reflux. She denies shortness of breath, exertional component, pleuritic pain, leg swelling, use of hormonal therapy, or sweating. No right upper quadrant pain. Improves with antacids. No FH or heart disease or other risk factors.

Upon exam, you find:

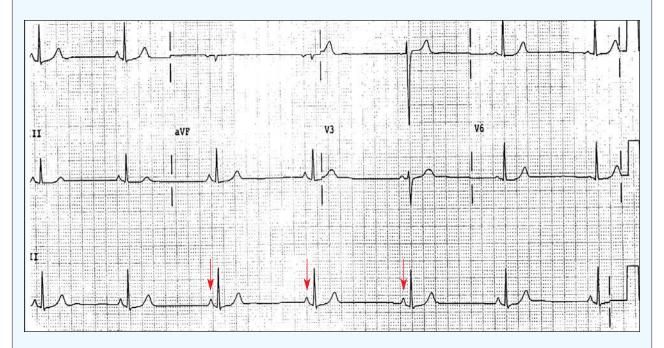
General: A&O, NAD, conversational and interactive. Normal body habitus

- **Lungs:** Clear bilaterally
- Cardiovascular: Regular rhythm, without m,r,g
- **Chest:** There is point tenderness over the left lower sternal border
- **Abdomen:** Soft with very minimal tenderness epigastric but elsewhere soft and NT, no distention, without r/r/g
- **Ext:** No edema or asymmetry, pulses are 2+ and equal in all extremities, no pain with palpation

An ECG is performed before you evaluate the patient. Review the ECG 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**

- Normal sinus rhythm
- First-degree AV block
- Second-degree AV block
- Third-degree heart block
- Junctional bradycardia
- Sinus bradycardia

#### Diagnosis

This ECG shows a sinus rhythm with a rate of 38. The normal rate is 60-100, so this is not simply a normal sinus rhythm.

The normal PR interval is 120-200 ms, and this PR is 155, which is normal; this is not first-degree AVB.

There is a P wave before each QRS and the PR interval is consistent; therefore, this is not second- or third-degree AVB.

Regarding the P waves: There are P waves before each QRS, so similarly this is not a junctional rhythm (where the depolarizing influence is from the AV node as opposed to the atrial node).

There are no T wave inversions concerning for ischemia; note that T wave inversions in aVR and V1 are normal. We do not see ST elevation or depression concerning for ischemia.

This ECG shows sinus bradycardia.

#### Learnings/What to Look for:

- The rate is normal (60-100), bradycardic (<60) or tachycardic (>100)
- With a very slow rate, consider heart block and ensure there is a P before each QRS and that there is not lengthening of the PR interval (Wenckebach) or a dropped QRS beat (Mobitz 2)
- Specifically evaluate each ECG for findings of ischemia such as T wave inversion or ST elevation or depression

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

- Sinus bradycardia is often an incidental finding, as in this case, and can occur as a normal variant or in athletes
- Compare to a previous ECG, if available
- Inquire if the patient is symptomatic including dizziness, weakness, fatigue, chest discomfort, shortness of breath, diaphoresis, hypotension or hypoxemia
- Medications such as beta blockers or calcium channel blockers may cause bradycardia as well as some electrolyte abnormalities. Inquire about meds in all patients. Lab testing should be individualized based on the providers pre-test estimation of risk
- Patients who are symptomatic should be emergently transferred to the emergency department



# A 43-Year-Old Man with Pruritic, Scaly Plaque and Vesicles on His Hands and Arms



#### Case

The patient is a 43-year-old man who presents to urgent care after work with an extremely pruritic fine scaly plaque and tense vesicles covering his hands and arms. He had been gardening the previous weekend, worked on his car, and prepared his boat for its first voyage of the season. He wasn't sure which activity might have caused such a terrible rash.

View the image 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**

- Allergic contact dermatitis
- Hogweed dermatitis
- Poison ivy-oak-sumac dermatitis
- Arthropod bites or stings

#### Diagnosis

This patient was diagnosed with allergic contact dermatitis due to exposure to poison ivy, poison oak, or poison sumac.

#### Learnings/What to Look for

- This is a hypersensitivity reaction to an oily resin found on the leaves and in the stems and roots of plants in the Rhus
- This dermatitis occurs in previously sensitized individuals, usually appearing 48 hours after antigen exposure

- Typically presents as erythematous, linear plaques with associated vesicles and bullae
- Pruritis is generally severe

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

- Treatment includes a course of oral prednisone, starting at 1 mg/kg/day (up to 80 mg), tapering over at least 14 days (or longer, for severe reactions)
- A 6-day tapering Dosepak should not be prescribed, as the reaction may rebound once the short course concludes

Acknowledgment: Images courtesy of VisualDx (www.VisualDx.com/JUCM).



#### REVENUE CYCLE MANAGEMENT Q&A

## Get Ready for the Next Round of Changes to E/M Guidelines

■ DAVID E. STERN, MD, CPC

he American Medical Association has announced it is taking the first steps towards revising the new Evaluation and Management (E/M) guidelines that the Centers for Medicare and Medicaid Services (CMS) introduced last year to reduce the administrative burden on clinicians with the Patients over Paperwork initiative.1 Effective as early as January 1, 2021, office visit Level 1 E/M code 99201 will be deleted. Additionally, while the history and exam will be required to be reviewed by the provider, they will not be scored as key components for selecting an E/M service level. Instead, providers will select E/M codes based on 1) the level of medical decision making (MDM) involved, or 2) the total time spent performing the service on the day of the visit. Regardless of the method chosen, medical necessity must still be documented to support the charge.

Guidelines for E/M services will restructured into three sections:

- 1. Guidelines common to all E/M services
- 2. Guidelines for office or other outpatient E/M services, to distinguish the new reporting guidelines for the office or other outpatient services codes 99202-99215
- 3. Guidelines for hospital observation, hospital inpatient, consultations, emergency department, nursing facility, domiciliary, rest home or custodial care, and home E/M services

The guidelines will be revised to ensure there is no conflicting information between the different sets. The AMA states they will also be adding an MDM table and definition of terms associated with the elements of MDM that will be applicable to codes 99202 through 99215.

You can also expect to see new definitions related to medical



David E. Stern, MD, is board-certified in internal medicine. He was a director on the founding board of UCA and has received the organization's Lifetime Membership Award. He is CEO of Experity (formerly DocuTAP and Practice Velocity), which offers industryleading SaaS EMR solutions, patient engagement technology, radiology over-read services, revenue cycle management services, and a robust analytics suite.

"The American Hospital Association (AHA) submitted comments to CMS on the proposed rule last year stating, By reducing payments for many providers, the proposal to collapse the payment rates for E/M visits devalues providers' time, increasing the already heavy pressure they face to maximize the number of patients they see each day."

decision making such as:

- "Number of Diagnoses or Management Options" is changed to "Number and Complexity of Problems Addressed"
- "Amount and/or Complexity of Data to be Reviewed" is changed to "Amount and/or Complexity of Data to be Reviewed and Analyzed"
- "Risk of Complications and/or Morbidity or Mortality" is changed to "Risk of Complications and/or Morbidity or Mortality of Patient Management"

Also approved was a revised definition of time associated with E/M codes 99202 through 99215, from "typical face-toface time" to "total time spent on the day of the encounter," eliminating the need to calculate how much of the time spent with the patient was directed towards counseling and coordination of care. The total time values associated with each office/outpatient E/M code will be redefined, as well. The AMA has also proposed to add guidelines for reporting time when more than one individual performs distinct parts of an E/M

While the E/M updates will relieve providers of the burden of duplicating documentation, it also comes with modifications

#### REVENUE CYCLE MANAGEMENT

Level	Current payment* (new patient)	Estimated payment beginning 2021**
2	\$76	
3	\$110	\$130 (or \$143 for primary care and nonprocedural care)
4	\$167	
5	\$211	\$211
Level	Current payment* (established patient)	Estimated payment beginning 2021**
2	\$45	\$90 (\$103 for primary care and nonprocedural care)
3	\$74	
4	\$109	
5	\$148	\$148
	2 3 4 5 Level 2 3	2 \$76 3 \$110 4 \$167 5 \$211  Level Current payment* (established patient) 2 \$45 3 \$74 4 \$109

to how services for new and established office/outpatient visit Levels 2 through 4 will be reimbursed. **Table 1** represents the latest payment model from CMS in a presentation of the 2019 Final Rule.2

It would be beneficial to review revenue generated from each E/M level to determine how this change will affect your

Several groups have opposed pairing this restructuring of payment rates with the documentation reduction. The American Hospital Association (AHA) submitted comments to CMS on the proposed rule last year stating, "By reducing payments for many providers, the proposal to collapse the payment rates for E/M visits devalues providers' time, increasing the already heavy pressure they face to maximize the number of patients they see each day."3

The American Medical Group Association (AGMA) agrees, stating that CMS is confounding two separate issues.

While CMS does not expect all specialties to experience a loss in revenue, they have proposed new add-on codes with reimbursement to be billed with codes 99202 through 99215 to help mitigate some of the effects of the new E/M payment structure. To date, CMS has proposed primary care add-on codes GPC1X "Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services" and GCGoX, "Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, or interventional pain management-centered care."

Prolonged services codes 99354 and 99356 will be revised to exclude reporting for "office or other outpatient setting" in order to make room for new prolonged services codes yet to be determined, to report prolonged service in the office and

"As these changes take effect as anticipated over the next few years, you can expect a substantial disruption to how E/M services are documented, coded, and billed. These changes in coding will apply across all payers."

outpatient setting. CMS has proposed add-on code GPRO1, "Prolonged evaluation and management or psychotherapy service(s) beyond the typical service time of the primary procedure in the office or other outpatient setting requiring direct patient contact beyond the usual service; 30 minutes"; that is also expected to go into effect on January 1, 2021.

As these changes take effect as anticipated over the next few years, you can expect a substantial disruption to how E/M services are documented, coded, and billed. These changes in coding will apply across all payers. However, private payers will likely take some time to implement changing fee schedules for these codes.

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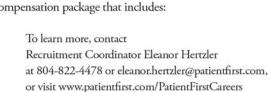
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#### DEVELOPING DATA

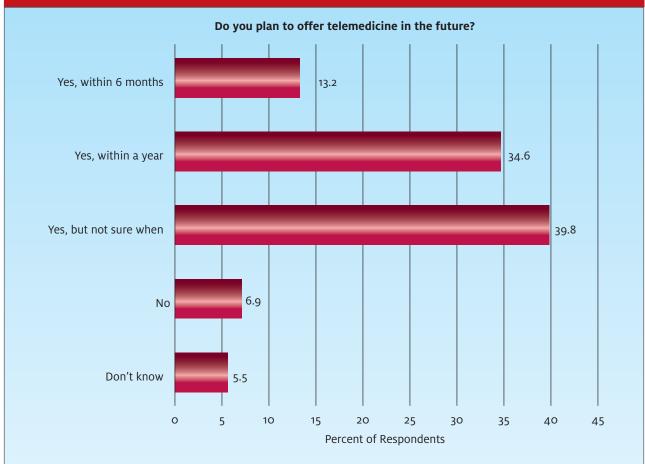
## Telemedicine in Urgent Care— Yay, Nay, or Too Soon to Say?

f you read this month's Urgent Perspectives column (page 1), you were treated to a dynamic conversation between two urgent care leaders about the relative merits—and potential drawbacks—of utilizing telemedicine in the urgent care setting.

The disparate opinions presented there are reflected in the larger urgent care marketplace, as well. The Urgent Care Association's 2018 Benchmarking Report notes an interesting

dichotomy: Only 1.58% of the sampling reflected in the report say they provide telemedicine—a drop from 9% in the previous report. However, 87% of respondents said they intend to offer telemedicine at some point in the future, with nearly half of those saying they'll probably do so within a year. Take a look at the graph below for further insights.

#### A GLIMPSE AT THE FUTURE OF TELEMEDICINE IN URGENT CARE



Adapted with permission from the Urgent Care Association 2018 Benchmarking Report. ©2019 UCA.

# JUCM wins again!





Congratulations to art director

Tom DePrenda on his Bronze Award for
Best Computer-Generated Cover



Congratulations to authors

Samrana Arefeen, MD and Khalid Aziz, MD
on their Silver Award for Best Case History

The American Society of Healthcare Publication Editors (ASHPE) recognizes editorial excellence in the field of Healthcare publishing. These two awards from ASHPE bring JUCM's award total to 17!

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