

VOLUME 10, NUMBER 6

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Urgent Care
 Association
 of America



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LETTER FROM THE EDITOR-IN-CHIEF

Analytics and Performance Metrics: The Good, the Bad, and the Ugly



t seems like *metrics* and *analytics* are the buzzwords to watch in 2016. Everyone from health-care administrators to carwash operators—is looking for ways to measure best practices, key business drivers, and employee performance to stand

out. Even my beloved Cleveland Browns became the first team in professional football to hire a chief strategy officer to apply analytics in picking players who give the team its best chance of winning.

Health care itself is into analytics, a trend that can be seen as either transformational or apocalyptic, depending on your view. Health care is measuring everything from patient satisfaction and wait times to readmissions and stent failures, and then using those metrics to build a case for changes that may or may result in better outcomes.

Urgent care has always embraced the notion of analytics, even if unknowingly. In the early years, practice founders identified major gaps in the health-care delivery system that were exploitable with new models care and service. Many metrics were used to meet consumer demands more adeptly and manage cash flow more predictably. It's what we have historically done quite well relative to our peers and was a major reason that urgent care was such a disruptive market force.

Now our competition is looking analytically at work flow and customer-service metrics to find opportunities for improvement. Whatever the tactics, analytics are being used to woo new customers and manage provider behavior. Urgent care operators must respond with the next generation of analytics to maintain their position as health-care disruptors. Our survival depends on it.

To most effectively integrate the use of metrics and analytics into our practices, we must first consider all the implications ... the good, the bad, and the ugly.

The good:

- Measuring key business and quality drivers
- Identifying outliers
- Clarifying root cause
- Creating targeted interventions
- Measuring performance improvement
- Quantifying hunches

- Challenging myths and anecdotes
- Leading change management
- Supporting lifelong learning

The bad:

- Embarrassing
- Paternal
- Disempowering

The ugly:

- Often unrealistic; clinical care is not delivered in a vacuum
- Exceptions to the rules, where the art of medicine lies and which can be the difference between life and death

Appreciating each of these implications, the opportunities and sensitivities alike, will help the urgent care provider and operator align on a management model that is effective, honest, and respectful. It is this alignment step that health systems and other health-care providers frequently skip, limiting the effectiveness and intent of the analytic model. To prevent this from occurring in your urgent care practice, identify components from every category—the good, the bad, and the ugly—that both parties can agree on. Then apply each of these elements to a regular and predictable cycle of measurement, communication, and response. This cycle of performance improvement and analytics will be challenging at first, but preparation, anticipation, and alignment of expectations will support a constructive process.

This partnership between operator and provider is our best opportunity for differentiating urgent care practice for the next 10 years. Let's get started!



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



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VOLUME 10. NUMBER 6



CLINICAL

10 Evaluation and Management of Ankle Injuries in Urgent Care

Acute ankle injuries can progress to chronic issues. It is essential that the urgent care clinician be aware of the mechanisms of common ankle injuries, their pathophysiology, essential diagnostic tests, and which injuries require transfer for a higher level of care.

Lisa Schuerman, RN, MSN, APNP

PRACTICE MANAGEMENT

19 We're All in This Together: Four Attributes of Effective Medical Center Teams

Creating and cultivating cohesive, goal-oriented, and patient-focused urgent care teams starts with visible front-line leaders who emphasize a strong service culture, open communication, personal accountability, and management transparency.



Alan A. Ayers, MBA, MAcc

CLINICAL



25 Zika Virus—Near Pandemic Proportions?



The clinical manifestations of Zika virus infection are generally mild in adults; the primary concern is the potential link to microcephaly in children of infected pregnant women. There is no cure, so prevention is paramount.

Mizuho Spangler, DO, and Michael B. Weinstock, MD

CASE REPORT

31 Sore Wrists with Soft-Tissue Hypertonicity and Swelling

It is important for urgent care providers to be able to recognize the lesserknown arthritides as causes of acute joint pain and to recognize their specific manifestations on x-rays. Further work-up is warranted because some of these diseases can be associated with various metabolic disorders.

May Mohty, MD, FAAP, FAAUCM, and Hamilton White, MS4



IN THE NEXT ISSUE OF JUCM

Scrotal pain has many causes, including infection, testicular torsion, hernia, cancer, and trauma. Knowing what to look for is key because there may be overlapping clinical presentations from multiple disease processes, and transfer for emergency treatment may be necessary.

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EDITOR-IN-CHIEF Lee A. Resnick, MD editor@jucm.com MANAGING EDITOR Katharine O'Moore-Klopf, ELS komooreklopf@jucm.com PROOFREADER Katharine R. Wiencke ASSOCIATE EDITOR, PRACTICE MANAGEMENT Alan A. Ayers, MBA, MAcc ASSOCIATE EDITOR, CLINICAL Michael B. Weinstock, MD CONTRIBUTING EDITORS Sean M. McNeeley, MD David Stern, MD, CPC MANAGER, DIGITAL CONTENT **Brandon Napolitano** bnapolitano@jucm.com ART DIRECTOR Tom DePrenda tdeprenda@jucm.com

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P U B L I S H I N G 120 N. Central Avenue, Ste 1N • Ramsey, NJ 07446

PUBLISHER Stuart Williams

swilliams@braveheart-group.com • (201) 529-4004

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Mission Statement

JUCM The Journal of Urgent Care Medicine supports the evolution of urgent care medicine by creating content that addresses both the clinical practice of urgent care medicine and the practice management challenges of keeping pace with an ever-changing healthcare marketplace. As the Official Publication of the Urgent Care Association of America and the Urgent Care College of Physicians, JUCM seeks to provide a forum for the exchange of ideas and to expand on the core competencies of urgent care medicine as they apply to physicians, physician assistants, and nurse practitioners.

Affiliations

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Wetrics and analytics aren't just buzzwords for other industries. They're tools in the urgent care industry for use in changing practices to produce what we hope are better outcomes for our patients and our staff. We're all checking patients' wait times, patient satisfaction, and patient flow through our centers. But let's make sure we're doing it in a way that's productive and respectful.

We all see plenty of patients with ankle injuries. After all, acute ankle trauma is responsible for 10% to 30% of sports-related injuries in young athletes. But do we all know the mechanisms of the most



common ankle injuries, their pathophysiology, the essential diagnostic tests, and which injuries require transfer for a higher level of care? In our clinical cover article, Lisa Schuerman, RN, MSN, APNP, outlines what practitioners need to know.

Schuerman is an urgent care clinician at Presbyterian Hospital in Albuquerque, New Mexico. She is a graduate of Marquette University in Milwaukee, Wisconsin.



The epidemic of Zika virus infections is all over the news, with outbreaks reported in Brazil, South America, and the Caribbean. There

is no cure yet, so authors Mizuho Spangler, DO, and Michael B. Weinstock, MD, provide the latest information so that you can advise your patients about prevention.

Spangler is Assistant Professor of Clinical Emergency Medicine, LAC+USC Keck School of Medicine, Los Angeles, California, and Executive Producer, *Urgent Care Reviews and Perspectives* (*UC:RAP*). Weinstock is Professor of Emergency Medicine and Adjunct, Department of Emergency Medicine, Ohio State University College of Medicine; Emergency Department Chairman and Director of Medical Education, Mount Carmel St. Ann's Hospital Department of Emergency Medicine, Immediate Health Associates, Inc., Columbus, Ohio; Associate Clinical Editor for the *Journal of Urgent Care Medicine*; and Editor-in-Chief, *UC:RAP*.

Being part of an urgent care team doesn't have to leave you feeling ineffective and resentful. In our *Practice Management* section, Alan A. Ayers, MBA, MAcc, shows how to cultivate four



specific attributes in your center to get everyone engaged and happily performing at their best.

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

In our case report, May Mohty, MD, FAAP, FAAUCM, and Hamilton White, MS4, write that your patients need you to be able to recognize the lesser-known arthritides as causes of acute joint pain and to know their specific manifestations.

Mohty is a clinical associate professor at the University of Arizona



College of Medicine–Phoenix in Arizona and an urgent care physician at CIGNA Healthcare of Arizona. White is a fourthyear student at Arizona College of Osteopathic Medicine at Midwestern University in Glendale, Arizona.

Also in this issue:

In *Health Law and Compliance*, **Stacey L. Zill, Esq.**, tells what urgent care providers in various U.S. states must do to be compliant with the Health Insurance Portability and Accountability Act of 1996 when giving medical records to patients and to other providers.

Zill is a partner at Michelman & Robinson, LLP, specializing in health-care litigation.

Sean M. McNeeley, MD, and the Urgent Care College of Physicians review new reports from the literature on inhaled steroids and children's growth velocity, pushing back from the work desk and moving throughout the day, e-cigarettes and adolescents, diverticulitis in younger patients, the spread of Lyme disease, self-collection of samples by patients who may have sexually transmitted infections, the uselessness of antibiotics in upper respiratory infections, and clarithromycin versus amoxicillin.

In *Coding Q*QA, **David Stern, MD, CPC**, explains excludes notations and code notes for ICD-10CM.

Our *Developing Data* piece provides statistics on the top 20 most-prescribed medications in 2014 at U.S. urgent care centers.

To Submit an Article to JUCM

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

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

We prefer submissions by e-mail, sent as Word file attachments (with tables created in Word, in multicolumn format) to *editor@jucm.com*. The first page should include the title of the article, author names in the order they are to appear, and the name, address, and contact information (mailing address, phone, fax, e-mail) for each author.

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P. JOANNE RAY

owhere else but at the UCAOA National Urgent Care Convention (April 17–20, with preconvention courses on April 16 and 17) can you find as comprehensive a selection of urgent care–specific practice management and clinical courses. For comparing vendors, services, and products

Provide the second seco

for your urgent care centers, there is

no match for the exhibitors and partners you will find among the nearly 200 vendors in the exhibit hall. And if you are looking to exchange ideas with industry professionals who are dealing with the same issues that you are, set your course for the Gaylord Palms Resort and Convention Center in the greater Orlando area. Register now for this spring's meeting to mix with more than 1,250 attendees and exhibitor representatives. To see a list of previous exhibitors, visit the UCAOA Virtual Exhibit Hall (http://www.ucaoa.org/search/custom.asp?id=1132).

More than 75 sessions across six open tracks are scheduled to meet your education needs and help you gather great actionable ideas and knowledge to take home. As a registered attendee, you will receive complimentary access to all convention recordings. The main convention schedule-at-a-glance, at http://c.ymcdn.com /sites/www.ucaoa.org/resource/resmgr/2016_Spring_Convention/ 2016Spring-SAAG-1.12.16.pdf and immediately after this column, will help you find dozens of applicable courses providing immediately implementable business solutions and expanding your clinical knowledge. All educational tracks are open so you can personalize your learning experience.



P. Joanne Ray is Chief Executive Officer of the Urgent Care Association of America. She may be contacted at *jray@ucaoa.org*.

Members receive a significant discount on the conference fee, and groups of four registering together from the same organization receive a 20% discount. Your registration provides complimentary Wi-Fi; access to meals, exhibit-hall evening receptions, and up to 27 AMA PRA category 1 credits; access to more than 80 presenters who are industry experts, in addition to hundreds of expert attendees and exhibitor representatives; 14 hours to explore the vendor displays in the exhibit hall; and complimentary downloading of all course materials and recorded sessions (audio-synched with Power-Point slides). UCAOA has secured special discounted rooms for attendees at the Gaylord Palms Resort, only 10 minutes away from the main gates of Disney.

To get more information, to register yourself or your team or exhibit, or to sponsor an activity, visit the convention webpage (https://ucaoa.site-ym.com/?2016Spring) or call 877-698-2262. We stand ready to help you.









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April 17-20, 2016 (Main Convention) April 16-17, 2016 (Pre-Convention Courses)

2016 Spring Convention Schedule-at-a-Glance

rlando

Sunday, April 17			
8am-6pm	Attendee Registration Osceola Lobby		
3:30-5:30pm	State Networking Meetings		
5-5:45pm	Mix & Mingle Reception Florida Exhibit Hall Lobby		
5:45-7:15pm	Opening Reception Florida Exhibit Hall F		

Saring Convention

Please note: The 2016 Spring Convention Schedule-at-a-Glance is tentative and subject to change. Plan your travel around the entire convention, not just one particular session.

For the latest information, visit ucaoa.org/?2016Spring. On site, please refer to the convention program or the mobile app for final details.

Monday, April 18						
6:30am-6pm	Attendee Registration Osceola Lobby					
6:30-7:45am	State Networking Meetings					
7-8am	Attendee Breakfast & Network	Attendee Breakfast & Networking Opportunities Osceola C-D				
8-9:15am	Opening Keynote by Joseph G	irenny Osceola C-D				
9:15-9:30am	Coffee Break Near Classroom	5				
9:30-10:30am	Updates on Pediatric Guidelines Victor Chou, MD Naples	Are You a Dermatology Expert? Chrysa Charno, PA-C, MBA Osceola 1-3	Patient Impressions and Priorities for a Positive Patient Experience Enaka Yembe, MD Tampa	Urgent Care State of the Union: Future Success or Saturation Michael Boyle, MD, FACEP Osceola 4-6	Occupational Medicine: Workers' Compensation Best Practices Don Herip, MD, MPH, FACOEM Osceola A	High-Performance Cultural Operating System Joseph Grenny Osceola B
10:30-11:15am	Coffee Break Florida Exhibit H	all F				
10:30-11:30am	Exhibit Hall Open Florida Exhi	ibit Hall F				
11:15am- 12:15pm	Finger Tip Injuries in the Urgent Care Clinic Thomas Gocke, MS, ATC, PA-C, DFAAPA Naples	Understanding the Myths and Integrating Evidence- based Medicine (Part 1) Stephen Engelberg, PAC, PhD Osceola 1-3	Breaking the Chain of Embezzlement Kurt Tullar, JD Tampa	Measuring and Improving Patient Satisfaction Mary Kate Dilts Skaggs, MSN, RN, NE-BC Osceola 4-6	OccMed Clinic Setup Bonnie Peterson, BSN Osceola A	A Plan for Growth: The Second Center and Beyond Jili Tahmooressi, RN- BC, BS, BSN, MBA; Moinca Ruiz-Vallez Osceola B (Hospital Focus)
12:15-12:30pm	Transition Break					
12:30-1:45pm	Members' Luncheon Osceola	C-D				
1:45-2pm	Transition Break					
2-3pm	MRSA Update Joseph Mazziotta, MD Naples	Understanding the Myths and Integrating Evidence- Based Medicine (Part 2) Stephen Engelberg, PAC, PhD Osceola 1-3	Building a Positive Team Culture Sarah Arora Tampa	Diagnose Your Center's Performance: A Process to Evaluate for Operational and Financial Excellence Martin Karpiel, MPA Osceola 4-6	Integration of Occupational, Employee Health and Urgent Care Within a Health System Christine Stallkamp, MD, FAAFP, CHCQM Osceola A (Hospital Focus)	Consolidation/M&A Activity in Urgent Care Dexter Braff Osceola B
2-7:30pm	Exhibit Hall Open Florida Exh	ibit Hall F				
3-3:45pm	Coffee & Dessert Break Florida	a Exhibit Hall F				
3:45-4:45pm	Everything Non-Clinical That You've Ever Wanted to Know, But Were Afraid to Ask Victor Chou, MD Naples	Pearls and Things You Cannot Miss! Ron Elfenbein, MD Osceola 1-3	More Than Just Acute Pharyngitis: Demonstrating Value to a Large Health System John Barrett MD; Teresa Abell, RN; Joseph Vance, MHA Tampa (Hospital Focus)	Preparing for a Laboratory Survey Ann Bachman, BS MT(ASC), CLC(AMT) Osceola 4-6	Occupational Medicine: Sales/Marketing Don Herip, MD, MPH, FACOEM Osceola A	Data Driven Decision Making: Perception is Not Always Reality Jeff Pendino Osceola B
4:45-5pm	Coffee Break Near Classrooms					
5-6pm	Dealing With Difficult to Treat Wounds and Ulcers Joseph Mazziotta, MD Naples	Treating the Pregnant Patient in the Urgent Care Setting Jeannie Kenkare, DO Osceola 1-3	Everything You've Ever Wanted to Ask About Urgent Care Within the Large Health System John Barrett, MD; Teresa Abell, RN; Joseph Vance, MHA Tampa (Hospital Focus)	Top Legal Issues Facing Urgent Care Damaris Medina, Esq; Ron Lebow Osceola 4-6	Catastrophe Averted - So, Now What Do We Do With the ICD-10 Data? Amy Dunatov, MHP, FACMPF, CCS-P, ICDCD-CM Osceola A	Improve Your Center's Performance: A Strategic Approach to Evaluating and Driving Your Business Forward Luke Hart Osceola B
6-7:30pm	Exhibit Hall Reception Florida Exhibit Hall F					

The UCAOA National Urgent Care Convention isn't just a meeting. It's one destination providing all-things urgent care.

Renew your passion for urgent care, spark new business ideas, challenge your clinical skills, develop new connections and catch up with peers, get advice from industry experts, explore innovative products, and much, much more. See our new, exciting events and education planned for the 2016 Spring Convention! Register by Thursday, March 17 to avoid late tuition; visit ucaoa.org/?2016Spring or call 877-698-2262.

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PARAReference of Legendration Registering Lemmin Rest Schularing Lem	6:30am-5pm	Attendee Registration Osceola Lobby					
Partial Barband Ba	7-8am	Attendee Breakfast & Legislative Update Osceola C-D					
9-913amCoffee Break / Hoar Classon9151015Dor Worry, Berkappy: Prestina Andreik Coffmoedic Injuries Brenden Killbane, Millon Corection In Millon Discribes And Nillon Prestina Andreik Coffmoedic Injuries Brenden Killbane, Millon Discribes And Nillon Prestina Andreik Coffmoedic Injuries Brenden Killbane, Millon Discribes Andreik Coffmoedic Injuries Branden Killbane, Millon Discribes Andreik Andreik Killbane, Millon Discribes Andreik Killbane, Millon Discribes Andreik Killbane, Millon Discribes Andreik Killbane, Millon Discribes Andr	8-9am	The Pre-Operative Evaluation in the Urgent Care Setting Jennie Kenkare, DO Naples	Urgent Care Triage Criteria for Adult Patients-Best Practices Don Herip, MD, MPH, FACOEM Osceola 1-3	The Three R's of Coding: Risk, Reimbursement and Reward Sharon Nicka, CPC, RN Tampa	OSHA/HIPAA Updates Ann Bachman, BS, MT(ASC), CLC(AMT) Osceola 4-6	Engaging With Millennials: How to Market Your Facility to the Mobile Generation Chris Behan Osceola A	Tune Up the Front Desk for Improved Collections Cheyenne Brinson, MBA, CPA Osceola B
\$\begin{tityped} \begin{tityped} titype	9-9:15am	Coffee Break Near Classroon	ns				<u>.</u>
10.19.11.103Content Control	9:15-10:15am	Don't Worry, Be Happy: Treating Anxiety and Depression in the Urgent Care Setting Michael Loeb, MD Naples	Frequently Missed Pediatric Orthopedic Injuries Brenden Kilbane, MD Osceola 1-3	Best Administrative, Operational and Clinical Practices for Urgent Care Centers in Tomorrow's Market Nate Newman, MD Tampa	Crafting a Legal and Effective Social Media Policy Spencer Hamer Osceola 4-6	Volume to Value: Population Health and Urgent Care Gregory Carroll, MD Osceola A	Key Performance Indicators for Urgent Care Billing Martin Karpiel,MPA Osceola B
10.13am-130paExist PE11.13am-12.15 pm 13.13am-12.15 pm 14.13am-12.15 pm 14.13am-12.15 pmDamona Dractice Mythy Than Amp & Costing Youn Than Amp & Costing Youn Than Amp & Costing Youn Pacing Island Woney, and Cassing Harnick O'Malley, NDI Occeals 1-3Data Drive Decision Making: Sumanon, NN, MKSA, Cosciels 4-3Feablishing a Quality Pacing Island Koley, and Sumanon, NN, MKSA, Sumanon, NN, MKSA, Sumano	10:15-11:15am	Coffee Break Florida Exhibit	Hall F				
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3:15-4:15pmMultiple Applications for Mindgement of Common Hand, Wrist and Upper Care Setting J Alejandro Badia, MD, FACS Osceola 1-3Developing a Scalable, Repeatable Model for Growth Lynne Rosen J TampaTelemedicine for the Urgent Care Operator J David Boucher, MPH, FACE (OP O Sceola A)Clinical Documentation in the World of ICD10 for the Urgent Care Provider Pavid Boucher, MPH, FACE (OP O Sceola A)Clinical Documentation in the World of ICD10 for the Urgent Care Provider4:15-4:30pmCoffee Break Near Classrow- Doceola 1-3Voltages in Wound Care Management Patrick O'Malley, MD Osceola 1-3A Deep Dive Into Yelp] Chris Behan TampaDisaster Recovery/ Business Continuity Patrice Pash, RN, BSN Osceola 4-6Contracting and Credentialing as Primary Care and Urgent Care] Michael Boyle, MD, FACE Osceola B Michael Boyle, MD, FACE Osceola 1-3Moep Dive Into Yelp] Chris Behan TampaDisaster Recovery/ Business Continuity Patrice Pash, RN, BSN Osceola 4-6Contracting and Credentialing as Primary Care and Urgent Care Michael Boyle, MD, FACE Osceola B KHOS plotace B osceola 4-6Moep Dive Into Yelp Care and Urgent Care Tammy Mallow Osceola A KHOS plotace B osceola 4-6Moep Dive Into Yelp Care and Urgent Care Tammy Mallow Osceola A KHOS plotace B osceola 4-6Moep Dive Into Yelp Care and Urgent Care Tammy Mallow Osceola B KHOS plotace B osceola 4-6Moep Dive Into Yelp Care and Urgent Care Tammy Mallow Osceola A KHOS plotace B osceola 4-6Moep Dive Into Yelp Care and Urgent Care Tammy Mallow Osceola B KHOS plotace B osceola 4-6Moep Dive Into Yelp Care and Urgent Care Tammy	2:15-3:15pm	Coffee & Dessert Break Florid	da Exhibit Hall F				
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	7-9pm						

Wednesday, April 20					
7-9:30am	Attendee Registration Osceola Lobby				
7:30-8am	Attendee Breakfast Osceola C-D				
8-9:15am	Closing Keynote by Karyn Buxman Osceola	C-D			
9:15-9:30am	Coffee Break Near Osceola C-D				
9:30-10:45am	New! Payer Roundtable Moderator: Boyd Faust, CPA; National & Regional Payer Representatives Osceola C-D				
10:45-11am	Coffee Break Near Classrooms				
11am-12pm	Dermatologic Diagnosis and Point of Care Decision Support Art Papier, MD Naples	Management of Needle Stick and Body Fluid Exposure in Urgent Care: Treatment of the Exposed Healthcare Worker Tracey Davidoff, MD Osceola 1-3	Care Coordination Robin Shannon, RN, MN, MBA Tampa	Workplace Safety/Violence Prevention Spencer Hamer, JD Osceola A	
12pm	Convention Adjourns				

KEY: Clinical Sessions

Practice Management Sessions

Osceola is located on the Ballroom Level (Level 2) Florida Exhibit Hall F is located on the Exhibit Level (Lower Level)

Clinical

Evaluation and Management of Ankle Injuries in Urgent Care

Urgent message: Acute ankle injuries can progress to chronic issues. It is essential that the urgent care clinician be aware of the mechanisms of common ankle injuries, their pathophysiology, essential diagnostic tests, and which injuries require transfer for a higher level of care.

LISA SCHUERMAN, RN, MSN, APNP

Introduction

The ankle is one of the most common sites for acute musculoskeletal injuries, with sprains accounting for 75% of ankle injuries. The ankle joint is composed of the tibia, fibula, and talus. The ligaments bind the bones together. Ankle sprains occur when the ligament is stretched beyond its limits and ligament fibers tear. An ankle injury, if not properly treated by the urgent care clinician, can result in long-term chronic ankle instability.

Case Presentation

Emily is a 20-year-old collegiate soccer player. She presents to an urgent care center, reporting that she has had foot pain for the preceding week. She reports that she was seen by her primary-care provider 1 week earlier, and the physician diagnosed a grade I ankle sprain. Her injury occurred while playing soccer 7 days earlier. Initially, she did not have pain on the lateral side of her foot—only on the lateral side of the ankle. She completed a week of RICE (rest, ice, compression, and elevation) with analgesics, but her pain continued. She ambulates with an antalgic gait. Her vital signs are nor-

Lisa Schuerman, RN, MSN, APNP, is an urgent care clinician at Presbyterian Hospital in Albuquerque, New Mexico. She is a graduate of Marquette University in Milwaukee, Wisconsin.



mal. Assessment of the foot reveals swelling over the fifth metatarsal. X-ray results are pending.

Background

It is vital for the health-care provider to be aware of the tests and treatments required for proper patient care. In

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Deltoid ligament. (From Gray H. Anatomy of the Human Body. Philadelphia, PA: Lea & Febiger; 1918: plate 354. Image available from: https://en.wikipedia.org/wiki/Medial_ ligament_of_talocrural_joint#/media/File:Gray354.png.)





addition, the provider must know which patients require a higher level of care in an emergency department (ED) or at an orthopedic clinic to help prevent chronic issues. Acute ankle trauma is responsible for 10% to 30% of sports-related injuries in young athletes.¹ Each year, an estimated 1 million people in the United States present to clinicians with acute ankle injuries.² More than 40% of ankle sprains have the potential to cause chronic problems.³ There are different types of ankle sprains, which are graded according to the amount and type of damage to the ligaments and stability. In addition, the Ottawa ankle rules are helpful for determining a diagnosis. Clinical knowledge of ankle injuries is usually limited in practitioners' training. Therefore, urgent care providers must become familiar with what laboratory tests must be ordered, what examination techniques to use, and how to interpret test results.

Pathophysiology

There are three main groups of ankle ligaments: the deltoid (medial), talofibular (lateral), and the syndesmosis. The deltoid ligaments support the medial part of the ankle. Four ligaments make up the deltoid ligament and form a triangle in the medial portion of the ankle. An injury to the medial part of the ankle is usually associated with a fracture (**Figure 1**).

ANKLE INJURIES IN URGENT CARE



The talofibular ligaments support the lateral part of the ankle. This is the weakest portion of the ankle joint, and thus many sprains occur here on the lateral side. The majority of ankle sprains are inversion injuries and are in this category (Figure 2).

The interior ligaments make up the syndesmosis, which connects the tibia and fibula (**Figure 3**). Between 5% and 10% of ankle injuries occur here. These are high ankle sprains, which are caused by sudden twisting injuries and require expert care and follow-up with an orthopedic practitioner.

Figure 4 shows the bones of the foot.

Medical History and Physical Examination

A thorough medical history is needed to help guide the practitioner through a complete physical examination. Questions that practitioners should ask themselves include the following:

- What types of laboratory and other investigative tests are important to perform?
- Are x-rays necessary in this case?
- What treatments are beneficial in this situation?
- Does this patient need referral to a higher level of care?

These are important aspects of the medical history:

- When did the injury occur?
- How did the injury occur? What is the mechanism of injury?
- What is the quality of the pain?
- Is there radiation of the pain?

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Table 1. Red-Flag Ankle Injuries

- Fifth metatarsal fracture (Jones fracture, zone 2).
- Tenderness over the physis in children
- High ankle fracture
- Achilles tendon rupture
- Maisonneuve fracture
- Tarsal navicular fracture
- Neurologic deficit with or without vascular compromise
- Displaced fracture
- Open fracture
- Compartment syndrome
- Crush injury
- What is the severity of the pain?
- How long has this been going on, and what changes have occurred? Has this ever occurred before in this patient?

Examination of the ankle should be done with the patient standing, walking, and then sitting. First have the patient stand, so that you can examine the ankle in the "normal" position. Inspect the ankles and feet and then compare the injured joint with the noninjured joint, looking for symmetry. Next, ask the patient to walk without shoes or socks, and observe their gait. The patient should be able to walk normally on their toes and heels, placing one foot in front of the other. Any variance should be documented. Then, observe the feet and ankles while the patient dangles their legs off the table. You should note slight plantar flexion and inversion of the feet. Here, you will want to palpate the patient's medial and lateral malleoli. Remember, the distal portion of the fibula constitutes the lateral malleolus. At this point, you should also palpate the Achilles tendon and perform the squeeze test to ensure that the Achilles tendon is intact and that there is not a tear in the syndesmosis between the distal tibia and fibula. Differential diagnoses include sprain, fracture, and dislocation.

Grading

Grading of ankle sprains focuses on the degree of ligament damage. A grade I sprain, stretching without tearing of the ligament or without instability of the joint, can be fitted with an ankle stirrup-type splint. The patient can be given crutches, be given instructions on their use, and be prescribed a nonsteroidal antiinflammatory agent, such as ibuprofen, 200 to 800 mg every 6 hours. Teaching the *RICE* mnemonic to the patient regarding home treatment is helpful. Follow-up for grade I sprains includes use of an ankle stirrup and

Table 2. Zone Classification for Metatarsal Fractures			
Zone	Description		
Zone 1, pseudo– Jones fracture	Involves the proximal tubercleNonunion is uncommon		
Zone 2, Jones fracture	 Involves the metaphyseal-diaphyseal junction Is an acute injury Carries an increased risk of nonunion because of the vascular supply 		
Zone 3	 Is a proximal diaphyseal fracture Is usually seen as a stress fracture in athletes Carries an increased risk of nonunion because of the vascular supply 		

engaging in weight-bearing as tolerated. Crutches should be used for the shortest time possible. The patient can return to their primary-care provider in about 2 weeks for further follow-up if needed. Once the patient can ambulate without pain and range-of-motion exercises do not cause pain, the patient can then begin strengthening the muscles surrounding the joint.

In a moderate sprain, or a grade II sprain, there is some tearing and instability. There is usually more swelling and ecchymosis than there is in a grade I sprain. Point tenderness may also be present, with a resulting loss of joint function. Treatment for a grade II sprain is the same as for a grade I, with the addition of a Jones cast or a walking boot. For a grade II sprain, physical therapy may also be required. Crutches will also be needed, because staying off the foot will be imperative for the first 5 to 7 days to prevent chronic issues.

For severe sprains, or grade III sprains, treatment includes placing the patient in a large, bulky dressing or a Jones cast. Alternatively, a walking boot can be used to prevent the patient from using crutches and yet allow participation in activities of daily living. The walking boot may be a better alternative for some patients, but it is expensive. It should be used for about 4 to 6 weeks, with follow-up care by an orthopedist.

A computed tomography (CT) scan may be useful to assess the degree of injury for grade III or syndesmotic injuries. Grade I sprains usually do not require an x-ray. However, radiographs of a grade II or III sprain may be necessary to rule out an ankle fracture, especially if the patient is unable to ambulate immediately after the injury occurred or cannot take four steps in your presence. *You do not want to miss a high ankle fracture, because there is the possibility of chronic pain and instability.*

Diagnostic Testing

Helpful diagnostic modalities include x-ray, CT, and magnetic resonance imaging (MRI).

- X-rays can
 - Help rule out a strain versus a fracture
 - Help in assessing narrowing of the space between the bones, which are normally covered by cartilage; narrowing can be a sign of arthritis
 - Help in evaluating bone spurs, which are overgrowths of a joint and can be a sign of osteoarthritis
 - Show a fracture
- CT can
 - Help in the evaluation of ankle pain
 - Depict cross-sectional slices of the ankle
 - Help in the diagnosis of ankle fractures and can show soft tissue such as cartilage, ligaments, and muscles
 - Show arthritis and sprains
- MRI can
 - Show soft-tissue structures
 - Show the bone, which is very useful in diagnosing injuries of the cartilage, tendons, and ligaments

Management of Specific Injuries

Table 1 lists red-flag ankle injuries.

Ankle Strain

The most appropriate treatment for ankle sprains depends on which grade they are. The treatment is usually RICE. Resting time depends on the grade of the injury and can vary from 5 days for lower-grade to up to 6 weeks for severe tears or grade III sprains.

Fifth Metatarsal Fracture

Table 2 lists metatarsal fractures by zone. Multiple classification systems are used to describe the fractures. For example, there is the Torg classification system, which is used for fractures that are within 1.5 cm of the metatarsal tuberosity.⁴

Fractures of the fifth metatarsal can be easily missed (Figure 5). A Jones fracture (Figure 6) located in zone 2 is usually the result of a jumping or pivoting activity like basketball or soccer. The patient may have mild or severe pain and will usually have point tenderness over the fifth metatarsal. Treatment always requires avoidance of weight-bearing and use of a cast for 6 to 8 weeks, as long as the fracture is not displaced.





Zone 3: fifth metatarsal fracture. (Used with permission under a Creative Commons CCo 1.0 Universal Public Domain Dedication [https://creativecommons.org/publicdomain/ zero/1.0/deed.en]. Original image available from: https://commons.wikimedia.org/wiki/File:Jones_fracture_ healing_zones_according_to_Polzer.jpg.)

Figure 6.

Jones fracture, zone 2, located at the metaphysealdiaphyseal junction. (Used with permission under a Creative Commons Attribution-Share Alike 3.0 Unported license [https://creativecommons.org/licenses/by-sa/3.o/deed.en] from Mdscottis. Original image available from: https://commons.wikimedia.org/wiki/File:Cropped version_of_Jonesfracture.jpg.)

Table 3. Management of Common Ankle Sprains

Acute care

- 1. Rest of the joint
- 2. Ice every 2–3 hours for 15 minutes at a time
- 3. Compression with an elastic bandage
- 4. Elevation of the limb to decrease swelling
- 5. Analgesic, preferably a nonsteroidal anti-inflammatory, for no longer than 72 hours

Follow-up treatment

- Progressive range-of-motion exercises, including exercises that incorporate proprioceptive techniques and ankle strengthening
- 2. Physical therapy as needed if the sprain is grade II or III
- 3. Slow incorporation of incorporate weight-bearing as tolerated

High Ankle Sprain or a Syndesmotic Sprain

Syndesmotic sprains, also called high ankle sprains, occur with rotational injures like external rotation or with high-impact sports such as soccer. Detecting high ankle sprains is imperative because the syndesmotic ligament connects the tibia and fibula, and a high ankle sprain can also accompany a fracture. Testing for this type of sprain or fracture includes the squeeze test and the external rotation test. One or both of these tests will elicit pain from a patient with a syndesmotic sprain. An x-ray will also be needed to rule out a fracture. Treatment for these sprains includes RICE (Table 3). If there is moderate to severe pain and the patient requires a walking boot, instruct them to wear the boot for up to 6 weeks. A good measure of healing is the hop test. If there is not a fracture and the patient can hop 15 times on the foot, then strengthening and weight-bearing can begin. A fracture requires use of a cast and avoidance of weight-bearing for up to 12 weeks. A displaced fracture may need surgical intervention to prevent chronic issues in the future.

Achilles Tendon Rupture

The Achilles tendon is the largest tendon in the body, connecting the calf muscles to the heel bone. The Achilles tendon can be torn during high-impact sports such as running and jumping, with the patient reporting a pop or snap and immediate sharp pain in the calf. *Surgery is almost always required and merits a transfer to the ED and consult with an orthopedist.*

Maisonneuve Fracture

The Maisonneuve fracture (**Figure 7**) is both a fracture and a sprain and usually occurs from a falling accident related to a sporting event. The patient will have pain in the upper part of the fibula or tibia, and the ankle will feel quite unstable. The patient may have difficulty walking on it. *This type of fracture generally requires surgical intervention* along with the basic interventions for a sprain. Crutches will be needed for up to 12 weeks. Transfer to the ED and orthopedic referral will be needed.

Tarsal Navicular Fracture

A tarsal navicular fracture is usually diagnosed when there is a high level of suspicion for it. This fracture can be missed because of a lack of knowledge on the provider's part, resulting in a delayed diagnosis. The patient may have pain in the forefoot. The mechanism of injury is related to the localization of stress placed on an avascular navicular bone. A navicular fracture is generally a stress-related fracture in a runner or someone who presents with vague midfoot pain. Unfortunately, this fracture does not show up well on x-ray because of the many bones overlapping in the area. In addition, the talonavicular nerve runs along the medial portion of the arch of the foot and thus is involved in midfoot pain. This can make for a tricky diagnosis and is usually not one that clinicians think about. If the x-ray findings are unequivocal, the clinician should then order a bone scan, followed by a CT scan. Treatment is RICE, followed with avoidance of weight-bearing and use of a cast and crutches for 6 to 12 weeks, with duration depending on how quickly the fracture heals. If one of these fractures is found, the patient must be evaluated by an orthopedist.

Avulsion Fracture

An avulsion fracture occurs when a bone fractures and a portion of it is torn away from the main mass of the bone. This is usually a result of a physical trauma such as a fall or a pull. Generally, this does show up on a simple x-ray. Treatment for this fracture is the same as for a sprain, assuming it is a nondisplaced fracture. For a displaced fracture, internal fixation and reduction by an orthopedic surgeon will be required.

Case Resolution

Assessment of Emily's injured foot reveals continued swelling over the fifth metatarsal. Further assessment reveals tenderness on the lateral fifth metatarsal. Before her x-ray is read, you suspect a fifth metatarsal fracture. While you are explaining to her the difference between a nondisplaced and displaced fracture, the radiologist calls to discuss the x-ray with you. The x-ray shows a



Maisonneuve fractures (A) of the medial malleolus and (B) of the upper fibula. (Figure A is adapted with permission under a Creative Commons Attribution-Share Alike 3.0 Unported license [https://creativecommons.org/licenses/by-sa/3.0/deed.en] from RotorMotor2. Original image available from https://commons.wikimedia.org/wiki/File:Maisonneuve_fracture_Malleolus.jpg. Figure B is adapted with permission under a Creative Commons Attribution-Share Alike 3.0 Unported license [https://creativecommons.org/licenses/by-sa/3.0/deed.en] from RotorMotor2. Original image available from https://creative commons.org/licenses/by-sa/3.0/deed.en] from RotorMotor2. Original image available from https://creative.org/wiki/File:Maisonneuve_fracture_Fibula.org/wiki/File:Maisonneuve_fracture_Fibula.org/wiki/File:Maisonneuve_fracture_Fibula.org/wiki/File:Maisonneuve_fracture_Fibula.JPG.)

zone 2 fracture of the fifth metatarsal—a Jones fracture (Figure 6). You order placement of a non-weight-bearing cast, teach her how to walk with crutches, and instruct her to follow up with an orthopedist in 1 day.

Take-Home Points

- Palpate the entire fibula and tibia.
- Do not disregard medial or lateral malleolar tenderness.
- Always examine the fibular head in ankle injuries.
- Always examine the base of the fifth metatarsal.
- Determine whether the patient can bear weight. If negative x-ray findings are not convincing, then splint the ankle, advise the patient to avoid weightbearing, and recommend follow-up care in 1 week.
- Use caution in those under the age of 18 years. In these patients, ossification is incomplete, there is an increased tendency toward broken bones, and ligaments are stronger than the bones.

- Use extra caution in assessing those with limited cognition and verbalization skills or neuropathies, in those who are intoxicated, those with diabetes mellitus, and in those who are uncooperative.
- Encourage follow-up with a primary-care provider if healing has not begun in 5 to 7 days.
- Although the majority of ankle injuries that are seen in urgent care centers are minor and can be treated on an outpatient basis, keep in mind situations that call for referral for further evaluation.

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Practice Management

We're All in This Together: Four Attributes of Effective Medical Center Teams

Urgent message: Creating and cultivating cohesive, goal-oriented, and patient-focused urgent care teams starts with visible front-line leaders who emphasize a strong service culture, open communication, personal accountability, and management transparency.

ALAN A. AYERS, MBA, MAcc

Introduction

The stress, resentment, and dissatisfaction that one experiences being part of a disconnected and ineffective team are not easily forgotten. Common sense may lead one to believe that the safest path is to ignore the team's dysfunction and consider it just a part of the job. After all, suggesting that there is room for improvement would just make things worse, and besides, would anyone listen? Over time, team members who realize they cannot influence the direction of the organization start to identify as victims. But this attitude of resignation only makes things worse, especially for the patients for whom the team is responsible. **Table 1** shows the behaviors, attitudes, benefits, and costs associated with being a victim as opposed to being accountable.

Playing the Role of Victim Has Benefits

The role of victim can be played with little or no effort. Victims never risk anything, they never do any wrong, and best of all, they get a lot of attention and sympathy without ever working for it. The eternal problem with victims is their effortless contributions to a team's inef-



fectiveness. Without the desire to have any control whatsoever over their circumstances, victims will not be held accountable for their own actions, because someone else is always to blame. With these defense mechanisms in place, an organization of victims has no chance for the kind of growth that occurs by learning from one's mistakes. Instead, a victim's mastery of denial and projection protects them from acknowledging the weak-

Alan A. Ayers, MBA, MAcc, is Vice President of Strategic Initiatives for Practice Velocity, a member of the Board of Directors of the Urgent Care Association of America, and Practice Management Editor of the *Journal of Urgent Care Medicine*.

Table 1. Attributes of Victims vs. People Accountable for Their Actions				
Victim		Accountable		
Benefits	Costs	Benefits	Costs	
Sympathy	No control	Control	Admitting mistakes	
No wrong	No growth	Learning	Looking imperfect	
No risk	No respect	Growth	Incurring risk	
Attention	Results suffer	Better results	Required to take action	
Behaviors		Attitudes		
Denies business realities		Seeks clarity about problems and defines issues		
Projects onto and actively blames others		Applies their attention, energy, and focus		
Is resigned to the status quo		Explores new possibilities		
Feels others are responsible for change		Makes plans for, and implements, change		

nesses and failures at the root of the team's ineffectiveness. **Table 2** lists can versus can't attitudes—victims embrace the *can't*, whereas the accountable seek out the *can*.

Accountable Teams Start with Commitment to a Goal

Effective teams seldom occur spontaneously. Rather, creation of a successful and effective team involves a great deal of work, planning, and a strong sense of commitment from each team member. Effective teamwork occurs when team members are working together toward the same clearly identified goal. In the case of urgent care, this goal should entail serving patients in a courteous, professional, and efficient manner. Team members should be respectful of each other's opinions and suggestions, and everyone should understand the value of giving due consideration to the ideas that arise from each other's life experiences. A team that puts forth a unified effort to reach common goals is compensated with a more satisfying work experience and greater productivity.

With this thought in mind, it's important to understand that conflicts can erupt even in the most cohesive teams whose members usually work together in relative peace and harmony. An effective team leader prepares for the inevitable skirmish in advance by having a structured conflict-resolution plan in place. Once a conflict is satisfactorily resolved, team members should take advantage of the learning and growth opportunity gained by looking at a problem from a different perspective. This idea of conflict being advantageous in certain situations embraces the concept of cognitive diversity in relation to the effectiveness of a team. Teams consist of people with different talents, levels of ability, and knowledge. If all team members think about the same problem in the same way, it is extremely difficult to come up with a new or inventive approach to resolve problems. Thus, having differing experiences and perspectives will add flavor to the mix of ideas. When a problem is identified and placed in the "I can't" column under the category of "We've never done that before," members of an effective team will see the chance to use their "I can" attitude and say, "We have the opportunity to be first."

An effective team is flexible, making every effort to adapt to new circumstances. Members are confident their team leader or manager supports them in the same way as their teammates. A manager must provide leadership for the group, but an effective leader should know just how much or how little management is necessary to inspire maximum productivity from the team. The effective leader recognizes the need for clearly defined tasks and responsibilities but also knows that strict adherence to pigeon-holed job descriptions limits employees' ability to reach their full potential. Team members are willing to take on responsibilities beyond their job descriptions, often see that as a learning opportunity. On the best teams, all members feel accountable for their actions in their own jobs and share a sense of ownership in achieving overall goals.

Effective Leaders Encourage Open Communication

Open communication is a vital characteristic of an effective team. Employees believe that their leader is approachable, values their ideas, and listens to their input. In turn, successful leaders show appreciation for team members and give frequent feedback in acknowledgment of their efforts and achievements. Communication between

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On a Mission to expand urgent care access in rural America

S tan Bevis was a 20-year-old nursing student when his father died suddenly. Waiting 20 minutes for an ambulance while performing CPR on his father, Bevis became acutely aware of the desperate need for rural healthcare. By the time help arrived, it was too late. That's when Bevis's goal of expanding access to



Stan Bevis, Fast Pace Founder

medicine in rural areas turned into a mission.

The need for healthcare in rural areas is well documented. A 2014 report "Access to Rural Health Care" found that barriers to healthcare result in unmet needs including preventative and screening services, treatment of illnesses, and preventing patients from needing costly hospital care. About a quarter of the U.S. population lives in rural areas, but only about 10 percent of U.S. physicians practice in rural America.

Bevis, a registered nurse with experience flying as part of a life flight crew, wanted to open a medical clinic in an underserved area. His wife, also a nurse, encouraged him, even though they had their hands full with four children at home.

In 2009, Bevis opened the first Fast Pace Urgent Care Clinic in Collinwood, a southern Tennessee town of fewer than 1,000 people. The walk-in clinic offered access every day of the week, a novel concept in an area where primary care offices weren't even open every weekday.

"Even in communities that are served by providers, many times they're only open Mondays, Tuesdays, Wednesday mornings and maybe every third Friday," Bevis said. "People were so appreciative of having this access to urgent care."

Now Fast Pace Urgent Care has a network of more than 30 clinics across Tennessee and

By: Dorothy Wallheimer

Kentucky. Bevis credits some of his rapid growth to his 2012 partnership with Chicago-based equity firm Shore Capital Partners. In his early startup days, Bevis chose new locations based on a gut instinct of the needs he saw in those communities. Nowadays, he said, "the private equity guys like to put numbers around things." Working with the private equity firm has helped Bevis expand quickly with more assurance of success.

Demographic data show rural populations are older and poorer than those in urban areas. A larger percentage of rural population relies on government assistance, and fewer have employeeprovided health care coverage. Patient education is still one of the biggest obstacles to expanding

"People are so trained that they have to make an appointment and then wait days and days. We need to explain what urgent care is."

healthcare in these areas. Bevis said he's had to convince his own mother on several occasions that she could just walk into the urgent care center; she didn't need to have an appointment. "People are so trained that they have to make an appointment and then wait days and days. We need to explain what urgent care is," he said.

He remembers one patient, a masonry worker, who had a big concrete job going. Even though he felt sick, he wasn't going to take the next day off to go see the doctor, Bevis said. Someone convinced him after work to visit urgent care, where he was assessed and sent on to the hospital for three stents.

"This obviously hit home with me given my history with my dad. Our clinics' extendedhours services saved this man's life," Bevis said. "And he didn't have insurance, but we have a very reasonable self-pay process for that reason."

"We feel very fortunate that we've been part of some really good outcomes."

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Table 2. Sample of Can Versus Can't Attitudes

Can't Attitudes (I Can't!)

We've never done it before It's too complicated It will never work There is not enough time We already tried it It's a waste of time We don't have the experience They'll take care of it It's good enough They're a bottleneck It'll never fly We don't have enough training It's not going to be any better It can't be done No one communicates Isn't it time to go home I don't have any idea Let someone else deal with it We're always changing direction I never receive feedback It's too radical a change It takes too long for approval They won't buy it It's not my job

Can Attitudes (I Can!)

We have the opportunity to be first Let's look at it from a different angle Let's give it a try We will reevaluate some priorities We learned from the experience Think of the possibilities Let's network with those who do I'd like to follow it through with you There is always room for improvement I'll get them involved earlier We'll never know if we don't try I'll teach myself or ask for a mentor We'll try it one more time It will be a challenge Let's open the channels Days go so quickly around here I'll come up with some alternative I'm ready to learn something new We're in touch with our customers I'll ask my manager for feedback Let's take a chance We'll walk through the system We'll do a better job educating them I'll be glad to take the responsibility



Urgent Care Assurance Company, RRG An insurance company created and owned by urgent care physicians.

take control.

a compelling investment opportunity in a business you know better than any other...*your own*. team members is necessary, and interactions are frequent in a successful team. Data and information about the practice's strategies, tactical plans, and real-time performance are readily shared. The most effective teams are willing to approach problems in new ways, and they are open to considering the innovative or out-of-the box solutions offered by their teammates. "On the best teams, all members feel accountable for their actions in their own jobs and share a sense of ownership in achieving overall goals. Open communication is a vital characteristic of an effective team."

Although there is no one-size-fits-all approach to the creation of an effective team, the following attributes are offered as general guidelines. A plan to cultivate these attributes should be made only after careful consideration of all known factors that contribute to the unique circumstances of the team, as well as consideration of the individual members' strengths.

Attribute 1: A Strong Service Culture

An effective team will create and sustain a strong service culture. More specifically this involves focusing on capturing repeat visits from loyal patients. Urgent care is in the patient satisfaction business, because centers are successful only insofar as patients return for future medical needs and tell others to do likewise. Thus, strength of a center's relationship with patients can be measured by reach and loyalty. *Reach* refers to the number unique patients the center serves, and *loyalty* refers to the proportion of a patient's total care that is through the facility or health system.¹ The first step in creating an effective team entails hiring and training people who can effectively build relationships with patients.

Attribute 2: Managers Lead from the Front, Not the Top Having managers who lead from the front, rather than the top, is another attribute necessary for creating a successful and effective team. In many cases this can be accomplished by the leader's first taking on the toughest tasks to show that they can be done.² Many real leaders³ do not believe in asking their team to do anything they themselves would not do. It's one thing to tell people what to do, but it is an entirely different thing for the leader to actually show or demonstrate what needs to be accomplished. Managers at all levels should understand all systems and processes in the center. Such familiarity demonstrates to team members that all jobs contribute to the overall goal and that the appropriate response to facing a problem is to jump in and devise a solution. Leading by example builds teams of individuals who can function independently when the need arises.

Active management entails changing the outcome of business situations before the end of the day. Much like a snowball rolling down a hill, issues can grow out of proportion when left unchecked. Leading from

the front, an effective manager will not allow a situation to grow so large that it becomes unmanageable. Rather, the manager will intervene at the first signs something is amiss.

Some leaders monitor and share key performance metrics via a dashboard or scorecard approach.⁴ To be effective, each team member must understand the numbers that drive the business. Using graphic illustrations to show how a team is performing relative to its goals, the leader and team members can understand what is currently happening within the business and intervene early when issues appear, to make sure that day-to-day operations stay on track.

Attribute 3: Culture of Transparency

Building an effective medical team requires creation of a culture of transparency. Transparency can be defined as "a lack of hidden agendas or conditions, accompanied by the availability of full information required for collaboration, cooperation, and collective decision making."5 A transparent culture can help team members feel safe discussing problems affecting patient care, such as HIPAA (Health Insurance Portability and Accountability Act) guidelines, malpractice risks, payor and Medicare compliance, patient safety, and clinical quality guidelines. Rather than hide or ignore problems within the practice, committed team members engage incident-reporting processes early and take part in devising solutions. They realize that there will be no retaliation for sincerely raising issues that could affect patient safety and quality of care. Rather, they understand the dire risks to patients and the practice of ignoring or hiding problems.

Attribute 4: Culture of Accountability

A culture of accountability that starts at the top is the final attribute necessary for building an effective medical team. Health-care providers have used performancemanagement systems and quality-improvement methods in an attempt to improve the quality and outcomes of health-care services, but they had little success until there was a change in organizational culture to complement the tools and processes used to improve quality.⁶

If an organization wishes to continuously learn and use evidence-based practices, it

must create a sense of accountability within employees. Instead of shifting from one flavor of the month to the next, accountability ensures the permanence of performance management and continuous improvement by holding people to their commitments on a daily basis.⁶

To create a culture of accountability, it is important to reinforce that not only will the quality of patient care improve but also the quality of work will improve organization-wide. If employees associate the development of a culture of accountability with being reprimanded, it is unlikely that they will accept the new direction. Instead, what is required is a complete and total focus on emphasizing that this change will improve health-care quality and employee satisfaction.

Accountability is very similar to stewardship in health administration because it demonstrates responsibility to the patient population that the organization serves. As with stewardship, accountability aims to ensure careful and responsible management of human, physical, and financial resources. A culture of accountability contains a set of common elements wherein⁶

- The common belief is continuous learning and improvement at the individual, unit or department, and organizational levels
- Decisions regarding care and direction are guided by evidence-based protocols and clinical practice guidelines but not by individual preference
- Performance measurement is an essential element in assessing outcomes and guiding improvement initiatives
- Reporting errors is encouraged and is not punished
- There is collaboration and coordination among and between all levels of the organization and across all specialties.

It would be a mistake to think that leadership is primarily an administrative function because in a health-

"Having managers who lead from the front, rather than the top, is another attribute necessary for creating a successful and effective team. In many cases this can be accomplished by the leader's first taking on the toughest tasks to show that they can be done."

care setting, most protocols are a combination of both administrative and clinical processes. The implication of this is that in addition to a chief executive officer, the change process must involve a team of leaders and individual managers to help inspire change across business and clinical functions. As an example of accountability beginning at the top, a physician champion must help to

motivate others in order to gain physician buy-in.⁶

The ultimate goal of creating a culture of accountability is to create a continuously learning organization, which promotes the acquisition and use of new knowledge as a strategy for coping with change and also recognizes the critical need to empower workforces to learn and participate in continuous improvement.

Conclusion

Effective teams do not evolve by chance. In urgent care, they start with a strong emphasis on serving patients, are driven by leaders who engage the front line in a common goal, and function in a framework of transparency and accountability. With the 20/20 vision that hindsight gives, a wise person chooses to learn from the dysfunctional team-member experience and seeks ways to build more effective teams moving forward. They might even apply the knowledge they gained in those difficult times when confronted with a "can't" attitude of "It'll never fly" and change it to "We'll never know if we don't try." Although a positive attitude alone will not accomplish a task, it makes the rest of the job much easier.

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Clinical

Zika Virus—Near Pandemic Proportions?

Urgent message: The clinical manifestations of Zika virus infection are generally mild in adults; the primary concern is the potential link to microcephaly in children of infected pregnant women. There is no cure, so prevention is paramount.

MIZUHO SPANGLER, DO, and MICHAEL B. WEINSTOCK, MD

Introduction

The Zika virus epidemic is gaining a lot of media attention, deservedly so; there have been large outbreaks of infection in Brazil, South America, and the Caribbean, with numbers of cases anticipated to increase, even in nontropical parts of North America.^{1–3}

The Zika virus is a single-stranded RNA virus from the Flaviviridae family. This flavivirus is similar to other tropical viruses such as dengue, chikungunya, and yellow fever. It is transmitted to humans through the bites of infected mosquitoes, most notably the *Aedes aegypti* mosquito.^{1–3}

Zika virus was first identified among rhesus monkeys in the late 1940s in the Ugandan forests of Africa, and was later discovered to exist in human hosts as well.² *Aedes* mosquitoes typically breed in water-holding containers and are known to be aggressive daytime biters.^{1,2} Roughly 1 in every 5 patients infected with Zika virus by mosquitoes will become symptomatic.¹

Mizuho Spangler, DO, is Assistant Professor of Clinical Emergency Medicine, LAC+USC Keck School of Medicine, Los Angeles, California, and Executive Producer, *Urgent Care Reviews and Perspectives* (UC:RAP). Michael B. Weinstock, MD, is Professor of Emergency Medicine and Adjunct, Department of Emergency Medicine, Ohio State University College of Medicine; Emergency Department Chairman and Director of Medical Education, Mount Carmel St. Ann's Hospital Department of Emergency Medicine, Immediate Health Associates, Inc., Columbus, Ohio; Associate Clinical Editor for the *Journal of Urgent Care Medicine*; and Editor-in-Chief, UC:RAP.



Clinical Presentation

Clinical symptoms are relatively mild in adults, lasting a few days to 1 week. Common symptoms include¹

- Fever
- Maculopapular rash
- Arthralgias and myalgias
- Headache
- Conjunctivitis

Complications

The primary concern in Zika infection is the potential link to neurologic sequelae. In 2015, nearly 4000 infants

born in Brazil were reported to have microcephaly and severe neurologic compromise.^{2,4–6} Our current understanding of Zika is still limited, and causation has yet to be established, but it is known is that Zika virus can cross transplacental barriers, presumably infecting fetuses in utero.^{4,6–8} Rare cases of Guillain-Barré, potentially linked to Zika, have also been reported in adults, but this is far less common than its effects on newborns and its risk to pregnant women.

In January 2016, the Hawaii State Department of Health reported the first U.S. case of microcephaly in a newborn; the infant's mother had traveled from Brazil. Shortly thereafter, cases of Zika-infected patients were reported in Texas, Florida, and the U.S. Midwest.^{2,4}

Sexual Transmission

In February 2016, the Centers for Disease Control and Prevention (CDC) reported three probable cases of Zika virus transmitted via sexual intercourse and/or infected semen. In all three cases, male patients who had developed symptomatic Zika illness were noted to have infected semen. It is currently unknown whether asymptomatic men can transmit Zika virus to their sex partners. Sexual transmission of Zika virus from infected women to their sex partners has yet to be reported.⁴

On February 5, 2016, the CDC recommended that patients who reside in or who have traveled to areas with active Zika virus transmission either abstain from sexual activity or consistently use a protective barrier method (condoms), particularly if their female partner is pregnant. Pregnant women with potential exposure should be evaluated. Health-care providers are advised to follow the CDC's guidelines for evaluation and testing of pregnant women.^{4,6,7}

Treatment

There is no specific antiviral medication or treatment for Zika infection.^{1–3} Management should be aimed at symptomatic relief, similar to treating other viral syndromes. This includes consuming fluids, resting, and taking analgesics and antipyretics such as acetaminophen.^{1,2} Avoid nonsteroidal anti-inflammatory drugs until dengue infection is ruled out, owing to the risk of possible hemorrhagic complications. Zika-endemic areas are geographically similar to areas where dengue and

"[The virus] is transmitted to humans through . . . infected mosquitoes, most notably . . . Aedes aegypti." chikungunya are endemic, and thus all three viruses must be considered in the differential diagnosis.

Current State of Affairs

As of early February 2016, a total of 35 travel-associated cases of Zika had been reported in the United States, and with summer approaching there, this number is expected to increase dramatically.^{2,3,5}

Zika virus infection is now a nationally reportable condition, and health-care providers are encouraged to report suspected cases to their local or state health departments.^{1,6–8} Unfortunately, testing for Zika at point of care is currently not available. However, the CDC and a few U.S. state health department laboratories are capable of polymerase chain reaction testing.^{2,3,8}

Prevention

Because there is no specific treatment, prevention is the best approach to limiting the spread of the virus.^{1–4,7,9} Travel to endemic areas should be avoided if possible, particularly for pregnant women and those women actively trying to get pregnant. If travel to endemic areas is mandatory, it is advisable to wear protective clothing and use mosquito repellent. Given the high suspicion for sexual transmission, barrier protection during sexual intercourse should be used.^{2–5,9}

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ABSTRACTS IN URGENT CARE

- Inhaled Steroids Do Not Reduce Growth in Children with Asthma
- Don't Just Sit There All Day—Get Up and Move Often
- E-cigarettes Are Unsafe for Adolescents
- Diverticulitis Is More Common Than Once Thought, Especially in Younger Patients
- Lyme Disease Is Spreading to the U.S. Southeast

- Self-Collection of Samples Eases
 Women's Anxiety in Testing for Sexually
 Transmitted Infections
- Antibiotics for Upper Respiratory Tract Infections Are Usually Unnecessary
- Clarithromycin May Not Be the Best Choice, Because of Increased Cardiovascular Risks

SEAN M. MCNEELEY, MD

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

Inhaled Steroids Do Not Reduce Growth in Children with Asthma

Key point: Inhaled steroids did not reduce growth velocity in a 1-year study.

Citation: Wardenier NR, Klok T, de Groot EP, Brand PL. Height growth in children with asthma treated with guidelinerecommended dosages of fluticasone and electronically assessed adherence. *Arch Dis Child*. 2015 December 7. doi: 10.1136/archdischild-2015-309654.

Adherence to therapy is important for children with asthma. Many factors, including fear of adverse effects, influence adherence. It has been postulated that the growth reduction seen only for the first year goes away because of decreased adherence rather than because of adjustment to the medication. This study looked at 99 children with asthma who took inhaled fluticasone over 1 year, for a minimum of 3 months, to see if adherence was related to reduction of growth. Adherence was monitored by electronic devices. The relationship between cumulative fluticasone dose and height growth velocity over



Sean M. McNeeley, MD, is an urgent care practitioner and Network Medical Director at University Hospitals of Cleveland, home of the first fellowship in urgent care medicine. Dr. McNeeley is a board member of UCAOA, UCCOP, and the Board of Certification in Urgent Care Medicine. He also sits on the *JUCM* editorial board. 1 year was analyzed. Mean adherence was 84%. Significant growth velocity reduction was not noted. For the urgent care provider, this is one more piece of information to relay when attempting to ensure adherence to medication therapy for asthma in children. However, this was a small study, so further research to confirm these results would be helpful.

Don't Just Sit There All Day—Get Up and Move Often

Key point: Get up and move.

Citation: Henson J, Davies MJ, Bodicoat DH, et al. Breaking up prolonged sitting with standing or walking attenuates the postprandial metabolic response in postmenopausal women: a randomized acute study. *Diabetes Care*. 2016;39:130–138.

Several recent studies have shown that just getting moving has a positive effect on metabolism. This small study of 22 postmenopausal obese women at risk for type 2 diabetes attempted to determine whether short periods (5 minutes) of standing or walking had an effect on glucose or triglyceride levels in comparison with prolonged sitting. Patients participated in all three types of behavior: prolonged sitting (7.5 hours); sitting for 7.5 hours, broken up by standing for 5 minutes every 30 minutes; and sitting for 7.5 hours, broken up by light walking for 5 minutes every 30 minutes. The participants' diet was controlled. Postprandial glucose levels were reduced in both the standing and light-walking groups. This is a good reminder for both urgent care providers and their patients that standing or walking even for short periods will improve glucose control.

E-cigarettes Are Unsafe for Adolescents

Key point: Electronic cigarettes have adverse effects on adolescents.

Citation: Wang MP, Ho SY, Leung LT, Lam TH, et al. Electronic cigarette use and respiratory symptoms in Chinese adolescents in Hong Kong. *JAMA Pediatr.* 2016;170:89–91.

Although electronic cigarettes (e-cigarettes) may have fewer chemicals than traditional cigarettes do, there still are risks involved. This study anonymously surveyed 45,128 students in sixth and seventh grades regarding use of e-cigarettes and respiratory symptoms such as cough and phlegm production. Status as a previous or current smoker was also surveyed. All types of users (nonsmokers, current smokers, past smokers) of e-cigarettes showed significantly more respiratory symptoms. The odds ratio was as high as 2 for never-smokers and 1.28 for all. Although these findings are nonspecific, they are good information to pass to all adolescents who think e-cigarettes are safe. Good times for urgent care providers to mention this information are during visits to treat upper respiratory infections and visits for sports physical examinations.

Diverticulitis Is More Common Than Once Thought, Especially in Younger Patients

Key point: Keep a lookout for diverticulitis. Citation: Bharucha AE, Parthasarathy G, Ditah I, et al. Temporal trends in the incidence and natural history of diverticulitis: a population-based study. *Am J Gastroenterol*. 2015;110:1589–1596.

Diverticulitis shows up at urgent care centers particularly early in the course of the disease. Most data on the occurrence of diverticulitis are hospital-based and, per the study's authors, greatly underestimate the actual incidence of diverticulitis because most patients with it are treated as outpatients. This study was a retrospective review of diverticulitis diagnoses from 1980 to 2007. Results showed a 50% increase in diverticulitis since 2000. The disease is now being diagnosed more often in younger patients, but with more recurrences of milder disease. The authors also questioned the number of surgeries after complicated diverticulitis bouts because the rates of recurrence and severe bouts were not significantly increased by a severe occurrence. The applicability of these findings is limited because the study was from a single area, but its size and scope were large. For the urgent care provider, these findings should cause more careful consideration of the diagnosis in younger patients with mild but consistent symptoms and perhaps questioning whether options such as surgery after severe disease should be recommended.

Lyme Disease Is Spreading to the U.S. Southeast

Key point: Could it be Lyme disease?

Citation: Lantos PM, Nigrovic LE, Auwaerter PG, et al. Geographic expansion of Lyme disease in the southeastern United States, 2000–2014. *Open Forum Infect Dis*. 2015;2: ofv143. doi: 10.1093/ofid/ofv143.

Lyme disease is a significant cause of tick-borne disease, especially in the northeastern United States. In the past, the majority of cases of Lyme disease were found from northern Virginia and up to the New England states. This study's authors reviewed cases of Lyme disease in Virginia and North Carolina and found a significant spread of Lyme disease in Virginia, particularly since 2007, with appearances also being noted in southern Virginia in the mountain areas. Although North Carolina did not have a significant disease presence, the current changes are concerning for spread to this area. The authors do note that the disease process itself is under-reported by as much as 90%, and thus tracking cases can be difficult. Particularly for urgent care providers in the Northeast, Minnesota, and Wisconsin, it makes sense to maintain a high index of suspicion for this disease. Also, it is important to keep in mind that these areas are frequent vacation destinations in the summer, so patients who travel to these areas may present with symptoms on their return. [Editor's note: For more on tick-borne diseases, see the article "Urgent Care Diagnosis and Management of Tick-Borne Diseases" in our January 2016 issue, at www.jucm.com/urgent-care-diagnosis-andmanagement-of-tick-borne-diseases/.]

Self-Collection of Samples Eases Women's Anxiety in Testing for Sexually Transmitted Infections

Key point: Here is another method for diagnosing sexually transmitted infections.

Citation: Arias M, Jang D, Gilchrist J, et al. Ease, comfort, and performance of the HerSwab vaginal self-sampling device for the detection of *Chlamydia trachomatis* and *Neisseria* gonorrhoeae. Sex Transm Dis. 2016;43:125–129.

One of the greatest challenges of diagnosis and then treatment of sexually transmitted infections is patient anxiety about discussing the issue and getting the testing performed. Although there are quick and simple tests for diagnosis especially for women, the tests can be uncomfortable and embarrassing. A total of 189 women participated in this study comparing physician-collected vaginal swabs and swabs that patients self-collected with the HerSwab device. All participants underwent both kinds of sample collection, with test order randomized by computer. For self-collection, women reported an ease of 97.1%, a comfort level of 88.3%, and a

ABSTRACTS IN URGENT CARE

preference for the method of 80%. Overall agreement was 85% for chlamydia and 98% for gonorrhea, including 7 more patients with positive results in the self-collection part of the study. For the urgent care provider, these findings point to another option for ensuring proper diagnosis and treatment of sexually transmitted infections.

Antibiotics for Upper Respiratory Tract Infections Are Usually Unnecessary

Key point: New guidelines reinforce the need to think twice before prescribing antibiotics for upper respiratory tract infections.

Citation: Harris AM, Hicks LA, Qaseen A; High Value Care Task Force of the American College of Physicians and for the Centers for Disease Control and Prevention. Appropriate antibiotic use for acute respiratory tract infection in adults: advice for high-value care from the American College of Physicians and the Centers for Disease Control and Prevention. *Ann Intern Med.* 2016 January 19. doi: 10.7326/M15-1840. [Epub ahead of print.]

This article from the American College of Physicians and the Centers for Disease Control and Prevention is a narrative literature review of the use of antibiotics for acute upper respiratory infections in adults. The authors used guidelines from professional societies, meta-analyses, systematic reviews, and randomized clinical trials. Best practices are presented, including these:

- No testing or antibiotics should be initiated in bronchitis unless pneumonia is a possibility.
- Treatment for group A streptococcal pharyngitis should be based on the results of a rapid strep test and/or culture.
- Bacterial sinusitis should only be diagnosed and treated after 10 days of symptoms, onset of severe symptoms, or signs that include high fever, facial pain, or purulent drainage or after onset of worsening symptoms after 5 days of diminishing illness.
- No antibiotics should be given for the common cold.

Clarithromycin May Not Be the Best Choice, Because of Increased Cardiovascular Risks

Key point: Patients may be at increased cardiovascular risk when taking clarithromycin.

Citation: Wong AY, Root A, Douglas IJ, et al. Cardiovascular outcomes associated with use of clarithromycin: population based study. *BMJ*. 2016;352:h6926. doi: 10.1136/bmj.h6926.

In this 5-year study in Hong Kong, more than 300,000 adults prescribed clarithromycin were compared with more than 100,000 who were prescribed amoxicillin. During treatment, the risk of myocardial infarction was much greater for those taking clarithromycin than for those taking amoxicillin (44/1000 vs. 19/1000). Unfortunately the clarithromycin cohort was older and more likely to have chronic obstructive pulmonary disease or type 2 diabetes, so the results might not be completely generalizable. For the urgent care provider, this is one more study that questions the risk of antibiotic use. The findings may help guide the choice of antibiotics when these two medications are considered.

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Case Report

Sore Wrists with Soft-Tissue Hypertonicity and Swelling

Urgent message: It is important for urgent care providers to be able to recognize the lesser-known arthritides as causes of acute joint pain and to recognize their specific manifestations on x-rays. Further work-up is warranted because some of these diseases can be associated with various metabolic disorders.

MAY MOHTY, MD, FAAP, FAAUCM, and HAMILTON WHITE, MS4

Introduction

he deposition of calcium pyrophosphate dihydrate crystals in and around joints is called CPPD (calcium pyrophosphate dihydrate deposition) disease. This condition manifests in a variety of ways along a spectrum. One manifestation has long been known by the name pseudogout, which is called acute CPP crystal arthritis. This refers to an acute attack of CPP crystal-induced arthritis, which clinically resembles an acute gouty arthritis induced by monosodium urate crystal deposition. CPPD can also contribute to a more chronic osteoarthritis that does not present so acutely. The term chondrocalcinosis refers to calcifications seen in hyaline cartilage on x-rays, and the condition is frequently seen in patients with CPPD disease. Radiographically, a dense line within the hyaline cartilage parallels the articular surface, with concretions of calcium pyrophosphate exuded beyond the subchondral articular surface. Although chondrocalcinosis is often thought of as being synonymous with CPPD disease, it is not seen in all cases of CPPD disease, nor is it specific for CPPD disease when seen.¹

May Mohty, MD, FAAP, FAAUCM, is a clinical associate professor at the University of Arizona College of Medicine–Phoenix in Arizona and an urgent care physician at CIGNA Healthcare of Arizona. **Hamilton White**, **MS4**, is a fourth-year student at Arizona College of Osteopathic Medicine at Midwestern University in Glendale, Arizona.



Because CPPD disease is less well known than other arthritides such as osteoarthritis or rheumatoid arthritis, it is important clinically for providers to be aware of this disorder because it can present similarly to other causes of joint pain. CPPD disease can also be associated with a variety of metabolic disorders, and thus it is important to screen for certain conditions in patients with CPPD disease. The following case shows one way in which CPPD disease may present, plus the appropriate workup necessary once CPPD is suspected.



(A) Posteroanterior view of the wrist showing chondrocalcinosis of the wrist: radiocarpal joint and triangular fibrocartilage. (B) Lateral view of the wrist showing chondrocalcinosis.

Case Presentation

A 82-year-old man presented to an urgent care center with pain and swelling in both of his wrists. He reported that the pain felt like soreness in his wrists at rest that is aggravated with pronation and supination. He had been taking acetaminophen, which had provided some relief, but he had avoided taking nonsteroidal anti-inflammatory drugs because his primary-care physician had advised him to do so. He had a history of neuropathy in both hands, and had undergone carpal tunnel surgery on both wrists in the past. He reported no trauma to his hands or wrists that might have caused his current discomfort. His wrist pain had steadily been increasing over the last few weeks to months. A review of systems revealed no rashes, fever, chills, nausea, recent weight loss, or recent illness. Of note in the patient's chart was a past knee x-ray showing chondrocalcinosis compatible with CPPD disease.

Physical Examination

On initial presentation, the patient's vital signs were as follows:

- Height: 5 ft 9 in (175.26 cm)
- Weight: 182 lb (82.55 kg)

- Blood pressure: 125/78 mm Hg
- Pulse: 88 beats/min
- Respiratory rate: 18 breaths/min
- Temperature: 98.1°F (36.7°C)
- Oxygen saturation: 98% on room air

Findings on physical examination were significant for circumferential tenderness to palpation over both wrists, along with soft-tissue hypertonicity and swelling that was more prominent over the right wrist. Findings for the Tinel sign were positive bilaterally, and there was notable atrophy of the thenar eminence on the left hand. No neurovascular compromise was detected. Complete range of motion was intact in both wrists, although movement aggravated the patient's symptoms. No crepitus was detected with movement.

Laboratory Tests and Imaging

The patient underwent the following laboratory tests:

- Calcium
- Phosphorus (inorganic)
- Alkaline phosphatase
- Serum iron
- Magnesium
- Transferrin
- Thyroid-stimulating hormone
- Ferritin

Initial evaluation of the patient began with obtaining an x-ray of the right wrist (**Figure 1**), which was read as showing moderate osteoarthritis as well as chondrocalcinosis. Calcifications were seen in the radiocarpal joint and in the triangular fibrocartilage.

Because CPPD disease is associated with various metabolic disorders, blood work was done to screen for possible contributing or associated conditions. A definite link has been found between CPPD disease and hyperparathyroidism, hemochromatosis, hypophosphatemia, and hypomagnesemia, but only a possible association has been seen with familial hypocalciuric hypercalcemia, among other conditions.^{1,2} With this in mind, measurement of the patient's level of thyroid-stimulating hormone was ordered to rule out thyroid pathology. Tests for serum ferritin, serum iron, and transferrin levels were ordered to screen for hemochromatosis (Table 1). The patient was also screened for hypomagnesemia and hypophosphatemia, because these conditions have also been associated with acute attacks of CPP arthritis and with chondrocalcinosis.³ The patient's calcium level was also evaluated to determine whether there was underlying hypercalcemia.

With a diagnosis of CPPD disease suspected, the patient was sent home and instructed to begin a 5-day course of prednisone to decrease the swelling and inflammation in his wrists, and he was told that the results of his blood work would be reported to him. He was instructed to follow up with his primary-care physician to discuss the laboratory results. For all blood work, the results were within normal limits.

Diagnosis

The diagnosis was bilateral wrist pain due to CPPD disease.

Discussion

With the variety of ailments that can cause arthralgic pain, it is important to maintain a high suspicion for CPPD disease as a possible cause. At this time, further clinical research is necessary to clarify the causes of CPPD disease and to discover more effective and lasting treatments. An early and thorough diagnosis, however, can be helpful in detecting and treating other associated conditions that the patient might have.

Epidemiology

The incidence of CPPD disease increases with age, irrespective of race.⁴ It is common in both males and in females, but slightly more common in females. Younger patients who present with CPPD disease are more likely to have a secondary contributing cause, such as a metabolic disorder. Although the exact incidence of CPPD disease worldwide is unknown, a study in France showed that CPPD disease was the cause of 10,691 hospital admissions between 2009 to 2011 in that country.⁵

Clinical Presentation

CPPD disease can be difficult to diagnose because the clinical presentation is so varied. The majority of patients with CPPD disease actually do not experience joint symptoms. For those who do experience joint symptoms, CPPD disease can mimic multiple arthritides, such as gout, rheumatoid arthritis, neuropathic arthropathy, and osteoarthritis.⁶ Clinicians should have a high suspicion for CPPD disease in patients older than 50 years who present with joint pain. Although chondrocalcinosis is frequently seen on images in patients with CPPD, it is not seen in all patients affected by the disease.¹ Studies of patients with CPPD disease indicate that the joints most frequently affected by chondrocalcinosis, in descending

Table 1. Laboratory Test Results			
Test	Value		
Alkaline phosphatase	75 IU/L		
Calcium	9.3 mg/dL		
Ferritin, serum	251 ng/mL		
Iron, serum	46 μg/dL		
Magnesium, serum	1.8 mg/dL		
Phosphorus, serum	2.8 mg/dL		
Transferrin	198 mg/dL		
Thyroid-stimulating hormone	1.65 U/L		

order of frequency, are knees, wrists, hips, symphysis pubis, and metacarpophalangeal joints. Chondrocalcinosis is usually found bilaterally in all of these joints except at the hips.⁵

Treatment

Many cases of acute CPP crystal arthritis are self-limited. It is important to screen for other conditions associated with CPPD disease, but attempts at treating these associated diseases unfortunately have not proven to halt the progression of crystal deposition.⁶ There is a dearth of clinical trials showing proven strategies for treating CPPD disease, and thus most treatment strategies focus on reducing joint inflammation. The European League Against Rheumatism (EULAR) published recommendations in 2011 for the management of CPPD disease. For acute CPP crystal arthritis, they recommend "cool packs, temporary rest and joint aspiration combined with steroid injection."7 For chronic inflammatory arthritis with CPPD, they recommend the use of nonsteroidal anti-inflammatory drugs or "low-dose colchicine 0.5 to 1.0 mg daily." They also recommend giving parenteral or oral corticosteroids.

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^{2.} Announ N, Guerne PA. [Diagnosis and treatment of calcium pyrophosphate crystalinduced arthropathy.] [Article in German.] *Z Rheumatol.* 2007;66:573–578.

^{3.} Jones AC, Chuck AJ, Arie EA, et al. Diseases associated with calcium pyrophosphate deposition disease. *Semin Arthritis Rheumatol*. 1992; 22:188–202.

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^{5.} Abhishek A. Calcium pyrophosphate deposition disease: a review of epidemiologic findings. *Curr Opin Rheumatol.* 2015;28:133–139.

Rosenthal AK, Ryan LM, McCarthy DJ. Calcium pyrophosphate crystal deposition disease, pseudogout, and articular chondrocalcinosis. In: Koopman WJ, Moreland LW, eds. Arthritis and Allied Conditions. 15th edition. Philadelphia, PA: Lippincott Williams & Wilkins; 2005:2373.

^{7.} Zhang W, Doherty M, Pascual E, et al. EULAR recommendations for calcium pyrophosphate deposition. Part II: management. Ann Rheum Dis. 2011;70:571–575.

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Turning Over Patient Records on Request

Stacey L. Zill, Esq.

Urgent message: Urgent care providers subject to the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 need compliant procedures for handling patient requests for medical records, including transfer of patient records to other providers.

S. federal and state laws require providers to allow patients access to their medical records. This includes records supplied by another provider (e.g., a specialist who has forwarded a report to the primary-care physician) that may be contained within the requested file.

On the federal level, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) not only regulates how patients' health information is handled to protect privacy but also gives patients the right to see and obtain a copy of their records. In most cases, once a request for medical records is made, a provider covered by HIPAA must furnish a copy within 30 days, which may be extended another 30 days for good cause. During this period, providers must share any notes or records they have created, copies of any test results, and any information provided to them about the patient by another physician if that information was used to determine the patient's diagnosis and/or treatment. However, health-care providers may deny access to certain records, usually those related to mental health, if they believe that the viewing of these records could endanger the patient's physical health.

Although most states have similar requirements regarding making medical records accessible to patients, they differ with respect to timing.¹ In California, for instance, providers must permit inspection of medical records within 5 working days from the date of request and ensure that a copy of the medical record is transmitted to the patient within 15 days.²

Stacey L. Zill, Esq., is partner at Michelman & Robinson, LLP, specializing in health-care litigation.

"All states agree that patients are entitled to inspect and obtain copies of their records. As a result, patients' requests for their medical records are to be taken seriously. If possible, providers should have patients sign consent forms agreeing to medical-record release terms prior to treatment to avoid confusion about what materials to produce down the line."

In Colorado, however, hospitals must provide discharged patients with copies of their medical records within 10 days of their request and provide inpatients the opportunity to inspect their records within 24 hours.³ Physicians must provide copies of patient medical records to patients within a reasonable time or 30 days. In Hawaii, the turnaround time is tighter still, with providers required to furnish a copy of a patient's medical record on request. However, should they fail to meet this deadline, they are allowed a 10-day grace period before being penalized. The list of states with a shorter time period than provided for in HIPAA goes on from there to include Maryland,⁴ Nebraska,⁵ Nevada,⁶ New York,⁷ Tennessee,⁸ Texas,⁹ Virginia,¹⁰ Washington,¹¹ Wisconsin,¹² and Wyoming.¹³

For the remaining states, the HIPAA requirements apply either because the state's laws mirror HIPAA or because they require providers to make medical records accessible within "a reasonable time" or in a "timely manner," or do not specifically set forth a time period. Under these circumstances, the law is preempted by HIPAA.¹⁴

Although states may differ in terms of what records must

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be produced to the patient on request (the California Medical Association, for instance, requires complete and current information regarding the patient's diagnosis, treatment, and prognosis), all states agree that patients are entitled to inspect and obtain copies of their records. As a result, patients' requests for their medical records are to be taken seriously. If possible, providers should have patients sign consent forms agreeing to medical-record release terms prior to treatment to avoid confusion about what materials to produce down the line.

Notes

 Idaho, Kansas, Kentucky, North Carolina, and Vermont have no laws specifically granting patients access to their medical records. As a result, the requirements and obligations of HIPAA apply.

2. California Health and Safety Code, §123110. Available from: http://www.leginfo.ca.gov/cgi-bin/calawquery?codesection=hsc

3. Code of Colorado Regulations 1011-1:11-5.2; Colorado Revised Statutes Annotated, §25-1-802. Available from: https://www.sos.state.co.us/CCR/NumericalCCRDocList.do? deptID=16&deptName=1000%20Department%200f%20Public%20Health%20and%20 Environment&agencyID=144&agencyName=1011%20Health%20Facilities%20and%20 Emergency%20Medical%20Services%20Division%20(1011,%201015%20Series) and http://www.healthinfolaw.org/node/3225/

4. Maryland Code, Health—General, §4-309. Available from: http://marylandcode.org/ ghg-4-309/

5. Nebraska Revised Statutes, §71-8403. Available from: http://nebraskalegislature.gov/ laws/statutes.php?statute=71-8403

6. Nevada Revised Statutes, §629.061. Available from: https://www.leg.state.nv.us/ nrs/NRS-629.html#NRS629Seco61

7. New York Public Health Law, §18. Available from: https://www.health.ny.gov/professionals/patients/patient_rights/access_to_patient_information.htm

8. Tennessee Code Annotated, §63-2-101 and §68-11-304. Available from: http://law.justia.com/codes/tennessee/2010/title-63/chapter-2/63-2-101 and http://law.justia.com/codes/tennessee/2010/title-68/chapter-11/part-3/68-11-304/

9. Texas Health and Safety Code Annotated, §241.154 and §181.102; Texas Administrative Code, §133.42; and §165.2; and Texas Occupational Code Annotated, §159.006. Available from: http://www.healthinfolaw.org/node/3192/, https://texreg.sos.state.tx.us/ public/readtac\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_ploc=&pg=1&g_tac =&ti=25&pt=1&ch=133&rl=42, http://www.healthinfolaw.org/state-law/tex-health safety-code-ann-%C2%A7-1&1102, https://texreg.sos.state.tx.us/public/readtac\$ext. TacPage?sl=R&app=9&p_dir=&p_rloc=&p_ploc=&pg=1&g_tac=&ti=2&pt=9&ch=1 65&rl=2, and http://codes.lp.findlaw.com/txstatutes/OC/3/B/159/159.006

10. Virginia Code Annotated, §32.1-127.1:03 and §54.1-2403.3; 18 Va. Admin. Code, §85-20-26. Available from https://vacode.org/32.1-127.1:03/, http://law.justia.com/codes/ virginia/2006/toc5401000/54.1-2403.3.html, and http://www.healthinfolaw.org/node/ 3205/

11. Revised Code of Washington, §70.02.080. Available from: http://www. healthinfolaw.org/state-law/wash-rev-code-%C2%A7-7002080

12. Wisconsin Statutes, §146.83. Available from: http://law.justia.com/codes/wisconsin/2014/chapter-146/section-146.83

13. Wyoming Statutes Annotated, §35-2-611 and §33-26-402; Wyoming Board of Medicine Rules and Regulations, chapters 3 and 4. Available from: http://www.healthinfolaw.org/state-law/requirements-patient-examination-and-copying-recordswyo-stat-ann-%C2%A7-35-2-611, http://law.justia.com/codes/ wyoming/2011/title33/ chapter26/section33-26-402, and http://wyomedboard.wyo.gov/resources/boardof-medicine-rules-and-regulations

14. There are some states with hybrid laws where the HIPAA requirements apply to covered entities, plus additional requirements for entities not covered by HIPAA. For example, in Montana, non-covered health-care providers must give patients access to medical records within 10 days of receiving a written request (Montana Code Annotated, §50-16-541; available from: http://leg.mt.gov/bills/mca/50/16/50-16-541; available from: http://codes.ohio.gov/orc/3701.741; Ohio Administrative Code 3701-83-07 and 3701-84-07; available from: http://www.ehalthinfolaw.org/node/2549/, http://codes.ohio.gov/orc/3701.741, http://codes.ohio.gov/oac/3701-83-07, and https://www.odh.ohio.gov/en/rules/final/3701-80-to--89/f3701-84.aspx). In Utah, non-covered health-care providers must permit patients to inspect or obtain a copy of records unless access is restricted by law or judicial order, and providers must comply with HIPAA deadlines when providing a copy of a patient's records (Utah Code Annotated, §78B-5-618; available from http://le.utah.gov/xcode/Title78B/Chapter5/78B-5-S618.html).

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Case

A 36-year-old man comes to an urgent care center reporting pain in his back that began the previous day. The pain is sharp and worse with certain changes in position. He does a lot of lifting at his job stocking shelves in a grocery store, but he cannot relate the onset of the pain to any specific lifting that he has done.

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

THE RESOLUTION



Differential Diagnoses

- Cardiomegaly from heart failure
- Pericardial tamponade
- Esophageal rupture (Boerhaave syndrome)
- Left lower lobe infiltrate
- Pleural effusion

Physical Examination

On examination, the patient is found to be afebrile and to have a pulse of 112 beats/min, a respiration rate of 20 breaths/min, and a blood pressure of 97/54 mm Hg. Alert and oriented, he seems minimally uncomfortable, speaks normally, and provides a good medical history. Both of his lungs are clear to auscultation. He has a regular heart rate and rhythm without murmurs, rub, or gallop. His abdomen is soft and nontender, without rigidity, rebound, or guarding. In the extremities, his peripheral are pulses 2+ and equal.

Diagnosis

Because of radiographic findings (**Figure 2**), the diagnosis is acute aortic dissection.

Learnings

Patients with aortic dissection can often present in an innocuous manner, but rapid diagnosis is vitally important, because mortality is as high as 58% without surgery, increasing by 1% to 2% per hour of delayed diagnosis. Complicating manners, 15% of patients have a painless dissection, and 13% present as having syncope. Risk factors include male sex, hypertension, cocaine use, family history, and connective-tissue diseases such as Mar-fan syndrome and Ehlers-Danlos syndrome. The aorta is the main outflow of the heart, taking blood from the left ventricle, through the aortic valve into the aortic arch and its three main branches. Those three branches are (proximal to distal) the brachiocephalic artery, which divides into the right subclavian artery and the right internal carotid artery; the left carotid artery; and the left subclavian artery. If the dissection progresses to involve the coronary arteries, the patient with have symptoms of myocardial infarction, whereas if it involves the pericardial space, the patient will have symptoms of tamponade. Involvement of the carotid arteries may manifest with neurologic symptoms or stroke.

What to Look For

Normal findings on chest x-rays cannot be used to rule out a dissection, but if there are findings, they may include the following:

- Widened mediastinum
- Rightward tracheal displacement
- Irregular aortic contour—loss of aortic knob
- Indistinct aortopulmonary window
- Left pleural effusion

With suspicion of aortic dissection and unstable vital signs, activate the emergency medical system and immediately transfer the patient to an emergency department. Inform the emergency medical system that the patient's condition is unstable and will require emergency transfer with lights and sirens. If there is time, place two intravenous lines and obtain an electro-cardiograph. Chest x-ray findings will not change treatment, so do not have the patient leave the urgent care examination room to walk down the hall and get a chest x-ray. Call the emergency department and speak with the physician who will be caring for the patient to inform them that there is an unstable patient with likely aortic dissection who will arrive shortly. This may help with notification of the vascular surgeon and preparation of an operating room.

Sources of delay in transfer due to delay in diagnosis include patients with a blood pressure of more than 105 mm Hg, fever, female sex, and transfer from a tertiary facility.

It is important to diagnose aortic dissection rapidly, and the condition should be suspected with sudden onset of severe chest pain as well as with chest pain associated with headache, numbness, neck pain, or limb ischemia.

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CODING Q&A

Excludes Notations and Code Notes

DAVID STERN, MD, CPC

How do I use Excludes 1 and Excludes 2 instructions in International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10CM)?

A Put simply, the Excludes 1 notation means that you cannot code any excluded code with the main (listed) code. Conditions listed with Excludes 1 are mutually exclusive. For example, code E11 (type 2 diabetes mellitus) has an Excludes 1 notation with the following codes listed:

- Diabetes mellitus due to underlying condition (Eo8.-)
- Drug or chemical induced diabetes mellitus (Eo9.-)
- Gestational diabetes (024.4-)
- Neonatal diabetes mellitus (P70.2)
- Postpancreatectomy diabetes mellitus (E13.-)
- Postprocedural diabetes mellitus (13.-)
- Secondary diabetes mellitus NEC [not elsewhere classified] (E13.-)
- Type 1 diabetes mellitus (E10.-)

In general, these codes are mutually exclusive by definition, so they make sense to a clinician. For example, a patient with type 2 diabetes can never be diagnosed with concurrent type 1 diabetes, because the patient has either type 1 or type 2 diabetes—never both.

The Excludes 2 notation indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. It is acceptable to use both the code and the excluded code(s) together, when appropriate. For example, code Jo3 (acute tonsillitis) lists an Excludes 2 notation for code J35.0 (chronic tonsillitis) because the patient can present with both conditions



David E. Stern, MD, CPC, is a certified professional coder and is board-certified in internal medicine. He was a director on the founding board of UCAOA and has received the organization's Lifetime Membership Award. He is CEO of Practice Velocity, LLC (www.practicevelocity.com), NMN Consultants (www.urgentcareconsultant.com), and PV Billing (www.practicevelocity.com/ urgent-care-billing/), providers of software, billing, and urgent care consulting services. Dr. Stern welcomes your questions about urgent care in general and about coding issues in particular. "In general, [Excludes 1] codes are mutually exclusive by definition, so they make sense to a clinician. For example, a patient with type 2 diabetes can never be diagnosed with concurrent type 1 diabetes, because the patient has either type 1 or type 2 diabetes—never both."

at the same time. If the medical record indicates that the patient does have chronic tonsillitis and presents to your office today with acute tonsillitis, it would be appropriate to code both Jo3 and J35.0 for the visit. The Excludes 2 notation, however, indicates that a patient with simple chronic tonsillitis should never receive a diagnosis of acute tonsillitis unless both conditions are actually present.

I get confused when I see "code first," "code also," and "use additional code" notes. Can you explain the differences?

Codes that have both an underlying etiology and multiple body system manifestations because of the underlying etiology require that the underlying condition be coded first, and then the manifestation. Wherever such a combination exists, there is a "use additional code" note at the etiology code and a "code first" note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes: etiology, followed by manifestation.

In most cases, the manifestation codes will have in the code title "in diseases classified elsewhere." Codes with this title are a component of the etiology-manifestation convention. The code title indicates that it is a manifestation code. "In diseases classified elsewhere" codes are never permitted to be used as first-listed principal diagnosis codes. They must be used in conjunction with an underlying condition code, and they must be listed after the underlying condition.

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CODING Q&A

"A 'code also' note is an instruction that two codes may be required to fully describe a condition, but the sequencing of the two codes depends on the severity of the conditions and the reason for the office visit."

For example, code H42 (glaucoma in diseases classified elsewhere) has "code first" underlying conditions, such as these:

- Amyloidosis (E85.-)
- Aniridia (Q13.1)
- Lowe syndrome (E72.03)
- Rieger anomaly (Q13.01)
- Specified metabolic disorder (E70–E88)

For a patient with glaucoma caused by amyloidosis, you would code E85.- (amyloidosis) first and then code H42 (glaucoma in diseases classified elsewhere) on the claim form.

A "code also" note is an instruction that two codes may be required to fully describe a condition, but the sequencing of the two codes depends on the severity of the conditions and the reason for the office visit.

For example, for a patient who presents with a lobar pneumonia just shortly after a visit for documented influenza, the provider would code J11.08 (influenza due to unidentified influenza virus with specified pneumonia). This code has a note to code also another specified type of pneumonia, J18.1 (lobar pneumonia, unspecified organism), so the provider would next review the documentation to see what type of pneumonia the patient has and then assign that code as well (i.e., J12.9, viral pneumonia, unspecified). Although the patient may actually no longer have an active influenza infection, this coding process is designed to allow tracking of pneumonia incidence that is directly attributable to known influenza infections.

In other cases where two codes are required to describe a condition, a "use additional code" note will be present at a complication or manifestation code to indicate that more codes are needed. The additional codes used are secondary codes that are to be sequenced after any underlying cause and after the main manifestation. For example, code J10.83 (influenza due to other identified influenza virus with otitis media) has a "use additional code" note to remind the coder to code for any associated perforated tympanic membrane (H72.-). You would list code J10.83 first and then choose an appropriate code in the H72 range, like H72.01 (central perforation of tympanic membrane, right ear).

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DEVELOPING DATA

ata from the 2014 Urgent Care Chart Survey of 150 million visits by patients to more than 800 different urgent care clinics, conducted by the *Journal of Urgent Care Medicine*, reveal that the top three most-prescribed medications at U.S. urgent care centers were, in descending order:

- Zithromax (azithromycin), for 12.12% of visits
- Amoxil (amoxicillin), for 8.25% of visits
- Deltasone (prednisone), for 7.07% of visits

The top 20 medications are shown here. We will report on the next 20 most-prescribed in another issue.

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

TOP 20 MEDICATIONS PRESCRIBED (BRANDS AND GENERICS TOGETHER)

	Drug Name	Generic Name	Percent of Visits at Which Medication Was Prescribed	Total Projected Prescriptions
1	Zithromax	Azithromycin	12.12%	18,175,033
2	Amoxil	Amoxicillin	8.25%	12,380,910
3	Deltasone	Prednisone	7.07%	10,606,363
4	Augmentin	Amoxicillin-potassium clavulanate	5.68%	8,519,510
5	Lortab	Hydrocodone-acetaminophen	4.57%	6,856,068
6	Bactrim	Sulfamethoxazole-trimethoprim	3.94%	5,916,195
7	Flonase	Fluticasone	3.58%	5,367,929
8	Cipro	Ciprofloxacin	3.35%	5,026,096
9	Ibuprofen	Ibuprofen	3.09%	4,640,901
10	ProAir HFA	Albuterol sulfate	3.03%	4,538,739
11	Tessalon	Benzonatate	2.99%	4,486,941
12	Keflex	Cephalexin	2.76%	4,132,960
13	Medrol	Methylprednisolone	2.66%	3,988,532
14	Zofran ODT	Ondansetron	2.12%	3,186,760
15	Flexeril	Cyclobenzaprine	2.04%	3,066,376
16	Omnicef	Cefdinir	2.03%	3,051,528
17	Levaquin	Levofloxacin	1.93%	2,899,930
18	Cheratussin AC	Codeine-guaifenesin	1.86%	2,793,466
19	Ultram	Tramadol	1.82%	2,724,036
20	Naprosyn	Naproxen	1.70%	2,546,624
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