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Urgent Care
Association
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URGENT CARE
MEDICINE

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The Official Publication of the UCAOA and CUCM

CLINICAL **cme**

Be on the Ready to Recognize Arrhythmias

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LETTER FROM THE EDITOR-IN-CHIEF

From Don't Be Evil to Do the Right Thing: The Code of Conduct Evolution



In the year 2000, Google famously adopted the corporate code of conduct motto, Don't Be Evil to represent its approach to both business and workplace behavior. At the time, the approach seemed sensible, but today it feels strikingly out of touch. It's a low bar that misses the mark on one of the most pressing issues of our time: respect and freedom from harassment, at work, at home, and at play.

Don't be evil is simply not good enough anymore. The ugliness of workplace culture—and, in particular, discrimination and harassment related to race, religion, and gender—is now front-page news. And it reflects an opportunity to change generational habits of disrespect that are pervasive in our work environments. From the doctor's office to the construction site, we are failing to demonstrate and uphold the principles of equality and freedom that this country was founded on, and we must do better.

Healthcare is a complex work environment. We operate under significant stress and the problems we care for are complicated and emotional. To blow off steam, we frequently resort to banter and humor without appreciating the potential for harm. In our profession, by definition, we are expected to give opinions and counsel, but too often that overflows from the exam room to the nurses' station. And finally, healthcare is a melting pot of cultures, religions, races, and genders. The sum of these factors is a highly charged work environment that is ripe for everything from simple misunderstandings to outright harassment. Appreciating and respecting this potential will help us plan an approach to workplace conduct that works for everyone without degrading the culture or comradery.

The first step any organization needs to take is to establish a code of conduct, communicate it frequently, get buy-in from all employees, and commit to a zero-tolerance policy for violations. We all must accept this approach and work hard to avoid the pitfalls that can lead to an incident.

We can illustrate our commitment by being especially sensitive to situations that are prone to misinterpretation or hostility. How do we do that, you ask? Perhaps the surest way to avoid trouble is to be conscious in your communication, careful with your opinions, and resolutely avoid intimate workplace relationships and overtures.

Here are 10 specific things to consider that can help foster a safe and respectful work environment:

1. Any relationship, no matter how mutual you believe the interest is, can lead to harassment, intentional or not. It's wise to avoid them completely.
2. The workplace is not the place for political, social, and religious debates. These are notorious for disintegrating into hostility. Don't think for a minute that you can navigate these respectfully. Again, it's best to just avoid them completely.
3. Be careful about gossip, complaining, and negativity.
4. In difficult or controversial situations, don't be quick to judge. Give these "time to breathe" and you may be surprised by the perspective you gain.
5. Don't be impulsive, and be careful about negative assumptions regarding intent.
6. Be inclusive and sensitive. Build bridges instead of trenches.
7. Be respectful in your communications, written or verbal.
8. When you sense a situation is escalating or becoming personal, call a "time-out." Call on others to stop and be accountable to a respectful work environment.
9. If you are in a position of power, by profession or title, you must be very self-aware and careful. Using rank or power to retaliate against someone should not be tolerated.
10. Be very careful with humor. What may be an attempt to lighten the mood can easily be interpreted as divisive, disrespectful, or inappropriate. Think before you speak.

These are challenging times for our society, and these issues naturally permeate into the workplace. But we have the opportunity to make progress if we commit to getting better. The urgent care industry should *do the right thing* in support of a safe and civil workplace, free of harassment and threat. ■

Lee A. Resnick, MD, FFAFP
Editor-in-Chief, *JUCM, The Journal of Urgent Care Medicine*



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CLINICAL

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Patients often look to urgent care when they experience unsettling arrhythmias. Immediate recognition of benign vs life-threatening etiologies is essential to effective management and, at times, the patient's survival.

Riaz Fabian, DO and L. Wayne Coats, DO, FACO

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As health systems move closer to a retail approach to meeting consumer needs, urgent care has to be on its game to stay ahead of the curve.

Alan A. Ayers, MBA, MAcc

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Brett Whyte, MD and Kyle Coon

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31 A 5-Month-Old with Symptoms Beyond the Presenting Complaint



The presenting complaint is exactly that—the complaint that's being presented.

Understanding the full scope of the presentation can be challenging when the patient is a preverbal child.

Michael Weinstock, MD

HEALTH LAW AND COMPLIANCE

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Urgent care operators that offer occupational medicine services must ensure they're in compliance with applicable state laws regarding privacy of drug screen results.

Alan A. Ayers, MBA, MAcc

IN THE NEXT ISSUE OF JUCM

Injuries to the upper extremity due to falls on outstretched hands (FOOSH) happen in an instant, but the consequences can last a lifetime without immediate, accurate diagnosis and management. Urgent care providers are ideally suited to provide that—assuming they're aware of the possible pitfalls. Read what they are, and how to prepare for them, in the February issue of JUCM.

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Lee A. Resnick, MD, FFAFP

editor@jucm.com

MANAGING EDITOR

Harris Fleming

hfleming@jucm.com

ASSOCIATE EDITOR, PRACTICE MANAGEMENT

Alan A. Ayers, MBA, MAcc

ASSOCIATE EDITOR, CLINICAL

Michael B. Weinstock, MD

CONTRIBUTING EDITORS

Glenn Harnett, MD

David E. Stern, MD, CPC

MANAGER, DIGITAL CONTENT

Brandon Napolitano

bnapolitano@jucm.com

ART DIRECTOR

Tom DePrenda

tdeprenda@jucm.com



185 State Route 17, Mahwah, NJ 07430

PUBLISHER

Stuart Williams

swilliams@jucm.com • (201) 529-4004

CLASSIFIED AND RECRUITMENT ADVERTISING

Justin Daniels

YM Careers

jdaniels@yourmembership.com • (727) 497-6565 x3328

Mission Statement

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

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Collectively, cardiac arrhythmias may be among the most perilous—and potentially deadly—presentations in the urgent care center. So much so that there may be an inclination among some urgent care providers to transfer the patient immediately. Doing so out of hand, however, may be unnecessary (and unnecessarily costly).

Yes, for the patient who truly needs emergent care it's clearly the right choice. A well-informed understanding of the nuances of cardiac arrhythmias can help the clinician understand which patient can be treated on site safely, efficiently, and economically.

And that's the point of this month's cover article, Urgent Care Evaluation of Arrhythmias, by **Riaz Fabian, DO** and **L. Wayne Coats, DO, FACOI**. In it, Dr. Fabian explains the differences among extra beats, supraventricular tachycardia, ventricular arrhythmias, and bradycardia arrhythmias, as well as the telltale signs of each, using real-world EKGs as a guide. His article begins on page 11. Dr. Fabian is a first-year internal medicine resident at Adena Hospital. Dr. Coats is Internal Medicine program director, Adena Regional Medical Center.



The line between what's necessary and what's simply done as a matter of course (even if that equates to being overly cautious at times) is a key part of our latest Quality Improvement article, as well. More specifically, it attempts to address the question, what would happen if patients with specific presentations presented to urgent care but "only" saw a nurse? Not to give anything away, but clinical outcomes and patient satisfaction scores didn't suffer, and the costs incurred by patients and payers were lower than if they'd seen a more advanced practitioner. The "how and why" of the story may be helpful in your locations.



Nurse-Only Visits in Urgent Care: An Analysis of Outcomes and Patient Satisfaction Relative to Traditional Care, by **Brett Whyte, MD, FACEP** of Winona Health and **Kyle Coon, BS**, Winona State University, starts on page 24.

If greater involvement by nurses and other non-physician providers is likely to become more prevalent as urgent care evolves, that would match the evolution of urgent care in the broader, marketplace context. **Alan A. Ayers, MBA, MAcc** offers a preview of what that might look like, as stakeholders in our industry move further into a retail-like approach to match consumer needs and expectations. Urgent Care 2.0: Health Systems Taking the Retail Approach to the Next Level can be found on page 19.



Mr. Ayers, who is chief executive officer of Velocity Urgent Care and associate editor, practice management for *JUCM*, also shares his wealth of knowledge on the business side of urgent care in Implications of HIPAA and Employee Confidentiality Rules on Positive Drug Test Results (page 34). With the growth of occupational medicine in the urgent care arena matching the prevalence of drug addiction (especially to opiate medications), more employers than ever are interested in screening their workers for various illicit substances. As such, it's critical to understand the associated rights, protections, and obligations under the law.

One especially somber obligation of urgent care providers under the law is the duty to report even the suspicion of child abuse. Sometimes, that presents silently, requiring the clinician to look beyond the stated complaint and be vigilant for what's *not* being said. This can be especially vexing when a child—the patient—is too young to express himself. That's exactly the situation in this month's case report by **Michael Weinstock, MD**. His article, A 5-Month-Old with Symptoms Beyond the Presenting Complaint, and which is taken from an actual case, begins on page 31.



Dr. Weinstock is the associate program director of the Adena Emergency Medicine Residency program; director of medical education and research for Adena Health System; adjunct professor of emergency medicine in the Department of Emergency Medicine at Wexler Medical Center at the Ohio State University; and the associate editor, clinical content for *JUCM*.

Finally, we're pleased to help you ensure that you're getting the maximum reimbursement for the services you perform with a summary of urgent-care relevant changes to CPT codes for 2018, authored by **David Stern, MD, CPC**, the leading authority on the subject. Dr. Stern's Revenue Cycle Management column starts on page 43. ■

To Submit an Article to JUCM

JUCM, The Journal of Urgent Care Medicine encourages you to submit articles in support of our goal to provide practical, up-to-date clinical and practice management information to our readers—the nation's urgent care clinicians. Articles submitted for publication in *JUCM* should provide practical advice, dealing with clinical and practice management problems commonly encountered in day-to-day practice.

We prefer submissions through our content management portal. Navigate to <https://jucm.scholasticahq.com> to find instructions and to submit your paper for consideration. The first page should include the title of the article, author names in the order they are to appear, and the name, address, and contact information (mailing address, phone, fax, e-mail) for each author.



CONTINUING MEDICAL EDUCATION

Release Date: January 1, 2018

Expiration Date: December 31, 2018

Target Audience

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

Learning Objectives

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

Accreditation Statement



This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Case Western Reserve University School of Medicine and the Institute of Urgent Care Medicine. Case Western Reserve University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

Case Western Reserve University School of Medicine designates this journal-based CME activity for a maximum of 3 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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- **Lee A. Resnick, MD, FAFGP**
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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CONTINUING MEDICAL EDUCATION

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

Urgent Care Evaluation of Arrhythmias (p. 11)

1. Which arrhythmia most commonly causes sudden death?

- a. Supraventricular tachycardia
- b. Ventricular tachycardia
- c. First-degree AV block
- d. Atrial fibrillation
- e. Atrial flutter

2. Which medications may cause a sensation of palpitations?

- a. Sympathomimetic drugs
- b. Anticholinergics
- c. Diuretics that may cause electrolyte abnormalities
- d. Beta blocker withdrawal
- e. All of the above

3. Which of the following are signs of hemodynamic instability that would require transfer?

- a. Hypotension
- b. Tachypnea
- c. Hypoxemia
- d. Confusion
- e. All of the above

Urgent Care 2.0: Health Systems Taking the Retail Approach to the Next Level (p. 19)

1. Which of the following is true in regard to the “Uberization” or the “Uber” effect of healthcare?

- a. It is the idea that market forces are driving healthcare to embrace the retail-centric and consumer-focused ethos, similar to big industry disruptors such as Uber
- b. Consumers want fast, convenient, affordable, seamless, and high-quality services, along with digital channels
- c. This describes a dramatic change in the healthcare field in which providers are commoditized and summoned through a smartphone app
- d. A and B
- e. All of the above

2. When desiring a full-fledged, digital engagement for consumers, which of the following should be implemented?

- a. Allowing patients to schedule appointments and check wait times via smartphone
- b. Patients receive text message updates and are able to email providers
- c. Patients can refill prescriptions at any Walgreens or CVS pharmacy
- d. A and B
- e. All of the above

3. What do data indicate in regard to social media and patients posting reviews about their experience at an urgent care?

- a. Patients are unwilling to post about any experience at an urgent care, as they consider their healthcare choices to be “private”
- b. Patients are most likely to post a negative review on a third-party website, and leave a positive review on the urgent care’s direct website
- c. Patients will only use third-party websites
- d. Patients will always find something to complain about

Case Report: A 5-Month-Old with Symptoms Beyond the Presenting Complaint (p. 31)

1. How many children are victims of child abuse or maltreatment in the U.S. every year?

- a. 10,000
- b. 50,000
- c. 100,000
- d. 200,000
- e. Over 1 million

2. A nonambulatory 5-month-old child would be expected to have routine bruising from normal activities.

- a. True
- b. False

3. Which of the following are categories of child maltreatment?

- a. Child neglect
- b. Physical abuse
- c. Emotional abuse
- d. Sexual abuse
- e. All of the above



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UCAOA Certification Options, Specialty Sections Grow with Our Industry

■ LAUREL STOIMENOFF, PT, CHC

As the urgent care industry evolves, our members have also evolved. In response, the Urgent Care Association of America is launching new certification opportunities and specialty sections.

Certification

The UCAOA Board and Certification Committee have responded to industry diversification with updated certification criteria. Historically, UCAOA certification recognized a qualified urgent care as one open 7 days a week, offering comprehensive medical services for patients of all ages. A limited-scope pure pediatric urgent care could also qualify. UCAOA has subsequently established categories for Rural, Occupational Medicine, and Seasonal urgent care centers, with additional limited-scope options being considered. Occ Med is the first certification that can be coupled with another; MD Now's 26 Florida centers being the first to attain this designation.

Sections

The newly formed Sections were historically known as Special Interest Groups (SIGs), focused on providing online networking opportunities to a defined community. Some of these SIGs, such as Revenue Cycle, will continue while the newly established Sections will have a much broader function.

Charters have been developed, and champions established, for Telemedicine and eHealth (Bill Lewis, MD), Pediatric Urgent Care (Parul Martin, MD), and Hospital & Health Systems (Robert Rohatsch, MD) Sections. Others in the works include Occupational Medicine/Worker's Health, and UC Operations & Management.

Expanded Resources and Collaboration

Our new Sections will offer more sophisticated communities, collaboration, and resources to assist with the diverse services

and patient populations treated by today's urgent care centers. More specifically, *clinically oriented* Sections will:

- Strengthen advocacy efforts, including payer outreach and regulatory affairs
- Use UCAOA communication outlets to promote quality in the delivery of services to specific populations
- Monitor and support the dissemination of relevant research to section members
- Collaborate with the Certification and Accreditation Committee regarding care, scope, safety, and quality
- Work with the Urgent Care Foundation and the College of Urgent Care Medicine on relevant projects
- Appoint a designee to work with our Education Committee to develop relevant educational experiences to be showcased via online courses or at UCAOA conferences

Tailored Section Content

Sections will establish communication outlets, guide education efforts, and focus on each's unique administrative and clinical issues. As an example, a hospital or health system-based urgent care may have greater resources at its disposal than a non-system-affiliated urgent care, but it may face unique challenges, such as making a system-based EMR fit the needs of an urgent care where efficiency and throughput are essential patient satisfiers. The Hospital & Health System Section could research and report on EMR adoption and integration best practices specific to their urgent care settings, providing tailored guidelines to its community.

UCAOA members can join any (and many) Sections of interest; one doesn't have to work at a pediatric urgent care center to join the Pediatric Section. Caring for pediatric patients in your urgent care center is reason enough to join. There is no cost to join, as Section membership is a benefit of being a UCAOA member.

It's a New Year!

So, come join a new Section or pursue new opportunities for center certification to further take advantage of all UCAOA membership has to offer. Email jkrall@ucaoa.org for more information on Sections or bgaddis@ucaoa.org for certification. ■



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



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Urgent Care Evaluation of Arrhythmias

Urgent message: Initial evaluation of a patient with an arrhythmia in the urgent care setting can be as difficult as it is critical to the patient's survival—one key concern being sudden cardiac death, which occurs in roughly 328,000 cases annually.

RIAZ FABIAN, DO and L. WAYNE COATS, DO, FACO

Introduction

Cardiac arrhythmias are a group of conditions in which a patient has an abnormal heart rate or rhythm. They are caused by any disruption of the electrical conduction system of the heart, which impacts the normal activation sequence of the myocardium. Arrhythmias can be broadly classified into four main categories: extra beats, supraventricular tachycardia, ventricular arrhythmias, and bradycardia arrhythmias.

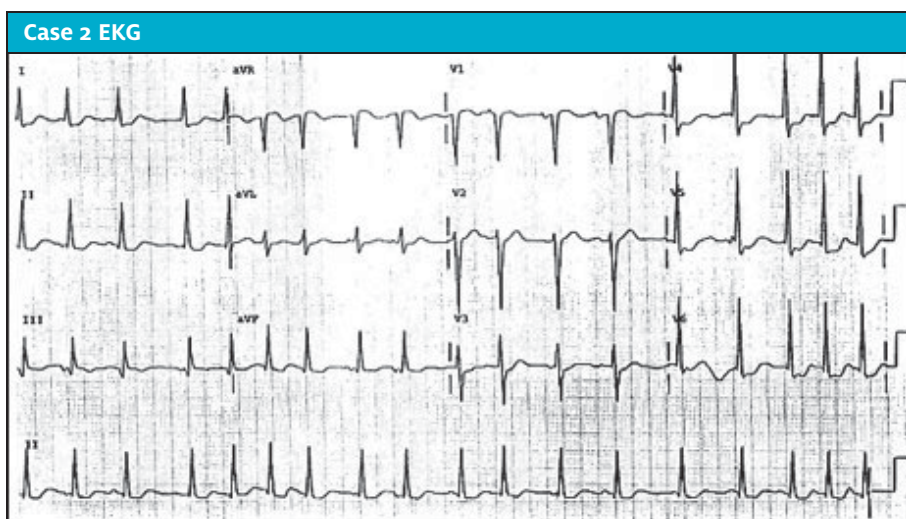
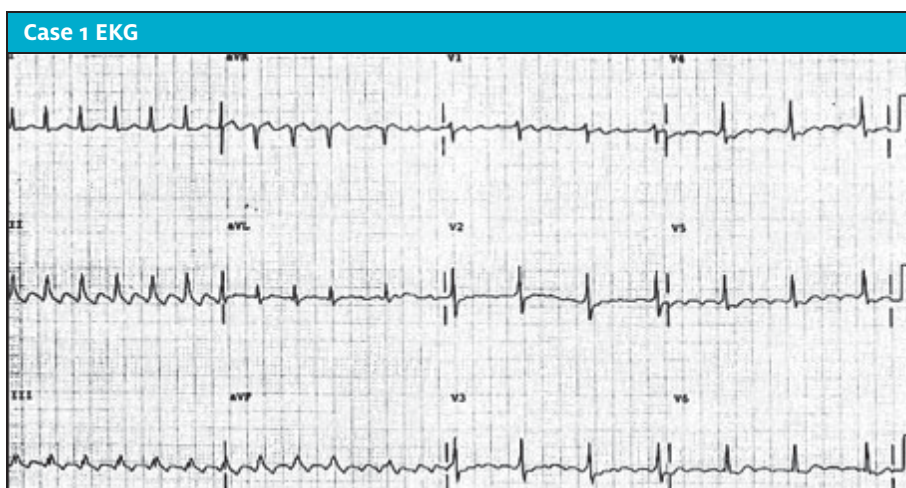
1. *Extra beats* include premature atrial contractions (PACs), premature ventricular contractions (PVCs), and premature junctional contractions (PJC). Extra beats are very common and usually not associated with long-term complications. Extra beats can occur naturally, but can also be associated with caffeine, excessive exercise, nicotine, or stress.
2. *Supraventricular tachycardia* types include atrial fibrillation, atrial flutter, and paroxysmal supraventricular tachycardia. They are caused by abnormal electrical activity in the upper portion of the heart above the ventricles. These arrhythmias are typically caused either by an abnormality in the AV node or an abnormal pathway that bypasses the normal electrical conduction pathway of the heart.
3. *Ventricular arrhythmias* include ventricular tachycardia and ventricular fibrillation. In these cases, the abnormal electrical activity originates in the ventricles themselves. Ventricular tachycardia can either be sustained or nonsustained. If sustained for a long period of time, ventricular tachycardia is capable of causing hemodynamic compromise, as the ventricles contract too quickly



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to fill completely. It can also lead to ventricular fibrillation, which results from disorganized electrical activity that causes the myocardium to quiver rather than pump effectively, resulting in cardiac arrest. Ventricular fibrillation is a cardiac emergency, and must be treated quickly to avoid death. Potential causes of ventricular arrhythmias include coronary artery disease, myocardial infarction, and electrolyte imbalances.

Riaz Fabian, DO is a first-year Internal Medicine Resident at Adena Hospital. **L. Wayne Coats, DO, FACO** is Internal Medicine Program Director, Adena Regional Medical Center. The authors have no relevant financial relationships with any commercial interests.



4. *Bradycardias* are defined as a heart rate <60 beats per minute. This may be a normal finding in well-conditioned athletes, but may also be caused by an abnormality in the sinus node or conduction blocks in the heart's electrical system.

The initial evaluation of a patient presenting with an arrhythmia can be difficult, as many of the signs and symptoms present are nonspecific. One common presentation is the sensation of a rapid or irregular heartbeat, also known as palpitations. If the arrhythmia is severe enough to impede cardiac output, the patient may also complain of chest pain, lightheadedness, or syncope. One of the biggest concerns regarding arrhythmias in the urgent care setting is the development of sudden cardiac death. Sudden cardiac death occurs in approximately 328,000 cases per year, 80% of which can be attributed

to ventricular arrhythmias.^{1,2}

In a suspected arrhythmia, the most important steps for the urgent care provider include confirmation of hemodynamic stability and, if present, to obtain a 12-lead EKG or rhythm strip. The following discussion will focus on arrhythmias which may present to the urgent care, with a discussion of etiology, urgent care management, and considerations for transfer.

Case Presentations

Case 1

A 74-year-old man presents to urgent care with a chief complaint of racing heart and generalized weakness of 2 days' duration.

Case 2

A 73-year-old male presents to urgent care with a chief complaint of intermittent palpitations of 2 weeks' duration. He is a smoker and uses 2 L/min of home oxygen, but denies any new shortness of breath.

Case 3

A 42-year old female presents to urgent care with a chief complaint of intermittent palpitations of 2 weeks' duration. She has previously been diagnosed with anxiety. Her EKG shows the following:

Case 4

A 26-year-old male presents to urgent care with a chief complaint of palpitations of 3 days' duration.

History of Present Illness

The first step in evaluating a complaint of palpitations or a clinical finding of an irregular, rapid, or slow heart rate is to obtain a history directed toward life-threatening etiologies, including acute coronary syndrome. This would include assessing for the following:

- Chest pain, tightness, pressure, or discomfort
- Shortness of breath

- Diaphoresis
- Dizziness
- Fatigue

If any of the above are present and there is concern for acute coronary syndrome, pulmonary embolism, aortic dissection, or other life-threatening condition, initiate emergent transfer.

Next, evaluate the complaint of palpitations further. For the patient with suspected arrhythmia, focus on:

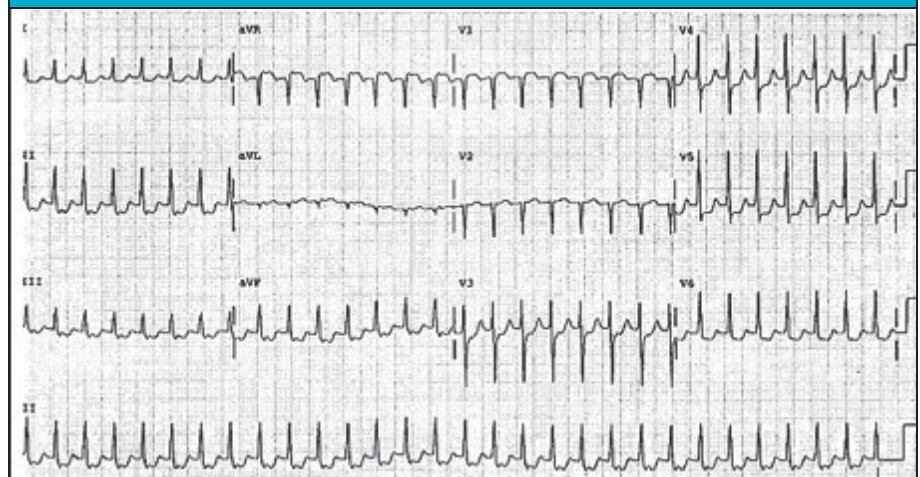
- Timing and duration of symptoms
- Constant or intermittent
- Onset; abrupt onset is suggestive of supraventricular tachycardia (SVT) or ventricular tachycardia (VT)
- Associated symptoms (eg, dizziness, chest pain, shortness of breath) which occur during the sensation of palpitations
- Known history of arrhythmias, structural heart disease, endocrine disorders such as hyperthyroidism, or psychiatric disorders such as anxiety, all of which are potential risk factors for the development of an arrhythmia^{3,4}
- Assess for sympathomimetic drugs, vasodilators, anticholinergics, diuretics which may cause electrolyte abnormalities, or beta blocker withdrawal
- Substance abuse, especially stimulants such as cocaine and amphetamines
- Previous therapies
- History of cardiovascular disease, recent surgical or invasive procedures, or any new medications⁵

Note that younger patients or patients with a history of palpitations are more likely to have an arrhythmia such as SVT. Atrial fibrillation is more commonly seen as patients become older.

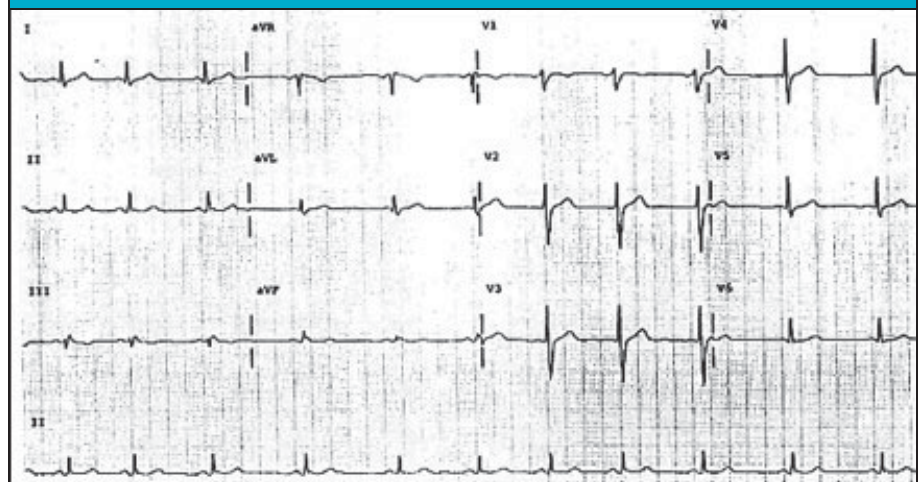
Physical Examination

Physical examination begins with an assessment of the

Case 3 EKG



Case 4 EKG



vital signs. If there are signs of hemodynamic instability, including hypotension, tachypnea, hypoxemia, or confusion, transfer should be initiated.

The most important parts of the physical exam include the following:

- **General appearance** – Pale or grey in appearance, diaphoretic, confused
- **Neck** – JVD, which may occur from heart failure or cardiac tamponade
- **Respiratory** – Bibasilar crackles may be present with heart failure, wheezing may be present in COPD (which may occur with multifocal atrial tachycardia)
- **Cardiovascular** – Assess heart rate and rhythm (regular or irregular). Arrhythmias may be associated with certain heart murmurs (eg, supraventric-

ular arrhythmias and nonsustained VT are commonly associated with a mitral valve prolapse⁶; hypertrophic cardiomyopathy (HCM) has been associated with Afib and VT.⁷ This condition is characterized by a harsh holosystolic murmur that increases with Valsalva maneuver and standing from a squatting position)

- **Peripheral pulses** – Regularity and character of patient's pulses should be noted; an irregular rhythm may be suggestive of atrial fibrillation
- **Extremities** – Check for edema, temperature, mottling, and pallor

Diagnostic Workup

Often, it is useful to follow a step-wise process for EKG interpretation:

1. Rate
 - Normal rate
 - Bradycardic or tachycardic
2. Rhythm: Determine rhythm; regular vs irregular
3. Examine P waves
 - Are p waves present?
 - Are the p waves uniform?
 - Do p waves have 1:1 relationship with QRS complex?
 - Atrial flutter may have a P to QRS ratio of 2:1, 3:1, 4:1 or more
 - In 2nd degree heart block (Mobitz Type I), the PR interval progressively lengthens until a QRS is dropped
 - In 2nd degree heart block (Mobitz Type II), the QRS beats are intermittently dropped without PR prolongation
 - In 3rd degree block, there is a complete dissociation between P waves and QRS complex. This indicates that the atria and ventricles beat independently of one another
 - Is P-R interval normal? (0.12-0.20s)
 - In first degree AV block, PR interval exceeds 0.20 seconds
 - Is P-R interval constant?
4. Examine QRS Complex
 - Normal duration? (0.08-0.12s)
 - Is QRS wide? (>120 ms)
 - Does QRS complex occur at regular intervals? If not, this may suggest an irregular rhythm like atrial fibrillation
5. Look for signs of infarcts/ischemia. Myocardial ischemia may cause an increase in the activation of the sympathetic nervous system, primarily due to

pain. This predisposes a patient to the development of ventricular and supraventricular tachyarrhythmias.

- Q waves (sign of prior infarct)
- ST Elevation (sign of infarction)
- ST Depression (sign of ischemia)
- T wave inversion (sign of ischemia)

Laboratory testing

Typically, laboratory testing is not necessary for an asymptomatic benign arrhythmia; however, if an abnormality is suspected in a stable patient, consider checking electrolytes or thyroid studies. If the patient is unstable, with symptoms concerning for myocardial infarction or pulmonary embolism, or with a life-threatening arrhythmia, emergent transfer is indicated.

Management of Specific Arrhythmias

The treatment of a cardiac arrhythmia depends primarily on whether or not the patient is hemodynamically stable. If the patient is unstable, initiate ACLS/BLS; cardioversion if applicable.

Patients with hemodynamic instability (ie, low blood pressure, altered mental status, and other signs of hemodynamic compromise) or who have cardiac arrhythmias accompanied by chest pain (which may be a sign of myocardial ischemia) must be transferred to a hospital.

Case 1 Diagnosis: Atrial Flutter

In case 1, a 74-year-old man presented with the complaint of racing heart and generalized weakness of 2 days' duration.

EKG analysis

This EKG demonstrates the classic "saw-tooth" pattern of atrial flutter. This arrhythmia is characterized by a ventricular rate of approximately 150, and multiple p waves preceding a QRS pattern in a 2:1, 3:1, or a 4:1 pattern. The ventricular rate will vary according to this pattern. A 2:1 atrial flutter, for example, with an atrial rate of 300 beats per minute will produce a ventricular rate of 150.

The presence of p waves in this EKG rules out SVT and ventricular tachycardia. The presence of uniform p waves rules out multifocal atrial tachycardia. The presence of multiple p waves preceding the QRS complex rules out sinus tachycardia.

Key points for atrial flutter

- Keep in mind that atrial flutter can be a regular or

irregular rhythm, and may be difficult to distinguish from sinus tachycardia. Differentiation between the two can be made with an EKG

- Classic “saw tooth” pattern best seen in leads II and VI
- As with atrial fibrillation, patient may be at risk for subsequent CVA; anticoagulation must therefore be considered
- A thorough H&P is of utmost importance in assessing the patient for signs and symptoms of hemodynamic compromise and ischemia

Pearls for urgent care management/considerations for transfer

- A 12-lead EKG should be done to evaluate for other causes of tachycardia that may not be seen on a simple cardiac monitor (eg, Wolff-Parkinson-White syndrome, ischemia, and SVT)
- Distinguish between first episode and subsequent episode, duration of palpitations, and whether the patient is anticoagulated, as this may have implications for rate vs rhythm control
- Almost all such patients require transfer to the emergency department, unless there is a history of atrial fibrillation/flutter and the rate spontaneously returns to normal; the patient should be placed on a monitor and observed in the urgent care center while waiting for transport

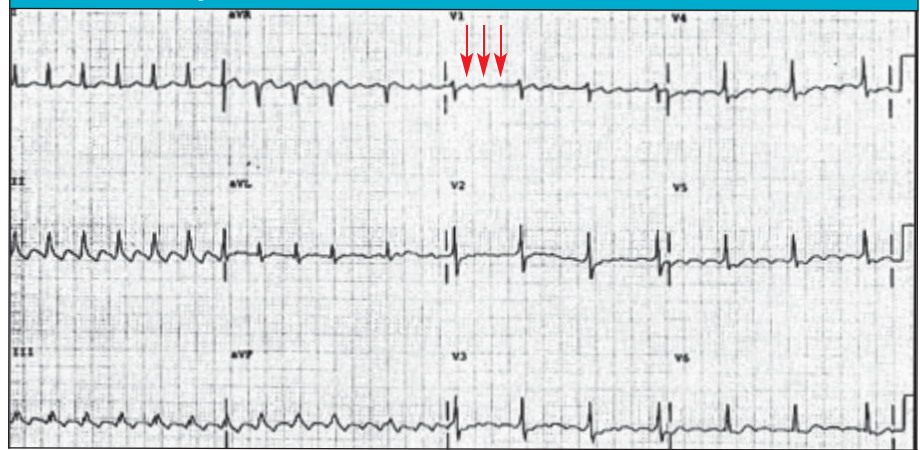
Case 2 Diagnosis: Multifocal Tachycardia (MAT)

In case 2, a 73-year-old male presented to urgent care complaining of intermittent palpitations of 2 weeks' duration. He is a smoker on 2 L of home oxygen.

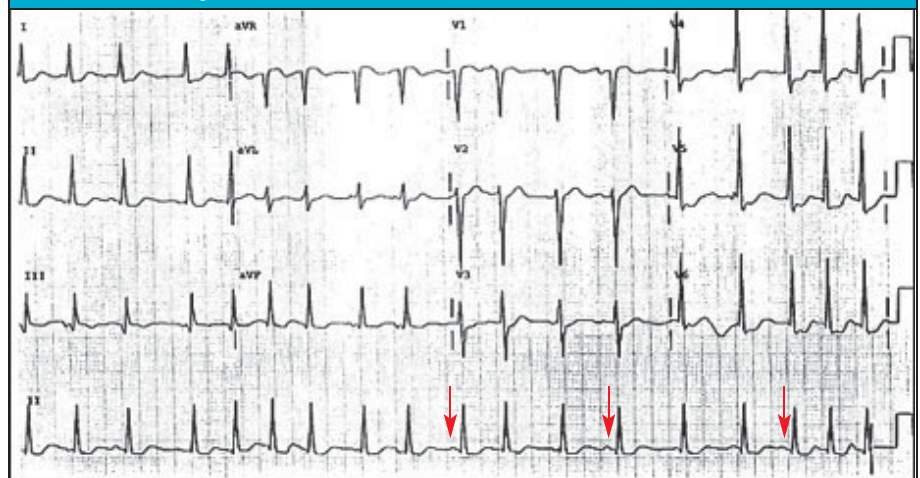
EKG analysis

This patient's EKG reveals the presence of an irregular rhythm, but it is sinus. Notice the different p wave mor-

Case 1 EKG Analysis



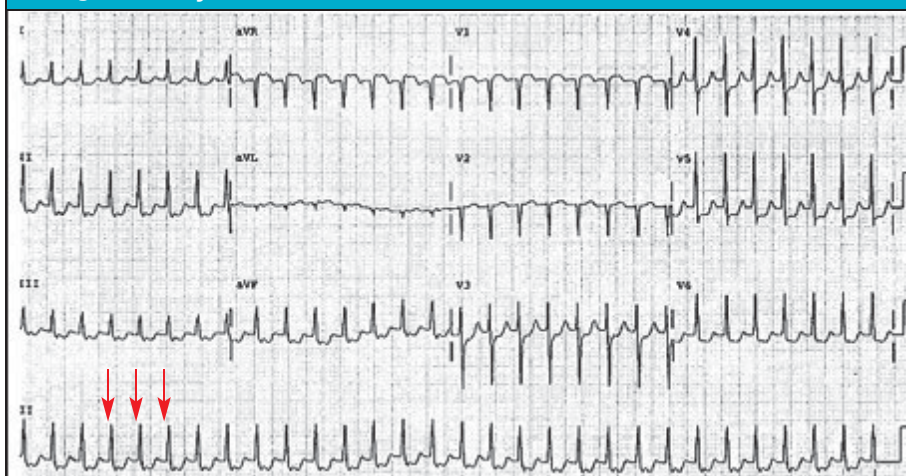
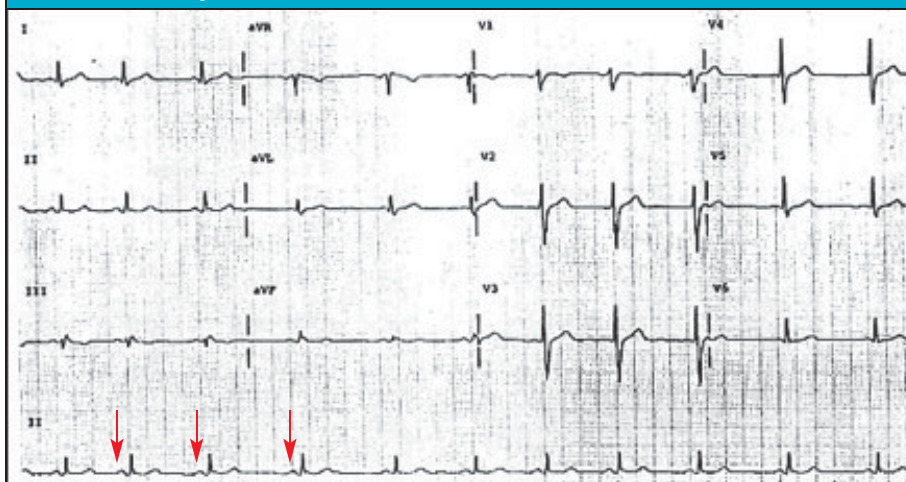
Case 2 EKG Analysis



phology. There are some nonspecific ST changes, but no ST elevation concerning for an acute MI. There are prominent r waves consistent with left ventricular hypertrophy (LVH). The arrows point to the “multifocal” p waves.

Learnings/what to look for:

- MAT is an atrial rhythm, and not ventricular
- Complexes are narrow and irregular, but p waves are present, ruling out atrial fibrillation
- The ST segments are decreased in the anterior lateral leads (V4-6), but this is a nonspecific finding. Comparison to past EKGs and correlation with the patient's symptoms are important
- MAT occurs commonly in patients with COPD, likely present in our patient with his history of smoking and the scattered wheezing heard on lung auscultation

Case 3 EKG Analysis**Case 4 EKG Analysis****Pearls for urgent care management and considerations for transfer**

- Although the rhythm is benign, the underlying cause may require further evaluation and management (eg, with sepsis, pulmonary embolism, or ischemia)
- Return to the bedside and use the history and exam to risk stratify for serious underlying causes of the MAT. Inquire about chest pain, shortness of breath, syncope, dizziness, diaphoresis, fever, medication, or drug use
- If the rhythm is found incidentally and the patient is asymptomatic/without new symptoms, further evaluation and management can be done on an outpatient basis
- Compare the EKG with previous EKGs if available
- Indications for transfer include suspicion of sepsis, res-

piratory failure, myocardial ischemia, pulmonary embolism, theophylline toxicity, or consideration of other life-threatening etiology

Case 3 Diagnosis: Supraventricular Tachycardia

In case 3, a 42-year-old female with a known history of anxiety presented with intermittent palpitations of 2 weeks' duration.

EKG analysis

The EKG reveals a tachycardic rate with regular rhythm, which excludes both atrial fibrillation and multifocal atrial tachycardia. There are no flutter waves, making the diagnosis of atrial flutter unlikely (also, the atrial flutter rate is typically 150). The QRS complexes are narrow, excluding ventricular tachycardia. P waves are not seen. The tracing is most consistent with supraventricular tachycardia. There are some ST depressions which could be a rate-related ischemia; these generally resolve with the management of the SVT.

Learnings/what to look for

- SVT is a regular, narrow complex and tachycardic rhythm
- The mechanism is a re-entrant tachycardia
- Distinguish from atrial fibrillation (irregular, irregular rhythm), atrial flutter (flutter waves and typical rate of 150), ventricular tachycardia (wide complex QRS), and sinus tachycardia (presence of p waves)
- Symptoms may include sensation of palpitations, lightheadedness, shortness of breath, chest pain, or weakness

Pearls for urgent care management and considerations for transfer

- Unstable patients displaying hypotension, confusion, diaphoresis, or chest pain should have an IV placed

and be put on the monitor (if time allows) and be transferred to an emergency department

- Stable patients may attempt the Valsalva maneuver by “bearing down.” Postural modification, by having the patient Valsalva and the clinician perform a passive leg raise (per the recently published REVERT trial⁹) may also be effective
- ED management will initially proceed with adenosine administration, while unstable patients may require cardioversion
- With SVT, consider Valsalva maneuver or postural modifications at the bedside
- During the straining phase: Patient is placed on the bed in high Fowler’s position (head elevated to 80°–90°). Patients are then given a 10 mL syringe and told to blow continuously into the syringe for 15 seconds, displacing the plunger in the process. This is an effective way of generating the recommended 40 mmHg of intrathoracic pressure needed for the Valsalva maneuver⁸
- Relaxation phase: lay patient supine and manually elevate their legs
- In the REVERT trial, 43% of patients returned to normal sinus rhythm after the application of this method^{9,10}

Case 4 Diagnosis: Sinus Arrhythmia

In case 4, a 26-year-old male presented complaining of palpitations of 3 days’ duration.

EKG analysis

The EKG reveals a sinus rhythm, with p waves preceding each QRS, excluding atrial fibrillation. This is not a tachycardic rhythm (excluding MAT, SVT, or sinus tachycardia). The QRS interval is normal, ruling out a bundle branch block or a ventricular rhythm. There are no ischemic changes suggestive of ACS (no ischemic ST changes or abnormal T wave inversions). This EKG shows sinus arrhythmia.

Learnings/what to look for

- Sinus arrhythmia is common in young patients and is a normal physiologic response, typically due to increased or decreased vagal tone during breathing (inspiration increases the vagal tone causing a decrease in the heart rate)
- It is a benign rhythm and sometimes will be appreciated by the patient, and other times may be asymptomatic

Pearls for urgent care management and considerations for transfer

- Sinus arrhythmia is a benign rhythm
- If the rhythm is found incidentally and the patient is asymptomatic/without new symptoms, no further testing is necessary
- Compare the EKG to previous EKGs if available
- Indications for transfer include suspicion of ischemia, cerebral hypoperfusion (dizziness, altered consciousness, hypotension), sepsis, respiratory distress, pulmonary embolism, drug toxicity, or consideration of other life-threatening etiology

Conclusion

Cardiac arrhythmias are a common cause of morbidity and mortality and are important to recognize in the urgent care setting. An arrhythmia must be addressed in a timely fashion to prevent further morbidity (and mortality). A focused HPI and PE are of utmost importance in arriving at the correct diagnosis. A 12-lead EKG is necessary to determine the precise arrhythmia present. Based on the results of the EKG, treatment can be geared toward preventing hemodynamic compromise, and possibly restoring the patient to sinus rhythm. In certain cases, patients may need to be placed on long-term anticoagulation. In addition, certain lifestyle modifications (eg, smoking cessation, reducing or eliminating caffeine, regular exercise) may help reduce the risk of further arrhythmias in the future. ■

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Urgent Care 2.0: Health Systems Taking the Retail Approach to the Next Level

Urgent message: Spurred by disruptive market entrants and burgeoning consumerism, health systems are increasingly adopting retail principles to better meet consumers' shifting expectations. Thus, urgent care stakeholders, either as standalone operators or partners with a hospital/health system, must further expand upon their retail offerings in order to fend off increased competition.

ALAN A. AYERS, MBA, MAcc

Healthcare in the U.S. is undergoing a number of dramatic changes, one of which is what some insiders are calling the “Uberization of healthcare.” Also referred to as the “Uber effect,” market forces are driving healthcare to belatedly embrace the retail-centric, consumer-focused ethos that has long been the standard in other industries. And for good reason: en masse, today's healthcare patients are thinking and acting like bona fide consumers, and are actively shopping for providers who will treat them as such.

Consumers want fast, convenient, affordable, seamless, and high-quality services, and they want engagement via digital channels—much like Uber and other disrupters offer through their platforms.

Of course, urgent care laid the consumer-focused groundwork some 30 years ago: Imagined as a viable alternative to limited primary care access and expensive, overcrowded emergency departments, urgent care offered same-day appointments, short waits, convenient locations, affordable visits, and extended hours—in retrospect, the ideal vehicle for ushering in healthcare consumerism. Hence, consumers flocked to the model, and sparked a meteoric rise that's still going strong to this day.

Indeed, urgent care was the first retail health play. Today, though, disruptive new entrants are flooding the market with ambitious innovations that threaten to



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siphon off market share from established healthcare players, including urgent care. These entrants are often pure play disrupters who have created successful busi-

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

nesses filling the gaps of traditional healthcare providers, and are collectively setting a new baseline for transparency, access, and service delivery. Thus, the onus is on existing health systems to innovate and compete, or watch their market share dwindle.

The Shift Toward Digital and Retail Healthcare

Global research and consulting firm McKinsey asserted in a recent report that in 2016, venture-capital firms invested upwards of \$7 billion globally in the digital health space, and are on pace to eclipse that figure this year. Other than the dot.com era of 20 years ago, no recent investment category has seen an increase of this magnitude. To illustrate, consider the following examples of what three disrupters and innovators, digital and otherwise, are doing in the healthcare space:

- San Francisco-based Cellscope is developing technology that allows consumers to capture high-quality medical images on their devices, then forward them to a clinician for review and diagnosis.
- A health system in Minnesota, attempting to create a new standard in patient experience, purposely designed a medical center with the architectural look and feel of an Apple store.
- A hospital in North Carolina, borrowing from online dating technology, implemented an algorithm-based online portal that matches patients with providers based on 14 personality traits and characteristics.

Clearly, the advent of widespread connectivity, cloud computing, and mobile devices has resulted in a growing class of empowered, digitally native consumers accustomed to booking flights, ordering meals, and checking account balances through digital channels, quite literally at their fingertips. This evolution can be mostly attributed to disruptive innovators, whose expansive range of services and offerings have shifted consumer expectations. And now those consumers—by voting with their wallets—are demanding similar levels of access, transparency, convenience, and experience from their healthcare providers.

Urgent Care 2.0: The New Baseline

Urgent care is currently a hot ticket, as the ownership stakes increasingly shift toward venture capital firms,

“Full-service digital platforms must go from being the exception to the norm for any healthcare organization that’s serious about competing for patients’ share of wallet.”

insurers, and hospital systems looking to leverage the many advantages the model offers: reduced costs, value-based and accountable care, geographical footprint expansion, and a consumer-friendly health system access point. However, new entrants with nimble and easily scalable business models, including retail clinics and telehealth providers, are courting those very same patients. And by successfully disrupting existing business models with innovative solutions, disruptive entrants are staking a solid claim, and capturing market share in the process. Thus, hospitals chains,

payors, and independent urgent care operators can’t simply stand pat with the status quo, or give in to complacency. Rather, they must make a concerted effort to take their urgent care offerings to the next level, and offer a wholly improved level of patient experience.

In short, the industry must fully commit to transitioning to a phase that some experts have dubbed *Urgent Care 2.0*: Clinics that have a standardized look and feel, while offering a fully retail, digitally supported, consumer-friendly experience without sacrificing care quality or clinical excellence. To that end, we’ve compiled a number of consumer-focused initiatives, based on the collective research of healthcare firm Advisory Board Company along with other healthcare leaders, that urgent care can adopt to differentiate their brand, and compete on consumer experience.

Full-service digital platforms – Given consumer expectations, just about every business nowadays has one or more digital channels—be it a website, mobile app, or both—for communicating with and servicing customers. Yet, Advisory Board research found that as recently as 2014, only 10% of healthcare firms offered even basic online scheduling.

For any healthcare organization that’s serious about competing for patients’ share of wallet, full-service digital platforms must go from being the exception to the norm. Patients want to schedule appointments, check wait times, receive text message updates, email their providers, and refill prescriptions—all from their smartphone. Urgent care operators must make the commitment to invest in technology platforms that allow full-fledged digital engagement with consumers, as they’re now heavily weighing such criteria when choosing a provider. And the

communication doesn't necessarily have to be one-way: clinics can utilize these channels to push out offers, updates, discounts, and promotions.

Self-publishing of patient reviews –

Social networking has become a way of life for consumers; hence, they regularly consult third-party review sites for information about providers while in the deciding phase. Research has found, however, that online sources such as Yelp! and Google+ tend to feature reviews that disproportionately skew negative. In fact, patients are twice as likely to report a negative experience to a third-party site as a positive one. And other patients indeed base their decisions on positive or negative reviews.

This offers compelling proof that patient experience, and social proof, are the new differentiators. Hence, simply monitoring and responding on third-party review sites is no longer enough. In fact, it behooves urgent care to begin self-publishing patient reviews on their own online platforms. Several health systems have already done so, with encouraging results. Additionally, research data indicate that satisfied patients are more likely to post reviews to the provider's website rather than on a third-party source, which serves to balance out the negative reviews, and paints a more accurate picture of the service level consumers can expect.

Expansion of hours – Intermountain Healthcare of Salt Lake City, UT recently started a late-evening pilot program in its urgent care clinics in an effort to become more consumer-focused. Intermountain, responding to high levels of late-hour utilization of the ED, expanded their urgent care closing hours to as late as 1 AM.

Urgent care, already synonymous with widened access, can study the Intermountain pilot program and further expand its hours if there is a clear need within that community, and it's operationally feasible. Especially for urgent care centers affiliated with health systems, the potential financial drawbacks of extended hours can be offset by the long-term patient loyalty (and concomitant revenue) engendered from providing such expansive access.

Preregistration options – Advisory Board surveys show that 84% of healthcare patients prefer prearrival prereg-

“Expanding preregistration options is a sound investment for eliminating a major source of patient frustration, saving time, and improving clinic operational efficiency.”

istration options for expediting the process, reducing waits, and alleviating frustration.

Preregistration options can also verify insurance in advance, reduce registration bottlenecks, and increase up-front collections. Urgent care can expand its preregistration options via three channels: website, mobile apps, and unstaffed kiosks. It's a sound investment for eliminating a major source of patient frustration, saving time, and improving clinic operational efficiency.

Hardwired service recovery –

As there are bound to be missteps in any service delivery, a fully fleshed-out service recovery model must be designed, then organizationally hardwired to reduce the number of aggrieved patients who would otherwise defect. Again, patient experience is a key differentiator here, such that service recovery can no longer be taken lightly: It must become an organizational imperative.

One way urgent care can improve its service recovery is by creating social media teams that monitor patient feedback, in real time and after the visit. El Camino Hospital in Silicon Valley employs social media teams for reputation management purposes, and uses them to respond to frustrated patients, demonstrating that they care and are actively monitoring user comments.

Another effective service recovery method is implementing a mobile service recovery app through in-clinic Wi-Fi. Northshore-LIJ Health System in New York uses such a system, so that when patients log in to the Wi-Fi network, a pop-up prompts the user to answer the question, “How satisfied are you with the service?” Any patient who responds “unsatisfied” triggers an alert within the system, and a staff member responds within a few minutes.

Wait-time transparency – Although an issue that can slip under some provider's radar, Advisory Board research concludes that leaving patients in the dark about wait times is a primary source of dissatisfaction.

Dekalb Medical Group in Decatur, GA, after consistently receiving subpar wait-time patient satisfaction scores, realized that they needed a different approach. They understood that communication of delays is important to their patient experience strategy, so to improve in that area, they implemented a two-pronged approach:

- First, each patient, whether in a lobby or exam room, receives an update if 10 minutes have passed and they haven't been seen.
- Second, physicians will approach the patient in-person, acknowledge the wait, and offer a direct apology. This method has resulted in a dramatic increase in patient satisfaction scores surrounding wait times for Dekalb patients. The lesson? Any urgent care operation that does not already have a wait-time transparency protocol in effect should implement one as soon as possible.

Provider video profiles – Although the aforementioned online dating example is probably not the optimal approach for an episodic, ambulatory model like urgent care, efforts can be made to familiarize patients with their clinicians via video.

Health systems, including MetroHealth in Cleveland, OH, are increasingly responding to consumer requests for provider video profiles, and are making short video clips available on their websites. The videos introduce the provider and allow them to explain their approach to care delivery, giving patients a glimpse into the provider's personal style. Some urgent care centers are already using social media platforms like Facebook for that very purpose, posting short video introductions of their staff and clinicians. This approach is very effective for branding, and giving patients a sense of familiarity and comfort that is often a key factor when deciding which center to patronize.

Conclusion

McKinsey noted that disrupters don't usually have a dramatic effect on a market for several years. However, when consumer behavior and the scale of disruption reaches a tipping point, the effects are widespread. Thus, existing healthcare incumbents like urgent care, and the health systems and payors invested in them, must strive to meet the new baseline of transparency, access, and convenience that pure play healthcare entrants and disrupters are setting.

For this to happen, urgent care systems, long a con-

“To remain competitive, urgent care must wholeheartedly invest resources in the patient experience, as it has in clinical excellence.”

sumer-focused healthcare delivery model, must take the next step into the so-called Urgent Care 2.0 era, and become even more retail in its offerings. Taking a cue from leading disrupters like Uber, Netflix, and AirBnB, urgent care can increase its leveraging of digital platforms toward offering a more comprehensive range of consumer-focused services, and start filling the remaining gaps. Full-service mobile apps, social media, video content, and

dedicated service recovery initiatives are just some of the vehicles that urgent care can employ to further roll out the red carpet for consumers and engage them where they are.

In sum, patient experience is becoming just as important as clinical excellence, and if urgent care wholeheartedly invests resources in that area, it will achieve the differentiation necessary to remain competitive. ■

Summary

- One part of the ongoing evolution of the healthcare marketplace especially relevant to urgent care is known as “Uberization” or the “Uber effect,” in which market forces are driving healthcare to embrace the retail-centric and consumer-focused ethos, similar to big industry disruptors such as Uber.
- Venture-capital firms invested more than \$7 billion in the global digital health space in 2016—and they're on pace to eclipse that in 2017. No recent investment category has seen an increase of this magnitude for decades.
- Widespread connectivity, cloud computing, and mobile devices has resulted in more empowered, digitally native consumers who now expect greater access, transparency, and convenience from healthcare providers.
- Patients are most likely to post negative reviews on third-party websites (eg, Yelp! or Google+). Conversely, they're more apt to post positive reviews on the provider's website (as opposed to on a third-party site).
- Full-service mobile apps, social media, video content, and dedicated service recovery initiatives are all vehicles urgent care operators can employ in their efforts to increase consumer engagement.



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Nurse-Only Visits in Urgent Care: An Analysis of Outcomes and Patient Satisfaction Relative to Traditional Care

Urgent message: As shown in an in-house study by one urgent care operator, protocol-driven, nurse-only care of specific presenting complaints may be one way to help curb healthcare spending while not compromising on quality of care or threatening patient-satisfaction scores.

BRETT WHYTE, MD and KYLE COON

Abstract

Basic healthcare costs are rising at a staggering and, it's widely considered, unsustainable rate. As a result, lower-cost alternatives that maintain quality and satisfaction are being explored across all care settings. One such initiative provides nurses at Winona Health Urgent Care with detailed algorithms to address common complaints such as sore throat and dysuria in otherwise healthy people for the purpose of comparing the overall quality, cost, and patient satisfaction of "nurse-only" care vs traditional provider care. The hypothesis that nurse-only care for these complaints maintains quality and patient satisfaction at a lower cost was tested through post-care telephone survey of patients. Patients must have met inclusion criteria for nurse-only care and be without exclusion criteria, in order to be considered for either arm of the study.¹ Ten to 14 days post visit, qualified patients from either category were asked if they experienced an improvement or resolution of symptoms; if additional follow-up visit(s) were required for the same problem; and how they rank their overall satisfaction. Data were collected in aggregate form, leaving no patient identifiers, and analyzed for differences between provider and nurse-only categories. Lastly, cost of care for both groups was investigated in order to determine if the nurse-only protocol is a lower-cost alternative to the traditional provider care. Collected data



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provided comparisons of satisfaction scores between both groups; tracked whether the need for additional visits for the same complaint was higher in the nurse-only category; and revealed the percentage of patients with resolution of symptoms between both groups. There was no statistical difference between the two groups in overall satisfaction, resolution of symptoms,

Brett Whyte, MD practices emergency and family medicine with Winona Health in Winona, MN. **Kyle Coon** is a research technologist at the Mayo Clinic in Rochester, MN. The authors have no relevant financial relationships with any commercial interests.

or need for additional visits for the same problem. The nurse-only group had a much lower total cost of care to the patient.

Background

The total cost of care for basic healthcare services is staggering and widely considered unsustainable. Healthcare costs as a percent of gross domestic product (GDP) in the United States was 17.5% in 2014—higher than any other nation.² In addition, healthcare consumer price index (CPI) has outpaced general CPI every year since 2008, indicating that the problem is worsening.³ Efforts to provide lower-cost alternatives to traditional care while maintaining quality and patient satisfaction are essential to meaningful reform. In the urgent care setting, isolated sore throats and uncomplicated dysuria are common chief complaints. We have developed “nurse-only” protocols for these chief complaints, encompassing the entirety of care. The Minnesota Board of Nursing was consulted to assure that the protocols were compliant with Minnesota statutes regarding condition-specific protocols and fell within nursing scope-of-practice parameters. Previous studies have evaluated appropriate antibiotic prescribing habits retrospectively in patients with pharyngitis in nurse-only vs traditional care.⁴ Our goal was to evaluate this process prospectively for quality, cost, and satisfaction data and compare the nurse-only group with a group of patients with similar chief complaints seen by a physician or associate-level providers in the same clinic. To measure satisfaction and quality, data points for patient satisfaction with the process, resolution of symptoms, and frequency of repeat visits for the same complaint were collected. In addition, total cost of care was compared between the two groups.

Methods

Patients seen in urgent care for isolated sore throats or dysuria and fulfilling inclusion criteria and not having any exclusion criteria (see Appendix) were included in the study.¹ Patients who agreed to participate in the study were given the option of nurse-only protocol driven care vs traditional provider-based care, creating the two arms of the study. Patient interviews were conducted by the investigators for data collection by phone 10-14 days after the initial visit. If needed, a second or third phone call was made in this 4-day window before the patient was considered “lost to follow-up.” As part of the interview, patients were asked to rank their satis-

Table 1. Data distribution among categorical satisfaction data for nurse-only and provider groups

	Unsatisfied (0-3)	Neutral (4-6)	Satisfied (7-10)	Total
Nurse	1 (0.40%)	2 (0.81%)	245 (98.8%)	248
Provider	0	0	15 (100)	15
Total	1	2	260	263
P-value: 0.8378				

Table 2. Data distribution for additional healthcare visits among both nurse-only and provider groups

	No	Yes	Total
Nurse	242 (97.6%)	6 (2.4%)	248
Provider	14 (93.3%)	1 (6.7%)	15
Total	256	7	263
P-value: 0.9459			

faction with their visit on a scale from 0 (very unsatisfied) to 10 (very satisfied). Also, patients were asked if they required additional follow-up visits for the same complaint and to classify their clinical course of symptoms as either “worse,” “no change,” “improved,” or “resolved.” Patient questions during these phone calls were referred to appropriate licensed professionals when needed. Data were collected from January 2016 to March 2016. Statistical analysis of the data was performed, and comparisons were made between the nurse-only and traditional care groups using JMP Pro 12 statistical analysis software. There was no cost to subjects in excess of standard charges for similar patients not involved in the study.

Results

Data were recorded into categories, placing counts of 0-3 as unsatisfied, 4-6 as neutral, and 7-10 as satisfied.⁵ Table 1 was analyzed using Fisher’s Exact Test to deter-

“There was no evidence that the nurse-only group received lower satisfaction scores than the provider group.”

“There was no evidence that the need for additional healthcare visits was higher in the nurse-only group than in the provider group.”

mine if there was evidence that satisfaction scores were lower in the nurse-only group. It was found that Fisher's Exact Test reported p-values >0.05 for categorical analyses (0.8378), denoting no evidence that the nurse-only group had lower satisfaction scores from patients than the provider group.

The need for additional healthcare visits for the same problem was also examined between nurse-only and provider groups to measure quality. These data were collected by contacting patients over the phone and examined using JMP Pro 12 statistical analysis software. Data

from Table 2 present no evidence that the need for additional healthcare visits was higher in the nurse-only group than in the provider group. This was determined using Fisher's Exact Test to analyze the data in Table 2, which presented a p-value of 0.9459, (denoting no evidence of statistical difference between the two categories).

An additional aspect of this study tested if the percentage of patients with either improvement or resolution of symptoms 10-14 days after their visit was lower in the nurse-only group compared with the group that saw a provider. These data were also used as a variable to measure overall quality. Data for this examination were collected via patient survey over the phone. The patients were asked to categorize their clinical course into four groups: resolved, improved, no change, or worse. It was found that the nurse-only group did not present a lower rate of symptom alleviation than the provider group according to the p-value obtained from Table 3's data, 0.110.

Finally, a cost analysis was compared between nurse-only and provider groups.⁶ Cost for services of both complaints relating to tests for isolated sore throats (rapid strep test) and uncomplicated dysuria (urinalysis), as well as provider services charged by Winona Health Urgent Care, were examined. Both nurse-only and provider groups conduct a rapid strep screening for patients complaining of isolated sore throats to test for pharyngitis. Winona Health Urgent Care charges \$86 for both groups for this service. Likewise, both groups conduct a urinalysis for patients complaining of dysuria to test for a urinary tract infection, which costs \$33 for both groups. However, the provider group on average charges a fee of \$151 for a level 3 office visit for both complaints, which presents the opportunity for cost savings for the nurse-only visit. The nurse-only group shows a total cost saving of 64% for visits regarding isolated sore throats and an 82% cost savings to patients for visits regarding dysuria compared with the provider group, as seen in Table 4.

There was a larger-than-expected

Table 3. Symptom resolution between nurse-only and provider groups^a

	Worse	No Change	Improved	Resolved	Total
Nurse	1 (0.4%)	5 (2%)	29 (11.7%)	213 (85.9%)	248
Provider	0	0	0	15 (100%)	15
Total	1	5	29	228	263
P-value: 0.110					

Table 4. Service charges for each group and test performed for each complaint, as well as total cost for both types of complaints for each group, and the total cost reduction of the nurse-only group visit compared to the provider

Group/Service	Service/Charge	Average Total Cost per Service	Cost Analysis
Nurse-only – office charge	Level 3 office visit \$0		
Isolated sore throat	Rapid strep test \$86	\$86	64% cost reduction
Dysuria	Urinalysis \$33	\$33	82% cost reduction
Provider – office charge	Level 3 office visit \$151		
Isolated sore throat	Rapid strep test \$86	\$237	
Dysuria	Urinalysis \$33	\$184	

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variance in the total number of patients between categories (nurse-only 248 and provider 15) because the vast majority of patients that qualify for nurse-only protocol choose that route of care, compared with seeing a provider. Patient contact rates of 63% for nurse-only patients and 71% success for providers, respectively, was achieved. As a whole, the evaluation of quality, satisfaction of care, and cost analysis between nurse-only and provider visits for the chief complaints of isolated sore throats and dysuria presented results that supported the original hypothesis: The nurse-only program at Winona Health Urgent Care does in fact provide patients with a satisfactory and more cost-effective alternative to traditional provider care.

Limitations

This study has several limitations. One is that the study arms were not randomized, but based on patient preference. Patient rationale for selecting an arm of the study was not studied, but could include perceived severity of illness or perceived financial consequences of their choice, injecting variation into the two groups and making comparisons less conclusive. Also, a large majority of patients when given the option chose nurse-only care in our population, making the volume in each arm of the study unequal. Finally, nurses and providers were aware of the study and that follow-up phone calls would be made, perhaps influencing their decision-making and demeanor relative to nonstudy patients.

Conclusion

Exploring new ways in medicine to lower cost while maintaining quality and patient satisfaction are important to a sustainable healthcare system. Protocol-driven care for two basic chief complaints by RNs in this study showed no statistical difference in quality or satisfaction relative to traditional care at a much lower cost to the patient. Total savings to patients from this process in this clinic alone is approximately \$600,000 annually.³ Expanding this concept to additional uncomplicated medical complaints is supported by this early success.

“The evaluation of quality, satisfaction of care, and cost analysis between nurse-only and provider visits supported the original hypothesis: The nurse-only program provided patients with a satisfactory and more cost-effective alternative.”

Patients strongly preferred participating in the nurse-only pathway when offered the option (94%).

We were aware that the nurse-only program was popular, but the strong preference for it over traditional provider-based care was surprising. Patients were not directly asked why they preferred nurse-only care, but we would speculate that the lower cost and perceived faster service were motivators. The nurse-only protocols involved in the study have objective laboratory evidence to rely on in medical decision-making. Perhaps this improves the confidence of patients in nurse-only care in these areas, leaving more subjective medical decision-making to those with a

higher level of training. However, in this sample, there were no identified patients with an alternative diagnosis identified in follow-up visits. That does pose as a risk, and attempts to mitigate it were made in the inclusion/exclusion criteria of the nurse-only protocol (see **Appendix**). ■

Acknowledgments

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Appendix

RN Visit for Pharyngitis (Strep Throat)**Effective Date:** 5/1/2015**Author:** Dr. Brett Whyte**Reviewed by:** Martha Bollman**Approved by:** Dr. Allen Beguin, Medical Practice Committee**Definitions:** To provide in a safe, efficient manner, approval for treatment by the RN as the agent of the prescriber.**Purpose:** To provide a process for the RN to evaluate and treat positive pharyngitis (strep throat) results.**Procedure:****Inclusion Criteria**

1. A sore throat without other signs or symptoms (eg, cough, earache, neck pain) for ≤ 10 days
2. Patient age ≥ 2 years
3. No documented pharyngitis within the past month
4. Patient or family member chose nurse-only care

Exclusion Criteria (yes answer to any of the following)

1. Are you having trouble breathing?
2. Are you having trouble swallowing your own secretions?

3. Does it hurt when you open up your mouth?
4. Are you allergic to penicillins (amoxicillin) and macrolides (erythromycin, azithromycin, clarithromycin)?
5. Abnormal vital signs (sbp >165 , dbp >95 , HR >115 , RR >25)

Exam

1. Complete vital signs
2. Throat exam (no pre-tonsillar swelling); see photo

Rapid Strep

1. Negative – symptom care recommendations
2. Positive – treat with antibiotics according to attached guidelines
3. Generate school/work release for 1 day if requested
4. If follow-up culture is positive, treat according to attached guidelines

First-line, amoxicillin

PCN Allergy = Azithromycin

(Antibiotic prescriptions should be entered electronically as a verbal order of a provider working that day.)

Strep Treatment Standing Orders

Pediatrics			11 kg	13 kg	15 kg	17 kg	9 kg	21 kg	25 kg	30 kg	35 kg
Amoxicillin 400 mg/tsp	Twice daily	10 days	3 mL	3.75 mL	4.25 mL	4.75 mL	5.25 mL	6 mL	7 mL	8.5 mL	10 mL
Azithromycin 200 mg/tsp	Once daily	5 days	3.5 mL	4 mL	4.5 mL	5 mL	5.75 mL	6.25 mL	7.5 mL	9 mL	10.5 mL
Amoxicillin 500 mg	Three/two times daily	10 days									
Azithromycin 500 mg (Z-pak)	500 mg daily day 1, 250 mg daily, days 2-5										

IM Antibiotics			<35 kg	>35kg
Bicillin LA million units	QD	1 day	600,000	1,200,000

Nurse-Only Uncomplicated Urinary Tract Infection**Evaluation and Treatment Algorithm (Revised 4/28/2015)****Inclusion Criteria**

1. Symptoms of urinary tract infection such as frequency of urination, dysuria or nocturia.
2. Female >15 and <65 years old
3. Patient or family member chose nurse-only care

Exclusion Criteria (yes answer to any of the following)

1. Vaginal discharge or irritation present
2. Fever, vomiting, abdominal pain, pelvic pain, or flank pain present
3. Allergic to sulfa, nitrofurantoin and cipro
4. Current UTI not responding to treatment
5. Any of the following are present:
 - a. Diabetes
 - b. Pregnancy (may do urine pregnancy test if unsure)
 - c. Symptoms >7 days
 - d. Pyelonephritis in past year
 - e. Hospital-acquired infection
 - f. Renal failure
 - g. Presence of indwelling catheter, stent, or nephrostomy tube
 - h. Taking Coumadin
 - i. Recent urinary tract instrumentation
 - j. Functional or anatomic abnormality of the urinary tract
 - k. Renal transplantation
 - l. Immunosuppression
6. Excluded if urinalysis result is positive for additional conditions, including:
 - a. Glucose ≥ 100 g/dL
 - b. Ketones moderate or Large (>40 mg/dL)

- c. Bili moderate or Large
- d. Uro ≥ 2 mg/dL
- e. Protein ≥ 100 mg/dL

Urinalysis result:

1. Repeat UA (or have see provider) if many squamous epithelial cells are present. Results are not reliable
2. Positive if any of the following are present:
 - a. Positive leukocyte esterase
 - b. Positive nitrate
 - c. >10 WBCs/high power field
 - d. Any bacteria present

If urinalysis is negative, UTI is not confirmed and provider visit recommended. If urinalysis is positive, treat as outlined below.

Antibiotics

1. Nitrofurantoin 100 mg 1 pill orally twice daily for 5 days (1st choice, about \$40, 98% efficacy)
2. Cipro 250 mg 1 pill orally twice daily for 3 days (2nd choice, about \$30, 86% efficacy)
3. Bactrim DS 1 pill orally twice daily for 3 days (3rd choice, about \$5, 84% efficacy)
4. Pyridium 200 mg 1 po three times daily for 2 days for dysuria if desired (warn patient that this will turn urine neon orange and not to be alarmed; contacts can also stain, about \$5)

Prescriptions should be entered electronically as a verbal order of a provider working that day.



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Reference: 1. <https://www.federalregister.gov> See "Microbiology Devices: Reclassification of Influenza Virus Antigen Detection Test Systems Intended for Use Directly with Clinical Specimens" (82 Fed. Reg. 3609) for the relevant performance specifications.

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A 5-Month-Old with Symptoms Beyond the Presenting Complaint

Urgent message: Treating preverbal children can be challenging under every-day circumstances for pediatricians who know the child and the family. Urgent care providers who may not have the benefit of that history must be especially vigilant for all available signs and symptoms to make diagnoses based on the full scope of the presentation.

MICHAEL WEINSTOCK, MD

Case Presentation

(Please note: The Case Presentation is drawn directly from the treating physician's notes, without editing or correction, to reflect the conditions at the time of presentation.)

5 month old male with multiple visits for URI in the past with complaint of cough for 4 days associated with clear rhinorrhea and tugging at the ears. Taking fluids and bottle well. There have been 8 wet diapers. Does have diarrhea X 4. Mother complains of easy bruising and there is bruising at the external right ear and left wrist. Had been on an ATB 2-3 weeks ago—does not know name of ATB.

Hx: URI

Meds: None

Social history: Presents with the mother

Immunization history: Immunizations are UTD

Physical Exam

General: No acute distress

Head: Ant. fontanelle is soft and concave

Neck: Soft and supple without meningeal signs

Oral: Mucous membranes are well hydrated

Ears: TM's pink bilat

Lungs: Coarse breath sounds without wheezing

CV: RRR

Abd: Soft, NT, positive bowel sounds

Skin: Hyperkeratotic areas without petechiae/purpura to right temple area. Positive ecchymosis to superior



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helix right ear. No petechiae/purpura about torso or extremities or face

Differential Diagnosis

- Pneumonia
- Thyromegaly
- Pneumothorax

Michael Weinstock, MD is the Associate Program Director, Adena Emergency Medicine Residency; Director of Medical Education and Research, Adena Health System; Adjunct Professor of Emergency Medicine, Wexner Medical Center at The Ohio State University; and Associate Clinical Editor of *The Journal of Urgent Care Medicine*. The author has no relevant financial relationships with any commercial interests.

- Pulmonary TB
- Cardiomegaly

On the Front Lines in the Urgent Care Center: Where Do I Go Next? A discussion of the evaluation and management of child abuse

Figure 1.

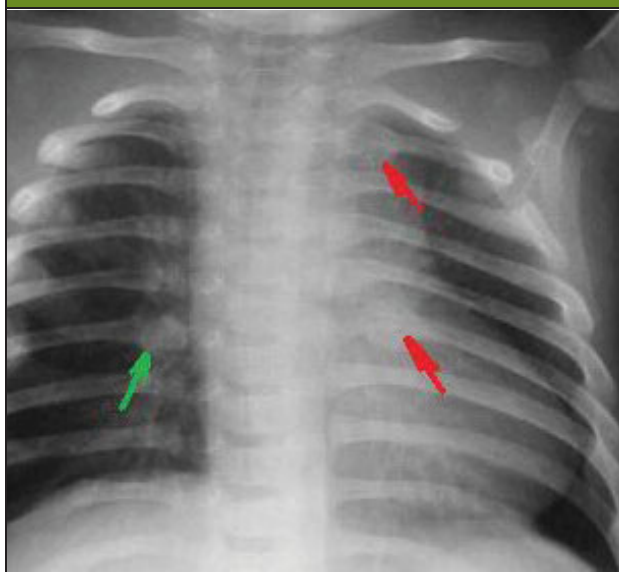


Image courtesy of National Institutes of Health

Diagnosis

Multiple rib fractures with suspicion for child abuse

General

Child maltreatment is divided into four categories:

- Child neglect
- Physical abuse
- Emotional abuse
- Sexual abuse

Child maltreatment is underreported and underdiagnosed due to difficulty with recognition and failure to consider this in the differential diagnosis. Neglect is the most common child maltreatment, with physical abuse second. Physical abuse affects all cultures and socioeconomic groups. The incidence is similar for male and female children. This risk of abuse increases with age, but fatal and serious injuries are most common under the age of 2. The Fourth National Incidence Study of Child Abuse and Neglect (NIS-4) reported that in the U.S., 1.25 million children were maltreated: 61% neg-

lected, 26% physically abused, 12% emotionally abused, and 11% sexually abused (children may fall into more than one category). Each year, there are 1,500 deaths per year from child abuse, with 80% occurring in children <4 years of age.

Risk factors for parents include difficulty bonding with the child, a caregiver who was maltreated as a child, unrealistic developmental expectations, disciplines with physical punishment, physical/mental/cognitive health issues, parental lack of self-control, alcohol/drug abuse, criminal activity, social isolation, depression or low self-esteem, lack of parenting skills due to age or lack of education, and financial difficulties.

Risk factors for the child include being an unwanted baby, high needs (prematurity, disabled, chronic illness), difficult to comfort, mental health issues, multiple birth, many siblings, exhibits violence, criminal behavior, self-abuse, animal abuse, and aggression toward peers.

Obtaining the History

History starts with an exploration of risk factors (as listed above), including prematurity, alcohol/drug abuse in the caregivers, financial difficulties, developmental delay in the child which may lead to poor child-parent bonding, and accidental pregnancy or unwanted children. Additional history incorporates a pediatric history including birth history, immunizations, siblings, milestones; a social history including caregivers, parental substance use, and socioeconomic status; and a family history of any hypocoagulable states or history of siblings or parent with nonaccidental injuries.

Physical Examination

Observe interaction with parent(s) or caregiver, respiratory rate, and general appearance (ie, well-kept vs disheveled). Examine the skin for bruising in concerning locations such as around the ear, face, and areas not likely to be injured with typical pediatric activities. In our case, a 5-month-old would be nonambulatory and not expected to have any bruising. Eyes should be checked for retinal hemorrhages, facial fractures, or bruising. Inspect the chest for pain or swelling, and old vs new fractures. Check the abdomen for pain secondary to internal injury and inspect and palpate the extremities for fractures, bruising, or burns.

Testing

X-ray will be determined based on location of pain. With strong suspicion of abuse in an infant, a skeletal survey may be done. An initial skeletal survey (Kempe series)

will assess for occult fractures. Rib fractures and long-bone fractures are more prevalent in children with inflicted traumatic injuries, with rib fractures having the highest probability for abuse at 70%. There is a high correlation between multiple fractures and abuse; 80% of inflicted fractures are seen in children <18 months old.

Advance imaging with CT or MRI will rarely be done, but can be considered if indicated. Noncontrast head CT will evaluate for subdural hematoma, subarachnoid hemorrhage, cerebral contusion, cerebral edema, infarction, and white matter changes. A diffusion-weighted MRI may distinguish between acute and chronic cerebral infarction.

Labs will rarely be indicated, but consideration of clotting abnormalities with bruising can be obtained (typically from the receiving hospital). If a bleeding problem is suspected, a basic bleeding evaluation (platelets, PT, and PTT) may suggest the need for more sophisticated bleeding evaluation and/or hematology consultation.

Indications for Transfer

Most patients with the following will be sent to the ED (if there is a pediatric emergency department, this is preferential):

- Hemodynamic instability
- Altered consciousness
- Shortness of breath
- Retinal hemorrhages
- Concerning symptoms (eg, abdominal pain or headache) with diagnostic uncertainty and suspicion of child maltreatment
- Suspicion of child maltreatment that requires emergent intervention and evaluation

Management

Any *suspected* child maltreatment must be reported. Mandated reporters, which include physicians, are required to report suspected child maltreatment to the appropriate authorities. Professionals (physician, teacher, nurse, social worker, etc.) reporting in good faith are immune from legal liability arising from the report. However, failure to report can result in both malpractice liability and criminal prosecution. Typically, severely injured children have a history of prior “minor” injuries (as in this case) and/or a history of abuse in siblings. This means there may be

“There may be opportunity to prevent significant morbidity and mortality either to the 'index' abused child and/or to their siblings.”

an opportunity to prevent significant morbidity and mortality either to the “index” abused child and/or to their siblings.

Summary/Clinical Pearls

- Bruises (or fractures) in a nonambulatory infant are presumed to be child abuse until proven otherwise
- Physicians are mandated to report any *suspicion* of child abuse. Failure to do so can lead to criminal penalties for the physician, in addition to malpractice claims
- Inflicted bruises typically have a regular uniform appearance, a distinct pattern, occur in protected nonexposed areas, and are of different ages

Acknowledgment: This case and the information about the follow-up reflect the actual documentation. This case is adapted from the book *Bouncebacks!* (2006, Anadem Publishing), by Michael Weinstock, Ryan Longstreth, and Greg Henry and includes 30 case presentations with risk management commentary. Thanks to Anadem Publishing for permission to reproduce the case. ■

Recap: Parent and Child Risk Factors of Child Maltreatment

Parent

- Difficulty bonding with the child
- Maltreated as a child
- Unrealistic developmental expectations
- Disciplines with physical punishment
- Physical/mental/cognitive health issues
- Parental lack of self-control
- Alcohol/drug abuse
- Criminal activity,
- Social isolation
- Depression or low self-esteem
- Lack of parenting skills due to age or lack of education
- Financial difficulties

Child

- Being an unwanted baby
- High needs (prematurity, disabled, chronic illness)
- Difficult to comfort
- Mental health issues
- Multiple birth
- Many siblings
- Exhibits violence
- Criminal behavior
- Self-abuse
- Animal abuse
- Aggression toward peers



Implications of HIPAA and Employee Confidentiality Rules on Positive Drug Test Results

■ ALAN A. AYERS, MBA, MACC

Urgent message: In addition to drug testing their own employees, many urgent care centers offer drug testing as a service to other employers. Therefore, it's important to understand the laws affecting the privacy of drug screen results.

Introduction

It's standard procedure throughout the country for employers to require employees and applicants to submit to drug testing both before and after being hired. There isn't any overarching federal law that requires or prohibits drug testing by private employers, but many states have enacted laws regarding employee drug testing. However, the results of a drug test are generally protected by both federal and state laws.¹

This article will examine the impact of HIPAA requirements on employee drug test results, the protections afforded employees, and the potential liability for healthcare providers such as urgent care centers.

Drug Test Results as Protected Health Information

HIPAA is a concern for all healthcare organizations, including privately owned urgent care companies. The rules pertaining to patient privacy are reasonably clear, but questions arise as to whether drug test results are protected health information under HIPAA when performed for employment purposes.

Federal statutes, including HIPAA, the ADA (Americans With Disabilities Act²), and other employment laws (eg, the Drug-Free Workplace Act (DFWA), the Fair Credit Reporting Act (FCRA), and U.S. Department of Transportation regulations) re-

"Drug test results may not be disclosed to third parties except as required by law or pursuant to a court order."

quire companies to treat test results as confidential. Most states regard drug-testing results as confidential, as well.

Drug test results may not be disclosed to third parties except as required by law or pursuant to a court order. This can include an investigation or litigation concerning a claim related to the drug test, such as an employment issue, workers' compensation, or a criminal matter.³

Within an employer's organization, policies should state who has access to this personal health information (PHI). This may include the human resources department and the hiring or supervising manager. An employer should have restrictions on how (and if) such information can be shared with others. As part of this process, employees who undergo a drug test will typically sign a release at the time of the test to permit the employer to receive the results.

Healthcare Provider Drug-Testing Policies

It is important to note that the HIPAA Privacy Rule doesn't protect an employee's employment records—even if the information in those records is health-related. And in most instances, the HIPAA Privacy Rule doesn't apply to the actions of an employer. However, the Privacy Rule does protect an employee's medical or health plan records if she is also a patient of the provider or a member of the health plan.⁴ This specifically refers to medical treatment sought in the employer's primary business (ie, the employee becomes a patient), in which the medical record would be treated with the same privacy protections as every other patient record. Thus, it makes no difference if the employer is a



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*.

healthcare provider, like an urgent care center. Even though an urgent care facility may perform the drug testing in-house, rather than employing a third-party collection point—which may offer greater privacy protections—the rules for PHI are applied across the board for all employers. An urgent care owner should add procedures on access and disclosure of results to its drug testing policy when the drug testing is performed onsite.

Policies usually state that testing laboratories may conduct testing only for substances included on a disclosure list given to the individual, and may not conduct testing unrelated to drug usage.

Employers commonly keep all records concerning test results in medical files that are maintained separately from the company's personnel files. Drug test results, like all medical information about urgent care center employees, should be kept confidential. According to the Equal Employment Opportunity Commission, "if the results of a drug test reveal the presence of a lawfully prescribed drug or other medical information, such information must be treated as a confidential medical record."⁵

The individual, department, or the facility that receives drug test results should share drug test results only as needed. A manager may only need to know that an employee or applicant passed or failed the test without any further details. There are other situations when it's necessary to disclose the test, such as unemployment eligibility determination, workers' compensation claims, and disability benefits. The employee's consent may be required, depending on the specific situation and applicable regulations. A prudent strategy would be to obtain written consent for release from the applicant or employee whenever possible.⁶

Typically, private employers will have their own policies in place if an individual tests positive for drugs. These may include mandatory rehabilitation, firing, or not being hired for the position initially. Although some employers elect to do so, a private employer such as an urgent care facility isn't required to allow an employee or prospective employee to complete rehabilitation or to allow him a "second chance" before termination for drug use.

HIPAA Authorization

HIPAA stipulates that "covered entities" must provide HIPAA-compliant authorization before releasing drug and alcohol test results. Collection facilities or labs employed for the drug test will typically have an authorization form.

Urgent care employers should also remember that HIPAA doesn't preempt more rigorous state law requirements.⁷ A state may have drug testing laws and privacy laws that apply to drug tests as a matter of personal privacy, with tougher standards than the federal law.⁸

Decriminalized Marijuana

Many questions have arisen with the decriminalization of marijuana in several states.⁹ Specifically, employers are concerned about employees who are under a doctor's care with a legal

prescription for marijuana. The fact that the employee is under the care of a doctor is HIPAA-protected, but employees can be tested for drugs. In most cases, the question focuses on the rationale for the drug test. The employer must have *reasonable suspicion* that the employee has been taking drugs before he can be tested. This means that the employer has a legitimate reason to think that the employee has been taking drugs.

Arizona, Arkansas, Connecticut, Delaware, Illinois, Maine, Minnesota, Nevada, New York, Pennsylvania, and Rhode Island now have laws with explicit language with some degree of employment protection, typically prohibiting adverse action against an employee or applicant based on their status as a medical marijuana cardholder or participation in a medical marijuana program. For example, the states of Arizona¹⁰ and Delaware⁸ have protections in place prohibiting any punishment for medical marijuana users who aren't impaired on the job, but not for recreational users.

Note that if an employee is required to take a drug test, the employer should treat all their employees fairly and equally. Failure to do so may subject the employer to a discrimination action.

Liability

Healthcare providers like urgent care centers must be concerned with the potential liability for the inappropriate disclosure of an employee's drug results. The release of test results—even to the police—without a court order or the employee or applicant's written consent could result in the urgent care being subject to litigation.¹¹ In addition, disclosure of drug test results to unauthorized third parties could lead to an employee or applicant bringing a lawsuit based on negligence, invasion of privacy, intentional infliction of emotional distress, defamation, or violations of HIPAA and other federal law. A jury can award additional damages for pain and suffering.³

To date, few cases have held for private sector employees against random drug testing, either in refusing to take the test on privacy grounds and being fired, or when drug test results were inaccurate. Most state courts have held that the employment-at-will doctrine exceeds employees' privacy rights. The California Supreme Court is the only court to hold differently, because that state is one of the few whose state Constitution includes a right to privacy. As such, state private sector employees (not job applicants) have been found to be protected by the right to privacy.¹²

It's vital for employers to have clear, consistent definitions of what behavior justifies drug testing. Thorough training on how to handle employee testing is a must.

Conclusion

In addition to complying with HIPAA and state laws, an urgent care operation should have in place a drug testing policy as part of its employment policies. This should be crafted to allow for maximum flexibility for the employer.

In summary, test results and other PHI from a drug test should not be disclosed to another employer or to a third-party individual, government agency, or private organization without the prior written authorization of the person tested.

It's critical that this policy be communicated and understood by all personnel who might be impacted. This includes the owner, upper management, frontline supervisors, and the urgent care facility's employees. ■

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A 21-Year-Old Male with Persistent Ankle Pain Following Trauma



Figure 1.

Case

The patient is a 21-year-old male who presents with persistent ankle pain 4 weeks after suffering a trauma. He fell while scaling the exterior of his dormitory, trying to gain entry into a second-floor window –because he’d locked his keys inside.

View the image taken (**Figure 1**) and consider what your diagnosis and next steps would be. Resolution of the case is –described on the next page.

THE RESOLUTION



Figure 2.

Differential Diagnosis

- Cyst formation
- Fracture/crack of the talus
- Ligament damage
- Osteochondral lesion
- Synovitis

Diagnosis

There is a thin curvilinear lucency along the lateral corner of talar dome. The patient has an osteochondral lesion (OCL).

Learnings

- OCL are focal areas of cartilage damage and injury of the adjacent subchondral bone
- OCL can occur after a single traumatic injury or as a result of repeated trauma. Common symptoms include prolonged pain, swelling, catching and/or instability of the ankle joint
- Persistent ankle pain despite appropriate treatment after several months may raise concern for an OCL

Pearls for Urgent Care Management and Consideration for Transfer

- Initial, conservative treatment consists of immobilization and instructions for non-weightbearing, with or without non-steroidal anti-inflammatory drugs, for up to 6 weeks
- The patient should be advised to consult an orthopedist or return to urgent care for follow-up
- Progressive weightbearing and physical therapy are often necessary to achieve optimal outcomes
- Rarely, surgery may be required ■



A 44-Year-Old Man with Intermittent Dizziness

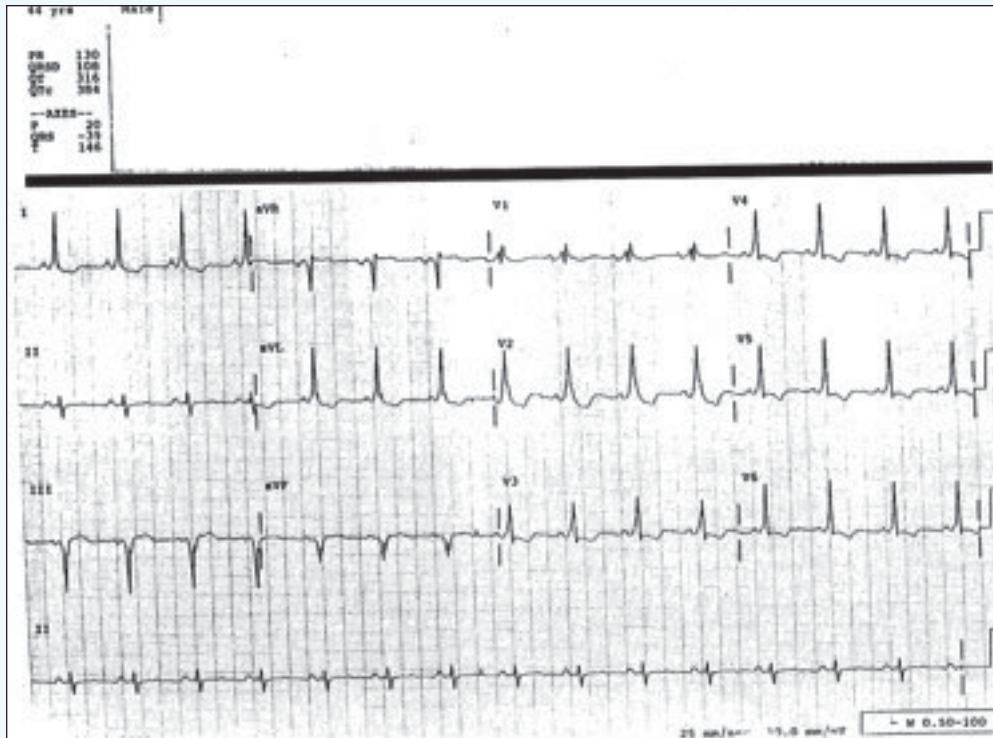


Figure 1.

Case

A 44-year-old man presents to your urgent care center complaining of intermittent dizziness. He denies shortness of breath, fever, chest pain, and syncope.

Upon exam, you find:

General: Alert and oriented

Lungs: CTAB

Cardiovascular: RRR without murmur, rub, or gallop

Abdomen: Soft and NT without r/r/g

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

THE RESOLUTION



Figure 2.

Differential Diagnosis

- Sinus tachycardia
- AV block 1st degree
- Multifocal atrial tachycardia
- Wolff-Parkinson-White syndrome
- Third-degree AV block

Diagnosis

The patient was diagnosed with Wolff-Parkinson-White syndrome (WPW). The ECG reveals a gradual upsloping of the initial reflection of the QRS complex, called delta waves (see arrows). Additional ECG finds may include a shortened PR interval (<120 ms), a widened QRS complex, and ST/T wave changes.

Learnings

- WPW is a supraventricular re-entrant rhythm which may have a normal rate or fast rate

- Symptoms may include a sensation of palpitations, dizziness, chest discomfort, shortness of breath, fatigue, or syncope
- The findings of WPW may be seen incidentally on an ECG done for another reason (eg, pre-op)

Pearls for Urgent Care Management and Considerations for Transfer

- Compare to previous ECG, if available
- If a patient is asymptomatic with an ECG done for another reason, outpatient referral to cardiology is appropriate
- If the patient is symptomatic with chest discomfort, shortness of breath, tachycardia, hypotension, hypoxemia, or altered mental status, then immediate referral to the ED is indicated
- Management may include IV antiarrhythmics, cardioversion for an unstable patient, or radiofrequency ablation of the accessory pathway ■



A 3-Year-Old with Lesions on His Thumb

Figure 1.



Case

A mother brings her 3-year-old son to urgent care with multiple skin lesions on his thumb, which he frequently sucked for comfort. The grouped configuration of lesions was painful and had developed over the last 5 days to become vesicles.

Upon exam, you note that the boy has a nearly healed cold sore on his lip, pain in his wrist, and an elevated temperature.

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

THE RESOLUTION

Figure 2.

**Differential Diagnosis**

- Herpetic whitlow
- *Mycobacterium marinum* infection
- Reactive arthritis
- Spider bite
- Contact dermatitis

Diagnosis

The correct diagnosis is herpetic whitlow, or distal digital herpes simplex virus (HSV). This is an uncommon infection occurring on the fingers or periungually, either from HSV1 or HSV2. In children, herpetic whitlow from HSV1 is more common. Tellingly, it's also more common in dental and medical personnel who do not regularly wear gloves. Toe involvement from toe sucking has been reported in infants. Digital-to-genital contact of HSV2 is also a mode of transmission.

Learnings

- After an incubation period of 3-7 days, during which there may be local erythema and edema, as well as tenderness, a group of vesicles appears around the perionychium and on the volar digital skin. These may progress to erosions, or may become pustular first and simulate a felon
- Lesions may involve the distal-free edge of the nail and extend into the nail bed, which often results in hemorrhage
- Swelling of the hand with lymphatic streaking may also occur
- Recurrences of herpetic whitlow may be seen, especially in immunosuppressed individuals

Pearls for Urgent Care Management and Consideration for Transfer

- Herpetic whitlow is self-limited, though topical treatments may provide symptomatic relief
- Tense vesicles may be unroofed to help alleviate symptoms
- Antibiotics should not be used except in cases complicated by bacterial superinfection ■



2018 Current Procedural Terminology (CPT) Code Changes

■ DAVID E. STERN, MD, CPC

There are 314 code changes in the CPT manual for 2018, with 172 new codes, 60 revised codes, and 82 deleted codes. Most of the changes affect surgery procedures, but several changes are relevant to urgent care. For your convenience, we have listed these changes in expected relevance to urgent care:

Radiology

Codes for x-rays of the chest and abdomen have been deleted and replaced with codes based on the number of views; the guidelines give specific instruction on what has changed:

- New code 71045, "Radiologic examination, chest; single view" replaces deleted codes 71010 and 71015
- New code 71046, "Radiologic examination, chest; two views" replaces deleted codes 71020, 71023, and 71035
- Coders are also directed to use codes 76000, "Fluoroscopy (separate procedure), up to one hour, physician or other qualified health care professional time," and code 76001, "Fluoroscopy, physician or other qualified health care professional, time more than one hour, assisting a non-radiologic physician or other qualified health care professional (eg, nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)" for deleted code 71023
- New code 71047, "Radiologic examination, chest; three views" replaces deleted codes 71021, 71022, and 71035
- New code 71048, "Radiologic examination, chest; four or more views" replaces deleted codes 71022, 71030, and 71034
- New code 74018, "Radiologic examination, abdomen; one view" replaces deleted code 74000
- New codes 74019, "Radiologic examination, abdomen; two views" and 74021, "Radiologic examination, abdomen; three or more views" replace deleted codes 74010 and 74020.



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

Vaccines and Toxoids

There were two new flu vaccines introduced in July 2017 that will appear in the CPT manual in 2018:

- 90756, "Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use"
- 90682, "Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use"

Application of Casts and Strapping

Multilayer compression bandage applications codes 29582 (thigh and leg) and 29583 (upper arm and forearm) were deleted. No guidance for replacement codes was provided. Coders should be aware of this procedure code deletion, but still code for the supplies that are used.

Pathology and Laboratory

While new genetic testing codes make up the bulk of the changes in pathology codes, there are two new Zika virus tests that will be available:

- 86794, "Zika virus, IgM"
- 87662, "Zika virus, amplified probe technique"

Home and Outpatient International Normalized Ratio (INR) Monitoring Services

Anticoagulant management services codes 99363 and 99364 have been deleted and will now be reported with new codes:

- 93792, "Patient/caregiver training for initiation of home international normalized ratio (INR) monitoring under the direction of a physician or other qualified health care professional, face-to-face, including use and care of the INR monitor, obtaining blood sample, instructions for reporting home INR test results, and documentation of patient's/caregiver's ability to perform testing and report results"
- 93793, "Anticoagulant management for a patient taking warfarin, must include review of interpretation of a new home, office, or lab international normalized ratio (INR) test result,

patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed”

Further guidelines for code 93793 state that the code cannot be reported more than once per day and that it also cannot be billed with new and established Evaluation and Management (E/M) codes 99201 through 99215 or with consultation codes 99241 through 99245.

Cognitive Assessment and Care Plan Services

Healthcare Common Procedure Coding System (HCPCS) Level II code G0505 has been replaced with CPT code 99483, “Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home with all of the following required elements: Cognition-focused evaluation, including a pertinent history and examination;

- Medical decision-making of moderate or high complexity;
- Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity;
- Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDRI]);
- Medication reconciliation and review for high-risk medications;
- Evaluation for neuropsychiatric and behavioral symptoms,

including depression, including use of standardized screening instrument(s);

- Evaluation of safety (eg, home), including motor vehicle operation;
- Identification of caregivers(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks;
- Development, updating or revision, or review of an Advance Care Plan;
- Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neurocognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support
- Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.”

Pulmonary Diagnostic Testing and Therapies

New code 94618, “Pulmonary stress testing (eg, six-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed” replaces deleted code 94620. One other code added to this section is 94617, “Exercise test for bronchospasm, including pre- and post-spirometry, electrocardiographic recording(s), and pulse oximetry.”

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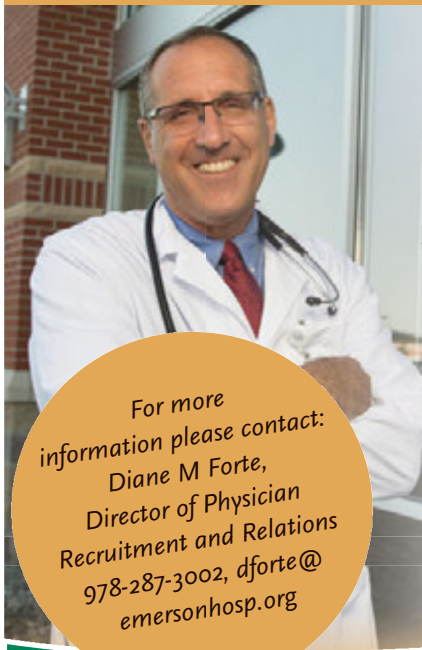
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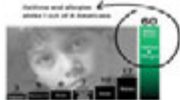
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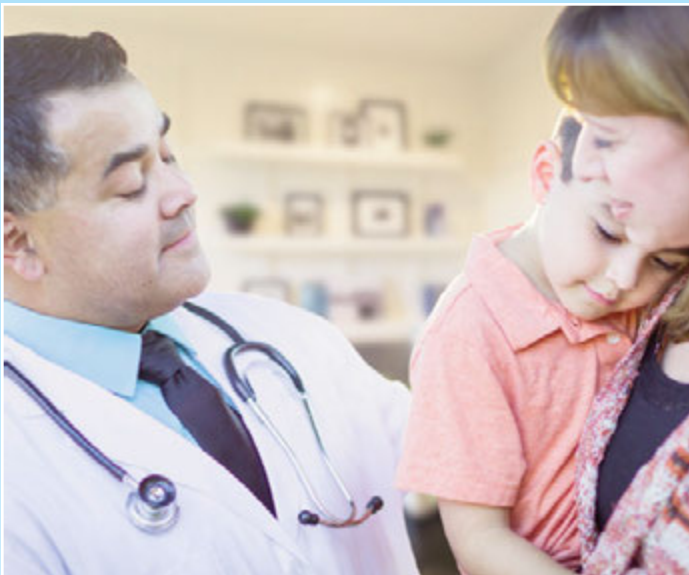


DEVELOPING DATA

A Snapshot of Pediatric Urgent Care Operations

In October, we offered a glimpse at the operating hours of pediatric urgent care centers around the country. We also promised to share more on that growing segment of the urgent care marketplace—and this month we're following through on that.

Methods: Cross-sectional survey of U.S. pediatric urgent care centers (35 respondents). Administrative and operational metrics were collected, and averages reported as medians. The data are part of a larger pool that we expect to be the subject of an expansive article in a future issue of *JUCM*. ■



75 minutes, median
registration to
discharge order

2-3 providers/shift
on staff

2 patients/provider
per hour

~25,000 patients
per year
(average)

2% transfer rate
(IQR 1.0 - 2.5)

Procedures Commonly—and Uncommonly—Performed in Pediatric Urgent Care Centers

Common procedures	Uncommon procedures
<ul style="list-style-type: none">• Nursemaid reductions• Splinting• Simple suturing/staples/medical glue• Foreign body removal• Incision & drainage• Trephination• Fluorescein eye staining	<ul style="list-style-type: none">• Multilayer suturing• Moderate sedations• G-tube replacement• Reduction of non-nursemaid dislocations

Data source: Montalbano A. Organization for Urgent Care Health (OUCH): 2015 Data. Kansas City, MO. December 2016.



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