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Urgent Care Evaluation of **Pneumonia**

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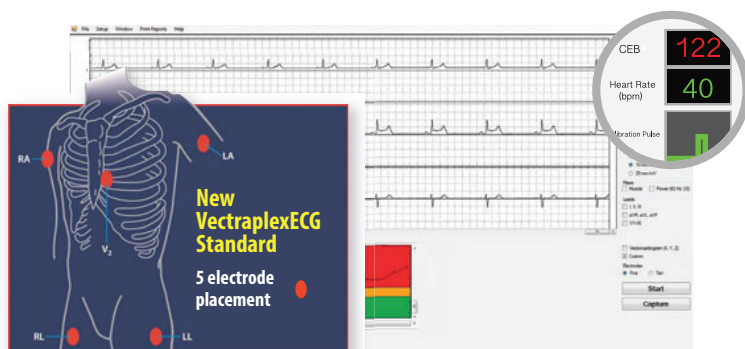
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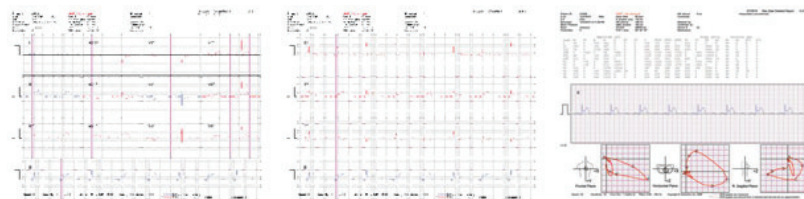


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LETTER FROM THE EDITOR-IN-CHIEF

Clinical Practice Guidelines: Holy Grail or Holy %&\$#!@?



Clinical practice guidelines have been gaining interest, along with a little ire, over the last decade. Fueled by Medicare reform, the Affordable Care Act, Meaningful Use, and value-based reimbursement models, clinical practice guideline development has been envisioned as a critical way to achieve consistent care quality in a cost-effective and evidence-based way.

This is nothing new of course. I remember memorizing the U.S. Preventive Services Task Force Screening Guidelines in residency in preparation for boards. I recall with fascination the lectures in medical school describing how screening guidelines are developed, sacrificing individual opportunity for the public good, and some fairly arbitrary cost-of-care thresholds.

Imperfect by nature and rather socialist in their ideal, practice guidelines are once again exerting their influence in an utterly exhausted healthcare economy grasping for sustainable solutions. Some physicians have expressed grief over the “cookie cutter” medicine that these seem to promote. The same providers bemoan loss of control and professional intrusion. And they do have a point. But the train is out of the station on this issue and technology will almost certainly have it picking up speed. Thus, it is incumbent on us to seize control of the process and determine our own “best practice” standard.

The Institute of Medicine (IOM) defines clinical practice guidelines as “statements that include recommendations, intended to optimize patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.”

Most specialty societies develop practice guidelines on behalf of their members and practicing providers at large. While these efforts vary in how they adopt the IOM standards, they are all directionally correct: Creating a reasonable best practice standard that applies to “most,” though not all, patients with specific conditions and presentations.

There are so many practice guidelines available, the federal government deemed it necessary to create the National Guideline Clearinghouse just to keep track of them all. And, because each needs to withstand the scrutiny of the scientific community, they are invariably bloated with data and detail that can blur their intended purpose of mass appeal and application.

In an effort to track and apply relevant practice guidelines for urgent care, I regularly scan and monitor the specialty societies for conditions and presentations that we see with regularity in our setting. From the Infectious Diseases Society of America and the National Heart, Lung, and Blood Institute (NHLBI) to the American Academy of Pediatrics and American College of Emergency Physicians, there is no shortage of recommendations to review. Every few months there is a new guideline released or old guideline revised with relevance to urgent care: bronchiolitis, gonorrhea, urinary tract infections, and community-acquired pneumonia, to name just a few.

What I have found through this effort is encouraging, but more work needs to be done. There are two recurring challenges:

1. “TMI” (too much information): The NHLBI asthma guidelines are 440 pages long. The 74-page “Summary Report” seems slender by comparison. Filtering these guidelines for practical advice is a tall task for any practitioner.
2. Relevance: Clinical guidelines are only valuable if they are relevant to your practice. For example, best practice in urgent care is necessarily different than that of primary care. The availability of testing and treatment varies in each of these settings, as do the follow-up and disposition decisions.

So, for these efforts to be meaningful to urgent care providers, we must spend time interpreting and filtering the existing guidelines. This is a big project, but the good news is that we do not need to reinvent the guidelines themselves. A little bit of reorientation for our setting, a little trim and an edit here and there, and we will have a nice library for urgent care practice.

If we overthink or overreach on this, we will be left holding the bag. This is a real opportunity for defining our own best practice, before someone else does it for us. Stay tuned....■

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



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VOLUME 11, NUMBER 5



CLINICAL

11 Urgent Care Evaluation of Pneumonia

Cold, inclement weather marks the high season for community-acquired pneumonia. Vigilance for its risk factors needs to be acute if you're going to help protect the most vulnerable patients.

Glenn Harnett, MD and Jill Sellers, BSPHarm, PharmD

HEALTH LAW AND COMPLIANCE

24 Complying with the Stark Law Across Multiple Center Locations



An exception built into the Stark law allows urgent care centers to offer a wider range of services in-house than you might think. Be careful not to stray too far afield if you have multiple locations, though.

Ron Lebow

PRACTICE MANAGEMENT

30 Enhancing Urgent Care Profits with Travel Medicine



Adding travel medicine to the menu of services you offer might be a relatively simple way to enrich your bottom line and draw in new patients—provided you know the proper steps to follow.

Alan A. Ayers, MBA, MAcc

CASE REPORT

38 A Rare but Insidious Cause of Abdominal Pain



Sometimes, a diagnosis that's not even on the radar is the right one—and missing it could mean dire consequences for your patient.

Anisha Turner, MD

IN THE NEXT ISSUE OF JUCM

Who's the boss? The answer may seem black and white if you're looking at your organizational chart, but the chain of command can either drag your urgent care center down or help anchor a trustworthy staff securely in place. It all depends on whether top management truly supports or negates supervisors' efforts. Read how in a new article by Alan A. Ayers, MBA, MAcc next month.

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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 health-care 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 regarding the clinical and business best-practices for running an urgent care center.

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As **Lee Resnick, MD, FAAFP** asserts in the opening line of his column this month, “Clinical practice guidelines have been gaining interest, along with a little ire, over the last decade.” The point he raises isn’t whether you personally view them as either a “Holy Grail” or “holy %&\$#!@,” however; it’s more an acknowledgment that, like it or not, this the Age of Guidelines and urgent care has a great opportunity to exert influence over which guidelines are implemented in this setting—and how they’re implemented. As Dr. Resnick points out, it’s not going to happen automatically. To understand more, read his column.

Less controversial—but no less important in urgent care and all clinical settings—is evaluation and treatment of patients with pneumonia. We’re in the midst of the typical peak season for community-acquired pneumonia, specifically, so it’s the perfect time to evaluate what the key risk factors are, what pathogens are most likely to appear, and, inevitably, “What next?” for patients who may be most vulnerable and at greatest risk for significant morbidity and mortality.

It’s a subject **Glenn Harnett, MD** and **Jill Sellers, BSPHarm, PharmD** are ideally suited to address—and they do so in Urgent Care Evaluation



of Pneumonia, starting on page 11. Dr. Harnett is principal of the Resistance Consulting Group in Mountain Brook, AL, which provides consulting services to leading urgent care organizations, pharmaceutical, and laboratory industries, investment groups, and antibiotic stewardship programs. Dr. Sellers is executive director of the medical education company Medavera, Inc. in Springfield, MO.



On the other end of the “common/uncommon” spectrum is Bouveret syndrome, a rare type of gallstone ileus. The danger is that some symptoms of this potentially deadly condition—those the patient would probably be most likely to report—could easily be attributed to several, fairly benign etiologies. A Rare but Insidious Cause of Abdominal Pain (page 38), by **Anisha Turner, MD**, a third-year resident in the Emergency Medicine/Family Medicine program at Louisiana State University Medical Center – Shreveport reminds us that it’s important to take symptoms whose source is hard to pinpoint at face value, and to not presume the most common answer is the right one.



Similarly, residents of the U.S. take for granted that the water they drink won’t make them sick, and that disease prevention programs will do what they’re intended to do most of the time. They can’t afford to do that when traveling abroad, however. You can help them travel the world in good health by offering high-level travel medicine services—all the while improving the health of your bottom line. **Alan Ayers, MBA, MAcc**, vice president of strategic initiatives for Practice Celocity, LLC and practice management editor of *The Journal of Urgent Care Medicine*, explains how in Enhancing Urgent Care Profits with Travel Medicine on page 30.

Locations also figure into this month’s Health Law & Compliance feature, albeit on a much smaller scale. Specifically, if your urgent care business has multiple locations then it’s extremely important—as in, *legally*—that you understand the ins and outs of the Stark law as explained by **Ron Lebow**, who serves as counsel with Michelman & Robinson’s Health Care Department in New York City. Complying with the Stark Law Across Multiple Locations begins on page 24.



Also in this issue:

Sean M. McNeeley, MD highlights new urgent care-relevant literature about how long children really do need to be held back from their regular activities after experiencing a concussion; whether shortening a course of antimicrobials could help mitigate development of resistant organisms in otitis media; use of alpha blockers in treating patients with large kidney stones; how it is that patients who are allergic to penicillin have poorer prognoses in some infections; how you can prepare for the next time an opioid addict turns up in your office; and more.

In *Coding Q & A*, **David E. Stern, MD, CPC**, offers tips on how to make sure your urgent care center is compensated fully when physicians, nurses, technicians—any clinician—apply a cast or a splint.

Finally, *Developing Data* reveals data comparing the seasonality of sexually transmitted infections with overall urgent care visits. (The numbers may surprise you.) ■

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CONTINUING MEDICAL EDUCATION

Release Date: February 1, 2017
Expiration Date: January 31, 2018

Target Audience

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

Learning Objectives

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

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CONTINUING MEDICAL EDUCATION

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

Urgent Care Evaluation of Pneumonia (p. 11)

1. Which of the following may be present with pneumonia?

- a. Fever
- b. Cough
- c. Sputum production
- d. Shortness of breath
- e. All of the above

2. Which of the following are true?

- a. Most cases of pneumonia are caused by pneumocystis
- b. Pneumonia is caused by inflammation in the mainstem bronchus
- c. In the United States, the annual incidence of CAP is approximately 5 million people, with almost 75% of these cases being treated on an outpatient basis
- d. It is not important to check a pulse oximetry reading in patients suspected of having pneumonia
- e. Patients recently admitted to a healthcare facility should be prescribed the exact same antibiotic as patients who have community-acquired pneumonia

3. An elderly patient with a diagnosis of pneumonia and a very low oxygen saturation should be admitted to the hospital for antibiotics.

- a. True
- b. False

Enhancing Urgent Care Profits with Travel Medicine (p. 30)

1. Based on the article, which of the following is/are reason(s) to provide ancillary services like travel medicine?

- a. To offset the rise of business costs by adding additional revenue streams
- b. To raise a center's public awareness by attracting new patients
- c. To reduce the tax obligations of limited liability corporations
- d. A and B
- e. None of the above

2. Which of the following are primary markets for travel medicine?

- a. Evangelical churches, particularly those with heavy utilization for short-term mission trips

- b. Individual travelers, primarily retirees
- c. Career-related travelers, working for airlines or multinational corporations
- d. B and C
- e. All of the above

3. Which of the following is the workflow for a travel medicine service?

- a. Call for appointment, conduct pretravel physical, issue travel kit, administer vaccinations, conduct post-travel physical
- b. Call for appointment, conduct pretravel physical, conduct post-travel physical
- c. Call for appointment, issue travel kit, administer vaccinations, conduct post-travel physical
- d. Call for appointment, conduct pretravel physical, issue travel kit, conduct post-travel physical
- e. Call for appointment, administer vaccinations, issue travel kit

A Rare but Insidious Cause of Abdominal Pain (p. 38)

1. In Bouveret syndrome, which are true about lab results?

- a. The WBC count will always be elevated
- b. Potassium will always be low
- c. The lactate will always be elevated
- d. The hemoglobin will always be low
- e. Lab findings are nonspecific and may be normal

2. CT is the imaging modality of choice in Bouveret syndrome, with an overall sensitivity of:

- a. 10%
- b. 15%
- c. 20%
- d. 25%
- e. 93%

3. Bouveret syndrome is caused by the passage of a large gallstone through a biliodigestive fistula and into the duodenum or pylorus, resulting in gastric outlet obstruction.

- a. True
- b. False

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Urgent Care: Bringing Our Value Proposition to the Payer Community

■ LAUREL STOIMENOFF, PT, CHC

UCAOA's most recent Benchmarking Survey data indicated the median number of patient visits per day in an urgent care center was 32, down slightly from the prior year; however, based on the current database of urgent care centers in the United States, this would translate to urgent care centers caring for nearly 85 million visits per year.

The Centers for Disease Control and Prevention's 2012 National Ambulatory Medical Care Survey¹ quantifies outpatient physician office visits as follows: total visits, 928.6 million; visits/100 persons, 300.8; percentage of visits made to primary care physicians, 54.6%. Therefore, assuming ambulatory care visits remained consistent with activity reported in 2012 and primary care visits represent 54.6% of all visits (or 507 million), urgent care would represent over 16% of all primary care visits and over 9% of all outpatient physician visits.

Statistically, it would seem urgent care has earned its seat at the table as we discuss reform.

Recent studies conducted in Massachusetts and Colorado concluded that 40% of emergency department visits were for nonemergent conditions that could be more appropriately and cost-effectively cared for in less acute settings, including urgent care centers. One illustrated that ED visits per 1,000 residents were reduced by 30%² in markets where urgent care centers or retail clinics had a presence.

All this should be cause for great optimism, yet our phones ring with members pleading for help. The contracting and credentialing process has become so protracted that it threatens the viability of many start-ups, particularly if they did not have the foresight to begin the process early in their development. Networks are being narrowed in many areas, principally by denying access to new entrants. Contract language specific to urgent care centers now often dictates staffing models and hours of operation, and places limitations on wellness and fol-

low-up care despite the fact that many of our patients do not have a primary care provider.

These new rules of participation extend far beyond those of state medical boards charged with public protection. Established urgent care organizations may be exhaling a sigh of relief that this isn't their problem—but what happens when that contract comes up for renewal?

We *all* have a responsibility to demonstrate our worth. While UCAOA will continue to have dialogue nationally, most payer negotiations are at the state or regional level. So, what can you do?

- Be **relentless** in demonstrating how you are innovating and how your strategies align with the payer's.
- **Integrate** with the greater healthcare community. If the patient has a PCP, work to establish reasonable communication methods that ultimately reduce costs, eliminate redundant testing, and improve health.
- Demonstrate how your center supports **ED diversion strategies**.
- **Provide data.** Urgent care can provide information payers don't have access to, or simply haven't collected. How many of their members say they do not have a PCP? If they have a PCP, was he or she accessible when care was needed? How many sought care after 5:00 PM during the week or on weekends—and what savings from an ED visit were therefore realized? How many of their members received radiography, lab, or other services, often delivered outside of the office visit as part of the payer's global fee?
- Use the data to **educate** payers on the value your centers bring and **seek opportunities for improvement**.
- **Share** your successes and best practices, as well as barriers, with UCAOA's Payer Relations Committee.

Our voice deserves to be heard—and our continued growth depends on us speaking out. ■



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

References

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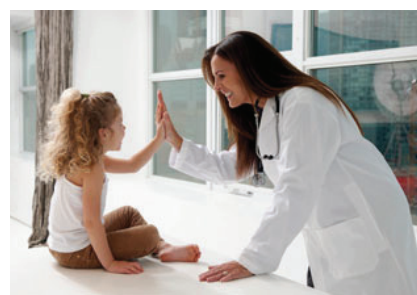
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[†]Respiratory syncytial virus.

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Urgent Care Evaluation of Pneumonia

Urgent message: The incidence of community-acquired pneumonia (CAP) is seasonal in nature, with a peak during the winter months and a trough in the summer months. In the urgent care setting, primary concerns are risk factors for CAP, as well as current treatment and testing guidelines.

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Overview

Pneumonia is an acute alveolar lung infection that presents with infiltrates upon chest imaging and is often accompanied by fever, cough, sputum production, shortness of breath, and physical findings of consolidation and elevated white blood counts. CAP is defined as pneumonia not acquired in a hospital, hospital environment, or a long-term care facility and includes pneumonia caused by bacterial, viral, fungal, and zoonotic organisms. The term community-acquired bacterial pneumonia (CABP) refers to all cases of CAP that are specifically caused by bacteria.

The most common CAP bacterial pathogens include *Streptococcus pneumoniae* (60% of total U.S. incidence), *Haemophilus influenza* and *Moraxella catarrhalis*, which account for approximately 85% of the total U.S. incidence of CAP.¹ Atypical bacterial pathogens, which do not have a cell wall and cannot be gram stained or cultivated, such as *Mycoplasma pneumoniae*, *Legionella*, and *Chlamydia pneumoniae*, account for the majority of the remaining cases of CAP. Ambulatory CAP (also known as walking pneumonia) is most common among young adults and is usually due to atypical CAP pathogens.

It is estimated that the U.S. population will increase 38% by 2040; pneumococcal pneumonia hospitalization rates are expected to double in that same time period. Population growth is fastest in older age groups who also experience the highest rates of CAP despite the increase in pneumococcal vaccination rates and improved vaccines.²



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Viral causes of pneumonia include rhinovirus, adenovirus, influenza A and B, parainfluenza, and respiratory syncytial virus. A 2015 study published in *The New England Journal of Medicine*, the Centers for Disease Control and Prevention (CDC) Etiology of Pneumonia in the Community (EPIC) Study, found a higher incidence of viral pneumonia than in previous studies conducted in the 1990s. This may be due to the more sensitive molecular and antigen-based laboratory diagnostic tests currently available.³ Common fungal causes of pneumonia include blastomycosis, coccidioidomycosis, and histoplasmosis.

Dr. Harnett is principal of the Resistance Consulting Group in Mountain Brook, AL. He has received honoraria and/or consulting fees from Alere, Cembra, and UCAOA, and the CME Program has determined there is no conflict of interest. **Dr. Sellers** is executive director of the medical education company Medavera, Inc. in Springfield, MO. She has no relevant financial relationships with any commercial interests.

Table 1. Risk Factors for Community-Acquired Pneumonia

- Lung disease (asthma, chronic obstructive pulmonary disease, cystic fibrosis, bronchiectasis)
- Diabetes
- Heart failure
- Chronic renal disease
- Chronic hepatic disease
- Sickle cell anemia
- Compromised immune system
- Decreased cough reflex or swallowing problems
- Influenza
- Smoking
- Alcohol abuse
- Homelessness
- Malnourished
- Recent cold or flu
- Chemical, pollutants, or toxic fume exposure

Table 2. CAP Pathogens Identified by Sputum Color

Pathogen	Sputum Color
<i>Streptococcus pneumoniae</i>	Rust
<i>Pseudomonas</i> <i>Haemophilus</i> Pneumococcal species	Green
<i>Klebsiella</i> species	Red
Anaerobic species*	Multicolored
*Sputum is often foul smelling and bad tasting	

In addition, it is important that urgent care physicians are aware of the correlation between pneumonia and influenza, as the two diseases have overlapping symptom profiles. Influenza incidence has a seasonality comparable to CAP and can be a predisposing factor for acquiring pneumonia, especially in older adults and those with comorbid conditions. Urgent care physicians should note the potentially deadly correlation between pneumonia and influenza. Pneumonia is the most common complication of influenza, and leads to significant morbidity and mortality.⁴

Pneumonia Risk Factors

The two most important risk factors for patients developing CAP are extremes of age—children who are ≤ 2 years old and adults who are ≥ 65 years old. Other risk factors are listed in **Table 1**.

Risk factors need to be addressed in a thorough his-

tory of any patient with respiratory or other complaints consistent with pneumonia. Doing so can help drive appropriate testing, disposition, and treatment decisions. Take special care to be cognizant of social history, as social risk factors can play a large role in the appropriate care of patients with CAP. Smokers, alcoholics, drug users, the homeless, and those exposed to occupational hazards, as well as patients with other social issues that inhibit their ability to care for themselves, all need to be identified in order to make appropriate clinical decisions, especially regarding patient disposition.

Epidemiology and Incidence

Annual incidence of CAP in the United States is approximately 5 million people, with almost 75% of these cases being treated on an outpatient basis. Pneumonia is the second-leading cause of hospitalization and the eighth-leading cause of death, claiming more lives than breast or prostate cancer.^{5,6} The associated costs of pneumonia exceed \$17 billion each year. Pneumonia is responsible for approximately 3.2 million emergency department visits, 2.6 million hospitalizations, and 4.5 million ambulatory care visits. The Centers for Disease Control and Prevention (CDC) has stated that drug-resistant *S pneumoniae* (DRSP) is responsible for 1.2 million CAP cases per year and 19,000 excess hospitalizations in the U.S.⁷

Clinical Presentation

The incubation period for CAP is usually 1-3 days. Symptoms may include abrupt onset of fever and chills or rigors, a productive cough, dyspnea, tachypnea, hypoxia, tachycardia, malaise, and weakness. A sputum-producing cough is the most common presenting symptom, and the color/character of the sputum can assist the clinician in determining the offending pathogen (**Table 2**). The diagnosis of CAP in elderly patients can be more difficult, as they often do not report classic symptoms but rather present with weakness, mental status changes, or functional decline. Be sure that elderly and other high-risk patients are routinely questioned regarding pneumococcal and influenza vaccination status, because failure to vaccinate increases the risk of CAP.

History and Physical Exam

There are many clues to be gleaned from the history of present illness, as well as the social and past medical histories and physical exam (**Table 3** and **Table 4**). For example, patients with concurrent chest pain or shortness of breath (SOB) should have other potential life-threatening cardiologic and pulmonary causes considered as well.

The history may help identify likely pathogens and patients most at risk for CAP. In addition to asking about the classic findings of cough, shortness of breath, fever/chills, and exposure to ill persons, inquire about patients at risk for pneumonia. Knowledge of comorbid conditions such as HIV/AIDS, cancer/chemotherapy, immunosuppressive conditions, COPD, and chronic lung disease may help to localize patients at risk and tailor therapy to organisms specific to patients with these conditions. The social history may reveal recent travel, potential occupational exposures, smoking, alcoholism, and behavior such as IV drug use. Chronic alcoholics and patients with swallowing difficulties are more likely to have aspiration pneumonia associated with gram-negative (*Klebsiella pneumoniae*, *acinetobacter*) and anaerobic pathogens. Immunocompromised patients, such as those with HIV, may present with less common pathogens. PCP pneumonia is still the most common opportunistic infection in people with HIV/AIDS. Those with a CD4 cell count <200 are at highest risk.

The physical exam should focus first on abnormal vital signs such as tachypnea, tachycardia, or low pulse oximetry. The general appearance of the patient may reveal clues such as confusion, use of accessory muscles/nasal flaring in an infant, or intermittent coughing or a whoop (pertussis). Lung findings may include adventitious breath sounds such as crackles, rhonchi, or wheezing. Examine the skin for track marks (possibly indicating IV drug use), the mouth for oral hairy leukoplakias (pearly, vertically oriented lines on the tongue which is associated with AIDS), and clubbing or cyanosis suggestive of COPD.

Vaccination

Most pneumococci are encapsulated with complex capsular polysaccharides. These polysaccharides are antigenic and form the basis for classifying pneumococci by serotypes. There were 92 serotypes documented as of 2011. In recent years, these polysaccharides have been used to develop effective pneumococcal vaccines. Pneumococci are common asymptomatic inhabitants of the nasopharynx.

Persons who are at increased risk for CAP, as described previously, should receive pneumococcal vaccines as recommended by the CDC.

Pneumococcal conjugate vaccine PCV13 (PREVNAR 13) is recommended for all children <5 years old, all adults ≥65 years, and people ≥6 years with certain risk factors. Pneumococcal polysaccharide vaccine PPSV23 (Pneumovax) is recommended for all adults ≥65 years

Table 3. Physical Examination Findings in CAP

- Adventitious breath sounds (rales/crackles, rhonchi, wheezes)
- Decreased intensity of breath sounds
- Egophony
- Whispering pectoriloquy
- Dullness to percussion
- Tracheal deviation
- Lymphadenopathy
- Pleural friction rub
- Bradycardia^a
- Periodontal disease^b
- Bullous myringitis^c
- Cutaneous nodules^d
- Decreased gag reflex^e

^aMay indicate *Legionella* etiology

^bMay indicate an anaerobic and/or polymicrobial infection

^cMay indicate a *Mycoplasma pneumoniae* infection

^dMay indicate a *Nocardia* infection

^eSuggests risk for aspiration pneumonia

Table 4. Differential Diagnosis in CAP

- Asthma
- Atelectasis
- Bronchiectasis
- Bronchiolitis
- Bronchitis
- Chronic obstructive pulmonary disease
- Foreign body aspiration
- Fungal pneumonia
- Lung abscess
- *Pneumocystis jiroveci pneumonia*
- Respiratory failure
- Viral pneumonia
- Neoplasm

of age. People age 2–64 years old who are at high risk of pneumococcal disease should also receive PPSV23. The timing of vaccination varies by age and the presence of comorbid/high-risk conditions. Currently, only 63% of adults >65 years are properly vaccinated and less than 25% of adults in other high risk groups are vaccinated.⁷ Urgent care clinicians play an increasingly important role in their communities, and should encourage pneumococcal vaccination when indicated.

Radiography

Though management may be based on a clinical diagnosis, the IDSA guidelines state that chest x-rays are con-

Table 5. Clinical Indications for More Extensive Diagnostic Testing⁸

Indication	Blood culture	Sputum culture	<i>Legionella</i> UAT	Pneumococcal UAT	Other
Intensive care unit admission	■	■	■	■	■ ^a
Failure of outpatient antibiotic therapy		■	■	■	
Cavitary infiltrates	■	■		■	■ ^b
Leukopenia	■			■	
Active alcohol abuse	■	■	■	■	
Chronic severe liver disease	■			■	
Severe obstructive/structural lung disease		■			
Asplenia (anatomic or functional)	■			■	
Recent travel (within past 2 weeks)			■		■ ^c
Positive <i>Legionella</i> UAT test		■ ^d	NA		
Positive pneumococcal UAT test		■		NA	
Pleural effusion	■	■	■	■	■ ^e
NA = not applicable; UAT = urinary antigen test ^a Endotracheal aspirate if intubated, possibly bronchoscopy or nonbronchoscopic bronchoalveolar lavage ^b Fungal and tuberculosis cultures ^c See Table 8 for details ^d Special media for <i>Legionella</i> ^e Thoracentesis and pleural fluid cultures					

sidered the standard method for diagnosing the presence of pneumonia; the presence of an infiltrate confirms the diagnosis.⁸ Despite that, it must be noted that the accuracy of plain chest radiography for detecting pneumonia is dependent on several variables including the experience of the interpreting clinician, the stage of infection (initial stage more difficult to detect), dehydration, and confounding factors such as concurrent congestive heart failure and chronic lung disease. Recent prospective and retrospective studies have shown that in patients admitted with a clinical diagnosis of CAP, the initial chest radiograph lacks sensitivity and may not demonstrate an infiltrate in 11%-47% of patients.⁹ Even with the absence of radiologic findings, clinicians should consider empiric antibiotic treatment if there remains a high clinical suspicion for CAP. Clinical variables that should raise suspicion for the diagnosis of pneumonia include: age >65 years, moderate to severe comorbid conditions, and current smokers. Historical and physical exam findings that increase the suspicion of pneumonia include fever, chills, sputum production,

orthopnea, altered mental status, cyanosis, dullness on percussion, crackles, abnormal vital signs (ie, HR>100 beats/min, RR>20 breaths/min or T>100.4 degrees F), and room air O₂ sat <92%. Another study revealed that patients with and without radiographic confirmation of pneumonia had similar rates of positive sputum cultures and blood cultures during hospitalization. The authors concluded that the absence of radiographic findings should not supersede clinical judgment and empiric treatments in these patients.¹⁰

Laboratory

Laboratory tests may include a serum chemistry panel and complete blood count (CBC) with differential. CBC results may reveal leukocytosis with a left shift in a bacterial infection, yet its absence (particularly in elderly patients) should not cause the clinician to discount the possibility of a bacterial infection, as leukopenia may be a clinical sign of impending sepsis.

Other options include pneumococcal and *Legionella* urine antigen testing. Per the most recent IDSA guide-

lines: “Patients with CAP should be investigated for specific pathogens that would significantly alter standard (empirical) management decisions, when the presence of such pathogens is suspected on the basis of clinical and epidemiologic clues. (Strong recommendation; level II evidence.)”⁸ Specifically, IDSA recommends *S pneumoniae* urine antigen testing for patients with the following clinical indications: outpatient antibiotic therapy failure, leukopenia, active alcohol abuse, severe liver disease, asplenia, pleural effusion, and intensive care unit admission (Table 5). The IDSA guidelines recommend *Legionella* urine antigen testing only for the following indications: failed outpatient antibiotic therapy for CAP, require intensive care admission, immunocompromised, exposure to an outbreak of Legionnaires’ disease, or travel history within 2 weeks before onset of illness. Further study and clinical experience is still needed to clarify the clinical value of newer advanced molecular testing and biological markers, especially in the urgent care environment.

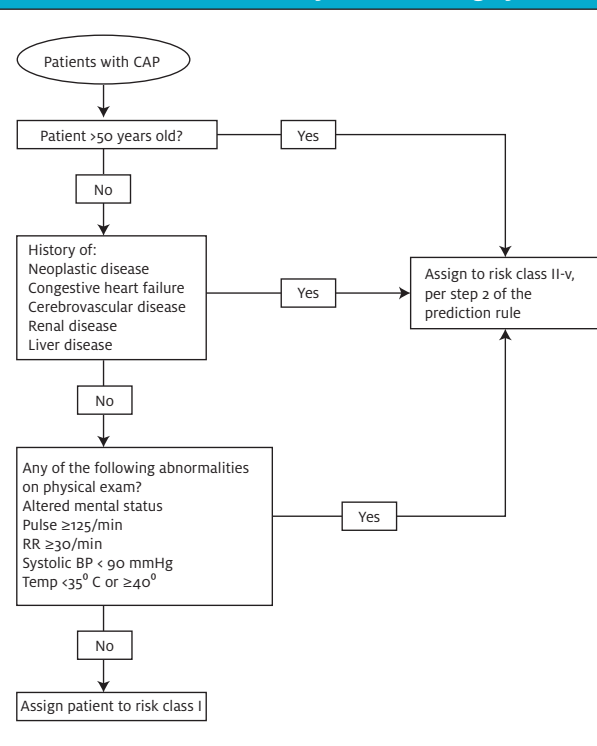
Serologic assays and sputum cultures can be nonspecific, while blood cultures are insensitive. Neither are practical nor indicated in the urgent care setting.

Risk Stratification

Initial risk stratification in CAP helps guide the clinician in major decisions regarding diagnostic modalities, treatment decisions, and patient disposition (site of care). The site-of-care decision on whether or not a patient needs hospital admission is an important economic consideration in CAP, as the cost of inpatient care for pneumonia is logarithmically higher than outpatient care. Low-risk CAP patients should be treated as outpatients whenever possible to avoid complications of hospital-acquired superinfections and thromboembolic events. Also, CAP patients treated as outpatients are more likely to return to work and other activities faster than those admitted as inpatients. It is important to understand that most people prefer to be treated as outpatients whenever possible. Providers should also consider barriers to outpatient treatment such as frailty, lack of response to previous therapy, severe social or psychiatric problems, substance abuse, homelessness, and unstable living conditions when making site-of-care treatment decisions.

Severity-of-illness scores, such as the CURB-65 criteria, or prognostic models, such as the Pneumonia Severity Index (PSI), can be used to identify patients with CAP who may be candidates for outpatient treatment. The PORT score (based on the PSI scoring sys-

Table 6. Pneumonia Severity Index Scoring System



Source: Fine MJ, Auble TE, Yealy DM, et al. A prediction rule to identify low-risk patients with community-acquired pneumonia. *N Engl J Med.* 1997;243:250.

tem) is a tool used to help guide the decision regarding the site of care (Table 6 and Table 7). The stratified risk classes are based on measured mortality rates within 30 days of diagnosis. All patients ≤50 years of age who have none of the coexisting illnesses or physical examination abnormalities identified in step one of the rule are assigned risk class I and should be candidates for outpatient treatment due to very low mortality rates. Risk class II patient also have low mortality rates; it is recommended that these patients also be treated at home. Patients in class III may benefit from a period of observation in the emergency room before a decision is made regarding the site of care, but patients in risk classes IV and V require hospital admission. Any patient >50 years of age is automatically classified as at least risk class II, even if they have no other risk criteria. PSI scores may underestimate the patient’s need for admission due to barriers to outpatient admission mentioned above. Conversely, the PSI may overestimate the mortality in higher-risk patients. The IDSA guidelines also recommend that physicians consider home therapy for patients in PSI risk classes I, II, and III.

Table 7. Classification of Pneumonia Risk

Characteristic	Points Assigned*
Demographic Factor Age • Men • Women Nursing home resident	Add age (years) Add age (years) - 10 +10
Coexisting Illnesses Neoplastic disease [†] Liver disease [‡] Congestive heart failure [§] Cerebrovascular disease Renal disease [¶]	+30 +20 +10 +10 +10
Physical Examination Findings Altered mental status [#] Respiratory rate ≥ 30 /min Systolic blood pressure < 90 mmHg Temperature $< 35^{\circ}$ C or $\geq 40^{\circ}$ C Pulse ≥ 125 /min	+20 +20 +20 +15 +10
Laboratory and Radiographic Findings Arterial pH < 7.35 Blood urea nitrogen ≥ 30 mg/dL (11 mmol/L) Sodium < 130 mmol/L Glucose ≥ 250 mg/dL (14 mmol/L) Hematocrit $< 30\%$ Partial pressure of arterial oxygen < 60 mmHg** Pleural effusion	+30 +20 +20 +10 +10 +10 +10
<p>*A total point score for a given patient is obtained by adding the patient's age in years (age minus 10 for females) and the points for each applicable patient characteristic. Points assigned to each predictor variable were based on coefficients obtained from the logistic regression model used in step 2 of the prediction rule.</p> <p>[†]Any cancer, except basal or squamous cell cancer of the skin, that was either active at the time of presentation or diagnosed within 1 year of presentation.</p> <p>[‡]A clinical or histologic diagnosis of cirrhosis or other form of chronic liver disease, such as chronic active hepatitis.</p> <p>[§]Systolic or diastolic ventricular dysfunction documented by history and physical examination, as well as chest radiography, echocardiography, MUGA scanning, or left ventriculography. A clinical diagnosis of stroke, transient ischemic attack, or stroke documented by MRI or CT scan.</p> <p>[¶]A history of chronic renal disease or abnormal blood urea nitrogen and creatinine values documented in the medical record</p> <p>[#]Disorientation (to person, place, or time, not known to be chronic), stupor, or coma.</p> <p>**In the pneumonia PORT cohort study, an oxygen saturation value $< 90\%$ on pulse oximetry or intubation before admission was also considered abnormal.</p> <p>PORT Scoring System Total Score < 70 = Risk Class II Total Score 71-90 = Risk Class III Total Score 91-130 = Risk Class IV Total Score > 130 = Risk Class V PORT and CURB 65 scores used to determine the point of care for treatment—home vs hospital vs ICU</p> <p>Adapted from PSI/PORT Score: Pneumonia Severity Index for CAP. Fine MJ. Available at: https://www.mdcalc.com/psi-port-score-pneumonia-severity-index-cap/. Accessed January 17, 2017.</p>	

The CURB-65 scale is simpler to use in determining pneumonia severity, yet it is less sensitive than the PSI (Table 8). Clinicians assign one point for each criterion (eg, confusion, blood urea nitrogen, respiratory rate, blood pressure, age) met by the patient. If the individual scores 0-1 points, then outpatient treatment is appropriate. Two points indicates hospitalization and inpatient treatment. A score of 3 or more points warrants inpatient

treatment in the intensive care unit. The use of the CURB-65 and PORT scores may be problematic in the urgent care setting, as many centers do not have point-of-care diagnostic testing or access to arterial blood gas testing. If a center does not have the ability for point-of-care blood urea nitrogen testing and the patient still has a CURB-65 score of 2 or higher, then they clearly meet hospital admission criteria.

Treatment

The IDSA and the Thoracic Society of America (TSA) provide excellent evidence-based guidelines for the treatment of outpatients, inpatients, and ICU patients with CAP. The IDSA/TSA Consensus Guidelines on the Management of Community Acquired Pneumonia in Adults⁸ for outpatient CAP recommend the following:

1. Outpatient Treatment

a. Previously healthy and no risk factors for DRSP infection:

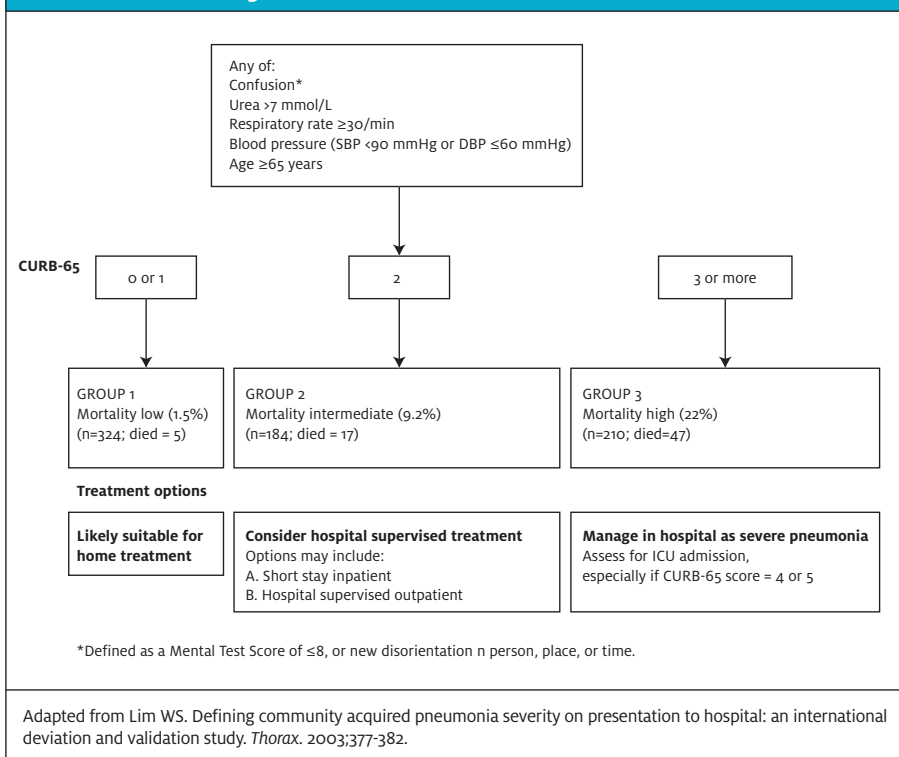
1. A macrolide (azithromycin, clarithromycin, or erythromycin) (strong recommendation; level I evidence) OR
2. Doxycycline (weak recommendation; level III evidence)

b. Presence of comorbidities, such as:

1. Chronic heart, lung, liver, or renal disease; diabetes mellitus; alcoholism; malignancies; asplenia; immunosuppressing conditions; or use of immunosuppressing drugs
2. Use of antimicrobials within the previous 3 months (in which case an alternative from a different class should be selected)
3. Other risks for DRSP infection
 - a. Respiratory fluoroquinolone (moxifloxacin, gemifloxacin, or levofloxacin [750 mg daily]) (strong recommendation; level I evidence) OR
 - b. A beta lactam PLUS a macrolide (strong recommendation; level I evidence)
 1. High-dose amoxicillin (eg, 1 g 3 times daily) or amoxicillin-clavulanate (2 g 2 times daily) are preferred beta lactams
 2. Alternative beta lactams include ceftriaxone, cefpodoxime, and cefuroxime
 3. Doxycycline [level II evidence] is an alternative to the macrolide

As bacterial resistance rates have increased, new pneumococcal serotypes have been identified, and referred to as drug-resistant *Streptococcus pneumoniae* (DRSP).

Table 8. The CURB-65 Scale



These DRSP serotypes are particularly resistant to currently available macrolides, such as azithromycin. The current IDSA guidelines on the management of CAP recommend the use of an alternative to macrolides in areas where DRSP rates are >25%.⁸ They also recommend clinicians become aware of the prevalence of drug-resistant pneumococci in their treatment area to help aid antibiotic decision making.

Most large hospital systems produce antibiograms which detail local bacterial resistance rates to common CAP pathogens and can aid the urgent care clinician in their treatment decision. Macrolide resistant rates of >25% in the U.S. leave clinicians with little choice in the outpatient treatment of CAP other than doxycycline or the fluoroquinolones. In July 2016, the FDA issued new warnings on the fluoroquinolone class in regard to side effects involving tendons, muscles, joints, nerves, and the central nervous system and stated that the risk of these side effects outweigh the benefits for patients with acute bacterial sinusitis, acute exacerbation of chronic bronchitis, and uncomplicated urinary tract infections. Routine use of fluoroquinolones for the above diagnoses in the urgent care setting should be avoided whenever possible. However, the FDA did determine that the benefits of fluoroquinolone use outweigh the risks of side

Table 9. Risk Factors for Possible DRSP Infection

- Recent antibiotic use (within 3 months)
- Age >65 years
- Immunosuppressive illness
- Multiple medical comorbidities
- Exposure to a child attending a daycare center
- Alcohol abuse
- Asthma/COPD
- Diabetes mellitus

effects for serious bacterial infections such as pneumonia.¹¹ Fluoroquinolones are also more likely to cause *Clostridium difficile* infection than either doxycycline or the macrolides.⁹ Along with local resistance rates, it is important that antibiotic selection decision making take into account the patient's risk factors for possible infection with DRSP (Table 9). DRSP risk factors were present in approximately half of outpatient CAP cases treated in the acute care setting; however, guideline-concordant antibiotic therapy was infrequent.¹²

The most prevalent causative organism in CAP is *S pneumoniae*, regardless of the host or the setting. Empiric antibiotic therapy should always be selected with this microorganism and its drug-resistant serotypes in mind.

The IDSA guidelines recommend that patients with CAP should be treated for a minimum of 5 days (Level I evidence), should be afebrile for 48-72 hours, and should have no CAP-associated sign of clinical instability (ie, T>37.8 C, HR>100, RR>24, SBP<100, room air O2 sat<90, inability to maintain oral intake, or altered mental status) before therapy is completed.⁸ Longer therapy is usually reserved for patients with prolonged clinical instability and for nonresponders if the initial therapy was not active against an identified pathogen. Response to antibiotic therapy should be evaluated within 48-72 hours of treatment initiation, as the vast majority of outpatients with CAP become clinically stable in that timeframe. Urgent care clinicians should ensure that patients are closely followed up, whether via a confirmed referral or repeat urgent care visit. Antibiotics should not be changed within the first 72 hours unless marked clinical deterioration occurs or the causative pathogen is identified. Chest x-rays usually clear within 4 weeks in patients <50 years old, yet resolution can be delayed for ≥12 weeks

in older individuals. Patients of any age who remain symptomatic should undergo follow-up imaging.¹³

Conclusion

Community-acquired pneumonia remains a deadly disease and is commonly encountered in the urgent care setting, especially in the winter months and during "flu season." Urgent care clinicians should take care to choose the proper disposition for patients with CAP and make sure patients receive adequate follow-up referrals and instructions. Awareness of current treatment options, local antibiotic resistance rates, and length-of-treatment guidelines will help the clinician in providing the current standard of care in CAP. The diagnosis of CAP by clinical presentation along with the presence of diagnostic chest x-ray findings should be followed by empiric treatment with the most narrow-spectrum and safest drug possible. Assessment of local resistance patterns is important for appropriate treatment considerations, along with risk stratification. Additional diagnostic testing and pathogen identification is a consideration when appropriate pretest indications are present, though their utility in urgent care has not yet been established. ■

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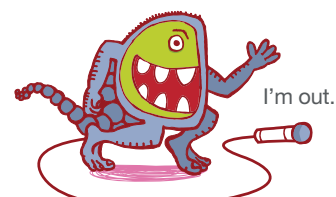
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ABSTRACTS IN URGENT CARE

- How Much Rest for Concussed Children?
- Shortening ABX Therapy Doesn't Stop Resistance
- Big Stones? Try Alpha Blockers
- Penicillin Allergies and Outcomes
- Cooking Fuel and Pneumonia in Children
- Can Oxacillin Help Stem MRSA?
- Antibiotics for Pneumonia
- Opioid Addicts and Urgent Care

■ SEAN M. MCNEELEY, MD

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

Earlier Return to Activities May Benefit Concussed Children

Key point: Another (possibly surprising) view on rest after concussion.

Citation: Grool AM, Aglipay M, Momoli F. Association between early participation in physical activity following acute concussion and persistent postconcussive symptoms in children and adolescents. *JAMA*. 2016;316(23):2504-2514.

In this prospective, multicenter cohort study, approximately 2,400 children aged 5-18 years with acute concussion diagnosed at nine emergency departments across Canada were evaluated for persistent postconcussive symptoms (PPCS). Each child's physical activity was rated as none, light aerobic, sports specific, noncontact drills, or full contact practice. Compared with patients ordered to rest and who had no physical activity, patients with early physical activity were less likely to have PPCS. Rates of PPCS at 28 days were 43% in those with no physical activity, and 25% in those with physical activity. For the urgent care provider, this information is somewhat challenging to previous suggestions of necessary rest. A well-designed randomized clinical trial as suggested by the authors

would be the most appropriate next step in validating this information. ■

Shortening Duration of Therapy in Kids Not the Answer to Resistance

Key point: Five-day therapy for otitis media is probably a bad choice.

Citation: Hoberman A, Paradise JL, Rockette HE, et al. Shortened antimicrobial treatment for acute otitis media in young children. *N Engl J Med*. 2016; 375(25):2446-2456.

Duration of antibiotics for otitis media has traditionally been 10 days for younger children. This study looks at duration of 5 or 10 days for acute otitis media in 520 children age 6 months to 23 months. Both groups were given amoxicillin clavulanate for either 10 days or 5 days, with 5 days of placebo. This was a noninferiority trial.

Endpoints included response and recurrence. There were twice as many failures with the 5-day regimen vs the 10-day treatment (34% vs 16%). For the urgent care provider, shorter duration prescriptions in this age range are not advised. Further studies with more patients and different age ranges would be interesting. ■



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Alpha Blockers Especially Helpful with Larger Kidney Stones

Key point: Alpha blockers may be a good option for patients with larger ureteric stones.

Citation: Hollingsworth JM, Canales BK, Rogers MAM, et al.

“Stones between 5 mm and 10 mm were more likely to pass with alpha blocker treatment; the effect improved as size increased.”

Alpha blockers for treatment of ureteric stones: Systematic review and meta-analysis. *BMJ*. 2016;355:i6112.

This Cochrane review evaluated the use of alpha blockers to assist in passage of renal stones. The primary endpoint was passage of the stone; secondary endpoints included time and pain. A total of 55 trials were included, with results showing an improved chance of stone passage with alpha blockers. Smaller stones were not significantly helped, as most stones <5 mm pass spontaneously. Stones between 5 mm and 10 mm were more likely to pass with alpha blocker treatment. The effect improved as the stone size increased. Both increased speed and less pain were noted with alpha blockers. Serious adverse events were similar between treated and untreated groups. For the urgent care provider, this is more good evidence to consider alpha blockers for renal stone treatment. ■

Penicillin-Allergic Patients May Have Poorer Prognoses in Some Infections

Key point: *Penicillin allergy may indicate poorer prognosis.*

Citation: Macy E, Contreras R. Health care use and serious infection prevalence associated with penicillin “allergy” in hospitalized patients: a cohort study. *J Allergy Clin Immunol*. 2014;133(3):790-796.

This study looked at hospitalized patients with stated penicillin allergies, comparing duration of stay and rates of C diff, MRSA and VRE with matched cohorts. A total of 51,582 patients were matched with two controls each. Results included more use of broad-spectrum antibiotics in allergic patients. All three concerning secondary resistant infections were almost a third more prevalent in case patients. Hospital stays were longer in the penicillin allergic patient, as well. For the urgent care provider, the increased risk of penicillin-allergic patients is noteworthy even if the patient population does not reflect our setting. More research into antibiotic choice and failures would be helpful. ■

A Stovetop Solution to Pediatric Pneumonia?

Key point: *Biomass cooking fuel does not reduce pneumonia.*

Citation: Mortimer K, Ndamala CB, Naunje AW, et al. A cleaner burning biomass-fuelled cookstove intervention to prevent pneumonia in children under 5 years old in rural Malawi (the Cooking and Pneumonia Study): a cluster

randomised controlled trial. *Lancet*. [ePub December 6, 2016.]

This is an unusual study for this column to review—however, it is an interesting study showing that sometimes good intentions don’t result in an expected outcome. Also, as the urgent care community grows, many centers and large organizations are providing international care or assistance, and this might be of interest to them. It is hypothesized that indoor pollution increases the rate of pneumonia in young children and countries where solid fuels are used to cook. This trial attempted to replace the stoves currently used with more efficient stoves and, hopefully, reduce the rate of pneumonia. A total of 10,750 children were enrolled in the study. The pneumonia rate in these children was greater than 15 per 100 children years both in the control and experimental groups. Unfortunately, the authors were unable to prove reduction in pneumonia rate based on changing the type of stove used. For the urgent care provider, this study is a reminder that pollution and smoke can be a significant cause of pediatric respiratory illnesses, including pneumonia. ■

Can an Old Antibiotic Learn New Tricks?

Key point: *Adding back an old antibiotic might help with MRSA.*

Citation: Waters EM, Rudkin JK, Coughlan S, et al. Redeploying β -lactam antibiotics as a novel antivirulence strategy for the treatment of methicillin-resistant *Staphylococcus aureus* infections. *J Infect Dis*. [ePub November 14, 2016.]

Community-acquired MRSA is known to be more virulent but less resistant in the hospital. The authors in this mouse-based study attempted to prove that using oxacillin in patients with MRSA decreased virulence of the staph infection—the idea being the more virulent staph would be replaced by that with more resistance but less virulence. Although the study is by no means a final answer, particularly in patients with severe infection, purposely increasing the resistance may be a way to reduce the virulence. For the urgent care provider, it’s important to note that community-acquired MRSA tends to be less resistant and more virulent. Assuring adequate coverage when the patient is less ill will, hopefully, prevent worsening. Obviously, further human studies are necessary to draw any definite conclusions. ■

Antibiotics for Pneumonia: Does Route Make a Difference?

Key point: *IV antibiotics no better than by mouth after discharge for pneumonia.*

Citation: Shah SS, Srivastava R, Wu S, et al. Intravenous versus oral antibiotics for postdischarge treatment of complicated pneumonia. *Pediatrics*. [e-Pub December 16, 2016.]

Choice of method of antibiotic treatment continues to be a gray area in medicine. This study looks at IV vs PICC line therapy for children with pneumonia at time of hospital discharge. The care of more than 2,100 children, of which 13% received antibiotics via PICC line with the remainder receiving oral antibiotics, was reviewed to determine failure rates. Although this is a cohort study which may bias to patients receiving IV vs oral antibiotics, oral antibiotics actually had a lower failure rate. Statistically, the difference was not significant. For the urgent care provider, although not directly correlated, this offers more confidence that even patients who may have intramuscular IV antibiotics in the office and don't need hospitalization are likely to do well on oral antibiotics. Further research in this area would be helpful. ■

Addicts Aren't Getting Hooked at Urgent Care—But They May Turn Up as Patients

Key point: Urgent care centers must have a plan to address opioid overdose and prescribing.

Citation: Rudd RA, Seth P, David F, et al. Increases in drug and opioid-involved overdose deaths – United States, 2010–2015. *MMWR*. [ePub December 16, 2016.]

Drug overdose deaths nearly tripled from 1999 to 2014. In 2014, approximately 61% of the 47,055 drug overdose deaths were opioid-related. This represents over 28,000 deaths. That number rose to 33,000 in 2015. Unfortunately, while methadone-related deaths declined by 9.1% between 2015 and 2014, deaths related to heroin and other synthetic opiates (other than methadone) made up the difference. This epidemic affects all 50 states. Although death rates are highest among males between the ages of 25 and 44 years, all ages and demographics have been affected. The take-home message is clear: Although this ongoing epidemic—and related deaths—do not have their origin in urgent care, urgent care centers need to have a plan to recognize and treat overdoses that may, unfortunately, arrive at their center. ■

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Complying with the Stark Law Across Multiple Center Locations

■ Ron Lebow

Urgent message: The “in office ancillary services exception” to the Stark law enables urgent care centers to offer a range of services in-house, but complications arise when the urgent care operation consists of multiple locations.

Urgent care centers are almost certainly familiar with the Stark law, a federal conflict-of-interest statute designed to help curb physician self-referral. It is a particularly exacting regulation, but there are numerous exceptions that may help healthcare providers avoid liability—the common federal exception Stark In-Office Ancillary Services Exception (IOASE) being one. This exception is designed to protect the in-office provision of certain designated health services (DHS) that are truly ancillary to the medical services being provided by the physician to his group’s patients. Meeting this exception, however, can prove challenging for owners who operate multiple centers.

Stark Casts a Wide Net

The federal Stark law (42 USC § 1395nn), which applies to Medicare and Medicaid, 1) prohibits a physician from making referrals for (ie, ordering) certain DHS payable by Medicare or Medicaid to an entity that the physician, or an immediate family member of the physician, has an investment/ownership interest in or a compensation arrangement with, and 2) prohibits the filing of claims for those referred services unless the arrangement satisfies a statutory exception. Compensation arrangements also include employment and contractor relationships.

Despite frequent misunderstanding by operators, urgent

care centers are subject to the Stark law just like any other medical practice or facility comprised of physicians. The DHS rendered by them includes x-rays, laboratory testing, and, sometimes, the provision of durable medical equipment.

State Stark law equivalents, known as Physician Self-Referral Prohibitions, often apply to all payors, including insurance and patient private pay payments, where similar designated services are involved. Intent is irrelevant; the Stark law is strict liability. In other words, it essentially assumes that arrangements that do not meet the exception criteria are too dangerous to be permitted (regardless of what the parties intended); ie, expensive for payers and contrary to patient interest because the physician is profiting from his own referral of specialty services.

It is therefore critical for an urgent care center to be in strict compliance with a Stark law exception. Most states’ exceptions to the law mirror those of the federal law; though the federal government has more quickly and often enacted exceptions which the states could not keep up with. Accordingly, many attorneys are comfortable that state authorities will not necessarily pursue action if compliance with the federal law exception criteria can be achieved. However, mere technical violations can be fodder for insurance companies seeking to recoup reimbursement, which can be powerful leverage when accompanied by the threat of the criminal violation becoming a part of the public record.

The Contours and Limits of the ‘Separation’ Strategy

Most urgent care providers will be familiar with the IOASE, and likely have received counsel regarding how to maintain compliance with the Stark law exception. Often, however, owners utilize the time-honored “legal protection” practice of setting up separate sites under a different entity for each location, each having a separate tax identification number. This is for the legitimate purpose of insulating assets of one center from any manner of lawsuits, as well as payer recoupments (offsets or refunds) attributable to another center. It also serves the perceived goal of reducing the collection “footprint” to minimize



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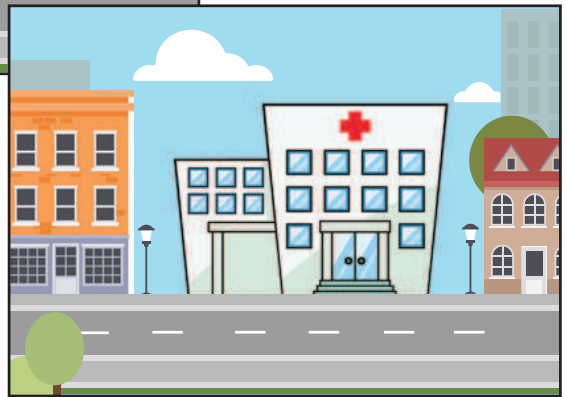
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appearing on the radar of payers as a larger player (though this assumption neglects that payers can cross-reference physician owner provider numbers).

Some owners also separate the entities to minimize personnel for each location, to avoid higher employee benefit-related costs, or to fall short of the imposition of certain labor laws. Additionally, separate tax IDs allow for localized and discrete collateralization of bank lending. Regardless of the incentive, however, most non-healthcare attorneys and clients view separation as a best practice without realizing that it causes strict violation of the Stark law.

The primary challenge facing centers seeking to comply with the IOASE is meeting what is known in common parlance as the 75% test, which comes in two parts. An important factor in applying this test is that the government does not look to the location of the patient care services; but rather, it conducts the calculations based on the distinct operating entity identity (ie, its tax ID).

The first part, which is particularly germane to the analysis when operating out of multiple tax IDs, measures the total amount of “patient care services” rendered by physicians who are owners and W-2 employees under that particular tax ID. The government’s bright-line rule does not distinguish its analysis on whether the physician is working part-time or full-time for the center. Essentially, the test looks at how much time that physician works for that particular tax ID compared with the amount of time he works under a different tax ID. This is measured by both the amount of time billed through the tax ID and the time involved in clinical oversight (for example, in the urgent care context, medical directorship services) of that tax ID.

The phrase *patient care services* is specifically defined to include any task(s) performed by a physician in the group practice that addresses the medical needs of specific patients or patients in general, regardless of whether they involve direct patient encounters or generally benefit a particular practice. For example, patient care services can include services such as consulting with and supervising other physicians, or time spent training staff members, arranging for equipment, or performing certain administrative or management tasks.

First Test

To conduct the first test, a calculation is performed for each physician based on the time he dedicates to the single tax ID in relation to his dedication of time and billing to other tax IDs. The percentage calculated for each physician-owner and employee is added up, with the collective percentage amount divided by the total number of owners and employees attributable to that tax ID. The resulting average percentage must equal at least 75%.

For example, if a physician practices 40 hours per week in total and spends 30 hours per week on patient care services

“A group must demonstrate compliance by measuring patient care services by provable substantiating metrics.”

for a specific group, the physician has spent 75% of his time providing patient care services for the group (30/40).

As further illustration, if one physician practices through a tax ID for a total of 50 out of her 60 hours worked per week, another physician practices through the same group for a total of 15 out of his 15 work hours per week (ie, he works exclusively for the group on a part-time basis, having no outside work obligation), and another physician practices for 30 of her 50 hours worked per week, then the first 75% test is satisfied ($50/60 + 15/15 + 30/50 = 83\frac{1}{3}\% + 100\% + 60\%$; then, dividing the total %s by three physicians results in 81.11%, which is greater than 75%).

If you have physicians cycling through different locations with discrete entity tax IDs, then their percentage will approach 10% to 20% (or even less), bringing the number down to an average below 75% and failing the Stark law bright-line objective test. For example, 100% plus 20% divided by two physicians is only 60%. The challenge becomes exacerbated when you have an owner who spends perhaps only 10% of her time across a number of separate professional entities serving in a medical director capacity, if at all.

Obviously, a crystal ball is not available to measure compliance in advance for a given year. Nevertheless, a group must be able to demonstrate compliance by measuring patient care services by provable substantiating metrics: 1) the total time each member spends on patient care services documented by any reasonable means (eg, time cards, appointment schedules, practice management software reports); or 2) any alternative measure that is reasonable, fixed in advance of the performance of the services being measured, uniformly applied over time, verifiable, and documented. If it cannot be proven, it never happened.

Independent contractors (who are paid on a 1099 basis), however, are not counted at all for purposes of the first part of the 75% test. This has led those seeking to comply to believe that they can simply classify physicians who cycle through their locations on a part-time basis as contractors, to avoid diluting the 75% average calculation above. Urgent care centers have predominately done this by accident, however, as many emergency physicians are used to classification as contractors, and

expect it. Similarly, part-time providers who occasionally work a shift or cover a center on a relatively limited basis prefer this classification. Additionally, owners may prefer avoiding the costs associated with W-2 categorization. This accident or strategy, depending on perspective, is flawed at its inception.

Second Test

The second so-called 75% test measures whether members (ie, employees and owners) of the group personally conduct no less than 75% of the physician-patient encounters of the group. It is designed to prohibit a group practice from utilizing a disproportionately significant number of independent contractor physicians. The Centers for Medicare and Medicaid Services' (CMS') regulatory commentary (but not statutory or regulatory text) provides that the encounters are measured per capita, and not by a metric based upon time. The term "physician-patient encounters" is not specifically defined under the Stark law or regulations, but would imply a direct encounter between the physician and patient.

Combining multiple locations into a single tax ID, or, alternatively, combining regionally contiguous locations into a single tax ID may be the only answer to satisfying the first test, as distinct operating entities cannot always practically meet the 75% test within the four corners of their operation. The second part of the test is rather obvious as to the best approach: making physicians W-2 employees.

Conclusion

In addition to the above-referenced tests, there are other criteria of the IOASE which must be met, but those are easier to accomplish in the context of a unified entity under a single tax ID and in an urgent care setting. We also note that the above scenario and challenges could even be present within a single location—for example, a primary care or orthopedic practice with the same owner as the urgent care center is co-located in the center. It is accordingly critical that bona fide efforts be made to analyze existing corporate structure and physician relationships, and to achieve precautionary compliance. ■

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In each issue, *JUCM* will challenge your diagnostic acumen with a glimpse of x-rays, electrocardiograms, and photographs of conditions that real urgent care patients have presented with.

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

Lateral Humeral Condyle Fracture

Figure 1.



Figure 2.



Case

A 14-year-old boy presents to urgent care complaining of lateral right elbow pain that began after a fall on the playground yesterday, in which he landed on his outstretched hand. He has no significant medical or surgical history. The elbow pain is worse with range of motion. He denies any wrist or shoulder pain, and there is no head trauma. There are no paresthesias to the hand or arm.

View the images taken (**Figures 1** and **2**) and consider what your diagnosis would be.

Resolution of the case is described on the next page.

THE RESOLUTION

Figure 3.

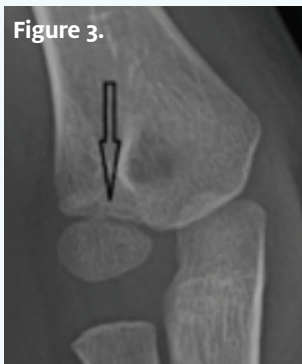


Figure 4.

**Differential Diagnosis**

- Osteolytic lesion
- Lateral condyle fracture
- Elbow dislocation
- Radial head fracture
- Fat pad sign

Physical Examination

Examination reveals the following:

Vitals: Afebrile, pulse 88, respirations 20, BP 92/76

General: Alert and oriented, no acute distress, facial grimace

Lungs: Clear to auscultation bilaterally

Cardio: Regular rate and rhythm without murmur, rub, or gallop

Abdomen: Soft and nontender without rigidity, rebound, or guarding. No bruising or distention

Extremities: There is pain with palpation over the right elbow

Physical exam reveals the patient is in significant pain. Tachycardia may be present from the pain or from an associated injury. The patient will have tenderness with palpation over the lateral aspect of the elbow and decreased range of motion. Check sensation and peripheral pulse.

Diagnosis

The x-ray reveals a fracture of the lateral humeral condyle. Subtle curvilinear lucency is seen at the distal margin of the lateral humeral condyle. Capitellum appears normal. No joint effusion is apparent.

Learnings

A pediatric condyle fracture is one of the most common fractures, accounting for 20% of elbow fractures. The findings are often subtle, but it is an important fracture to diagnose. The mechanism often occurs after a fall onto an outstretched hand, typically with the forearm in abduction and the elbow in extension. It occurs most often between the ages of 6 and 10. Injuries may also in-

volve the brachial artery and the ulnar nerve.

The elbow is composed of the distal humerus, the radial head, and the olecranon (proximal ulna). The capitellum is the distal aspect of the lateral humerus. It is typically displaced posteriorly with a supracondylar fracture, from force applied down the radius (eg, a fall on an outstretched hand will transmit force down the radius causing the proximal radius to “push” the capitellum posteriorly). In the normal elbow, a line drawn along the anterior aspect of the humerus should intersect the middle 1/3 of the capitellum. If the capitellum is fractured, it will be displaced posteriorly, and the “anterior humeral line” will not transect the capitellum.

What to Look For

Testing initially involves a plain x-ray series. **Figure 3** has a subtle finding, demonstrated by an arrow which reveals a lucency. Other x-ray findings include the presence of a “fat pad” sign. A line should be drawn on the anterior aspect of the humerus to ensure it transects the middle 1/3 of the capitellum. An easy way to remember this finding is to keep in mind a common mechanism of lateral condyle fracture: a fall on the outstretched hand transmits energy up the radius placing pressure, which results in displacement of the capitellum posteriorly. When the “anterior humeral line” is drawn, the capitellum will be posterior to the line. **Figure 4** demonstrates a much more obvious fracture.

Inquire about the mechanism, which will often be from a fall onto an outstretched hand. The patient will have elbow pain, increased with range of motion. Inquire about paresthesias which may be from injury to the ulnar nerve or brachial artery, pain in the joint above and below, as well as other injuries which may have been sustained.

Treatment

In the urgent care center, initial management involves adequate analgesia and immobilization. Fractures of the lateral condyle of the humerus are unstable even when immobilized. These fractures are also prone to nonunion since the fracture is intraarticular and is bathed in synovial fluid. The arm should be placed in a sling and swathed for comfort, with the patient referred to an orthopedic surgeon for follow-up.

Indications for transfer include the following:

1. Open fractures
2. Concerning mechanism of injury, such as major trauma from a motor vehicle collision
3. Consideration of abuse
4. Vascular or nerve injury
5. Unstable vital signs ■

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Enhancing Urgent Care Profits with Travel Medicine

Urgent message: Travel medicine is a service addition that enables urgent care operators to attract more patients and increase revenue from existing patients while leveraging existing infrastructure and personnel.

ALAN A. AYERS, MBA, MAcc

Introduction

In the face of rising fixed costs and falling payer reimbursements, even successful urgent care centers can struggle to grow profits year after year. Thus, urgent care operators often look to ancillary services like travel medicine to boost profitability and add new revenue streams.

Travel Medicine Basics

The Cleveland Clinic defines the objectives of travel medicine as follows:

- Counsel patients about how to avoid risky behavior and exposure to infectious agents or disease vectors (pretravel counseling).
- Immunize against illness when it is difficult to limit exposure.
- Use preventive or symptom-triggered medications when immunization vaccines are not available.

Travel medicine remains a wide-open market. According to the Federal Office of Travel & Tourism Industries, U.S. citizens have made close to 300 million visits to international destinations in the past decade. However, many of these destinations lack basics like clean water systems and adequate disease control programs. Vaccinations and safety education are, therefore, in high demand for international travelers and can provide a new revenue stream to a clinic willing to offer travel medicine services.

Getting Started in Travel Medicine

Provider Certifications in Travel Medicine

Clinicians who offer travel medicine do not require any unique "certification," as the field isn't a specifically rec-



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ognized medical specialty. Travelers who want to maximize the likelihood that they're receiving quality, travel-related care, however, will likely verify that their chosen travel medicine provider has an active membership with at least one of the leading travel medicine organizations, such as the International Society of Travel Medicine (ISTM; <http://www.istm.org/>) and the American Society of Tropical Medicine & Hygiene (ASTM&H; <http://www.astmh.org/>).

Membership offers benefits such as access to a professional network of peers, listings in online global travel clinic directories, official certification, member discounts on travel medicine-related products and supplies, and recognition as a leader in travel medicine. Even with a travel medicine organization membership, though, the

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field continues to evolve and grow amid an ever-changing global landscape. As such, providers typically need to perform no less than 10 pretravel consultations per week to maintain the expertise necessary to provide competent advice and care.

The Basics of Travel Medicine

Travel medicine consists of two primary services: travel medicine consultations, and travel vaccinations.

Consultation: Many travelers are unaware of, or take for granted, risks associated with travel. When they learn about infectious diseases and unsafe water, however, they're generally more than happy to pay for a consultation. The basics are as follows:

- Review the patient's travel itinerary and planned activities.
- Consult travel health software to determine international health risks at patient's destination. TRAVAX (www.travax.nhs.uk), an interactive, membership-based website that provides real-time travel health information for healthcare professionals, is the most commonly used software. The website of the Centers for Disease Control and Prevention (CDC; www.cdc.gov/travel) also has up-to-date, global travel health information.
- Conduct a medical history and physical exam to assure patient can participate safely.
- Provide a kit for the patient to take on the trip. Typically, these contain basic first aid items; prophylactic meds for malaria, diarrhea, and motion sickness; and antibiotics, etc., attractively packaged and sold for a price premium.
- Conduct a post-trip evaluation to assure patient is medically clear to resume regular life activities.

Travel vaccinations: Ensure that the patient has the required/preventive vaccinations for each destination.

Getting Set Up as a Travel Medicine Clinic

Following are the medical record components, policies and procedures, and equipment and supplies needed to provide travel medicine services:

Medical Record Components

- Standard travel clinic form (for consistent charts). Travelers should complete the form, which should be available on your website, in advance and emailed to you when the appointment is scheduled. Clinics should also have forms available when the patient checks in or in the waiting room in case the traveler forgot to bring them.

■ Traveler Demographics

- Name, date of birth, address, phone numbers, email address
- Referring physician name, address, telephone/fax numbers
- Referring business name and address (if occupational medicine)
- Dates of departure and return
- Destination—countries and areas within countries (ie, urban vs rural)
- Nature of travel—business, sightseeing, visiting friends/relatives, study/teaching, missionary service
- Medical history
 - Pregnancy, immunosuppressing conditions, HIV risk factors
 - Medications
 - Medication or food allergies (particularly to eggs for the vaccines)
 - History of hepatitis or jaundice
- Travel history/travel-related illnesses
- Country of birth and duration of residence
- Unusual illnesses
- Immunization history
- Advice given
- Medications given
- Immunization form for vaccines administered
- Required information: Vaccination type, dose, date of administration, manufacturer and lot number, site of administration, name and title of administrator
 - Comment section (eg, patient refusal to receive certain recommended vaccinations or prophylactic measures)
- Signature line

Policies and Procedures

- Informed consent for vaccines (patients need to read and hear clinician recite information about the potential benefits and side effects of each vaccine)
- U.S. Public Health Service written Vaccine Information Statements. For vaccines not covered by these statements, the manufacturer should have a written information sheet that can be used. Otherwise, the clinic should write its own information statements. Additional information can be found at the following CDC link: <http://www.cdc.gov/vaccines/hcp/vis/index.html>

Equipment and Supplies Needed

- Facilities

- Waiting area displaying travel magazines, health bulletins, and educational videos
- Consultation and vaccine administration rooms
- Computer in each consultation room for accessing the travel medicine practice database
- Fax machine for obtaining vaccine records or insurance referrals from traveler's PCP
- Refrigerator and freezer for vaccine storage. Keys to vaccine storage:
 - Vaccine storage should be sole use
 - Refrigerator/freezer should be plugged into emergency power source to prevent accidental spoilage, and/or connected to an alarm for alerts should temperatures deviate from standard
 - Mandatory monitoring and recording of temperature twice daily, especially for yellow fever vaccine
 - Temperature ranges
 - Refrigeration 35°-46°F (optimal: 40°)
 - Frozen storage (yellow fever, varicella) ≤ 5° (optimal: 0°)
 - Vaccines should never be stored in the refrigerator door, due to potential exposure to warmer temperatures
- Vaccine logs to assure supplies are always sufficient to meet demand
- Yellow fever vaccine – Regulated by state departments of health, requirement of designated medical director and reporting of adverse events; validation stamp to be recorded on the International Certificate of Vaccination
- Supplies
 - Latex gloves, syringes of multiple sizes, needles of different lengths and gauge, bandages, alcohol pads, cotton gauze, lidocaine/prilocaine cream, sharps receptacle, adrenaline, and antihistamines
- Create a personal rapport with the patient and set expectations for the visit during the call
 - Put knowledgeable, enthusiastic, and informative staff on the phone
 - Have a precrafted script for dealing with prospective travel medicine patients
 - Hand off call to travel medicine nurse or administrator, or promise a callback if front desk staff/receptionists are unfamiliar with the program
 - Be sure to call back within an hour
 - Explain how long the visit will take, what will be discussed at the appointment, and benefits of the consultation
 - Questions to ask of patient:
 - Are you a frequent traveler?
 - Do you have an immunization record?
 - What insurance do you have? (**Note:** Insurance rarely covers travel medicine services administered in urgent care centers)
 - Information to tell the patient:
 - How long the appointment will last
 - What will happen at the appointment
 - What to bring to the appointment
 - What the appointment will cost
 - What immunizations will cost
 - Insurance billing policy/payment terms
 - Refer patient to website/web resources

The physician should schedule 1 hour for the actual consultation. Patient should bring a driver's license/passport/ID, immunization records, medical history, travel itinerary, and payment. Depending on the nature of the consult, it could either be a nurse simply administering the needed vaccines per the CDC website, or a physician conducting an in-depth examination including:

- Patient health history
- Review of trip itinerary
- Review of safety information for each destination
- Cultural topics that could potentially affect patient health (ie, food, weather)
- Administration of some, or all, recommended vaccinations during the initial visit

Travel Medicine Process

The clinical process of a travel medicine service could be best illustrated as follows: **Call for appointment → Conduct pretravel physical → Issue travel kit → Administer vaccinations → Conduct post-travel physical**

Call for Appointment

Traveler arranges appointment with clinic. This is when the travel form should be completed, prior to the in-person visit, allowing the physician to check immunizations and acquire vaccine supplies. This is also the time when the clinic can begin providing an excellent pre-appointment experience:

Pretravel Physical

The pretravel physical is much like a standard physical, and may include the following testing, as required by some countries prior to obtaining an entry visa:

- Serology for immunity to hepatitis A
- Serology for immunity to hepatitis B
- Serology for immunity to measles
- HIV testing

Common Travel Vaccines				
Vaccine	Brand Name/ Trade Name	National Drug Code	Packaging	Manufacturer
Hib	PedvaxHIB®	00006-4897-00	10 pack – 1 dose vial	Merck
Zoster Vaccine Live	Zostavax®	00006-4963-41	10 pack - 1 dose vial	Merck
Influenza (age 36 months and older)	Fluzone Quadrivalent No-Preservative	49281-0416-50 49281-0416-10	10 pack – 1 dose syringe 10 pack – 1 dose vial	Sanofi-Pasteur
Pneumococcal 13-valent (Adult)	Prevnar 13™	00005-1971-02	10 pack – 1 dose syringes	Pfizer
Pneumococcal Polysaccharide (23 Valent)	Pneumovax®23	00006-4837-03 00006-4943-00	10 pack - 1 dose syringes 10 pack – single dose vial	Merck
HPV – Human Papillomavirus 9-valent	Gardasil®9	00006-4119-03	10 pack – 1 dose vial	Merck
Varicella-Adult	Varivax®	00006-4827-00	10 pack - 1 dose vial	Merck
Hepatitis A-Adult	Vaqta®	00006-4096-02 00006-4841-41	10 pack – 1 dose syringe 10 pack – 1 dose vial	Merck
Hepatitis B-Adult	Engerix-B®	58160-0821-11 58160-0821-52	10 pack - 1 dose vial 10 pack - 1 dose syringe	GlaxoSmithKline
DTaP	Daptacel®	49281-0286-10	10 pack – 1 dose vial	Sanofi-Pasteur
Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis	Adacel	49281-0400-10 49281-0400-15	10 pack - 1 dose vial 5 pack - 1 dose syringe	Sanofi
Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis	Boostrix®	58160-0842-11 58160-0842-52	10 pack - 1 dose vial 10 pack - 1 dose syringe	GlaxoSmithKline
Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis	Adacel®	49281-0400-10 49281-0400-15	10 pack - 1 dose vial 5 pack - 1 dose syringe	Sanofi-Pasteur
Measles, Mumps, & Rubella-Adult	M-M-R®II	00006-4681-00	10 pack - 1 dose vials	Merck
Measles, Mumps and Rubella (MMR)	M-M-R®II	00006-4681-00	10 pack - 1 dose vial	Merck
Meningococcal Conjugate	Menactra	49281-0589-05	5 pack - 1 dose vial	Sanofi
Meningococcal conjugate (groups A, C, Y, and W-135)	Menactra®	49281-0589-05	5 pack - 1 dose vial	Sanofi- Pasteur

Table 1. Criteria for Clinics Providing Yellow Fever Vaccinations

Yellow fever is a viral infection that occurs in Africa and South America. About 99% of people develop immunity within 1 month of receiving the vaccination. The vaccination, however, is not without risks (including severe allergic reactions, neurological problems and organ failure) and is thus regulated more strictly than other vaccinations by state health departments. Most states require certification and a stamp to administer yellow fever vaccine.

Following are the general guidelines for providing yellow fever vaccination as part of an international travel clinic:

- Provide a comprehensive personal travel consultation and risk assessment to patients before and after international travel.
- All clinic staff, including physicians, physician assistants, nurse practitioners, registered nurses, licensed practical nurses, medical assistants, etc. who are prescribing or administering yellow fever vaccination must complete the Yellow Fever Vaccine Course at the Centers for Disease Control and Prevention website (<https://wwwnc.cdc.gov/travel/page/yellow-fever-vaccine-course>). State health departments often require a continuing education certificate for each staff member seeking authorization to provide the vaccine.
- Provide travel vaccinations to include hepatitis A, hepatitis B, polio, measles, mumps, rubella, tetanus, diphtheria, pertussis, pneumococcal, meningococcal meningitis, rabies, rotavirus, human papillomavirus, varicella, zoster, Japanese encephalitis, typhoid, and yellow fever. The facility must also provide prophylaxis for malaria.
- Ensure that a physician will be immediately available to handle any severe adverse reactions.
- Ensure that a protocol is in place for anaphylaxis treatment, that staff receive training, and that the protocol and training are reviewed annually. In addition, the clinic must demonstrate appropriate and adequate knowledge of basic life support and CPR.
- Have an agreement with a laboratory to test and diagnose parasite infections.
- Demonstrate adequate resources for acquiring up-to-date information on travel recommendations, restrictions, and requirements, eg, the CDC's "Yellow Book" and travel website; travel warnings of the U.S. State Department; the World Health Organization's *International Travel and Health Vaccinations Requirements and Health Advice*; and TRAVAX.
- Demonstrate knowledge and understanding of the procedure for reporting vaccine adverse reactions to the federal Vaccine Adverse Event Reporting System (VAERS) and to the state department of health.
- Ensure that the clinic obtains one official yellow fever vaccination stamp specifically registered to it by the state department of health, using the state licensure number of a provider currently practicing at the facility. This number will be on file at the state health department and the CDC. If the provider whose license number is on the stamp leaves the clinic, ensure that a new stamp is obtained and the old one is returned to the state health department. Report any lost or stolen stamp to the state health department immediately.
- Only administer yellow fever vaccine at the address indicated in the certification letter and never redistribute the vaccine to other sites.
- Participate in periodic workshops and conferences related to travel medicine.

(Adapted from: Minnesota Department of Health, Criteria for Clinics Providing Yellow Fever Vaccinations. <http://www.health.state.mn.us/divs/idepc/immunize/travel/yfccriteria.pdf>. Accessed July 6, 2016.)

Issue Travel Kit

Suggested contents of a basic travel health kit include the following:

- Patient's usual prescription medications (including extras)
- Analgesic (aspirin or acetaminophen or nonsteroidal anti-inflammatory)
- Throat lozenges
- Decongestant
- Antihistamine
- Cough suppressant/expectorant
- Loperamide
- Antibacterial wipes or towelettes
- Antibiotic for diarrhea
- Bismuth subsalicylate
- Sunscreen
- Antifungal cream

- Steroid cream
- Antimalarial medication
- Insect repellent
- Bandages and adhesive
- Water purification tablets
- Oral rehydration salts
- Tweezers/scissors
- Antacid
- Digital thermometer

The travel medical kit should be well organized in a protective and convenient carrying case or pouch. Extremes of weather, terrain, and activity should be factored into its contents. Especially for travel to developing countries, some experts suggest also carrying needles, syringes, and intravenous catheters, as these instruments, in some countries, are often reused under nonsterile conditions.

Administer Vaccines

Travel immunizations include:

- Hepatitis A
- Hepatitis B
- Typhoid
- DTaP (diphtheria, whooping cough, tetanus)
- Tetanus
- Yellow fever
- MMR (measles, mumps, rubella)
- Meningococcal
- Rabies
- Antimalarial (prescription)
- Antibiotics (prescription)

Should the patient not have their immunization record, the physician can still move forward with the consult under the assumption that those vaccinations have not been administered.

Post-travel Physical

Post-trip follow-up is good marketing, and necessary for medical surveillance. Hence, consultations should be managed by a physician, and all travel medicine specialists should be trained to recognize key symptoms in the returning traveler; they can be referred to the appropriate care provider as needed.

Fees and Revenues

Travel medicine industry anecdote suggests that travelers will pay up to \$1,200 for travel vaccines and consultations when necessary. Scott Summers, director of marketing for regional chains for Cardinal Health, goes as far as to say that the total margin opportunity in travel medicine is around 30%. Numbers like these clearly show travel medicine to be a potentially lucrative ancillary service, with the standard fees bearing this out.

Still, prices do vary significantly by provider. Prices for a nurse consultation can range anywhere from \$35 to \$65, while a physician consultation with a nurse administering the vaccinations can range from \$75 to \$150. Additionally, providers who are able to effectively articulate the value of a consultation to a patient gain a competitive advantage in regards to pricing. Being aware of lower-cost travel vaccine options such as the local health department, or the pharmacy/retail clinic, is also important, both when setting and justifying prices to patients. Consumers are likely to shop around for travel medicine services, and will make a decision based on either price or confidence in the chosen provider's expertise/professionalism.

Building Rapport During the Pre-appointment Experience

Although shopping around for medical service providers is not customary in the United States, the discretionary nature of international travel means consumers are likely to have questions. It's therefore essential that your front-line staff be enthusiastic and prepared to answer previsit consumer inquiries regarding:

- How long to block for an appointment
- What would happen at the appointment
- What to do/expect if no immunization record
- What to bring to the appointment
- What immunizations you would require
- What the appointment would cost
- What the immunizations would cost
- Any other possible costs, cost savings, or discounts
- What insurance is accepted
- Payment terms and less expensive options
- Relevant websites/online resources
- Timeframe of callback, if necessary

The opportunity is to improve the pre-appointment experience with a shorter elapsed time to provide information and set an appointment. Additionally, many providers do a poor job of justifying the cost of a consultation. Explaining the benefits of the consultation not only instills confidence in your capabilities vs your competition, but can also justify a higher appointment price.

Travel Medicine Marketing

There are four primary markets that consistently utilize travel health services:

- Evangelical churches, particularly those with a school attached. They generally see heavy utilization for short-term mission trips and frequently travel as large groups.
- Individual travelers (typically senior citizens).
- Immigrants returning to their home country with children born in the United States but not previously immunized for that country.
- Occupational medicine employees, especially airline/transportation employees who need vaccines to work certain routes and/or government leaders and executives in multinational corporations (eg, Ford and GM) who travel abroad frequently.

Marketing tactics for these groups can include:

- Word-of-mouth among travelers, physician referrals, health agencies, or travel agencies
- News releases or interviews to print, radio, or TV media concerning travel medicine care, and/or travel-related topics

Table 2. Travel Medicine Market Conditions

- There are multiple travel health provider choices in most major markets, and potential patients can easily switch among them. Although shopping around for medical providers is not yet customary in the U.S., it is a growing development, and travel health provides an easy opportunity to do so.
- There is free and easy access to information regarding travel health both from the internet and from phone conversations with providers themselves. Potential users can become very well informed before they spend a dime.
- Customers range from very savvy, frequent travelers to novice first-time travelers. Different types of customers require different levels of information and types of customer service. Understanding and designing services for different customer types may present competitive opportunities.
- The basic service package for travel health is fairly consistent among most providers and includes an appointment with a travel health medical specialist followed by the administration of vaccines. Numerous and clear points of competitive distinction may be difficult to create in actual service delivery. However, no providers are currently telling the “travel health story” very well. Opportunity exists to gain competitive advantage by being the best at explaining why the consultation is a critical step in ensuring successful travel.

- Search engine optimization, pay-per-click advertising (to get top page ratings in Google)
 - Listing in CDC Provider Directory (<http://wwwnc.cdc.gov/travel/page/find-clinic/>)
- Development of a travel medicine brochure with mailings to: physicians, travel agencies, churches, immigrant/advocacy groups, study abroad offices, and HR offices in global corporations. The marketing brochure should contain the following information:
 - Provider demonstrating knowledge of disease epidemiology and prevention
 - Availability of all vaccines necessary for travel
 - Provision of advice and prevention strategies on uncommon diseases
 - Availability of written resources on disease prevention
 - Additional information for brochure:
 - Information detailing reasons for seeking pretravel care
 - What care will be provided
 - Hours of operation
 - Directions to the facilities
 - Contact numbers
 - Web address
 - Statistics about travel population served by the clinic
 - Pictures of travel destinations
 - Education sessions for physicians and the travelling (lay) public

To reach existing urgent care patients, place travel medicine literature and posters in every exam room. These materials are available from the vaccine manufacturer. This is doubly important during years featuring global

events such as the Olympics or the World Cup, wherein global travelers will number in the tens of thousands.

Lastly, after the travel visit, don't forget to send a letter to the patient's PCP, detailing which vaccines were administered and what medications prescribed.

Conclusion

In this day and age of increased global travel, travel medicine can be a very profitable ancillary service for urgent care clinics. As a cash-only business, it allows a clinic to develop a substantial revenue stream apart from payer reimbursements and accounts receivables. And with diseases like yellow fever and encephalitis being very real global threats, travelling patients quickly learn what an essential service travel medicine really is.

The key to successfully offering travel medicine services is having a full grasp of the entire clinical process, from the pre-appointment call to the post-travel physical, and properly executing the key details in each step. But regardless of how well a provider can perform a travel health consultation, if the marketing efforts aren't targeted and aggressive, dollars will be left on the table. Hence, travel health urgent care providers must familiarize themselves with the four primary travel medicine markets, and build comprehensive campaigns that make inroads with key influencers such as evangelical clergy leaders, immigrants, seniors, and career-related travelers.

In sum, travel medicine is a growing business with a sizeable market. For urgent care operators seeking ways to offset the rising costs of doing business, a firm commitment to offering travel medicine service has the potential to reap substantial dividends. ■

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A Rare but Insidious Cause of Abdominal Pain

Urgent message: Recognizing the need for work-up and referral in patients, even if their symptoms are relatively common, is crucial for optimal outcomes

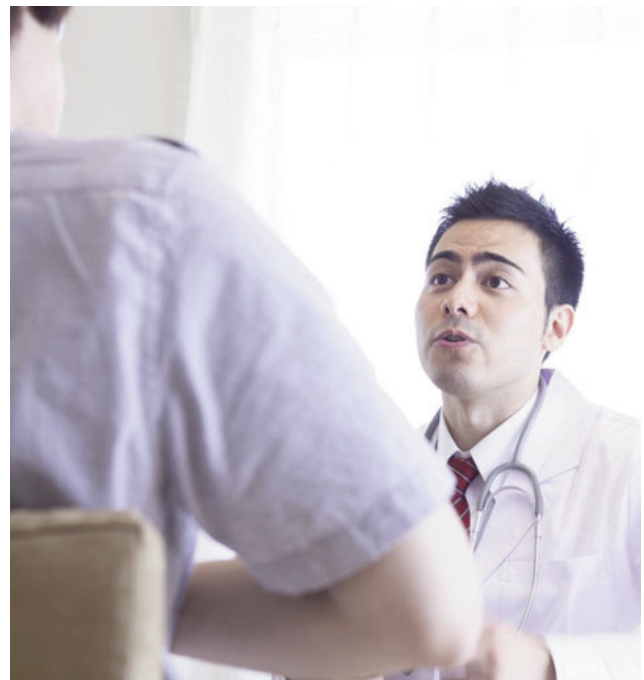
ANISHA TURNER, MD

Introduction

Abdominal symptoms can be attributed to a wide array of causes. When etiology is not immediately apparent, searching for signs and symptoms the patient may not have reported—or even be aware of—may be the first steps toward timely diagnosis and treatment. In this case, the abdominal symptoms were ultimately due to an extremely rare condition that required surgical treatment.

Case Presentation

A 62-year-old male presented to an urgent care facility with complaint of abdominal cramping, nausea, and vomiting intermittently for years, with gradual worsening over the past 2 to 3 months. Approximately a half hour to an hour after consuming liquids or solids, the patient would become nauseated and have nonbloody, nonbilious emesis with occasional bloody streaks. Accompanying symptoms include weight loss (approximately 50 pounds over 3-4 months), heartburn, and intermittent dysphagia to solids. The patient is a nonsmoker and nonalcoholic. Past medical history includes nonischemic cardiomyopathy/congestive heart failure (LVEF 15%-20% with grade II diastolic dysfunction), hypertension, diabetes, hyperlipidemia, GERD, and depression. He denied abdominal surgeries and family history of malignancy. He has never had a colonoscopy. Of note, he was seen 2 weeks prior with similar symptoms, had a negative laboratory work-up, and was sent home with promethazine PO/suppository prescriptions with strict ER precautions.



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Physical Examination

On physical examination, vitals were stable. Patient was diaphoretic, his oropharynx was dry, and he exhibited skin tenting. Abdominal exam was remarkable for normoactive bowel sounds and diffuse abdominal tenderness without rebound, guarding, or peritoneal signs. The remainder of exam was unremarkable.

Differential Diagnosis

The differential diagnoses of intractable vomiting

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include, but are not limited to, small bowel obstruction, with most common causes being adhesions or hernia obstruction; diabetic gastroparesis; nonulcer dyspepsia; cyclic vomiting syndrome; hiatal hernia; infectious etiology; or psychogenic/somatization. Additionally, pseudo-obstruction should be considered when there is a metabolic or electrolyte disturbance. In cases where weight loss or loose stool is present, malignancy and inflammatory bowel disease should also be included in the differential diagnosis.

Urgent Care Work-up

Patient was started on intravenous fluids due to obvious dehydration, as well as antiemetics due to his complaint of nausea. Complete metabolic panel and complete blood count were ordered, with results pertinent for leukocytosis (30×10^9 per L) with left shift (absolute neutrophil count 26,000) and mildly elevated Cr (1.4). Abdominal x-ray was obtained.

Management and Outcome

Patient was sent to the emergency department, where a CT scan showed dilated bowel loops, a dilated gastric lumen, and pneumobilia suggestive of a type of gallstone ileus called Bouveret syndrome (**Figure 1**).

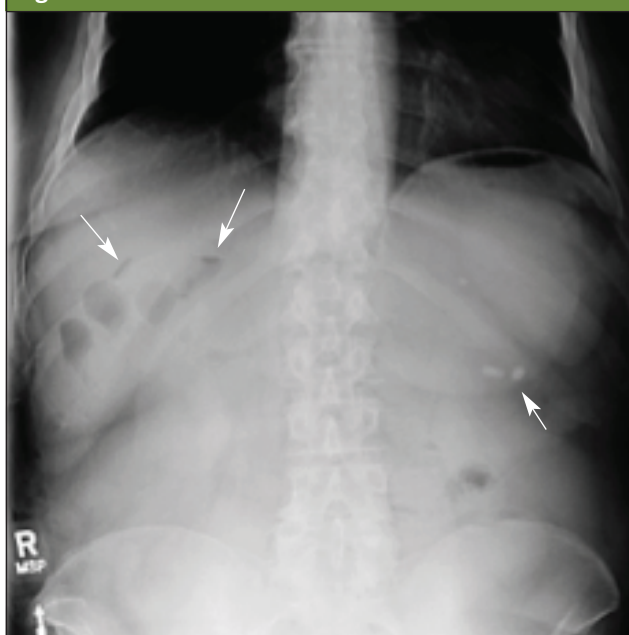
Surgery was consulted for gallstone ileus with distal jejunal obstruction (**Figure 2**, **Figure 3**). Patient was reexamined by the surgery team, who noted abdominal distension and guarding. A nasogastric tube was placed, and patient was taken to the operating room with a pre-operative diagnosis of gallstone ileus, gastric outlet obstruction, jejunal partial obstruction, and cholecystoduodenal fistula.

Patient underwent exploratory laparotomy, lysis of adhesions, drainage of intra-abdominal abscess, cholecystectomy, and primary repair of 2.5 cm duodenal fistula. He was found to have acute-on-chronic cholecystitis. Two flat JP drains were placed in the right upper quadrant, in the area of the gallbladder fossa, as well as along the edge of the duodenal repair. Patient was taken to the surgical intensive care unit postoperatively, started on ciprofloxacin and metronidazole and on octreotide to minimize any volume loaded through the duodenum, with nasogastric suction for 5 days. He was transferred to the general floor on post-op day 4, NGT and JP drain removed on post-op day 5, and discharged on post-op day 6.

Discussion

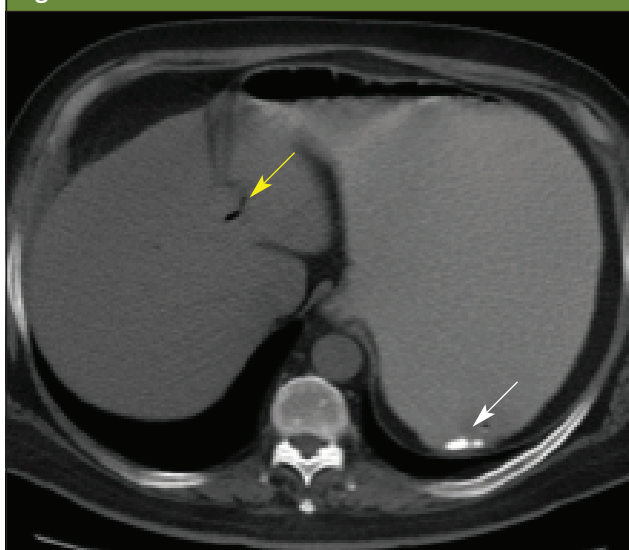
Of all mechanical bowel obstruction cases, gallstone

Figure 1.



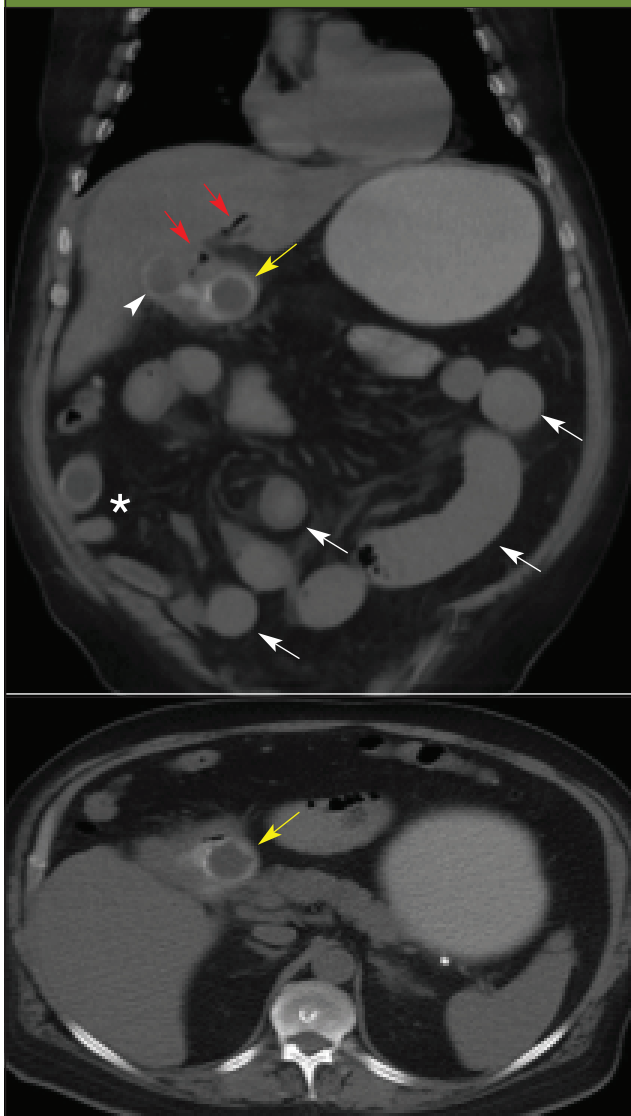
Abdominal x-ray upright shows paucity of gas in small bowel obstruction and pneumobilia (upper left) along with retention of contents secondary to gastric outlet obstruction (right).

Figure 2.



Upright view and computed tomography of the abdomen after administration of positive oral contrast show a dilated gastric lumen and retention of contents secondary to gastric outlet obstruction (white arrow). Paucity of gas in the small bowel and pneumobilia (yellow arrow) are common findings in Bouveret syndrome.

Figure 3.



Isotropic coronal (a) and axial (b) noncontrast CT of the abdomen. Multiple hypodense calculi with egg-shell calcifications are visualized in the gallbladder (arrowhead), duodenum (yellow hollow arrows) and small bowel (asterisk). A duodenal biliary calculus (yellow arrow), pneumobilia (red arrows) and dilated bowel loops (white solid arrows) are consistent with the Rigler's triad.

ileus is one of the rarest forms. It is caused by a gallstone entering the bowel and causing an obstruction. Gallstone ileus is a complication of gallstones in only 0.5% of patients with gallstone disease¹; it occurs in <0.1% of all mechanical obstruction cases in the United States.² It is, however, a more common cause of nonstrangulat-

“Gallstones most commonly impact at the terminal ileum and ileocecal valve... but can cause impaction in any part of the bowel.”

ing mechanical small bowel obstruction, accounting for 1%-4% in all patients and up to 25% in the elderly.¹ This case featured a rare but insidious cause of gallstone ileus called Bouveret syndrome, which has been identified in a little over 300 cases in literature since its first description in 1654.^{2,3} Bouveret syndrome is caused by the passage of a large gallstone through a biliodigestive fistula and into the duodenum or pylorus, resulting in gastric outlet obstruction.⁴

Gallstone ileus and Bouveret syndrome are more common in women than in men (3.5 females to 1 male³), with a long history of cholelithiasis, repeated episodes of acute cholecystitis, stones >2-8 cm, and age >60 years.⁸ Even though gallstones most commonly impact at the terminal ileum and ileocecal valve due to their narrow lumen and potentially less active peristalsis,⁷ they can cause impaction in any part of the bowel,² such as the duodenum in Bouveret syndrome.

The presentation of gallstone ileus and Bouveret syndrome is typically nonspecific, and often with waxing and waning symptoms of nausea, vomiting, abdominal distension, and pain.¹⁰ Usually, the symptoms begin 5-7 days prior to medical consultation, and it has been reported that 43%-48% are preceded by a history of recent biliary colic bouts, jaundice, or acute cholecystitis.¹¹ Importantly, the intensity of the pain often does not correlate with the underlying anatomic alteration.¹¹ Laboratory studies are also nonspecific, as only one-third of patients present with jaundice and/or alteration of hepatic enzymes.¹²

The abdominal radiograph is the mainstay of imaging in small-bowel obstruction. The most frequent findings of Rigler's triad are as follows:¹⁴

- pneumobilia
- bowel obstruction
- aberrant gallstone

An aberrant gallstone is present in only 40%-50% of cases.¹⁴ Ultrasound can be used, but difficulties of locating stones and distortion by bowel gas makes ultrasound suboptimal.¹⁰ Unfortunately, abdominal plain radiography is usually of low diagnostic value in those with Bouveret syndrome because it is diagnostic in only 21% of these cases.¹³ CT is the imaging modality of choice² in Bouveret syndrome, with an overall sensitivity, specificity, and diagnostic accuracy of 93%, 100%, and 99% respectively.¹⁴ Therefore, if there is a clinical suspicion for the diagnosis but negative x-ray findings, a CT scan should be performed.

The gallstones that result in obstruction are usually >2.5 cm², as those smaller than 2.5 cm typically pass through spontaneously and are managed conservatively.¹⁰ The consensus is that a general surgeon should be consulted for each case to assess whether conservative or surgical management should be pursued.

Given the advanced age and extensive comorbidities with which the typical patient usually presents, many have adopted the stance that endoscopic or percutaneous approaches such as laser or extracorporeal shock-wave lithotripsy should always be attempted prior to surgery.¹⁵ However, endoscopic strategies usually fail, and approximately 91% of patients require surgical treatment.^{15,16} Because of the limited number of reported cases, the optimal surgical method of treatment has been the subject of ongoing debate.²

Despite advances in diagnosis and management, mortality remains high, ranging from 12% to 27%, par-

*“Gallstones smaller than
2.5 cm typically pass
spontaneously and
are managed
conservatively.”*

tially because of nonspecific symptoms, unremarkable biochemical investigations,¹ high misdiagnosis rate, and delayed discovery.⁴ Therefore, gallstone ileus must not be forgotten as a potential diagnosis in such cases. ■

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Splint and Cast Application Performed by Someone Other than Physician

■ DAVID E. STERN, MD, CPC

Q. Can you bill for splint and cast applications done by someone on staff other than the physician?

A. Yes, the American Medical Association (AMA) provided guidance on this in the *Current Procedural Terminology (CPT) Assistant*, April 2002 issue: "You will note that the reference to 'physician' has been retained in the clinical examples provided. This inclusion does not infer that the cast/splint/strap procedure was performed solely by the physician, as nurses or ED/orthopaedic technicians also apply casts/splints/straps under the supervision of the physician." The narrative further explains that the use of "physician" in the clinical scenarios given is to differentiate the individual patient physician encounters and the procedures performed in the clinic setting.

Bill an application code only if work is involved making the cast or splint out of materials such as plaster or fiberglass.

For example, an x-ray reveals a nondisplaced fracture of the head of the right radius, initial encounter, *International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)* code S52.124A on a 10-year-old patient. You stabilize the affected extremity by applying a static, short arm fiberglass splint and refer the patient to an orthopedist. Since you are not providing restorative care and have referred the patient on, you can bill both for both the supplies used to make the splint and the application, using the following codes:

- Q4024, "Cast supplies, short arm splint, pediatric (0-10 years), fiberglass"
- 29125, "Application of short arm splint (forearm to hand); static"

If the key components for the Evaluation and Management

(E/M) codes are met, then also report the appropriate level of E/M with modifier -25, "Significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or service" appended.

Using the same patient example, let's say the physician agrees to follow the patient through the healing process and the splint will be the definitive ("restorative") treatment for this fracture. This is considered to be definitive care and the rules for billing are a little different. You can still bill for the splint supplies. In lieu of billing the splint application code, you would bill CPT code 24650, "Closed treatment of radial head or neck fracture; without manipulation" if no manipulation was required, or CPT code 24655, "Closed treatment of radial head or neck fracture; with manipulation" if manipulation was required before applying the splint.

If the key components for the E/M codes are met, then also report the appropriate level of E/M with modifier -57, "Decision for surgery" appended.

When supplying and/or applying orthoses described in the "Orthotic Procedures and Services" section of the *Healthcare Common Procedure Coding System (HCPCS) Level II* manual, the application code is built into the pricing and should not be coded separately. These codes are also known as "L-codes." Thus, if you apply a prefabricated Velcro wrist splint, code L3906, "Wrist hand orthosis (WHO), without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment."

The Centers for Medicare and Medicaid Services (CMS) defines the different types of orthoses as follows:

- Off-the-Shelf
 - Prefabricated
 - May or may not be supplied as a kit
 - Minimal adjustment can be done
 - Does not require expert fitting; ie, L3908, "Wrist hand orthosis (WHO), wrist extension control cock-up, non-molded, prefabricated, off-the-shelf"
- Custom Fitted
 - Prefabricated



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

- May or may not be supplied as a kit
- Requires substantial modification upon delivery
- Requires expert fitting by a certified orthotist or someone with equivalent specialized training; ie, L3807, "Wrist hand finger orthosis (WHFO), without joint(s), prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise"
- Custom Fabricated
 - Custom fabricated for one individual
 - Custom measurements
 - Fabrication may involve using calculations, templates, and components
 - Substantial modification prior to fitting to the patient
 - Requires expert fitting by a certified orthotist or someone with equivalent specialized training; ie, L3808, "Wrist hand finger orthosis (WHFO), rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment"

CMS further defines the term *qualified practitioner* as a physi-

cian or other individual who is:

- A qualified physical therapist or occupational therapist;
- Licensed in orthotics or prosthetics by the state in which the item is supplied (if that state provides licensing);
- Specifically trained and educated to provide or manage the provision of prosthetics and custom-designed or custom-fabricated orthotics, and is certified by the American Board for Certification in Orthotics and Prosthetics, Inc. or by the Board of Orthotist/Prosthetist Certification (in the case where the state does not provide licensing).

For additional information, consult the Social Security Administration's Special Payment Rules for Particular Items and Services section on Payment for Durable Medical Equipment (https://www.ssa.gov/OP_Home/ssact/title18/1834.htm#h).

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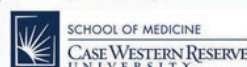
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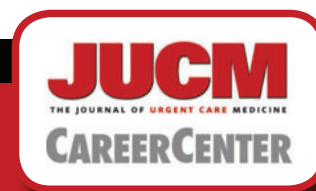
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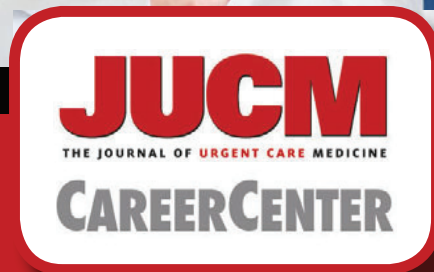
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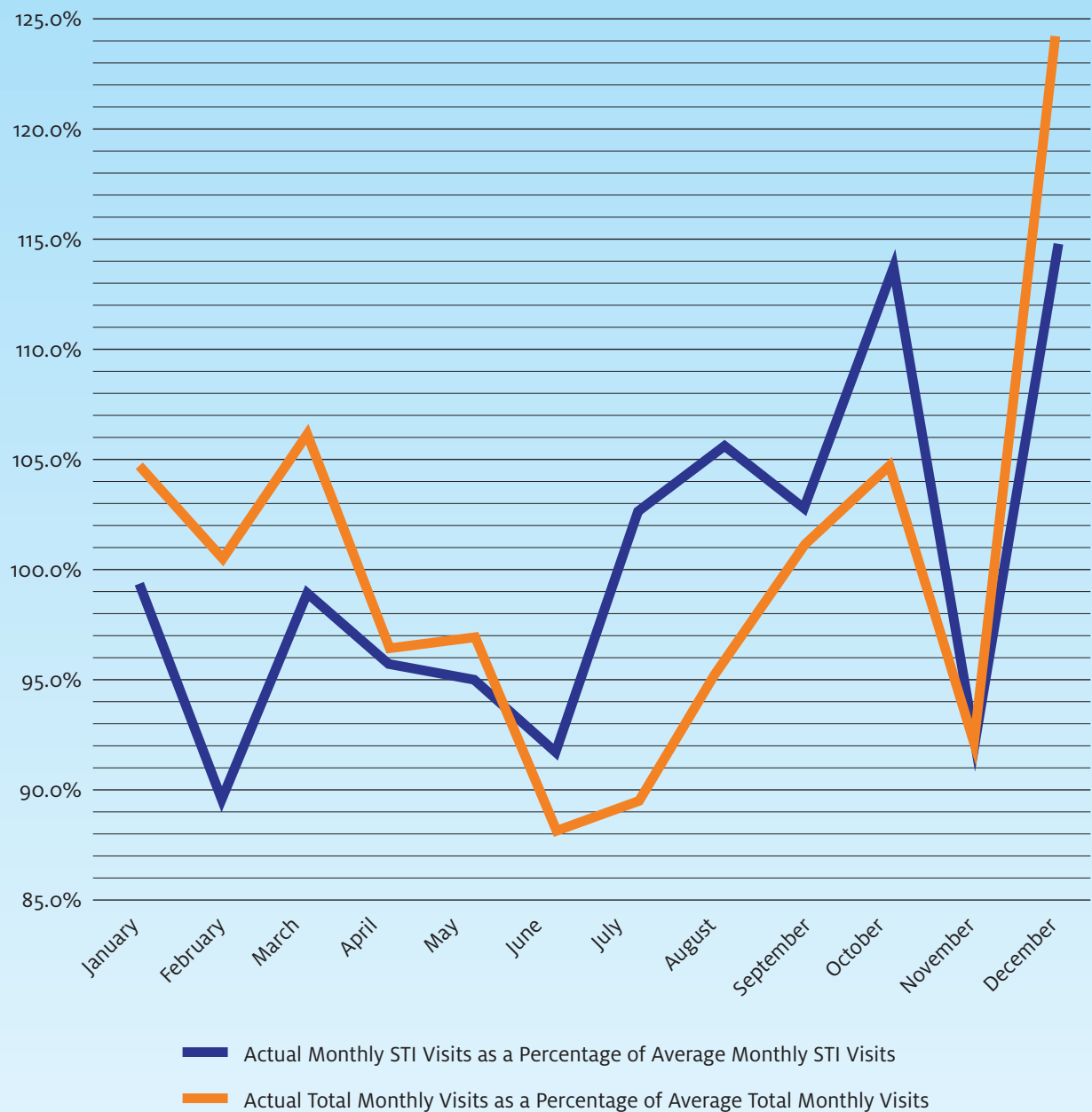




DEVELOPING DATA

A Practice Velocity study of 63,000 patient charts presenting with one of 35 diagnoses associated with sexually transmitted infections (STI) between January 2010 and November 2016 reveals the highest incidence occurs during the late summer/early autumn. With urgent care's typical seasonality driven by upper respiratory illness, which is most prevalent in the winter months, STI presentations actually run contra-seasonal to "typical" urgent care volume.

SEASONALITY OF SEXUALLY TRANSMITTED INFECTIONS VS NORMAL URGENT CARE SEASONALITY



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