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 of America



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### LETTER FROM THE EDITOR-IN-CHIEF

## Provider Credentialing: An 800-Pound Gorilla



Predentialing has become a recurring nightmare for physicians of all specialties, in every state and in every practice setting.

Eager for a fresh start, and energized by new opportunity, we decide to make a job

change. Recruiters colorfully praise these openings, as if every job pays more than our current one, is closer to parks and culture, and exists in a region with a lower cost of living and, of course, better weather. After a short courtship, our dream of 300 sunny days per year tips the scales, and we decide to take the plunge. We carefully manage our termination notice to be timed with our new start date, confirm our tail coverage, and happily apply for licensure in our new home state.

Then, shamefully unanticipated, like a New Year's hangover, it arrives on our doorstep: the credentialing packet. More than a pound of paper, with links to several virtual pounds more, is apparently necessary to ensure that we aren't criminals, quacks, or uninsurable hacks. There are the expected attestations that we have not been convicted of felonies, are not addicted to drugs, and are not incapable of performing our duties. There are predictable questions about malpractice claims and extra blank pages for the embarrassing job of explaining them. Then there are the acronyms: CAQH, NPDB, FCVS, PDC, ABMS, and the like. And, of course, there is the task, in the words of Richmeister from *Saturday Night Live*, of "making copies." Lots and lots of copies: DEA licenses, state medical board licenses, board certifications, and a host of others.

All told, physicians and the practices that hire them spend thousands of hours and billions of dollars every year on credentialing. That's right, *billions*—with a capital *B*. And though some centralization has been adopted, the process remains fragmented, inefficient, and wildly unpredictable. Why? Because that's just how the third-party payors like it. After all, the harder it is for physicians to get credentialed, the harder it is for them to get paid. And who's more accomplished at making it harder to get paid than insurance companies? The amount of time it takes to credential a provider with each payor can seem entirely random. For some, it's 30 days; for others, it's 6 months. This disparity reveals something ugly: Payors, it seems, have found a legal loophole to restrict trade, costing physicians and their practices billions of dollars in unpaid claims and needless delays.

The problem is even more acute in urgent care, where the doors must remain open 7 days a week, 365 days a year. We simply don't have the luxury of planning 6 months in advance. When an urgent care practice loses a provider, it is lucky to get a 60-day notice on a voluntary termination (and much less on an involuntary one). Then the practice has to source, recruit, and hire a new provider, which can take months. Once the provider is hired, significant resources must be applied to credentialing. And then the provider waits, often for months, just for the privilege of getting paid. Urgent care operators are often forced to use locum tenens providers to bridge the credentialing gap while delaying the start date of their permanent replacement and thus exposing the practice and its patients to unpredictable risk. In the meantime, the new hires continue to get bombarded with other offers and are frequently lured away, forcing the practice to restart the whole process all over again.

There must be a better way. According to many experts, a more streamlined and centralized credentialing would save billions of dollars. A consistent and legally defined limit on the time it takes for payors to credential new providers would allow practice operators to more predictably time their hires without fear of discontinuity or unpaid claims. Physicians would feel freer to change jobs and pursue new opportunities without the excessive burden of paperwork. Simple reforms like these could easily be introduced into ongoing efforts to reform health care and reduce costs. I wish I were more optimistic about the like-lihood this will actually happen.

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



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#### CLINICAL

# 8 Urgent Care Management of Geriatric Falls

In the decade between 2003 and 2013, falls accounted for 62.6% of nonfatal injuries in the United States. Though many falls in the aged are minor, it is crucial to remember that falls in this population are associated with high morbidity and mortality and loss of independence.

Rebekah Blickendorf, MD

#### PRACTICE MANAGEMENT

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Urgent care was once considered a novelty model of health care. Now it is a maturing industry, yet it has barely scratched the surface of what is possible. A look at ZOOM+ shows that the industry is still ripe with new possibilities for those willing to imagine.



#### Alan A. Ayers, MBA, MAcc

#### CASE REPORT

#### 25 Shin Pain



Shin pain in adolescent athletes is not always simply shin splints. What you find in the physical examination and medical history may point to more serious injuries such as nondisplaced tibial shaft fractures.

Christopher Tangen, DO, and Ryan Shilian, DO

#### IN THE NEXT ISSUE OF JUCM

Acute ankle trauma is responsible for 10% to 30% of sports-related injuries in young athletes each year in the United States. Lisa Schuerman RN, MSN, APNP, writes that because of the multiple injuries that an ankle can sustain, it is important that practitioners be able to differentiate between those treatable at an urgent care center and those requiring evaluation in an emergency department or at an orthopedic clinic.

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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 healthcare marketplace. As the Official Publication of the Urgent Care Association of America and the Urgent Care College of Physicians, JUCM seeks to provide a forum for the exchange of ideas and to expand on the core competencies of urgent care medicine as they apply to physicians, physician assistants, and nurse practitioners.

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### JUCM CONTRIBUTORS

What's the 800-pound gorilla in the room ignored by both urgent care practitioners and urgent care owner-operators? It's the unwieldy credentialing process. Physicians and the practices that hire them now spend thousands of hours and billions of dollars every year on credentialing. Editor-in-Chief Lee Resnick, MD, FAAP, advocates for shrinking that gorilla down to a manageable size by streamlining and centralizing credentialing, and by legally limiting the time it takes for payors to credential new providers. Are you willing to help make that happen?

Although many falls in the elderly are minor, they are associated with high morbidity and mortality and loss of independence. In our cover article, Rebekah Blickendorf, MD, notes that one



fall generally begets more falls: About two-thirds of geriatric patients who fall will have another fall within the following 6 months, and a fall is often the inciting event for a downward spiral of function.

Blickendorf is a second-year emergency medicine resident at the Indiana University School of Medicine in Indianapolis, Indiana.



In our *Practice Management* section, Alan A. Ayers, MBA, MAcc, shows how ZOOM+ is redefining the future of urgent care around the needs of its community in the U.S. Northwest. In following

the ZOOM+ story, other urgent care operators can learn much about attaining revenue growth from a maturing business model.

Ayers is Practice Management Editor of the *Journal of Urgent Care Medicine*, a member of the board of directors of the Urgent Care Association of America, and Vice President of Strategic Initiatives for Practice Velocity.

In our case report, Christopher Tangen, DO, and Ryan Shilian, DO, caution that not all shin pain is simply shin splints. Stress fractures and



acute nondisplaced tibial fractures are also possibilities.

Tangen is Medical Director of Sports Medicine and Ryan Shilian is a Traditional Rotating Intern, both at University Hospitals Regional Hospitals—Richmond Campus, in Richmond Heights, Ohio.

#### Also in this issue:

In *Health Law and Compliance*, **Spencer Hamer**, **JD**, spells out for managers of urgent care centers what information they can ask for and what information they cannot require when dealing

with their employees' requests for leave under the Family Medical Leave Act and the Americans with Disabilities Act.

Hamer is a partner working in the Irvine, California office of the law firm of Michelman & Robinson, specializing in labor and employment matters for health-care clients.

Sean M. McNeeley, MD, and the Urgent Care College of Physicians review new reports from the literature on azithromycin versus doxycycline for chlamydia, computed tomography scans in sudden-onset headaches, vitamin D and migraines, lurking MRSA, nasal isopropyl alcohol for nausea, eosinophilia and long-term antibiotic use, anakinra for hidradenitis suppurativa, and how best to decide which patients with likely acute coronary syndrome can go home.

As a special bonus for our readers this month, we have four Insights in Images—two more than usual—to test your diagnostic acumen.

In Coding Q&A, **David Stern, MD, CPC**, details 2016 changes in *Current Procedural Terminology* codes.

Our *Developing Data* piece breaks down the frequency of specific diagnosis codes used in 2014 at U.S. urgent care centers.

#### 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-todate 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.

Manuscripts on clinical or practice management topics should be 2,600–3,200 words in length, plus tables, figures, and references. Articles that are longer than this will, in most cases, need to be cut during editing.

We prefer submissions by e-mail, sent as Word file attachments (with tables created in Word, in multicolumn format) to *editor@jucm.com*. 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.

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P. JOANNE RAY

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**P. Joanne Ray** is chief executive officer of the Urgent Care Association of America. She may be contacted at *jray@ucaoa.org*.

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## Clinical

# Urgent Care Management of Geriatric Falls

**Urgent message:** Falls are a common reason for geriatric patients to present for medical care. In this population, even seemingly minor falls can lead to significant injury, and falls may occur in the first place because of serious underlying medical illnesses. It is critical for the urgent care provider to distinguish which of these patients can be treated in the urgent care setting and which require transfer to a higher level of care.

REBEKAH BLICKENDORF, MD

#### Introduction

The U.S. population continues to age. By 2030, onequarter of Americans will be older than 65 years.<sup>1</sup> Falls are a common reason for this population of patients to present for medical care. Approximately 30% to 40% of this group fall each year.<sup>2</sup> In the decade between 2003 and 2013, falls accounted for 62.6% of nonfatal injuries<sup>3</sup> and were the leading cause in the geriatric population of nonfatal hospital admissions because of injury.<sup>4</sup> Falls are also the leading cause of fatal injury in the geriatric population.<sup>4</sup> Although many falls are minor, it is crucial to remember that falls in this population are associated with high morbidity and mortality and loss of independence. One fall generally begets more falls: About two-thirds of geriatric patients who fall will have another fall within the following 6 months,<sup>5</sup> and a fall is often the inciting event for a downward spiral of function.

Although falls in the elderly are a leading cause of morbidity and mortality, their falls are also a serious con-

**Rebekah Blickendorf, MD,** is a second-year emergency medicine resident at the Indiana University School of Medicine in Indianapolis, Indiana.



cern to practitioners working in urgent care centers because such centers treat many such patients and

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#### Table 1. Common Risk Factors for More Severe Injury in Falls

- Anticoagulation
- Long-term steroid use
- Chronic renal disease
- Liver disease
- Osteoporosis

because the majority of elderly patients continue to live in the community either alone or with family members who assist them. Although falls have the potential to cause serious or fatal injury, two-thirds of falls do not result in serious injury.<sup>1</sup> The urgent care provider can usually intervene in the many nonserious injuries caused by falls. Although patients with obvious lifethreatening pathology will present to trauma centers, patients may sustain injuries with potential for significant morbidity, such as subdural hematomas and hip or extremity fractures, from seemingly insignificant trauma. The urgent care provider must maintain a high suspicion for serious injury in the geriatric patient who has fallen and be prepared to transfer the patient to a facility with resources for a comprehensive evaluation.

Just as importantly, the urgent care provider must maintain a high suspicion for why the patient fell. A fall is often a symptom of serious underlying pathology, such as infection, electrolyte imbalance, stroke, or cardiac pathology, even if the patient reports a history of a mechanical fall. The urgent care provider can intervene and prevent future injuries by educating the patient and the family about physical therapy and fall prevention.

#### **Approach to Evaluation**

#### **History**

It is crucial to obtain a thorough history of the events surrounding the fall, to frame the approach to the workup, treatment, and case disposition. This is often challenging in a patient population that may have baseline neurocognitive deficits. In such situations, seek input from family and caretakers. Attempt to obtain information from witnesses. Determine a timeline of events:

- How long ago did the fall occur?
- Can the patient or the family estimate downtime?
- If there was a significant delay in presenting for care, why was there a delay, and what changed that caused the patient to present now?

Determining the amount of force and the mechanism of injury is important. Knowing the following can help the provider anticipate injury pattern and stratify the patient's risk for severe injury:

#### Table 2. Must-Catch Medical Causes of Falls and Their **Red Flag Features**

Cause	Features	
Abdominal aortic aneurysm	Fall + syncope or with abdominal, flank, or back pain, hypotension, and light- headedness	
Acute coronary syndrome	Fall + collapse with chest pain, shortness of breath, diaphoresis, nausea	
Cardiac arrhythmia	Fall + syncope, palpitations, shortness of breath, light-headedness, chest discomfort	
Pulmonary embolism	Fall + syncope, shortness of breath, chest pain, calf swelling and tenderness or both, and immobilization	
Seizure	Fall + seizure activity, post-ictal period, tongue biting, incontinence	
Stroke (ischemic or hemorrhagic)	Fall + focal neurologic symptoms, aphasia, altered mental status, headache	
Structural heart disease	Fall + syncope, chest pain, shortness of breath, light-headedness, murmur	
Subarachnoid hemorrhage <sup>a</sup>	Fall + syncope, sudden-onset headache, meningismus, and nausea or vomiting (or both)	
<sup>a</sup> Editor's note: for more on subarachnoid hemorrhage, see the case report "Sudden-Onset Severe Headache" in our January 2016 issue: http://www.jucm.com/sudden-onset-severe-headache/.		

- The height of the fall
- The surface on which the patient fell
- The point of impact on the body

Because a ground-level fall in an elderly patient can lead to significant injury, avoid the trap of accepting the patient's conclusion that the mechanism was a minor one. Other medical conditions and certain medications may lead to an increased risk for more severe injuries (Table 1).

The cause of the fall will determine which way to turn in decision-making. There is a great difference in management of falls that are clearly mechanical (e.g., "I tripped on the garden hose while watering flowers") and falls that might have been caused by syncope or another underlying medical condition (Table 2). Ask about prodromal symptoms prior to the fall such as the following:

- Light-headedness
- Nausea

#### Table 3. Medications Associated with Increased Risk of Falls

- Anticholinergics
- Anticonvulsants
- Antipsychotics Anxiolvtics
- Antidepressants
- Antihypertensives
- Insulin and secretagogues Sedative-hypnotics
- Antiparkinsonian agents
- Type I antiarrhythmics

Data from Bauer TK, Lindenbaum K, Stroka MA, et al<sup>6</sup> and Zia A, Kamaruzzaman SB Tan MP

- Shortness of breath
- Palpitations

Maintain a high suspicion of syncope, presyncope, or other medical cause of falls that should prompt transfer to an emergency department (ED) for further evaluation.

It is also vital to obtain a current list of medications. Medications can often predispose patients to falls, and polypharmacy is associated with an increased incidence of falls.<sup>2</sup> [Editor's note: For more on polypharmacy, see the article "Medication Issues in Urgent Care" in the February 2015 issue of JUCM: http://www.jucm.com/medicationissues-urgent-care/.] Table 3 lists medications frequently associated with geriatric falls. Also, the urgent care practitioner should be aware that elderly patients frequently take anticoagulants, which can cause life-threatening internal bleeding from relatively minor trauma.

Ask whether this is the first time the patient has fallen or whether falls are recurring. If falls are a new problem, the provider should consider what could have changed with the patient to predispose them to fall. If this has been an ongoing issue, have the patient and the family made efforts to reduce fall risk? Is there a possibility of old untreated injuries?

Obtaining a brief past medical and surgical history is necessary to uncover potential medical illness as a cause of a fall and chronic conditions that may predispose to falls or are associated with risk for more severe injury. Table 4 lists medical conditions associated with an increased risk of falls.

#### Physical Examination

#### Vital Signs

A work-up for a patient who has fallen should start with assessment of vital signs. Patients with abnormal vital signs for which the provider cannot easily account should be sent to an ED. Tachycardia and bradycardia may increase suspicion that a fall was caused by arrhythmia. Postural blood pressure changes may also lead to falls. Remember

#### Table 4. Common Medical Conditions Associated with **Increased Risk of Falls** • Arthritis • Orthostatic hypotension Dementia Parkinson disease Epilepsy • Peripheral neuropathy • History of stroke (with • Sarcopenia

Data from Homann B. Plaschg A. Grundner M. et al.<sup>8</sup>

neurologic deficits)

that a "normal" blood pressure in an elderly person may actually be low, considering that the population often has slight hypertension.

#### Mental Status

Begin with brief orientation questions. Questions about well-known current events may be helpful, as can simply seeing if the patient can provide the history of the fall. Occasionally, patients seem on first interaction to have a normal mental status, but subtle deficits surface as the medical history and physical examination proceed. Family members can help the provider determine whether the patient's current mental status differs from baseline. Patients with variance from baseline require evaluation in an ED.

#### General Examination

Lacerations, skin tears, ecchymosis, and joint deformities may be obvious even in a clothed patent. However, failing to have the patient disrobed can cause a provider to miss significant injuries. Likewise, it is impossible to do a good examination of a knee or hip while the patient is wearing pants, or of a shoulder if the patient does not remove a sweater.

#### Head, Eyes, Ears, Nose, and Throat

Be sure to do the following:

- Examine for obvious signs of facial or head trauma such as deformity, ecchymosis, and hematomas.
- Assess pupils for shape and reactivity, and the conjunctiva for hemorrhage.
- Assess extraocular movement for signs of entrapment and nystagmus.
- Examine the nose for septal hematoma.
- Look for signs of basilar skull fractures, which include ecchymosis behind the ear (Battle sign), periorbital ecchymosis, and hemotympanum.

Patients with hematomas, signs of basilar skull fracture, or findings concerning for facial fracture or injury to the globe will need advanced imaging and consultation with a specialist.

#### Neck and Back

Assess range of motion and palpate for midline tenderness. *Midline tenderness, pain with range of motion, and any report of neurologic symptoms (focal numbness or weakness) should prompt placement of a cervical collar and transfer for advanced imaging.* 

#### Geriatric Falls

#### Cardiopulmonary

Look for signs of injuries to the chest wall—for example, crepitus, bruising, or tenderness (especially to anteroposterior compression). Patients with unequal breath sounds will require chest imaging. An absence of breath sounds suggests pneumothorax, although diminished breath sounds at the lung bases may indicate hemothorax. A murmur found on cardiac examination could indicate that a structural or functional cardiac issue caused the fall.

#### Abdomen and Flanks

Examine the abdomen and flanks for tenderness, distention, and hematomas. *Patients who take anticoagulants may require transfer to an ED for large hematomas of the abdominal wall or flank. In the acute setting, abdominal distention associated with abnormal vital signs should prompt immediate transfer to a facility with access to a surgeon, because of concern for hemorrhage.* 

#### Extremities

In most patients, the extremity examination can be focused according to pain and presenting symptoms. For patients who are unable to communicate, a systematic approach is required. Be sure to do the following:

- Document areas of swelling, deformity, or ecchymosis.
- Assess painful joints for range of motion, point tenderness, stability, and crepitus.
- Examine the joint above and below the site of injury, and beware of referred pain (e.g., hip pain may present as knee pain, and arm pain could be due to a neck injury).
- Always assess neurovascular status distal to an injury.

#### Neurologic Examination

In a patient without head or neck injury or focal symptoms, a simple assessment of gross strength and sensation often constitutes sufficient neurologic examination. *Patients with any abnormal findings on a neurologic examination will require transfer to an ED for advanced imaging.* The Romberg test, in which the patient stands with the feet together and closes the

eyes, tests proprioception, the loss of which can contribute to ataxia and falls.

#### Gait Assessment

Observing the walking patient is a fundamental part of the neurologic examination. Watch for ataxia and a wide-based gait. Have the patient walk with whatever assist device he or she uses at home. The "get up and go" test is a quick and easy way to assess gait: The patient begins seated in a chair. They are instructed to stand up without using the armrests, walk 10 ft (approximately 3 m), turn around, walk back, and return to a seated position in the chair as quickly as possible. Patients should be able to perform this in <16 seconds. Patients who are unable to do so or who have difficulty completing the test require further evaluation of their strength, gait, and balance.

The urgent care provider often has limited diagnostic resources—sometimes only x-ray and point-of-care laboratory testing. The medical history and physical examination are the most important tools. Many patients will need additional diagnostic studies and will require transfer to an ED.

#### Point-of-Care Urinalysis

Infection can cause gait change and disequilibrium in the aged. High specific gravity could be a sign of dehydration, perhaps leading to positional hypotension. Hemoglobin can be an indication either of renal injury (leading to red blood cells in the urine) or of myoglobin in the urine, which is associated with rhabdomyolysis (muscle death).

#### X-Rays

Common sites of fracture include the distal radius, the humerus, and the hip. Rib fractures and vertebral compression fractures are also common in the geriatric population. Rib fractures can be difficult to appreciate on chest x-ray, and computed tomography (CT) scanning may be required for diagnosis. Plain films may miss occult hip fracture, especially femoral neck fracture. *If clinical concern for fracture persists despite negative findings on film, the patient should be immobilized and referred for additional imaging*.

#### **Common Injuries**

#### Skin Tears and Lacerations

Most skin tears and lacerations can be treated in the urgent care setting with irrigation and primary repair. For simple, superficial injuries, wound glue may be sufficient for closure. Injuries that require suturing can be challenging to repair in the geriatric population because of thin subcutaneous tissue. Techniques for improving success involve suturing through adhesive skin closures (e.g., Steri-Strip closures) placed either horizontally across the wound or vertically along the wound edges.<sup>9,10</sup> Patients with especially frail skin may not tolerate sutures and may be simply dressed and bandaged and referred for wound care as necessary. Bio-occlusive dressings may be associated with poor healing and thus are not preferred.

#### Contusions and Hematomas

Contusions and hematomas due to falls are usually self-limited injuries that can be treated with ice and analgesia. *Patients who have large contusions or hematomas and are taking anticoagulants may require ED referral for CT scanning*. This is especially true of abdominal wall hematomas, which can be of large volume, or flank hematomas, which can be associated with retroperitoneal hematoma or renal injury. *Hematomas*  that appear to be rapidly expanding should raise concern for arterial injury. Apply direct pressure and transfer the patient to an ED.

#### Sprain and Strains

Muscle strains and joint sprains generally respond well to conservative treatment such as ice and elevation, pain control, and early mobilization. However, pain and symptom management can be difficult in the geriatric population. Nonsteroidal anti-inflammatory drugs should be avoided in patients with renal insufficiency and should generally be used with caution in the geriatric population. Patients with liver disease may be unable to take acetaminophen. Benzodiazepines are sometimes prescribed for muscle spasm but can lead to drowsiness, instability, and recurrent falls. Before sending patients home, consider how their mobility and their ability to perform activities of daily living will be affected by their injuries. A wrist sprain may be a minor injury for a 22-year-old, but it may render an elderly patient unable to rise from a chair or to use an assist device.

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#### Wrist Fractures

A common fracture pattern after a fall is the FOOSH injury-a fall on an outstretched hand. In geriatric patients, this most commonly leads to fractures of the distal radius. Nondisplaced fractures of the distal radius or the ulnar styloid may be amenable to splinting and outpatient follow-up. Splint preferences vary by provider and may be guided by the recommendations of the orthopedic surgeons that provide follow-up for the urgent care patients. A sugar-tong splint or volar short arm splint is a typical choice. Ensure good follow-up for patients who are given splints, because splints can affect daily functions and the use of assist devices. More frequently, distal radius fractures are significantly displaced with intra-articular involvement, requiring closed reduction. Splint displaced fractures to stabilize the injury, and then transfer the patient to an ED. Open fractures should be covered in a sterile dressing prior to splinting. Patients with neurovascular deficits, skin tenting, or open fractures require urgent fracture reduction and expedited transfer to an ED.

#### Humeral Fractures

Mid-shaft or proximal humeral fractures are common in the geriatric population because of osteoporosis and age-related bone loss. These fractures may also result from a FOOSH injury with an extended elbow or with direct impact to the humerus. Proximal fractures that are minimally angulated (<45°) and displaced (<1 cm) and uncomplicated mid-shaft fractures can be treated with a sling and swathe, pain control, and early orthopedic follow-up. All other fractures require transfer to an ED for orthopedic consultation. Humeral fractures are associated with several neurovascular complications. A thorough neurovascular examination is essential. Proximal humerus fractures are associated with damage to the axillary nerve or the brachial plexus. Radial nerve injury is a complication seen with mid-shaft and distal humerus fractures. Any patient with motor or sensory deficits requires immediate ED transfer.

#### **Hip Fractures**

The majority of patients with hip fractures will present primarily to an ED. Occasionally, however, a hip fracture will present subacutely. Hip fractures are usually clinically and radiographically apparent. When a provider suspects injury despite negative findings on radiographs, the patient should undergo magnetic resonance imaging or CT scanning to rule out occult fracture. Significant pain with weight-bearing and inability to bear weight are red flags. *Confirmed hip fractures require hospital admission for*  *surgical treatment.* The urgent care provider should document a neurovascular examination prior to transport.

#### Head Injury

Age-related brain atrophy not only increases the risk of intracranial hemorrhage and injury by minor mechanisms but may also delay the onset of signs and symptoms of intracranial hemorrhage, because more blood can collect before there is a change in significant intracranial pressure. Bridging vessel fragility is another important age-related risk factor. Therefore, providers should maintain a high index of suspicion for intracranial injury in geriatric patients. Up to 26% of these patients may present with a normal findings on neurologic examination and still have intracranial hemorrhage.<sup>11</sup> This is especially true of patients who take anticoagulants, including aspirin and clopidogrel. These patients can also have delayed bleeding. Intoxicated patients and those have a history of chronic alcoholism are at high risk as well. The urgent care provider should have a low threshold for transferring the elderly patient who has fallen to an ED for CT imaging. Giving clear discharge instructions to the patient and their caregivers, including signs and symptoms for delayed intracranial bleeding, is paramount.

#### Neck Injury

Although most patients with gross neurologic deficits will present to the ED, sometimes significant neck injuries can present subtly. Have a low threshold to transfer any patient with significant neck pain for CT imaging. Plain x-rays are no longer the standard of care for evaluating traumatic neck injury and are notoriously difficult to interpret in this age group, given the near omnipresent degenerative changes. A classic injury in the elderly patient who has fallen is central cord syndrome. This occurs from a whiplash injury, because the patient's neck is extended during impact with an object during a fall. Patients with central cord syndrome present with greater muscle weakness in the upper extremities than in the lower extremities and with loss of sensation to temperature and pinprick in a "cape" distribution. Fracture of the dens is another common injury, and it is potentially unstable. Patients with any suspected neck injury require immobilization with cervical collar and transfer to an ED.

#### **Rib Fractures**

Suspect rib fractures in patients with ecchymosis and tenderness of the chest wall, pleuritic chest wall pain, or pain with anteroposterior compression. Nondisplaced rib fractures are frequently radiographically occult, requiring a CT scan for diagnosis. Elderly patients with rib fractures often require admission for pain control and monitoring of their pulmonary status. *Rib fractures in the elderly can be deadly because splinting from pain can lead to atelectasis and pneumonia*. *Have a low threshold for transferring to an ED patients whose respiratory status is limited by pain even if films do not reveal fracture*.

#### Rhabdomyolysis

Patients with prolonged or an unknown downtime should have a creatinine kinase level checked, which often requires ED transfer. Rhabdomyolysis as a result of immobility after a fall can lead to significant morbidity and mortality because of renal damage, electrolyte abnormalities, and disseminated intravascular coagulation. These patients will require laboratory monitoring and intravenous fluid administration on an inpatient basis. Signs of rhabdomyolysis include tenderness to the muscle, discoloration of the overlying skin, and dark urine. However, patients may have muscle death without these signs or symptoms.

#### **Disposition**

Patients whose presentations are concerning for a medical or pharmacologic cause of fall should be immediately transferred to an ED. This is especially important in patients with syncope or presyncope. These patients are frequently admitted for work-up and treatment. Patients with confirmed or suspected significant injuries will require transfer for definitive treatment. Those who are unsteady on gait assessment or who have frequent falls should have a physical therapy assessment. Never hesitate to transfer a patient to an ED if there are immediate concerns about safety in the home.

Even if the patient has no significant injuries after a fall, the urgent care provider has the opportunity to profoundly affect the health of a geriatric patient by identifying modifiable risk factors for falls and counseling the patient and the family about fall prevention. Although the provider may not have the time or the resources to fully address fall-reduction interventions, taking a few minutes to discuss basic fall prevention and the importance of primary-care follow-up is an important component of care of these patients.

Several commonly cited modifications to the home may decrease the risk of falls<sup>2</sup>:

- Removing throw rugs
- Placing nonslip rugs and assist bars in bathrooms
- Installing additional lighting
- Removing any cords or wires

Other interventions often require input from the primary-care physician, a physical therapist, or another specialist. Although it may not be appropriate for the urgent care provider to modify medications if the cause of falls might be related to polypharmacy, strongly encourage primary-care follow-up for medication modification. If there is concern for visual deficit as a cause of falls, the patient may benefit from an ophthalmology referral. Some patients may benefit from outpatient physical therapy for strength and balance training, home environment assessment and modification, and instruction on how to properly use assist devices.<sup>12</sup>

#### **Take-Home Points**

- Falls in the elderly are common and have the potential for great morbidity and mortality.
- Never assume that a fall is purely mechanical; take a few minutes to elicit a clear medical history to rule out a medical cause of the fall.
- Elderly patients may have significant injuries despite minor mechanisms; maintain a high index of suspicion when obtaining the medical history and performing the physical examination.
- If there are red flags during the work-up in these cases, be ready to transfer the elderly to a higher level of care.
- Even if the patient has only minor injuries, taking the time to provide education and to ensure good followup can have a profound impact on the patient's health and on the family.

#### References

1. Sterling DA, O'Conner JA, Bonadies J. Geriatric falls: injury severity is high and disproportionate to mechanism. J Trauma. 2001;50:116–9.

2. Rao SS. Prevention of falls in older patients. Am Fam Physician. 2005;72:81-8.

3. Centers for Disease Control and Prevention. Injury Prevention & Control: Data & Statistics (WISQARS<sup>™</sup>). Atlanta, GA: Centers for Disease Control and Prevention [last updated 2015 December 8; cited 2015 November 6]. Available from: http://www.cdc. gov/injury/wisqars/index.html.

4. National Council on Aging. Falls prevention facts. Arlington, VA: National Council on Aging [cited 2015 November 6]. Available from: https://www.ncoa.org/news/resourcesfor-reporters/get-the-facts/falls-prevention-facts/.

5. Perry BC. Falls among the elderly. J Am Geriatr Soc. 1982;30:367-71.

6. Bauer TK, Lindenbaum K, Stroka MA, et al. Fall risk increasing drugs and injuries of the frail elderly—evidence from administrative data. *Pharmacoepidemiol Drug Saf.* 2012;21:1321–7.

7. Zia A, Kamaruzzaman SB, Tan MP. Polypharmacy and falls in older people: balancing evidence-based medicine against fall-risk. *Postgrad Med*. 2015;127:330–7.

8. Homann B, Plaschg A, Grundner M, et al. The impact of neurological disorders on the risk for falls in the community dwelling elderly: a case-controlled study. *BMJ Open*. 2013;3:e003367.

9. Lin M. Trick of the trade: Steristrip–suture combo for thin skin lacerations. 2011 March 30 [cited 2015 November 6]. In: *Academic Life in Emergency Medicine* blog [Internet]. 2011. Available from: http://www.aliem.com/trick-of-trade-steristrip-suture-combo/.

10. Davis M, Nakhdjevahi A, Lidder S. Suture/Steri-strip combination for the management of lacerations in thin-skinned individuals. J Emerg Med. 2011;3:322-3.

11. Mack LR, Chan SB, Silva JC, Hogan TM. The use of head computed tomography in elderly patients sustaining minor head trauma. *J Emerg Med.* 2003;24:157–62.

12. Enderlin C, Rooker J, Ball S, et al. Summary of factors contributing to falls in older adults and nursing implications. *Geriatr Nurs.* 2015;36:397–406.

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## **Practice Management**

# From ZoomCare to ZOOM+: What Can Urgent Care Learn?

**Urgent message:** ZoomCare, which operates 28 walk-in clinics in the Pacific Northwest, has long been a technological innovator, launching web registration, scheduling, and telemedicine in its markets. In the past year, ZoomCare has evolved further to create ZOOM+, integrating urgent care with insurance, primary care, wellness, specialists, and ancillary services. As ZOOM+ redefines the future of urgent care around the needs of its community, there is much that other urgent care operators can learn in attaining revenue growth from a maturing business model.

ALAN A. AYERS, MBA, MAcc

#### Introduction

The rise of urgent care has put health-care delivery on notice: There is a new, disruptive model, born of consumer frustration and standing as a viable alternative for minor medical episodes. The outdated access paradigm of long primary health-care provider (PCP) appointment waits and lengthy, expensive emergency department (ED) visits was under siege, and would give ground to urgent care, which promised reduced wait times, extended hours, lower prices, and a retail-like customer-service orientation. Since early in the first decade of the 21st century, the urgent care model gained momentum, spread like wildfire, and became the darling of physician entrepreneurs, hospital systems, venture capitalists, and private equity firms looking to cash in on the next big thing in health care.

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operator in the area of Portland, Oregon, was hard at work reinventing the incumbent model via its comprehensive integration of mobile technology throughout its patient-service model. Touting itself as the world's first neighborhood clinic and smartphone-based healthcare delivery system, ZoomCare successfully leveraged its mobile online scheduling feature—an industry first to take the burgeoning concept of on-demand health care to unprecedented levels of brand differentiation and consumer loyalty in the Pacific Northwest.

#### ZoomCare to ZOOM+

Yet in spite of the surging popularity of the various urgent care models, traditional primary-care proponents held firm to their long-standing admonition: The urgent care model—in exchange for neighborhood convenience, extended hours, and faster service—served to fragment care, hinder preventive medicine, and undermine the concept of a medical home. To deal with that criticism, ZoomCare came up with a resounding answer: ZOOM+.

The original ZoomCare, based in Hillsboro, Oregon, and founded in 2006 by David Sanders, MD, and Albert DiPiero, MD, had already introduced several on-demand health-care innovations, including the following:

- A full-featured, easily navigable, mobile-ready website: Showing clinic locations, service offerings, a health-care provider roster, and company press releases
- Online clinician profiles: Including a full headand-shoulders photo, educational credentials, and medical specialty
- Mobile online scheduler: Allowing patients to select, from available time slots, the provider they trust, the provider recommended by friends and family, or a provider of the same sex
- Late-night operating hours: In some locations as late as midnight, a boon for midday workers and students who cannot miss work or school
- In-clinic medication dispensing: Helping to provide faster relief for patients, improved compliance with care instructions, and fewer prescription errors
- Telemedicine: Online-based voice consultations and evaluations within the State of Oregon
- In-house medical specialists: Reducing the need for outside referrals and helping to facilitate longitudinal care relationships

These and other offerings such as naturopathy and mental health services positioned ZoomCare as an urgent care operator who truly understood the power of innovation, as evidenced by its leveraging of web and mobile technology in ways that the on-demand healthcare space had not really seen. The result was a thriving company that garnered rave reviews and popular acceptance in the Portland area.

Then in May 2015, ZoomCare, largely through an infusion of private equity cash, rebranded and relaunched as ZOOM+. Whereas ZoomCare merely built upon the already popular urgent care model, ZOOM+ has positioned itself as a comprehensive health system, complete with its own insurance, based on the idea of maximizing health and performance rather than merely treating sickness or even pursuing wellness. The company's new motto of "Twice. 1/2. Ten" means "Twice the health at half the cost and ten times the delight." The motto represents the de facto mission statement of ZOOM+ founders Sanders and DiPiero, who set out with the idea to deliver care that is affordable, accessible, and delightful through structural and cultural innovation. In sum, ZOOM+ is proving that the urgent care model can indeed be the complete, on-demand medical home that PCP proponents have declared impractical.

#### **ZOOM+Notables**

Rather than branching out and extending its primarycare footprint geographically, ZOOM+ opted to go vertical and built atop its preexisting neighborhood clinic platform by investing in infrastructure, technology, and people. The result is a complete health-care system designed to be used every day to achieve maximum human performance. The ZOOM+ model is highlighted by several innovative features, including the following.

#### Performance Health Insurance System

The Performance Health Insurance System is the linchpin of ZOOM+ model, because it is designed to enhance human performance rather than merely treat sickness. The ZOOM+ founders encountered inherent friction when attempting to deliver complete care through the status quo insurance model, so they developed a new insurance carrier. Built from the ground up, ZOOM+ insurance functions like traditional insurance but adds performance-enhancing services that other plans simply are not designed to offer.

Packaged as ZOOM+Plans, this insurance provides total health-care coverage with unlimited primary, urgent, and specialist services via the following payment tiers:

ZOOM+Zero: A zero-deductible plan

- ZOOM+100: People fully pay for their own care until they reach their maximum deductible, and then ZOOM+ pays
- ZOOM+Gov: Federally mandated, this option includes gold, silver, and bronze plans. Note that ZOOM+ accepts other private insurance plans but does not take Medicaid or Medicare.
- ZOOM+Mobile: Health care that is 100% accessible by smartphone. ZOOM+ members can schedule appointments, access and manage their health records, and book coaching sessions online. After creating an account on the ZOOM+ website, members gain access to a menu portal that allows to them view records, submit questions, see test results, and even speak face-to-face with a provider through their mobile device.
- Twenty-eight neighborhood clinics: ZOOM+ is composed of 28 neighborhood clinics located in the Pacific Northwest. With 23 clinics in Portland, Oregon, and 5 in Seattle, Washington, ZOOM+ segments its primary, urgent, and specialist care services into individual ZOOM+ studios to form a small-footprint neighborhood health campus.
- Culture fit: ZOOM+ understands that for such a radical health-care model to flourish, it must approach its hiring process with great care in regard to culture fit. Hence, Drs. Sanders and DiPiero place a premium on candidates who are flexible, are adaptable, and can thrive in a dynamic environment. ZOOM+ even goes so far as to eschew the traditional job interview and instead have applicants shadow their potential coworkers throughout a typical workday, and even role-play actual on-the-job scenarios. This process is deliberate and fluid, designed to weed out applicants who are not a great fit with the ZOOM+ brand and ethos.
- What, When, Where: ZOOM+ has simplified its scheduling system by replacing its "Schedule a Provider" feature with an intuitive "What, When, Where" web module. On the ZOOM+ home page, a patient can select the service they want (What), the time they want it (When), and the location they want to receive it (Where), using a simple dropdown menu accessible through a smartphone or mobile device. On the basis of their input, the system then displays the best matches. Note that for urgent care visits, ZOOM+ guarantees a visit with a physician assistant (PA) or nurse-practitioner (NP) within 15 minutes, and a visit with an ED physician within 30 minutes.

- ZOOM+Guru: Performance Health Insurance members get access to their very own ZOOM+Guru, or personal health assistant. Through these gurus, members can request help and advice in areas such as scheduling care, benefits disbursement, and coordination of follow-up care.
- Flat and transparent pricing: There are no price surprises in the ZOOM+ pricing model; every service and procedure has a clearly listed price. Deductibles depend on individual insurance plans for nonmembers.

#### *ZOOM+Places*

ZOOM+Places is the umbrella under which ZOOM+ provides its specialist, urgent, and primary care with the help of its partners, including Oregon Science & Health University (OSHU). For members of Performance Health Insurance, most services are free of charge. ZOOM+Places employs a team of physicians, doctors of naturopathic medicine (NDs), PAs, and NPs to deliver care through its ZOOM+Advanced, ZOOM+Care, and ZOOM+Primary platforms, which are detailed as follows:

#### ZOOM+Advanced

The ZOOM+Advanced platform provides on-demand access to medical specialists through Zoom+ partnerships with OSHU and Portland-area hospital systems.

- ZOOM+Specialists: Offering 100-plus same-day, no-wait appointments with board-certified specialists in areas such as
  - Cardiology
  - Dermatology
  - Endocrinology
  - Audiology
  - Ear, nose, and throat
  - Gastroenterology
  - Neurosurgery
  - Pulmonary
  - Podiatry
  - Allergy and asthma
  - Neonatology
  - Nephrology and dialysis
  - Oncology and hematology
  - Ophthalmology and optometry
  - Pain management
  - Rheumatology
  - Speech therapy and occupational therapy
  - Urology

With ZOOM+Specialists, there is no need for a refer-

ral, and procedures and evaluations can be scheduled via smartphone or mobile device. The approach is designed to move away from one-on-one specialist care to a more collaborative, team-based approach to care and wellness.

- ZOOM+Surgery: Coming soon, on-demand surgery scheduled from a phone or mobile device
- ZOOM+Hospital: Also coming soon, expedited and preferred access to OSHU and Portland-area hospital systems

#### ZOOM+Urgent Care

The ZOOM+Urgent Care platform allows for more than 500 on-demand, no-wait visits each day for injuries, ill-nesses, and wellness. The platform is broken down as follows:

- ZOOM+Care: This is the standard urgent care solution, handled primarily by PAs and NPs, and it features on-site prescription medication 365 days a year. It provides basic urgent care for on-demand injury and illness treatments. It also includes immunizations, vaccinations, laboratory tests, and physical therapy at each clinic.
- ZOOM+Super: This program was created to bridge the gap between urgent care and EDs. ZOOM+ Super treats 80% of patients who would ordinarily end up going to an ED, but it does so in a fraction of the time and a tenth of the cost. This dramatic reduction in the use of expensive and unnecessary ED resources helps drive down health-care costs. Conditions like fractures, serious infections, kidney stones, and intense headaches can be treated during a ZOOM+Super visit. The entire visit, lasting about 60 minutes, includes x-rays, computed tomography, and ultrasound, as well as a comfortable Super room complete with television, a Wi-Fi connection, and space for accompanying family and friends.
- ZOOM+Video: The ZOOM+ telemedicine solution, ZOOM+Video, enables unlimited, worldwide ondemand video visits for minor illness and injury. With the proliferation of mobile devices with highdefinition video capabilities, ZOOM+Video is a fast, no-hassle option for minor issues such as rashes, ringworm, pinkeye, and cold sores. Additionally, for nonmembers, the \$35 video visit fee is deducted from the final bill if the clinician must refer the patient to a ZOOM+ clinic for in-person treatment. ZOOM+Video is free for members, and most separate insurance plans cover video visits because of

the passage of Oregon state law SB144, which requires all video medical visits to be reimbursed by insurance companies.

#### ZOOM+Primary

ZOOM+Primary is the all-inclusive platform for ZOOM+ primary-care services. Its stated mission is to use "food, movement, and medicine" to both attain maximum performance and eliminate most lifestyle diseases such as heart disease and diabetes. ZOOM+Primary is based on three components: cloud-based medical care, ZOOM+Health classes, and health coaching. The platform is divided into five categories of service, with each housed in its own separate studio.

- ZOOM+Brain: This program consists of not only mental health services but also brain-performance training to enhance cognitive function and mental focus. Mental health services include treatments for obsessive-compulsive disorder, anxiety, attentiondeficit hyperactivity disorder, insomnia, and depression.
- ZOOM+Performance: This service is focused on athletic performance, creative energy, and mental acuity. On-site naturopaths take assessments of a patient's baseline cellular, brain, and athletic benchmarks, then devise commensurate food, movement, and relationships plans to help reach their potential. When a member is beginning a ZOOM+ Performance program, there is first a comprehensive baseline performance assessment, and then subsequent performance sessions based on individual need. The initial assessment and follow-up sessions are free for Performance Health Insurance members, whereas nonmembers are afforded transparent pricing and the option for their insurance plan to cover the fees.
- ZOOM+Prime: This service was designed to be a radical departure from the status quo of prescribing drugs and providing reactive care for chronic illness, rather than proactive care as prevention. ZOOM+Prime instead teaches that the modern Western lifestyle and diet is responsible for a majority of chronic illness, and espouses exercise combined with a plant-based diet to prevent and reverse disease. To that end, ZOOM+ even offers a program called Prime 90 designed to help members "get off [their] meds in 90 days" through a combination of plant-based eating, movement, lifestyle coaching, and digital education through video and email support.

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- ZOOM+Smile: Described as an "Apple Genius Bar for your teeth," ZOOM+Smile aims to make the traditional dentist appointment as leisurely an affair as a trip to the coffee shop. ZOOM+Smile features Healthy Clean White 57—an on-demand dentalcare package that includes an examination, cleaning, and whitening, all in 57 minutes or less, scheduled from a smartphone. If the dentists encounter a problem, they can refer patients to the ZOOM+Smile team for a follow-up visit. Every ZOOM+ member receives one free annual Healthy Clean White 57 service.
- ZOOM+Kids: The ZOOM+ pediatric care system is ZOOM+Kids, touted as a program that artfully merges "Montessori and modern pediatrics." The program delivers complete pediatric care, designed to help parents raise healthy, happy kids. Features include a 24/7 parent hotline, personalized parent coaching, and a movement studio and demonstration kitchen where kids and parents can take healthy lifestyle classes together. ZOOM+Kids currently sees more than 2000 kids a month.

#### ZOOM+Meds, ZOOM+Labs, and ZOOM+Imaging

Supplementing the ZOOM+Places platforms and supporting members toward achieving their health and fitness goals are the following teams programs:

- ZOOM+Labs: Providing on-demand laboratory tests, although the timetable for results varies depending on the specific type of test.
- ZOOM+Meds: ZOOM+ clinics dispense medications at each of their 28 locations, with home delivery available for members.
- ZOOM+Imaging: On-demand x-rays, computed tomography scans, and ultrasound scans. Results are delivered immediately.

#### **Disrupting and Advancing the Urgent Care Model**

Although the urgent care industry has made huge strides toward helping to usher in a better, improvedaccess paradigm, as a whole it has barely scratched the surface of what is possible. An urgent care operator such as the former ZoomCare, for instance, was already pushing the proverbial envelope with its widespread integration of mobile-friendly technology throughout its platform. With ZOOM+, however, it took the concept of disruption to a new level in the unveiling of the first complete on-demand neighborhood health system in the United States. Offering such a comprehensive platform of services and features, coupled with personal health gurus, collaborative care teams, and performance coaches at the ready, ZOOM+ undoubtedly can be considered a de facto medical home. Hence, by an innovator like ZOOM+, the old PCP admonition about the allure of urgent care serving to undermine complete care was effectively rendered moot.

Admittedly, the ZOOM+ model has the massive advantage of investor capital and its own health insurance, two things many independent urgent care centers do not have access to. The lesson from ZOOM+, however, may be more than just plugging in investor capital to overcome obstacles. Rather, it seems to be more about reimagining what is possible and devising radical new solutions for old problems. Furthermore, adopting that sort of disruptive, pioneering ethos almost always goes back to culture. ZOOM+ notably seeks out business trendsetters and innovators to fill its nonclinical executive roles. With Drs. Sanders and DiPiero at the forefront, ZOOM+ and its disruptive care team is attempting show what a health-care system can be when it sets out to transform basic urgent care to an inviting human performance campus—all while capturing the high-tech, welcoming vibe of an Apple Genius Bar or neighborhood Starbucks.

#### Conclusion

What is the takeaway for urgent care operators everywhere? Even when faced with the burden of the status quo insurance model and limited financial capital, you can still seek ways to push the envelope and reimagine what is possible with your service model.

As technology prices fall, are you exploring ways to implement telemedicine into your practice model, for example? Does your clinic offer education for patients on how food and movement can be medicine, thereby lessening patients' reliance on your prescription pads? Can you find a way to implement mobile-friendly health records and self-scheduling through your website? Is it possible for a urgent care owner-operator association to form its own insurance in the pursuit of human potential, rather than merely curing illness? The possibilities are numerous; the challenge seems to be taking a hard look at your own status quo and figuring out novel and innovative ways to solve problems.

Remember, the urgent care model itself was once considered a novelty. Today, with close to 10,000 clinics nationwide, the industry is still ripe with new possibilities for those willing to imagine.

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# Case Report Shin Pain

**Urgent message:** Lower extremity injuries are very common in adolescent athletes. Urgent care providers must remember that shin pain is not always simply shin splints.

CHRISTOPHER TANGEN, DO, and RYAN SHILIAN, DO

#### Introduction

A lso known as medial tibial stress syndrome, shin splints are described as the painful inflammation of the tibial periosteum, which is generally caused by repetitive physical activity.<sup>1</sup> Repetitive injuries can cause incomplete fractures, or microfractures, of the tibia. These tibial stress reactions can predispose the bone to acute fractures.<sup>2</sup>

#### **Case Presentation**

A 15-year-old high school athlete fell directly onto his right shin while practicing football. He experienced severe pain and was transported off the practice field, where he was immediately evaluated by his athletic trainer. At that time, the pertinent finding was mid-shaft tibial tenderness to palpation. The athlete was sent home on crutches, and it was recommended that he rest and ice the area and also use ibuprofen for pain. His pain persisted the next day, and he sought treatment in an urgent care center. At that time, he was unable to ambulate because of severe pain, so he used a wheelchair.

Findings on his medical history, surgical history, social history, and family history were unremarkable. He had no allergies, and he was not taking any other medications.

#### **Physical Examination**

Evaluation of the patient showed the following:

- Temperature: 98.7°F (37°C)
- Pulse: 63 beats/min



Blood pressure: 127/83 mm HgOxygen saturation: 100%

On physical examination, the patient was found to be in mild discomfort but was fully alert. No abnormal findings were noted on his cardiovascular and respiratory examinations. Examination of his right lower extremity revealed severe tenderness and also edema overlying the mid-shaft of the right tibia. A tibia-fibula squeeze test of his right leg elicited pain. The leg was neurovascularly intact.

Christopher Tangen, DO, is the Medical Director of Sports Medicine and Ryan Shilian, DO, is a Traditional Rotating Intern, both at University Hospitals Regional Hospitals—Richmond Campus, Richmond Heights, Ohio.



Figure 2. Lateral radiograph of the tibia and fibula.



#### Diagnosis

Acute nondisplaced fracture of the right mid-tibial shaft.

#### Resolution

The patient's leg was stabilized in a long leg splint, and he was given crutches and referred to an orthopedic surgeon. Acetaminophen-codeine oral tablets, 300/30 mg, were prescribed for pain.





After orthopedic evaluation within 3 days, the patient was given a long leg cast and was instructed to continue avoiding bearing weight on his right leg.

Anteroposterior (**Figure 1**) and lateral (**Figures 2 and 3**) tibia and fibula plain film radiographs were ordered. These revealed an acute nondisplaced fracture of the mid-diaphysis of the right tibia (**Figures 1, 2, and 3**).

#### Discussion

#### Medical History

Shin splints are considered to exist on a spectrum of tibia injuries that includes simple overuse injuries from repetitive stress, stress fractures, and acute fractures.<sup>1</sup> Lack of conditioning, imbalances in muscle training, and trauma are factors that lead to worsening injuries. Patients with shin splints will present with a history of diffuse shin pain for up to several weeks. The specific time patients experience pain is an important piece of the medical history. Athletes with shin splints will often report that their pain is worse right after participating in sports, but they will notice their pain with every step they take if they have acute or stress fractures.

#### **Physical Examination**

Shin splints generally present with pain along a portion or majority of the tibial border, often with diffuse tenderness. Recent stress fractures or acute tibial fractures will present with specific tenderness to palpation and Urgent Care CME Designed By Urgent Care Leaders

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SCHOOL OF MEDICINE CASE WESTERN RESERVE often have associated softtissue swelling at the area of the fracture and pain with weight-bearing.<sup>3</sup>

With acute tibial shaft fractures, patients are unable to bear weight because of severe pain and edema.<sup>3</sup> Pain, pulselessness, pallor, paresthesias, and poikilothermia can be signs of compartment syndrome. *Indications for emergency orthopedic referral within 6 hours include compartment syndrome, neurovascular injury,*  "The specific time patients experience pain is an important piece of the medical history. Athletes with shin splints will often report that their pain is worse right after participating in sports, but they will notice their pain with every step they take if they have acute or stress fractures."

open tibial shaft fractures, and the presence of concurrent dislocation of the knee or ankle.<sup>3</sup>

#### Diagnostic Testing

Plain film radiographs are the first imaging step in the evaluation of a suspected tibial fracture. If further injury is suspected, computed tomography imaging and ultrasound can be considered for a complicated fracture and vascular etiology, respectively.

#### Treatment

#### General

General treatment of shin splints includes ice, rest, stretching, avoidance of repetitive injury, physical therapy, and nonsteroidal anti-inflammatory drugs. Athletes can attempt to prevent shin splints and stress fractures by running on softer surfaces, performing daily hamstring and calf stretches, ensuring proper fit of their shoes, and gradually increasing repetitive stress activities.

#### Tibial Shaft Fractures

Tibial shaft fractures that are nondisplaced and that are not comminuted can be comfortably treated by primary-care physicians and urgent care providers. Initial treatment of closed tibial shaft fractures involves immobilization in a long leg posterior splint, applied with the knee held in 10° to 20° of flexion. If a patient is having persistent pain after splint placement, it can be a sign of limb ischemia or compartment syndrome.<sup>2</sup>

#### Long-Term Course and Complications

It is important for the patient to avoid weight-bearing on the affected extremity for 1 to 2 weeks. Then as soon as the edema subsides (in 2–3 weeks), the cast is changed to better immobilize the affected area. It usually takes an additional 1 to 4 weeks for evidence of satisfactory healing to be detectable on radiographs. At this point, the cast can be exchanged with a walking cast boot or a shortleg walking cast. It normally takes 10 to 14 weeks for nondisplaced fractures to heal.<sup>3</sup>

Potential long-term complications of immobilization of a nondisplaced tibial fracture include nonunion, malunion, complex regional pain syndrome, joint stiffness,

infection, and refracture.3

#### **Red Flags**

The limb must be examined for palpable bony deformities, signs of infection, compartment syndrome (the five P's: poikilothermia, paresthesia, paralysis, pallor, and pain), and other vascular injury, all of which require immediate treatment.<sup>4</sup> Cyclical pain, fever, and unexplained weight loss can be clues in the medical history for consideration of fractures from primary or secondary bone tumors, or from infectious etiologies such as osteomyelitis.

#### **Take-Home Points**

School and recreational sport seasons bring many patients to urgent care centers for various lower extremity complaints, and the majority of athletes with shin pain have shin splints. Primary-care physicians and sports medicine specialists are appropriate specialists for recommendations for follow-up and referral in cases of shin splints that do not heal after initial treatment.

However, because not all shin pain is caused by shin splints, obtaining a thorough medical history and conducting a detailed physical examination, along with interpreting plain films, may lead to discovery of more serious injuries such as nondisplaced tibial shaft fractures.

#### References

4. Rudloff MI. Fractures of the lower extremity. In: Canale ST, Beaty JH, eds. *Campbell's Operative Orthopaedics*, 12th edition. Philadelphia, PA: Mosby; 2013: 2617–2724.

<sup>1.</sup> Medial tibial stress syndrome (shin splints). In: Safran A, Zachazewski J, Stone DA, eds. Instructions for Sports Medicine Patients. 2nd edition. Philadelphia, PA: Saunders; 2012: 617–620.

<sup>2.</sup> Pallin DJ. Knee and lower leg. In: Marx J, Hockberger R, Walls R, ed. *Rosen's Emergency Medicine: Concepts and Clinical Practice*, 8th edition. Philadelpha, PA: Saunders; 2013: 731–744.e1.

<sup>3.</sup> Patellar, tibial, and fibular fractures. In: Eiff MP, Hatch RL, eds. Fracture Management for Primary Care, 3rd edition. Philadelphia, PA: Saunders; 2011: 245.

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### HEALTH LAW AND COMPLIANCE

## Complying with Medical Information Restrictions of the Family Medical Leave Act and Americans with Disabilities Act

Spencer Hamer, JD

**Urgent message:** Urgent care centers that are subject to the Family Medical Leave Act and the Americans with Disabilities Act are limited on the types of questions they can ask related to employee requests for leave. To avoid legal problems, managers should understand the requirements for leave and implement a process for handling information requests.

#### Introduction

wo common laws that employers must deal with regarding employee leave requests are the Family Medical Leave Act (FMLA) and the Americans with Disabilities Act (ADA). Not surprisingly, these laws contain a large amount of regulations governing leave rights that may present a stumbling block for many employers. Knowing the acts' basic requirements is therefore critical.

#### Family Medical Leave Act

The FMLA applies to employers with 50 or more employees within 75 miles of the worksite of the employee requesting leave. To be eligible, employees must be employed for 12 months and work at least 1250 hours during the 12-month period preceding the leave. Employees can take FMLA leave for a serious health condition of their child, spouse, or parent; birth and care of a newborn; adoption or foster care of a child; a "qualifying exigency" for an armed forces active-duty family member, or care for an injured military service member or veteran.

**a** 

**Spencer Hamer, JD**, is a partner working in the Irvine, California office of the law firm of Michelman & Robinson, specializing in labor and employment matters for healthcare clients. The employer may request initial medical certification after the employee requests a "serious health condition" leave. It must make the request in writing within 5 business days after learning of the need for leave, or if the leave was unforeseeable, within 5 business days after the leave begins. The employer may request certification at a later date only if it has reason to question the length or appropriateness of the leave. The request must advise the employee of the consequences of failure to provide adequate certification.

- A medical certification is sufficient if it states
- 1. The date on which the serious health condition commenced
- 2. The probable duration of the condition
- The appropriate medical facts regarding the condition within the knowledge of the health-care provider who is providing certification
- 4. That the employee is unable to perform the functions of his or her position

Certification for intermittent or reduced-schedule leave must include the dates on which planned medical treatment is expected, a statement of medical necessity, and the expected duration. The U.S. Department of Labor (DOL) has certification forms (WH-380-E, employee's serious health condition; WH-380F, family member's serious health condition) that employers may use.<sup>1</sup> Employers may develop their own forms, but they may not require additional information.

If the employee provides an incomplete or insufficient certification, the employer must indicate in writing what additional information is necessary and give the employee 7 days to pro-

<sup>1</sup>www.dol.gov/whd/forms/index.htm

vide it, unless the employee reasonably needs more time. If the employee fails to provide certification for a foreseeable leave, the employer may delay leave until it receives the documentation. When the leave is unforeseeable, the employee must provide certification within 15 days, or as soon as reasonably possible. The employer may delay the leave while awaiting certification. If the employee never provides it, the leave is not treated as FMLA leave.

If the employee submits a certification signed by a healthcare provider, the employer may not request additional information. It may contact the health-care provider to make sure that the certification is authentic, or to clarify it, but must give the employee a chance to provide that information first. If the employer contacts the provider, it must do so through a healthcare provider, human resources professional, leave administrator, or management official. The employee's direct supervisor cannot communicate with the provider. If FMLA leave is running concurrently with workers' compensation leave, the employer may contact the employee's workers' compensation health-care provider, in accordance with applicable workers' compensation laws.

If the employer doubts the validity of the certification, it may require a second opinion at the employer's expense. It may select the provider, but the provider cannot be one the employer regularly uses, unless health-care access in the area is very limited. If the first and second opinions are consistent, that ends the issue. If there is contradiction, the employer can seek a third opinion at its own expense, which will be final and binding, from a provider jointly designated or approved by the employer and the employee.

Although the notice of request for an initial medical certification must be in writing, subsequent requests can be made verbally. An employer may request a medical recertification no more than once every 30 days, unless circumstances regarding the request significantly change or the employer receives information casting doubt on the validity of the certification or reason for absence. An employee must be given at least 15 days to recertify. An employer may not require a second or third opinion. The employer may include a record of the employee's absences, such as a pattern of Monday and Friday absences, with the recertification form and may also ask about the likely duration and frequency of absences.

At the conclusion of FMLA leave for the employee's own serious health condition, the employer may require a fitness-forduty certification if it requires it of all similarly situated employees returning from FMLA leave. Fitness-for-duty certification is allowed every 30 days for an employee taking intermittent or reduced-schedule leave if safety concerns exist. No second or third opinions are allowed. If the employer has a basis to question the certification, it may restore the employee to work and seek its own evaluation at its expense. A fitness-for-duty certification may only relate to the particular condition that caused the need for leave. It must state that the employee is able to return to work and must specifically address the ability to perform essential job functions. The employer may contact the health-care provider—with the employee's permission—to clarify fitness to return, but only for the condition at issue. The employee's return cannot be delayed while clarification is being obtained. Where certification is unclear, an employer may require an independent medical examination at the employee's expense.

An employer may require certification in accordance with DOL regulations for a "qualifying exigency" arising because a family member is on active military duty. The DOL has a form (WH-384) for this purpose.<sup>1</sup>

#### Americans with Disabilities Act

Under the ADA, an employer may not ask about the existence, nature, or severity of a disability except in relation to the job and consistent with business necessity. To justify business necessity, the employer must show that it had some reason for suspecting the employee would be unable to perform essential job functions, or would pose a danger to the health and safety of the workplace.

The business necessity standard may be met before an employee's work performance declines if significant evidence could cause a reasonable person to ask whether an employee is capable of performing. To establish business necessity, the employer must show that it serves a legitimate business purpose, such as ensuring that the workplace is safe and secure, cutting down on egregious absenteeism, or preventing infectious disease. If business necessity exists, the inquiry may be no broader or more intrusive than necessary, and it cannot probe into unrelated medical conditions. For example, an employer may require a warehouse laborer whose back impairment affects the ability to lift to be examined by an orthopedist, but not to undergo a test for human immunodeficiency virus. An employer must notify an employee in advance that a fitness-for-duty report will be required.

A medical examination may also be required to determine whether an employee poses a direct threat to the health or safety of the employee or others. Employers have broader rights to demand medical examinations on the basis of a direct threat than for other reasons.

An employee with a prolonged history of illness and absenteeism that has affected job performance may be required to undergo a physical examination to determine whether the employee can do the job, even if it might disclose a disability, if the employee refuses to cooperate with the employer's lessinvasive attempts to obtain this information from the employee's physician.

An employer may also request medical information if the

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#### HEALTH LAW

"Under the ADA, an employer may not ask about the existence, nature, or severity of a disability except in relation to the job and consistent with business necessity.... The employer must show that it had some reason for suspecting the employee would be unable to perform essential job functions, or would pose a danger to the health and safety of the workplace."

employee has requested a reasonable accommodation, such as a leave of absence. Other medical inquiries are generally prohibited. For example, requiring a general diagnosis of an employee's illness after sick leave is prohibited, because it may perpetuate stereotypes; requiring employees to disclose what prescription drugs they use is prohibited because it could reveal actual or perceived disabilities.

Under both the FMLA and the ADA, information regarding certifications, medical histories of employees or family members, and information collected during permissible inquiries or examinations must be maintained in separate medical files and kept confidential. The employer may disclose such information only to supervisors and managers to determine restrictions and accommodations, first-aid and safety personnel for medical or emergency treatment, and government officials investigating compliance.

#### Steps for Compliance

Employers covered by the FMLA and/or the ADA should prepare in advance for handling issues regarding medical information. Key components of this preparation include the following:

- Identifying who will be responsible for responding to leave inquiries, and providing the appropriate training
- Preparing and updating employment policies and procedures, such as new-hire documentation and employee handbooks
- Obtaining all appropriate forms necessary for receiving and responding to requests for FMLA and ADA leave
- Providing employees with a clear path to raises issues they may have with the leave-of-absence process.

Although the amount of regulation regarding FMLA and ADA medical information requests is complex, proper planning will enable employers to handle these issues with confidence. However, keep in mind that employment laws change, so your center should consult a lawyer who specializes in them.



### ABSTRACTS IN URGENT CARE

- Azithromycin Versus Doxycycline for Chlamydia
- Do CT Scans Make Lumbar Puncture Unnecessary in Sudden-Onset Headache?
- Taking Vitamin D May Cut Migraine Rate
- Lurking MRSA May Cause Recurrent Infections

- Stopping Nausea with Nasal Isopropyl Alcohol?
- Eosinophilia with Long-Term Use of Antibiotics
- Anakinra for Hidradenitis Suppurativa
- Assessing Which Patients with Likely Acute Coronary Syndrome Can Go Home

SEAN M. MCNEELEY, MD

ach month the Urgent Care College of Physicians (UCCOP) provides a handful of abstracts from or related to urgent care practices or practitioners. Sean McNeeley, MD, leads this effort.

#### Azithromycin Versus Doxycycline for Chlamydia

### *Key point: Azithromycin is a little less effective than doxycycline for chlamydia.*

Citation: Geisler WM, Uniyal A, Lee JY, et al. Azithromycin versus doxycycline for urogenital *Chlamydia trachomatis* infection. *N Engl J Med*. 2015;373:2512–2521.

This study of a population in a youth correctional facility compared the effectiveness of azithromycin with doxycycline in the treatment of chlamydia. A total of 567 participants were randomized to regimens of azithromycin or doxycycline after diagnosis of chlamydia, recommended by the Centers for Disease Control and Prevention. After 28 days a test of cure was performed. Patients were watched closely to eliminate chance in contracting the disease again. The cure rate of azithromycin was 97%, whereas it was 100% for doxycycline. Although those findings are not definitive, the study does provide good information. Acute-care providers should balance the ease of treat-



**Sean M. McNeeley, MD,** is an urgent care practitioner and Network Medical Director at University Hospitals of Cleveland, home of the first fellowship in urgent care medicine. Dr. McNeeley is a board member of UCAOA, UCCOP, and the Board of Certification in Urgent Care Medicine. He also sits on the *JUCM* editorial board. ment (one dose with azithromycin) with cure rates and also let patients know that the easier treatment may fail.

#### Do CT Scans Make Lumbar Puncture Unnecessary in Sudden-Onset Headache?

Key point: Can lumbar puncture be skipped in evaluation of subarachnoid hemorrhage?

Citation: Blok KM, Rinkel GJ, Majoie CB, et al. CT within 6 hours of headache onset to rule out subarachnoid hemorrhage in nonacademic hospitals. *Neurology*. 2015;84:1927–1932.

Two previous studies revealed a negative predictive value of almost 100% for third-generation computed tomography scans read by university-based radiologists for patients considered at risk of subarachnoid hemorrhage. This study considered findings for scans done with third-generation scanners and read at community facilities within 6 hours of onset of symptoms. A total of 760 patients were scanned. In only 1 of the patients was a mild subarachnoid hemorrhage missed, for a negative predictive value of 99.9%. Although this is not a frequent diagnosis made during urgent care visits, the process at emergency departments after patients with sudden-onset headaches leave urgent care centers may soon be changing: The researchers concluded that lumbar puncture can be avoided in patients who undergo computed tomography scans within 6 hours of headache onset. Being aware of the potential change and not creating fear of a

#### ABSTRACTS IN URGENT CARE

need for lumbar puncture will likely benefit conversations with patients with sudden-onset headaches. [Editor's note: For more on subarachnoid hemorrhage, see the case report "Sudden-Onset Severe Headache" in our January 2016 issue, at www.jucm.com/ sudden-onset-severe-headache/.]

#### **Taking Vitamin D May Cut Migraine Rate**

*Key point: Consider adding vitamin D to reduce migraine frequency.* 

Citation: Buettner C, Nir RR, Bertisch SM, et al. Simvastatin and vitamin D for migraine prevention: a randomized controlled trial. *Ann Neurol*. 2015;78:970–981.

Patients with migraine frequently seek care in the urgent care setting. According to the authors of this randomized, placebocontrolled study, migraines are the 8th most frequent cause of disability worldwide. They investigated the use of vitamin D plus simvastatin for migraine prevention. Approximately 60 patients were monitored for 12 weeks to determine migraine frequency, and then treated either with simvastatin and vitamin D or with matching placebo tablets and capsules. Patients in the treatment group had a mean of 8 fewer days of migraine, whereas those in the placebo group actually experienced 1 additional day of migraine. Although this was a small study and should be replicated, its findings may provide some insight into another way to reduce migraines. It is unlikely that an acutecare provider would add simvastatin to a treatment plan for patients with migraine, but for those patients already taking it, the addition of vitamin D, 1000 IU twice daily, might reduce migraine frequency.

#### Lurking MRSA May Cause Recurrent Infections

*Key point: Methicillin-resistant* Staphylococcus aureus *hiding in cells may cause recurrent infections.* 

Citation: Lehar SM, Pillow T, Xu Min, et al. Novel antibiodyantibiotic conjugate eliminates intracellular *S. aureus. Nature.* 2015;527:323–328.

This study investigated the possibility of an intracellular reservoir of methicillin-resistant *Staphylococcus aureus* (MRSA) that may be susceptible to an antibody-based cure at least in mice. The authors speculated that this may be the cause of recurrent infections or even treatment failures. Although the findings are not well validated enough to change treatment, they do suggest a potential etiology for MRSA recurrence. The authors created an antibiotic bound to an antibiotic that would not enter mammalian cells until cleaved by a cell infected by MRSA. The antibiotic used was closely related to rifampicin. This may eventually provide a way to treat patients frustrated by multiple episodes of infection.

### Stopping Nausea with Nasal Isopropyl Alcohol?

Key point: Isopropyl alcohol may reduce nausea.

Citation: Beadle KL, Helbling AR, Love SL, et al. Isopropyl alcohol nasal inhalation for nausea in the emergency department: a randomized controlled trial. *Ann Emerg Med*. 2015 Nov 21. pii: S0196-0644(15)01361-X. doi: 10.1016/j.annemergmed. 2015.09.031.

Nausea and emesis are frequent issues in urgent care centers. Many newer treatments are usually effective at helping, but patient factors occasionally limit their use. In this double-blind, placebo-controlled trial, 80 patients with nausea or emesis were treated with either nasal isopropyl alcohol or saline, and nausea scores were assessed at 10 minutes after treatment. Those in the treatment group averaged a score of 3 on an 11-point verbal numeric response scale, whereas those in the saline group averaged a score of 6. Although the sample size was small, these are interesting findings. For the acute-care provider, this is information to file in the if-all-else-fails category of treatments.

#### Eosinophilia with Long-Term Use of Antibiotics

*Key point: Eosinophilia is more common with the long-term use of antibiotics than previously thought.* 

Citation: Blumenthal KG, Youngster I, Rabideau DJ, et al. Peripheral blood eosinophilia and hypersensitivity reactions among patients receiving outpatient parenteral antibiotics. J Allergy Clin Immunol. 2015;136:1288–1294.

It is known that eosinophilia after long-term use of antibiotics is possible, but there is little data on how common it is. Because eosinophilia may portend other allergic consequences, the researchers looked at the incidence of this phenomenon. A total of 826 former inpatients who had a normal eosinophil count before treatment were evaluated. Of these, 210 developed eosinophilia. These patients were also four times as likely to have a rash and twice as likely to have renal injury. Although this population is not a direct parallel to most urgent care patients, the median course of the condition was just over a month. Occasionally, with multiple treatments, acute-care patients could develop longer courses. This should raise concerns for milder allergic reactions and the potential of longterm damage by antibiotics.

#### Anakinra for Hidradenitis Suppurativa

Key point: A recombinant human interleukin-1 receptor antagonist may be a treatment for severe hidradenitis suppurativa. Citation: Tzanetakou V, Kanni T, Giatrakou S, et al. Safety and efficacy of anakinra in severe hidradenitis suppurativa: a randomized clinical trial. JAMA Dermatol. 2016;152:52–59.

#### ABSTRACTS IN URGENT CARE

#### "The addition of vitamin D, 1000 IU twice daily, might reduce migraine frequency."

Severe hidradenitis suppurativa (HS) is a challenging disease that frequently brings patients to urgent care centers for incision and drainage as well as advice for prevention. Few options for treatment are available. In a small trial in Greece, a total of 20 patients were randomized to treatment with either anakinra (a recombinant human interleukin-1 receptor antagonist) or placebo for severe HS. Improvement was noted in 20% of the placebo group and in 67% of the treatment group. Obviously a biologic therapy such as anakinra would not be started in an urgent care setting, but acute-care providers may want to provide information about this study to patients who must cope with the disease.

#### Assessing Which Patients with Likely Acute Coronary Syndrome Can Go Home

Key point: Using risk scores and troponin to determine whether to discharge patients with potential acute coronary syndrome can be complicated.

Citation: Carlton EW, Khattab A, Greaves K. Identifying patients suitable for discharge after a single-presentation high-sensitivity troponin result: a comparison of five established risk scores and two high-sensitivity assays. *Ann Emerg Med.* 2015;66:635–645.

Millions of patients are evaluated every year for symptoms of potential acute coronary syndrome. Finding a way to determine whether their risk is low enough for them to be able to go home can be difficult. This study evaluated clinical risk scores and troponin assay findings to see if a single troponin test can be used to obtain a negative predictive value of 99.5% while still sending 30% of patients home. The following prediction scores were used: modified Goldman; Thrombolysis in Myocardial Infarction (TIMI); Global Registry of Acute Cardiac Events (GRACE); History, ECG [electrocardiograph], Age, Risk Factors, Troponin (HEART); and Vancouver Chest Pain Rule. Troponin I (867 patients) and high-sensitivity troponin T (959 patients) were used for evaluation. Patients with suspected acute coronary syndrome and benign electrocardiographic findings were evaluated by risk score and troponin. Results were very complex. According to the authors, a TIMI score of o or ≤1 and a modified Goldman score  $\leq 1$  with high-sensitivity troponin T, and a TIMI score of o and a HEART score of  $\leq 3$  with high-sensitivity troponin I had the potential to achieve a negative predictive value  $\geq$  99.5% while identifying > 30% of patients as suitable for immediate discharge. For the urgent care provider, this provides some hope for rapid assessment but also underscores the importance of understanding the risk scores and knowing which troponin assay is in use.

#### How JUCM's Editorial Process Helps Our Authors

Our authors do the hardest part of publication, researching and writing articles to add to the urgent care literature. Then once we have assessed the big-picture issues during peer review, we polish the manuscripts until they shine, through a process called copyediting. Here is a partial list of the issues that our editors address during copyediting:

- Grammar
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- Logic
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o Did the author present enough information so that readers with various levels of expertise—longtime physician, nurse-practitioner, intern, medical student—can understand what is meant, or are there information gaps that should be explicitly addressed?

o Even though a specific abbreviation is already defined in the text, is it also defined in the caption for the figure where it is used, so that skimming readers don't have to search the entire article to find out what the figure's abbreviation means?

• Consistency (e.g., did the authors use an abbreviation throughout, or did they use the full term sometimes and the abbreviation at other times?)

· Topic, figure, and table cross-references in text

• Verification of names of drugs, genera and species, and actual people, places, and organizations

- Appropriate citation of references
- · Wordiness (getting rid of it)

• Jargon (making sure jargon is used appropriately—or whether it needs to be used at all)

- Bias-free writing:
  - o Sex
  - o Gender identification

o Parents versus nonparents when discussing pediatric patients

o Emotions (e.g., in research papers, using "killed the rats" instead of the emotion-laden "sacrificed the rats")

Style:

o Uppercase versus lowercase

o Standardizing references to follow American Medical Association style

o Trademarks versus generic names

 Presentation (What works best for reader comprehension here: straight text, a bulleted list versus a numbered list, a sidebar, a table, a figure?)

• Meta-issues (e.g., can we add an editorial comment referring readers to another article in the same issue or in a past issue on a topic related to the one covered in an article in our current issue?)

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# CLINICAL CHALLENGE: CASE 1

This feature will challenge your diagnostic acumen with a glimpse of x-rays, electrocardiograms, and photographs of conditions that real urgent care patients have presented with.

If you would like to submit a case for consideration, please e-mail the relevant materials and presenting information to *editor@jucm.com*.

# Chronic Cough and Shortness of Breath



ing productive of green sputum, shortness of breath that worsens with exertion, and chills. He says he has a chronic morning cough but states that the sputum has changed color and that his dyspnea has increased. He says he has not had any fever, chest pain, or lower extremity pain or swelling.

View the image taken (**Figure 1**) and consider what your diagnosis would be.

#### **Differential Diagnoses**

- Pneumonia
- Pneumothorax
- Heart failure
- Pulmonary embolism
- Lung cancer

#### **Physical Examination**

On examination, the patient was found to be afebrile, and he had a pulse rate of 98 beats/min, a respiration rate of 24 breaths/min, and a blood pressure of 142/88 mm Hg. He was alert and oriented. The physician noticed tachypnea when the patient walked from the waiting room to the examination room.

The patient had decreased breath sounds bilaterally with minimal bilateral symmetric wheezing. He had a reg-

Case

A 74-year-old man without a significant past medical history presents to an urgent care center reporting 3 days of cough-

ular heart rate and rhythm without murmur, rub, or gallop. His abdomen was soft and nontender without rigidity, rebound, or guarding. He had no pain or swelling of the lower extremities.

#### THE RESOLUTION



His peripheral pulses were 2+ on a scale of o to 4 and were equal in all four extremities. The patient's chest x-ray had the typical appearance of chronic obstructive pulmonary disease (COPD): large, dark lungs; flattened thoracoabdominal diaphragm; and a small, vertically oriented heart (**Figure 2**).

#### Diagnosis

The diagnosis was COPD.

#### Learnings

COPD affects 30 million Americans and is the fourth leading cause of death in the United States. Airway obstruction is present in 14% of white male smokers, compared with 3% of nonsmokers. COPD classically encompasses several diffuse pulmonary diseases, including chronic asthma, bronchiectasis, chronic bronchitis, cystic fibrosis, and emphysema.

The American Thoracic Society defines COPD as the progres-

sive development of airflow limitation that is not fully reversible.

Most patients with COPD have components of both chronic bronchitis and emphysema. Chronic bronchitis is characterized by a recurrent and productive cough on most days for  $\geq$ 3 months in 2 consecutive years without another explanation. It is caused by obstruction of small airways. Emphysema results from the destruction of interalveolar septa characterized as having abnormal, permanent enlargement or air spaces distal to the terminal bronchiole without obvious fibrosis. It is caused by enlargement of air spaces and destruction of lung parenchyma, loss of lung elasticity, and closure of small airways.

The medical history should record consideration of fever, cough, dyspnea, chest pain, peripheral edema, and a change from baseline (chronic) symptoms. Inquire about the use of home oxygen and about current or past use of cigarettes.

The physical examination often reveals acute decompensation that is evident when the patient first enters the room, and there is often evidence of tachypnea, diaphoresis, or altered consciousness. Other findings such as the use of home oxygen, pursed-lip breath-

ing, use of accessory muscles, and periorbital cyanosis may indicate impending respiratory failure. The lung examination typically reveals decreased lung sounds with a prolonged expiratory phase, and symmetric wheezing. The extremities should be evaluated for edema and the presence of symmetric pulses.

COPD exacerbations can be safely treated on an outpatient basis with a combination of antibiotics, steroids (inhaled or systemic), and  $\beta_2$ -agonist inhalers. Antibiotics decrease the risk of clinical failure.

Immediate referral to an emergency department is necessary if any of the following are present:

- Respiratory distress
- An oxygen saturation of <90%
- Hemodynamic instability
- The possibility of an alternative diagnosis such as pulmonary embolism, pneumonia, pneumothorax, or myocardial infarction



# CLINICAL CHALLENGE: CASE 2

### Ankle Injury Sustained During an Amateur Football Game



#### Case

A 25-year-old man presents to the urgent care center after a backyard game of football in which he twisted his ankle. Because of alcohol intoxication, he cannot remember the mechanism of injury. He reports isolated right ankle pain and is unable to bear weight. On physical examination, he has pain with palpation of the ankle, but there are no gross signs of deformity. An ankle x-ray has already been done by the time you see the patient, and your findings for that x-ray are negative. As you continue the physical examination, however, you palpate the proximal fibula, and he feels pain, so you order a new x-ray.

View the image taken (**Figure 1**) and consider what your diagnosis would be.

#### **Differential Diagnoses**

- Patella dislocation
- Tibial plateau fracture
- Comminuted fracture of the tibial shaft
- Osteolytic lesion of the proximal fibula
- Spiral fracture pathognomonic of physical abuse

#### THE RESOLUTION



#### Diagnosis

Spiral fracture of the proximal fibula (Maisonneuve fracture; **Figure 2**).

#### Learnings

The proximal tibia and fibula are held together by a strong interosseous membrane. When there is a significant ankle injury, typically an internal rotation of the leg on a planted foot (causing *external* rotation of the foot), this membrane can be torn, with resultant spiral fracture of the proximal fibula, called a Maisonneuve fracture. It may be present even without an ankle fracture.

The mechanism is typically a sportsrelated injury, but these fractures can also occur from slipping on the ice, running, walking, a motor vehicle accident, or a fall from a height. These fractures are often overlooked because patients typically report pain at the ankle but not at the proximal fibula. If this area is not palpated, a Maisonneuve fracture may be missed. When there is pain with palpation at the proximal fibula, obtain a fibula x-ray to look for a Maisonneuve fracture. This is an unstable fracture and typically requires surgical repair.

Treatment in an urgent care center involves immobilization, use of crutches and avoidance of weight-bearing, and referral to an emergency department (ED) or an orthopedist. Pain medication should be administered.

Consider compartment syndrome when there are signs and symptoms of significant swelling, severe pain (often out of proportion to the pain level expected for the injury), possibly bruising, and paresthesias. Consider other injuries to the joints above and below, as typically is done with orthopedic injuries.

Make copies of the x-rays to send to the ED or orthopedist. If there is suspicion of a significant ankle injury, a stress ankle x-ray can be performed, but if the disposition is to the ED or orthopedics and the patient cannot bear weight, this will be unlikely to change treatment.

Even when there is not a history of pain at the proximal fibula, palpate this location in all ankle injuries to assess for a Maisonneuve fracture.



# CLINICAL CHALLENGE: CASE 3

# Generalized Abdominal Pain with Nausea



#### Case

A 67-year-old man presents, reporting constipation that has lasted 3 days. He has a constant, generalized dull abdominal pain that is intermittently worse, occurring in what he describes as waves. He has nausea and reports that he has vomited once. He reports no blood in the urine or stool, and no weight loss, dysuria or urinary frequency, or dizziness.

View the image taken (**Figure 1**) and consider what your diagnosis would be.

#### **Differential Diagnoses**

- Small bowel obstruction
- Osteolytic lesion
- Gastric malignancy
- Pulmonary infiltrate
- Calcified aortic abdominal aneurysm

#### **Physical Examination**

The patient's medical history reveals hypertension and that he underwent an appendectomy and tonsillectomy in the past. The patient is a nonsmoker and customarily drinks 2 glasses of wine per night. His temperature is 99.2°F (37.3°C), and he has a pulse rate of 104 beats/min, respirations of 16 breaths/min, a blood pressure of 112/78 mm Hg, and an oxygen saturation of 98%. He is alert and oriented, is in no acute distress, and is breathing normally.

The patient's lungs are clear to auscultation bilaterally. He has a regular heart rate and rhythm without murmur, rub, gallop. He has a well-healed midline abdominal scar, and his abdomen is not distended. He does have mild general-

#### THE RESOLUTION



ized abdominal discomfort with palpation, but there is no rigidity, rebound, or guarding.

#### **Medical History**

In patients with apparent constipation, inquire about the initial episode versus chronic constipation, frequency of stools, stool consistency, any need to strain, and pain with defecation. Patients with intermittent constipation and diarrhea may have irritable bowel syndrome. If there is pain associated with the complaint of constipation, ask about the location of pain, its onset (acute vs. gradual), its character (constant vs. intermittent), and any medications used for the pain and whether they have been used in the past

Concerning associated symptoms include weight loss, fever, blood in the stool or urine, and dizziness. A history of malignancy, radiotherapy, or abdominal surgeries may indicate a diagnosis of cancer or small bowel obstruction.

#### Testing

An acute abdominal series is performed. The urgent care provider interprets the findings as "within normal limits but full of stool."

#### Diagnosis

The patient has constipation (Figure 2).

#### Learnings

Constipation includes primary motor (neurologic) disorders, defecation disorders, and adverse effects of medications. Constipation is defined by the American Gastroenterological Association as difficult or infrequent passage of stool, hard stool, or a feeling of incomplete evacuation. Prevalence in adults ranges between 2% and 27%, with up to 74% of nursing-home residents using daily laxatives. Constipation-predominant irritable bowel syndrome is abdominal discomfort with two of these three symptoms: relief of pain after defecation, hard stools, or less-frequent stools.

#### Treatment

- Exclude secondary causes of constipation.
- Hydrate the patient.
- Instruct the patient to increase intake of dietary fiber.
- Consider the following medications for the patient:
  - Polyethylene glycol (MiraLAX)—osmotic
  - Docusate (Colace)—stool softener
  - Psyllium (Metamucil)—fiber
  - Magnesium hydroxide (milk of magnesia) saline cathartic
  - Mineral oil—lubricant
  - Lactulose—osmotic
  - Bisacodyl (Dulcolax)—stimulant cathartic

#### Indications for Transfer to an Emergency Department

- Uncertain diagnosis
- Intractable pain
- Unstable vital signs
- Concurrent abdominal pain in elderly patients
- Presence of red flag symptoms such as the following:
  - Blood in the stool
  - Vomiting
  - Weight loss
  - History of previous surgeries
  - A medical history of malignancy

Figure 1 is by James Heilman, MD, from https://commons.wikimedia.org/wiki/ File%3AConstipation.JPG. Figure 2 is modified from Figure 1. The original image is used with permission under a Creative Commons Attribution 3.0 Unported license, which allows adaptation of the image: https://creativecommons.org/licenses/by/3.0/deed.en.

# CLINICAL CHALLENGE: CASE 4

### Sudden-Onset Left-Sided Chest Pain



#### Case

A 32-year-old man with a history of pneumothorax presents to the urgent care after a sudden onset of left-sided chest pain that started 30 minutes earlier when he was inhaling while smoking a cigarette. He reports shortness of breath, dizziness, and diaphoresis.

View the image taken (**Figure 1**) and consider what your diagnosis would be.

#### **Physical Examination**

On examination, the patient had a temperature of 99.7°F (37.6°C), a pulse rate of 138 beats/min, a respiration rate of 40 breaths/min, and a blood pressure of 72/43 mm Hg. He was alert and oriented, sweaty, panicky, and tachypneic. On examination of his lungs, he had decreased lung sounds on the left and clear on the right. He had tachycardia, and his heart had a regular rhythm, without murmur, rub, or gallop. His abdomen

was slightly distended, soft, and nontender, without rigidity, rebound, or guarding. He was profusely diaphoretic. He had no swelling or pain in his extremities and no calf muscle pain, and his peripheral pulses were weak and thready.

#### **Differential Diagnoses**

- Pneumonia
- Hemothorax
- Lung cancer
- Cardiac tamponade
- Free air under the diaphragm

#### Tests

Testing for uncomplicated cases involves a chest x-ray performed during inspiration. The conventional wisdom is that an x-ray during forced expiration may show the pneumothorax, but one study found equal rates of visualization for inspiratory

#### THE RESOLUTION



films and for expiratory films. Patients with chronic obstructive pulmonary disease (COPD) and bullous changes may mistakenly be diagnosed with pneumothorax. Careful review of the chest x-ray and comparison with previous x-rays is important to prevent unnecessary transfer to an emergency department (ED) or placement of a tube thoracostomy, which might worsen the patient's condition.

A chest x-ray (**Figure 2**) was performed, which revealed a tension pneumothorax. Note the compressed left lung, the lack of lung markings on the left, deviation of the trachea to the opposite (right) side, and deep sulcus (costophrenic angle) on the left.

#### Diagnosis

The patient has tension pneumothorax, which is a medical emergency.

#### Learnings

A pneumothorax can occur from trauma or spontaneously. A primary spontaneous pneumothorax occurs in patients without lung disease, whereas a secondary spontaneous pneumothorax occurs in patients with a history of known lung disease such as COPD or a history of previous pneumothorax.

The visceral pleura (outer lining of the lung) approximates against the parietal pleura (the inner lining of the thoracic cavity). When air enters the space between the visceral and parietal pleura, it will be evident on chest x-ray as a dark, air-filled cavity; that is a pneumothorax. The most common underlying causes of spontaneous pneumothorax are COPD and tuberculosis. A proposed mechanism of spontaneous pneumothorax is rupture of subpleural bullae into the pleural space (the space between the visceral and parietal pleura).

Patients with pneumothorax usually report chest pain, shortness of breath, or both. The acuity of onset in nontraumatic pneumothorax may be rapid, during an episode of negative pressure within the intrathoracic cavity, as can occur with inhalation of a cigarette or when inhaling from other types of smoking devices, or it may be gradual with a smaller pneumothorax. Patients typically localize the site of pain to the affected side.

#### Treatment

- For patients with spontaneous pneumothorax who are hemodynamically stable, observation with a repeat chest x-ray the next day is an appropriate therapy. This should be coordinated with a thoracic surgeon or pulmonologist.
- For patients with a large pneumothorax or one causing symptoms of shortness of breath or hemodynamic instability, the patient should be transferred to an ED for decompression, either with a valve or chest tube.
- If there is evidence of tension, emergency medical services (EMS) should be promptly activated.
- If the patient is hemodynamically unstable and the wait for EMS will be prolonged, needle decompression should be performed in the second intercostal space, midclavicular line, with an 18-gauge catheter placed *over* the rib. When a rush of air is obtained, remove the needle and leave the catheter in place.

#### Indications for Transfer to an Emergency Department

- With a small, nonacute pneumothorax in the presence of hemodynamic stability, the patient can be transferred by a private vehicle.
- If the patient is hemodynamically unstable, as evidenced by significant tachycardia, tachypnea, and hypotension, then transfer should be done by EMS.
- With signs of tension pneumothorax, the patient should be decompressed before transfer. ■

Figure 1 from Brims F. Tension pneumothorax—an alternative view [2014 August 22]. Life in the Fast Lane [blog]. Available from: http://lifeinthefastlane.com/tension-pneumothorax-an-alternative-view/. Figure 2 is a modified version of Figure 1. (Used with permission under a Attribution-NonCommercial-ShareAlike 4.0 International license: http://creativecommons.org/licenses/by-nc-sa/4.0/.)



## 2016 *Current Procedural Terminology* Changes Pertinent to Urgent Care

DAVID STERN, MD, CPC

his month's column is an update on recent changes to *Current Procedural Terminology* (CPT) codes. Changes for 2016 are fairly minimal.

#### **Evaluation and Management**

There were two revisions and two additions to the "Evaluation and Management" section. Add-on codes **99354**, "Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour," and **99355**, "... each additional 30 minutes," were revised to add the term *psychotherapy* in the description.

Some good news in this section is that there are now two new add-on codes that allow billing when clinical staff provide prolonged care:

- 99415: "Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or other outpatient setting, direct patient contact with physician supervision; first hour"
- **99416:** "... each additional 30 minutes"

The payors will have their own rules for billing and payment, but these codes do appear on the Medicare Physicians Fee Schedule<sup>1</sup> (MPFS), at nominal rates of around \$9.00 for code 99415 and \$0.80 for code 99416, depending on your Medicare jurisdiction.



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.urgentcareconsultant.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.

#### Cerumen Removal

The one addition to the "Auditory System" section has been long overdue. Code **69209**, "Removal of impacted cerumen using irrigation/lavage, unilateral," has been added. This code cannot be reported with code **69210** for the same ear, and it still must be reported only when the cerumen is impacted. This code will be reimbursed by the Centers for Medicare & Medicaid Services at rates of \$10 to \$15, depending on what Medicare jurisdiction you are in, according to the MPFS. It has a professional component/technical component (PC/TC) indicator code of 5, which identifies codes that describe services covered incident to a physician's service when provided by auxiliary personnel employed by the physician and working under the physician's direct personal supervision.

#### Radiology

The "Radiology" section and guidelines have been updated, and codes were added to specify the number of views taken. The written report has been further defined as being handwritten or electronic. Many revisions have been made where the term *images* replaces the term *film*. There were 14 revisions, 21 additions, and 25 deletions.

Code **72080**, "Radiologic examination spine; thoracolumbar junction, minimum of 2 views," was revised. Code 72090 was deleted, and we are directed to use new codes instead:

- 72081: "Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view"
- **72082:** "... 2 or 3 views"
- **72083:** "... 4 or 5 views"
- **72084:** "... minimum of 6 views"

Several changes were made in the "Lower Extremities" section:

Code 73500 was deleted and replaced with new code 'https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Physician-FeeSched/index.html

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#### CODING Q&A

**73501**: "Radiologic examination, hip, unilateral, with pelvis when performed; 1 view."

- Code 73510 was deleted and replaced with new codes 73502, "Radiologic examination, hip, unilateral, with pelvis when performed, 2–3 views," and 73503, "Radiologic examination, hip, unilateral, with pelvis when performed, minimum of 4 views."
- Code 73520 was deleted and replaced with new codes 73521, "Radiologic examination hips, bilateral, with pelvis when performed, 2 views"; 73522, "Radiologic examination hips, bilateral, with pelvis when performed, 3–4 views"; and 73523, "Radiologic examination hips, bilateral, with pelvis when performed, minimum of 5 views."
- Codes 73530 ("Radiologic examination, hip, during operative procedure") and 73540 ("Radiologic examination, pelvis and hips, infant or child. Min[imum] of 2 views") were deleted, and we are now directed to new codes 73501, 73502, and 73503, as already described here.
- Code 73550 was deleted and replaced with new codes 73551, "Radiologic examination, femur; 1 view," and 73552, "Radiologic examination, femur, minimum 2 views."

#### Vaccines

The "Medicine" section had 50 revisions, 14 additions, and 19 deletions. Most of these were in the "Vaccines/Toxoids" section. The use of the codes did not change, but the vaccine and toxoid codes were revised to include the vaccine or toxoid abbreviation, and the number of doses. For example, code **90655**, "Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use," was revised to add (*IIV3*) to the code.

New codes are as follows:

- 90697: "Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenza type b PRP-OMP [Neisseria meningitidis outermembrane protein] conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use"
- 90620: "Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB), 2 dose schedule, for intramuscular use"
- 90621: "Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB), 3 dose schedule, for intramuscular use"
- 90625: "Cholera vaccine, live, adult dosage, 1 dose schedule, for oral use"

Codes 90645 and 90646 were deleted.

#### Nebulizer Administration

In the "Pulmonary" section, code **94640**, better known as a nebulizer treatment, was revised to include therapeutic purposes and sputum induction.

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### DEVELOPING DATA

ata from the 2014 Urgent Care Chart Survey of 1,778,075 blinded visits by patients to more than 800 different urgent care clinics, conducted by the *Journal of Urgent Care Medicine*, reveal that for 2014, the top three diagnosis codes at U.S. urgent care centers involved, in descending order:

- Wounds,15.9%
- Sinusitis, 11.4%
- Respiratory conditions, other, 11.2%

The bottom three diagnosis codes involved, in descending order: • Influenza, 1.6%

- Tonsillitis, 1.5%
- Gynecologic issues, 1.5%

The survey's methodology and data abstraction forms were initially designed in 2008 by researcher Robin M. Weinick, PhD, then an assistant professor at Harvard Medical School and a senior scientist at the Institute for Health Policy at Massachusetts General Hospital, and now associate director of RAND Health.



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