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Urgent Care
Association
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URGENT CARE
MEDICINE

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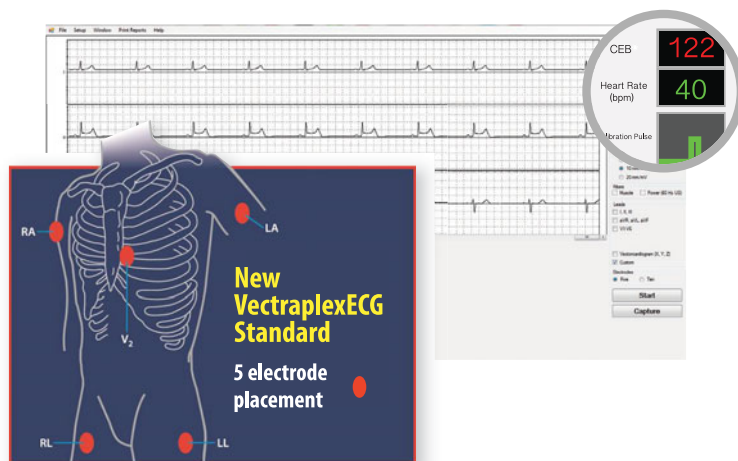
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LETTER FROM THE EDITOR-IN-CHIEF

Quality Improvement: An Urgent Care Imperative



QI – Continuous Quality Improvement: The process by which an organization identifies a problem, plans action to address the problem, implements the plan, and reviews the results for effectiveness. In healthcare, we commit to CQI in order to affect outcomes; we focus on systems and process and how inefficiencies and lack of integration lead to undesirable outcomes. We scrutinize and identify a problem and propose a plan to change the process to improve outcomes.

Here's a very simple example: A universally accepted clinical quality goal is to reduce the use of imaging for acute, non-traumatic back pain. A QI initiative would audit the current state of adherence to the clinical standard, then identify aspects of the existing systems and processes that contribute to overuse of imaging. In this example, the EMR could be used as a tool to remind clinicians of the standard when they order back imaging, or patient education could be given during intake for back pain complaints. These are both illustrations of how we can use systems and processes already in place to make small changes that might lead to better outcomes. After implementing the changes, the practice would reassess for effectiveness of their interventions.

As you can see, QI differs significantly from original research. In QI, we are less concerned about methodology, blinding, and causality. The only thing that matters is whether outcomes improve. To that end, QI is inherently approachable, and not intended to consume unreasonable resources and time.

In other words, anyone can do it.

This commitment to QI is especially important for urgent care. As a discipline, we are still defining “best practice” and our role in healthcare delivery. We also want to demonstrate we are committed to making healthcare delivery better. The good news is that the very existence of urgent care was initiated out of the desire to make healthcare delivery better, to make it more efficient and patient focused. Our discipline was literally born out of a collective and transformational QI initiative. We are natural problem solvers, a great fit for QI efforts.

At *JUCM*, we believe we have an obligation to be a forum for discipline development and advancement. To date, we have focused on clinical and practice management content that

“teaches” best practice but we have not been a voice for practice-level quality improvement initiatives.

With this issue, we begin the conversation by publishing a report focused on a simple, yet effective, QI project from a rural urgent care group in Texas. They recognized that they were seeing a lot of patients with undiagnosed chronic diseases like hypertension. Like most urgent cares, they referred these patients to primary care, often by giving them a card with the practice information on it. When they audited this process, they realized that many of the patients never followed up as suggested. They recognized that the “handoff” to primary care was incomplete, but that there was an opportunity for improvement, ultimately resulting in better compliance. They were right. They implemented a new process by which the urgent care made the PCP appointment prior to discharge and were able to demonstrate a higher rate of follow-up.

The publication of this QI project represents a commitment from *JUCM* to encourage our discipline to improve care and improve practice such that we demonstrate better healthcare outcomes. In support of this goal, Quality Improvement Reports will be a regularly occurring department in *JUCM*. Its success is dependent on contributions from our urgent care community, so we encourage all our readers to submit QI initiatives for consideration of publication in a future issue. For an easy-to-read primer, refer to this Health Resources and Services Administration toolkit: <https://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>.

Pursuit of quality improvement is our mandate as healthcare professionals. You're already part of the urgent care revolution. Let's all continue to work together to move our discipline forward—and improve the lives of our patients in so doing. ■

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



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CLINICAL

11 Improving Appropriate Antibiotic Use for Common Clinical Conditions in Urgent Care

Urgent care clinicians have the power to either further the widespread problem of antibiotic resistance or to curb its growth through antibiotic stewardship—and in so doing, save the lives of patients with common diagnoses.

Patricia Sweeney, PhD, CRNP, FNP-BC

PRACTICE MANAGEMENT

19 Recognizing and Preventing Provider Burnout in Urgent Care



Urgent care demands that providers meet goals for fast patient turnaround and positive patient experiences, which when combined with tight staffing makes recognizing and preventing provider burnout a priority for urgent care providers.

Alan A. Ayers, MBA, Macc

QUALITY IMPROVEMENT

24 Elevated Blood Pressure Referrals in an Urgent Care Setting to Increase Follow-Up Appointments with Primary Care Providers



Chronic conditions typically fall under the broader primary care umbrella. But if you're the first one to discover that a patient has, say, hypertension, how can you increase the odds that they'll follow up with their "regular" doctor?

Barbara Hayes, DNP, FNP-C

CASE REPORT

29 Altered Mental Status in an Elderly Patient Due to Chronic Salicylate Toxicity



When the patient's self-reporting isn't sound, the clinician needs to maintain a high index of suspicion for life-threatening conditions.

Vivian Lei, MD, and Joan Henning, MD

HEALTH LAW AND COMPLIANCE

36 Why Are You Being sued?



Providing so many services to so many patients in urgent care can be a double-edged sword. For every opportunity to help someone, there's the risk of veering off into territory that's a foul of the law. And we're not just talking about medical malpractice.

Frank J. Fanshawe, Esq and Rosemary Weaver McKenna, Esq

IN THE NEXT ISSUE OF JUCM

Your patient doesn't remember doing anything out of the ordinary. All they know is, they're in terrible pain with a joint that's also bright red and swollen. The red-hot joint, as authors Tracey Q. Davidoff, MD and Michael Loeb, MD explain in the next issue of JUCM, can be much more than an uncomfortable inconvenience, though—it can be the cause of significant morbidity and mortality unless you know what to do.

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Mission Statement

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

Affiliations

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We've heard a lot lately about the dangers of overprescribing antibiotics—including in the pages of this journal. However, responsibly reducing the growth of resistance to these life-saving drugs is not simply a matter of writing fewer prescriptions; it's a matter of writing the *right* prescriptions. **Patricia Sweeney, PhD, CRNP, FNP-BC** leads us through an analysis of what that actually means in Improving Appropriate Antibiotic Use for Common Clinical Conditions in Urgent Care, starting on page 11.



It's a distinction that really matters in an era when patients who really do have acute bacterial infections are as likely to run to their neighborhood urgent care center as any other care setting. And as an assistant professor at the Passan School of Nursing of Wilkes University in Wilkes Barre, PA, Dr. Sweeney is the right person to address it.

Of course, improving the quality of the care administered in urgent care centers can mean more than making the right call for the right reasons. Sometimes it means improving the odds that patients will do the right thing after they leave your location, even if you never see them again. Sure, you make referrals for patients to follow up with their primary care provider. But what can you really do beyond that?



Barbara Hayes, DNP, FNP-C, a nurse practitioner at Matagorda Family Practice, near Houston, TX, had a feeling that patients would follow through more often if they had a firm follow-up appointment already made before they walked out the door. So, she and her colleagues actually made follow-up appointments for some patients to see their "regular" doctor while they were still in the urgent care center. Then they compared how many of them actually kept that appointment vs the number of patients who left only with the suggestion to make an appointment for follow-up of a finding of elevated blood pressure. You can find out how well it worked by reading the first of a recurring series of Quality Improvement Reports: Elevated Blood Pressure Referrals in an Urgent Care Setting to Increase Follow-Up Appointments with Primary-Care Providers (page 24).

Recognition of another type of challenge that plagues all care settings—provider burnout—is also best handled from a proactive position, believe it or not. As always, there are a few factors that are unique to urgent care. **Alan A. Ayers, MBA, MAcc** is as attuned to the nuances of this practice setting as anyone, so he's the right person to address Recognizing and Preventing



Provider Burnout in Urgent Care (page 19). And, as with most aspects of practicing medicine, there are symptoms and sign that trouble's ahead, as well as preventive measures that can be taken to head it off. Mr. Ayers is vice president of strategic initiatives for Practice Velocity, LLC and practice management editor of *The Journal of Urgent Care Medicine*.

One stressor you might be able to relate to is the fear of litigation. Even if you practice your profession diligently and avoid the mere



shadow of a medical mistake, in our litigious society you can find yourself being sued for any number of reasons. As attorneys with deep experience in healthcare law, privacy, and data security **Frank J. Fanshawe** and **Rosemary Weaver McKenna**, both principals in the Albany, NY office of Jackson Lewis P.C., have some tips to help you understand how you can minimize your risk for landing in court. Their contribution to this issue, *Why Are You Being Sued?*, starts on page 36.



Another part of the job that can give providers pause is the feeling that something about a patient's presentation just doesn't seem right. It's a feeling you should trust, at least enough to look beyond the obvious signs and symptoms, as in the Case Report presented by **Vivian Lei, MD** and **Joan Henning, MD**, in which (through no fault of her own) a patient's self-reporting shouldn't be trusted entirely. *Altered Mental Status in an Elderly Patient Due to Chronic Salicylate Toxicity* begins on page 29.

Dr. Lei is a PGY3 at Vanderbilt Emergency Medicine; Dr. Henning is an assistant professor of Emergency Medicine at Vanderbilt University Medical Center.

Also in this issue:

Sean M. McNeeley, MD and **Glenn Harnett, MD** share their insights into current literature applicable to everyday practice in the urgent care center in *Abstracts in Urgent Care*. This month, that includes a look at new data measuring potential risk with oral steroids; maintaining clear protocols for antibiotic use in children with urinary tract infections; getting faster spontaneous voiding for clean-catch urine in infants; and more.

Finally, **David E. Stern, MD, CPC** counsels readers on maximizing reimbursements when coding for repairing multiple lacerations. Understand how complexity and method of closure can make a big difference! ■



CONTINUING MEDICAL EDUCATION

Release Date: June 1, 2017
Expiration Date: June 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

Accreditation Statement



This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Case Western Reserve University School of Medicine and the Institute of Urgent Care Medicine. Case Western Reserve University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

Case Western Reserve University School of Medicine designates this journal-based CME activity for a maximum of 3 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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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.

Improving Appropriate Antibiotic Use for Common Clinical Conditions in Urgent Care (p. 11)

1. Which of the following is true?

- a. Antibiotic resistance is a serious public health threat in the U.S., resulting in more than 2 million people who become ill with drug-resistant organisms annually and 23,000 who die as a result
- b. Antibiotic resistance is not a problem as long as the patient completes their whole prescription
- c. When acute sinusitis is diagnosed, prescribing antibiotics always results in rapid resolution of the patient's symptoms
- d. Antibiotic resistance may occur, but no one has ever died as a result
- e. Although acute bronchitis is almost always viral in origin, treatment with antibiotics "just to be sure" is a good idea

2. Which of the following is true?

- a. Acute rhinosinusitis is common in urgent care and is associated with the most antibiotic prescriptions
- b. About 12% of adults in the U.S. were diagnosed with rhinosinusitis in 2012
- c. Over 90% of all cases of rhinosinusitis are viral
- d. Approximately 50% of adults and 89% of children diagnosed with rhinosinusitis receive an antibiotic
- e. All of the above

3. A cold is a self-limiting, nonspecific upper respiratory infection that is the most frequent acute illness in the U.S. causing symptoms of low-grade fever, cough, rhinorrhea, nasal congestion, sore throat, headache, and body aches. The type of virus varies by season. How many viruses have been shown to be responsible for the common cold?

- a. 5
- b. 10
- c. 15
- d. 20
- e. >200

Preventing Physician Burnout in Urgent Care (p. 19)

1. According to the article, physician burnout is defined as:

- a. A long-term stress reaction that manifests itself in dysfunctional behaviors
- b. A dead-end consequence of long-term drug and alcohol abuse
- c. A decision to put out one's cigarette and quit smoking for good
- d. None of the above
- e. All of the above

2. According to the article, which of the following factors contribute to physician burnout in urgent care?

- a. Fast-paced patient care environment
- b. Increasing regulatory demands on physicians
- c. Cumbersome electronic medical record systems
- d. Conflicts in values and leadership
- e. All of the above

3. Which of the following does the article cite as indicative of an unbalanced work/personal life?

- a. Work becomes an ongoing obstacle to participating in activities with family and friends
- b. Physicians lose their desire for self-care, ignoring personal time, exercise, and small indulgences
- c. Personal life becomes a stressor in itself and, thus, something physicians want to avoid
- d. None of the above
- e. All of the above

Case Study: Altered Mental Status in an Elderly Patient Due to Chronic Salicylate Toxicity (p. 29)

1. The clinical signs and symptoms of acute and chronic salicylate poisoning are similar and include which of the following?

- a. Nausea and vomiting
- b. Tinnitus
- c. Dyspnea
- d. Hyperventilation
- e. All of the above

2. Why are elderly patients more likely to develop chronic salicylate toxicity?

- a. Chronic renal insufficiency and coadministered medications
- b. Cost of medications
- c. Geographic considerations
- d. Because women live longer than men
- e. Loss of fat tissue in the skin

3. Which of the following is true?

- a. Elderly patients should always have a family member present during the encounter
- b. Patients and family should be questioned specifically about over-the-counter or herbal medications
- c. Confidential conversations should occur first with the children, then with the patient
- d. Elderly patients generally have excellent hearing and proprioception
- e. Elderly patients never confuse medications due to vision problems



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Next Steps to Success: Distinguish Your Center with Accreditation

■ LAUREL STOIMENOFF, PT, CHC

As on-demand healthcare continues to grow, accreditation from the Urgent Care Association of America can differentiate you from the pack. UCAOA's is the only accreditation that recognizes and requires a distinct urgent care scope of services.

UCAOA also offers certification, either exclusively or for those on the path toward accreditation. Certification is based solely on the scope of services. UCAOA has recently expanded its certification options to recognize the seasonal-, rural- and occupational medicine-focused urgent care centers.

Centers meeting criteria for accreditation are dually recognized as Certified and Accredited.

Why Pursue UCAOA Accreditation?

When accreditation standards become routine practice, centers benefit from unanticipated efficiencies; including staff in the values of quality and safety may foster more engaged, customer-focused employees. Similarly, achieving accreditation requires teamwork that generates a sense of pride and accomplishment.

Examples of key quality and safety procedures required to achieve accreditation include:

- Verification of patient identity before providing care
- Precautions to prevent medical errors
- An overarching quality plan
- An infection control and prevention plan
- Demonstration of integrated care processes

In addition, accreditation demonstrates that centers have achieved excellence in eight critical areas:

1. Patient care processes
2. Patient privacy/rights/responsibilities

3. Scope of care
4. Physical environment
5. Health record management
6. Quality improvement
7. Governance
8. Human resources

UCAOA Accreditation is a trustworthy "seal of approval" for patients armed with mobile devices—and instant access to patient reviews. Accredited centers undergo site surveys to ensure they meet established and defined standards, giving patients the confidence that the center has demonstrated its commitment to excellence. Accredited centers market their achievement to payers and networks, as well as prospective referral sources such as pharmacists, physicians, school nurses, employers, and risk managers.

Members have told us some health plans require accreditation for new urgent care centers. With more intending to do the same, applications for accreditation are on the rise.

Medical malpractice insurance carriers are recognizing UCAOA Accreditation for its impact on quality and safety, with some offering organizations a risk management credit of 2.5% to 15% once accreditation is attained.

Not Ready to Commit? Consider UCAOA Certification

While it is most cost-effective to pursue certification at the same time as accreditation, the UCAOA Certified Urgent Care program can be a first step toward accreditation. It affirms the urgent care center's scope of practice meets UCAOA criteria for easy access and scope of services. In one state, certification allows the urgent care center to receive higher reimbursement through the state's workers' compensation fee schedule.

UCAOA is proud of the centers who have attained certification and accreditation. There are many ways to demonstrate a commitment to quality and safety, but we can assure you these individuals are doing their part to raise the bar! ■



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



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Improving Appropriate Antibiotic Use for Common Clinical Conditions in Urgent Care

Urgent message: Increasingly, patients with symptoms of acute infection run to their nearest urgent care center. As such, urgent care clinicians can contribute greatly to national efforts to save lives by stemming the growth of antibiotic resistance through good antibiotic stewardship.

PATRICIA SWEENEY, PhD, CRNP, FNP-BC

Despite being a recent healthcare phenomenon, urgent care centers are responsible for a growing percentage of outpatient healthcare, with an estimated 160 million total annual visits at more than 9,300 sites in the United States.^{1,2} This is attributed to long wait times in hospital emergency departments for nonemergent care, the shortage of primary care providers, a greater number of patients entering the healthcare system due to the Affordable Care Act, and patients' desire for immediate access to care.² These clinics do not require appointments, are usually conveniently located, are open 7 days a week, and have extended evening hours. This makes them an attractive option for patients seeking medical care for common episodic illnesses.

Urgent care is considered a cross between emergency care and family practice, with the predominant focus on acute presentations of disorders on the lower end of disease severity.³ The majority of patients present with symptoms of acute respiratory infections such as cough, fever, and sore throat and are diagnosed with the common cold, rhinosinusitis, pharyngitis, influenza, acute otitis media, bronchitis, and pneumonia. These account for up to 60% of patient visits.^{1,4}

While these problems can be viral or bacterial in nature, they are often associated with antibiotic use. It is estimated that up to 50% of antibiotics prescribed in outpatient settings are either unnecessary or are inappropriate in selection, dose, or duration.⁵ This type of



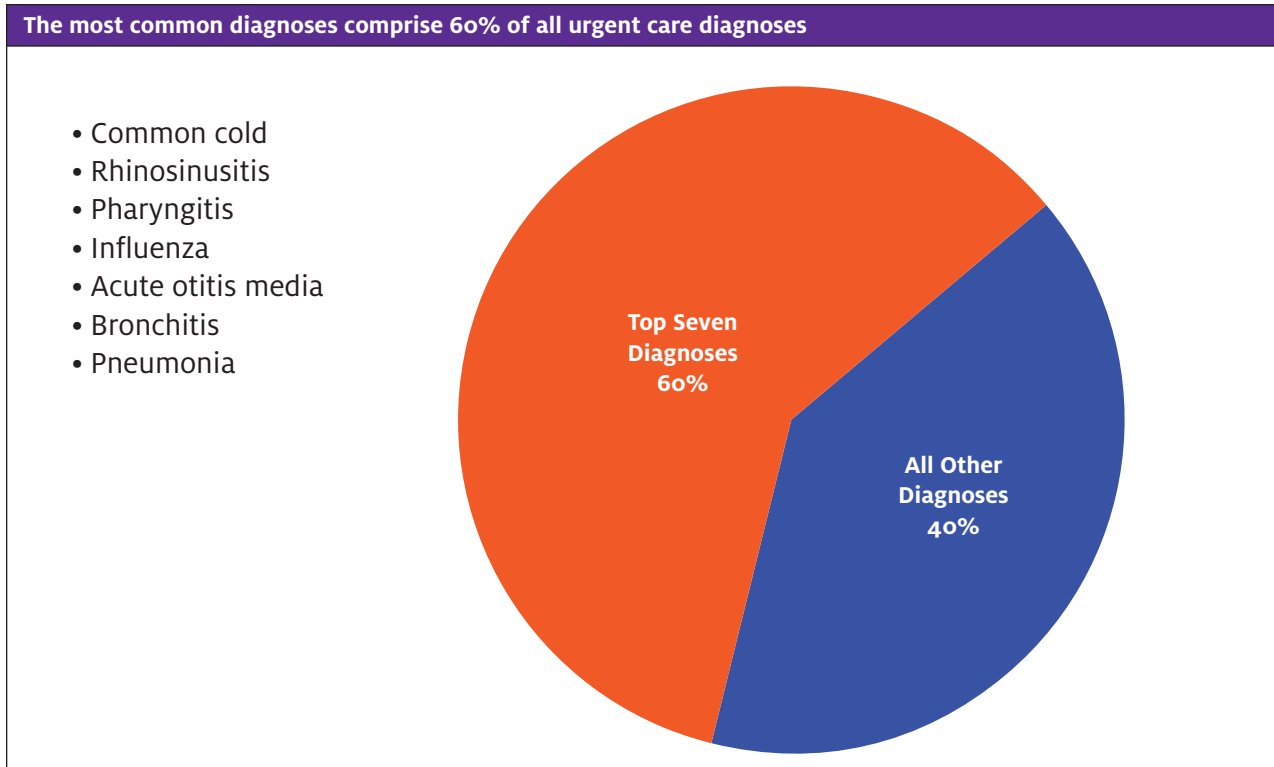
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prescribing is the main factor contributing to antibiotic resistance, making this a concern in urgent care sites and requiring the education of providers.⁵⁻⁷

Antibiotic Resistance

Antibiotic resistance is a serious public health threat in the U.S., resulting in more than 2 million people who become ill with drug-resistant organisms annually; 23,000

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die as a result.⁷ While antibiotic resistance was once only associated with hospital settings, recent data show there are now resistant organisms in outpatient settings.⁸ Clinicians play a part by giving antibiotics for illnesses when they are not needed. Some reasons cited for this are patient expectations, limited time with patients, poor communication, and the uncertainty of a diagnosis.⁹

A poll of urgent care providers found that 17% of respondents reported writing a prescription for an antibiotic even when a viral infection was suspected because patients demanded one.¹⁰ Since providers in urgent care usually do not have an established relationship with patients, it may be more difficult to resist the pressure when patients request an antibiotic. Diagnostic uncertainty also influences when antibiotics are prescribed. Many URIs initially present with similar symptoms, so it can be difficult to distinguish problems where an antibiotic truly is needed. Physical exam findings such as fever, purulent sputum, and tonsillar exudate have been found to have higher rates of antibiotic prescriptions for URIs.¹¹ A national plan for antibiotic stewardship in outpatient settings has been developed to combat antibiotic resistance. This plan incorporates the use of clinical guidelines to assist providers in making an appropriate diagnosis and treatment for many of the

common disorders in urgent care.¹²

In order to understand the problem of inappropriate antibiotics in urgent care, it is important to learn about common clinical problems and how antibiotics are used for those conditions. Typical upper respiratory conditions seen are among those associated with inappropriate prescribing.⁵ It is well known that the majority of URIs, including rhinosinusitis, acute bronchitis, the common cold, and pharyngitis are viral and will not respond to antibiotics.⁵ It is important to distinguish a viral from bacterial causes using established criteria and current evidence to support clinical decision making.

Common Conditions in Urgent Care

The Common Cold

A cold is a self-limiting, nonspecific upper respiratory infection that is the most frequent acute illness in the U.S. Children have up to seven episodes per year, and adults have two to three colds annually.¹³ There are more than 200 viruses that cause the common cold, and these vary by season. Symptoms often include a low-grade fever, cough, rhinorrhea, nasal congestion, sore throat, headache, and body aches. These vary in severity, are usually not severe, and last up to 10 days. Symptoms may last longer in patients who smoke. The

physical exam findings in most patients will show few abnormalities, and the lower respiratory tract is not usually affected. Lung examination is typically clear.^{13,14}

The common cold should be differentiated from other URIs, since antibiotics are never warranted. Patients with the common cold will have nasal discharge (usually clear), compared with those with acute bacterial rhinosinusitis (ABRS) who have purulent discharge and associated facial pressure. Patients with a cold may have a low-grade fever in the first few days, while severe illness in ABRS involves a fever $>102.2^{\circ}\text{F}$. Patients should be monitored for complications of a common cold that may require antibiotics, including acute otitis media and ABRS.¹³⁻¹⁵

Anecdotally, some clinicians find it best to avoid using the term *common cold* with patients, in favor of *upper respiratory infection*, as the latter term “sounds” more like an illness than something “common.”

THE COMMON COLD

Bottom line on antibiotics

- U.S. children catch up to seven colds per year; adults have two or three
- Colds are caused by >200 viruses
- Antibiotics are *never warranted* for patients diagnosed with a common cold

Pharyngitis

Pharyngitis, or “sore throat,” is also a common illness that may be viral or bacterial. It is estimated that 5%–15% of sore throats in adults and 20%–30% in children are caused by group A beta-hemolytic *Streptococcus* (GAS), yet up to 70% of all patients diagnosed with pharyngitis will receive an antibiotic.^{5,16,17} Infection with GAS is the only common indication for antibiotics in patients with a sore throat, given to prevent complications. It may be difficult to distinguish GAS from viral pharyngitis, since they present with a sore throat and pain with swallowing. Fever, headache, or malaise may also be present; some patients also complain of “swollen glands” or anterior neck pain with enlarged lymph nodes. Children may also have abdominal pain or vomiting.^{18,19}

The Centor or modified Centor criteria can be used to identify patients who are more likely to have GAS. Criteria include the presence of fever ($>100.4^{\circ}\text{F}$), tonsillar exudates, tender cervical lymphadenopathy, and absence of cough; some clinicians also consider the age of the patient.^{18,20} Patients who meet ≥ 2 Centor criteria should receive a rapid antigen detection test (RADT) to establish the diagnosis.

A throat culture is recommended to confirm the results of the RADT in children, but not in adults due to the low incidence of GAS in the adult population.^{18,19} Antibiotics should be used only for those with a positive RADT test. A 10-day course of amoxicillin or penicillin V remains first-line therapy. Alternatives for penicillin-allergic patients include cephalexin, cefadroxil, clindamycin, or macrolides. It is important to note that there is an increased resistance of GAS to azithromycin and clindamycin.^{18,19}

PHARYNGITIS (aka, “SORE THROAT”)

Bottom line on antibiotics

- Just 5%–15% of sore throats in adults and 20%–30% in children are caused by beta-hemolytic *Streptococcus* (GAS)
- Up to 70% of all patients diagnosed with pharyngitis will receive an antibiotic

Rhinosinusitis

Acute rhinosinusitis is common in urgent care and associated with the most antibiotic prescriptions.⁵ Approximately 12% of adults in the U.S. were diagnosed with rhinosinusitis in 2012.²¹ It is estimated that 90%–98% of all cases of rhinosinusitis are viral,¹⁵ yet up to 50% of adults and 89% of children receive an antibiotic.^{5,22} Establishing an accurate diagnosis of ABRS is important in preventing antibiotic resistance. Clinical guidelines can assist the provider in identifying those patients who need an antibiotic.^{15,23,24}

Presence of a purulent drainage with nasal obstruction and facial pain/pressure/fullness, or both, that persist without improvement for ≥ 10 days, or severe symptoms at the beginning of the illness in adults, are highly correlated with a bacterial infection.^{15,25} Severe symptoms include fever $\geq 102^{\circ}\text{F}$ and purulent nasal discharge or facial pain lasting ≥ 3 –4 days. Other symptoms indicating ABRS are fever, cough, fatigue, decreased or absent sense of smell, maxillary dental pain, and ear fullness or pressure.¹⁵ Patients may start with a viral URI and develop ABRS, indicated by URI symptoms for 5–6 days with some initial improvement, followed by worsening symptoms such as new-onset fever, headache, and change in nasal discharge.^{15,23,25}

In the pediatric patient, the diagnosis of ABRS is based on the presence of a daytime cough, persistent illness with nasal discharge, or both for >10 days without any improvement. ABRS is also assumed if there is a severe onset of symptoms with a fever of at least 102.2°F with purulent nasal discharge for 3 consecutive days.²⁴

The initial treatment of uncomplicated acute rhinosi-

nusitis in adults is watchful waiting and symptomatic relief.^{15,23} Pediatric patients with mild illness should also be offered observation for 3 days.^{15,24} Patients may need an antibiotic if they do not improve within 7 days or if they worsen at any time.^{15,23,24} One strategy to enhance compliance for observation is to give patients a postdated prescription along with instructions on when the antibiotic is needed. When antibiotics are warranted, there are conflicting recommendations about which antibiotics are first line for children and adults. Standard-dose amoxicillin/clavulanate is recommended for both children and adults by the Infectious Diseases Society of America (IDSA),¹⁵ while amoxicillin may be considered appropriate for some pediatric patients.²³ High-dose amoxicillin/clavulanate is considered for children and adults in regions with high levels of antibiotic resistance to strep pneumoniae, severe infection, children in daycare, antibiotic use or hospitalization within the previous month, presence of a comorbid condition, or extremes of age.¹⁵

Selection of the antibiotic should be based on the organism most likely causing the infection. There is an increased presence of B-lactamase-producing pathogens as a cause of ABRS in children, warranting the recommendation for amoxicillin/clavulanate.²⁴ Duration of treatment is generally 5-7 days for adults and 10-14 days for children, based on severity of the illness or failure to respond within 5 days of treatment. Alternatives for adults are doxycycline, or a respiratory fluoroquinolone for those with penicillin allergies.^{15,23,24} Macrolides and trimethoprim-sulfamethoxazole are not recommended due to high levels of resistance against strep pneumoniae.^{15,23}

RHINOSINUSITIS

Bottom line on antibiotics

- Observation of varying lengths is recommended as initial treatment for adults and children
- Only 2%–10% of all cases of rhinosinusitis are bacterial
- Up to 50% of adults and up to 89% of children with rhinosinusitis will receive an antibiotic

Acute Bronchitis

Cough is a common presenting symptom in urgent care, and acute bronchitis (AB) is the most common diagnosis given to adults presenting with a cough in outpatient settings. It is defined as an acute respiratory infection that involves inflammation of the bronchi, manifesting as a cough, with or without sputum production and lasting ≤ 3 weeks.^{26,27} AB is most often due to a virus, yet there are reports that up to 70% of patients

diagnosed are given antibiotics.⁵ Initially, it may be difficult to distinguish the cough of AB from influenza, rhinovirus, coronavirus, and respiratory syncytial virus since cough is an early symptom. AB should be considered when a cough lasts >5 days, though it may last ≤ 3 weeks. The cough is associated with sputum production in 50% of patients, though the color of sputum is not indicative of bacterial infection.²⁸ For a diagnosis of AB, there should be no evidence of pneumonia, acute asthma, or exacerbation of COPD.^{28,29}

The primary evaluation should focus on identifying the correct diagnosis and any other possible causes of a cough that would need additional evaluation or treatment. Patients with AB usually have few systemic symptoms. They may have wheezing or chest wall tenderness from coughing. Physical exam findings consistent with AB are rhonchi (which often clear with coughing); wheezing may also be present.²⁷⁻²⁹ Indicators that suggest pneumonia or influenza are a combination of fever, cough, sputum production, and constitutional symptoms such as fatigue, malaise, and shaking chills. A chest x-ray may be required if pneumonia is suspected or in patients with abnormal vital signs (pulse >100 /minute, respiratory rate >24 breaths/minute, or temperature $>38^{\circ}\text{C}$), abnormal lung findings, or in patients of advanced age. Treatment of AB is symptomatic. Antibiotics are not recommended.²⁶⁻²⁸

ACUTE BRONCHITIS

Bottom line on antibiotics

- Acute bronchitis is *most often viral* in nature in both children and adults
- Up to 70% of all patients with acute bronchitis will receive an antibiotic

Otitis Media

Acute otitis media (AOM) is an inflammation or infection of the middle ear that can occur at any age, though is most frequent in the pediatric population. It is the most common diagnosis for children's outpatient sick visits and the most common reason for antibiotic use in pediatric patients, with $>80\%$ of children receiving an antibiotic.⁵ AOM, or suppurative otitis media, is distinguished from otitis media with effusion (OME) by the presence of purulent fluid in the middle ear. OME is defined by the presence of fluid in the middle ear, without acute signs of illness or inflammation. OME may predispose a patient to AOM or occur as a result of AOM.^{30,31}

There is no gold standard for the diagnosis of AOM.³² The history findings may differ by age. Symptoms in the

young are nonspecific and may include fever, irritability, sleep disturbances, poor feeding, nausea, and diarrhea. Older children more commonly present with fever and ear pain. Adults have ear pain and decreased hearing, often following a URI or allergic rhinitis. Purulent otorrhea may be present if the tympanic membrane (TM) has ruptured. The physical exam will show varying degrees of inflammation, bulging, or a perforated TM. Pneumatic otoscopy is also recommended to evaluate TM mobility and make visualization of a middle ear effusion more apparent. The diagnosis can be made in children if there is moderate-to-severe bulging of the TM or the presence of a new onset of otorrhea that is not due to otitis externa. Other criteria used for a diagnosis of AOM include mild bulging of the TM with new onset ear pain or significant erythema of the TM. The presence of a TM with bulging, impaired mobility with redness or cloudiness are strong predictors of AOM.^{31,32}

Treatment is based on age and severity of illness. Observation in some pediatric patients is recommended. Clinicians should offer observation as an option for the initial treatment for children ≥ 6 months, with unilateral non-severe AOM and unilateral or bilateral AOM in children aged ≥ 24 months without severe signs or symptoms. Antibiotics are started if there is worsening or failure to improve within 48–72 hours. It is critical to provide information on pain relief for these patients. Antibiotics are recommended for adults, all children 6 months–23 months of age with mild bilateral disease, and for children ≥ 6 years who have severe unilateral or bilateral disease. Severe disease is described as moderate or severe ear pain for at least 48 hours, or a temperature of 102.2°F .^{31–33}

Amoxicillin or amoxicillin/clavulanate for 10 days is first line for children and adults. Selection and dose are based on age, severity of disease for adults, and history of antibiotic use within the previous 30 days or the presence of purulent conjunctivitis in children. Alternative antibiotics include cefdinir, cefuroxime, cefpodoxime or ceftriaxone. It should be noted that macrolides have limited effectiveness against *H influenza* and *S pneumoniae*.^{31–33}

OTITIS MEDIA

Bottom line on antibiotics

- Treatment for otitis media should be based on age and severity of illness
- Antibiotics are recommended for adults, all children 6 months–23 months of age with mild bilateral disease, and for children ≥ 6 years who have severe unilateral or bilateral disease

Solutions

The focus on combatting antibiotic resistance has extended to outpatient settings, including urgent care.^{34,35} The *White House National Action Plan for Combating Antibiotic-Resistant Bacteria* was developed in 2015 with a specific goal to reduce inappropriate antibiotic use in outpatient settings by 50% by 2020.³⁵ Resources for providers, clinic personnel, and patients are available from the Centers for Disease Control and Prevention (CDC),^{12,36–38} the IDSA,³⁹ and the Society for Healthcare Epidemiology of America.³⁹ Recommended strategies include antibiotic stewardship practices, patient and provider education, and tracking and reporting improvements.

Antibiotic stewardship is the effort to measure and improve how antibiotics are prescribed by providers and then used by patients. Key components are for providers to align prescribing practices with evidence-based practice guidelines, evaluate their current practice, and learn to communicate effectively to patients when antibiotics are not needed.^{12,37} While providers are aware that antibiotics should only be prescribed when a bacterial infection is known or suspected, it appears that this is more difficult to implement given the inability to differentiate among some disorders in the early stages of illness. The use of guidelines can aid in decision making, address variations in practice, and assist in the education of providers and patients.⁴⁰ Many organizations publish guidelines, so providers need to identify high-quality, trustworthy guidelines and use them to aid in making decisions about when antibiotics are needed.⁴⁰ Studies show that the use of evidence-based practice guidelines to determine treatment, requiring providers to document/justify antibiotic use, and using treatment algorithms in electronic medical records to support appropriate antibiotic use have been effective at reducing antibiotic use.^{39,41–43}

It may be difficult for providers to implement some of the newer recommendations such as watchful waiting or delayed antibiotics use. In addition, the desire to maintain positive satisfaction scores with patients who request an antibiotic, even when one is not warranted, can be powerful. Some patients feel they've received inadequate care if they leave the visit with "nothing." In order to keep them happy without prescribing an antibiotic inappropriately, it may be helpful to counsel the patient respectfully by saying something along the lines of, "It's not appropriate to give you antibiotics for this infection today, but what we *can* do..." then offer other, more appropriate remedies (eg, cough medicine). It may also be helpful to have a printed sheet with recommendations for nonprescription medications.

In these situations, it is important to involve the patient or family by providing education about changes in recommendations, the appropriate use of antibiotics, the recommended treatment plan, and symptom management. Information about the potential harm of antibiotics, including adverse drug events, should be given.^{37,39} All urgent care staff can participate in antibiotic stewardship by communicating information to patients about the proper use of antibiotics. Providing written educational materials in waiting areas and patient rooms is one recommended approach. Urgent care sites should also perform quality improvement programs to identify improvements in practice. The CDC's *Get Smart* program provides additional resources for patients and urgent care staff.³⁷

Summary

As more patients receive care for common viral illnesses associated with inappropriate antibiotic use in urgent care sites, providers are being called upon to review their own prescribing patterns and develop strategies of antibiotic stewardship. Providers need to incorporate evidence-based practice recommendations to assist in the accurate diagnosis and treatment of commonly presenting illnesses and to differentiate viral from bacterial disease. Urgent care site providers and staff should use available resources and educational materials for patients and all staff related to antibiotic use, and monitor the effects of any programs developed. ■

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Recognizing and Preventing Provider Burnout in Urgent Care

Urgent message: Urgent care demands that providers meet goals for fast patient turnaround and positive patient experiences, which when combined with tight staffing makes recognizing and preventing provider burnout a priority for urgent care providers.

ALAN A. AYERS, MBA, MAcc

It's been said that providers are the lifeblood of any healthcare organization. Indeed, they're the collective engines that make everything go, such that their focused engagement and dedicated patient care are critical for organizational success.

But that dedication often leaves those same providers carrying a heavy mental and emotional burden—leading a growing number to buckle under the stresses and strains of the profession. And although considered part and parcel of the job, providers are succumbing to those stresses to the point where practicing medicine leaves them with an emotional tank that's completely empty. In other words, they're burned out. (Please note that *they* could include *you*, especially if you've experienced feelings of exhaustion, alienation from work-related activities, or that your performance is lagging.)

A mostly silent but decidedly harmful disorder, provider burnout has reached such staggering levels that it's negatively impacting the entire healthcare industry. Unchecked burnout holds devastating consequences for the medical field, from providers quitting medicine altogether, to many of the rest suffering in silence while posing a very real danger to themselves and their patients.

What is Burnout and Why Does It Matter to your Practice?

Mayo Clinic provider Tait D. Shanafelt, MD describes burnout as, "a syndrome defined by depersonalization, emotional exhaustion, and a sense of lowered personal accomplishment." In short, provider burnout is a long-term stress reaction that typically manifests itself in a



variety of dysfunctional behaviors, eg, negative attitudes, a lack of empathy, and decreased energy and enthusiasm. Burnout is such a widespread problem that practices across the healthcare landscape are reporting cases in record numbers—to the tune of nearly half of all surveyed providers admitting to one or more symptoms. Seemingly overnight, the provider burnout epidemic has grown to such unwieldy proportions that health researchers now consider preventative measures, collectively, to be the "fourth aim" of healthcare—just behind improved population health, enhanced patient experience, and cutting costs. Indeed, burnout has grown into the "800-pound gorilla" of healthcare.

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Urgent care providers in particular—working in fast-paced practice environments that strive to maximize efficiency, emphasize patient throughput, and deliver efficient ambulatory care, on demand—find themselves at greater risk for burnout than ever before. Add to that the burden of a constantly evolving practice environment, with its increasing regulatory demands and often-cumbersome implementation of electronic medical records, and the stressors that lead to burnout can mount quickly. For some (especially owner-operators or providers whose compensation is tied to profits), the biggest culprit may be the ever-present desire to increase revenues, which actually drives much of the dysfunctional behavior that results in burned-out providers in the first place. For others, having the sense that they have “no voice” in the workplace can be extremely taxing.

Symptoms of Burnout

While words and phrases like “depersonalization” and “emotional exhaustion” are accurately used to characterize burnout, they leave much to be desired as far as being meaningful descriptors. So, in everyday language, what does provider burnout really look and sound like? In what ways does it manifest? The most common signs of clinical burnout will often include the following:

- Increased apathy toward the minute details of daily clinical practice
- Increased absenteeism and tardiness
- Cynicism and sarcasm toward patients and staff
- A pervading sense of boredom and stagnation
- Shortened attention span and difficulty concentrating for sustained periods
- An inclination towards “busy work” rather than meaningful interactions with staff and patients
- Physical, mental, and emotional fatigue
- Excessive pessimism
- Withdrawal from previously pleasurable pastimes (eg, gardening, vacationing, hobbies)
- Neglect of personal hygiene and healthy habits (such as exercise, diet, and adequate sleep)
- Lingering colds, headaches, insomnia, and chronic ailments of unknown origin
- Feelings of depression, disillusionment, anxiety, and hopelessness

As the above list is not exhaustive, burnout can and does manifest itself in a variety of additional ways. Depression is among the most serious, though, as severely burned-out providers can eventually become suicidal. This sobering conclusion is backed by numerous studies that point to burned-out providers carrying

a suicide risk 3-5 times higher than age-matched non-provider controls. So far, the evidence is indisputable: For providers, burnout can be a matter of life and death.

Causes/Risk Factors of Burnout

Due to the demanding nature of the profession, urgent care providers endure a multitude of stressors in their day-to-day work. As an exercise, look around your own clinic and see if you observe the following trouble signs:

- **A chaotic practice environment** – Is the environment conducive to a smoothly running, well-functioning operation, or is it hectic and chaotic? Are workflows tight and streamlined, or are they inefficient and poorly designed? Are overall wait times excessive, leading to a volatile mix of harried clinicians and irritable patients?
- **Conflicts in values and leadership** – Especially in larger urgent care operations and those aligned with hospital systems, do the administrators and “higher ups” consistently espouse values you don’t align with? Are there regular disagreements and conflicts with regards to, say, operations and patient care?
- **A high tolerance to stress** – Ironically, providers with the highest tolerance for stress are the ones most likely to burn out. In fact, the ability to endure the unremitting slings and arrows of daily practice is said to be a leading predictor of provider burnout.
- **Limited or no control over schedule and free time** – An inordinately high number of late-evening and weekend shifts coupled with few breaks in the work schedule can trigger stress reactions that eventually lead to burnout. A lack of schedule flexibility on top of a demanding workload is also a known burnout precursor.
- **Excessive emotional labor** – Providers who feign a pleasant, positive, and upbeat demeanor with patients—even if they’re feeling anything but—are said to be engaging in *emotional labor*. Excessive emotional labor has long been recognized as a major risk factor for burnout.
- **Too little time spent doing meaningful and satisfying work** – Providers inundated with uncompleted charts, engaged in mortal combat with unwieldy EMRs, or buried in administrative tasks—rather than delivering meaningful patient care—will eventually find their energy drained and enthusiasm sapped.

Lack of Work-Life Balance

In addition to the well-documented on-the-job stress

culprits, unbalanced and dysfunctional personal-life dynamics can result in a double whammy of burnout risk factors. In fact, researchers conclude that a lack of work life balance is the top culprit of provider burnout.

One common indicator of an unbalanced work life dynamic is when work becomes an ongoing obstacle to family events. Typically, quality time with family and friends provides a welcome respite from the stresses of a busy urgent care. But when a heavy workload interferes with that time, the provider begins to obsess, compromising workday focus and concentration. Another example of work life imbalance is when providers gradually lose their desire for self-care. As they struggle to disconnect from obsessing about work, severely stressed providers often get caught in a downward spiral of self-neglect, such that previously satisfying activities and small indulgences wind up on the back burner.

A third instance of work life imbalance, when the personal life itself becomes an additional stressor, might be more injurious than the first two combined. Whether due to financial woes, spousal conflicts, or just the normal trials and tribulations of raising children, a personal life dynamic that *adds* stress rather than alleviates it can put the provider on the fast track toward burnout.

Consequences of Burnout

Clearly, provider burnout is on the rise, and it's exacting a heavy toll on the profession. Already at epidemic levels, unchecked burnout has a number serious consequences on the profession, such as:

- Providers leaving the profession in droves, when the industry is already experiencing a provider shortage
- Higher rates of malpractice suits
- Poor patient satisfaction scores
- An increase in medical errors
- Lowered productivity, morale, and quality of care delivered
- Provider alcohol and drug abuse
- Increased costs in recruiting and procuring replacement providers

Taken together, the statistics, studies, and anecdotes paint a sobering picture: The medical profession is bursting at the seams with stressed-out, burned-out providers, and the damaging side effects can ripple across all aspects of their professional and personal lives. Because as the provider suffers, so does their staff, their patients, and the clinic as a whole.

Negative Energy Balances

All too often, discussions of provider burnout serve to

shed light upon its symptoms, manifestations, and consequences, while rarely examining the root cause. So, what does the research point to as the leading factor? A lack of life-balance skills almost always plays a central role.

The unspoken truth about provider burnout is that clinical training, more often than not, sends providers into practice unequipped to properly “practice” self-care. In fact, they’re more likely to have spent years ingraining the opposite. For physicians, specifically, the rigors of residency essentially “train” medical students to disregard their physical, mental, and emotional well-being in dogged pursuit of high marks and a future career. It should be no surprise then when these dysfunctional and unhealthy habits are later carried into their practice career.

So exactly how does a lack of self-care inevitably lead to burnout? Dike Drummond, MD, a renowned author and speaker on the subject, has built a business coaching physicians to visualize their physical, mental, emotional, and spiritual energy reserves the same way they do a bank account. Providers withdraw from these “accounts” during the course of life and practice, and deposit during times of rest and rejuvenation. The problems begin, says Drummond, when the energy accounts dip below negative for prolonged time periods. And these accounts don’t close; they simply continue going deeper into the red. And when they’ve been negative long enough, burnout symptoms begin surfacing.

What makes burnout so insidious is that a provider can continue to function in a depleted state. While a car with an empty tank will stop running, the provider running on empty continues to trudge along at a severely diminished capacity until they crash and burn.

Strategies for Preventing Burnout

By embracing an improved practice paradigm furthered by Drummond, provider burnout transforms into a *dilemma* that requires ongoing management, rather than a one-time *problem* that has a solution. As there is no one-size-fits-all approach to tackling provider burnout, it must be managed on different levels. To that end, the following breakdown outlines several approaches that workplace researchers and burnout experts have successfully taught to thousands of providers.

Define what you want out of the practice. Studies prove that much of the dysfunctional behavior that leads to burnout is revenue-driven. But in order to successfully manage burnout, revenue must take a backseat to behaviors that better align with the core values that originally led the provider to urgent care. Some examples of core professional values might include the following:

For all clinicians

- *How much do you want to work?* Does a part-time or full-time schedule better align with your values and life circumstances? How much flexibility do you need in your schedule? What percentage of your time are you willing to dedicate to necessary tasks such as email, phone calls, paper work, and patient care?
- *What scope of practice do you prefer?* A wider scope of practice will necessarily increase your workload. What type of work and/or procedures do you love doing? Again, don't allow income to be the sole factor. Think about what gives you the most satisfaction.

For owner-operators

- *Where would you like to work from?* Do you need an office that's close to home? Do you want to share office space to keep rent expenses low? The key is to explore any and all location options towards making your work life easier and more economical.
- *What type of work environment do you prefer?* Do you need an administrative and clerical staff? Would you like to be part of a team of providers?

In short, when laying a new practice foundation, you'll have to make some important decisions that help strike a balance between driving the maximum amount of revenue possible, and a clinic structure that offers you the most satisfaction while creating the least amount of stress.

Restoring the Work-Life Balance

The stresses of clinical practice will naturally deplete your physical, mental, emotional, and spiritual reserves, reducing your effectiveness in providing care to patients. Hence, restoring a healthy balance between personal and work life is critical in keeping those reserves at positive "balances" while also maintaining peak efficiency. The following tips can be used as a guide to help you develop your own approach while optimizing your contributions to the business:

- **Create a life calendar.** Even if it feels unnatural at first, commit to blocking out specific times each week for family activities, socializing with friends, or hobbies and pursuits. Commit to these activities by writing them on a calendar, and carry a snapshot of that calendar with you on your phone. And although you'll have to maintain a degree of flexibility should the clinic really need you, in all other cases you must get into the habit of saying "no," and staying loyal to your life calendar.
- **Incorporate schedule flexibility.** Ask that your clinic provide you a flexible work schedule. Perhaps it would better suit your lifestyle if you could work

longer hours one day and shorter hours the next. Or maybe it's more convenient to start your workday earlier or later on a certain day. Either way, flex scheduling is a great tool for helping providers maintain a healthy personal life balance.

- **Develop a work-life boundary ritual.** Find a symbolic behavior, action, or gesture that signals to your brain that you are now at home, and no longer at work. Perhaps it's changing out of your lab coat, taking a shower, doing some breathing/mindfulness exercises, or reciting a positive mantra. This behavior, when practiced over time, can help strengthen the work life boundary and allow the provider to more effectively recharge.

Additionally, clinics should critically examine their workflows for potential redesigns. Look for ways to alleviate time pressures for providers, and delegate more of the workload to other staff. Don't be afraid to ask your team to help with charting and documentation whenever they can. Also, invite your team to offer their input on how to improve the existing workflows. Provider support groups are another great option, as joining one can provide a safe, confidential place to commiserate and openly talk about not only professional concerns, but personal matters as well. Fellowship—rather than competing—with other providers this way allows for authentic and lasting friendships to form, which is enormously effective at releasing pent-up stress.

Conclusion

Burnout is a rampant problem among providers primarily because they struggle to ask for help when the demands of clinical practice become overwhelming. Due to deeply ingrained "superhero" and perfectionist tendencies, too many providers believe they should be able to shoulder any mental or emotional load, neglect their personal lives, and still perform their jobs at a high level. This dysfunctional way of thinking is of course a dead end, and inevitably leads to stressed, depressed, and ultimately ineffective providers.

To combat burnout, a proper work life balance must be restored, and fiercely guarded against the provider's natural inclination to jump in where they could be delegating. Along with workflow redesigns, support groups, and re-evaluating their core professional values, a healthy work life balance transforms burnout from a problem to be solved into a dilemma that can be effectively managed—allowing providers to enjoy a healthier and more fulfilling professional life. ■

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Quality Improvement Report: Elevated Blood Pressure Referrals in an Urgent Care Setting to Increase Follow-Up Appointments with Primary-Care Providers

Urgent message: Urgent care providers are valued for their ability to treat nonemergent acute healthcare needs efficiently, but in so doing they are also well positioned to identify other, underlying healthcare issues such as hypertension.

BARBARA HAYES, DNP, FNP-C

Introduction

Heart disease is the leading cause of death in the United States and accounts for approximately 24% of all deaths.¹ Many known risk factors are associated with heart disease, including high blood pressure. The Centers for Disease Control and Prevention estimates that 46,000 deaths each year may be prevented through effective treatment of hypertension, with an estimated savings of \$93.5 billion in direct and indirect costs.² However, due to its lack of outward signs or symptoms, high blood pressure often goes untreated. In fact, elevated blood pressure diagnosis often occurs secondary to other injuries and illnesses—many times in an urgent care setting.

Once identified, high blood pressure must be treated effectively, which includes follow-up care with a primary care provider (PCP), in order to reduce the morbidity and mortality rates associated with heart disease.

Urgent care facilities are engineered to treat nonemergent acute healthcare needs, but they are also an excellent source for identifying other underlying healthcare issues like elevated blood pressure. An estimated 3 million people are seen every week in urgent care facilities in the United States,³ and this number is increasing every year, offering new opportunities to address health-



care concerns like elevated blood pressure. Identifying and referring patients with undiagnosed and/or

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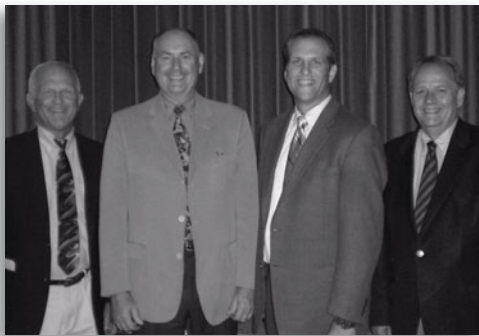
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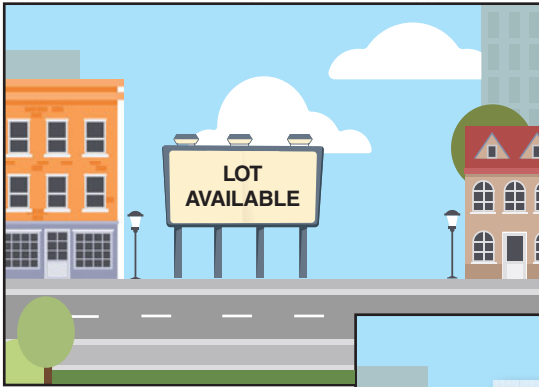
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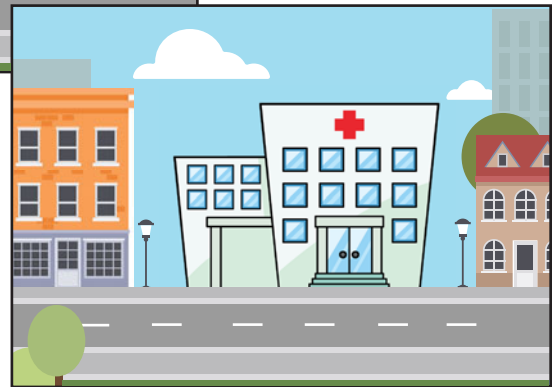
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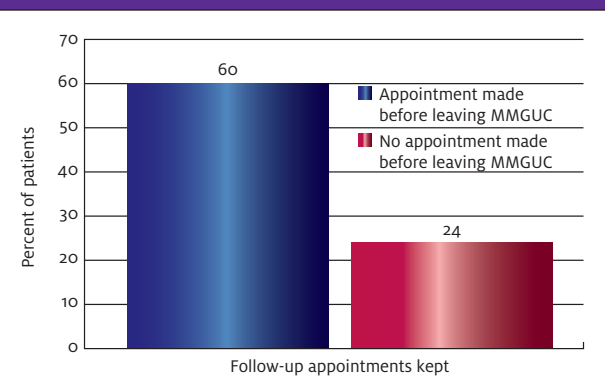
untreated elevated blood pressure during an urgent care visit is a relatively easy and inexpensive way to eliminate barriers in the treatment of hypertension. Follow-up appointments with a PCP may provide continuity of care through coordination and collaboration consistent with the Agency for Healthcare Research and Quality's (AHRQ) model for the Patient Centered Medical Home,⁴ resulting in better long-term health outcomes.

Little research exists on high blood pressure referrals and follow-up care in the urgent care setting or the emergency room setting. The Louisiana State University Public Hospital in New Orleans used a team approach to bridge the gap between newly diagnosed hypertensive patients in an urgent care facility and a PCP for ongoing evaluation and treatment. This method correlated with a study that evaluated the outcome of newly diagnosed hypertensive patients in an ED setting who were started on medications and then referred to a hypertension clinic for a team-approach follow-up appointment within 2 weeks. The results included a 12% increase in patients who had controlled blood pressure, as well as a reduction in healthcare costs.⁵

Another related study involved a nurse-led hypertension referral program for ED patients with blood pressure >140/90 mmHg. When contacted, 136 out of 222 were followed up for their blood pressure by a PCP after being given a referral at the time of discharge.⁶ The American College of Emergency Physicians' Policy Statement on the evaluation and management of asymptomatic hypertension, >140/90 mmHg, includes a referral for outpatient follow-up care.⁷ Shamji, et al⁸ addresses one of the major issues with urgent care referrals, which is the lack of guidelines for care transitions from the urgent care setting to a PCP, and notes that for patients without a PCP, the urgent care center may represent an important opportunity to establish a referral for the patient to a PCP in the community.

As a quality improvement initiative and for my doctoral project, I designed and implemented a project in the Matagorda Medical Group Urgent Care (MMGUC), a rural urgent care facility in Matagorda County, TX to determine whether subjects age 18 years and older who were seen and identified with elevated blood pressure ($\geq 140/90$ mmHg) were more likely to follow up with a PCP if an appointment was established prior to discharge from urgent care, compared with subjects who were identified with elevated blood pressure $\geq 140/90$ mmHg and were told to follow up with a PCP but did not have an appointment made for them prior to discharge from urgent care. The aim of the project was to

Making Follow-Up Appointments for Patients Drives Compliance



increase the number of subjects evaluated further by a PCP after being identified with elevated blood pressure during an urgent care visit.

Quality Improvement Project Results

A retrospective chart review was conducted using electronic medical records (EMR) to identify 50 adult subjects who were treated in the MMGUC for urgent illnesses or injuries and who also had elevated blood pressure $\geq 140/90$ mmHg, to determine whether or not they followed up with a Matagorda Medical Group PCP at 2, 3, or 4 weeks post urgent care visit. This was then compared with a prospective chart review that was conducted using the EMR to track the 50 consented adult subjects (age 18 years or older) who were treated in the MMGUC for urgent illnesses or injuries and who also had elevated blood pressure $\geq 140/90$ mmHg, to determine whether or not they followed up with a Matagorda Medical Group PCP as scheduled by the MMGUC receptionist prior to discharge from the urgent care.

Twenty-four percent, or 12 of the 50 subjects, identified in the retrospective group who *did not* have appointments made for them by the MMGUC staff followed up with a PCP within 4 weeks of the urgent care visit. Sixty percent, or 30 of the 50 subjects in the prospective group who *did* have appointments made for them by the MMGUC staff, followed up with a PCP within 4 weeks of the urgent care visit. Both an independent samples *t*-test and a chi square test of independence were calculated to determine if this information was statistically significant.

The independent samples *t*-test was used to determine whether membership in the retrospective or prospective group had an impact on whether the subject was seen in a follow-up appointment with a PCP (yes or no)

within 4 weeks post urgent care visit. Levene's test for equality was violated at $F = 11.036$, $p = 0.001$, so the t-test results required the use of unequal variances not assumed. The failure to have an equal variance was due to the large difference of 30 prospective subjects that were followed-up by a PCP compared with 12 retrospective subjects that were followed up by a PCP. Since the prospective group was larger in follow-up than the retrospective group by 18 subjects, it violated the assumption that both groups had equal variance. However, after correcting for the unequal variance, a significantly higher difference was noted in the t-test with the prospective group mean of 0.60 ($n = 50$, $SD = 0.495$) compared with the retrospective group mean of 0.24 ($n = 50$, $SD = 0.495$) at $t(96.211) = 3.877$ ($p < 0.0001$). In addition to the t-test, the same data were used to calculate a chi-square test of independence, and was significant at 13.300, $df = 1$, $p < 0.0001$.

Discussion

Making an appointment for subjects with a PCP prior to discharge from the MMGUC significantly increased the number of subjects who followed up with a PCP for further evaluation of their elevated blood pressure according to the independent T-test for this group. The chi-square test was also significant for this group, showing a strong association with follow-up care and making appointments for subjects prior to discharge from the MMGUC. These findings are consistent with literature discussed above regarding improved outcomes when follow-up appointments were made for subjects with high blood pressure seen in emergency and urgent care centers.

Recommendations

Urgent care facilities must develop policies that enable continuity of care through coordination with primary care providers. Scheduling an appointment prior to discharge from an urgent care center can improve access to care and empower patients to take an active role in their own healthcare. Improving collaborative efforts may result in a strong patient-centered team that focuses on the individual needs of the patient, with a goal of increasing the longevity and quality of life for the patient while decreasing the overall cost and disabilities associated with untreated high blood pressure.

Effective collaboration also relies on the use of health information technology for managing chronic health conditions like hypertension. Establishing an interoperable healthcare system that allows the free exchange of healthcare information among the healthcare team

would allow continuity of care between the patient's PCP and the urgent care provider. Unfortunately, few health information systems are able to communicate outside of their own providers. This makes it difficult for individual urgent care facilities and/or individual primary care providers to share information in a timely manner.

More research needs to be done in urgent care settings to establish best practice. This project introduced an intervention of making appointments with PCPs for subjects with elevated blood pressure during an urgent care visit to address the issue of whether or not it would improve the number of subjects who were followed up by a PCP. This was the only variable addressed as to why subjects did not follow up with a PCP after being diagnosed with elevated blood pressure. While the results were significant for this group, this study would need to be duplicated in other settings and other variables need to be considered to determine additional barriers to follow-up care.

Conclusion

Early detection and proper treatment of elevated blood pressure may improve health and decrease costs associated with the number-one cause of death in the United States, heart disease.

While this study has limitations, the results were consistent with other research that supports making referrals for follow-up care prior to patients leaving EDs or urgent care facilities. Future challenges include developing policies that ensure continuity of care between urgent care facilities and PCPs, developing healthcare systems that allow EMRs to be shared between urgent care facilities and PCPs, and doing more research that can be used to develop best practice policies. ■

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Altered Mental Status in an Elderly Patient Due to Chronic Salicylate Toxicity

Urgent message: Urgent care providers must maintain a high index of suspicion for life-threatening conditions when assessing patients whose self-reporting of symptoms can be vague and nonspecific.

VIVIAN LEI, MD, and JOAN HENNING, MD

Introduction

Elderly patients often present for medical evaluation with vague complaints, oftentimes requiring the provider to obtain additional history from family and caregivers. Urgent care providers must maintain a high index of suspicion for life-threatening conditions based on non-specific symptoms. This case demonstrates the importance of recognizing a rare but serious entity: chronic salicylate toxicity in an elderly patient with altered mental status.

Case Presentation

History of Present Illness

An 82-year-old female presents with generalized weakness for the past week. She lives with her husband and had not been able to get out of bed for the last 5 days. Her family stated that she had not eaten in 5 days. According to family members, her mental status was slightly depressed compared with baseline. She did complain of shortness of breath. She did not have chest pain, abdominal pain, vomiting, diarrhea, fever, cough, rhinorrhea, dysuria, headache, rash, blurred vision, or lymph node swelling.

Medical History

NKDA

PMH: Negative

PSH: Hemorrhoidectomy

Meds: Lisinopril, metoprolol, and nitroglycerin



SH: Nonsmoker, drinks two beers daily

Physical Exam

On initial presentation, her vital signs were as follows:

- Blood pressure: 146/65 mmHg
- Heart rate: 92
- Respiratory rate: 22

Vivian Lei, MD and Joan Henning, MD are both emergency medicine physicians at Vanderbilt University Medical Center. The authors have no relevant financial relationships with any commercial interests.

- Oxygen saturation: 100%
- Temperature: 97.6°F

On physical exam, she was alert but appeared dehydrated and mildly cachectic. Examination of the head, eyes, ears, nose, and throat was normal. She had normal respiratory effort and clear, equal breath sounds. Heart sounds were regular without murmurs, rubs, or gallops. Her abdomen was soft, nondistended, nontender, and without rebound or guarding. Her skin felt warm and dry, without visible rashes or lesions.

On neurologic examination, she was oriented to herself and place, but not to time. Cranial nerves II through XII were intact. Strength was 5/5 for flexion and extension in all four extremities. Sensation was intact. Deep tendon reflexes were equal and normal. Finger-to-nose testing was equal and normal bilaterally.

Diagnostic Testing

The patient's fingerstick blood glucose was 95. Her white blood cell count was elevated at 11,800. The rest of her CBC was normal. BMP was abnormal with a sodium of 129 mmol/L, potassium of 3.4 mmol/L, chloride of 95 mmol/L, bicarbonate of 13 mmol/L, and anion gap of 21. Her BUN was 51 mg/dL and creatinine was 1.4 mg/dL.

An electrocardiogram showed no acute changes. Urinalysis was unremarkable.

Based on her concerning BMP findings of an anion gap metabolic acidosis, she was referred to the emergency department for further evaluation.

ED Course

Diagnostic evaluation was continued in the ED, where she was found to have an elevated CK of 310. A troponin-I level was 0.01 ng/mL. Liver function tests were normal. Her d-dimer was >1000 ng/mL. TSH was normal.

A chest x-ray showed no acute cardiopulmonary disease. Based on the patient's elevated d-dimer, a V/Q scan was performed but showed no findings of pulmonary emboli. CT of the abdomen with IV contrast showed a large hiatal hernia, but no other acute findings.

“Common diseases can have atypical presentations in the geriatric population...with multiple complicating comorbidities and medications.”

ED Diagnosis

The patient was diagnosed with dehydration, an anion gap metabolic acidosis, and elevated CK level.

Hospital Course

The patient was admitted to the hospital for 7 days, where additional history provided by her husband revealed that she had been taking large amounts of aspirin for hip pain. Her salicylate level was five times the normal level. Nephrology evaluated the patient and felt that hemodialysis was not required emergently. She was hydrated aggressively and her anion-gap

acidosis improved over 3-4 days. Her hyponatremia and renal function improved with IV fluids. Her mental status improved slowly, and Psychiatry was consulted. Her delirium was determined to be multifactorial, and eventually she became fully oriented and appropriate. She was discharged to a short-term rehabilitation facility for physical therapy.

Discussion

Common diseases can have atypical presentations in the geriatric population, often presenting with the challenge of multiple complicating comorbidities and multiple medications. This case was difficult due to a lack of information about the patient's over-the-counter medications—she did not offer this information, but it is difficult to know if she was specifically asked. In patients who cannot provide a coherent history, utilize any additional sources of information, such as family or caretakers.

Aspirin remains a common over-the-counter analgesic and is regularly prescribed for cardiovascular and cerebrovascular disease. Once ingested, it is rapidly converted to salicylic acid, which acts directly on the medullary respiratory center, often leading to hyperventilation and a respiratory alkalosis. It also uncouples oxidative phosphorylation, leading to a metabolic acidosis. The resulting mixed acid-base presentation is classic for salicylate poisoning. Other salicylate formulations exist, such as topical salicylic acid, methyl salicylate (oil of wintergreen), and bismuth subsalicylate (eg, Pepto-Bismol).

The clinical signs and symptoms of acute and chronic salicylate poisoning are similar, and include nausea and

vomiting, tinnitus, dyspnea, hyperventilation, tachycardia, hyperthermia, and neurologic manifestations such as lethargy, confusion, delirium, agitation, hallucinations, seizures, and coma.¹ However, symptoms are milder and often have an insidious onset in chronic poisonings, leading to delayed or even missed diagnosis; this has been associated with higher morbidity and mortality.²

In this case, the diagnosis of salicylate toxicity was not made until the patient was hospitalized and further history obtained from the family.

The management of salicylate toxicity varies between acute and chronic ingestions. The “tip off” in this case was the presence of metabolic acidosis, as demonstrated by the serum bicarbonate level of 13, with an anion gap of 21.

The classic mnemonic of MUDPILES should be considered:

M – methanol, metformin
U – uremia
D – diabetic ketoacidosis
P – phenformin
I – iron
L – lactate
E – ethanol ketoacidosis, ethylene glycol
S – salicylates

With appropriate history, serum salicylate levels should be drawn; however, salicylate levels correlate poorly with symptoms, thus making serum levels an unreliable marker of illness. A patient’s clinical condition should ultimately guide therapy.

Treatment of *acute salicylate toxicity* consists of use of activated charcoal, restoring intravascular volume, alkalization of the serum and urine, and supportive measures. In patients presenting with acute lung injury, renal failure, seizures or coma, deteriorating clinical status, or persistent acidemia refractory to treatment, dialysis should be considered.

Chronic toxicity, which can occur even with therapeutic salicylate concentrations, is treated with drug withdrawal and supportive therapy in the absence of significant end-organ dysfunction.

The majority of poisonings in the elderly are unintentional

*“Urgent care providers
 can play a key role
 in early identification
 of possible medication
 toxicities.”*

and may result from underlying dementia, improper use of the product, improper storage, or mistaken identities.³ Elderly patients are more likely to develop chronic salicylate toxicity due to chronic renal insufficiency and coadministered medications.⁴ Salicylates should be considered early in the differential diagnosis of an unexplained acid–base abnormality, especially in elderly patients with nonfocal neurologic abnormalities.⁵

Urgent care providers can play a key role in early identification of possible medication toxicities by specifically inquiring about nonprescription medications and remedies. In any patient with suspected poisoning or medication toxicity, urgent care providers should call the United States Poison Control Network at 1-800-222-1222 to obtain emergent consultation with a medical toxicologist.

Take-Home Points

- Elderly patients with altered mental status require a thorough medical evaluation for high-risk clinical conditions.
- Patients and family should be questioned specifically about over-the-counter or herbal medications.
- Chronic salicylate toxicity is a life-threatening poisoning which has a subtle clinical course with a gradual onset of symptoms.
- Chronic salicylate toxicity must be considered in the presence of an unexplained anion gap metabolic acidosis and altered mental status.
- Management of salicylate toxicity is based on the patient’s clinical picture, rather than the serum salicylate level. ■

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ABSTRACTS IN URGENT CARE

- Reducing Inappropriate Prescriptions for Ped UTIs
- No Medications Are Risk-Free
- Faster Voiding for Clean-Catch Urine in Infants
- Spinal Manipulation for Low Back Pain
- Arrhythmia Risk No Higher with Azithromycin than with Amoxicillin
- How Soon is 'Too Soon' for hs-cTnT to Assess for AMI?
- New 'Leads' on Detecting MIs Faster

■ SEAN M. MCNEELEY, MD and GLENN HARNETT, MD

Each month the College of Urgent Care Medicine (CUCM) 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.

Taking Aim at Inappropriate Antibiotic Use in Children

Key point: *Use of a standard protocol for urine culture follow-up and discontinuation of unnecessary empiric antibiotics was both effective and safe in a high-volume pediatric care network.*

Citation: Saha D, Patel J, Buckingham D, et al. Urine culture follow-up and antimicrobial stewardship in a pediatric urgency care network. *Pediatrics*. March 16, 2017. [Epub ahead of print]

This quality improvement study's objective was to improve follow-up management of negative urine culture results in urgent care centers to reduce inappropriate antibiotic exposure in children. Using a multidisciplinary task force, the authors created and implemented a protocol for routine nurse and clinician follow-up of urine culture results, discontinuation of unnecessary antibiotics, and documentation in the medical record. The authors followed 910 patients who received empiric antibiotic therapy for UTIs but had negative urine culture results. Using the protocol, the antibiotic discontinuation rate increased from 4% to 84%, avoiding 3,429 (40%) of 8,648 antibiotic days prescribed. Of those patients who discontinued antibiotics, none was diagnosed with a UTI within 14 days of the initial urgent care encounter. The use of urine culture

follow-up management has immediate potential to improve antibiotic stewardship in the urgent care setting, with minimal burden on staff and clinician operational efficiency. ■

New Data Measure Risks with Oral Corticosteroids

Key point: *Remember—all medications have risks!*

Citation: Waljee AK, Rogers MA, Lin P, et al. Short term use of oral corticosteroids and related harms among adults in the United States: population based cohort study. *BMJ*. 2017; 357:j1415.

This cohort study looks at patients with short-term steroid use (<30 days) and potential complications at 30 and 90 days out. Endpoints included fracture, sepsis, and blood clot. This study included 1.5 million patients 18-64 years of age. Over 1/3 used steroids in a 3-year period. The incidence of the endpoints was at least double for all three events. Study weaknesses include retrospective nature and lack of ability to randomize. For urgent care providers, the most important take away is that no medication is benign, and risks must be balanced with advantages of treatment. ■

Faster Spontaneous Voiding for Clean-Catch Urine in Infants

Key point: *Gentle suprapubic cutaneous stimulation with gauze soaked in cold fluid (the Quick-Wee method) was shown to increase the rate of spontaneous voiding in infants requiring a clean-catch urine sample.*

Citation: Kaufman J, Fitzpatrick P, Tosif S, et al. Faster clean catch urine collection (Quick-Wee method) from infants: randomised controlled trial. *BMJ* 2017;357:j1341.



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

This randomized controlled trial of 374 Australian infants 1-12 months of age was undertaken to determine if a simple stimulation technique would increase the rate of spontaneous voiding for a clean-catch urine within 5 minutes. Infants were randomized either to stimulation using gentle suprapubic stimulation with gauze soaked in cold fluid (the Quick-Wee method) or standard clean-catch urine collection with no stimulation. The Quick-Wee method resulted in a higher rate of successful urine sample collection (30%) than standard urine collection (9%). There was no statistical difference in contamination rates between the two methods, and both parents and clinicians reported greater satisfaction with the Quick-Wee method. Of note for U.S. urgent care clinicians, and in contrast to the current UK guidelines, the American Academy of Pediatrics guidelines for urine collection only recommend noninvasive urine samples for screening purposes. Invasive catheterization or suprapubic aspiration samples are required by the AAP guidelines for definitive diagnosis prior to starting antibiotic therapy. ■

Some Studies Find Improvement and Low Risk in Manipulation for Back Pain

Key point: Modest benefit with spinal manipulation for low back pain noted.

Citation: Paige NM, Miake-Lye IM, Booth MS, et al. Association of spinal manipulative therapy with clinical benefit and harm for acute low back pain: systematic review and meta-analysis. *JAMA*. 2017;317(14):1451-1460.

This systematic review looks at spinal manipulation as a treatment for low back pain. The main outcome assessed was pain, with an attempt to look for potential harm. There was improvement noted in some but not all studies. Heterogeneity of results not explainable by variables present further confused this review. No serious long-term adverse events were reported. For the urgent care provider, this is one more modality that may benefit and is unlikely to cause significant harm. Patients should understand it is not a perfect answer, but one possible treatment. ■

No Increased Arrhythmia Risk with Azithromycin vs Amoxicillin

Key point: Azithromycin use was associated with an increased risk of ventricular arrhythmia when compared with nonuse of antibiotics but not did not increase risk of arrhythmias when compared with amoxicillin use.

Citation: Trifirò G, de Ridder M, Sultana J, et al. Use of azithromycin and risk of ventricular arrhythmia. *CMAJ*. 2017;189:E560-568.

This retrospective nested case-control study captured over 14 million new outpatient antibiotic users (no antibiotic use within the prior year) aged 85 or younger over a 13-year period. They

identified 12,874 (0.1%) users that developed a ventricular arrhythmia during the study period. Of those, 30 developed a ventricular arrhythmia while concurrently taking azithromycin. These 30 patients were compared to up to 100 control patients of the same age, sex, index date and database. Results revealed that compared with nonuse of antibiotics, the current use of azithromycin was associated with an increased risk of ventricular arrhythmias (OR 1.97, 95% CI 1.35-2.86). However, when comparing current use of azithromycin to current use of amoxicillin, there was no increase in risk of arrhythmias. The authors speculate that confounding by indication likely played a major role in the assessment of the association between current azithromycin use and ventricular arrhythmias because the increased risk disappeared when current amoxicillin use was used as the comparator. *Confounding by indication* refers to the increased baseline risk of ventricular arrhythmias associated with the indication of the antibiotic use (ie, the infection) rather than the exposure itself (ie, azithromycin). Caution is suggested in interpreting these results, as this study's findings conflict with several previous studies of potential azithromycin arrhythmic effects. ■

Ruling Out AMI with a Single Cardiac Troponin Enzyme Sample is Risky

Key point: A single hs-cTnT concentration level below the limit of detection, in combination with a normal ECG, may successfully rule out AMI in patients presenting with possible acute coronary syndrome. Data do not yet support this approach when the troponin level is drawn within 3 hours of symptom onset.

Citation: Pickering JW, Than MP, Cullen L, et al. Rapid rule-out of acute myocardial infarction with a single high-sensitivity cardiac troponin t measurement below the limit of detection: a collaborative meta-analysis. *Ann Intern Med*. April 18, 2017. [Epub ahead of print]

This article details a systemic review of recent prospective studies of patients presenting to EDs with symptoms suggestive of possible acute coronary syndrome who also had an ECG and a high-sensitivity cardiac troponin test (hs-cTnT) performed. The use of hs-cTnT levels has been shown in prior studies to reliably detect very low concentrations of troponin T. The authors hypothesized that an hs-cTnT below the threshold of detection combined with a normal ECG may reliably rule out AMI in patients presenting with chest pain. Results indicated that patients with hs-cTnT levels below the limit of detection who also presented with a normal ECG had a very low risk for AMI or serious adverse cardiac events within 30 days. The sensitivity point approached 99%. However, patients with AMI who present very early after symptom onset may not have detectable troponin levels. In fact, this study revealed that 50% of patients who were determined to have false negative results had their initial troponin level drawn within 3 hours of symptom onset.

“A new CEB could be a timely means to detect myocardial infarction.”

For this reason, the authors reiterate current guidelines that a single hs-cTnT level drawn within 3 hours of symptom onset is insufficient to reliably exclude patients with AMI. Urgent care clinicians should continue to use caution when attempting to “rule out” AMI with a single cardiac troponin enzyme sample, especially if it is not a high sensitivity assay. ■

Newly Discovered Biomarker May Help Detect Myocardial Ischemia Faster

Key point: A new cardiac electrical biomarker may improve timely detection of myocardial ischemia in patients.

Citation: Nketiah E, McCord J, Koenig G. Cardiac electrical

biomarker response during percutaneous coronary intervention. *JACC.* 2017;69(11); poster contributions.

Results of this small (N=12), prospective study of patients with acute coronary syndrome indicate that a new cardiac electrical biomarker (CEB) could be an efficient and timely means to detect myocardial infarction. The newly identified CEB provides a measure of dipolar energy in a 12-lead ECG, derived from three leads (I, aVF, and V2), and appears to have the capability to detect myocardial ischemia in real time. The researchers suggest that an obstruction of blood flow induced during percutaneous coronary intervention (PCI) causes localized myocardial ischemia, to which the new CEB may show a response. Ultimately, they concluded that the CEB shows a positive response to balloon and stent inflation during PCI, with a stronger response to balloon inflation in larger arteries, cases involving infarction, and in more severe stenosis. These findings may help inform decisions of when—and where—it is advisable for urgent care providers to refer patients presenting with symptoms of MI. (Disclosure: VectraCor, an advertiser in *JUCM*, is involved in research and development of related products.) ■

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Why Are You Being Sued?

■ FRANK J. FANSHAW, ESQ and ROSEMARY WEAVER MCKENNA, ESQ

Urgent message: “Winning” a lawsuit in which you’re the defendant runs a distant second to avoiding lawsuits altogether—never mind if you’re on the losing end and have to pay a judgment. Understanding relevant regulations and laws is the best way to stay out of court.

Today’s healthcare providers must carefully navigate their way around complex laws which regulate, restrict, and impact their practices. Urgent care providers who fail to navigate within these laws may find themselves on the wrong side of a lawsuit or regulatory action. Here are some tips to help you avoid these legal icebergs.

HIPAA/HITECH and Data Privacy

Like all healthcare providers, urgent care centers collect “attractive” data from patients—names, addresses, telephone numbers, Social Security numbers, and birthdates (as part of routine intake forms)—along with payment data (which can include credit or bank card numbers for copayments, as well as payer information). It is therefore not surprising that healthcare is both one of the most regulated industries with respect to data, but also the top industry impacted by data breaches. Data from the Ponemon Institute show that in the past 2 years, about 90% of healthcare entities have been the subject of a data breach. Because healthcare providers are at an increased risk for ransomware and other cyberattacks, it is important for them to comply with federal (and state law) privacy requirements and be prepared to respond to a data security incident.

The Health Insurance Portability and Accountability Act of 1996 includes three important rules: the privacy rule, the security rule, and the breach notification rule. Each has a different application and set of standards with which healthcare providers must comply. In particular, urgent care centers should

be aware of *and avoid* the most common compliance problems under HIPAA:

- Impermissible uses and disclosures of protected health information
- Lack of safeguards of protected health information
- Lack of patient access to their protected health information
- Use or disclosure of more than the minimum necessary protected health information
- Lack of administrative safeguards of electronic protected health information

Urgent care centers should be sure to take the following actions to minimize the risk of HIPAA noncompliance: 1) Review and adopt a compliant notice of privacy practices and HIPAA policies and procedures; 2) Ensure that third-party vendors sign compliant business associate agreements in instances where the vendor will have access to protected health information (including EHR vendors); 3) Conduct periodic employee training (this is not only required, but will help educate and keep your [potentially] changing staff up-to-date on important protocols for interacting with patients and maintaining the privacy and security of data); 4) Understand and appropriately respond to requests from patients for health information; and 5) Implement appropriate safeguards to secure data and take steps to prepare for a cybersecurity incident (including breach response preparedness, cyberliability insurance, and appropriate provisions in vendor agreements—particularly EHR vendors).

Collective Negotiation by Providers/IPAs

Working with other providers to combine forces and negotiate with payers for better fee schedules may make some business sense—but from a legal perspective, there can be significant risks to these collective negotiations. The Federal Trade Commission and the United States Department of Justice have repeatedly investigated collective negotiations through independent practice associations, treating these collaborations as “inherently suspect” business practices.

In order to avoid violating the antitrust rules, providers and independent practice associations (IPAs) who form collaborations to collectively negotiate with payers or health plans must



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be financially or clinically integrated. Financial integration requires the sharing of substantial financial risk, including losses and profits. Clinical integration requires mechanisms to control utilization of healthcare services, designed to make care delivery more efficient, control costs, and assure quality of care. Clinical integration will also require the selection of network physicians who will further these efficiency objectives, and a significant investment of capital (both financial and human) to build the necessary infrastructure and capability to make the efficiency objectives a reality.

The analyses used by the FTC and the DOJ in reviewing these cases are complex. Urgent care centers should be sure to consult with experienced legal counsel to carefully analyze any collective negotiation arrangements or proposed IPAs to ensure that they are in compliance.

Fee-Splitting

In most states, physicians (and perhaps other professionals) are subject to “fee-splitting” limitations which restrict their ability to allow nonprofessionals to share in the fees for professional services. These rules may impact the business arrangements between an urgent care center and third parties. One example of fee-splitting arises in the not-unusual context of a series of urgent care physician practices that operates several sites (perhaps in several states), under a management services arrangement with a management services organization (MSO), where the MSO’s fee is based on revenue generated.

Many states have implemented exceptions to their fee-splitting restrictions to allow certain percentage- or revenue-based compensation formulas; these exceptions fluctuate from state to state. New York, on the other hand, has been holding off on this for years; even there, however, legislation has been proposed (but not passed) which would allow healthcare professionals operating in the state to structure their practice management and billing services on a percentage basis.

While the fee-splitting restriction is not new, it is often overlooked when structuring professional practice-MSO relationships. Urgent care centers working with an MSO should be sure to check the restrictions of each state they are operating in to make sure practice MSO compensation is allowed under existing law. (It should also be considered when formulating incentive payments for nonprofessional employees.)

Stark and Antikickback

There are important differences between the physician self-referral (“Stark”) and antikickback rules both on a state and federal level with respect to application, liability standards, exceptions, and penalties. Discussion of these laws fills many volumes and shelves in law libraries—and while a full colloquium is outside the scope of this article, it would be remiss not to include a mention of these oft-violated laws.

State and federal Stark laws (often, but not always, aligned) prohibit the *referral by a physician, for a designated health service, payable by Medicare* (and other payers, depending on interpretation and state law), when the physician or his family have an *ownership or compensation interest in the entity* that will perform the designated health service. There are exceptions to this rule, which must be fully complied with (different from the safe harbors under the antikickback laws). It doesn’t matter if there was an intent to violate the law or a simple mistake—Stark is a strict liability law. State laws may also provide for certain patient notifications and disclosures to be made. There are significant civil penalties for a violation of the federal Stark law, including the possibility of exclusion from Medicare and Medicaid.

The state and federal versions of the antikickback laws do not allow *knowing and willful* receipt or payment of *any remuneration*, directly or indirectly, in exchange for a *referral for a service or the purchase of a service* covered under a *federal health-care program*. Unlike the Stark law, there are no express exceptions; rather, there are safe harbors which identify certain transactions and arrangements which do not violate the law. However, there could be other transactions or arrangements which are not included in a safe harbor and which do not violate the law. Generally, the violation must be knowing and willful (although this could vary under state law). There are significant criminal and civil penalties for violations.

Given the breadth of these prohibitions, and the extensive (and complicated) exceptions and safe harbors, urgent care centers should carefully review referral arrangements with physicians, particularly as they relate to productivity payments and payments for services such as physical therapy, occupational therapy, laboratory tests, or radiology and imaging services.

Corporate Practice Issues

The laws of all states provide for professional licenses to be given only to individuals, which means that only these individuals may practice that profession. This restriction is commonly referred to as “corporate practice.” For an organization to provide medical services, it must fall within an exception, which may include a professional entity (PC, PLLC, etc.) or a licensed clinic. Relationships between professional entities with nonphysician management companies should be carefully structured to keep within the limits of administrative services that are allowed to be subbed out (which are sometimes not so obvious), and to leave the retention of professionals and the decisions relating to professional services to the professional entity.

Conclusion

Violations of the above rules not only result in expensive lawsuits, but can also involve costly administrative proceedings, penalties, and reputational harm. An ounce of prevention certainly will cost less than a pound of cure. ■



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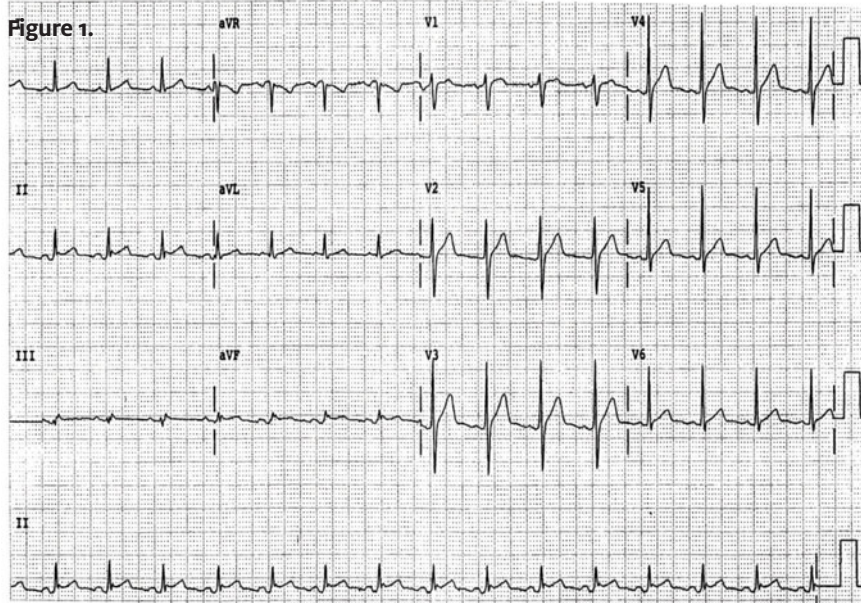
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A 37-Year-Old Man with a Two-Day History of Chest Pain



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

Case

The patient is a 37-year-old man who reports a two-day history of chest pain. It worsens with exertion, and when he lays back; it improves when he's sitting or leaning forward. He denies any diaphoresis, radiation, or back pain. No pleuritic aspect.

During the exam, he is alert and oriented, and in no distress. In addition, you find:

- Lungs: Clear to auscultation bilaterally
- Cardiovascular: Regular rate and rhythm without murmur, rub, or gallop
- Abdomen: Soft and nontender without rigidity, rebound, or guarding. No pulsatile abdominal mass
- Extremities: No pain or swelling of the lower extremities; pulses are 2+ and equal in all 4 extremities

PR	149
QRSD	90
QT	310
QTc	379
Axes	
P	60
QRS	42
T	35

THE RESOLUTION

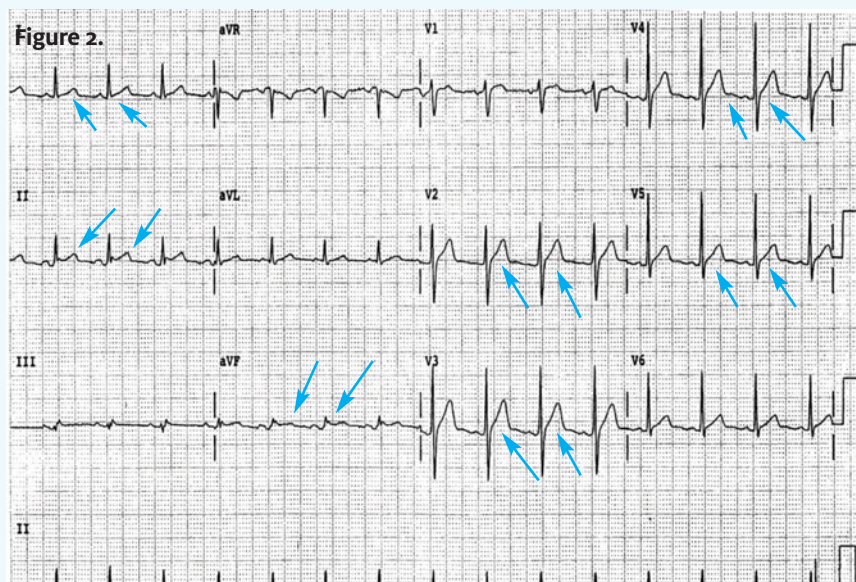


Figure 2. Note: Arrows point to the generalized ST elevations.

Differential Diagnosis

- A. Inferior STEMI
- B. Acute pericarditis
- C. Anterior STEMI
- D. Sinus bradycardia
- E. Ventricular tachycardia

Diagnosis

The ECG shows diffuse ST elevation secondary to acute pericarditis (answer B). Post ECG, the patient confirms he had a viral upper respiratory infection 2 weeks ago, with resolution of URI symptoms within the last few days.

Learnings

- ST elevation may be caused by an acute ischemia/infarction, but other causes include:
 - Ventricular aneurysm
 - Early repolarization
 - Prinzmetal's angina
 - Pericarditis (diffuse ST segment elevation)
- How can ST elevation from acute pericarditis be differentiated from a STEMI? The answer is, the STEMI generally occurs from occlusion of a coronary artery (plaque rupture → platelet aggregation → coronary artery occlusion). STEMI will generally occur in an *anatomic* distribution, and not a *generalized* distribution. For example:
 - Occlusion of the right coronary artery (RCA) will usually result in inferior ischemia, seen as ST elevation in the inferior leads (II, III, and aVF) and will often have

reciprocal change

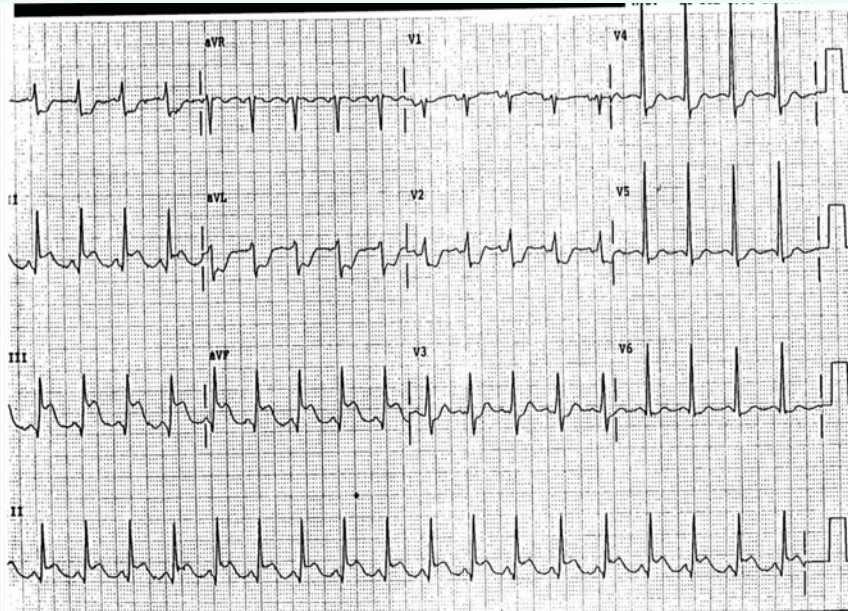
- Occlusion of the left anterior descending artery (LAD) will result in anterior ischemia seen as ST elevation in the anterior leads V3 and V4
- Occlusion of the circumflex artery will result in lateral ischemia seen as ST elevation in the lateral leads I, aVL, V5 and V6
- Key point: with acute pericarditis, the ST elevation is *generalized* and does NOT follow an anatomic distribution
- Etiologies of acute pericarditis include:
 - Idiopathic
 - Infectious—usually viral, but may include bacterial or even tuberculosis
 - Inflammatory—consider lupus, rheumatoid arthritis
 - Other—drugs, radiation, sarcoidosis, trauma
- The classical exam finding is a cardiac “rub,” a rough-type rubbing/scratching sound, though (as in our patient), this is not always present
- ECHO may be performed to look for pericardial effusion/tamponade
- Management is with NSAIDs

Pearls for Initial Management and Considerations for Transfer

- Unstable vital signs
- Diagnostic uncertainty
- Inability to follow up or return with worsening symptoms
- Inability to definitively exclude STEMI/ACS ■



A 42-Year-Old Woman with Short-Term Dizziness and Vomiting



Case

This 42-year-old woman presents to your urgent care center with a 2-hour history of intermittent dizziness and vomiting. She denies diarrhea or exposure to ill persons. Further history reveals that she has recently had some epigastric discomfort.

In the exam room, she is alert and oriented. She seems comfortable, in fact. In addition, you find:

- **Lungs:** Minimal bilateral symmetric wheezing
- **Cardiovascular:** Regular rate and rhythm without murmur, rub, or gallop
- **Abdomen:** Soft and nontender without rigidity, rebound, or guarding. No epigastric discomfort with palpation
- **Extremities:** No pain or swelling of the lower extremities; pulses are 2+ and equal in all 4 extremities

Just as you are getting ready to write a prescription for an antiemetic, the patient breaks out in a sweat. You order an ECG.

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

PR	130
QRSD	101
QT	292
QTc	395
Axes	
P	67
QRS	88
T	107

THE RESOLUTION

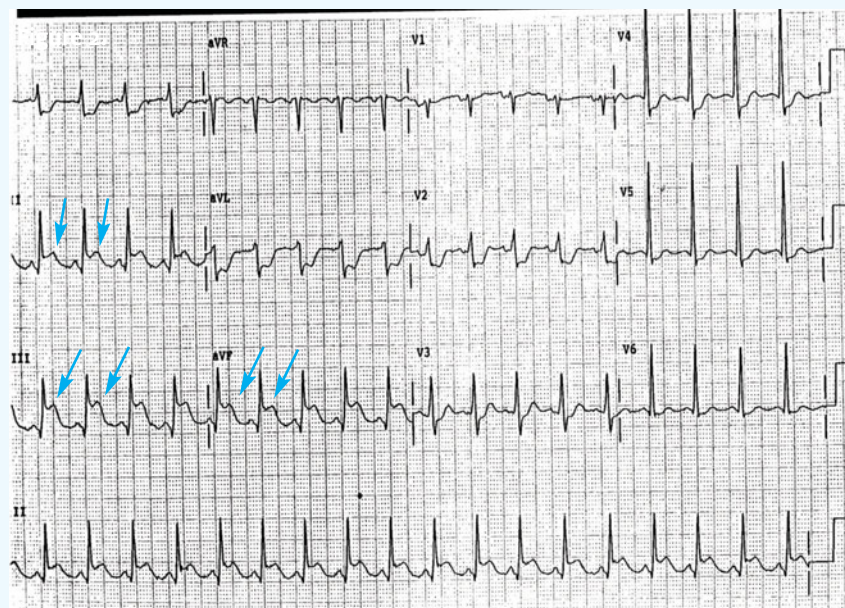


Figure 2. Note: Arrows point to the ST elevations in the inferior leads.

Differential Diagnosis

- A. Sinus tachycardia
- B. Supraventricular tachycardia
- C. Inferior STEMI
- D. Sinus bradycardia
- E. Ventricular tachycardia

Diagnosis

The ECG shows an inferior STEMI (answer C). There is ST elevation in the inferior ECG leads (II, III, aVF), with reciprocal changes consistent with an inferior STEMI.

Learnings

- Symptoms predictive of myocardial ischemia or infarction include:
 - Chest discomfort with exertion
 - Diaphoresis
 - Radiation
 - Vomiting

- Demographic groups where ischemic may present atypically include diabetics, the elderly, and women
- Inferior MIs may present as epigastric pain, and not chest pain
- Inferior STEMIs are typically due to an occlusion in the right coronary artery (RCA) and may affect the right ventricle, resulting in hypotension

Pearls for Initial Management and Considerations for Transfer

- An acute STEMI requires emergent transport to a center that can provide interventional catheterization services
- Place two IV lines, consider oxygen if hypoxemic, and place on a cardiac monitor while awaiting transport
- Have patient chew an aspirin while awaiting transport
- If patient is hypotensive, give IV fluids. Extreme caution should be used with sublingual nitroglycerin. ■

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Level of Billing Complexity Follows Level of Lacerations in Wound Repair

■ DAVID E. STERN, MD, CPC

Q. We had a patient present with multiple lacerations and were wondering how to bill, since some were repaired with sutures and some were repaired with staples.

A. Laceration repair is billed based on the complexity, length of the repair, and the anatomic site. The repair can consist of sutures, staples, or wound adhesive (eg, Dermabond). The *Current Procedural Terminology* (CPT) manual classifies the complexity of the repair of wounds as being simple, intermediate, or complex. *Simple repair* is used when the wound is superficial, primarily involving epidermis, dermis, or subcutaneous tissues without significant involvement of deeper structures where only one layer of closure is necessary using sutures, staples, tissue adhesive, or other closure materials. In addition, simple repair can be billed for chemical and electrocauterization of wounds not closed.

Intermediate repair is used when layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (nonmuscle) fascia, in addition to the skin closure, is necessary. Single-layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter also constitutes intermediate repair.

Complex repair is used for repairs that require more than layered closure, such as scar revision, debridement of traumatic lacerations or avulsions, extensive undermining, stents, or retention sutures.

The code sets for laceration repair are:



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.

“When multiple wounds are repaired, add together the lengths of those in the same classification...and from all anatomic sites that are grouped together.”

- 12001-12007 for simple repair to scalp, neck, axillae, external genitalia, trunk, and/or extremities (including hands and feet)
- G0168 for wound closure using tissue adhesive only when the claim is being billed to Medicare
- 12011-12018 for simple repair to face, ears, eyelids, nose, lips, and/or mucous membranes
- 12031-12037 for intermediate repairs to scalp, axillae, trunk and/or extremities (excluding hands and feet)
- 12041-12047 for intermediate repair to neck, hands, feet and/or external genitalia
- 12051-12057 for intermediate repair to face, ears, eyelids, nose, lips and/or mucous membranes
- 13100-13102 for complex repair to the trunk
- 13120-13122 for complex repair to scalp, arms, and/or legs
- 13131-13133 for complex repair to forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet
- 13151-13153 for complex repair to eyelids, nose, ears, and/or lips

When multiple wounds are repaired, add together the lengths (in centimeters) of those in the same classification (simple, intermediate, complex) and from all anatomic sites that are grouped together. For example, you perform a simple wound repair measuring 5 cm to the right index finger and

another simple wound repair measuring 7.8 cm to the right arm. In addition, it was necessary to perform an intermediate repair measuring 3 cm to the right middle finger.

In this example, you would bill CPT code 12042, "Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm" as the primary procedure. After adding together the lengths of the simple repair procedures to the finger and arm, you would also bill CPT code 12005, "Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm."

When billing two laceration repair codes for a single claim, it is important to review the fee schedule for the payor. For the CPT code with the lower reimbursement, the coder should append modifier -59, "distinct procedural services." Payors generally discount the secondary procedure (ie, CPT codes with modifier -59) by 50% or more. Therefore, it is important not to place the modifier -59 on the code with higher reimbursement.

Intermediate and complex repair procedures performed initiate a 10-day global period. CPT guidelines define standards for preoperative and postoperative services that are included in the surgical package as:

"Simple wound repairs have a global period of 0-days; no follow-up care is included in the code for the procedure."

- E/M service(s) subsequent to the decision for surgery on the day before and/or day of surgery (including history and physical)
- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- Immediate postoperative care, including dictating operative notes, and talking with the family and other physicians or other qualified healthcare professionals
- Writing orders
- Evaluating the patient in the post anesthesia recovery area
- Typical postoperative follow-up care

However, simple wound repairs have a global period of 0-days. Thus, no follow-up care is included in the code for the procedure. ■

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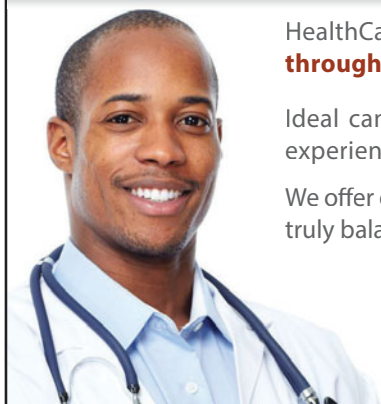
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DEVELOPING DATA

How often do patients utilize urgent care?

Urgent care thrives on repeat visits and positive word-of-mouth from loyal patients. Although many urgent care centers track the percentage of new vs established patients—those who have been seen in the past 3 years—few measure frequency of use by individual patients. This is an important measure used in other service businesses, however, based on the assumption that customers who patronize their favorite businesses more often also spend more money, and encourage others (either in person and online) to patronize the business as well.

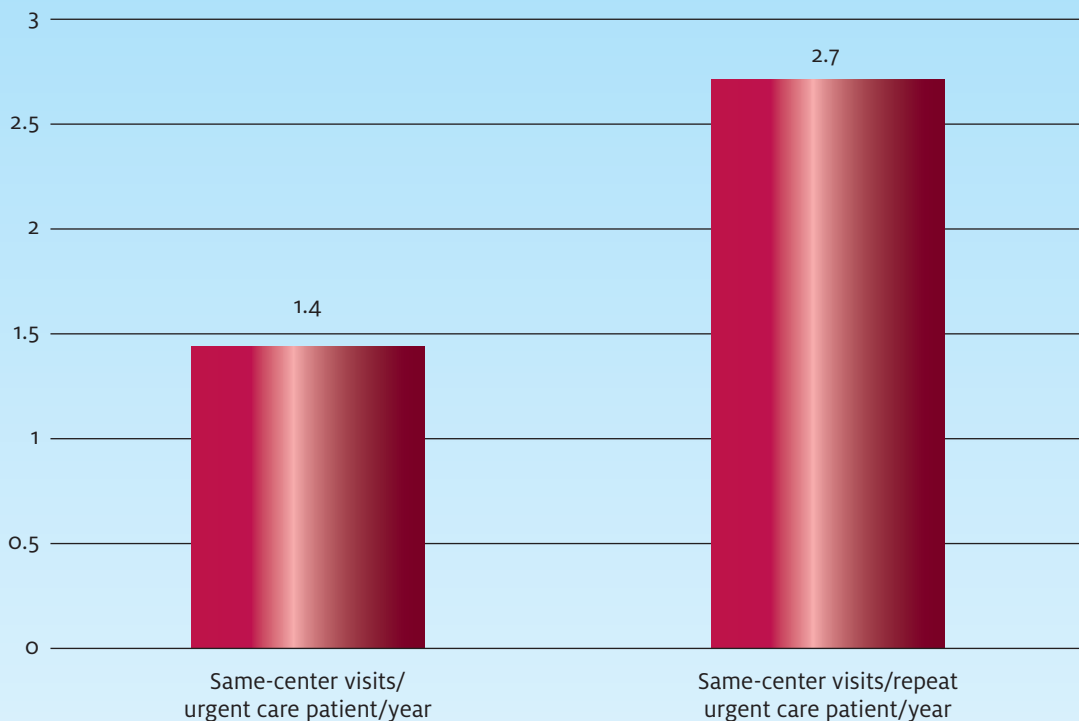
A Practice Velocity study of over 5 million urgent care encounters by 3.4 million patients in 2016 provides insight to the utilization patterns of urgent care patients.

The “average” urgent care patient depicted in the left-hand column utilizes a center 1.4 times per year, or approximately every 8–9 months. The “repeat” or “loyal” urgent care patients represented on the right visit the urgent care center approximately 2.7 times per year—or, once every 4 months or so. (This eliminates one-off users to provide insight on utilization of loyal patients.)

By offering quality medical care with good outcomes, getting patients in and out of the center quickly, treating patients with enthusiasm and respect, and eliminating hassles around registration and billing processes, urgent care operators are in a great position to foster patient loyalty, resulting in more frequent visits, which in turn equates to greater revenue for the center.

Ideally *your* urgent care center will become the provider of first choice, or the place the patient thinks of—and visits—when the need arises.

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