

# JUCM™

THE JOURNAL OF URGENT CARE MEDICINE®

MAY 2016  
VOLUME 10, NUMBER 8



Urgent Care  
Association  
of America



www.jucm.com

The Official Publication of the UCAOA and UCCOP

## Also in this issue

- 17 Practice Management**  
Open-Book Management:  
Using Transparency and  
Gamification to Engage and  
Empower Frontline Staff
- 25 Case Report**  
Pelvic Pain, Dysuria,  
and Back Pain in an  
Adolescent Female

**Diverticulitis**  
in the Urgent Care Setting



# The right fit naturally adapts.

Instinctive shifts throughout the day are nothing new to you. When facilities blend Urgent Care and Occupational Medicine sudden changes in workflow and documentation are expected. AgilityUC is perfectly fitted for the demands of both lines of service. Smooth operations with one integrated billing system and a solution that secures PHI from Workers' Comp data in one patient record. You're ready for whatever crosses your path.

**Learn more at [Rightfit.nethealth.com/AboutAgility](http://Rightfit.nethealth.com/AboutAgility).**

**AgilityUC™** | Software for  
Urgent Care

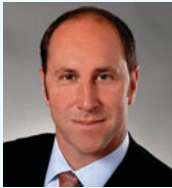


**nethealth.com**  
The Art of the Right Fit.®



## LETTER FROM THE EDITOR-IN-CHIEF

# The Secret of Success: Caring Is Believing



*"People don't care how much you know until they know how much you care."*

**D**r. James Gore, an old friend and an urgent care pioneer, shared those words of wisdom with me during a recent conversation. We were discussing the current state of health care and the challenges we face in urgent care with the rabid market activity we are seeing. We chatted a bit about the new faces and the outside interests entering the industry, and we laughed about all the mistakes being made by people looking for a quick buck. Those of us who have been in the business long enough know how much time and attention urgent care practices require in order to function properly and effectively meet the sometimes fickle needs of our patients. We know how complex and layered this business is. We know how regional and local the dynamics are. And we have the scars to show that we have learned from our mistakes and survived against the odds.

Yet it seems like many think that the urgent care model can be deconstructed into its individual parts, and that these can be mass-produced at scale and still achieve the same results. The flaw in this approach is that its success requires rapid growth and taking advantage of efficiencies. The problem with that is the lost opportunity to learn and pivot, one step at a time. There are no shortcuts to experience, and experience is the ultimate determinant of success for any business with a complex model with thin margins.

In response to this problem, I have seen large operators take two approaches: the "smarter than thou" approach and the "talent acquisition" approach. In the first approach, investors with strong track records in operating other businesses apply methods from those businesses to scale up an urgent care company. The risk is that they grow the company too fast and make too many assumptions, tantalized by their success with other business models. Many will end up putting on the brakes and reorganizing the business in response to underperformance. Ultimately, these investors have to slow down and learn the business just like the rest of us.

In the "talent acquisition" approach, a skilled and charismatic operator (usually a physician) who has successfully built a regional

network of 2 to 10 centers is hired to be the operative and leadership model for scaling up. The problem here is twofold: First, the transaction has made the seller financially comfortable and unmotivated. When your entire life savings is no longer at stake, it is human nature to slow down a bit. Second, what works for 2 to 10 centers is often *not* a good template for scale. A charismatic leader depends on personal interaction to influence others. Once that influence is diluted, this approach becomes much less effective. Unfortunately, for many it's the only leadership tool they have developed. Entrepreneurs can be quite ineffective in an organizational structure where communication and management require discipline, patience, and collaboration.

This brings me back to the opening quote: "People don't care how much you know until they know how much you care." I can't help but think that Dr. Gore has succinctly and eloquently summed up the secret sauce for success in urgent care. Big or small, independent or integrated, investor-owned or entrepreneurial venture, urgent care centers all have to answer to the same customer. And the core driver of consumer behavior in health care, more than any other variable, is whether the patient feels cared for. In fact, every other layer of this business is a commodity except for the care experience. You can find revenue-cycle expertise and financial and real estate know-how. Health-care operators and managers are ubiquitous, and the supply chain is full of options. But although all of these are critical functions, none of them matter to the patient. Unless you are focused relentlessly on the who and how of the care experience, you will not have sustained success in this competitive environment. Discovering how to deliver this experience, the elements that contribute to it, and the talent profiles of the people who execute it is the key to solving the urgent care riddle, regardless of how much you know. ■

Lee A. Resnick, MD, FAAFP

Editor-in-Chief, *JUCM, The Journal of Urgent Care Medicine*



# FASTER TEST RESULTS. HAPPIER PATIENTS.



## IMPROVE PATIENT SATISFACTION WITH IN-HOUSE TESTING, IN JUST MINUTES.

These days, no one likes to wait for treatment decisions. That's where the i-STAT® System and Piccolo Xpress® come in. Both deliver lab-accurate results for a wide range of panels and assays right in your office, in minutes. So you have the information you need during a patient's office visit.

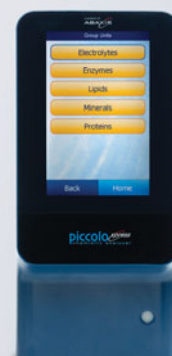
Improve patient care and patient satisfaction—that's a win-win.

- Most comprehensive CLIA-waived menu available
- Lab-accurate testing in minutes
- Simple, intuitive operation

i-STAT®



piccolo<sup>xpress</sup>  
chemistry analyzer



Scan to  
learn more



To learn more, contact your Abbott Point of Care or Distribution Representative, or visit [www.abbottpointofcare.com](http://www.abbottpointofcare.com) and [www.piccoloxpress.com](http://www.piccoloxpress.com)

For in vitro diagnostic use only ©Abbott Point of Care Inc. 038526 Rev. A 01/15 Piccolo Xpress® is a registered trademark of Abaxis, Inc. Abaxis Part Number 888-3271 Rev. A

**CHOOSE TRANSFORMATION™**

CORE LAB TRANSFUSION MOLECULAR POINT OF CARE INFORMATICS

**Abbott**



May 2016

VOLUME 10, NUMBER 8



## CLINICAL

# 8 Diverticulitis in the Urgent Care Setting

Abdominal pain due to acute diverticulitis is commonly seen in the urgent care setting. Much of the current treatment of this disease is in flux because it is under study, so we bring you this clinical update.

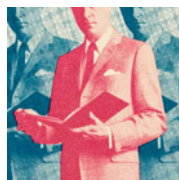
*Jilian Nicholas, DO, and Christopher Tangen, DO*

## PRACTICE MANAGEMENT

# 17 Open-Book Management: Using Transparency and Gamification to Engage and Empower Frontline Staff

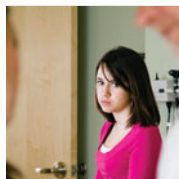
Want to turn around employee disengagement and increase your urgent care center's revenue? Try gamification to get your staff members feeling like part owners and to unleash their creativity in finding ways to help your center grow.

*Alan A. Ayers, MBA, MACC*



## CASE REPORT

# 25 Pelvic Pain, Dysuria, and Back Pain in an Adolescent Female



In treating adolescents, health-care providers must work from a broad differential that includes diagnoses common to children, those common to adults, and those unique to adolescents. It is especially important that adolescents be given time to speak with their providers without their parents in the examination room.

*Joshua T. Bautz, MD, LT, MC, USNR*

## IN THE NEXT ISSUE OF JUCM

About 6 million people in the United States have a nonhealing wound, and as the population ages, that number may rise exponentially. In the first part of this two-part article, authors Nathan M. Finnerty, MD, Collin G. Kaide, MD, and Michael Weinstock, MD, write that by properly diagnosing and treating these wounds, urgent care providers have the opportunity to differentiate life-threatening illness from life-inhibiting disease and thus improve outcomes for this population.

## DEPARTMENTS

- 7 From the UCAOA President
- 22 Health Law and Compliance
- 29 Abstracts in Urgent Care
- 33 Insights in Images
- 40 Coding Q&A
- 45 Developing Data

## CLASSIFIEDS

- 43 Career Opportunities

## JUCM EDITOR-IN-CHIEF

### Lee A. Resnick, MD, FFAFP

Chief Medical and Operating Officer,  
WellStreet Urgent Care  
President, Institute of Urgent Care  
Medicine  
Assistant Clinical Professor, Case Western  
Reserve University,  
Department of Family Medicine

## JUCM EDITORIAL BOARD

### Alan A. Ayers, MBA, MAcc

Urgent Care Consultants

### Tom Charland

Merchant Medicine LLC

### Richard Colgan, MD

University of Maryland School  
of Medicine

### Jeffrey P. Collins, MD, MA

Harvard Medical School  
Massachusetts General Hospital

### Tracey Quail Davidoff, MD

Accelcare Medical Urgent Care

### Kent Erickson, MD, PhD, DABFM

Unlimited Patient Care Center, PLLC

### Thomas E. Gibbons, MD, MBA, FACEP

Doctors Care

### William Gluckman, DO, MBA, FACEP, CPE, CPC

FastER Urgent Care

### David Gollogly, MBChB, FCUCP (New Zealand)

College of Urgent Care Physicians

### Wendy Graae, MD, FAAP

PM Pediatrics

### Nahum Kovalski, BSc, MDCM

Terem Emergency Medical Centers

### Sean M. McNeeley, MD

Network Medical Director,  
University Hospitals of Cleveland

### Shailendra K. Saxena, MD, PhD

Creighton University Medical Center

### Elisabeth L. Scheufele, MD, MS, FAAP

Massachusetts General Hospital

### John Shufeldt, MD, JD, MBA, FACEP

Urgent Care Integrated Network

### Laurel Stoimenoff

Continuum Health Solutions, LLC

### Thomas J. Sunshine, MD, FACOG

Doctors Express Cherrydale

### Joseph Toscano, MD

San Ramon (CA) Regional Medical Center  
Urgent Care Center, Palo Alto (CA)  
Medical Foundation

### Janet Williams, MD, FACEP

Rochester Immediate Care

## JUCM ADVISORY BOARD

### Kenneth V. Iserson, MD, MBA, FACEP, FAAEM

The University of Arizona

### Benson S. Munger, PhD

The University of Arizona

### Peter Rosen, MD

Harvard Medical School

### David Rosenberg, MD, MPH

University Hospitals Medical Practices  
Case Western Reserve University  
School of Medicine

### Martin A. Samuels, MD, DSc (hon), FAAN, MACP

Harvard Medical School

### Kurt C. Stange, MD, PhD

Case Western Reserve University

### Robin M. Weinick, PhD

RAND

## UCAOA BOARD OF DIRECTORS

### Robert R. Kimball, MD, FCFP, President

### Steve P. Sellars, MBA, President-Elect

### John C. Kulin, DO, FACEP, Secretary

### Roger Hicks, MD, Treasurer

### Sean M. McNeeley, MD, Treasurer-Elect

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

### Logan McCall, MBA, Director

### Damaris Medina, Esq., Director

### Barbara McKee, Director

### Pamela Sullivan, MD, FACP, Director

### Don Dillahunty, DO, MPH, ex-officio, Chair, UCF

### William Gluckman, DO, MBA, FACEP, CPE, CPC, ex-officio, President, UCCOP

### P. Joanne Ray, CEO

# JUCM

## EDITOR-IN-CHIEF

### Lee A. Resnick, MD, FFAFP

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



185 State Route 17, Mahwah, NJ 07430

## PUBLISHER

### Stuart Williams

swilliams@jucm.com • (201) 529-4004

## CLASSIFIED AND RECRUITMENT ADVERTISING

### Brent Fontaine

YM Careers

bfontaine@yourmembership.com • (860) 437-5700

## Mission Statement

JUCM The Journal of Urgent Care Medicine supports the evolution of urgent care medicine by creating content that addresses both the clinical practice of urgent care medicine and the practice management challenges of keeping pace with an ever-changing health-care marketplace. As the Official Publication of the Urgent Care Association of America and the 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

JUCM The Journal of Urgent Care Medicine (www.jucm.com) is published through a partnership between Braveheart Group, LLC (www.braveheart-group.com) and the Urgent Care Association of America (www.ucaoa.org).

## Disclaimer

JUCM The Journal of Urgent Care Medicine (JUCM) makes every effort to select authors who are knowledgeable in their fields. However, JUCM does not warrant the expertise of any author in a particular field, nor is it responsible for any statements by such authors. The opinions expressed in the articles and columns are those of the authors, do not imply endorsement of advertised products, and do not necessarily reflect the opinions or recommendations of Braveheart Publishing or the editors and staff of JUCM. Any procedures, medications, or other courses of diagnosis or treatment discussed or suggested by authors should not be used by clinicians without evaluation of their patients' conditions and possible contraindications or dangers in use, review of any applicable manufacturer's product information, and comparison with the recommendations of other authorities.

## Advertising

Advertiser and advertising agency recognize, accept, and assume liability for all content (including text, representations, illustrations, opinions, and facts) of advertisements printed and also assume responsibility for any claims made against the Publisher arising from or related to such advertisements. In the event that legal action or a claim is made against the Publisher arising from or related to such advertisements, advertiser and advertising agency agree to fully defend, indemnify, and hold harmless the Publisher and to pay any judgment, expenses, and legal fees incurred by the Publisher as a result of said legal action or claim. The Publisher reserves the right to reject any advertising that he feels is not in keeping with the publication's standards.

## Copyright

© Copyright 2016 by Braveheart Group, LLC. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording, or any information storage and retrieval system, without written permission from the Publisher.

## Address Changes

JUCM (ISSN 1938-002X) printed edition is published monthly except for August for \$50.00 by Braveheart Group LLC, 185 State Route 17, Mahwah, NJ 07430. Standard postage paid, permit no. 372, at Midland, MI, and at additional mailing offices. POSTMASTER: Send address changes to Braveheart Group LLC, 185 State Route 17, Mahwah, NJ 07430. Email: address.change@jucm.com



Editor-in-Chief Lee Resnick writes that with all of the changes in health care in general and in urgent care in particular, some appear to think that the urgent care model can be deconstructed into its individual parts and reassembled to create large-scale entities. But the unique mix of each urgent care center with its local culture means that such a thing is not possible. The core driver of consumer behavior in health care is whether the patient feels cared for. Thus, unless urgent care operators maintain focus on the who and how of the care experience, they will not succeed over the long term in this competitive environment.

Diverticulitis affects more than 40% of the Western world and approximately 74% of patients older than 80 years. Jilian Nicholas, DO, and Christopher Tangen, DO, explain how to differentiate between uncomplicated and complicated forms of the condition, and they provide a clinical update on disease management.

Nicholas is a traditional rotating intern with a surgical focus at UH Regional Hospitals in Richmond Heights, Ohio. Tangen is a specialist in sports medicine as well as Program Director of the Traditional Rotating Internship at UH Regional Hospitals.



Staff members who are emotionally invested in their work can hugely improve both the patient care experience and the bottom line of urgent care centers. How do center owners engender that level of personal investment? One popular tool is an open-book management style called the Great Game of Business. In our *Practice Management* section, author Alan A. Ayers, MBA, MAcc, explains how and why it works.

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

Author Joshua T. Bautz, MD, LT, MC, USNR, writes that treating adolescents requires finesse. First, some diagnoses are unique to this group of patients in comparison to children and adults. Second, adolescents may not provide all of the details pertinent to their medical history if they are not given time to speak with a health-care provider without their parents present.

Bautz is finishing his final year of postgraduate residency in emergency medicine at Vanderbilt University Medical Center in Nashville, Tennessee.

#### Also in this issue:

In *Health Law and Compliance*, **Ron Lebow, JD**, discusses prohibition by state laws of the doctrine of the corporate practice

of medicine, and how business arrangements to skirt those laws may present substantial legal risks to providers.

Lebow is a New York-based transaction and regulatory counsel for Michelman & Robinson, LLC, focused on business, contract, corporate, and regulatory matters affecting hospitals, urgent care centers, and individual physicians across the United States.

**Sean M. McNeeley, MD**, and the **Urgent Care College of Physicians** review new reports from the literature on the large percentage of clinical trials for which findings remain unpublished and the effect of lack of access to that data on patient care, the use of an intranasal nonsteroidal anti-inflammatory drug in pain treatment, the risk of myocardial infarction in older patients with influenza, teething toddlers who have fever, trimethoprim-sulfamethoxazole (TMP-SMX) in treating abscesses, whether to give codeine to children, the effectiveness of gout treatments, and TMP-SMX in methicillin-resistant *Staphylococcus aureus*.

In *Coding Q&A*, **David Stern, MD, CPC**, discusses fractures: codes for initial and follow-up treatment, codes for treatment of sequelae, and what services and supplies are billable.

Our *Developing Data* column provides statistics on which months were the busiest for patient visits to U.S. urgent care centers in 2014. ■

#### To Submit an Article to JUCM

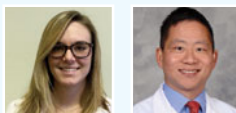
*JUCM*, *The Journal of Urgent Care Medicine* encourages you to submit articles in support of our goal to provide practical, up-to-date clinical and practice-management information to our readers—the nation's urgent care clinicians. Articles submitted for publication in *JUCM* should provide practical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

Manuscripts on clinical or practice-management topics should be 2600 to 3200 words in length, plus tables, figures, and references. Articles that are longer than this will, in most cases, need to be cut during editing.

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

#### To Subscribe to JUCM

*JUCM* is distributed to medical practitioners—physicians, physician assistants, and nurse practitioners—working in urgent care practice settings in the United States. To subscribe, log on to [www.jucm.com](http://www.jucm.com) and click on “Subscription.” ■





**Urgent Care Fall Conference**  
**Gaylord Opryland Resort**  
**& Convention Center**

**September 29 - October 1, 2016**  
**Nashville, Tennessee**

**2016**  
**NASHVILLE**  
**Urgent Care**  
**Fall Conference**



**Start planning your 2016 urgent care education with UCAOA!**

**NEW!**

**Urgent Care Regional Conference**  
**DoubleTree by Hilton Hotel**  
**Philadelphia Center City**  
**July 14-15, 2016**  
**Philadelphia, Pennsylvania**

**Philadelphia**  
**2016 Urgent Care**  
**Regional Conference**



**Urgent Care®**  
**Association**  
of America

Visit [ucaoa.org/?education](http://ucaoa.org/?education) for the latest information or call 877-698-2262.

Follow us on:



**#UCAOA16**





# National Urgent Care Awareness Month: May 2016

■ P. JOANNE RAY

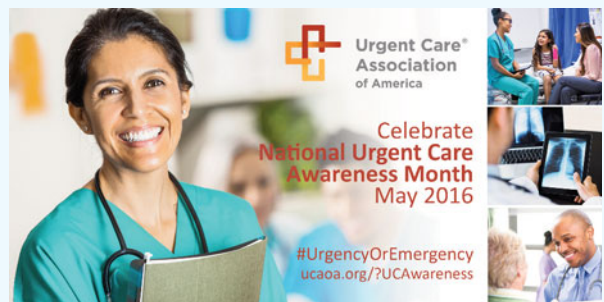
Celebrate National Urgent Care Awareness Month in May by drawing attention to the role of urgent care and helping your community determine where best to go when medical attention is needed. The month's focus is on educating payors, media, and the public on when to seek medical treatment at an urgent care center versus a hospital emergency department, a freestanding emergency department, or a retail center.

UCAOA has created the following resources for you at [www.ucaoa.org/?UCAwareness](http://www.ucaoa.org/?UCAwareness):

- Download the UCAOA members' media toolkit, which contains customizable media materials, helpful talking points, reference guides, outreach materials, and more.
- Customize the UCAOA press release "Urgency or Emergency? The Wrong Answer Could Be Costly" ([www.prweb.com/releases/2016/02/prweb13226182.htm](http://www.prweb.com/releases/2016/02/prweb13226182.htm)). Deploy this information to the resources within your own communities to help reinforce the important role your urgent care center plays in providing the best, most affordable patient care at times most convenient to them and to increase awareness of our vital industry.
- Reinforce the press release with the "Urgency or Emergency?" infographic at [http://c.ymcdn.com/sites/www.ucaoa.org/resource/resmgr/Media/UCAOA-Infographic-UCvsER\\_FIN.pdf](http://c.ymcdn.com/sites/www.ucaoa.org/resource/resmgr/Media/UCAOA-Infographic-UCvsER_FIN.pdf), which helps to explain to patients when to head for an urgent care center for treatment.
- Post this year's flyer ([http://c.ymcdn.com/sites/www.ucaoa.org/resource/resmgr/National\\_Urgent\\_Care\\_Awareness\\_Month\\_/UCAOA-NatlUCAwareness-flyer\\_.pdf](http://c.ymcdn.com/sites/www.ucaoa.org/resource/resmgr/National_Urgent_Care_Awareness_Month_/UCAOA-NatlUCAwareness-flyer_.pdf)) in your urgent care center or repurpose it as an ad to run in local publications.
- Add Urgent Care Awareness banners (<http://www.ucaoa.org/?ucawarenessbanners>) to your website, to your social media pages, and even as an e-signature to your emails.



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



*"The month's focus is on educating payors, media, and the public on when to seek medical treatment at an urgent care center."*

[ucaoa.org/?ucawarenessbanners](http://www.ucaoa.org/?ucawarenessbanners)) to your website, to your social media pages, and even as an e-signature to your emails.

- Share "The Healthcare Industry's Urgent Need for Urgent Care" ([http://c.ymcdn.com/sites/www.ucaoa.org/resource/resmgr/Infographics/UCAOA-UrgentCareInfographic\\_.pdf](http://c.ymcdn.com/sites/www.ucaoa.org/resource/resmgr/Infographics/UCAOA-UrgentCareInfographic_.pdf)), an infographic explaining the important role that urgent care centers play in keeping up with the everyday needs of the growing patient base. Distribute this to community groups and schools and ask them to share it with their constituencies.

The month is also a great opportunity to recognize your team members for their contributions. We encourage you to not only offer your thanks but also share valuable educational resources to advance patient care. Look for discounts on featured urgent care webcasts in the UCAOA Online Store in May!

If your center has a group membership, make sure you have provided your roster to the UCAOA so that everyone on your team has access and is aware of all the benefits afforded to them through your membership. If their names are not on file with the UCAOA, they will not be able to use benefits such as our online networking groups, helpful articles, tips in our weekly e-newsletter, and dozens of other online resources. ■

## Diverticulitis in the Urgent Care Setting

**Urgent message:** Abdominal pain due to acute diverticulitis is commonly seen in the urgent care setting. This is a clinical update on the management and treatment of acute diverticulitis.

JILIAN NICHOLAS, DO, and CHRISTOPHER TANGEN, DO

### Introduction

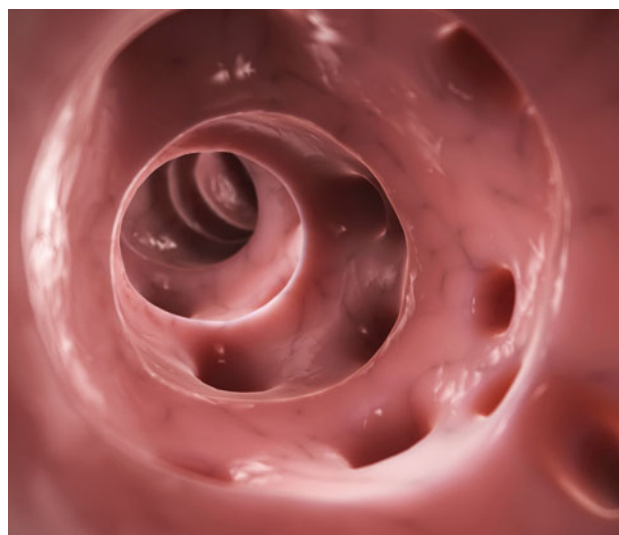
Abdominal pain commonly presents in the ambulatory setting, in anywhere from 1.5% to 8% of patients.<sup>1,2</sup> With diverticulitis being a common diagnosis in the presence of abdominal pain, the clinical challenge in an urgent care setting is determining uncomplicated from complicated diverticulitis.

### Diverticulosis

French pathologist Jean Cruveilhier described diverticulosis in 1849 as “bands of longitudinal muscle fibers in the sigmoid, a series of small, dark, pear-shaped tumors, which are formed by hernia of the mucous membrane through the gaps in the muscle coat.” Diverticula are described as outpouchings of mucosa and submucosa through the muscular layer of the colon (**Figure 1**) that arise in anatomic weaknesses within the bowel wall, such as areas where blood vessels penetrate into the wall.<sup>3</sup>

In the Western world, the prevalence of diverticulosis is thought to be approximately 30% to 40% of the population,<sup>4</sup> although that is likely an underestimate, because most patients have asymptomatic disease.<sup>3</sup> During colonoscopy, diverticulosis is the most commonly noted finding, seen in approximately 42.8% of all colonoscopies and up to 74.1% in patients older than 80 years.<sup>3</sup>

**Jilian Nicholas, DO**, is a traditional rotating intern with a surgical focus at UH Regional Hospitals in Richmond Heights, Ohio. **Christopher Tangen, DO**, is a specialist in sports medicine as well as Program Director of the Traditional Rotating Internship at UH Regional Hospitals.



©iStockPhoto.com

### Diverticulitis

Up to a quarter of patients with diverticulosis develop diverticulitis.<sup>4</sup> The term *diverticulitis* means that a diverticulum has become inflamed and infected, resulting in microperforation. The most common presenting symptoms of acute diverticulitis include abdominal pain and fever.<sup>5</sup> Hospitalizations for diverticulitis represent 150,000 admissions and 24,000 elective surgical procedures per year in the United States. Multiple microbes, including both anaerobic and facultative bacteria, commonly contribute to the infectious etiology in diverticulitis. The most commonly suspected organisms are *Bacteroides*,



The entire system from A to Z is awesome.

Integra Urgent Care reduced wait times with web check-in.

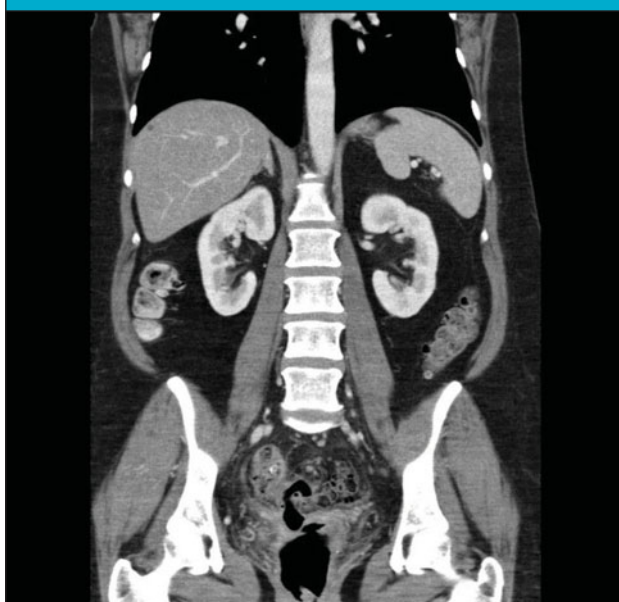
Read how in the Gupta family's story at [docutap.com/integra](http://docutap.com/integra).  
**CALL US FOR A ONE-ON-ONE DEMO. 888.912.8435**



A better urgent care experience.  
EMR | PM | RCM

**Figure 1. Diverticula in the large bowel.**

(Image available from: [https://commons.wikimedia.org/wiki/File:Diverticula,\\_sigmoid\\_colon.jpg](https://commons.wikimedia.org/wiki/File:Diverticula,_sigmoid_colon.jpg).)

**Figure 2. Computed tomography image of diverticulitis with fistula formation.**

(Image courtesy of Corey T. Jensen, MD.)

*Peptostreptococcus*, *Enterobacteriaceae*, viridans streptococci, and enterococci.<sup>4</sup> Diverticulitis is categorized as uncomplicated or complicated according to whether there is an abscess or fistula, obstruction, or free perforation.<sup>6</sup>

### **Pathogenesis of Diverticulitis**

Until recently, the pathogenesis of diverticulitis was thought to be obstruction of the neck of the outpouching diverticulum with a fecalith, which subsequently causes overgrowth of bacteria, inflammation, and even-

tually perforation with inflammation to surrounding structures. Recently, however, researchers have postulated that a change in the microbiota causes an alteration in immunity of the mucosa and results in chronic inflammation. Local infections caused by microperforation that result in formation of a small abscess can often be contained. However, with larger abscesses secondary to macroperforation, more serious complications can ensue, including peritonitis, fistula formation, and systemic symptoms.<sup>4</sup>

### **History of Present Illness**

When you suspect that a patient has diverticular disease, it is important to ask about the following:

- Dietary habits
- Systemic symptoms
- Significant comorbid conditions
- Immunocompromise
- Localization of pain, and any radiation
- Previous colonoscopy

### **Physical Examination**

Common presenting symptoms of diverticulitis include the following<sup>7</sup>:

- Abdominal pain in the left lower quadrant, which is present in 93% to 100% of patients with the disease
- Fever, present in 57% to 100%
- Leukocytosis, present in 69% to 83%

These are additional signs to look for during examination<sup>4</sup>:

- Guarding
- Rebound tenderness in the left lower quadrant
- Tenderness in the suprapubic area
- Hypoactive versus normal bowel sounds
- Palpable abdominal mass
- Fecaluria or pneumaturia, with fistula formation from the colon to the bladder
- Feces or flatus through the vagina, with fistula formation from the colon to the vagina

The differential diagnosis for diverticulitis includes the following:

- Irritable bowel syndrome
- Inflammatory bowel disease
- Carcinoma of the colon
- Endometriosis
- Ischemic colitis
- Infections
- Lactose intolerance



*"Until recently, the pathogenesis of diverticulitis was thought to be obstruction of the neck of the outpouching diverticulum with a fecalith. . . . However, researchers have postulated that a change in the microbiota causes an alteration in immunity of the mucosa and results in chronic inflammation."*

### Making the Diagnosis

The diagnosis of diverticulitis is commonly made after clinical evaluation of presenting symptoms. Surprisingly, approximately half of the patients in whom the diagnosis of diverticulitis is made solely by clinical presentation do not actually have the disease and are later found to have different diseases.<sup>4</sup> Imaging studies aid in the diagnosis of diverticulitis and help categorize severity of disease. The American College of Radiology suggests computed tomography (CT) as the initial diagnostic imaging modality (**Figure 2**) for patients presenting with left lower quadrant or right lower quadrant abdominal pain.<sup>1</sup> Both CT and ultrasound are used to evaluate diverticulitis, but CT is preferred, especially because it has been shown to be highly sensitive (97%) and highly specific (100%)<sup>4</sup> (**Table 1**). However, ultrasound can rival the accuracy of CT when used by experienced operators. Conventional radiology has poor diagnostic value and is not recommended for evaluating potential causes of abdominal pain.<sup>2</sup>

### Treatment

#### Outpatient Therapy Versus Inpatient Therapy

Outpatient treatment is recommended in the initial treatment for uncomplicated diverticulitis. It is also justifiable for diverticulitis with a peridiverticular abscess of <5 cm. Inpatient therapy for uncomplicated diverticulitis should be considered in patients who cannot tolerate oral hydration, who require narcotics, or whose condition does not improve despite outpatient therapy. Patients with complicated diverticulitis, such as the following, should be transferred to a hospital for treatment<sup>4</sup>: elderly patients, immunocompromised patients, and those with significant comorbidities, peritonitis, fistula, or large or distant abscess formation (**Tables 2 and 3**).

#### Antibiotics

The use of antibiotics in the treatment of acute divertic-

**Table 1. Computed Tomography Findings in Diverticulitis**

Findings in the Abdomen or Pelvis	Percent in Diverticulitis
Pericolic fat stranding	98
Diverticula	84
Bowel wall thickening	70
Phlegmon or abscess formation	35

Data from Sifri CD, Madoff LC. Diverticulitis and typhlitis. In: Bennett JE, Dolin R, Blaser MR, eds. *Mandell, Douglas, and Bennett's Principles and Practice of Infectious Diseases*. 8th edition. Philadelphia, PA: Saunders; 2015:986–989.

**Table 2. Red Flags in Diverticulitis**

- Systemic symptoms, signs of sepsis
- Diffuse peritonitis
- Immunocompromise
- Significant comorbidities
- Fistula: >5 cm or distant abscess

Data from Sifri CD, Madoff LC. Diverticulitis and typhlitis. In: Bennett JE, Dolin R, Blaser MR, eds. *Mandell, Douglas, and Bennett's Principles and Practice of Infectious Diseases*. 8th edition. Philadelphia, PA: Saunders; 2015:986–989.

**Table 3. Patients Who Require Inpatient Treatment**

- Those unable to tolerate oral hydration
- Those who require narcotic analgesia
- Those whose condition does not improve despite outpatient management
- Those with complicated diverticulitis

Data from Sifri CD, Madoff LC. Diverticulitis and typhlitis. In: Bennett JE, Dolin R, Blaser MR, eds. *Mandell, Douglas, and Bennett's Principles and Practice of Infectious Diseases*. 8th edition. Philadelphia, PA: Saunders; 2015:986–989.

ulitis is currently being challenged. Theories about causes of diverticulitis now focus on inflammation rather than infection, bringing into question the benefit of antibiotic use. Recently, two randomized controlled trials and two systematic reviews of data on hospitalized patients with CT-diagnosed uncomplicated diverticulitis concluded that there was no clear benefit from antibiotic therapy. The studies focused solely on inpatient treatment of uncomplicated diverticulitis, and therefore their results cannot be generalized to the treatment of complicated diverticulitis or diverticulitis in the outpatient setting. Because of that limitation and the narrow population analyzed, the American Gastroenterological Association (AGA) recommends individualizing the use of antibiotics in select patients instead of routinely prescribing it in acute uncomplicated diverticulitis. Outpatient treatment



**IS IT DOOM FOR YOUR PRACTICE?  
OR THE DAWN OF A NEW DAY?**

# **INVASION OF THE OMNIBUS**

The Omnibus Bill\* is here, bringing big changes  
in the way you get reimbursed for radiology. And that  
can be a good thing or a bad thing for your clinic.  
Which will it be? Watch what happens at

**[OmnibusInvasion.com/JUCMMay](http://OmnibusInvasion.com/JUCMMay)**

Presented by:



**KONICA MINOLTA**

\*Consolidated Appropriations Act of 2016

**Table 4. Outpatient Antibiotic Regimens (7–10 Days)**

- Ciprofloxacin, 500 mg orally twice a day, and metronidazole, 500 mg orally three times a day
- Amoxicillin-clavulanate, 875/125 mg orally twice a day
- Cephalexin, 500 mg orally twice a day, and metronidazole, 500 mg orally three times a day
- Trimethoprim-sulfamethoxazole orally four times a day, and metronidazole, 500 mg orally three times a day
- Clindamycin, 450 mg orally four times a day

Data from Stocchi L. Diverticulitis. In: McNally PR, ed. *GI/Liver Secrets Plus*. 5th ed. Philadelphia, PA: Elsevier; 2015:358–364.

of acute uncomplicated diverticulitis without the use of antibiotics has not been investigated.<sup>6</sup>

Patients with complicated diverticulitis should still receive antibiotics and inpatient treatment (**Table 4**). Such patients include those who are immunosuppressed, are pregnant, have signs of systemic inflammatory response syndrome or sepsis, or have significant comorbid disease.

### **Recommended Follow-Up**

Most patients with acute uncomplicated diverticulitis can follow up with their primary-care physician for monitoring of symptom resolution. If patients are prescribed antibiotics in an urgent care center, they should see their primary-care physician within 3 to 5 days. If their condition does not improve with conservative treatment or if symptoms worsen, they should follow up with their primary-care physician sooner or return to the urgent care center.

In addition, if there is concern about a possible underlying neoplasm not identified on CT images, a colonoscopy can be helpful in ruling out neoplasms. These patients should be referred to a gastroenterologist for colonoscopy. According to the AGA, a colonoscopy is recommended after an acute episode has resolved, to exclude underlying colorectal neoplasms. Colonoscopies are usually scheduled 6 to 8 weeks after an acute event, although optimal timing has not been established.<sup>6</sup>

Some patients may need consultation with a general surgeon for treatment of diverticulitis. The current standard of care recommends offering elective surgical resection to patients with more than two episodes of diverticulitis. In the past, surgical management was considered a reasonable treatment option. However, recent study findings have challenged this belief. The American Society of Colon and Rectal Surgeons suggest making

*“If patients are prescribed antibiotics in an urgent care center, they should see their primary-care physician within 3 to 5 days. If their condition does not improve . . . , they should follow up with their primary-care physician sooner or return to the urgent care center.”*

the decision to use surgery on a case-by-case basis. It is important to weigh the risks and benefits of surgery and to keep in mind the possible complications, such as infections, anastomotic leak, and cardiovascular or thrombotic events.<sup>8</sup> Up to 10% of patients who undergo resection have complications.<sup>6</sup>

These are important factors to consider when referring a patient with diverticulitis to a gastroenterologist:

- The timing and completeness of prior colonoscopy
- Comorbidities
- Persistent symptoms of abdominal pain or diarrhea
- Patient preference

These are important factors to consider when referring a patient for surgery:

- A history of two or more episodes of diverticulitis (the current standard of care)
- A lack of improvement with conservative treatment
- Generalized peritonitis or severe systemic symptoms
- The presence of immunocompromise
- Uncontrolled bleeding (without spontaneous cessation after administration of 4–5 U of packed red blood cells)

### **Prevention of Recurrent Acute Episodes**

#### *Nuts and Seeds*

It has long been thought that intake of nuts and seeds provokes acute attacks of diverticulitis, but this is now being questioned. In 2008, approximately 47,000 U.S. men with diverticulosis were enrolled in an observational study that followed the subjects for 20 years. The study reported no increased risk of diverticulosis or complications in men who ingested nuts, popcorn, and seeds. Surprisingly, men who consumed either nuts or popcorn multiple times a week had a decreased risk for complications.<sup>9</sup> Outside of that large observational study, data regarding consumption of these items are scarce. Therefore, the AGA advises that it is not necessary for patients with diverticulitis to avoid nuts and popcorn.<sup>6</sup>



### Mesalamine

The AGA also addresses the use of mesalamine in the prevention of recurrence. Multiple randomized controlled trials have been conducted with the primary end point being patients free of diverticulitis recurrence.<sup>6</sup> Even though study results were conflicting, the majority of the studies did not find that mesalamine worked superiorly to placebo for preventing recurrence.<sup>10</sup> The AGA currently suggests not using mesalamine for prevention of recurrence.<sup>6</sup>

### Rifampin

Rifampin is not currently recommended for recurrence prevention. Multiple studies showed a decrease in recurrence but did not show statistical significance, and thus more research is needed.<sup>6</sup>

### Probiotics

Probiotics are not recommended by the AGA at this time. Small studies with probiotics did show a reduction in recurrence, but it was not statistically significant. Owing to changing theories regarding the etiology of diverticulitis and the role that the individual microbiome plays, further studies are needed to clarify the potential of probiotics.<sup>6</sup>

### High-Fiber Diet

It has long been implied that a high-fiber diet will prevent diverticulosis and episodes of diverticulitis, and therefore physicians commonly recommend such a diet.<sup>10</sup> Researchers who conducted an observational study of patients without known diverticular disease who had experienced their first episode of diverticulitis concluded that a high-fiber diet reduced the risk of recurrence. The AGA also references one small study that showed reductions in complications and surgery in patients with a high-fiber diet. Although the data are insubstantial for proving high fiber intake to be beneficial, the AGA does not believe that fiber intake poses any risks, and it therefore suggests fiber intake for patients with a history of diverticular disease. It is important to discuss the adverse effects of increased fiber intake, such as abdominal bloating, with patients.<sup>6</sup>

### Physical Activity

Vigorous activity should be considered as a possible pre-

*“It has long been thought that intake of nuts and seeds provokes acute attacks of diverticulitis, but this is now being questioned. . . . Outside of [one] large observational study, data . . . are scarce. Therefore, the AGA advises that it is not necessary for patients with diverticulitis to avoid nuts and popcorn.”*

ventative for recurrence. An observational study of approximately 47,000 men showed a decreased risk of recurrence in those with vigorous activity levels.<sup>6</sup>

### Nonsteroidal Anti-inflammatory Drugs

The AGA suggests avoiding use of nonsteroidal anti-inflammatory drugs (NSAIDs) in patients with previous episodes of diverticulitis. This evidence is extrapolated from observational studies that showed an increased risk of occurrence. However, even though aspirin is an NSAID, the AGA recommends against advising patients to avoid its use, because the added benefit of aspirin use is greater than the risk of a diverticular episode.<sup>6</sup>

### Conclusion

Diverticulitis is a common cause of abdominal pain that presents in urgent care facilities. Much of the current treatment of diverticulitis is in flux, being under study, and thus AGA guidelines are conditional and based on current low-quality evidence. Additional research is necessary to provide evidence for the practices we follow. The current recommendation is to treat acute uncomplicated diverticulitis in an outpatient setting. Patients with complicated diverticulitis, including those with significant comorbidities, immunosuppression, or peritoneal signs, and those with evidence of fistula, abscess, or perforation, should be transferred to a hospital for treatment. ■

### References

1. Cartwright S, Knudson M. Diagnostic imaging of acute abdominal pain in adults. *Am Fam Physician*. 2015;91:452–459.
2. Brown H, Kelso L. Abdominal pain: an approach to a challenging diagnosis. *AACN Adv Crit Care*. 2014;25:266–278.
3. Bhuket TP, Stollman NH. Ileus and pseudo-obstruction. In: Feldman M, Friedman LS, Sleisenger and Fordtran's *Gastrointestinal and Liver Disease*. 10th edition. Philadelphia, PA: Elsevier; 2016:2123–2138.
4. Sifri CD, Madoff LC. Diverticulitis and typhilitis. In: Bennett JE, Dolin R, Blaser MR, eds. *Mandell, Douglas, and Bennett's Principles and Practice of Infectious Diseases*. 8th edition. Philadelphia, PA: Saunders; 2015:986–989.
5. Stocchi L. Diverticulitis. In McNally PR, ed. *GI/Liver Secrets Plus*. 5th ed. Philadelphia, PA: Elsevier; 2015:358–364.
6. Stollman N, Smalley W, Hirano I; AGA Institute Clinical Guidelines Committee. American Gastroenterological Association Institute Guideline on the Management of Acute Diverticulitis. *Gastroenterology*. 2015;149:1944–1949.
7. Ferri FF. Diverticular disease (diverticulosis, diverticulitis). In: *Ferri's Clinical Advisor 2016*. Philadelphia, PA: Saunders; 2016:434.
8. Piper MS, Saini SD. Diverticular diseases: a modern renaissance? *Clin Gastroenterol Hepatol*. 2015;14:104–106.
9. Strate LL, Liu YL, Syngal S, et al. Nut, corn, and popcorn consumption and the incidence of diverticular disease. *JAMA*. 2008;300:907–914.
10. Tursi A, Danese S. Preventing diverticulitis recurrence by selecting the right therapy for a complex disease. *Gastroenterology*. 2014;147:733–736.





Teleradiology  
S P E C I A L I S T S

# top-tier service



"It's the most important part of the job. Turnaround time is fun and technology is cool, but at the end of the day it's all about patient care."

-Dr. David Cohen, Founding Radiologist,  
Teleradiology Specialists

March averages:

Standard studies: 14.2 minutes

Stat studies: 8.1 minutes

888-819-0808 | [teleradiologyspecialists.com](http://teleradiologyspecialists.com)  
[info@teleradiologyspecialists.com](mailto:info@teleradiologyspecialists.com)

# When you need to test for Strep A



We have  
the test that  
fits the way  
*you* test.

Trusted brands, from rapid point-of-care immunoassays to confirmatory molecular assays.  
See us at [quidel.com/strepA](http://quidel.com/strepA) to find out more.



QuickVue



Sofia



AmpliVue



Solana



Lyra

# Practice Management

## Open-Book Management: Using Transparency and Gamification to Engage and Empower Frontline Staff

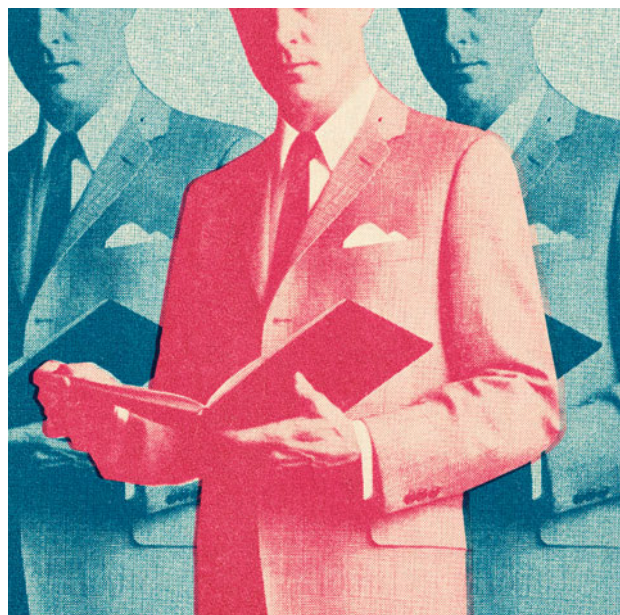
**Urgent message:** Urgent care operators can cultivate a sense of ownership using the techniques of open-book management, which entails teaching frontline staff members how a business makes money and turning the process of increasing profits into a game.

ALAN A. AYERS, MBA, MAcc

### Introduction

Urgent care requires dedicated, engaged, and focused frontline staff members to deliver the types of patient experiences that spur repeat visits and positive word of mouth. Yet a Gallup poll conducted in 2014 showed that a paltry 32% of U.S. workers are truly engaged in their jobs.<sup>1</sup> That means that more than two-thirds of America's workforce is simply going through the motions—which engagement experts have clearly demonstrated has a damaging effect on a company's bottom line.

This widespread disengagement was found to be especially prevalent among groups such as general laborers and customer-facing, or frontline, staff members, because they often perform the most physically and emotionally taxing duties while receiving the lowest pay. For an urgent care operator, likely dealing with slim margins already, a disengaged staff can have serious



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*.

1. Gallup. Majority of U.S. employees not engaged despite gains in 2014 [Internet]. Washington DC: Gallup, Inc.; © 2015 January 28 [accessed 2016 January 31]. Available from: <http://www.gallup.com/poll/181289/majority-employees-not-engaged-despite-gains-2014.aspx>

**Table 1. Financial Consequences of Employee Engagement**

Engagement Level	Return on Salary
Fully engaged	120%
Engaged	100%
Somewhat engaged	80%
Disengaged	60%
Data from Human Capital Institute, reported in Schweyer A. The economics of engagement [Internet]. McLean, VA: Incentive Research Foundation [published 2010 January 5; cited 2016 January 31]. Available from: <a href="http://theirf.org/research/the-economics-of-engagement/206/">http://theirf.org/research/the-economics-of-engagement/206/</a> .	

financial implications. General employee engagement levels, as they relate to their respective returns on salary, are illustrated by data from Human Capital Institute, a global talent management agency, in **Table 1**.

The hard truth of this staggering finding is clear: Essentially, the difference in value between a fully engaged employee and a disengaged employee is roughly *double* in terms of motivation, productivity, efficiency, accountability, and overall performance. It is why organizations readily spend millions on engagement experts; they know the numbers, and they know how dramatically an engaged-employee culture could potentially lift their companies.

But despite their sometimes massive price tags, not all employee engagement strategies originate from corporate boardrooms or focus groups. In fact, one of the most successful engagement philosophies was born at a struggling engine-remanufacturing plant in Springfield, Missouri.

### Introducing the Great Game of Business

In 1983, a plant manager named Jack Stack raised \$100,000 with the help of his partners, and then borrowed \$9 million more, to purchase Springfield ReManufacturing Corp. (SRC). At the time, SRC was a struggling division of International Harvester with slim prospects of survival. Although the plant was engulfed in financial problems, internal labor strife, and low morale, Stack and his partners knew that if they could somehow tap into the employees' collective knowledge, they had a chance to turn things around, save jobs, and make the plant flourish.

But they had seen that the traditional top-down, hierarchical management style was not going to work, so they came up with something novel: Open the books, teach employees how the business makes money, and turn the process of increasing profits into a game of sorts. Although it took them some time to refine and

### Sidebar 1. MiniGames Are Used to Make Incremental Progress Toward Organizational Goals

In the Great Game of Business, MiniGames are a mechanism for attaining short-term improvement in an organization. Improvements may be focused on correcting a weakness or pursuing an opportunity. MiniGames typically focus on the most important thing that a team can do now in support of the organization's long-term goal.

Teams identify a present problem or opportunity upon which they can effect change. When teams pick their own targets, as opposed to being assigned targets, they are more likely to hit them. The problem or opportunity must be measurable by an operational or financial number. Examples in urgent care include patient satisfaction scores, staff overtime hours, patient wait/throughput times, and center profitability. Teams set a common goal to attain the desired number during a certain time period (i.e., to go from X to Y by doing Z), typically between 6 weeks and 3 months. Often, MiniGames are run on a quarterly basis. Teamwork requires that the goal be one that can be met together. Picking individual winners means everyone else is a loser, which undermines teamwork.

To engage team members, a theme for the game is chosen that is promotable and memorable. Business training is incorporated to aid team members' understanding of the organizational impact. Teams design a scoreboard for tracking their progress that is simple and easy to understand, and they schedule regular huddles to review their standing.

Prizes are offered for meeting the goal, as are opportunities to celebrate. Prizes should motivate performance and create a memorable winning experience. Cash is thus typically a poor choice, but prizes with a trophy value, like movie tickets, gift cards, lunches, team outings, and time-saving services, are often more meaningful to recipients. Wins are communicated throughout the organization to inspire engagement in future MiniGames.

Adapted from Stack J. *The Great Game of Business: The Only Sensible Way to Run a Company*. New York, NY: Crown Business Publishing, 2013.

tweak the game, it turned out to be wildly successful. In a few short years, SRC's revenue doubled, earnings quadrupled, and the debt-to-equity ratio shrank from an unwieldy 89 to 1 to a respectable 5 to 1. Morale and engagement levels skyrocketed, and turnover, absenteeism, and the number of product defects plummeted. All of this was made possible by their creation of an open-book management style they dubbed the Great Game of Business (GGOB).

### Keys to the Game

Today, GGOB principles have been adopted by thousands of organizations, from Fortune 500 giants to freshly minted start-ups. Although space does not per-



mit an in-depth description of the GGOB here, the key concepts of the game can be summarized thusly:

- **Provide full transparency:** A GGOB company must open the books and show the company's financial standing to its employees, regardless of whether the numbers are up or down. Leadership does not worry about competitors learning their financial numbers, because GGOB leaders understand that the competition cannot easily replicate their superior employee culture, collective know-how, and best practices.
- **Teach how the numbers translate:** The line items on the income statement do not matter much if employees do not understand them or grasp how their daily work influences these numbers. A GGOB company first teaches financial literacy to its employees, and then it shows employees exactly how their individual work or department moves the numbers up or down.
- **Keep score:** Once the numbers and their relation to employee output is understood, then goals to improve the numbers are implemented (**Sidebar 1**). This is done with scorecards, dashboards, and weekly huddles that help track and forecast the critical numbers (**Sidebar 2**), often in real time.
- **Make it a game:** One of the keys to Stack's original concept was his understanding that people love games, so he applied the elements of a game—rules, teams, scores, results—to the daily operations of SRC. Of course, the games had various prizes that SRC's employees valued, keeping them competitive, engaged, and motivated to push their teams and departments to victory.
- **Give employees a stake in the game:** This might be the most important factor in making the GGOB work. Through the disbursement of awards, recognition, gifts, and generous financial incentives like quarterly cash bonuses if their work games resulted in the company's hitting its revenue targets, a dramatic shift took place. SRC's employees were no longer just paid workers; they became de facto part owners in the company. This transformation from employee to part owner



## STAT KIT® 550

### Emergency Medical Kit

- Lightweight (5lbs) and portable
- For all clinical disciplines
- For Practice, Home and Travel
- Basic set of medications

\*KMCA Medications are tracked for expiration and automatically replaced to maximize shelf-life and ensure readiness.

**Banyan®**  
Life-Saving Equipment, Medications & Training  
Since 1970

888-STAT KIT  
StatKit.com  
or contact your dealer

9511 v.1 04/2016

### Sidebar 2. Open-Book Management Begins with Defining a Critical Number

In the Great Game of Business, a **critical number** or **wildly important goal** is the one thing that

- At any given time is going to have the greatest impact on the business
- The business must achieve in order to succeed or survive
- Clearly defines winning

Critical numbers must be measurable in order for teams to show progress. They are determined by performing a 360-degree appraisal of the business that addresses the following perspectives and data sources:

- **Financial perspective:** Historical financial statements, financial goals, industry financial benchmarks, and financial trends
- **Marketplace perspective:** Customer surveys, sales and marketing plans, competitive information, market growth, and customer and marketing intelligence
- **Management perspective:** Management interviews, management surveys, and strategic planning meetings
- **Employee perspective:** Employee interviews, employee surveys, and operational planning meetings

Market-based sales plans and supporting budgets are used to create pro forma financial statements for identifying the critical number. Once the critical number is identified, weekly huddles are held to share information from scoreboards that show the status of the critical number. When the critical number improves, wins occur and team members celebrate and are rewarded financially.

Adapted from Stack J. *The Great Game of Business: The Only Sensible Way to Run a Company*. New York, NY: Crown Business Publishing, 2013.

unleashed unprecedented levels of accountability, innovation, performance, creativity, and unity. Employees understood that their daily work mattered and that they were a vital part of the company.

Of course, none of these principles would work if the prevailing culture did not support them. Hence, Stack, his partners, and SRC management made it a priority to tear down bureaucratic walls, boost morale at every opportunity, and have some fun. This included initiatives like encouraging shopworkers to paint their machines, hosting company fishing tournaments, and handing out turkeys at Thanksgiving. And it worked. SRC employees were so engaged that they began to take the reins unprompted, developing budgets and seeking out ways to reduce expenses.

### What Can Urgent Care Learn?

As GGOB principles became more widespread, they

were proven to be applicable to companies of virtually any size, across a multitude of industries. How might an urgent care operator, wrestling with many of the same employee engagement issues that plague the majority of American businesses, implement certain GGOB principles in their own operation? Of course, a medical clinic is not the same as an engine plant, so naturally there will be differences in scope and implementation. There are indeed principles, however, that will translate:

### *Build Financial Literacy*

Urgent care staff, from physicians to front-desk specialists, should have a basic understanding of the income statement—in particular, the operating income. Operating income is critically important because it most accurately reflects how management drives revenue and controls expenses. The next step is to tie operating income line items to key performance indicators (KPIs), which helps to bring the numbers into a context that staff members understand. These KPIs should be in line with both urgent care industry benchmarks and the clinic's size and scope of services, and they can include but are not limited to the following:

- **Days to bill and days in accounts receivables:** It is an urgent care truism that billing and collections are the lifeblood of any clinic, because you cannot meet payroll and other expenses with accounts receivable. Accounts receivable must eventually be converted to cash.
- **Evaluation and management code distribution:** Inconsistent coding will cause revenue fluctuations. Evaluation and management coding reflects the complexity of patient visits and directly translates to the compensation you receive. Although upcoding brings with it its own problems, undercoding due to incomplete or inaccurate documentation lowers reimbursements, which is essentially leaving dollars on the table.
- **First-pass resolution rates:** Above-average first-pass resolution levels indicate that claims have been documented, coded, and billed correctly. This is a clear indication of the cleanliness (i.e., completeness) of claims, which of course reduces resubmissions and delayed reimbursements.

These are but a few of the dozens of KPIs and metrics that urgent care management teams should track to gauge the health of their operation and identify trouble spots. But again, GGOB principles dictate educating staff on the financials so that they can see where their daily

work impacts the pertinent KPIs, which in turn show up on the income statement.

### *Play the Game*

When your staff knows and understands the numbers, then you can play games to improve them. Teams, rules, work groups, strategic decision-making, cross-training, fun prizes, scorecards, and dashboards are all key elements of the GGOB, and you can use them to foster a clinic-wide ethos of teamwork and accountability. When people go from being told what to do to being decision-makers, their level of ownership of the end result increases, and the company benefits all around.

### *Reward Success*

Although a typical urgent care clinic is limited by the doctrine of corporate practice of medicine and anti-kickback statutes in what it is legally allowed to do as far as employee equity participation, there are still ways to reward staff members so that they feel they have a true stake in the game. Some common rewards include

- Paid time off
- Catered lunches
- Team outings off-site (athletic event, theater performance, or other group activity)
- Gift cards (restaurants, big-box retailers)
- Vouchers or certificates for services (manicures, massages)
- Commemorative plaques, trophies, awards, and certificates

A key point to remember with a reward system is that prizes should be given out regularly. GGOB businesses compensate winners of their business games as often as feasible, never going longer than quarterly disbursement. This frequency keeps everyone motivated and vested because the prize is never far enough in the future that they lose focus.

### **Conclusion**

The GGOB began with one primary goal: to create a simple, straightforward, and replicable approach for harnessing the collective knowledge, experience, and common sense of employees, and then unleash it to improve the company. When the process is done correctly, the gains in efficiency, teamwork, profitability, and culture can literally transform a company.

Experts who have studied the GGOB suspect that beyond the rewards and bonuses, what really engages employees is being asked to participate in the big decisions on how to improve an aspect of business operations. This sense of empowerment and respect transforms the way employees see themselves and effectively unlocks levels of creativity, innovation, and problem-solving that would have otherwise remained dormant. After all, the person who performs the job every day understands it best. ■



## URGENT CARE CLINIC

## Medical Professional Liability Insurance

### YOU CARE FOR PATIENTS, NFP WILL TAKE CARE OF YOUR INSURANCE.

NFP's in-depth knowledge and years of experience allow us to provide competitively priced Medical Professional Liability Insurance for Urgent Care Clinics and their providers.

### KEEP YOUR BUSINESS HEALTHY, WEALTHY AND WISE WITH SMART SOLUTIONS.

Looking to save money by reducing your expenses? NFP Urgent Care Clients save money by reducing their insurance costs and risk.

As one of the largest brokers that arranges insurance for Urgent Care owners, our Total Quality Approach includes:

#### Preferred Coverage Features

- Per visit rating (type and number)
- Prior Acts Coverage
- Defense outside the limit
- Unlimited Tail available
- Exclusive "Best Practice" Discounts
- Protects the Clinic and Providers

#### Exceptional Service Standards

- Easy application process
- Risk Mgmt/Educational support
- Fast turnaround on policy changes

### WHEN IT COMES TO YOUR INSURANCE NEEDS, NFP GIVES PROFESSIONAL INSURANCE SERVICES WITH PERSONAL ATTENTION.

### Ready to know more?

Contact David Wood at  
800-695-0219, Ext. 44526, or  
david.wood@nfp.com.

Insurance services provided through  
NFP Healthcare Industry Insurance  
Services, Inc., an affiliate of NFP Corp. (NFP).  
CA license #0763921.  
173718 (PC-18863-15)



# STARTING YOUR OWN URGENT CARE?



**Don't do it alone.**

With more than 170 clinics under contract, we've got the expertise to ensure your successful urgent care startup. Urgent Care Consultants will guide you through the paperwork, site selection, construction, and timeline. Let us take you from startup to success.

815.713.2659

[www.urgentcareconsultants.com](http://www.urgentcareconsultants.com)



**Urgent Care Consultants<sup>SM</sup>**



## New urgent care EMR technology breaks the speed barrier

By: Dorothy Wallheimer

**T**he fastest urgent care EMR just got faster with the launch of Chartlet.

The newest release in Practice Velocity's award-winning electronic medical record offers one-click charting functionality to urgent care providers. It means charting on VelociDoc can be completed for many visits in about one minute.

"Since the beginning we've always had the dream of making the EMR faster than paper," said David Stern, MD, CEO of Practice Velocity. "And even before Chartlet our clients have told us we were succeeding. Chartlet takes speed to the next level."



David Stern, MD,  
CEO of Practice Velocity

Stern said he envisioned Chartlet almost 10 years ago when VelociDoc was first being developed.

"It's taken time to make it a reality, but the launch represents a real evolutionary breakthrough in EMR technology and speed," he said.

Chartlet is a tab that will appear within the EMR software and be accessible for about 80 percent of urgent care center chief complaints. When a patient comes in complaining of sore throat, sinus congestion, painful urination, cough/chest congestion, or back/muscle pain, the provider can use a single Chartlet template designed specifically for that issue.

"This is going to bypass everything else in the chart," explained Sharon Thomas, Product Owner in Research & Development at Practice Velocity. "It's just real slick and easy."

"Any tests or other items ordered during a patient visit show up in real time in Chartlet," Thomas said. "Providers can still work fast in the old view in VelociDoc, but they have to click back and forth between tabs. Now it's all visible on one screen."

---

*"It's certainly made the charting experience not only a friendly experience, but also streamlined. It's the fastest charting solution I have ever reviewed."*

---

The Practice Velocity team studied more than 100,000 patient visits before starting development of the Chartlet feature. That research allowed them to focus in on the five most common conditions for the initial Chartlet launch. More will be developed, and the company ultimately expects providers to be able to design their own Chartlets for any conditions most common to their practice.

Evan Dapo, PA-C, who works at MedAccess Urgent Clinics in Raleigh, North Carolina, is a product software consultant and reviewed Chartlet. He's worked on multiple EMR platforms and helped during the development of Chartlet. "It's certainly made the charting experience not only a friendly experience, but also streamlined. It's the fastest charting solution I have ever reviewed," Dapo said.

Comparing his work on Practice Velocity's VelociDoc with other EMRs, Dapo said: "It's not even a close comparison as to how quickly I can make it through the more traditional urgent care visits. And that's not even just the Chartlets themselves; it's Practice Velocity's software."

"Chartlet versus the competition," Dapo said, "it's just night and day."



# EMR: The fastest just got faster.

## Discover Chartlet.

Practice Velocity's #1-rated urgent care EMR now includes Chartlet, a single-page charting option allowing providers to move even faster through documentation. We're talking patient charts completed in 1 minute. And chartlet covers roughly 80 percent of urgent care chief complaints.

If less clicking through tabs and more time treating patients sounds good to you, it's time to try Chartlet.

Call 888.357.4209 or visit [practicevelocity.com](http://practicevelocity.com) to schedule a demo.





# THIS WILL NOT SOLVE YOUR BILLING PROBLEMS



Let our experts dig you out.

Call 888.357.4209  
Or visit [practicevelocity.com](http://practicevelocity.com)

**PRACTICE**  **VELOCITY**<sup>®</sup>  
Urgent Care Solutions<sup>®</sup>



# Corporate Practice of Medicine: Could Your Current Operating Structure Be at Risk?

■ Ron Lebow, JD

**Urgent message:** State laws prohibiting the corporate practice of medicine are often skirted by business arrangements that segregate a professional entity from a management company, but these arrangements can still pose significant risks to providers unless specific steps are taken to ensure the segregation of clinical and management activities.

### Introduction

The **corporate practice of medicine doctrine** dates back to the inception of physician licensure laws. The tenet is derived from the legal requirement that only a licensed physician can practice medicine. Although our system has evolved since physicians first began to practice, requiring significant capital investment, business acumen, and administrative attention, this doctrine is still alive as a basis for imposing risk on parties to a deal between investors, management providers, and licensed professionals.

### Risks

Providers, to skirt corporate practice of medicine laws, have historically created a legal structure in which a physician-owned professional entity contracts with a non-physician-owned management company. The professional entity passes all revenue through to the management entity. But there are significant risks with this arrangement, including the following:

- Physicians engaged in so-called doc-in-a-box relationships, where they are viewed as lending their license to

business companies and acting in essence as glorified employees, can risk loss of their license.

- The business parties themselves risk actions by states' attorneys general, who can use the violation to prosecute consumer fraud, impose significant fines, and even threaten criminal prosecution.
- Health-care payors can use the doc-in-a-box structure as a means to seek repayment under fraud-related allegations, particularly in the no-fault and workers' compensation realm, where such allegations are becoming standard.
- Additionally, civil litigants can sue the management company and attempt to hold it responsible for malpractice injury, arguing that profit incentives resulted in inappropriate clinical decision-making. They justify such actions out of concern that the manager will exercise excessive control or pressure over the practice, directly impacting patient care, professional decision-making, and product and service recommendations, including those resulting in unnecessary service use.

In some cases, the management vehicle entity is also owned by a physician founder—but make no mistake, these same risks are still relevant to the founder's business entity to the extent that it is engaged with other physician-practice entities.

### Factors Indicative of a Violation and Remediation Strategy

#### *Illegally Splitting Income from Patients and Payors Through Profit Sharing*

The cornerstone of a doc-in-a-box argument is that the physician is not the master of their own domain and is not entitled to reap the full reward of their own practice—their own



**Ron Lebow, JD**, is a New York-based transaction and regulatory counsel for Michelman & Robinson, LLC, focused on business, contract, corporate, and regulatory matters affecting hospitals, urgent care centers, and individual physicians across the United States.



*“Civil litigants can sue the management company and attempt to hold it responsible for malpractice injury, arguing that profit incentives resulted in inappropriate clinical decision-making. They justify such actions out of concern that the manager will exercise excessive control or pressure over the practice.”*

business—including the profits and return that would naturally inure to a business owner. When a management company clears out a bank account belonging to a physician after that physician collects their salary (whether it is couched as a profit distribution or salary from themselves—that is, their own professional entity—to themselves), that manager is arguably the real practice owner. What business owner would hand the majority of its revenues or profits to a third-party vendor? Accordingly, the nature of the management fee structure is strictly scrutinized.

Each aspect of the business relationship must be charged at a rate that is truly fair market value—a price that the market would negotiate in a bona fide arm’s-length transaction. However, the business investor may actually assume most if not all of the financial risk of the venture, with little or no capital contribution from the physician. The parties may decide to share this risk by entering into a percentage arrangement—where a percentage of profits or revenues is paid or split. In some states this is legal, provided that the percentage is justifiably fair market value, but a percentage could eventually fall outside of the range of fair market value as cash flow increases.

Percentage arrangements can also run afoul of legal prohibitions, such as the federal Anti-Kickback Statute and equivalent state laws. Accordingly, a flat annual fee or a combination of flat annual fees for various line items and variable cost charges should be used instead. The parties should also evaluate what portion of the investment constitutes a loan repayable by the physician entity, and formalize a promissory note representing the upfront lending.

Additional cash flow lending can be offered in the form of a contractual line of credit. Initial implementation charges from the manager, including recruiting, credentialing, branding, and marketing may justifiably be very high for the first several years, but ultimately these would have to decrease for an existing site after a certain period of time as economies are established and these functions level out.

The physician may be fearful, however, that such high initial charges will result in waiting too long for their own profit opportunity while the debt mounts. To alleviate this fear, because the parties rely on each other for mutual viability, the manager, as a creditor, can instead agree to wait in line, such that the physician-owner can pay themselves a certain amount of money per month after costs have been covered, and accordingly defer the profit margin (with interest accruing) until there is enough to cover it or a business sales transaction is consummated.

#### *Wielding Undue Control over the Center’s Finances by Controlling the Bank Accounts to Which the Practice Owners Themselves Do Not Have Access*

The party that controls the bank account is viewed as the true owner of the business. If the physician is locked out of the account, the violation is an easy case to make, and similarly when the money is swept from the physician account into the manager’s own account. The money should remain in the physician entity’s account, and the physician should have signatory authority over their own practice income. The manager might be granted additional signatory authority to administer payables, but if it pays itself, this could be viewed as inappropriate in some jurisdictions. As protection for the manager, collateral security should be secured over cash in the bank account, and, depending on the state’s enforcement environment, the manager might consider sweeping some specified portion of the funds into its own account to hold in the nature of a security deposit subject to replenishment. Naturally, after the investment of substantial funds and the guarantee of debt, more protection may be desired. Typically the physician practice owner will not be personally liable for any debt to the manager, with the fees payable only out of the actual profits available.

To create a disincentive against any threat to manager collateral rights, the contract might hold the physician personally liable in the limited instance that bank account funds or insurance payments are willfully diverted for the physician’s own gain. To ensure that money is available to cover the accruing debt or create a ready funding source for co-investment in future expansion when the practice goes from red to black on its financial statements, the agreement might include an obligation for the practice to maintain a minimum reserve (i.e., not distribute all practice entity profits to its owners and employees) that is based on a specified formula, to the extent of available cash. Finally, in the event of abandonment of the business by the practice, a liquidated-damages clause can be included in the agreement that allows for the manager to assess its damages against outstanding practice accounts receivable.

#### *Controlling Hiring and Firing of Clinical Staff*

The right to hire and fire is proof positive of business control and real ownership. The practice entity must retain ultimate

# Recruit Urgent Care Professionals online at JUCM CareerCenter

## Tools for Employers:

- Post Jobs Online
- Manage Resumes
- Track Job Performance
- Upgrade Opportunities



## Post an Urgent Care Job Today!



Open a barcode scanner app on your smartphone. Position your phone's camera over this QR code to scan.

**JUCM** CAREERCENTER  
THE JOURNAL OF URGENT CARE MEDICINE

[www.UrgentCareCareerCenter.com](http://www.UrgentCareCareerCenter.com)

(201) 529-4020 • [classified@jucm.com](mailto:classified@jucm.com)

## HEALTH LAW

*"The party that controls the bank account is viewed as the true owner of the business. If the physician is locked out of the account, the violation is an easy case to make, and similarly when the money is swept from the physician account into the manager's own account. The money should remain in the physician entity's account, and the physician should have signatory authority over their own practice income."*

authority over the licensed professionals it hires, including the terms of employment. To protect against excessive compensation arrangements by the practice entity, covenants can be included in the management contract attesting that they will constitute fair market value. Commonly, the question boils down to whether the manager itself can fire the practice owner. In many cases the parties enter into a **nominee ownership agreement**, pursuant to which the business entity holds a contractual right to take away the stock in the professional entity from the physician and find a friendlier replacement to hand it to. In states that adhere strictly to the corporate practice of medicine doctrine, this is not permissible. The ability to remove someone is the greatest degree of control anyone can have to influence decisions and acts. In some states, it is only justifiable if the physician also has ownership in the management company, so that there is contractual privity between the individual owners and reasons borne out of fiduciary duty, which is essentially the obligation to act fairly to one's business partners and the company of which one is a part. Even when a nominee ownership agreement is not permissible, making the physician practice owner also an owner in the management vehicle provides the added benefit of alignment of interests and an ability to enforce noninterference and proprietary secret covenants.

### Conclusion

These are just some of the considerations and structuring options available. Over time, the corporate practice of medicine doctrine and how it is enforced should itself evolve to recognize the inherent value that business relationships and investment have to patient-care quality and cost containment. Nevertheless, clinical decision-making autonomy should always remain sacrosanct. Thus, there is a delicate balance in any such relationship. ■

## Case Report

# Pelvic Pain, Dysuria, and Back Pain in an Adolescent Female

**Urgent message:** Adolescent patients present to urgent care facilities with unique needs and diagnoses. It is imperative that those who care for them be familiar with some of these diagnoses and keep in mind the importance of obtaining a full and accurate medical history and performing a thorough physical examination.

JOSHUA T. BAUTZ, MD, LT, MC, USNR

**Note:** This case is adapted from the book *Bouncebacks! Pediatrics* (2015, Anadem Publishing), by Michael B. Weinstein, Kevin M. Klauer, Madeline Matar Joseph, and Gregory L. Henry. The book includes 28 case presentations with risk-management commentary.

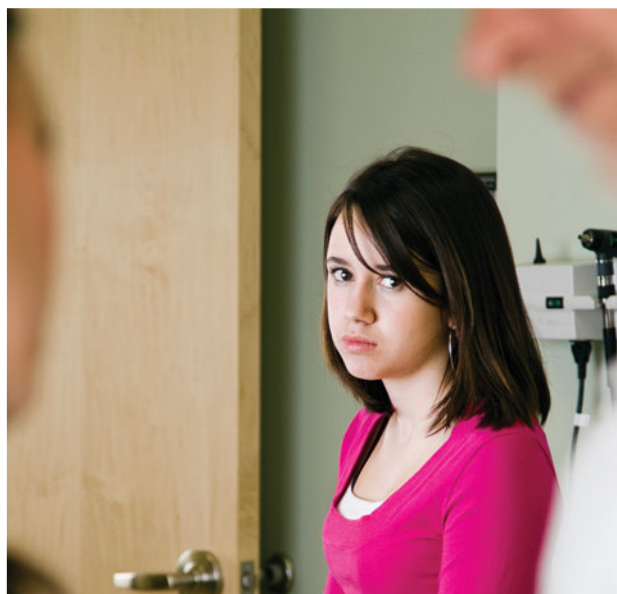
### Introduction

Adolescent patients can represent unique challenges for health-care providers. In caring for them, providers must work from a broad differential, including diagnoses common to children, those common to adults, and also those unique to adolescents. Obtaining a thorough history of illness is of the utmost importance in these patients, but doing so is often especially challenging.

### Case Presentation

A previously healthy 12-year-old girl presents to an emergency department (ED) with lower back pain. She is brought in by her mother. The girl is an active gymnast, but she does not report any specific trauma. Her pain is bilateral and nonradiating, and she describes it as having an intensity of 5 on a visual analog scale, on which the highest possible score is 10. It is worse with movement and when she sits up. She reports that she

.....  
**Joshua T. Bautz, MD, LT, MC, USNR**, is finishing his final year of post-graduate residency in emergency medicine at Vanderbilt University Medical Center in Nashville, Tennessee.



has not had any fever, urinary symptoms, weakness, or numbness. She reports transient relief with Tylenol.

### Physical Examination

Her physical examination reveals normal findings regarding her heart, lungs, and abdomen. Her vital signs are unremarkable. She has no flank tenderness or midline tenderness, but she does show paraspinal tenderness



over the lumbar region. She has a strength score of 5/5 on hip flexion and toe dorsiflexion, normal two-point discrimination in the upper and lower extremities, and negative findings on the straight-leg-raise test. It is noted that she has a normal gait but appears to be in pain when she moves.

### Diagnosis and Treatment

She is given Motrin and ultimately discharged with diagnosis of musculoskeletal back strain.

One week later, the patient and her mother return to the same ED. This time, a urinalysis is done, and findings show many epithelial cells. The new diagnosis is urinary tract infection. Despite having no fever or dysuria, she is discharged home with ciprofloxacin.

When her symptoms fail to respond to the medication, she and her mother again return to the same ED. Notes indicate that the mother is angry and demands magnetic resonance imaging. The patient has benign findings on examination of the back, without any concerning neurologic symptoms. A plain film of the patient's back is obtained, and a repeat urinalysis is done; the findings are unremarkable. The patient is interviewed without her mother present, and she reports no sexual activity, intravenous drug use, or problems at home. The family is told to follow up with their primary-care provider, but they are unable to get an appointment for several weeks.

When the pain worsens and the patient develops urinary retention, the patient and her mother present to a different ED. There, examination reveals normal vital signs but severe bilateral paraspinal back pain. A Foley catheter is ordered; however, a nurse notices abnormal anatomy when attempting to place the catheter. She alerts the ED physician. A subsequent genitourinary examination then demonstrates intact bulging blue hymen. The gynecology department is consulted, and the patient is admitted to the hospital for hymenotomy because the diagnosis is hematocolpos.

### Discussion

Hematocolpos is the accumulation of blood in the vagina due to an imperforate hymen, a congenital condition characterized by lack of vaginal patency because of failure of canalization of the connective tissue in the hymen.

*“Adolescent patients can represent unique challenges for health-care providers. In caring for them, providers must work from a broad differential, including diagnoses common to children, those common to adults, and also those unique to adolescents.”*

Blood then accumulates behind the closed space, leading to hematocolpos (blood in the vagina), hematometra (retained blood in the uterus), and hematosalpinx (blood in the fallopian tube). Hematocolpos is estimated to occur in approximately 0.1% of female newborns.<sup>1</sup> Its incidence is reported<sup>2</sup> to be 1 in 2000.

The typical presentation is in a premenarchal female with

cyclic lower abdominal and pelvic pain; however, the presentation can be variable.<sup>3</sup> Between 40% and 60% of patients will present with urinary hesitancy or dysuria, but there are several reports of patients presenting with lower back pain.<sup>4,5</sup> Although the physical examination is a key part of making the diagnosis of hematocolpos, it is imperative to perform pelvic and renal ultrasound imaging to confirm the underlying anatomic cause, because imperforate hymen, vaginal septum, and congenital vaginal abnormalities can all lead to the clinical symptoms of hematocolpos, and renal anomalies may be associated with genital anomalies.

The treatment for this condition is surgical intervention with hymenotomy. Failure to make the diagnosis leads to further accumulation of blood more proximal in the genitourinary system, including hematosalpinx. The presence of this blood is believed to destroy ciliary action in the fallopian tubes and can lead to adhesions and ultimately to endometriosis and decreased fertility.<sup>6</sup>

This case is a difficult one both because the ultimate diagnosis, hematocolpos, is a rare diagnosis and because the presenting symptom, back pain, is an atypical presentation of this problem. Additionally complicating the care of this patient is that making the diagnosis relies on obtaining a sexual history and performing a genitourinary examination on a member of a population many of us are uncomfortable with—the preteen patient presenting with his or her parents.

Although performing a genitourinary examination on every patient presenting with back pain is not only impractical but also unnecessarily invasive, there are important take-home points from this case. Perhaps the most important of these is that adolescents are not the same as children. It is imperative to build time into your interview for a discussion with them separate from the parents. Because of this, the importance of obtaining an accurate sexual history cannot be overstated. It is only

# The Smart ECG System

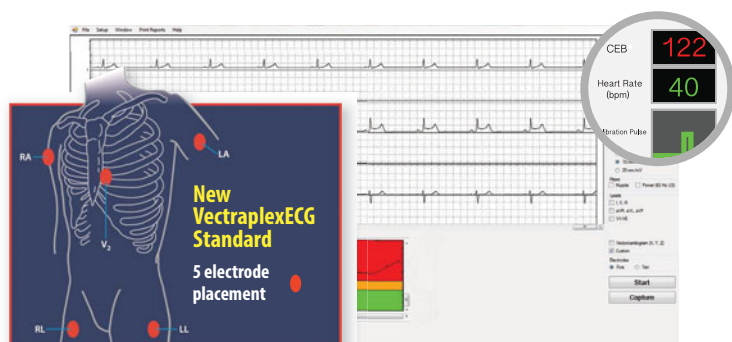
## ONLY 5 Electrodes Needed

### EASIER... FASTER... ACCURATE

VISIT US AT  
BOOTH #227

**free**  
live web demo  
Call 973.904.0444

VectraCor.com

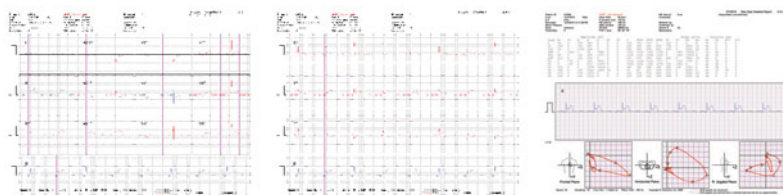


Only 5 electrodes needed for a derived 12-Lead ECG

Also a standard 12-lead ECG using 10 electrodes with computerized interpretation

CEB® - Cardiac Electrical Biomarker - a patented marker that detects ECG changes suggestive of a heart attack, using a simple color - coded system

\*At any time, view and print a 12-15-Lead ECG with vector loops



Easier for nurses & techs  
*simplified electrode placement*

More comfortable for your patients  
*only one chest electrode needed*

Completed and Ongoing Clinical Study Sites:

Johns Hopkins - Cleveland Clinic - Baylor Scott & White - Univ. of Penn - Thomas Jefferson - Univ. of Basel

**VECTRACOR**  
Diagnosing Better Care

speculation, but one could argue that the key in making the diagnosis in this case earlier would have been in obtaining two essential pieces of the medical history early on—cyclical pain and lack of menstrual bleeding—and connecting them, allowing this process to lead you to performing a genitourinary examination.

In reality, however, hematocolpos is most often diagnosed in an ED on subsequent visits. Accordingly, two additional learning points from this case deal with subsequent

patient encounters. When a patient presents a second time—or, as in this case, even a third time—additional and different items in the workup are indicated. In this case, we see the same workup (urinalysis and lumbosacral x-rays) being repeated. The findings from the patient's medical history and physical examination do not argue for the use of magnetic resonance imaging that the patient's mother had insisted on. The patient has no red-flag back-pain signs or symptoms.

In a young gymnast with these examination findings, spondylolisthesis would also be a likely diagnosis, one that could be missed with a plain film and could be found more accurately with computed tomography; however, computed tomography was also not done or discussed.<sup>7</sup> Interestingly, however, the patient's examination findings were not even entirely consistent with the initial diagnosis of musculoskeletal back pain. She had negative findings on the straight-leg raise, and her symptoms did not diminish even though she refrained from gymnastics practice.

In a patient presenting multiple times with the same complaint without a clear diagnosis, something different must be done. In this case, if the examination findings do not support additional imaging or laboratory testing, that something different may only have to be obtaining additional age-focused medical history or conducting an additional physical examination. When patients present with true pain that you cannot explain, additional questions are warranted.

Finally, this case highlights one of the basic tenets of urgent care: ensuring adequate follow-up. Although it was certainly appropriate to conduct further outpatient workup after the first two visits for this well-appearing

*“In a patient presenting multiple times with the same complaint without a clear diagnosis, something different must be done. In this case, if the examination findings do not support additional imaging or laboratory testing, that something different may only have to be obtaining additional age-focused medical history or conducting an additional physical examination.”*

patient, she would have benefited from more timely follow-up, and yet the patient's mother reported that they were unable to get an appointment with the primary-care provider for weeks. In a patient with an unclear diagnosis, this is not an appropriate time frame. Perhaps if the patient had been referred to a physical therapist or sports medicine specialist more urgently, it would have been revealed that her symptoms were not consistent with a musculoskeletal etiology, and the physician

could have obtained a more thorough medical history and conducted a physical examination and tests that were more appropriate.

## Conclusion

Hematocolpos represents a rare but important diagnostic challenge in the care of an adolescent patient presenting with pelvic pain, dysuria, and back pain. The case reported here highlights several important learning points, including these:

- Adolescents should be given time to speak with their physician without parents in the room.
- Sexual histories must be obtained from adolescent patients so that appropriate treatment can be provided.
- When patients present for subsequent visits, consider obtaining a more detailed medical history and performing a more comprehensive physical examination.
- In patients returning for multiple visits, expand the differential diagnosis.
- Ensure that there is timely outpatient follow-up. ■

## References

1. Parazini F, Gecchetti G. The frequency of imperforate hymen in northern Italy. *Int J Epidemiol.* 1990;19:763–764.
2. Adali E, Kurdoglu M, Yildizhan R, Kulusari A. An overlooked cause of acute urinary retention in an adolescent girl: a case report. *Arch Gynecol Obstet.* 2009;279:701–703.
3. Kumar K, Waseem M. An uncommon cause of abdominal pain in an adolescent. *South Med J.* 2008;101:1065–1066.
4. Chircop R. A case of retention of urine and haematocolpometra. *Eur J Emerg Med.* 2003;10:244–245.
5. Hingorani R, Swain A. An unusual cause of lower abdominal pain in pubertal girls. *Emerg Med J.* 2009;26:909–910.
6. Isenhour JL, Hanley ML, Marx JA. Hematocolpometra manifesting as constipation in the young female. *Acad Emerg Med.* 1999;6:752–753.
7. Campbell RS, Grainger AJ, Hide IG, et al. Juvenile spondylolysis: a comparative of CT, SPECT and MRI. *Skeletal Radiol.* 2005;34:63–73.





## ABSTRACTS IN URGENT CARE

- Results Unavailable for 71% of Trials
- Intranasal Nonsteroidal Anti-inflammatory Drug Helpful in Pain Treatment
- Influenza May Predispose Older Patients to Myocardial Infarction
- Teething in Toddlers Likely Does Not Cause Fever
- Trimethoprim-Sulfamethoxazole Associated with Better Cure Rate for Abscesses
- Food and Drug Administration Recommends Avoiding Codeine in Children
- Prednisolone and Indomethacin Equally as Good in Treating Gout
- More Evidence That Trimethoprim-Sulfamethoxazole Is Most Effective in Treating Methicillin-Resistant *Staphylococcus aureus*

■ SEAN M. MCNEELEY, MD

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

### Results Unavailable for 71% of Trials

**Key point:** Many research findings are not easily available to clinicians.

**Citation:** Chen Ruijun, Desai NR, Ross JS, et al. Publication and reporting of clinical trial results: cross sectional analysis across academic medical centers *BMJ*. 2016;352:i637.

Researchers investigated the amount of clinical trial findings at academic medical centers that are not published and thus not easily available to clinicians. In a cross-sectional analysis of academic medical centers, the investigators used Clinical-Trial.gov to identify all trials with a completion date between 2007 and 2010 that had a primary investigator at an academic medical center. They sought the percentage of such trials for which results were displayed that were defined as publication or as appearing within ClinicalTrial.gov, including double-blinded trials with more than 100 patients. Results were published within 24 months of trial completion for only 29% of the

trials. If more research results were available, better patient care might be possible. ■

### Intranasal Nonsteroidal Anti-inflammatory Drug Helpful in Pain Treatment

**Key point:** Another study provides an alternative to opioid analgesia.

**Citation:** Pollack CV Jr, Diercks DB, Thomas SH, et al. Patient-reported outcomes from a national, prospective, observational study of emergency department acute pain management with an intranasal nonsteroidal anti-inflammatory drug, opioids, or both. *Acad Emerg Med*. 2016; 23:331–341.

Using patient-reported outcomes from a pain-treatment study, researchers attempted to determine patient satisfaction with pain management with a nonsteroidal anti-inflammatory drug, opiate, or both, with the opiate as breakthrough therapy. The anti-inflammatory drug was nasally administered ketorolac, and in the “both” category, the opioid was clearly defined as rescue medication. Outcomes were self-reported by telephone over a 4-day period by a total of 824 patients with musculoskeletal or visceral pain. The decision about which treatment option to use was left to the health-care provider. Self-reported return to work and analgesia were higher with the ketorolac treatment than with either of the other options.



**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.

*“Cardiac injury in older patients is a potential result of influenza infection. The study assessed data for 38,197 patients who were tested for influenza and then for myocardial infarction; 4469 had positive findings. Of those, 600 underwent biomarker testing for acute infarction within 30 days, and 143 had positive findings. Most of the diagnoses of acute coronary syndrome in those patients occurred within 3 days of an influenza diagnosis.”*

Unfortunately, this was not a randomized trial, so the accuracy of its findings might be questioned. For urgent care providers, these findings are more evidence that opioid analgesia is less effective and may hinder the effect of other treatments for patients with musculoskeletal or visceral pain. ■

### Influenza May Predispose Older Patients to Myocardial Infarction

**Key point:** Watch for an acute myocardial infarction after an influenza diagnosis in older patients.

**Citation:** Ludwig A, Lucero-Obusan C, Schirmer P, et al. Acute cardiac injury events  $\leq 30$  days after laboratory-confirmed influenza virus infection among U.S. veterans, 2010–2012. *BMC Cardiovasc Disord.* 2015;15:109.

Cardiac injury in older patients is a potential result of influenza infection. The authors in this study assessed data for patients in U.S. Veterans Affairs facilities who were tested for influenza and then for myocardial infarction (MI). Of 38,197 patients tested for influenza, 4469 had positive findings. Of those, 600 underwent biomarker testing for acute MI within 30 days, and 143 had positive findings. Most of the diagnoses of acute coronary syndrome (ACS) in those patients occurred within 3 days of an influenza diagnosis. Although this is a small percentage of the total infections found, it is much larger than would be expected in the general population. For the urgent care provider, these findings are a good reminder to consider MI or ACS when an older patient has influenza and other symptoms such as dyspnea or chest pain. ■

### Teething in Toddlers Likely Does Not Cause Fever

**Key point:** Fever in toddlers is probably not caused by teething.

**Citation:** Massignan C, Cardoso M, Porporatti AL, et al. Signs and symptoms of primary tooth eruption: a meta-analysis. *Pediatrics.* 2016;137:1–19.

Parents commonly attribute fever in their toddlers to teething. Unfortunately, this may cause parents and providers to miss serious illness or treatable minor illness. There is little evidence that teething causes fever, as defined by the medical community. This meta-analysis included more than 3500 patients younger than 3 years who were teething and noted whether they had fever or other symptoms while teething. A fever was reported in approximately 25% of the children; however, the temperature was below the medical definition of fever. The most common symptoms were gingival irritation (87%), irritability (68%), and drooling (56%). Attributing a true fever to teething is probably ill advised. Making sure that parents understand this can prevent delayed diagnosis in some children. ■

### Trimethoprim-Sulfamethoxazole Associated with Better Cure Rate for Abscesses

**Key point:** Consider adding trimethoprim-sulfamethoxazole in treating abscesses.

**Citation:** Talan DA, Mower WR, Krishnadasan A, et al. Trimethoprim-sulfamethoxazole versus placebo for uncomplicated skin abscess. *N Engl J Med.* 2016;374:823–832.

In general, the treatment of abscesses with properly done incision and drainage works well without the use of antibiotics. Past studies have not shown any benefit from administering additional antibiotics. This study was conducted to determine whether trimethoprim-sulfamethoxazole (TMP-SMX) benefits patients with abscesses. The authors believed that because of the significant cure rate for just incision and drainage, previous studies were too underpowered to prove a difference between such treatment and treatment with the addition of antibiotics. In this double-blind study, 1247 patients aged 12 years or older with abscesses were treated in one of five U.S. emergency departments with standard incision and drainage and then either TMP-SMX or placebo for 7 days. The primary outcome tracked was clinical cure of the abscess by 1 to 2 weeks after treatment. The cure rate was significantly better in patients treated with antibiotics than in those who did not receive them (80.5% vs. 73.6%). Antibiotic-treated patients also had less need for further intervention, lower rates of infection at other sites, and lower rates of subsequent infection in household members.

For the urgent care provider, these results are difficult to act on. Although the improvement rate is statistically significant, it is still a small percentage of all of the previously mentioned

# URGENT CARE MOVES FAST. WE HELP YOU MOVE FASTER.

**80%**

COPAY  
COLLECTION  
RATE

**94%**

OF CLAIMS  
RESOLVED  
FIRST TRY

**6%**

INCREASE IN  
COLLECTIONS\*

LEARN HOW WE CAN HELP YOUR URGENT CARE BUSINESS  
AT [WWW.ATHENAHEALTH.COM/URGENTCARE](http://WWW.ATHENAHEALTH.COM/URGENTCARE)



EHR, PRACTICE MANAGEMENT, CARE COORDINATION, AND PATIENT ENGAGEMENT SERVICES BACKED BY A NETWORK OF 75,000+ PROVIDERS.

\*Based on a weighted average for athenahealth clients with valid pre-athenahealth benchmark data that had their 15-month anniversary with athenahealth between January 1, 2010, and October 31, 2013.



outcomes. The risk of treatment with sulfa drugs is well documented. Perhaps it makes sense to use TMP-SMX for patients with other risks like diabetes mellitus or those who are immunocompromised or have immunocompromised family members. Providers should definitely discuss with patients the risks and benefits of treatment with TMP-SMX. ■

### Food and Drug Administration Recommends Avoiding Codeine in Children

**Key point:** *There are new recommendations to stop using codeine in children.*

**Citation:** Codeine cough-and-cold medicines in children: Drug Safety Communication—FDA evaluating potential risk of serious side effects. Silver Spring, MD: U.S. Food and Drug Administration [updated 2015 July 1; cited 2016 March 10]. Available from: <http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm453379.htm>

Several authorities have discussed the use of codeine products in children, and little evidence has shown that codeine is any better than ibuprofen for pain. Recently an advisory panel of the U.S. Food and Drug Administration recommended against the use of codeine for pain or cough in children. In Europe, it is considered contraindicated in children aged 12 years and younger. Codeine is metabolized to morphine, but in many children the rate of metabolism is unpredictable. Those who metabolize it more quickly are susceptible to greater adverse effects, and those who metabolize it more slowly may benefit less from it. In the urgent care setting, avoiding the use of codeine in this age group is probably best. It may be helpful to discuss with parents the warnings from the Food and Drug Administration and from European agencies and to point out the drug's inferior performance in multiple studies. ■

### Prednisolone and Indomethacin Equally as Good in Treating Gout

**Key point:** *Prednisolone and indomethacin may have similar analgesic results in the treatment of gout.*

**Citation:** Rainer TH, Cheng CH, Janssens HJ, et al. Oral prednisolone in the treatment of acute gout: a pragmatic, multicenter, double-blind, randomized trial. *Ann Intern Med.* 2016 February 23. doi: 10.7326/M14-2070. [Epub ahead of print.]

The authors of this report note that several small studies have shown an equivalence between prednisolone and indomethacin in treating the symptoms of gout. For certain patients, each treatment presents its own benefits and risks. Knowing whether the two drugs are equivalent excludes one concern when deciding on appropriate treatment for an individual patient. In this double-blind multicenter, randomized, con-

*“Several authorities have discussed the use of codeine products in children, and little evidence has shown that codeine is any better than ibuprofen for pain. Recently an advisory panel of the U.S. Food and Drug Administration recommended against the use of codeine for pain or cough in children.”*

trolled trial from Hong Kong, 376 patients were evaluated for pain. On the basis of pain scores on a visual analog scale, the authors concluded that both medications had a similar effect on pain control. They do note that the diagnosis of gout was on clinical grounds, not on findings from joint aspiration, but this is the most common method for diagnosis at urgent care centers anyway. Thus, oral prednisolone and indomethacin may both be good choices for a patient presenting with gout. ■

### More Evidence That Trimethoprim-Sulfamethoxazole Is Most Effective in Treating Methicillin-Resistant *Staphylococcus aureus*

**Key point:** *Methicillin resistance in *Staphylococcus aureus* is decreasing in children.*

**Citation:** Sutter DE, Milburn E, Chukwuma U, et al. Changing susceptibility of *Staphylococcus aureus* in a US pediatric population. *Pediatrics.* 2016 Mar 1. pii: peds.2015-3099. [Epub ahead of print.]

Over time, the percentage of methicillin-resistant *Staphylococcus aureus* (MRSA) infections has actually decreased. Data for children have not been available from larger studies to determine the trend, but between 2005 and 2014, researchers in this study retrospectively analyzed 39,000 patients at U.S. military hospitals with at least one sample with positive findings for *Staphylococcus*. Most of the samples were from ambulatory patients with skin and soft-tissue infections. The highest rates of MRSA infections were seen in children younger than age 5 years. They found that as with adults, the rates of MRSA infections have been decreasing, although regional patterns are still an issue. Interestingly, clindamycin resistance is increasing in only those *Staphylococcus* infections with methicillin resistance, moving from 10% to 17%. Trimethoprim-sulfamethoxazole once again proved most effective in treating MRSA infections. For the urgent care provider, this information may be helpful in choosing treatment regimens. As always, knowing local resistance patterns is very important. ■



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

If you would like to submit a case for consideration, please e-mail the relevant materials and presenting information to [editor@jucm.com](mailto:editor@jucm.com).

## Wrist Pain in an Adult After a Fall

Figure 1.



### Case

A 62-year-old woman presents with left wrist pain that began after she fell onto her outstretched left hand earlier in the morning while walking her dog. She has wrist pain throughout the range of motion, as well as some pain in her hand. She sustained no injuries to her head or neck, and she has no head pain, neck pain, chest pain, or shortness of breath.

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



Figure 2.

**Differential Diagnoses**

- Colles fracture (distal radius fracture with dorsal angulation of the fracture fragment)
- Smith fracture (distal radius fracture with volar angulation of the fracture fragment)
- Ulnar styloid fracture
- Scaphoid fracture
- Carpometacarpal dislocation

**Physical Examination**

On physical examination, the patient is found to be afebrile and to have a pulse of 112 beats/min, a respiration rate of 24 breaths/min, and a blood pressure of 146/93 mm Hg. She is alert and oriented, winces when she moves her left wrist, and has no respiratory distress.

Her left wrist does have evidence of deformity, but there are no breaks in the skin. She has a 3+ radial pulse, and sensation is grossly intact. She has no pain over the anatomic snuffbox. There are some superficial abrasions over the palmar aspect of her left hand, but they produce only very minimal discomfort with palpation. She has no elbow pain.

**Diagnosis**

An x-ray of the wrist (**Figure 2**) is ordered. Image findings indicate a Colles fracture, which is a distal radius fracture with dorsal angulation of the fracture fragment.

**Figure 3** shows three views of a Colles fracture. Note that the carpal bones and bones of the hand are intact, and there is no ulnar styloid fracture.

**Learnings**

Wrist injuries account for 2.5% of emergency department visits. Lack of recognition of the fracture or improper treatment of it may lead to permanent functional disability. Injury to the distal radius requires assessment for concurrent injury to the carpal bones. The typical mechanism of injury with a Colles fracture is a fall onto an outstretched hand.

The distal radius is juxtaposed against the scaphoid and lunate carpal bones. The anatomic snuffbox is a triangular depression evident on the dorsoradial aspect of the wrist with extension of the thumb. This location should be palpated with every wrist injury, and the findings should be documented in the chart. For example, the documentation might read: "No pain with palpation at the anatomic snuffbox."

There are eight carpal bones.



Figure 3.

- Four bones are across the bottom, from left (radial aspect) to right:
  - Scaphoid
  - Triquetrum
  - Lunate
  - Pisiform
- Four bones are across the top row, from left (radial aspect) to right:
  - Trapezium
  - Capitate
  - Trapezoid
  - Hamate

**What to Look For**

Important elements of the medical history include mechanism of injury, location of pain and exacerbating factors, and examination of the joint proximal and distal to the injury. If there is an associated laceration, inquire about tetanus status. If the patient reports a clicking sensation, this may indicate a scapholunate ligamentous injury.

The physical examination should include documentation of inspection of the skin for swelling, abrasions, and lacerations; palpation of the area of greatest pain in the wrist (distal radius and ulna), as well as the metacarpal bones; and palpation of the anatomic snuffbox. The neurovascular status should be documented, including gross sensation and pulse.

A nondisplaced or minimally displaced fracture can be splinted, with orthopedic follow-up. Indications for follow-up in an emergency department or for expedited orthopedic follow-up include the following:

- An intra-articular fracture
- A significantly displaced fracture
- An open fracture
- A fracture in which there is significant swelling, causing concern that there may be a compartment syndrome
- A Colles fracture with the possibility of a carpometacarpal dislocation ■

*Acknowledgment: Images courtesy of Life in the Fast Lane (<http://lifeinthefastlane.com>).*



# Introducing the **new** VisualDx

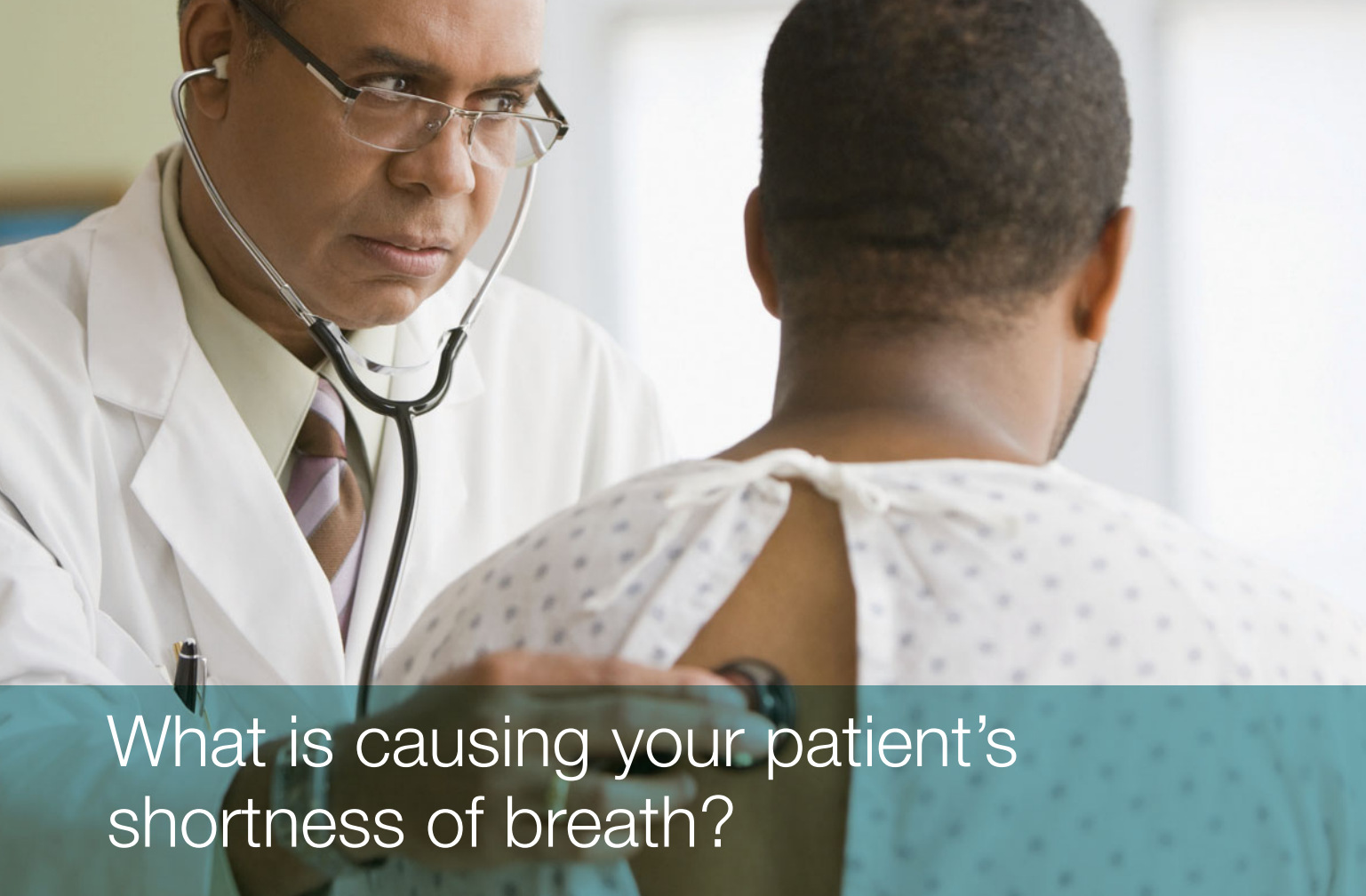


## NEW

- Double the diagnoses
- Introducing the Sympticon™
- Diagnostic support across general medicine

Discover the potential of VisualDx and start your FREE 30-day trial.  
Visit [visualdx.com/JUCM](https://visualdx.com/JUCM) to learn more.

**visualdx.com**



# What is causing your patient's shortness of breath?

**With the Alere Triage® System, Alere can help improve treatment decisions now.**

Patients presenting with shortness of breath provide a real challenge. Are the symptoms caused by Heart Failure, Pulmonary Embolism, COPD, or some other respiratory ailment? Having answers **now** will help to support appropriate treatment decisions.

- Results available in about 15–20 minutes with minimal hands-on time
- The only CLIA-waived test for BNP
- Allows for patient assessment while the patient is still present



Knowing now matters:



Alere Triage® MeterPro  
Alere Triage® BNP Test  
Alere Triage® Cardiac Panel\*  
Alere Triage® D-Dimer Test

**Please join Alere at the 2016 National Urgent Care Convention, booth #209.**  
**It's easier when everything works together. To learn more about our products and how they can help your facility, please visit [alere.com/jucm-cardiac](http://alere.com/jucm-cardiac) or call 1-877-441-7440**

\*Tests available for the Alere Triage Cardiac Panel are Myoglobin, CK-MB and Troponin I

© 2016 Alere. All rights reserved. The Alere Logo, Alere, Knowing now matters, MeterPro and Triage and are trademarks of the Alere group of companies. The photo is for illustrative purposes only. Any person depicted in the photo is a model. 10002629-01 04/16



## Finger Pain After Jamming During a Basketball Game

Figure 1.



### Case

A 19-year-old college student presents to an urgent care center with pain at the distal interphalangeal (DIP) joint of the middle finger of his right hand. He reports that the pain started suddenly the previous evening when the finger was jammed while he was playing basketball. The pain is worse through the range of motion, but there is no numbness and no pain at the proximal interphalangeal (PIP) joint.

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

Figure 2.

**Diagnosis**

An x-ray is obtained that shows a mallet finger (**Figure 2**) with avulsion of the proximal aspect of the distal phalanx.

**Treatment**

Conservative initial treatment is the standard of care for type 1 injuries (closed injuries either with or without avulsion fracture) when there is an avulsion fracture involving less than one-third of the articular surface and no DIP joint subluxation. A splint can be applied to the DIP joint only; the PIP joint does not need to be immobilized. The DIP joint should be immobilized in full extension or slight hyperextension. Avoid excessive extension, because that may result in vascular compromise of the dorsal skin. Surgical management is typically reserved for patients with open fractures and severe injuries; these require transfer to an emergency department.

**Learnings**

Fingers are the fourth most common site of fractures in adults. Such fractures happen more commonly in men than in women, with the average age at occurrence being 36 years. The most common mechanism for a mallet finger injury is sudden, forced flexion applied to the distal aspect of a finger, such as in a blow against a fixed object or during sports such as basketball or football, causing hyperflexion or, rarely, hyperextension. The most commonly injured fingers are the index, ring, and middle fingers on the dominant hand. Injury to the extensor tendon may also occur from a laceration or a crush injury.

**Differential Diagnoses**

- Osteolytic lesion
- Finger dislocation
- Spiral fracture of the distal phalanx
- Comminuted fracture

**Physical Examination**

On physical examination, the patient is alert and oriented, is not in acute distress, and is breathing comfortably. He has a temperature of 98.4°F (36.8°C), a pulse of 92 beats/min, a respiration rate of 16 breaths/min, a blood pressure of 112/76 mm Hg, and an oxygen saturation of 99% on room air.

His right middle finger has slight swelling over the DIP joint, but there are no skin color changes. When the hand is held parallel to the ground, there is a palmar droop to the distal phalanx. The neurovascular status is intact, with good capillary refill. He experiences pain with palpation over the DIP joint, mostly dorsally. Strength testing does not result in active dorsiflexion, but the patient can actively perform palmar flexion at the DIP joint. He has no pain with palpation of the PIP joint.

**What to Look For**

Look for the presence of visible deformity, and compare the injured finger to the other fingers. Assess the integrity of the skin, and look for swelling. Assess for open fracture, ecchymosis, and signs of infection such as erythema. The typical appearance of a mallet finger is seen from the lateral aspect; the distal phalanx is flexed. Palpate the dorsal aspect of the DIP joint, as well as the PIP and metacarpophalangeal (MCP) joints, for tenderness.

Assess strength by isolating the DIP joint: Stabilize the finger at the PIP and MCP joints and look for active extension of the finger by the patient. Also passively extend the finger. If the patient cannot do this, there may be entrapment of bone or soft tissue. Compare the injured finger to the other fingers. There is substantial variation in anatomy as well as age-related changes or arthritic changes, so a visible deformity is not necessarily diagnostic of injury or fracture. Check range of motion for flexion and extension, as well as lateral motion. If there is laxity laterally, this may indicate injury to a collateral ligament. Check the neurovascular status.

Obtain x-rays from three views: anteroposterior, oblique, and lateral. ■

# Urgent Care CME...

## *What's The Difference?*

- *All original content, not re-purposed from other Q & A databanks or lectures.*
- *Curated by the leader in urgent care education.*
- *Comprehensive, peer-reviewed curriculum reflects best-practice and relevancy while supporting our unique urgent care decision-making paradigm.*
- *Constantly updated with all the latest guidelines, interpreted for urgent care realities and decision-making.*

## Core Content in Urgent Care Medicine

Online Continuing Medical Education Program

### Lee A. Resnick, MD, FAAFP

- Editor -In-Chief, JUCM, The Journal of Urgent Care Medicine
- Founding Program Director, Fellowship in Urgent Care Medicine
- Founding Editor, Textbook of Urgent Care Medicine
- Assistant Clinical Professor of Family Medicine  
Case Western Reserve University School of Medicine  
University Hospitals Case Medical Center

USE THIS COUPON  
CODE : JUCM1  
FOR A \$300 DISCOUNT



Presented by

INSTITUTE OF  
URGENT CARE  
MEDICINE  
LEADERS IN URGENT CARE EDUCATION



SCHOOL OF MEDICINE  
CASE WESTERN RESERVE  
UNIVERSITY

**TO LEARN MORE VISIT [WWW.URGENTCARECME.COM](http://WWW.URGENTCARECME.COM)**



# Fracture Care

■ DAVID E. STERN, MD, CPC

**Q.** Will you please help me understand initial visit, subsequent visit, and sequelae related to fracture care? If the patient is treated elsewhere for a fracture and the provider just stabilizes the fracture and instructs the patient to then come to my office for reduction, is this a subsequent visit or an initial visit?

**A.** International Classification of Diseases 10th Revision, Clinical Modification (ICD-10-CM) guidelines state that a seventh character, **A**, is used for the initial encounter for the injury or condition while the patient is receiving active treatment for the injury. Examples of active treatment are

- Surgical treatment
- Emergency department (ED) encounter
- Evaluation and treatment by a new physician

Evaluation and treatment by a new physician is sometimes misunderstood by health-care providers and coders alike. You must determine whether the patient has previously received active treatment for this condition in any setting or by any provider.

For example, the patient is evaluated in an ED for a closed fracture of the distal phalanx of the right index finger. The ED provides comfort care by icing and immobilizing the finger, and then instructs the patient to follow up with an urgent care center in the morning. The ED's billing department reports ICD-10-CM code **S62.630A** because this is the patient's initial visit.

When the urgent care center rechecks the patient and reduces the fracture the next day, the patient is receiving initial active treatment for this fracture. The *Current Procedural Terminology* (CPT) code to bill is **26755**, "closed treatment of distal phalangeal fracture, finger or thumb; with manipulation, each." Per the ICD-10-CM guidelines, you would again report ICD-10-CM code **S62.630A** because this is the first time the patient is receiving active treatment from the urgent care center.



**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](http://www.practicevelocity.com)), NMN Consultants ([www.urgentcareconsultants.com](http://www.urgentcareconsultants.com)), and PV Billing ([www.practicevelocity.com/urgent-care-billing/](http://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.

*"Evaluation and treatment by a new physician is sometimes misunderstood by health-care providers and coders alike. You must determine whether the patient has previously received active treatment for this condition in any setting or by any provider."*

Subsequent care is defined in the ICD-10-CM guidelines as "encounters after the patient has received active treatment of the injury and is receiving routine care for the injury during the healing or recovery phase," and it is assigned using the injury code with the seventh character **D**, "subsequent encounter for fracture with routine healing." Examples of subsequent care are

- Cast change or removal
- Removal of external or internal fixation device
- Medication adjustment
- Other aftercare
- Follow-up visits after injury treatment

In the example of the patient with the phalanx fracture, if the fracture is healing as it should at the subsequent visit to the urgent care center, the center's office would report **S62.630D**, "displaced fracture of distal phalanx of right index finger, subsequent encounter with routine healing." CPT code **99024**, "postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for . . . reason(s) related to the original procedure," could also be included on the claim at no cost to represent the evaluation and management (E/M) portion of the visit.

Sequelae are the late effects of an injury and thus are assigned using the injury code with the seventh character **S**, "for use for complications or conditions that arise as a direct result of an injury, such as a scar formation after a burn. The scars are sequelae of the burn," according to ICD-10-CM guidelines.



*“Subsequent care is defined in the ICD-10-CM guidelines as ‘encounters after the patient has received active treatment of the injury and is receiving routine care for the injury during the healing or recovery phase,’ and it is assigned using the injury code with the seventh character D.”*

For example, a patient sustained a fractured right ankle that is now healed. However, the patient is in pain and sometimes has a limp as a result of the injury. When the patient presents for treatment for the pain, you would assign ICD-10-CM codes **G89.21**, “chronic pain due to trauma,” and **S82.891S**, “other fractures of lower right leg.” ■

**Q. What services can we bill for when we provide definitive care for a fracture?**

**A.** If you perform a service for definitive care of a fracture and plan to follow the patient through the healing process, you will bill the appropriate CPT code for the treatment performed, as well as CPT codes for any of the following:

- X-rays
- Cast supplies
- Splint supplies and/or durable medical equipment devices
- All supplies provided (e.g., sling, walking boot)

Refer to CPT codes in code range of **70000** through **79999** for the x-rays, and Healthcare Common Procedure Coding System Level II codes for the supplies.

If a separate E/M service was provided and documented separately during the initial visit, you would bill the appropriate E/M code (**99201** through **99215**) with modifier **-57**, which is described as follows: “decision for surgery: an evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.” You would not bill for the application of the splint or cast, because that is included in the CPT code for definitive treatment.

All postoperative visits for the fracture are included in the definitive care code for 90 days following the initial treatment. ■

Note: CPT codes, descriptions, and other data only are © 2011, American Medical Association. All Rights Reserved (or such other date of publication of CPT). CPT is a trademark of the American Medical Association (AMA).

Disclaimer: JUCM and the author provide this information for educational purposes only. The reader should not make any application of this information without consulting with the particular payors in question and/or obtaining appropriate legal advice.

# Find Your New Job TODAY!



## FREE Online Job Board:

**JUCM'S CareerCenter is a FREE Online Job Board and job search tool where job seekers can:**

- Receive New Jobs Via Email
- Apply Online
- Save Jobs
- Upload your Resume

**Start searching at:**  
**[www.UrgentCareCareerCenter.com](http://www.UrgentCareCareerCenter.com)**

**JUCM**  
THE JOURNAL OF URGENT CARE MEDICINE  
**CAREERCENTER**

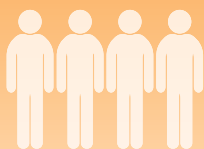
**(201) 529-4020**  
**[classified@jucm.com](mailto:classified@jucm.com)**



## Celebrate National Urgent Care Awareness Month this May

**4,100**

On average, urgent care centers are open 4,100 hours per year and treat nearly 14,000 patients.\*



**90%**

of urgent care centers have a wait time of 30 minutes or less to see a provider.\*



\*Based on 2013 data from the UCAOA 2014 Benchmarking Survey Results




Urgent care is a convenient and affordable option for all patients requiring immediate but non-emergency, non-life threatening care. As a vital link between primary care and emergency medicine, urgent care provides high-quality care by qualified healthcare professionals for sprained ankles and broken bones to eye infections and strep throat.



**Urgent Care<sup>®</sup>  
Association  
of America**

**Help UCAOA celebrate urgent care and bring awareness to our vital industry!**

**Urgent care centers are encouraged to host community events and staff activities during the week of May 18-22. Visit [ucaoa.org](http://ucaoa.org) for ideas and resources to start your planning process.**

Get social about National Urgent Care Awareness Month, share your center's activities with UCAOA and be sure to use #UrgentCare.   

*You Take Care of Patients.  
We Take Care of You.*



Are you looking for a satisfying career and a life outside of work? Enjoy both to the fullest at Patient First. Opportunities are available in Virginia, Maryland, Pennsylvania, and New Jersey.

Open 8 am to 10 pm, 365 days a year, Patient First is the leading urgent care and primary care provider in the mid-Atlantic with over 60 locations throughout Virginia, Maryland, Pennsylvania, and New Jersey. Patient First was founded by a physician and we understand the flexibility and freedom you want in both your career and personal life. If you are ready for a career with Patient First, please contact us.

To learn more about career opportunities at Patient First, contact Recruitment Coordinator Eleanor Dowdy at (804) 822-4478 or [eleanor.dowdy@patientfirst.com](mailto:eleanor.dowdy@patientfirst.com) or visit [prcareers.patientfirst.com](http://prcareers.patientfirst.com).

Each physician enjoys:

- Competitive Compensation
- Flexible Schedules
- Personalized Benefits Packages
- Generous Vacation & CME Allowances
- Malpractice Insurance Coverage
- Team-Oriented Workplace
- Career Advancement Opportunities



**bellin**  
health

Bellin Health invites you to consider an exceptional opportunity that will allow you to have it all...a busy, yet rewarding practice and tranquil waterfront living in the Green Bay metro. Enjoy spectacular scenery and beautiful lakefront developments in a true four-season climate. Bellin Health is growing again! We are expanding our services ~ we want to assure our patients have access to care when they need it. Bellin Health is actively seeking additional physicians, as well as Physician Assistants or Nurse Practitioners to join our expanding Urgent Care Clinic provider team. Applicants will need to be either BC/BE Family Practice Physicians or Certified Physician Assistants or Nurse Practitioners with 2-5 years' Urgent Care Clinic experience.

Additional Salary Information: Competitive base salary/benefit package plus quality & production incentive bonus, CME dollar & relocation allowance provided.

Contact: Michael Hale, Physician Recruiter - 920.445.7225 or  
Craig Hintz, Advanced Practice - 920.445.7213  
[Michael.hale@bellin.org](mailto:Michael.hale@bellin.org) [Craig.hintz@bellin.org](mailto:Craig.hintz@bellin.org)

**It's a fact.  
OhioHealth  
is a  
top-rated  
employer.**

**"BEST" FOR 9 YEARS**

Since 2007, OhioHealth has been ranked by *FORTUNE* magazine as one of the "100 Best Companies to Work For."



**TOP 15**

Truven Health Analytics named OhioHealth as one of the "15 Top Health Systems" in the nation in 2015.



OhioHealth is a nationally ranked, not-for-profit healthcare system including 12 award-winning campuses.

**Join our team as a urologist.**

- + Immediate opportunities for full-time, part-time and contingent work
- + Enjoy flexible scheduling and a variety of patient populations
- + Offers malpractice insurance, CME and excellent compensation/benefits

Search physician opportunities [OhioHealth.com/PhysicianJobs](http://OhioHealth.com/PhysicianJobs)

**Need more info?**

Natalie Kessinger | (614) 544.4332  
[Natalie.Kessinger@OhioHealth.com](mailto:Natalie.Kessinger@OhioHealth.com)



**Urgent Care opening at  
Sutter Health affiliate in  
Modesto, California.**

Family Medicine, Internal Medicine, ER  
or Urgent Care physicians may apply.  
12 eleven-hour shifts per month.

C.V. Allen, M.D.  
Phone: (866) 454-6853  
Fax: (209) 550-4892  
[gmgrecruiting@sutterhealth.org](mailto:gmgrecruiting@sutterhealth.org)  
[www.choosesuttergould.com](http://www.choosesuttergould.com)



### Office Retail Commercial

610 Stokes Road, Medford, NJ 08055

One story 3,600 SF building with 2 zone heat and central air, currently used for professional office, but excellent retail and commercial use possible. Zoned Community Commercial. Completely renovated in past 6 years. 21 car parking lot, repaved and striped in 2013. Building needs nothing, ready for your business.

Prime property is located in Burlington County, Medford Township, NJ on County Rt 541, aka Stokes Road, directly across from McDonald's Restaurant. 30,000+ vehicles @ day. Best location in Medford for Financial institute, retail or commercial activity.

### BEACH RESORT URGENT CARE CENTER FOR SALE -MD / DE *Enjoy The Beach Life!*

26 yrs successful CASH  
based center w/ 4400  
sq ft bldg for sale or  
lease

No hassling with  
insurance nor HMO's.

#### TURN KEY OPERATION

High traffic and  
visibility location.  
Owner will assist in  
transition.

*Enjoy the beach life while  
practicing medicine.*

Dr Jim Reeves 302-316-5075 • jimreeves99md@gmail.com

## MEDICAL SERVICES



X-Ray Systems – *new or used*  
Economy CR/DR options  
Nationwide Installation

*imaging solutions for your clinic & budget*

**CALL FOR MORE INFO!**

1.800.727.7290 x1209

**BlueRidgeXray.com**

Find the Right Job

[www.UrgentCareCareerCenter.com](http://www.UrgentCareCareerCenter.com)

**JUCM**  
THE JOURNAL OF URGENT CARE MEDICINE  
**CAREERCENTER**

## MEDICAL EQUIPMENT

### EKG Machines @ Rock Bottom Prices

*Medical Device Depot sells the best brands at the lowest prices!*

**Our EKGs come with BOTH  
a long-term warranty & in-office training.**

**CardioCare 2000:** Multi-channel EKG w/interp & full page printout

**\$2,275 \$1,225**

**Cardio7:** Interpretive EKG Machine, full page printout, alphanumeric keyboard & LCD Display

**\$3,154 \$1,710\***

**AT-2 Light:** Multi-channel EKG w/interp, full page printout & alphanumeric keyboard

**\$3,645 \$1,995**

**AT-2 Plus:** Multi-channel EKG w/interp, full page printout, alphanumeric keyboard & LCD Display

**\$3,995 \$2,677\***

\*Spirometry Option for the AT-2 Plus available for \$1,000; Cardio 7 available for \$740



AT-2 Plus EKG with Spirometry



Cardio 7 Interpretive EKG Machine

**We also offer the best prices on:**

Pulse Oximeters - Spirometers - PC Based EKGs  
Stress Test Systems - PC Based Holter Systems - Ambulatory BP Monitors  
Dopplers - Vital Signs Monitors - Refurbished Ultrasounds

**Call for more information or an on-site demonstration!**

**877-646-3300**

[www.medicaldevicedepot.com](http://www.medicaldevicedepot.com)



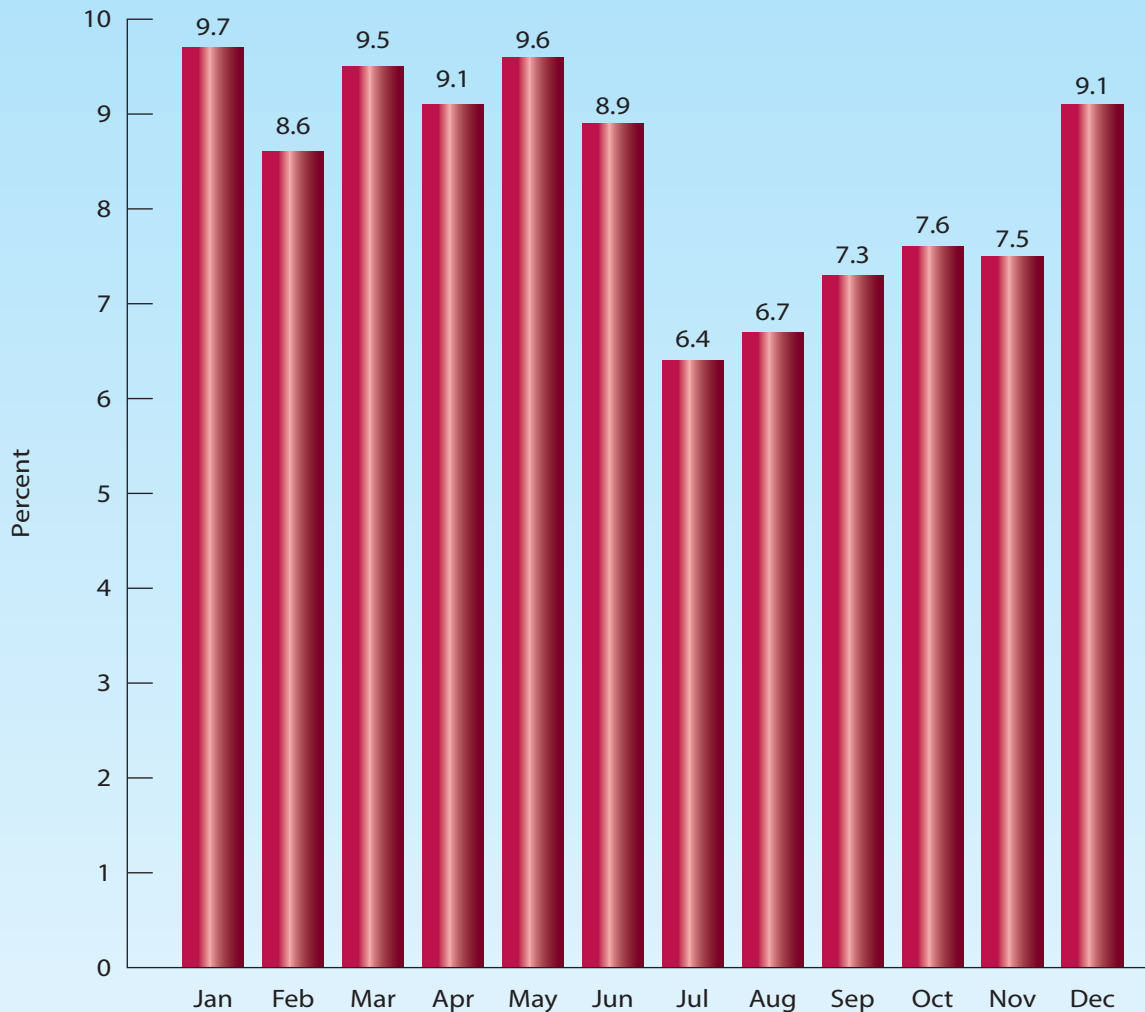
## DEVELOPING DATA

Data from the 2014 Urgent Care Chart Survey of 1,778,075 annual visits by patients to more than 800 different U.S. urgent care clinics, conducted by the *Journal of Urgent Care Medicine*, reveal that the busiest months of 2014 for patient visits were, in descending order:

- January, with 9.7% of all visits
- May, with 9.6% of all visits
- March, with 9.5% of all visits
- April and December, each with 9.1% of all visits

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.

### PERCENTAGE OF ANNUAL PATIENT VISITS BY MONTH





# EMR: The fastest just got faster.

## Discover Chartlet.

Practice Velocity's #1-rated urgent care EMR now includes Chartlet, a single-page charting option allowing providers to move even faster through documentation. We're talking patient charts completed in 1 minute. And chartlet covers roughly 80 percent of urgent care chief complaints.

If less clicking through tabs and more time treating patients sounds good to you, it's time to try Chartlet.

Call 888.357.4209 or visit [practicevelocity.com](http://practicevelocity.com) to schedule a demo.

