

JUCM[®]

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THE JOURNAL OF URGENT CARE MEDICINE[®]

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Original Research **Stemming the Scourge of Resistance in Urgent Care**

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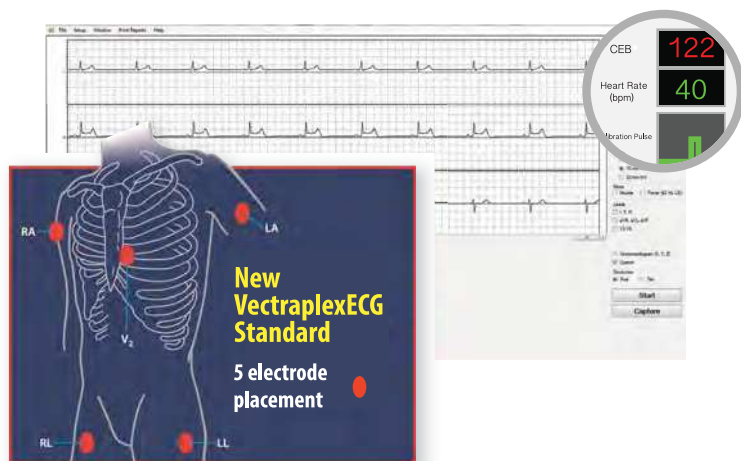
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LETTER FROM THE EDITOR-IN-CHIEF

Patient Satisfaction: The Redirection Game



In my previous column, I discussed the challenging issue of patient satisfaction and the provider behaviors that can contribute to poor service experiences. In this month's editorial, I will pivot the discussion to the patient profiles and behaviors that can trigger negative interactions and poor service reviews.

While most of us understand the importance of "customer service" in healthcare, we do not always dedicate ourselves to understanding the common traps and landmines that lead to service failures. As such, we allow ourselves to be baited into the same disruptive encounters repeatedly, taking little personal responsibility for the undesirable outcomes. Why? Because it is human nature to dismiss or want to correct bad behavior—especially from a position of authority.

Consider this example: As a parent, when a child is acting out, we say, "Stop that!" As a physician, when a patient is demonstrating inappropriate behavior, we say the same thing. Perhaps in a different way, but the message is the same: "Stop that!" Yet, most behavior experts would argue that this approach ignores the root cause of the behavior. A better approach combines empathy and redirection, and can be applied to many of the challenging behaviors we see every day in the urgent care setting. Our patients often present with unrealistic expectations, demanding antibiotics and testing beyond indication. The temptation is to correct the behavior without addressing the underlying concern. Our lack of continuity relationship and trust fuels the resentment. The outcome is predictable.

There are some simple things we can do to avoid this common service failure. Each of the approaches to the following patient types requires some self-awareness and redirection of our own behavior:

The Antibiotic Seeker: These patients believe they are sicker than you do, and think they know how to get relief from what ails them. The provider's reaction is often predictable and counterproductive, with a brief and limited exam followed by a lecture about antibiotic resistance. Here's a better approach:

- **Listen:** Do you really understand the root concern this patient is presenting with? Did you ask?
- **Touch:** The most common complaint you hear from patients with simple illnesses like URIs is, "The provider barely exam-

ined me." The simpler the problem, the more deliberate your exam should be—even if you glean nothing from it.

- **Explain and empathize:** Address the root concern and validate the discomfort and disruption, even when you think it's exaggerated.
- **Ego:** When you can offer no help, provide a graceful exit for patients who traded time and money for relief and got none. They feel stupid and rejected. The provider must provide a pathway to resolve these emotions. Back-up antibiotics can soothe the ego while addressing antibiotic overuse. Be specific about your expectations for their use.

The Transfer: These patients sought care from you and you were unable to provide that care. The encounter is ripe for feelings of rejection and anger. A busy provider is looking to avoid the complexity and effort required of these challenging presentations. They may make quick judgments and directives, without sensitivity. Patient complaints frequently look like this: "You refused to see me," or "Why was I billed for care you didn't provide?" Instead, try this:

- **Determine stability first:** When a patient presents with a concerning complaint, immediately assess their stability. If the patient is unstable, initiate emergency response protocols.
- **Fairly assess:** Most of these patients are stable. They are more likely to be compliant and appreciative if you demonstrate concern, take a fair history, and examine them.
- **Explain and empathize:** Be clear and specific about your concerns and recognize that spending the day in the ED is disruptive.

These are just two examples of patient encounters that lead to poor service outcomes. While we will never eliminate negative experiences, a little self-awareness and behavioral psychology can help us minimize the frequency and intensity. ■

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



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ORIGINAL RESEARCH

11 A Multimodal Intervention to Reduce Antibiotic Use for Common Upper Respiratory Infections in the Urgent Care Setting

Many patients with symptoms of URI come in expecting to receive antibiotics—even when they're not warranted. Read how one facility tackled this challenge with an eye toward preventing growth of resistant respiratory organisms.

Melissa Jones-Holley, DNP, MSN, APRN, FNP-c and
Tener Veenema Goodwin, PhD, MPH, MS, RN, CPNP, FAAN

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Alan A. Ayers, MBA, MAcc

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Babies vomit. However, vomiting for days without an obvious explanation should raise red flags—especially when severe diarrhea is added to the picture. See how this real-life case unfolded, complete with verbatims from the physician's and nurses' notes.

Ryan A. Fritz, MD

IN THE NEXT ISSUE OF JUCM

By design, urgent care centers are best equipped to treat nonemergent acute illness and injury. However, they are also an ideal setting for uncovering underlying healthcare issues. High blood pressure is an ideal example, as Barbara Hayes, DNP, FNP-C explains in *Elevated Blood Pressure Referrals in an Urgent Care Setting*, the first in a series of *Quality Improvement Reports* from JUCM.

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

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Antibiotics have been around longer than most of the people reading this. Certainly they're a part of everyday life in the average urgent care center. Their ubiquity is due to their effectiveness, of course, but the fact is that they've been used so widely for so long that some of the very organisms they were designed to kill have become resistant. According to the Centers for Disease Control and Prevention, 2 million people become infected with bacteria that are resistant to antibiotics every year—and 23,000 of them die as a result.



That doesn't stop patients from demanding a prescription for an antibiotic if that's what they think they need, of course (whether actual med school graduates agree or not), leaving prescribers in the unenviable position of either saying *no* to a paying customer or giving in and prescribing a drug they don't really need. The latter course of action only contributes to resistance.

Discussion of this concern is addressed in several ways in this issue, starting with the Letter from the Editor-in-Chief, in which **Lee A. Resnick, MD, FAAFP** touches on ways to satisfy the customer without compromising what's best for the patient.



Our cover article zeroes in on antibiotic prescriptions written for common upper respiratory infections. More specifically, authors

Melissa Jones-Holley, DNP, MSN, APRN, FNP-c and **Tener Goodwin Veenema, PhD, MPH, MS, RN, FAAN** recount the efforts of a team of clinicians to reduce overprescribing of antibiotics for URIs in their institution. This original research is the subject of *A Multimodal Intervention to Reduce Antibiotic Use for Common Upper Respiratory Infections in the Urgent Care Setting* starts on page 11.

Dr. Holley is on the Masters program clinical faculty at Johns Hopkins University School of Medicine, and is the director, Disease Management & Population Health at Carroll Hospital in Maryland. Dr. Veenema is an associate professor at Johns Hopkins School of Nursing; she's also affiliated with the Center for Humanitarian Health and the Department of International Health at Johns Hopkins Bloomberg School of Public Health.

Another common occurrence: a vomiting baby. Unfortunately, the explanation isn't always benign, or even easy to identify, as described in *Bouncebacks: An 18-Month-Old Boy with Vomiting* by **Ryan A. Fritz, MD** (page 27). This case, drawn from the book *Bouncebacks!*, published by Anadem Publishing, Inc., recounts an actual case in which the child continued to vomit, with other symptoms adding up on top of that, and through



several "bounceback" visits.

Dr. Fritz is chief resident and clinical instructor in the Department of Emergency Medicine at Vanderbilt University Medical Center and Vanderbilt University School of Medicine.



Just as competent clinicians are at the center of your center's ability to offer quality care, a strong manager is just as important to the overall health of your business. The hard part is finding one. **Alan Ayers, MBA, MAcc** offers some advice on the subject in *How to Hire Your Next Urgent Care Manager* (page 19). Mr. Ayers is vice president of strategic initiatives for Practice Velocity, LLC and practice management editor of *JUCM*.

He also lends his considerable and wide-ranging expertise in this issue with a Health Law and Compliance feature (page 23) that will guide you through the questions to ask yourself, and factors to consider, before deciding whether it makes sense for you to contest an unemployment claim from one of your former employees. It's not as simple as you may think, and over time there could be a lot of money riding on your ability to make the right call.

Also in this issue:

We mentioned that concerns over appropriate antibiotic prescribing would get the attention they deserve in this issue. That includes some of the abstracts reviewed by **Sean M. McNeeley, MD** and **Glenn Harnett, MD** (starting on page 31). In addition to discussion of whether patients with orthopedic implants really need preemptive antibiotics before undergoing dental procedures and a study in which some pediatric patients were treated with antibiotics-only for appendicitis, the authors share the urgent care-relevant highlights of new articles on use of vitamin D to prevent upper respiratory infections; managing febrile babies <3 months of age; whether direct-to-consumer advertising for prescription testosterone is always a good thing; and more.

What's sure to make a good thing even better is that **David E. Stern, MD, CPC** has broadened the scope of his Q & A feature in each issue. What used to be called *Coding Q & A* is now *Revenue Cycle Q & A*. In his first entry, Dr. Stern offers sage advice on how to negotiate contracts when your facility offers both primary care and urgent care services. Should you use the same tax identification number to reflect your offerings? See page 40 and you'll find out.

And speaking of revenue, you've probably noticed there is an ever-growing array of payment models out there. If you're wondering which are catching on, you'll find *Developing Data* (page 44) of interest this month. ■



CONTINUING MEDICAL EDUCATION

Release Date: May 1, 2017
Expiration Date: April 30, 2018

Target Audience

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

Learning Objectives

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

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CONTINUING MEDICAL EDUCATION

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

A Multimodal Intervention to Reduce Antibiotic Prescribing for Common Upper Respiratory Infections in the Urgent Care Setting (p. 11)

1. According to the Infectious Diseases Society of America, in what percentage of cases are antibiotics prescribed for upper respiratory infections?

- a. 5%
- b. 10%
- c. 15%
- d. 60%
- e. 95%

2. Which of the following are possible harms with prescribing antibiotics for patients with viral infections?

- a. Contributing to drug-resistant respiratory organisms
- b. Increased antimicrobial resistance
- c. Increased expense
- d. All of the above

3. According to the Centers for Disease Control and Prevention (CDC), how many lives are claimed per year in the United States by drug-resistant organisms?

- a. 100
- b. 150
- c. 200
- d. 23,000
- e. 23 million

How to Hire Your Next Urgent Care Manager (p. 19)

1. According to the article, which of the following statements pertains to hiring an urgent care manager?

- a. Hiring the right manager is one of the most important decisions an urgent care executive can make
- b. Hiring the right manager can reap huge dividends for the urgent care operation, while hiring the wrong manager can push an organization into chaos
- c. Excessive use of “I” statements during an interview may indicate a manager who has trouble delegating, is too focused on him/herself, or is not a team player
- d. Searching on a few targeted keywords in a social networking site like LinkedIn may yield an initial pool of applicants for an open manager position
- e. All of the above

2. According to the article, a “jack of all trades” manager capable of overseeing multiple business functions, including revenue cycle management and human

resources issues, is a more common fit for what type of urgent care operation?

- a. A large corporate organization in which specialized tasks are highly delineated among functional managers
- b. A hospital/health system in which specialized tasks are highly delineated among functional managers
- c. A small-to-midsized organization which lacks scale to break specialized functions into discreet departments
- d. A and B
- e. None of the above

3. According to the article, which of the following are desirable qualifications for an urgent care manager?

- a. There is no “one size fits all” educational and experience skillset for managerial candidates
- b. Some hospital-affiliated urgent care centers require the manager to have a background in nursing
- c. Friendly and even-tempered personality, as a manager will be working with all stakeholders
- d. Ability to motivate staff and judgment to know when to assume or delegate a task
- e. All of the above

Bouncebacks: An 18-Month-Old Boy with Vomiting (p. 27)

1. Which of the following are components of hemolytic uremic syndrome (HUS)?

- a. Microangiopathic hemolytic anemia (MAHA)
- b. Thrombocytopenia
- c. Acute renal failure
- d. Neurologic changes
- e. All of the above

2. Which of the following commonly cause HUS?

- a. Air pollution
- b. Swelling after a fracture
- c. The Shiga toxin from *E coli* 0157
- d. Chronic sinusitis
- e. Closed head injury

3. All of the following symptoms may be present with HUS except:

- a. Bloody stool
- b. Ecchymosis
- c. Confusion
- d. Rhinorrhea
- e. Fever



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I'm a Germaphobe—Here's Why

■ LAUREL STOIMENOFF, PT, CHC

I started my career as a hypochondriac with my *Merck Manual* always at my fingertips for quick reference, but subsequently elected to simplify my phobias and narrowed it down to being a germaphobe.

This evolution occurred as I spent the bulk of my patient care years in the hospital setting. Each year I would go through my mandatory training on infection prevention, receiving instruction on the latest research and best practices. MRSA was the enemy and we were committed to its eradication. I dutifully washed my hands in accordance with policy and donned and doffed personal protective equipment where indicated. Taking the full dose of any prescribed antibiotics was routine, so I didn't risk hosting some superbug for life. Nonetheless, I was incredibly naïve about the looming crisis that would make even the non-germaphobe shudder. Antimicrobial resistance (AMR) is believed to be responsible for the deaths of over 700,000 people per year worldwide. That number is anticipated to grow exponentially, to a point where *Review on Antimicrobial Resistance* predicts, if unchecked, it will grow to 10 million deaths by 2050, exceeding the impact of cancer. Simple surgeries will be high risk, the disease state will be prolonged, and the financial ramifications will be devastating unless radical action is taken by medical and agricultural communities.

A Partnership is Forged

The Urgent Care Foundation, UCAOA's 501(c)3 organization, has partnered with the Antibiotic Resistance Action Center (ARAC) at George Washington University. ARAC secured a grant that is being shared with the Foundation. Recognizing that antibiotic stewardship and proper prescribing is a complex issue and that withholding antibiotics when they're not indicated can be a patient dissatisfier, ARAC is working with UCAOA to identify best practices without adversely impacting the patient experience.



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

To that end, UCAOA collaborated with ARAC and released a position statement that states, in part, "To combat AMR, UCAOA will work with its members and constituents in the following four areas: 1) education and training, 2) clinical decision support, 3) antibiotic use data collection, and 4) evidence-based practice."

Urgent Care Under the Microscope

Top diagnoses in most non-occupational medicine-focused urgent care centers are highly relevant to antibiotic prescribing. This may be one reason UCAOA is fielding frequent calls suggesting ways we might partner to ensure industry-wide antibiotic stewardship. And I have yet to speak to a medical provider who does not lament the oft-protracted dialogue with the patient who is expecting antibiotics while other patients await care and the reception area is filling up.

That provider may be concerned about personal patient satisfaction scores, throughput time, and the fear that the patient who just paid a \$75 copayment and "is not leaving without a prescription" may be one who frequently posts reviews on Yelp. A recent survey by Demi & Cooper Advertising and DC Interactive Group revealed that 41% of people allow social media to impact their choice of a specific doctor, hospital, or medical facility.

While there are no data indicating that urgent care providers are more likely to prescribe antibiotics than those in any other medical setting, the boards of UCAOA, the College of Urgent Care Medicine, and the Urgent Care Foundation acknowledge that we have an obligation to do our part in thwarting the grim prognostications emanating from the CDC, the World Health Organization, and other venerable institutions.

Inappropriate prescribing in the medical community is only one piece of a very complex problem. We look forward to our ongoing partnership with ARAC and the urgent care community to influence change, educate our communities, and preserve patient confidence. Sean McNeeley, MD, network medical director of University Hospitals' Urgent Care in Cleveland and chair of the College of Urgent Care Medicine, summarized our responsibility nicely: "We want to do more than just our part in helping achieve this goal. *We want to lead the way.*" ■



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A Multimodal Intervention to Reduce Antibiotic Use for Common Upper Respiratory Infections in the Urgent Care Setting

Urgent message: Regardless of etiology or provider specialty, antibiotics are prescribed 60% of the time for the treatment of upper respiratory infections, contributing to drug-resistant respiratory organisms. Employing a multimodal intervention, the authors were able to appreciate a modest, statistically significant decrease in the rate of antibiotic prescribing among urgent care providers.

MELISSA JONES-HOLLEY, DNP, MSN, APRN, FNP-C and TENER VEENEMA GOODWIN, PHD, MPH, MS, RN, CPNP, FAAN

Introduction

Antimicrobial resistance is arguably one of the greatest risks to human health. Multidrug-resistant organisms are increasingly providing clinical management challenges to providers in ambulatory and inpatient settings—often, as a result of the improper use of antibiotics in the outpatient setting.^{1,2} Drug-resistant organisms have a tremendous impact on the morbidity and mortality rates for infectious diseases. Unfortunately, the development of new antibiotic agents to combat these organisms has decreased due to the minimized return on investments by pharmaceutical companies.^{2,3} As a result, drug-resistant infectious diseases claim the lives of at least 23,000 people annually in the U.S.⁴

Former President Obama issued Executive Order 13676 in 2014, with a national strategy to reduce the use of antibiotics in both inpatient and outpatient settings.⁵ Regardless of specialty, providers should practice the judicious use of antibiotics to preserve their effectiveness and prevent the emergence of a pre-antibiotic era.

Due to the overwhelming growth and utilization of



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urgent care centers (UCCs) in the U.S., urgent care (UC) providers have an opportunity to minimize the progres-

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sion of antimicrobial resistance through the appropriate use of antibiotics. UCCs provide care to >71 million patients annually in the U.S., with a large percentage of visits being for upper respiratory infection (URI).⁶ Though URIs such as nasopharyngitis, rhinosinusitis, pharyngitis, and bronchitis are usually viral in nature, it is estimated that antibiotics are prescribed 60% of the time for URIs regardless of etiology.⁷ These practices can impact patient outcomes and quality of care—and contribute to antimicrobial resistance.

Similar to global trends, our hospital-owned UCCs located in two suburban communities in the Mid-Atlantic region of the U.S. experienced high rates of antibiotic prescribing for URIs. Differences in provider type (physicians; physician assistants [PAs]; nurse practitioners [NPs]), knowledge base, confidence, and practice experiences, along with the lack of company-adopted treatment guidelines are possible contributors. A quality improvement initiative was implemented to standardize provider care through the use of evidence-based practice (EBP) guidelines for URI management. In this article, we will discuss how EBP interventions were translated into practice to reduce inappropriate antibiotic prescribing for URIs in the UC setting.

The Literature Review

A systematic review of the literature was conducted to discover interventions that demonstrated statistical significance in reducing antibiotic use for URI management in UCCs. Studies targeting UCCs were scarce; most occurred in primary care settings. Researchers measured guideline adherence by the reduction of antibiotic use for viral infections, and an increased use of first-line therapies for bacterial illnesses.^{8–10} When used in varying combinations, provider education, consensus meetings, algorithm use, prescriber feedback/audit, clinic champions, and patient education demonstrated effectiveness. Of these, provider education and prescriber feedback and audit were the most commonly used.

Interventions were most commonly measured by their ability to reduce the overall rate of antibiotic prescribing or the proportion of antibiotic prescriptions for URIs.^{7–13} A 10% relative reduction in the rate of antibiotic prescriptions for URIs among the intervention groups, compared with control sites, demonstrated statistical significance for some studies.^{12,13} We selected the most commonly used components from successful programs and considered their statistical significance, implementation time, feasibility, and the practice culture.

Methods

We conducted a quality improvement project for two hospital-owned UCCs with annual volumes of 26,800. This project was reviewed by the Johns Hopkins Medicine Institutional Review Board and deemed Not Human Subject Research. The intervention included: monthly 1-hour provider consensus meetings; review of clinical guidelines^{4,7,14} for URI diagnosis of bronchitis, nasopharyngitis, sinusitis, or URI not otherwise specified (URI-NOS); clinical pathway development for sinusitis; monthly prescriber feedback/audit; and patient education. Our aims were 1) to decrease the use of antibiotics for URIs at the urgent care centers by 10% and 2) to attain an 80% utilization rate of developed guidelines for URIs by the providers.

Selection and Description of Participants

The project team consisted of two NPs, two PAs, and three physicians who participated on a voluntary basis. The intervention targeted all providers employed by the UCCs (N=10) and patients diagnosed with bronchitis, nasopharyngitis, sinusitis, or URIs between October 1, 2014 and February 1, 2015. This timeframe was chosen based on prior studies and a historical analysis of URI encounters at the centers over the past 3 years.^{11,15,16}

Study Design

Team meetings were open to everyone and held monthly from October 1, 2014 through February 28, 2015. These meetings sought to facilitate compliance with the best practices in the management of URIs through review of evidence-based literature, compliance coaching, and problem solving. Each 1-hour meeting was agenda-driven. Agenda items included: the purpose, goals, and timeline of the project; impact of practice variances and antibiotic overuse; review of clinical guidelines for URIs; general information on provider compliance with guidelines; and a discussion on the perceived successes and challenges of the project.

Using a consensus approach, project team members had an opportunity to review EBP guidelines from the CDC, AAFP, and IDSA for bronchitis, sinusitis, and URI management. Team members were asked to adopt or adapt guidelines to best meet the needs of patients and to facilitate compliance. Upon consensus, these guidelines were adopted and clinical pathways were developed for each diagnosis using the American Heart Association standards for clinical pathway development to promote rigor and trustworthiness.¹⁷ The developed pathways and adopted clinical guidelines were made available to all

providers (during the provider meeting, through company email, and displayed at each provider work station) for use starting on October 1, 2014. These documents were accompanied by a policy and procedure for use, and details on the prescriber feedback and audit methods.

Provider compliance with clinical guidelines and pathways for URIs was assessed through monthly chart audits. Treatment plans of patients with sinusitis, bronchitis and URI-NOS were compared to the clinical guidelines and pathways to determine compliance. Based on this review, all clinicians were provided with monthly confidential, timely, direct, and written feedback via email by the project manager regarding the project measures during the intervention period. The feedback tool was adapted from a study measuring similar outcomes.⁸ De-identified aggregate data regarding prescription rates and guideline adherence were presented during the monthly team meetings.

The final component of this intervention targeted patients. The educational campaign provided verbal, written, and video messages/materials on the rationale for, and benefits of, appropriate antibiotic use. The campaign began on October 1, 2014 using exit care instructions from the electronic medical record and company-approved materials from the CDC's *Get Smart Know When Antibiotics Work* (*Get Smart*) campaign.

Upon discharge, exit care instructions were given to each patient regarding their diagnosis from the Practice Velocity electronic medical record (EMR). When appropriate, an additional instruction page on antibiotic nonuse was included. Exit care instructions complemented education from the provider, and outlined the common causes of the diagnosis, warning signs, and information on follow up. *Get Smart* materials were displayed at the centers and throughout the community.

Materials and mechanisms for marketing the campaign included *Get Smart* campaign posters and brochures, which were displayed throughout each center; participation as a CDC *Get Smart* partner; radio and publication interviews for the community; an article about the project targeting all providers in the hospital system; the center's health blog; and a video regarding the smart use of antibiotics on the center's website. Social media marketing on Facebook and Twitter shared facts on the smart use of antibiotics.

Data Collection

Baseline prescribing rates were obtained through a retrospective chart review of 273 patient encounters with URI diagnosis of nasopharyngitis, bronchitis, sinusitis,

Table 1. List of Diagnoses with Associated ICD9 Codes

Diagnosis	ICD9 code
Nasopharyngitis	460
Acute sinusitis	461, 461.1, 461.8, 461.9
Upper respiratory infection	465, 465.5, 465.8, 465.9
Acute Bronchitis	466

or URI-NOS during the intervention period. The sample size calculation was based on a 12% reduction in antibiotic prescriptions for URIs in a prior study.¹⁸ A sample size of 273 per group was determined using this effect size, with a type I error of .05, and 80% power.

Inclusion criteria included patients of all ages with one of the primary *International Classification of Diseases 9th* (ICD9) Revision codes listed in **Table 1**. A patient demographic report by ICD9 code was obtained using PVM (the Practice Velocity practice management system). A systematic randomization of the sample was conducted through the selection of every third chart under each ICD9 code from the report. Each selected chart was assigned a de-identified encounter number. Charts were obtained from Velocidoc, the Practice Velocity EMR, and reviewed using the chart audit tool. The tool was deemed reliable following a pilot of 20 charts. Exclusion criteria included: a concurrent diagnosis of influenza; comorbid conditions of COPD, diabetes, cancer, or immunosuppression; patients presenting for follow up within 1 week of initial encounter; oral antibiotic use within past 30 days; and patients with other diagnoses requiring oral antibiotic use, such as urinary tract infections. Demographic information including age, sex, and gender were collected in addition to the month and year of the encounter, smoking status, ICD9 code(s), provider type, and whether an antibiotic was prescribed. A password-protected database was created using Microsoft Excel to store de-identified data.

Reviewing URI encounters using the exact methods described above required the collection of additional data, including the treating provider and whether the treatment plan demonstrated adherence to the adopted guidelines. Provider names were de-identified to ensure confidentiality prior to entry.

Statistical Methods

The Microsoft Excel database was exported into the Statistical Package for the Social Sciences (SPSS) 22 for analysis. Data were sorted by time period (baseline and intervention), and frequencies were conducted on each variable to ensure the completeness of data prior to per-

Table 2. Demographic and Clinical Characteristics of Urgent Care URI Patient Encounters During Project Periods

Demographics	Baseline, n=273	Intervention, n=273	p value ^a
Mean Age, years (range)	34 (0-85)	36 (0-87)	0.940
Gender, No. (%)			0.929
Female	178 (65%)	176 (65%)	
Male	95 (35%)	97 (36%)	
Clinical Data	Baseline, n=273	Intervention, n=273	p value ^a
Diagnosis, No. of cases. (%)			<0.000
Bronchitis	82 (30%)	4 (2%)	
Nasopharyngitis	22 (8%)	4 (2%)	
Sinusitis	96 (35%)	158 (58%)	
URI	107 (39%)	112 (41%)	
Provider Type, No. (%)			<0.000
Physician	138 (50%)	145 (53%)	
Nurse practitioner	108 (40%)	61 (22%)	
Physician assistant	27 (10%)	67 (25%)	
Smoking Status, No. (%)			0.024
Nonsmoker	237 (87%)	253 (93%)	
Smoker	36 (13%)	20 (7%)	

^a t-test (age), χ^2 (categorical variables)

forming statistical tests. For the primary outcome variable, a 10% decrease in the rate of antibiotic prescribing for URIs, the chi square test of proportions χ^2 was used to compare prescribing rates between project periods. For the secondary outcome variable, attainment of an 80% utilization rate of URI guidelines, the frequency of guideline adherence was analyzed.

Providers were given feedback on the primary and secondary outcomes based on the analysis conducted for both outcomes using χ^2 . These rates were compared for each provider to the overall group for the time period reviewed.

Further analysis included an independent sample t-test to compare the mean ages of the sample between time periods, and χ^2 was used to explore differences between subgroups and the outcome variables. Statistical significance was determined by p values <0.05 with a confidence interval set at 95%.

Results

During the baseline period, the UCCs had 3,103 patient encounters with the ICD9 codes listed in Table 1, compared with 2,189 encounters during our intervention. There were no significant differences in the demographic variables of

age or gender between periods (Table 2). The mean age of patients included for baseline data collection was 33.6 years, compared with a mean age of 35.5 years for the intervention period. Significant differences were noted in the distribution of diagnoses, provider type, and smoking status between the time periods.

Suspected viral cases accounted for the majority of baseline encounters (n=211, nasopharyngitis, bronchitis and URI-NOS), but not during the intervention period (n=120). The majority of patients were nonsmokers; however, there were more smokers at baseline (13%) than during the intervention (7%). Physicians were the most frequent provider of care regardless of time period (50% at baseline vs 53% for intervention). However, more NPs provided care to patients than PAs at baseline than during the

intervention period (40% vs 25%).

The rate of antibiotic prescribing for the UCCs was reduced by 23.6% for bronchitis, sinusitis, nasopharyngitis, and URI-NOS visits collectively. There was a statistically significant change (p<0.05) in the proportion of patients prescribed an antibiotic as a result of the intervention (155/273, or 56.8%) compared with the baseline period (203/273, or 74.4%). After adjusting these results for diagnosis type, provider status, and smoking status, changes in the rate of antibiotic prescribing between our baseline and intervention groups remained significant (p<.000). For each additional patient receiving care for their URI, the odds of them receiving an antibiotic was reduced by a factor of .119, controlling for all other factors in the model (95% CI .060 to .237). The largest decrease was noted in the URI category, which demonstrated a 71% reduction from baseline (47%) to intervention (14%) as shown in Table 3. Smoking history was noted to be an independent predictor of antibiotic prescribing during the baseline period (p<.000), with 83% of smokers receiving an antibiotic for their URI. There was a 22% decrease in antibiotic prescriptions noted among smokers, with no significant differences (p=.441) noted between the smoking groups. Physicians prescribed a higher percentage of anti-

otics than their PA and NP colleagues (61%, 54%, and 49%, respectively, $p < 0.230$); however, the differences were not significant (Table 4.)

We obtained an 87% URI guideline compliance rate among providers. NPs were more likely to adhere to the guidelines, followed by physicians. The PA group had the lowest rate of adherence ($p < 0.002$) (Table 4). Using logistic regression, the physician and PA groups had a major influence on treatment guideline adherence. Treatment guidelines were less likely to be followed if a PA was the provider of care compared with the physician reference group with statistical significance—OR (95% CI) = .314 (.144, .685).

Table 3. Percentage of Antibiotics Prescribed for Each Diagnoses by Time Periods

Diagnosis	Baseline	Intervention	p value ^a
Bronchitis %, (abxrx/no.cases)	99% (81/82)	75% (3/4)	**
Sinusitis %, (abxrx/no.cases)	99% (95/96)	75% (140/158)	0.002
URI %, (abxrx/no.cases)	47% (61/129)	14% (16/116)	<0.000

^a χ^2 (categorical data)
 **unable to perform due to 3 cells having expected cell count <5; abxrx/no.cases = number of cases for which an antibiotic was prescribed / total cases of diagnosis within time period

Table 4. Proportion of Antibiotics Prescribed and Treatment Guideline Adherence by Provider Type for Intervention Period

Patient encounters, n=273				
	Physicians n = 145	Physician Assistants n = 67	Nurse Practitioners n = 61	p value ^a
Oral antibiotic prescribed	61%	54%	49%	0.230
Treatment guidelines followed	90%	75%	93%	<0.002

^a χ^2 (categorical data)

Discussion

Antibiotic overuse is a prevailing concern across the globe, as common infections present treatment challenges for healthcare providers and patients due to increasing antimicrobial resistance. To facilitate the judicious use of these drugs when treating common URI complaints in our setting, evidence-based interventions were reviewed for modeling and applicability. Most of the studies reviewed were conducted in the primary care setting. However, an intervention specific to the unique characteristics and culture of the urgent care setting was desired. Our purpose was to determine if EBP interventions that have been successful in reducing in antibiotic prescribing and improving adherence to EBP guidelines with statistical significance could be effectively translated into the UC setting and provide similar results.

Utilizing a multimodal intervention inclusive of provider consensus meetings, EBP guideline review and adaptation, clinical pathways, prescriber feedback and audit, and patient education (inclusive of a marketing campaign), we were able to appreciate a modest, statistically significant decrease in the rate of antibiotic prescribing among the UC providers. Buy-in from providers was evidenced through an 87% rate of compliance with EBP guidelines. Individual components of the intervention were not tested for significance; however, providers

agreed that each component contributed to the project's success and their personal rate of adherence.

Similar to prior studies, we demonstrated a decrease in the proportion of antibiotics prescribed for patients with URIs with statistical significance.^{12,13,19,20} We reduced the rate of antibiotic use in sinusitis. However, prior studies measured broad-spectrum antibiotic use for this diagnosis as opposed to overall prescribing rate.^{8,9,21} We found only one study that targeted UCCs.¹⁸ Comparable to our results, in this study, NPs were more likely to comply with guidelines. Additionally, we noted the PA group had the lowest rate of guideline compliance. However, it is important for us to consider that 80% of the PAs were part-time providers. Only one of the five PAs had 100% participation at the consensus meetings, while the physicians and NPs had a complete 100% rate of attendance. Participation, rather than provider type, may be the stronger factor.

The full involvement of stakeholders most likely contributed to the success of our interventions, as in prior studies.^{13,22} We involved the providers whose antibiotic prescribing habits were being targeted, and provided them with compelling evidence that a change in practice was warranted. Patient education materials served as a complement to provider decision making and offered a credible source to guide care and facilitate compliance.

Conclusion

Antibiotic prescribing was significantly reduced at two urgent care centers through the implementation of multimodal strategies targeting providers and patients. Such an approach could enhance compliance with URI evidence-based practice guidelines in the outpatient setting, resulting in the judicious use of antibiotics.

Limitations

There are several limitations to this study. The first was the composition of the provider staff. Our provider groups were small and there was a change in providers between the baseline and intervention periods. Additionally, all but one PA was employed on a part-time basis. The baseline period included two providers not employed with the practice during the intervention period, and two of the physicians began with the practice just prior to the intervention. Therefore, prescribing patterns and guideline adherence by provider groups should be interpreted with caution. Changes in prescribing habits could be attributed to the intervention or a change in providers.

The second limitation is the possibility of the Hawthorne effect among providers. Providers could select another diagnosis to justify their choice to prescribe an antibiotic, thus improving their rate of guideline adherence for the audit.

Thirdly, it is difficult to determine if the prescriber feedback and audit was effective. Due to delays in the IRB approval process, the feedback and audit component of the intervention did not begin at the onset of the intervention. Feedback and audit was only provided for the 2014 months of October, November, and December at 3-week intervals. Similar to other studies, future replications of this intervention should allow for timely feedback to providers at regular intervals.^{8,13} Finally, we did not assess patient satisfaction prior to, during, or upon completion of this project. Capturing patient perception, acceptance, and adoption of the initiatives surrounding judicious antibiotic use in the urgent care setting would be essential for the expansion and sustainability of the program. The ability to demonstrate an increase or no change in patient satisfaction could assist in obtaining buy-in and adoption from additional urgent care owners and companies.

While multimodal interventions have demonstrated the most success in reducing antibiotic prescribing for URIs, we are unable to determine the individual benefits of each component. In the future, a confidential Likert-scale survey could be used to assess provider attitudes

toward the individual components of the project and their effect on changing their prescribing habits.

Components from interventions used in ambulatory care settings were successfully translated into our UCCs to standardize care and reduce rates of antibiotic prescribing. With increasing rates of antimicrobial resistance globally, all providers should promote the judicious use of antibiotics. This project demonstrates through the involvement of frontline providers and patients, that practice variations can be reduced when EBP is fostered. Future studies should focus on the project's sustainability, and whether this intervention would demonstrate similar results in other urgent care settings. ■

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How to Hire Your Next Urgent Care Manager

Urgent message: Urgent care centers need engaged and effective operations leadership, which entails clearly defining managerial roles, individual skillsets, and personality characteristics and also having a process for attracting, interviewing, and qualifying managerial candidates.

ALAN A. AYERS, MBA, MAcc

Jim Clifton, the highly respected CEO of global performance and research leader Gallup, has often stated that hiring the right manager is by far the most critical decision a company makes. Given how multifaceted and demanding urgent care operations can be at times, this maxim rings especially true in our industry. Putting a competent, skilled urgent care professional in a leadership position can reap huge dividends, while handing the reins to a poor fit can throw the operation into chaos in short order. The question is, how can you ensure the next person you hire as a manager/operator/director is the best choice?

There are many strategies you could employ, but industry experts are in near consensus that by diligently adhering to the hiring best practices described here, you dramatically increase your odds of winding up with a great fit to lead your urgent care to peak performance and sustained profitability.

Define the Role

While the mission of every urgent care center is to provide fast, low-cost ambulatory care for minor illness and injury, the size and scale of the different operations can vary greatly. And for each type of entity, there's a best fit candidate it should hone in on. Hence, the first step in your managerial search is to define the role.

Smaller and midsize urgent care operations, for example, would be looking for a candidate who can go above and beyond the typical scope, and take on such tasks as revenue cycle management, human resources issues, and perhaps minor clinical responsibilities. Given the



necessarily leaner staffing model, a flexible, versatile, jack-of-all-trades manager capable of wearing multiple hats is the obvious choice here.

Larger-scale urgent care entities, and operations that may or may not be aligned with hospital systems, on the other hand, would have a more delineated hierarchy. This type of urgent care system would likely have a medical director/operations manager overseeing the operations of multiple clinics, with specialized staff below them on the organizational chart handling spe-

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cific departmental functions. In most cases, though, the overall responsibilities of the typical urgent care “operator” are very similar: manage all aspects of the day-to-day clinic operation.

In either scenario, it’s crucial to clearly define the role well ahead of your candidate search. Questions to consider:

- What’s the size and scale of my urgent care operation, as it relates to the full skillset my manager will need?
- How much clinical experience, if any, will my next manager need?
- How many hats will my manager be required to wear on a daily basis?
- What’s the proper mix of education and experience necessary to thrive in the role?
- Once you have the answers to these basic questions, you’re ready to move on to the next step in the hiring process.

Education and Experience

Although the amount and type of education and hands-on experience necessary can vary depending on the operation, both factors should line up with the primary responsibilities of the manager/operator role, which would include the following:

- Ensuring that the clinic(s) is opened and closed in accordance with operating hours, and is appropriately staffed
- Hiring, training, and supervision of clinical, administrative, and clerical staff
- Ensuring that business functions and clinical activities are in compliance with all company policies and procedures
- Maintaining properly functioning equipment while overseeing its maintenance and repair
- Ordering inventory and monitoring usage of supplies
- Interacting with patients, and addressing and resolving customer service concerns
- Balancing the cash drawer and making daily bank deposits
- Coordinating and facilitating vendor activities and services
- Overseeing the billing function and resolving refunds, billing holds, and accounting corrections
- Acting as a backup for the registration and clinical staff when there is a staffing shortage or high patient demand

This list of responsibilities is not exhaustive. However, the managerial candidate should have a minimum level of education and experience in the following areas:

- High school diploma (or equivalent) and at least 5 years’ experience in a management role
- Proven understanding of medical terminology, medical billing functions and systems, and medical coding
- Current and comprehensive training in HIPPA, OSHA, and all aspects of blood-borne pathogens
- Proficiency with common PC programs and applications such as internet, email, and Microsoft Office productivity tools
- Familiarity with and the ability to utilize a profit-and-loss report toward developing actions plans that maximize center profitability
- In-depth understanding of the principles and processes of high-level customer service, including customer issue resolution and assuring a consistently superior level of service
- Proven proficiency in supervising, coaching, and mentoring staff via interpersonal and communication skills

As mentioned, there is no one-size-fits-all educational and experience skillset for managerial candidates, as each organization and role will emphasize different requirements. Some hospital-affiliated urgent care operations require their center manager to have a nursing background, for instance, so naturally that candidate would need the commensurate licensing, certifications, and clinical education and experience that an administrator or office manager wouldn’t.

Conversely, in the case of a medical director or even a C-level urgent care executive, the skillset emphasis would be on higher-level strategic initiatives, the ability to oversee multiple centers and/or department functions, and delegating responsibilities down the chain of command.

Personality Characteristics

From the daily interactions with staff and patients, to the ebb and flow of general clinic demand, urgent care is a dynamic, fast-paced business model. As such, the center manager should be a leader who is intelligent, adaptable, organized, and an excellent communicator. His or her personality should be friendly and even-tempered, as they constantly deal with patients, physicians, vendors, clerical, clinical, and administrative staffers, and other company stakeholders. And while an easygo-

ing and affable demeanor is a plus, the manager must also possess a forceful yet magnetic personality, and seamlessly blend it with strong leadership capabilities. In a high-stress environment such as urgent care, after all, it won't be long before the manager must either deal with an internal crisis, mediate a dispute between staffers, or soothe an irate patient. Additionally, as the de facto "captain of the ship," the manager must have a knack for motivating staff, along with the judgement to determine when they should jump in and handle a situation or delegate to another capable staffer.

Overall, the manager should bring an infectious and positive attitude to work that inspires the team and provides a great example. By balancing an empathetic and caring attitude with a driven, focused approach to center performance and profitability, an urgent care manager is well equipped to successfully handle the many challenges the position entails.

How to Find the Best Candidates

Now that you have a clear understanding of the type of person you want managing your center, how do you go about finding them? As Jim Clifton emphasized, installing a manager or leader is not a decision your organization can afford to get wrong, so you'll want to tap as many quality sources as you can in rounding up a pool of viable candidates.

First, there's the old standby, word-of-mouth. Let your colleagues know you're looking for a manager, and ask around your professional circles to see if there's a potential great fit out there you could bring in for an interview. Additional sourcing strategies can include the following:

- Professional networking sites – Websites like LinkedIn are excellent places to find talented job seekers, including medical professionals. Typing in a few targeted search terms should quickly bring up a number of groups, companies, jobs, and medical professional profiles you can begin to research for viable candidates.
- Medical job boards – Online job boards specific to

“Overly negative recollections about past coworkers and patients can actually be more reflective of the candidate's own professional shortcomings.”

ing your managerial posting after a relevant Google search.

our industry are an ideal way to advertise your managerial opening, as you're almost certain to reach your target audience there. Additionally, experienced candidates who understand the value of professional medical organizations are already members, so they're self-vetting in that sense.

■ Website job posting – Posting your job opening directly on the company website is another good way to attract candidates. Especially for larger urgent care organizations, career-minded individuals should have little problem find-

Interviewing Tips

After whittling down the initial pool of candidates to a few qualified finalists, it's time to conduct interviews. As everyone you bring in has presumably met the minimum qualifications, the interview moves the hiring process along further, putting you face-to-face with the remaining managerial candidates. This is your opportunity to ask questions and further “feel out” candidates towards determining if they're the right fit for your manager position.

Questions should be devised to help you glean insights into your candidate's past experience, strengths and weaknesses, and prevailing attitudes toward work, patient care, and their coworkers. For example, always ask what they like about their current or past job. The answers you're looking for are the ones that correlate to your management position (eg, thriving in a fast-paced environment, the ability to perform in a fluid, dynamic workplace, and forming strong relationships with coworkers).

By contrast, be sure to ask what they least liked about their past job. Listen closely here, as these answers tend to be even more insightful. Industry experts agree that substandard pay and long hours are acceptable responses, but overly negative recollections about past coworkers and patients can actually wind up being more reflective of the candidate's own professional shortcomings.

Another important question to ask is how many hours the managerial candidate is willing to work. The

correct answer, of course, is as many as necessary. Again, the manager is the captain of the ship, so they should be willing to be at the center as much as necessary to ensure that things are running smoothly. A managerial candidate who is not open to working extra hours and a variety of shifts, including weekends, simply doesn't understand the requirements of the position and may not be a good fit.

Lastly, don't forget the challenging, open-ended questions: The toughest decision they had to make in their last job, the most challenging incident, how they resolved a major conflict, etc. Not only are you looking for answers that offer insight into their management style and how they deal with adversity, but you're also listening for the behavioral characteristics you value—calm, intelligent, resourceful, even-keeled, thoughtful, team player, and mature professional.

Red Flags

The same way you're evaluating managerial candidates for the positive traits necessary to thrive as your center's leader, you should also be on the lookout for warning signs and red flags. The last thing you want is a poor-fit candidate making it all the way through to the offer stage, only for you to discover that they're a flawed choice. A few common red flags:

- Asking about salary too soon – A candidate should not be inquiring about salary over the phone or via email until they have at least been onsite at the center, met and mingled with the staff they would be managing, and fully understand the requirements of the position and role. Managing a center is a real commitment, to be fulfilled by candidates who truly love the medical and patient care industry. Hence, money should never be the overriding consideration.
- Excessive "I" responses – Urgent care is a team environment, such that a candidate who answers every question with, "I did this" or "I accomplished such and such" may be indicating that they have trouble delegating, is too focused on themselves, or is not a team player. If a promising candidate answers this way often, you may need to probe further with additional questions.
- Lack of people skills – If, during the interview questions, the candidate's answers consistently indicate that he or she lacks awareness of the people skills required to thrive in the role—for instance, focusing too much on the technical aspects of their past experience and the current opening—it could be a red

flag. First and last, urgent care is a people business, so a candidate who doesn't share positive, uplifting, and interesting experiences with past patients and coworkers may not grasp the interpersonal skills it takes to successfully lead an urgent care.

Conclusion

Whether the job title is medical director, operations manager, center manager, medical administrator, or office manager, the overarching objective is essentially the same: installing a leader and "operator" for your urgent care. To that end, you want to hire a skilled and energetic healthcare professional who understands the ins and outs of the business, can effectively manage people and situations, and has an unflinching commitment to maximizing center performance and profitability. By adhering to these hiring best practices, your organization can go forward with the confidence that it will likely wind up with a great fit, and an ideal pairing that allows the manager and the organization both to flourish. ■

Summary

- The first step in finding the most ideal managerial candidate is to define the role as it applies to *your* urgent care center; what tasks will that person be expected to take on, for example?
- Common traits that are necessary for any candidate include being adaptable, organized, and an excellent communicator.
- Casting a wide net will yield a suitable number of prospects. Try such varied approaches as old fashioned word-of-mouth, scouring medical job boards and networking sites (eg, LinkedIn), and posting the job on your own website.
- Interviews should help you correlate the candidates' experience with your needs. Asking what they like or don't like about their current position will offer insights into whether they'd be a good fit.
- Observing how candidates handle open-ended questions can give you a glimpse of their behavioral characteristics: Are they calm, resourceful, thoughtful, intelligent, mature...?
- Common "red flags" that a candidate may not be a good fit include asking about salary too soon, using a lot of "I" statements, and dwelling on the technical aspects of the job at the expense of talking about how they deal with other people.



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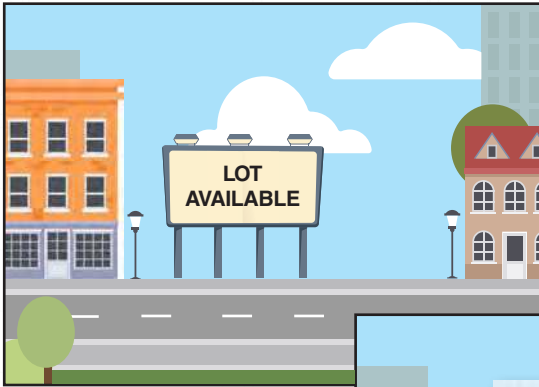


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When to Fight a Claim for Unemployment

■ ALAN A. AYERS, MBA, MAcc

Urgent message: While unemployment insurance claims can cost an urgent care center through higher future premiums, there are multiple considerations for when a center should contest or approve an unemployment claim.

Urgent care centers, as service businesses, frequently experience a high rate of turnover among frontline staff—eg, receptionists, clerks, and medical assistants. Whether an employee quits or is terminated for cause or performance, a common issue for urgent care center owners is determining in what circumstances an employee is entitled to unemployment compensation—and when an employer should contest an employee's claim for unemployment.

One of the most compelling reasons to contest a former employee's claim for unemployment centers on maintaining low unemployment insurance premiums in the future. The cost of just one claim may have a significant impact on the employer's bottom line; the number of claims the employer pays out each year and its effect on the overall business give employers pause to consider fighting an employee's claim for payment.

However, cost is not the only motivating factor for employers. This article will explore some of the other common reasons a company could decide to fight a claim, along with some of the rationales to resist this action.

Background

The California Employment Development Department (EDD) has exclusive jurisdiction to investigate an employee's claim for unemployment benefits and make an eligibility determination in that state.¹ An appeal of the EDD's decision is heard by an administrative law judge.² A claimant may appeal that decision

to the California Unemployment Insurance Appeals Board³ and, if still not satisfied, "may then seek a limited trial de novo in the superior court in an administrative mandate proceeding."⁴

The California EDD, rather than the employer, has the authority to determine whether a former employee can receive unemployment benefits.⁵ In California, terminated employees who claim unemployment benefits will receive the benefits unless the former employer contests the claim. Urgent care center owners in California have the option of contesting an employee's application for unemployment benefits.

Rates

When an employer first starts paying into the unemployment system, it is taxed at a "new employer" rate, based only on how many employees it has.⁶ After a few years, the employer will be assigned an experience rating, which depends on how many of its employees have filed for and received unemployment benefits. The more unemployment claims against an employer, the more it will have to pay. A single unemployment claim can put an urgent care owner into a higher tax bracket.⁷ As a result, some claims may be worth contesting, despite the fact that the urgent care center owner usually does not contest these claims.⁸ If an employer believes a worker is not entitled to benefits, it may decide to file an appeal in order to keep its experience rating as low as possible.⁹

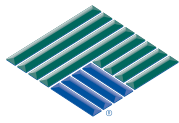
Discussion

There are several reasons for an employer to contest a former employee's unemployment claim. Some cases may be weaker than others, and urgent care center owners should thoroughly investigate each claim in order to understand what happened in each situation. Before contemplating an appeal of a former employee's claim, the owner should be certain his or her managers handled the job termination appropriately according to the company's written policies, and that the employee was clearly not entitled to unemployment benefits.

If an employee was laid off, the employer will have no basis



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to contest an unemployment claim. In addition, there are no grounds to contest the claim if the employee didn't engage in misconduct but was fired for another legitimate reason, such as poor performance, poor judgment, or his or her inability to learn new skills.

In addition to the possible increase in an owner's unemployment insurance rates, these are some of the most common reasons employers contest unemployment claims:¹⁰⁻¹²

Misconduct. In California, the EDD presumes that a terminated employee did not engage in misconduct that would disqualify him or her from receiving unemployment benefits, unless the employer contests the unemployment claim.¹³ Given this standard, an urgent care center owner is prudent to contest a claim only if there are sufficient grounds, such as the employee engaged in serious misconduct or quit without a compelling reason. The owner should be prepared with a strong, practical reason to contest that claim. When an employee is found to have been engaged in misconduct, an urgent care center owner may elect to forfeit its right to contest an unemployment insurance claim in negotiation of a severance agreement—particularly if the fired employee may be litigious. In that instance, the company would agree not to contest his or her unemployment benefits in exchange for the former employee agreeing not to sue the company.

Wrongful termination. Another reason to contest a claim is when an employer is concerned that the employee has plans to file a wrongful termination action. The unemployment application process is a valuable undertaking to discover the employee's version of the facts, as well as an excellent opportunity to collect evidence.

Illegal basis. The employee's claim alleges an illegal basis for the termination. For example, if an employee was fired for poor performance but claims he or she was terminated for reporting sexual harassment by a manager, an employer cannot allow this to go uncontested.⁵

Deterrence. Some employers will contest a claim to act as a deterrent to other workers considering such action, even when they are not entitled to benefits.¹⁴

Image. Similar to the message that is sent to the current staff, there is the public relations side to consider. A business may appear unsympathetic to current employees or to the public if it aggressively contests unemployment claims, even when the business owner has a strong case.⁸

An urgent care center owner should consider the overall cost of mounting an appeal if a claim for benefits is granted. While higher unemployment taxes will have an effect on overall profitability, the same can be said for the effort it takes to contest an unemployment benefit award for a former employee.

Contesting a Claim: Preparation

Prior to contesting an unemployment claim, the owner of an

urgent care center must collect all the necessary documentation, along with the facts of what transpired with the employee. Without a comprehensive file of evidence, statements, and documentation, an appeal is extremely difficult to win. For some facilities, unemployment claims may occur infrequently. As a result, the company must have a system in place to quickly gather relevant information. All urgent care centers should have policies concerning employment evaluations, terminations, and layoffs. Review the current policies to ensure accuracy and compliance with laws and regulations.

In addition, this investigation and documentation-gathering takes some time and effort, as well as the time lost participating in the hearing—all of which have a hard cost to the employer.¹³

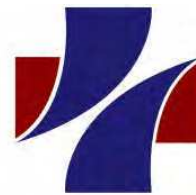
Lastly, in addition to all the considerations an urgent care center owner must make, it is important to point out that employers lose a majority of their appeals. According to the *Wall Street Journal*, employers won only 36% of the over 400,000 unemployment claims that they appealed in the most recent study.¹² This shows the importance of preparation and sound reasoning for making an appeal.

Conclusion

Every claim for unemployment benefits must be considered seriously, with preparation completed long before any claim is filed.¹² Contesting a former employee's unemployment benefits can prove to be expensive and time-consuming. Further, success is not assured. Owners of urgent care centers should understand what is necessary to contest a claim and examine the overall status of their business before deciding to move forward. ■

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An 18 Month-Old-Boy with Vomiting

In *Bouncebacks*, we provide the documentation of an actual patient encounter, discuss patient safety and risk-management principles, and then reveal the patient's bounceback diagnosis. This case is from the book *Bouncebacks!*, available at www.anadem.com and www.amazon.com.

RYAN A. FRITZ, MD

History of Present Illness

John is a healthy 18-month-old boy. One morning shortly after Christmas, he awoke with cough and congestion. After breakfast, he had an episode of vomiting. His symptoms remained mild for 3 days, though he continued to vomit. Two days later, he developed copious diarrhea; when his mother noticed it had red specks in it, she took him to the ED.

Initial Presentation—ED Visit #1

Mother's statement:

"There's something not right with my child; he won't drink. I've seen him sick before, but never this sick. He usually drinks when he's sick. He loves popsicles and juice, but he won't take either."

ED Documentation

Nursing note:

Child well appearing. Happy with mom and wants to be held. Rash on face and under Rt arm. Abdomen soft. Smiles at me once. Zofran administered. Awaiting MD review.

Physician note:

Chief complaint: Blood in stool

History of Present Illness (Per MD)

Mom reports 3 days of diarrhea and vomiting preceded by cough/congestion. Last diaper had specs of blood. In



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daycare with sick contacts. Zofran given in triage and now tolerating PO.

Review of Systems

Unless otherwise stated in this report 10 reviewed and negative.

Past Medical History: (blank)

Allergies: NKDA

Medications: None

Ryan A. Fritz, MD, MBA is Chief Resident and Clinical Instructor in the Department of Emergency Medicine at Vanderbilt University Medical Center. The author has no relevant financial relationships with any commercial interests.

PMH: None

Social History: Lives with mom and dad

Examination:

Vital signs (time 11:00): temp (F) 100.4 TM; Rt 188; pulse 32; resp (blank); syst (blank); diast (blank)

Constitutional: Alert and well developed

Mental status/psychiatric: Age-appropriately responsive to mother

Head: NCAT, soft fontanelle

Eyes: PERRL, EOMI, no discharge or conjunctival injection.

Ears: TMs clear.

Nose: Mild yellow rhinorrhea.

Throat: no lesions or erythema

Neck: Full range of motion, no lymphadenopathy

Lung: Clear to auscultation and breath sounds equal.

Heart: No murmur.

ABD: Soft, Non tender to palpation, no guarding.

Neurological: Grossly non focal.

ED Course

11:15 – Zofran 2 mg ODT. Tolerating po.

DIAGNOSIS: Vomiting, gastroenteritis.

Disposition (12:00): Patient was discharged home by the ED physician. Instructions: follow up with your pediatrician in 2-3 days “if continued vomiting.” Condition upon discharge ____ (*blank*). Rx for Zofran ODT. Return to ER if symptoms change.

The Bounceback

ED VISIT #2 (2 days after initial ED visit)

■ **RN note:** Sick appearing child, severely dehydrated, with gross blood noticed in diaper. Temperature 102.4. Mom reports abdominal pain and bloody diarrhea for 5 days. Petechiae on face decreased per mom.

■ **MD notes:**

HPI: Mom reports child has had 5 days of diarrhea with blood and vomiting. Some abdominal pain, colicky in nature. Not tolerating fluids today. Seen by PCP this morning and had some juice from cup after Phenergan.
PE: T, 102.4; HR, 190; RR, 40; BP, 79/45; Sat, 94%. Child moderately sick appearing dehydrated, sunken eyes dry mucosal membranes. Not playful. Abdomen tender to palpation all quadrants. Gross blood in diaper with diarrhea. (No mention of petechiae.)

ED course: CBC (WBC: 17, H/H: 10/31 Plt: “PND” Pending), Chemistry (Creatinine-1.2, Glucose-80), Stool sent for culture, O&P, leukocytes and C. Diff. 20 cc/kg IV

bolus x 2 administered. 2 mg IV Zofran given.

Testing: US (indication r/o intussusception). Negative
MDM: Patient improved after bolus and tolerating oral Gatorade and part of a Popsicle. Called GI to arrange outpatient follow-up for continued bloody diarrhea. Nuclear Medicine Tech is on vacation and Meckel’s scan can be done Tuesday. Left message for the patient’s PCP to follow up stool studies. Bleeding around IV site has stopped.

Diagnosis: Diarrhea, vomiting, abdominal pain unknown etiology

■ **RN Note prior to dc:** Pt improved, tolerated part of a Popsicle and 4 oz of Gatorade. One bowel movement prior to discharge with scant blood and diarrhea. Discharge delayed 15min for bleeding at IV site, controlled with 10 min of pressure

ED VISIT #3 (3 days after initial ED visit)

■ John arrives via EMS intubated for respiratory failure, cyanosis, and a heart rate of 45. Compressions were started prior to arrival, but were stopped after a code dose of epinephrine was administered and heart rate had increased to 85 and SBP improved from 50 to 75.

■ Initial vitals HR 65, respirations 20 (intubated), temperature 96.8 and SBP 70.

■ Dopamine drip was started after fluids

■ CT scan of the brain ordered to r/o abuse is negative. CXR showed atelectasis and no signs of infection

■ ABG revealed a concomitant metabolic and respiratory acidosis thought to be due to cardiac arrest and having had multiple days of diarrhea

■ EKG shows only bradycardia

■ Blood work reveals leukocytosis of 25 with a left shift, lactate of 5.6, Hb-6, Platelets-25, Creatinine-2.6, ScVO2-50 and a K-2.9

■ Non-blanching petechiae visualized

■ Vancomycin and Rocephin are started for empiric tx of suspected meningitis

■ LP was deferred because the ER team felt patient was too unstable

■ The patient was paralyzed while the hypothermia protocol was induced

■ Pt transferred to the ICU

ICU Course

■ Multiple rounds of epinephrine and atropine were given for bradycardia

■ Dopamine 35 mcg/kg/min and epinephrine 1 mcg/kg/min is started

■ John codes with PEA arrest followed by asystole

- After 40 minutes of resuscitative efforts John is pronounced dead

Final Diagnosis and Cause Of Death

- Hemolytic uremic syndrome/Thrombotic thrombocytopenic purpura (HUS/TTP)
- Stool cultures tested positive for Stx2 Shiga toxin and O157:H7 *E. coli*

Medical Discussion: Hemolytic Uremic Syndrome

Hemolytic uremic syndrome (HUS) and thrombotic thrombocytopenic purpura (TTP) share many features and are widely believed to exist on a continuum, with HUS much more common in pediatrics. Either syndrome can be seen at any age, but the majority of HUS cases are found between 7 months and 6 years of age. Traditional HUS is defined by the triad of:

1. Microangiopathic hemolytic anemia (MAHA)
2. Thrombocytopenia
3. Acute renal failure

HUS is characterized by endothelial cell injury, intravascular platelet-fibrin thrombi, and vascular damage. The continuation of the disease progresses to include:

4. neurologic changes and
5. fever

This completes the pentad of TTP.^{1,2}

The classic D+ HUS (D for diarrhea) is caused by the deadly Shiga toxin *Escherichia coli* and is often preceded by colitis. Shiga toxin Stx2 is more likely than Stx1 to be associated with D+ HUS. HUS occurs in ≤15% of patients infected with the O157:H7 Shiga toxin producing *E. coli*. Most cases come after outbreaks in places with multiple children in close contact. The most common food-borne cause of HUS is ingestion of undercooked meat, with cattle being the most common animal reservoir.^{1,3}

The D-HUS (no diarrhea HUS) is thought to be mediated by the complement system or familial factors.⁷ The most common D- HUS (atypical HUS or aHUS) syndrome is associated with both lung and CNS infections. It is primarily caused by strep pneumonia with other etiologies suspected, including drugs and sepsis.^{8,9} Unfortunately, atypical HUS is frequently caused by strains of strep pneumonia that are not included in the standard 7-valent or 23-valent vaccines, such as serotype 19A.¹ D- HUS accounts for up to 15% of HUS.⁴ There are no diarrhea-inducing bacterial toxins released, but rather direct endothelial injury from the offending drug/illness which causes a complement factor mutation resulting in aHUS and TTP. Another form of atypical HUS, familial HUS, is caused by a genetic mutation affecting the complement regulatory proteins.⁵

The deficiency of the enzyme ADAMTS-13 plays a special role in TTP. Note the job of von Willebrand factor (vWF) is to promote platelet aggregation, while the ADAMTS-13's job is to degrade vWF before it can induce unnecessary clots. With a deficiency of ADAMTS-13, many unstable platelet-based clots form and are not degraded, so the clotting continues. These platelet aggregations get stuck in the kidneys, causing the acute renal failure seen in HUS/TTP. The subsequent kidney injury may be so severe that dialysis is needed. A similar mechanism is thought to be responsible for the waxing and waning neurologic disturbances seen with the disease.⁶ Clots obstruct cerebrovascular flow and then dissolve, resulting in fluctuating mental status. Colonic ischemia and perforation are also possible from these same micro-emboli. The clots in the vascular system are thought to cause red blood cells to fragment into schistocytes which are pathognomonic for MAHA when found on a peripheral smear. This is a key point: finding schistocytes on a peripheral smear is pathognomonic for HUS.

Mortality rate has dropped to <5% with treatment, but remains as high as 75% in underdeveloped countries. Unfortunately, the diagnosis remains difficult because the onset is so rapid in seemingly otherwise healthy children.²

The cornerstone of treatment for HUS/TTP is plasma exchange (plasmapheresis with fresh frozen plasma exchange). Decreased time to initiation of treatment is directly linked to improved outcomes. RBC transfusion may be considered with severe bleeding when plasma exchange is not immediately available. Platelet transfusion is associated with increased morbidity and mortality, and should be avoided unless directed in consultation with hematology in an acutely life-threatening situation. Aggressive fluid resuscitation is critical to avoid oligoanuric states that are associated with the more serious complications. Ultimately however, dialysis may be required if kidney injury progresses.⁷ ■

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ABSTRACTS IN URGENT CARE

- Vitamin D to Prevent URIs?
- Managing Febrile Babies <3 Months of Age
- New Syncope Guidelines from ACC/AHA/HRS
- Pre-Procedure Antibiotics for Dental Patients with Ortho Implants
- Consider *C diff* in Patients with Unexplained Diarrhea
- Antibiotics-Only vs Appendectomy in Peds with Appendicitis
- Ads Drive Prescription Requests, for Better or Worse

■ SEAN M. McNEELEY, MD and GLENN HARNETT, 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 and Glenn Harnett, MD lead this effort.

Consider Vitamin D Supplementation for Patients Prone to URIs

Key point: Vitamin D supplementation was both safe and protective against acute respiratory tract infection.

Citation: Martineau AR, Jolliffe DA, Hooper RL, et al. Vitamin D supplementation to prevent acute respiratory tract infections: systematic review and meta-analysis of individual participant data. *BMJ*. 2017;356:i6583.

An ounce of prevention would definitely be a good idea when it comes to upper respiratory infection. With the currently limited treatments for the common cold, a chance to prevent them could only benefit patients. This systematic review and meta-analysis of double-blind randomized studies considered 25 trials, including a total of 11,321 participants age 0 to 95 years, considered whether vitamin D supplementation reduced the risk of URI, as well as safety of supplementation. No increased risk of adverse events was noted. Risk of URI decreased overall (odds ratio 0.88 was noted). In those patients with low vitamin D, the odds ratio was even lower at 0.81. For the acute care provider, this at least offers a suggestion for the patient not in

need of antibiotics, but wanting something concrete for their copay. ■

Is the Classical Path Always Needed for Febrile Infants <3 Months Old?

Key point: Outpatient management without antibiotics or lumbar puncture is appropriate for selected febrile infants <3 months of age who have close follow-up.

Citation: Mintegi S, Gomez B, Martinez-Virumbrales L, et al. Outpatient management of selected young febrile infants without antibiotics. *Arch Dis Child*. 2017 Mar; 102(3):244-249.

Despite numerous studies showing the vast majority of children in the 21–90-days-old age group presenting with fever without a source (FWS) have a benign viral disease, a complete septic workup to include lumbar puncture, blood cultures, IV antibiotics, and hospital admission for at least 48 hours has been the classically recommended treatment path for this patient population. This path may lead to unnecessary hospitalizations, nosocomial infections, nonjudicious use of antibiotics, emergence of resistant bacteria, and serious adverse effects of antibiotics. This prospective cohort study investigated patients between 21 and 90 days old who presented to an emergency department (ED) with FWS. Patients were classified as either low or high risk for serious bacterial infection (SBI). Low risk was defined as well appearing, age >21 days, no leukocyturia, absolute neutrophil count <10 000, CRP <20 mg/L, procalcitonin <0.5 ng/mL, and no clinical deterioration during their stay in the ED. All told, 586 patients



Sean M. McNeeley, MD, is an urgent care practitioner and Network Medical Director at University Hospitals Cleveland Medical Center, home of the first fellowship in urgent care medicine. Dr. McNeeley is a board member of UCAOA and

UCCOP. He also sits on the *JUCM* editorial board. **Glenn Harnett, MD**, is principal of the No Resistance Consulting Group in Mountain Brook, AL.

“The new guidelines offer urgent care clinicians a chance to learn the latest evidence-based treatment of patients with syncope.”

at low risk for SBI were managed without a lumbar puncture and treated as outpatients without antibiotics. Only two patients were subsequently diagnosed with SBI; neither had an adverse outcome. The results indicate that in carefully selected infants with FWS, outpatient management without antibiotics and lumbar puncture is appropriate. ■

New Guidelines on Patients with Syncope

Key point: *The differential diagnosis of the cause of syncope is extremely broad and may involve multiple organ systems, comorbid conditions, and diverse histories.*

Citation: Shen WK, Sheldon RS, Benditt DG, et al. 2017 ACC/AHA/HRS Guideline for the Evaluation and Management of Patients with Syncope: Executive Summary. *J Am Coll Cardiol*. 2017 March 9 [Epub ahead of print].

These ACC/AHA/HRS guidelines on the evaluation and management of syncope are quite extensive, with the Executive Summary itself weighing in at 231 pages. The document provides guidance and recommendations on the evaluation and management of patients with suspected syncope in the context of many different clinical settings, causes, and selected circumstances. Particular emphasis was placed on the need to consider the numerous potential sources of syncope, including cardiac arrhythmias, ischemic heart disease, structural heart disease (including CHF, cardiomyopathy and valvular causes), neurogenic causes, orthostasis, reflex conditions, metabolic causes, and many others. Detailed guidance is also applied to age, lifestyle, comorbid conditions, and specific populations. The guidelines include recommendations and algorithms on the essential diagnostic work-up required, suggested consultations, treatment, and disposition of the diverse population of patients who present with syncope. Level 1 recommendations for all patients include a detailed history and physical examination, a resting 12-lead ECG, risk assessment, and admission for all patients with syncope who have a potentially serious medical condition relevant to the cause of their syncope. Those conditions include cardiac arrhythmias, patients with pacemaker/ICDs, cardiac ischemia, cerebrovascular accidents, valvular or structural cardiac abnormalities, severe anemia or GI bleeding, and persistent vital sign abnormalities, among many others. These guidelines represent

an excellent opportunity for urgent care clinicians to become aware of the latest evidence-based treatment of patients who present with syncope. ■

Rethinking Antibiotics Before Dental Procedures for Patients with Orthopaedic Implants

Key point: *Patients with orthopaedic implants rarely need antibiotic prophylaxis for dental procedures unless they meet multiple specific criteria.*

Citation: Quinn RH, Murray JN, Pezold R, et al. The American Academy of Orthopaedic Surgeons appropriate use criteria for the management of patients with orthopaedic implants undergoing dental procedures. *J Bone Joint Surg Am*. 2017;99(2):161-163.

Systemic antibiotic prophylaxis for orthopaedic implant patients undergoing dental procedures has been standard practice for the last three decades. This is despite previous evidence that shows the chance of oral bacteremia being related to prosthetic joint infections is extremely low. Much like during dental procedures, oral bacteremia frequently occurs secondary to normal activities of daily living such as brushing teeth, and eating. These *Appropriate Use Criteria* from the American Academy of Orthopaedic Surgeons were created by an expert panel of dentists, orthopaedic surgeons, and infectious disease physicians after a comprehensive literature review. The five main criteria used to determine the necessity of antibiotic prophylaxis included whether the dental procedure manipulated the gingiva, periapical space, or oral mucosa; whether the patient had a previous history of prosthetic infection; time since implant <1 year; an immunocompromised state; and current poor glycemic control in diabetics. The expert panel reviewed 64 different patient scenarios involving a combination of the above criteria and only voted to strongly recommend antibiotic prophylaxis in eight of those scenarios. Each of those scenarios involved patients who met at least four out of five of the main criteria. Antibiotic choices recommended included ampicillin, ceftriaxone, cephalexin, azithromycin, or clarithromycin. The article also includes a link to a clinical decision app in which a clinician can enter their patient's data and instantly receive a recommendation regarding the use of prophylactic antibiotics in that patient. ■

Diarrhea Due to *C diff* Is on the Rise

Key point: *Think *C diff* with isolated diarrhea.*

Citation: Abrahamian FM, Talan DA, Krishnadasan A, et al. *Clostridium difficile* infection among U.S. emergency department patients with diarrhea and no vomiting. *Ann Emerg Med*. 2017. February 24. [Epub ahead of print]

ABSTRACTS

*Think about C diff
when isolated
diarrhea is present,
even if no risk factors
are identified.*

The incidence of diarrhea caused by *Clostridium difficile* has been on the rise. This prospective study of 10 emergency departments looked at patients >2 years of age with more than three episodes of diarrhea over 24 hours and no emesis to determine the incidence of C diff. A total of 422 patients with a mean duration of 3 days of diarrhea were evaluated. At least one risk factor was present for 41%. A total of 43 patients (10%) were identified as infected. Of those infected, 39.5% had no identified risk factor. For the urgent care provider, this is a good reminder to think about C diff when isolated diarrhea is present, even if no risk factors are identified. ■

Antibiotics-Only vs Appendectomy in Young Patients with Uncomplicated Appendicitis

Key point: Surgical intervention may be avoidable in pediatric patients with uncomplicated appendicitis.

Citation: Huang L, Yin Y, Yang L, et al. Comparison of antibiotic therapy and appendectomy for acute uncomplicated appendicitis in children: a meta-analysis. *JAMA Pediatr.* 2017 March 27. [Epub ahead of print]

This meta-analysis of recent clinical trials comparing antibiotic therapy-only vs appendectomy in pediatric patients with uncomplicated appendicitis suggests that antibiotics-only as the initial treatment may

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ABSTRACTS IN URGENT CARE

"We need better studies to evaluate DTCA risks and benefits."

be a feasible and effective option without increasing the risk for complications. Uncomplicated appendicitis refers to those infections where the inflamed appendix remains intact, as opposed to complicated appendicitis which includes the development of a perforation, abscess, mass, or gangrene. Nonoperative, antibiotic-only treatment was effective in 90.5% of patients reviewed in this analysis. However, the failure rate in antibiotic-only treatment was higher compared with initial appendectomy, especially in cases where an appendicolith was present. Surgery remains the suggested treatment option for pediatric patients with either complicated appendicitis or uncomplicated appendicitis associated with an appendicolith, while antibiotic-only treatment may be appropriate for uncomplicated appendicitis *not* associated with an appendicolith. The authors suggest the need for further RCTs involving antibiotic-only treatment for uncomplicated appendicitis in the pediatric population. ■

How 'Good' Are Good DTC Ads, Really?

Key point: *Ads are having their intended effect—but is this good or bad?*

Citation: Layton JB, Kim Y, Alexander GC, Emery SL. Association between direct-to-consumer advertising and testosterone testing and initiation in the United States, 2009-2013. *JAMA*. 2017;317(11):1159-1166.

If you watched any television recently, you will have seen direct-to-consumer ads for prescription medications. Despite the frightening list of side effects, patients continue to contact physicians about prescribing these medications. This study looks at the relationship of prescriptions for testosterone and direct-to-consumer advertising (DTCA) for testosterone, considering the Nielsen ratings of DTCA and rate of prescriptions for testosterone. Three outcomes were studied: rate of testosterone testing, initiation of medication, and initiation of medication without recent testing. All three outcomes were increased. However, the absolute numbers were small compared with the number of ads seen monthly. Because this was not individual data, this study did not specifically answer study questions of whether the ads increased appropriate testing and initiation or increased prescriptions that may have been not needed, or both. The questions of the benefit or harm of DTCA is very important for all medical care. New treatments for acute illness or injury will likely be advertised at some point, as well. For now, we need better studies to evaluate DTCA risks and benefits. ■



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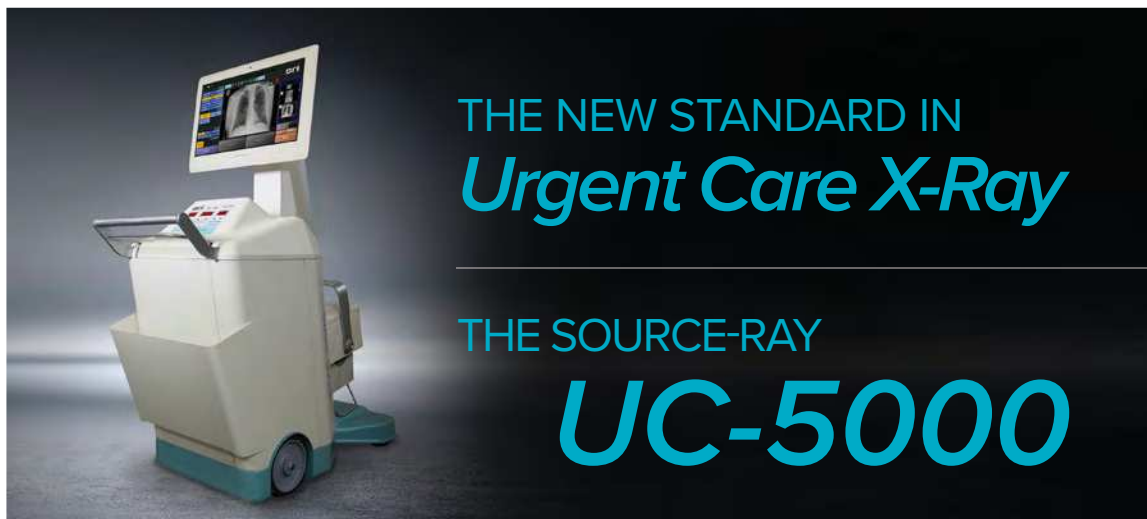
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David J. Cohen, MD is Board Certified in Radiology and the Founder & Medical Director of Teleradiology Specialists



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

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

Elbow Pain and Swelling After a Fall



Case

A 28-year-old woman presents to urgent care with elbow pain and swelling following a mechanical fall. She reports the pain is worse with range of motion. There is no shoulder or wrist pain, and no paresthesias.

Exam confirms pain with palpation and decreased range of motion. The radial pulse is 2+; sensation distal to the elbow is grossly intact. The patient is afebrile, has a pulse of 104, respirations 20, and BP 124/80.

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

THE RESOLUTION

**Differential Diagnosis**

- Fat pad sign
- Osteolytic lesion
- Radial head fracture
- Elbow dislocation
- Nightstick fracture

Diagnosis

The x-ray reveals a fat pad sign, or elevated posterior fat pad, with positive elbow joint effusion. The lateral view of the elbow shows a focal area of lucency in the posterior aspect of the elbow at the level of the olecranon fossa, closely apposed to the bone.

Learnings

- Normal fat in the olecranon fossa is not visible unless up-lifted by joint effusion.
- Elbow fractures may not be evident on an x-ray, but secondary signs, such as a fat pad elevated by bleeding, may indicate that there is a fracture.
- An anterior fat pad is often normal, but if elevated it is abnormal.
- A posterior fat pad seen on a lateral x-ray of the elbow is always abnormal. If a posterior fat pad is identified without a visible fracture, then an occult fracture should be suspected and will be present up to 75% of the time.
- In adults, an occult fracture is usually found to be a radial head fracture, whereas in children it is typically a supra-condylar fracture.

Pearls for Initial Management and Considerations for Transfer

- When performing an x-ray of the elbow, look for a dislocation, bony lesion, fracture, or abnormal fat pad.
- If a fracture is not seen, but an abnormal fat pad is seen, treat the patient “as if” a fracture were seen, with immobilization and orthopedic referral.
- Indications for emergent transfer may include intractable pain, uncertainty of diagnosis, possibility of compartment syndrome, consideration of septic arthritis or necrotizing soft tissue infection (NSTI), potential for dislocation, or a Salter-Harris fracture. ■

Acknowledgment: Image courtesy of Teleradiology Specialists.



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Optimizing Tax ID Numbers, and Coding for Health Risk Assessments

■ DAVID E. STERN, MD, CPC

Q. We are planning to open a new clinic that will offer both primary care and urgent care services. Can we use the same tax identification number (TIN) when we start negotiating contracts with insurance payors?

A. Based on our experience with doing this many times, if you attempt to use the same TIN for both primary care (PC) and urgent care (UC), you are likely to see the following results:

- Some payors are likely to refuse to give both contracts to the same entity.
- Some will be fine with giving both contracts to the same entity, but their processing software will cause major problems with payments. We have seen the payors not pay on the UC patients for months, causing serious cash flow issues. In general, the payor does not upgrade their processing software, and the only solution is two different TINs.
- Some will be fine with giving both contracts to the same entity, but may—unbeknownst to their own contracting specialist—end up processing all claims (UC and PC) at the lowest rate for each line item or each overall claim. Again, in general, the payor does not upgrade their processing software, and the only solution is two different TINs.
- Some payors may offer two contracts to the same TIN and may be able to process accurately claims with POS -11 for office (PC) and POS -20 for urgent care.

Although the last option may happen for a few payors, it is almost certainly not going to work for the majority. Thus, our recommendation is to contract for one TIN for UC and another TIN for PC. ■



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

“Per the AMA, adding the term ‘patient-focused’ to the descriptor of new code 96160 and ‘caregiver-focused’ to code 96161 clarifies the intents of each code, which was lacking before.”

Q. Can you offer guidance on how to use the new codes regarding the completion of health risk assessments?

A. Effective January 1, 2017, the American Medical Association (AMA) deleted Evaluation and Management code (E/M) code 99420, “Administration and interpretation of health risk assessment instrument (eg, health hazard appraisal)” and introduced Current Procedural Terminology (CPT) codes 96160, “Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument” and 96161, “Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument.” These codes were added in the Medicine section to allow alignment with other assessments. They are intended to identify practice expense only, as they are for the administration of the health risk assessment instrument typically given by non-physician clinical staff.

According to the AMA, adding the term “patient-focused” to the descriptor of new code 96160 and “caregiver-focused” to code 96161 clarifies the intents of each code, which was lacking before. For identification of additional components inherently included as part of the services, the phrase, “...with scoring and documentation, per standardized instrument” was added to the descriptor for both codes.

For example, a teenaged patient presents to the urgent care with a possible concussion after being tackled during a football game. An Acute Concussion Evaluation (ACE) form is

completed by clinical staff. Code 96160 can be billed for scoring of the standardized instrument for the patient.

The AMA offers the following clinical example for billing code 96161: "An intellectually disabled patient is accompanied by his parent/caregiver during a preventive medicine service visits. The parent/caregiver admits the patient is increasingly more difficult to manage and things are falling apart at home. The depression inventory is selected and prepared for completion by the clinical staff, who explained the purpose and how to complete the instrument to the patient's parent/caregiver. Upon completion of the instrument by the parent/caregiver, the clinical staff scored the instrument and recorded the results. The clinical staff provided summarizing feedback to the parent/caregiver regarding instrument scoring and provided the physician or other qualified healthcare professional with the results of the depression inventory."

Services provided by the physician are captured in the E/M code reported for the patient encounter. This includes interpretation of the rating scale, discussion of the results, summary report in the patient's medical record, and any referral to the

"Services are captured in the E/M code. This includes interpretation of the rating scale, discussion of the results, summary report in the patient's medical record, and referral to the primary care provider or mental health provider."

parent's/caregiver's personal primary care provider or mental health provider.

Keep in mind these codes are not to be used with codes 99408, "Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes" and 99409, "Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes." ■

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For More Information Contact:
Shawneen Flanders-Clark
Physician Recruiter

sflander@sansumclinic.org
805-689-8256
www.sansumclinic.org

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For more information, contact Amy Silcox, physician recruiter, at 540-224-5187 or amsilcox@carilionclinic.org.


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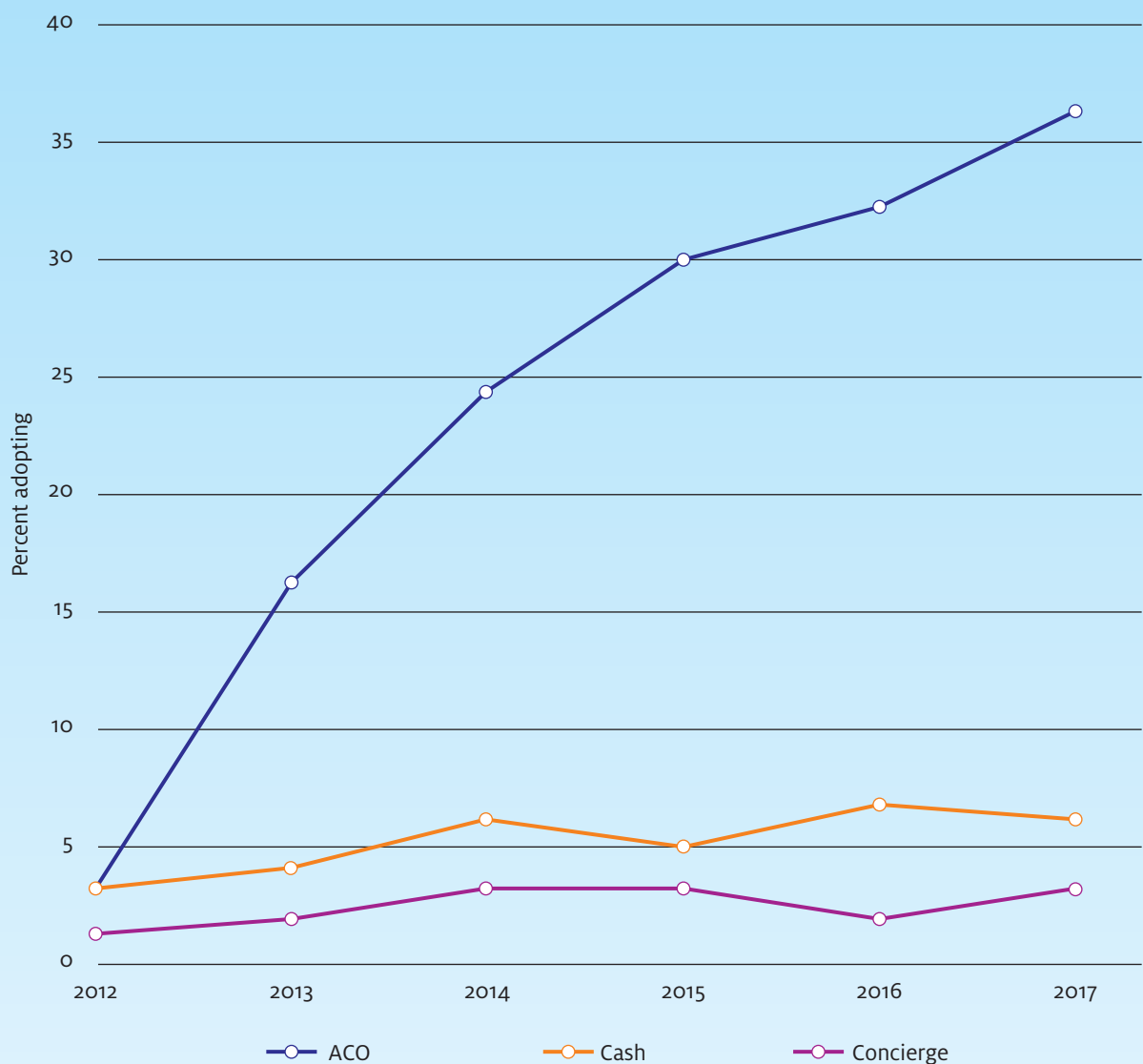


DEVELOPING DATA

Are Alternative Payment Models Catching On?

There's little evidence that emerging payment models (eg, concierge medicine, cash-only practices, and accountable care organizations [ACOs]) are gaining any serious traction in urgent care—but that doesn't mean they're not making headway elsewhere. ACOs, in particular, are growing in usage among physicians, according to the *Medscape Physician Compensation Report 2017*. Usage of cash-only and concierge models is also growing, albeit much more modestly, as the graph below shows.

ADOPTION OF ALTERNATIVE PAYMENT MODELS AMONG PHYSICIANS



Data source: *Medscape Physician Compensation Report 2017*. Available at: <http://www.medscape.com/slideshow/compensation-2017-overview-6008547>. Accessed April 11, 2017.

Data reflect the responses of 19,270 physicians across >27 specialties between December 20, 2016 and March 7, 2017.



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