LETTER FROM THE EDITOR-IN-CHIEF

Addressing Without Managing: Defusing the Ticking Time Bombs in Urgent Care

In the world of urgent care, it's assumed that we exist to provide immediate, episodic care for discrete problems. The sore throat, sprained ankle, and laceration are our bread and butter. However, we do not practice in a vacuum. We share patients with other clinicians who longitudinally follow and manage their multiple comorbidities.

Additionally, for the growing number of patients *without* a primary care provider, we commonly serve as the sole point of contact with the healthcare system and, therefore, offer the *only* opportunity to identify undiagnosed and potentially dangerous behaviors and conditions.

While UC practice is certainly fast-paced and problem-focused, as clinicians we still have a duty to address the issues that will lead to poor health outcomes when they come to our attention, even if they aren't the "reason for the visit" that day.

Some of us may have a visceral reaction to this notion. Practicing in UC is, after all, a choice we've made, often because managing chronic health problems holds little allure. That's certainly true for me. But hear me out. I am not advocating that we *manage* these conditions, but rather that we *address* them when noticed rather than turning a blind eye and moving on to our next patient.

This isn't as challenging as it may sound at first.

The difference between *managing* and *addressing* is significant. *Managing* implies that we are evaluating the accuracy of a diagnosis and devising an individualized treatment plan. *Addressing*, on the other hand, simply means that if we become aware of concerning signs, symptoms, and/or health behaviors, we don't ignore them. *Addressing* involves informing the patient of our concerns over potential health consequences of the issues identified, and recommending any appropriate next steps after the UC visit.

Managing is much more involved. It's akin to responding to a spill in the milk aisle. I'm not suggesting we should be cleaning it up ourselves, but it is civically remiss to pass by

and continue shopping as if the gallon-sized puddle didn't exist when it would take little effort to alert a nearby employee of the hazard.

We have the same duty when we see a looming threat in an unsuspecting patient. We don't need to find the mop and bucket ourselves, but it's easy to make a potentially significant difference for our patient by calling out the danger we see before a predictable bad outcome unfolds.

Let's examine a few common examples of impending threats that we might notice in an average UC shift.

Elevated Blood Pressure Readings

Taking complete vitals for each patient is standard practice in nearly every UC. Therefore, elevated BP readings will occur multiple times per shift (and if this isn't the case, you better check your BP cuff). This is almost always incidental to the patient's chief complaint. So, then, the question becomes what do we do with this incidentally out-of-range data?

Imagine a case of a 55-year-old man who presents for a laceration to his forearm while remodeling his bathroom. He's not anxious or in obvious pain. His blood pressure is 172/99. You recheck it and it's unchanged. He hasn't seen a doctor in 5 years because he's "healthy." He states he "feels fine" and isn't really too concerned about the reading.

"As poor outcomes will take years to manifest, to find meaning in addressing these risks we must strive to find ways to convince ourselves that these interventions matter."

This patient almost certainly has hypertension (although a repeat measurement will be required on another day to confirm this). But because he "feels fine," his BP is of little concern; he reiterates with a bit of annoyance that he's "just here for the stitches." We as healthcare providers, however, know better. There's a reason hypertension is known as the "silent killer." If it's left untreated, this patient will be at a significantly increased risk of stroke, kidney disease, and MI in the coming years.

Furthermore, based on this patient's history of seeking medical care, it's unlikely he will be seen by a healthcare provider again anytime soon. Therefore, in cases like this, spending a few minutes educating the patient about the perils of untreated hypertension and urging him to find a PCP could be lifesaving, even if hearing about it isn't on his agenda for the visit.

Conversely, ignoring this patient's elevated BP puts both the patient and you at significant risk. The patient is obviously at increased risk of long-term poor outcomes. However, perhaps less apparent is the risk that you assume as the provider in this case if you fail to *address* this (especially because his BP quite likely may not be checked again until he's in the ED for a stroke). There is abundant legal precedent upholding our duty as clinicians to *address* abnormal incidental findings, including elevated BP readings, even if unrelated to the reason for the patient's visit.

Poorly Controlled Diabetes

Next, consider a 44-year-old obese woman with type 2 diabetes presenting with dysuria and frequency. Her urine dip is negative except for 3+ glucose, 2+ protein. She reports that she "always takes her diabetes medication" when you mention the glucose in the urine.

For many of us, it may be tempting to stop here. But, it would be short-sighted to inform the patient that she does not have a UTI and discharge her without saying something more when her urine dip suggests uncontrolled hyperglycemia and end-organ dysfunction.

Imagine instead you ask a few more questions and discover her diabetes was diagnosed 4 years ago and she was started on metformin 500 mg twice daily. She has gained 60 pounds in the interim. She never checks her blood sugar and has never had a retinal exam, foot exam, or A1c performed since diagnosis. You ask your medical assistant for a quick fingerstick glucose and find her blood sugar is 280 mg/dL.

This patient requires education and follow-up for routine diabetic care before the predictable and irreversible negative consequences of prolonged hyperglycemia appear. Explaining the high likelihood of vision loss, neuropathy, vascular complications, and amputation if her diabetes remains poorly controlled can make a huge impact on this woman's lifetime morbidity from the disease.

Furthermore, it is worthwhile to take a few more minutes to explore the patient's attempts at weight loss and dietary practices around sugar and other refined carbohydrates. Failing to address the importance of proper diet on diabetes implicitly provides a message that her condition is out of her control and that her diet is irrelevant, which obviously couldn't be further from the truth.

Smoking

Let's look a one more very common UC scenario. A 38-year-old man presents with cold symptoms, including cough, for 3 weeks and frustration because he's not getting better. He has a normal chest x-ray and oxygen saturation. You diagnose him with bronchitis and appropriately and courteously decline his request for antibiotics. Well done. But there's always a bit more going on. As you sit across from him, you can't help but notice the uncanny and pungent smell of cigarette smoke permeating the exam room.

At this point you have two options: a cynical (and hopefully internal) roll of the eyes *or* taking a moment to address his tobacco use head on. In this case, this is not only a chronic health concern, but also immediately relevant to his complaint: a lingering cough. In very little time at all it can be explained that, while the antibiotics he came seeking will not speed his recovery, cutting down on cigarettes will. Explaining the effects of tobacco on respiratory cilia function and clearing mucus, for example, offers a perfect opportunity to counsel smokers about the importance of quitting. Finding a path to relevance and relatedness to the reason for the visit creates a teachable moment.

It's easy to feel defeatist around counseling for tobacco cessation because it is one of the hardest habits to kick. A number of studies on the subject, however, have shown that hearing a message to quit from a clinician is among the most potent sources of motivation to quit. And while the patient is often not enthusiastic to receive the message in the moment, it's impossible to predict which of these seeds prompting further reflection will bear fruit, and when.

A Word on Charting

Of course, charting that you addressed the identified issues with the patient is critical for closing the loop on the intervention. Thankfully, the common issues that we stumble across as we see patients in UC are relatively few in number: bike helmet use, overdue health maintenance, weight loss, safer sex prac-

tices, and reducing alcohol and tobacco. Most EMR systems now offer a macro or dot phrase function to allow for easy documentation of these frequent refrains with just a few keystrokes.

Adding these phrases will not only serve as medicolegal protection in demonstrating your holistic concern for the patient beyond their immediate presentation, but it will also serve to best capture the complexity of the care provided. After the significant 2021 overhaul in billing and coding for ambulatory care, this description of complexity through the enumeration of "problems addressed" has become one of three essential elements of the medical decision making (MDM) portion of our notes. And, in case you missed it, the MDM is now the sole portion of an UC clinician's chart used to determine the billing level of service.

At first glance, addressing issues which lack immediate relevance to patients' UC presentations seems like the antithesis of urgent care medicine. Most of us have chosen UC because we get our kicks by seeing immediate results from our efforts: stopping a nosebleed or reducing a nursemaid's elbow. We rarely witness the consequences of failing to address long-term risks. As poor outcomes will take years to manifest, to find meaning in addressing these risks we must strive to find ways to convince ourselves that these interventions matter. And, admittedly, it takes considerable and conscious effort to find reward in the best of all possible outcomes: the disaster that never happens.

Thankfully, the effort actually required to have these short conversations isn't much. Rather, the challenge lies in adopting a new mindset and altering our habitual approach. But, it's worth it because well-timed nudges are surprisingly potent. Changing a ship's heading by a few degrees as it leaves New York City can be the difference between arriving in Ireland and North Africa. Small nudges, moreover, multiplied across thousands of patients and many years offer the potential for a tremendous cumulative impact during our careers.

So, try mentioning the effects of uncontrolled diabetes on wound healing or smoking on immune function instead of making small talk the next time you find yourself suturing or waiting for a patient's chest x-ray to load. Your efforts may feel fruitless in the moment, but take solace that years in the future, someone will be glad you didn't overlook the ticking time bomb you happened upon that evening when all they had asked of you was for something to help with their cough. ■