

# JUCM<sup>®</sup>

THE JOURNAL OF **URGENT CARE** MEDICINE<sup>®</sup>

NOVEMBER 2019  
VOLUME 14, NUMBER 2

**UCA** URGENT CARE  
ASSOCIATION

 COLLEGE OF  
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www.jucm.com

The Official Publication of the UCA and CUCM

CLINICAL **cme**

## Pregnant Patients in Urgent Care

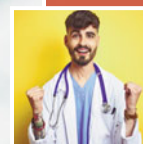
*Know the special risks  
before you treat*

### ALSO IN THIS ISSUE

- 21 Case Report**  
Those Ruddy Cheeks Might Be a Sign of Something Serious
- 34 Occupational Medicine**  
Hit Your KPIs or Your Occ Med Services Could Be DOA
- 43 Health Law and Compliance**  
Lease Exclusivity: What You Don't Know Really Can Hurt
- 46 Revenue Cycle Management**  
Don't Let the New Medicare Cards Catch Your Front Desk by Surprise

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# Pediatric Urgent Care—*Specialized* Medicine on the Front Lines

■ DAVID MATHISON, MD, MBA

Thirty years ago, there was widespread concern that specialty medicine was “a problem.” Consumers were self-selecting specialty (vs primary) care for routine ailments, thus driving up the cost of healthcare. Without restrictions, consumers could choose neurologists for headaches, orthopedists for ankle sprains, and dermatologists for acne—all very appropriate with complexity, but unnecessary and costly for routine problems. Hence came the dawn of managed care armed with gatekeepers, referral requirements, and preferred networks to limit the use of specialty care and maximize cost containment by expanding the role of primary care.

Now urgent care is anchored in the marketplace as an alternative to these traditional models. As our industry continues to grow in number and scale, specialty urgent cares are becoming more prevalent. Particularly in dense metropolitan areas where there is room for differentiation, specialty urgent cares feature personnel who have additional training and some services and equipment that may not be available at other urgent care facilities. But most of all, differentiated urgent care centers have brought specialization back to the forefront, often *without* the excessive costs that helped carve the path to managed care years ago.

Pediatric urgent care (PUC) was a natural “specialized” step in the evolution of this growing urgent care industry. Combining pediatric expertise with the equipment and an environment customized to children, a niche field was born wherein parents could choose pediatric specialists on-demand.

While PUC is fundamentally unique, its evolution is not dissimilar to how pediatric emergency medicine (PEM) was formed. In the 1990s, there were mounting concerns that general emergency departments lacked the expertise and equipment to care for severely ill and traumatically injured infants



and children. The field of PEM was born to diagnose and treat this unique and vulnerable population, with PEM physicians training for 5-6 years after medical school, and the field becoming accredited by the American Board of Pediatrics. Pediatric EDs grew in number and scale, and became an alternative to the care traditionally provided in a general ED. Unlike other specialty care that was traditionally more expensive, however, pediatric EDs were typically *not* more costly and were often heralded for reducing costs through more judicious lab testing and radiology utilization, lower admission rates, and more reliance on clinical exam to guide decision-making.

Today, as in general urgent care, freestanding PUCs are growing out of private and academic sectors; about half are hospital-affiliated and half independent. Another similarity is that the vast majority of ED care delivered to children could be shifted to urgent care.

While this ED–UC shift is not unique in pediatrics, it’s perhaps more weighted in children where the solutions are commonly reassurance, supportive therapy, or simple treatment rather than advanced diagnostics. The vast majority of children seek care for relatively straightforward problems (eg, asthma, fractures, foreign bodies, etc.) that tend to be uncomplicated in otherwise healthy children. This shift may threaten the future of community PEM, as some institutions consolidate or restructure hospital-based pediatrics, with low-acuity pediatric ill-



**David Mathison, MD, MBA** is Vice President, Clinical Operations, South Atlantic for PM Pediatrics and a pediatric emergency physician.

*“With increasing costs of hospital-based care and the greater consolidation of hospital-based pediatrics, pediatric urgent care will continue to grow and may be the ultimate intermediary between routine pediatric practices and tertiary children’s hospitals.”*

nesses and injuries being handled more frequently in ambulatory environments or at tertiary centers.

The success of freestanding PUCs is anchored by the ability to rapidly earn trust with a family. While many general urgent care staff do an excellent job caring for children, the experience may not be uniform in the eyes of the parent. Pediatric urgent care promotes an experience specific to children with every encounter and by every staff member. However, the specialization that PUCs offer is very different than other “retail” businesses that contour to the needs of children. The kids’ haircut shop, for example, may feature the same product but packaged in a child-friendly environment, with staff who are more patient with the needs of children. What PUC offers is fundamentally unique, and the result is a very different product from general UCs. Some of the distinguishing characteristics include:

- **Complementary to the “medical home.”** Unlike many adults who seek urgent care, pediatric patients invariably have an accessible primary care physician in the pediatrician, many of whom offer walk-in hours for sick visits. Therefore, the use of PUC may be weighted more as a complement rather than an alternative to the primary doctor. With increasing risk-sharing contracts and insurance subsidies, primary care practices are incentivized to keep children out of the ED and may be more likely to partner with urgent care centers to deliver care when the pediatrician’s office is closed.
- **Hours of operation.** Because of the emphasis on after-hours services and because of the evening peaks for respiratory and fever care, many pediatric urgent care centers are open later than many general UCs—often until 11 PM or midnight.
- **Procedural care.** Many PUCs are capable of procedural care in anxious young children, which may be beyond the comfort level of general UCs who lack anxiolysis and distraction therapy.
- **Acuity/observation.** Many otherwise healthy children will turn around with several hours of respiratory or fluid therapy. As such, PUCs are more likely to provide observational

care if there is sufficient capacity. This may feature IV fluid hydration, IV antibiotic administration, and prolonged respiratory management which may not be commonplace in other urgent care centers.

- **Staffing.** While the staffing at PUCs varies nationally, the core models feature personnel with pediatric expertise. The physicians are typically pediatricians, often with ED experience or with additional fellowship training in PEM. Similarly, nurse practitioners are often PNPs rather than FNPs, and nurses often have experience in hospital pediatrics. Because pediatric residency programs may lack some of the trauma and efficiency training necessary for urgent care, several fellowship and apprenticeship programs have spawned, with great results.
  - **Volume trends.** The hourly visit trends for kids are unique because children are dependent on parents for transportation and because respiratory illnesses and injuries often peak at certain times of day. For example, croup and asthma flares commonly peak in the evening, and childhood injuries often occur more on weekends and later in the afternoon, when pediatricians are not available.
  - **Chronic illness.** Children with chronic illnesses may be more likely to seek care from specialized PUCs because of greater comfort with pediatric staff who have expertise with these conditions. This may include developmental disorders such as autism spectrum or medical device problems such as gastrostomy tube malfunction. Also, patients with medical disease such as type I diabetes or chronic asthma may use a PUC as triage to help determine if an ED visit is really necessary.
  - **Advocates for children.** When children need further specialty care, PUC providers connect with the specialists in the community who best care for each particular problem. Since pediatric specialists are far fewer in number than adult specialists, staff at PUCs work with these experts in the community more consistently and are adept at advocating for children who need continuation of care for acute and chronic problems such as hernias, glomerulonephritis, uveitis, and recurrent urticaria.
- This is all to say that the future of PUC is promising. Specialized urgent care offers consumers the self-selection of specialty care combined with the convenience and accessibility of urgent care.
- Many PUCs report that about 50% of patients are less than 5 years old, so patient capture occurs at a young age, allowing the family to become PUC customers for the next 18+ years. As PUC brand-awareness increases, consumers can expect a replicable experience. And with increasing costs of hospital-based care and the greater consolidation of hospital-based pediatrics, PUC will continue to grow and may be the ultimate intermediary between routine pediatric practices and tertiary children’s hospitals. ■





**CLINICAL**

## 11 When Pregnant Patients Present to the Urgent Care Center

Women who are pregnant still get sick and injured just like the rest of us, though of course they have additional concerns related to their pregnancy. Their care requires special consideration. Appreciating how diagnoses, imaging, testing, and treatment affect the patient and her unborn child is essential to the safety of both.

*James Hicks*

**CASE REPORT**

## 21 An 11-Year-Old Girl with Red, Itchy Rash



Urticaria can be a deceptively simple diagnosis. Identifying the cause is a critical step in determining how severe the possible consequences could be, and in initiating the correct treatment.

*Kelsey Reed, MSN, APRN, FNP-C*

**PRACTICE MANAGEMENT**

## 29 Urgent Care Looks to Find Its Identity through Gen Z and Millennials



This isn't your grandfather's healthcare marketplace. As researchers continue to define generations (Gen X, Millennials, Gen Z...) we learn more about the habits and preferences that drive them. Those insights can help you hone your offerings and your message so they choose your urgent care center.

*Dan Stanek*

**HEALTH LAW AND COMPLIANCE**

## 43 What Use Restrictions Can Landlords Impose on Urgent Care Facilities?



Lease exclusivity is a tricky business. As an urgent care operator you can use it to your advantage, but by the same token you need to be aware of limitations and restrictions that could make it harder for you to compete.

*Alan A. Ayers, MBA, MAcc*

**IN THE NEXT ISSUE OF JUCM**

Ear pain is a common complaint in the urgent care setting. It's so common, in fact, that it can be easy to misread the cause, leading to treatment delays and, maybe, a lost opportunity with a patient who won't return. Especially in this era of rampant antibiotic resistance (including patients who come in assuming you'll prescribe an antibiotic for their painful year), getting to the correct diagnosis right off the bat benefits both the patient and your urgent care center. Read *Ear Mimics: It's Not All About Otitis Media* in the December issue of *JUCM* to gain helpful insights.

**DEPARTMENTS**

- 7 From the UCA
- 8 Continuing Medical Education
- 24 Abstracts in Urgent Care
- 34 Occupational Medicine
- 37 Insights in Images
- 46 Revenue Cycle Management Q&A
- 49 Developing Data

**CLASSIFIEDS**

- 48 Career Opportunities

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*JUCM The Journal of Urgent Care Medicine* (ISSN 19380011) supports the evolution of urgent care medicine by creating content that addresses both the clinical practice of urgent care medicine and the practice management challenges of keeping pace with an ever-changing healthcare marketplace. As the Official Publication of the Urgent Care Association and the College of Urgent Care Medicine, *JUCM* seeks to provide a forum for the exchange of ideas regarding the clinical and business best-practices for running an urgent care center.

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



# JUCM CONTRIBUTORS

Urgent care is challenging enough when you're assessing and treating one patient at a time. When there's a second one to consider—one who is unable to speak for themselves and who is going to be directly affected by how you treat Patient A—things can get infinitely more complicated.

That's the challenge when a pregnant woman presents to urgent care. Whether her primary complaint is related to her pregnancy or not, it's a consideration in every decision you make. And those considerations are different depending on how far along she is (assuming she's even aware of her status yet).

These challenges—and how to address them—are the subject of this issue's cover article, *When Pregnant Patients Present to the Urgent Care Center* (page 11). In it, **James Hicks, MD** takes a methodical approach to explain what to look out for throughout pregnancy, but also trimester-by-trimester and extending into the postpartum phase.



Dr. Hicks is the lead physician for urgent care at Hudson Headwaters Health Network in Queensbury NY



It's likely our clinician readers are more accustomed to (and possibly more comfortable with, consequently) treating children than they are mothers-to-be. That doesn't mean diagnoses and treatment are any simpler, necessarily, though. That's certainly a good introduction to this month's case report, *An 11-Year-Old Girl with Red, Itchy Rash* by **Kelsey Reed, MSN, APRN, FNP-C**. The diagnosis in this case is deceptively simple; while it wasn't too hard to reach, understanding the long-term implications (and how to help the patient manage them) is equally important. Find out why by reading the article, starting on page 21). Ms. Reed is an advanced practice registered nurse for the state of Illinois.

"Assessment" of a different sort is an absolute necessity if you want to run a successful business, in any field. You need an uncomplicated, reliable way of understanding how you're doing at any given moment. What makes up that data set will be different from one urgent care operator to the next, but there are some that will be pretty consistent across the industry. The challenge is to figure what they are for *your* business, and understand how to track them.

As the president and medical director of Reliant Immediate Care Medical Group, **Max Lebow, MD, MPH**—who also happens to be our go-to expert on occupational medicine in the context of urgent care—knows a thing or two about keeping things on track both clinically and business-wise. He shares his insights as the author of *The Top 15 Occ Med Key Performance Indicators for Your Urgent Care Center* (page 34).



Understanding where you're *going* can be equally important

as how you're *doing*, of course. Many of the decisions you'll be making about how to appeal to patients depends, obviously, on how their preferences change. And that's different from one age group to another.



If you want to see how, you need to read *Urgent Care Looks to Find Its Identity Through Gen Z and Millennials*, starting on page 29. In it, **Dan Stanek**, executive vice president of the consulting firm WD Partners, reveals data from exclusive research his company conducted on what patients of various generations are looking for, and where they hope to find it.

While the legalities of your lease arrangement may seem a more mundane topic, the fact is that your location—and the other businesses that surround your location—may impact the traffic that comes through your front door as much as anything else. The conditions of your lease can be either a tremendous asset or a hindrance. Read *What Use Restrictions Can Landlords Impose on Urgent Care Facilities?* (page 43), by **Alan A. Ayers, MBA, MAcc**, to learn how. Regular readers know he's the chief executive officer of Velocity Urgent Care, LLC and practice management editor of *JUCM*.



## Also in This Issue

Flu season is starting with a vengeance this year. So, it's helpful that **Cornelius O'Leary, MD** of Emergency Care Dynamics (and our Abstracts in Urgent Care author) turned his attention to the latest developments in influenza vaccination, as well as emerging treatments for community-acquired pneumonia. He also looks at recent articles concerning abdominal pain in patients with IUDs; cancer-causing agents found in a common medication; and other topics. Turn to page 24 to get the lowdown.

Finally, in *Revenue Cycle Management* (page 46), **David Stern, MD** updates us on the Medicare card transition. It ends, officially, on December 31. Read it to ensure you and your front-end staff are up to date. (Dr. Stern is the CEO of Experity, formerly DocuTap and Practice Velocity.)

## Thanks to Our Peer Reviewers

We rely on the urgent care professionals who volunteer to serve as peer reviewers to ensure the content we publish is relevant and unbiased. This month, we thank:

- **Robert Blumm, MA, PA, DFAAPA**
- **Rajesh K. Davit, MD**
- **Luis de la Prida**
- **Courtney Bennett Wilke, MPAS, PA-C**

If you'd like to do support the journal—and the development of urgent care-specific literature—as a peer reviewer, send an email with your CV to [editor@jucm.com](mailto:editor@jucm.com). ■



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# How Do You Choose?

■ RICHARD PARK, MD

I have a question for you: How do you decide whether to attend a conference? Is it the location, or the speakers, or whether you still need CME, or have continuing education dollars for the year? If you are like most people, those are probably the factors that you look at.

But, if you are reading this, *you are probably not like most people*. Most people don't go into a business like ours, particularly in healthcare. Healthcare is hard enough (increasing regulations, diminishing reimbursements) without adding in the retail aspects of what we do (focusing on patient experience, choosing sites and people to drive visits). Makes me wonder sometimes what we were thinking!

But then, of course, I remember what we were thinking (what we *are* thinking)—we are thinking about taking care of people and *all* that that entails. And that continues to make us unique leaders in healthcare.

So, what does that have to do with deciding whether to attend a conference—and more specifically, our own convention? We've been thinking about this a lot.

If you look at it objectively, there's no reason to come just for content these days. The content is great, but we've made a lot of it available online. There's no reason to come for the location, either—every place we go is open the other 361 days of the year so you could go there anytime. So why am I going and why do I want you to come with me?

*It's because of us.* This is the only time, now once a year, that we get to see and spend time with lots of others like *us*. It's the only time and place we can get out of our centers and out of our own heads and immerse ourselves in each other's points of view. It's where we can challenge each other, question each other, and speak deeply *together* about our successes and failures and fears and hopes for our shared future.

You can't do that online like you can face-to-face; face-to-face is unique. We've been thinking about this a lot, too. We've



*“The 2020 UCA Annual Convention @ Expo is scheduled to take place May 3-6, 2020 at the Paris Hotel in Las Vegas.”*

been asking ourselves whether we've done a good enough job making the convention that unique place and moment in time, and we don't think we have. So, we've been taking it apart and putting it back together again to make it better, and *almost completely different*, starting with UCA2020.

UCA's CEO Laurel Stoimenoff and the UCA team will start sharing details soon on [ucaoa.org/Convention](http://ucaoa.org/Convention), but to me, it ultimately doesn't matter where it is or the specific details of this session or that session, because it's where I'm going to go to connect with my industry and my people.

I already know when it is—May 3-6—and I'm working my calendar (and my team's calendar) around it now to make sure we can be there. I hope you will do likewise. It won't be the same without you. ■

**Richard Park, MD**  
President, Board of Directors, UCA



**Richard Park, MD** is the founder and CEO of CityMD, and president of the Board of Directors of the Urgent Care Association.



# CONTINUING MEDICAL EDUCATION

**Release Date:** November 1, 2019  
**Expiration Date:** October 31, 2020

## 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 the Urgent Care Association and the Institute of Urgent Care Medicine. The Urgent Care Association is accredited by the ACCME to provide continuing medical education for physicians.

The Urgent Care Association 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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*Member reported no financial interest relevant to this activity.*
- **Alan A. Ayers, MBA, MAcc**  
*Member reported no financial interest relevant to this activity.*

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## When Pregnant Patients Present to the Urgent Care Center (p. 11)

- 1. The quantitative hCG should double in a normal pregnancy every 48-72 hours until it reaches a level of:**
  - a. 5,000–10,000 mIU/L
  - b. 8,000–10,000 mIU/mL
  - c. 10,000–20,000 mIU/mL
  - d. 15,000–17,000
- 2. Postpartum hemorrhage can occur up to 12 weeks following pregnancy. How often does it occur?**
  - a. 1% of pregnancies
  - b. 10% of pregnancies
  - c. 20% of pregnancies
  - d. 25% of pregnancies
- 3. Mastitis occurs in approximately 10% of breastfeeding mothers, most commonly in the second and third weeks postpartum. It can present with:**
  - a. Localized breast tenderness with erythema
  - b. Pain
  - c. Malaise
  - d. Fever
  - e. All of the above

## An 11-Year-Old Girl with Red, Itchy Rash (p. 21)

- 1. Which of the following should be included in the differential diagnosis for cold urticaria?**
  - a. Familial cold autoinflammatory syndrome
  - b. Cold-induced urticarial vasculitis
  - c. Serum protein disorders
  - d. All of the above
- 2. Cold urticaria may result from exposure to:**
  - a. Cold objects
  - b. Cold fluids
  - c. Cold food
  - d. Cold weather
  - e. All of the above

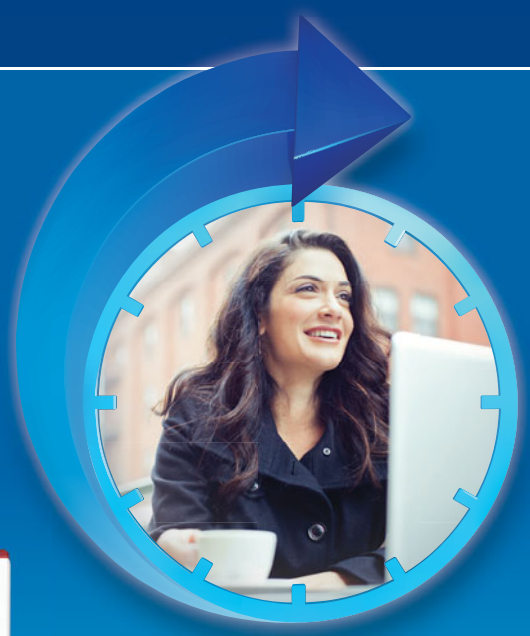
## 3. If a patient is diagnosed with cold urticaria, initial treatment in the urgent care center should include:

- a. An H2 antihistamine
- b. A nonsedating antihistamine
- c. Both H2 and nonsedating antihistamines
- d. Warm compresses
- e. Treatment for cold urticaria should not be initiated in the urgent care setting

## Urgent Care Looks to Find its Identity through Gen Z and Millennials (page 29)

- 1. Which of the following was *not* among the top three reasons mentioned when participants in a WD Partners survey were asked for the reasons they chose their most recent site for medical care?**
  - a. Convenient location
  - b. Walk-in appointment availability
  - c. Insurance coverage
  - d. Low price
  - e. All of the above were mentioned as the main reason
- 2. In the same survey, 80% of people in these age groups said they are “happy” with their healthcare, overall:**
  - a. Gen Z and Millennials
  - b. Millennials and Gen X
  - c. Gen X and Baby Boomers
  - d. Baby Boomers and Silent Gen
- 3. For which of the following “wellness services” did the most respondents say they would be willing to consider urgent care, as opposed to other settings?**
  - a. Sleep issues
  - b. Nutrition/dietary advice
  - c. Weight management
  - d. Massage
  - e. Mental wellness

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# When Pregnant Patients Present to the Urgent Care Center

**Urgent message:** Care of the pregnant patient in urgent care can be complex, as every test or treatment needs to take into account both the mother and her unborn child. Conditions which would be considered benign and self-limited in healthy patients take on a different level of concern, and must be managed differently, in the pregnant patient.

JAMES HICKS, MD  
(WITH REVIEW BY EDWARD DENIOUS, MD, FACOG)

## Introduction

There appears to be a wide range of comfort levels within urgent care centers regarding pregnancy. While most obstetrical practices encourage the patient to call their obstetrician first, distance to a clinic or hospital, patient preference, avoidance of higher costs, and emergency room avoidance may all drive patients to an urgent care for issues during pregnancy. Familiarity with pregnancy-related issues should be part of our comprehensive care.

## Diagnosis of Pregnancy

The accuracy of office testing for pregnancy is close to 100%<sup>1</sup> and the usual point-of-care testing for hCG generally gives reliable results as early as 8-10 days postimplantation.<sup>2</sup>

Pregnancy tests measure the beta subunit of human chorionic gonadotropin (hCG), but within this molecular family are a number of variants, including intact, nicked, free, and hyperglycosylated hCG.<sup>3</sup> Reasons for a negative urine pregnancy test can include very low levels of beta hCG or detection of hCG variants, an issue more common in home pregnancy testing and most likely to occur at about 8 weeks gestation when the variant levels are high.<sup>3</sup> There is no standardization of over-the-counter or office-based testing;<sup>4</sup> therefore providers should be aware of potential limitations in their POC product. Use of a quantitative serum hCG can detect lower levels of hCG, improving the clinical sensitivity. The lower detection level also decreases the specificity,



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as low concentrations of hCG can be associated with reasons other than a viable pregnancy, such as molar pregnancy and other neoplasms, recent miscarriage or abortion, fertility medications, urinary tract infection, and other kidney disease.<sup>5</sup>

Serial quantitative hCG measurements can clarify pregnancy status such as miscarriage vs early pregnancy. Most importantly in the urgent care setting, these numbers can suggest an ectopic location. In general, quantitative hCG should double in a normal pregnancy every 48-72 hours until it reaches a level of about 10,000-

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General Health Considerations and Complaints Throughout Pregnancy	
<ul style="list-style-type: none"> <li>• Influenza (and immunization)</li> <li>• Upper respiratory infection</li> </ul>	<ul style="list-style-type: none"> <li>• Oral care</li> <li>• X-rays</li> </ul>

20,000 mIU/mL. Failure to do so should prompt further investigation or referral.

While monitoring serial hCG is a reasonable initial approach, it is best combined with transvaginal ultrasound. In the case where ultrasound cannot demonstrate the location of a pregnancy and the  $\beta$ -hCG concentrations continue to rise, ectopic pregnancy is likely and a clear management strategy should be initiated.<sup>6</sup> This should prompt referral to OB/GYN if not already arranged, or to the emergency room for the symptomatic patient.

### General Health Considerations

Pregnancy does not eliminate the need for preventive health or, for that matter, lower risk for everyday injuries and illness. Some patients may have the mistaken impression that they should not undertake the same precautions as they might have before their pregnancy. The need for immunization, dental care, and proper diagnosis of potential orthopedic injuries, for example, does not diminish—and in some ways it is even greater.

### Influenza and URIs

Given the long and often severe flu season, we should consider influenza in pregnancy. Influenza immunization in pregnancy is recommended by any standard and appears to be safe. Our obstetrical friends encourage immunization; however, vaccine resistance, while unwarranted, is high with about 50% of pregnancy women receiving no vaccine.<sup>7</sup> Influenza in pregnancy is associated with fetal and maternal complications,<sup>8,9</sup> so while much of symptomatology may be “above the belt” the systemic nature of influenza may complicate pregnancy and augment the need for increased surveillance at a level exceeding urgent care offerings.

Antivirals can be used in pregnancy, and ACOG also recommends “postexposure antiviral chemoprophylaxis (75 mg of oseltamivir once daily for 10 days) be considered for pregnant women and women who are up to 2 weeks postpartum (including pregnancy loss) who have had close contact with someone likely to have been infected with influenza.” It again seems prudent to address these issues in the urgent care setting with consultation and close follow-up with your OB consultant.<sup>8</sup>

More commonly, you may see pregnant women at any stage of pregnancy with upper respiratory complaints of a milder nature. Nasal steroids for the common cold seem to be occasionally used, but there isn't good evidence to support offering these despite their low risk in pregnancy.<sup>10,11</sup> There is little evidence to support use of phenylephrine in pregnancy, and while pseudoephedrine had been used for years, a small association with birth defects exists. Primatene mist is now available again in the U.S. and has some association with birth defects in animal studies, among other concerns.<sup>12</sup> First- and second-generation antihistamines are likely safe in any trimester and can be used, though second-generation antihistamines such as loratadine and cetirizine are preferred.<sup>13</sup> For cough, dextromethorphan can be used. Benzonatate was an old Category C-designated cough medicine and should probably not be used. A recent Medical Letter suggests that risk of adverse reactions such as laryngospasm and accidental ingestion by children should necessitate avoidance of this medication.<sup>14</sup>

### Oral Care

Also present throughout pregnancy are changes affecting oral health, with increases in periodontal, gingival, and carious disease that may prompt an urgent care visit. The old wives' tale “Gain a child, lose a tooth” should prompt us to refer our patients for dental care assertively for acute care, as well as ongoing dental care and hygiene throughout pregnancy.

### X-rays in Pregnancy

Just because you're pregnant doesn't mean you stop getting injured. In fact, due to the changes in center of gravity and weight along with relative ligamentous laxity, pregnant women are more prone to accident and injury presumably due to a relative increase in instability. One group found that pregnant women have a fall and fracture rate similar to the elderly.<sup>15</sup> But even minor falls have been suggested as a cause of adverse fetal outcome. In one study there was a four-fold increase in preterm labor, an eight-fold increase in abruption, and a doubling of fetal distress with trauma. It is likely that most falls we would see are minor, and initial assessment and treatment are not dissimilar from the nonpregnant patient, keeping in mind some increase risk to the passenger.

X-rays in pregnancy may cause alarm for patient and providers, but diagnostic x-rays during pregnancy are considered safe. Exposures above 5 rads (about 2 CT scans of the abdomen) might prompt referral or further counseling (to a radiation physicist<sup>16</sup>). To this end, there

is an excellent resource from the Health Physics Society that provides clear answers regarding x-ray exposure with usual imaging.<sup>17</sup>

Even after minor trauma with no apparent involvement of the abdomen, patients should be counseled on risks associated with abrasion, including vaginal bleeding, abdominal or back pain, uterine tenderness, uterine contractions, and firmness in the uterus or abdomen.

It is possible that a pregnant patient with perceived minor trauma from a motor vehicle accident can show up in an urgent care. While presentation may be seemingly benign, there is a strain on the uterus caused by forward motion and contre coup effect that increases pregnancy complications, even in minor accidents.<sup>18</sup> As evaluation of the patient may require more advanced imaging, including urgent ultrasound and possibly MRI along with lab testing (when was the last time you did a Kleihauer Betke test?), referral to the emergency room is reasonable, especially after 23 weeks.<sup>19</sup> Risks to the pregnancy are less clear in the first trimester. (In fact, entering relevant terms into a search engine produces a list dominated by law firm websites.)

Traumatic injury and depressive presentations might also prompt the savvy urgent care practitioner to consider evaluation for intimate partner violence (IPV). While there is no clear data suggesting that IPV is *more* common during pregnancy, it is associated with numerous negative pregnancy outcomes.<sup>20</sup> Awareness of reporting requirements, documentation, safety planning, and appropriate referrals should be part of the care we provide. Informational posters and pamphlets in your clinic, including the bathrooms, may be helpful for those patients unable or unwilling to disclose abuse.

## First Trimester

### General

Patients may present with bleeding or spotting, and the differential can include threatened or missed abortion, tubal pregnancy, or infection. A fetal Doppler is a relatively inexpensive device and should be able to identify fetal heart tones at approximately 10-12 weeks—though in practice 12-14 weeks is more likely given variations in body habitus. Fetal heart tones measure in the range of 120-160 bpm. As point-of-care ultrasound devices drop in price, urgent care operators might consider this in addition to its other uses.

### Medications

Prescribing *any* medication to a pregnant patient presents a host of concerns for possible complications. Risk can be

### Health Considerations and Complaints in the First Trimester

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• Medication safety</li> <li>• Nausea and vomiting</li> <li>• Vaginal bleeding</li> </ul> | <ul style="list-style-type: none"> <li>• Miscarriage</li> <li>• Ectopic pregnancy</li> </ul> |
|--|--|

minimized with close attention to institutional regulations regarding medications appropriate for this population. Some EMR systems have the capability to flag those that are not considered to be safe. Guidance may also be obtained by consulting the FDA's Pregnancy and Lactation Labeling Rule, which replaced the agency's A, B, C, D, and X categories.

### Nausea and Vomiting

Nausea and vomiting affect 50% of pregnant patients in the first trimester.<sup>21</sup> Severe vomiting or symptoms that extend beyond the more common window of 4-12 weeks estimated gestational age (EGA) might prompt consideration of other issues. Erroneous dates and multiple fetuses might be obstetrical causes, while gall bladder disease or diabetes might be nonobstetrical issues to consider.<sup>22</sup> Intravenous fluid itself improves symptoms and, if available, a dextrose-containing solution may work a little better at reducing nausea and will reduce embryos' and fetal exposure to ketosis.<sup>23</sup> The ability to provide parenteral hydration, particularly in consultation with your obstetrical consultants, provides a valuable service and can relieve immediate complaints.<sup>23</sup>

Some complementary medical practices such as acupuncture and acupressure (eg, wristbands) may have benefit in the treatment of pregnancy-associated nausea and vomiting.<sup>24</sup> Ginger seems to have some value above placebo, as does B6 alone.<sup>24</sup> B6 is generally prescribed in relatively large doses of 25 mg 3 times daily<sup>25</sup> and doesn't seem to be associated with any adverse fetal outcomes.<sup>26</sup> First-line antiemetic therapy can be antihistamines (such as diphenhydramine 25-50 mg every 4-8 hours) or phenothiazines<sup>27</sup> such as promethazine 25 mg orally or rectally every 4 hours. These groups of medications have shown benefit above placebo and appear to be safe for use in pregnancy.

A combination of B6 and doxylamine (trade name Diclegis) is also used as an antiemetic. This is a delayed-release product containing 10 mg each of doxylamine and pyridoxine and was listed as Pregnancy Category A when that system was used. The labeling now reads "No increased risk for congenital malformations has been reported in epidemiologic studies in pregnant women." The combination of the medications seems to be syner-

Health Considerations and Complaints in the Second Trimester	
<ul style="list-style-type: none"> <li>• General pain and discomfort</li> <li>• Vaginal discharge</li> <li>• Pregnancy rhinitis</li> <li>• Edema</li> </ul>	<ul style="list-style-type: none"> <li>• Shortness of breath</li> <li>• Gastroesophageal reflux disease</li> <li>• Asthma</li> <li>• Urinary tract infection</li> </ul>

gistic.<sup>28</sup> Cost can be an issue if Diclegis is not covered by the patient's insurance. In such cases, it may be advisable to consult with or refer to an obstetrician with experience instructing patients on dosing the two over-the-counter components of this medication.

A reasonable off-label usage of extant OTC options would be B6 10-25 mg 3-4 times daily and adding doxylamine (Unisom SleepTabs) 12.5 mg 3-4 times daily.<sup>28</sup> Ondansetron until recently was commonly used in pregnancy as it appears to have better results than B6 and placebo, but there have been some concerns about reported risks of teratogenicity. A recent article did not find significant association with birth defects,<sup>29</sup> but for the time being its use should not be considered first line.<sup>30</sup> Antiemetics such as metoclopramide and methylprednisolone can also be used as second-line choices for hyperemesis, but by this point referral or consultation with obstetrics is warranted.

### ***Vaginal Bleeding***

#### ***Miscarriage***

While miscarriage is a potential issue in the first trimester, occurring in at least 30% of pregnancies,<sup>31</sup> vaginal bleeding can occur in early pregnancy with or without miscarriage. Patients who present with a primary complaint of unusual bleeding may not yet know their pregnancy status. Examination may review blood or tissue per os, a friable cervix, or an open cervix, but providers might refrain from definitive diagnosis without further imaging, serial hCG measurement, or consultation. The absence of visible tissue or an open cervical os should prompt an evaluation for viable uterine pregnancy vs ectopic, and should be ascertained with transvaginal ultrasound.<sup>32</sup> The patient needs to be aware of their Rh status, as Rh-negative women with any bleeding before 20 weeks' gestation are commonly given RhO(D) immune globulin (RhoGam) within 72 hours to suppress Rh alloimmunization, the standard of care in the United States.<sup>32</sup> While it is unlikely RhoGam would be offered in the urgent care setting, discussion of the importance of close obstetrical follow-up is essential.

### ***Ectopic Pregnancy***

Ectopic pregnancy is always a concern in a patient with a positive pregnancy test and bleeding, with or without abdominal pain. It is estimated that up to 2.4% of pregnancies are extrauterine,<sup>33</sup> and the clinical presentation may range from asymptomatic and incidentally found tubal pregnancies to severe hemorrhagic shock. They are most commonly diagnosed in the sixth through ninth weeks of gestation with presenting complaints of mild vaginal spotting with aching pelvic pain,<sup>33</sup> but symptoms can resemble other concerning intraabdominal processes such as appendicitis or adnexal infection. Of course, a positive pregnancy test should prompt further investigation. Because diagnosis of extrauterine pregnancy requires serum hCG measurement and formal transvaginal ultrasound, referral to OB or the ED is probably the safest approach. If your urgent care center can administer these tests in a timely manner, the decision tree for follow-up depends on visualization of an extrauterine mass with a positive pregnancy test, without intrauterine pregnancy. Inability to find such a mass in the appropriate clinical setting should prompt an expanded differential and close follow-up.<sup>34</sup>

### **Second Trimester**

Most often, by the second trimester you will be dealing with patients who know they are pregnant. As such, they are also more likely aware (and worried) that anything affecting their own health is also affecting the health of the fetus. Further, there are issues in the second trimester directly related to the pregnancy that may be safely managed in the urgent care.

### ***General Pain and Discomfort***

Round ligament pain, which is most prevalent in the second trimester, is a benign cause of abdominal discomfort presenting with reproducible unilateral pain and no peritoneal signs, thought to be caused by stretching of the suspensory ligaments of the growing uterus during the second trimester.<sup>35</sup> Similarly, onset of low back pain may prompt an urgent care visit. Commonly, this is due to an increase in uterine weight and relative weakness in abdominal muscles, but red flags might include trauma, vaginal bleeding, fever, or associated abdominal pain or contractions.

### ***Vaginal Discharge***

Vaginal discharge generally changes during pregnancy, increasing such that it may be mistaken for vaginitis.<sup>36</sup> Physiologic discharge of pregnancy usually is whitish or



clear with little odor. Greenish or yellow discharge with a strong odor and associated redness or itching should prompt further investigation. Bacterial vaginosis and vaginitis during pregnancy are linked to increased risk of preterm delivery<sup>37</sup> and when symptomatic, patients present with malodorous discharge, vaginal pH >4.5, and the presence of clue cells. They are generally treated with metronidazole 250 TID x 7 days or clindamycin 300 BID x 7d. Vaginal treatment is also acceptable with metronidazole gel or clindamycin cream.<sup>38</sup>

Pregnant women are more prone to candidiasis<sup>39</sup> due to hormonal changes, and office diagnosis remains observation of the organism (hyphae or budding yeast) on wet prep with saline or 10% KOH. If this is negative, one can consider culture for *Candida* or empirical treatment with topical azole therapy for 7 days.<sup>40</sup> While there is some basis for safety profile of fluconazole orally in pregnancy, there also appears to be enough concern for fetal adverse effects that topical antifungals should be preferably used.<sup>41</sup>

### ***Pregnancy Rhinitis***

Nasal congestion due to “pregnancy rhinitis” is common, affecting roughly a third of women in the second trimester, and is thought to be due to hormonal changes.<sup>42</sup> Unfortunately, there are no well-studied treatments for pregnancy rhinitis. Topical nasal steroids may be useful if there are underlying allergic causes.<sup>43</sup> Oral decongestants are generally not recommended.

### ***Edema***

Edema may present throughout pregnancy. Normally, total body water increases by 6-8 L during pregnancy,<sup>44</sup> and unless indicative of preeclampsia this is managed conservatively with loose clothing and elevation of affected extremities. Resting in the left lateral decubitus position theoretically improves lower extremity circulation by moving the uterus off the inferior vena cava. Compression hose can help, but there is a tendency toward varicosity formation which is not prevented by these measures.<sup>45</sup> Varicosities can be uncomfortable and can include vulvar symptoms, which should be referred back to OB. Diuretics are not generally used in pregnancy and would be avoided in the urgent care center.

### ***Shortness of Breath***

Similarly, shortness of breath may develop due to uterine growth and hormone changes and is a common complaint in the second and third trimester. There is a relative increase in pulmonary embolism during pregnancy; VTE is roughly 10 times more common in preg-

nancy, complicating roughly 1/1,000.<sup>46</sup> Diagnosis is more difficult due to the physiologic changes of pregnancy that may mimic those of VTE; D-dimer testing should be performed cautiously in the urgent care setting,<sup>47</sup> as there is currently some debate about the variable levels fluctuating during pregnancy.<sup>47</sup>

Therefore, if there is clinical suspicion or the presence of risk factors such as prior VTE, heritable thrombophilia, age >35, smoking, or immobility, referral to the ED is warranted for more advanced imaging and consultation. If available, compression ultrasound is helpful for extremity DVT evaluation; however, MRI is now recommended for evaluation of pelvic DVT suspicion.<sup>48</sup> Even more confusing are the various choices to evaluate for pulmonary embolism. Suspicion of PE should be evaluated emergently in the ED.

### ***Gastroesophageal Reflux Disease (GERD)***

Gastroesophageal reflux disease may develop in the second trimester as uterine growth starts displacing organs upwards, complicated by hormonally related relaxation of the lower esophageal sphincter and a relative decrease in gastric motility.<sup>49</sup> Symptoms that occur later in the second or third trimesters or are severe should prompt investigation for other issues such as GB or PUD, preeclampsia with HELLP syndrome. Aluminum-, magnesium-, or calcium-containing antacids should be first line. H<sub>2</sub> blockers are generally considered safe during pregnancy,<sup>50</sup> as are proton pump inhibitors<sup>51</sup> (though under the FDA's previous system omeprazole was listed in category C).

### ***Asthma***

Asthma is the most common chronic medical condition reported in pregnancy,<sup>52</sup> and exacerbations may certainly present to urgent care. For years we have been taught that roughly a third of pregnant patients improve, a third remain the same, and a third worsen.<sup>53</sup> Compared with pregnancy uncomplicated by asthma, the gravid asthmatic is at risk of a range of perinatal complications.<sup>54</sup>

Since an urgent care provider is most likely to see an exacerbation of underlying disease, we should be comfortable recommending use of inhaled beta agonists. Recommendations can also include double ICS for 7-10 days or adding oral corticosteroids.<sup>55</sup> It seems that acute care providers are reluctant to use steroids in their pregnant patients,<sup>56</sup> but these are no less indicated in a pregnant patient who has failed other measures. There may be small potential increases in cleft lip, preeclampsia, and low birth weight with systemic corticosteroids, but it isn't possible to ascertain whether this is due to the medica-

### General Health Considerations and Complaints in the Third Trimester

- Rash
- Preeclampsia

tion or the underlying disease.<sup>57</sup>

#### UTI

Urinary tract infection can be a complication at any point in pregnancy. There is a higher frequency of bacteriuria during pregnancy, so we should perhaps consider urinalysis another “vital sign” assessment for the pregnant patient. Asymptomatic bacteriuria may be noted by the presence of leukocyte esterase or nitrite on a dipstick, though urine culture is the standard for this diagnosis and is generally done as screening in the first and third trimesters. If you have evidence of asymptomatic bacteriuria, consider culturing the urine and forwarding the information to the obstetrical provider, and treat the patient as this condition can develop into cystitis or pyelonephritis and is associated with increased risk of intrauterine growth retardation and low birth weight. Symptomatic cystitis can be managed in the urgent care setting, but providers should be aware that symptomatic infection is associated with preterm labor and lower birth weight.<sup>58</sup> Urine culture should be obtained, with the results communicated to the OB, particularly if Group B *Streptococcus* is identified as this has ramifications for antibiotic management in the third trimester. Nitrofurantoin and sulfonamides can be used in the second trimester, but are better offered as second-line choices in the first trimester due to data suggesting a higher rate of birth defects.<sup>59</sup> Toward the end of pregnancy, these two agents are associated with neonatal jaundice and kernicterus, while nitrofurantoin is also potentially a cause for neonatal hemolytic anemia in G6PD mothers.<sup>60</sup> So, when possible, first-line choices throughout pregnancy should be amoxicillin 500 q 8-12 hours for 3-7 days or cephalexin 500 every 6-12 hours for 3-7 days.<sup>60</sup> Relatively longer courses, such as 7 days of treatment, may be beneficial compared to nonpregnant women.<sup>61</sup> Pyelonephritis should be suspected if there are signs of sepsis such as fever, chills, nausea and vomiting, and flank pain. Contractions may occur. Suspected pyelonephritis in the pregnant patient should be referred to the ED in most cases. While there is support for outpatient treatment in some situations,<sup>62</sup> these decisions should be made after assessment of fetal and maternal wellbeing and likely in consultation with an obstetrician.

#### Third Trimester

There are critical issues that present primarily in the third trimester, such as preeclampsia, preterm labor, and amnionitis. Depending on your local scenario, it may be prudent to at least assess a pregnant patient in the urgent care for stability and triage. Headache, severe edema, elevated blood pressure, decreased fetal movement, or imminent delivery might prompt EMS transport from your facility. Other complaints are safer to treat in the urgent care setting.

#### Rash

Pruritic urticarial papules and plaques of pregnancy (PUPPP) is one of the more common pregnancy-related dermatoses, occurring in about 1 in 300 pregnancies, usually in the third trimester.<sup>63</sup> As the name implies, this is an intensely pruritic rash, often on the abdomen and along striae. There are no adverse outcomes known, and treatment is largely supportive with antihistamines and topical corticosteroids.<sup>64</sup>

Patients with pruritus but no obvious lesions might be considered for cholestasis of pregnancy. Intrahepatic cholestasis of pregnancy may cause pruritus with rash and has been associated with increased fetal mortality and, if suspected, requires increased antenatal surveillance and discussion with obstetrics. This suspicion is confirmed with laboratory testing, and severe cases may require ursodiol. From an urgent care perspective, suspicion might prompt securing alkaline phosphatase levels, LFTs including bilirubin and bile acid levels, and prompt follow-up with their OB.

#### Preeclampsia

In the U.S., the rate of preeclampsia is 3.4%,<sup>65</sup> with contributing factors of smoking and obesity. With symptoms ranging from mild to severe, it is associated with new-onset proteinuria (more than 1+ on a dip, BP > 140/90) after 20 weeks gestation. Symptoms can include severe headaches, visual changes, edema, and abdominal pain.

Laboratory abnormalities can include thrombocytopenia, abnormal LFTs, renal insufficiency, and hyperuricemia.<sup>66</sup> It may superimpose on chronic or gestational hypertension (new onset HTN after 20 weeks without proteinuria). HELLP syndrome is a concerning complication of hypertensive disease, which can have sudden onset of H(emolysis) E(levated) L(iver enzymes) L(ow) P(latelets) and can progress to DIC, renal failure, pulmonary edema, and placental abruption. If suspected, referral to the emergency room is warranted with transportation by EMS.

## Postpartum Issues

Even a healthy delivery does not preclude the possibility of a patient presenting with complaints directly related to her pregnancy. Bear in mind that there should still be concern for the newborn in mothers who are breastfeeding.

### Postpartum Preeclampsia

Preeclampsia, unfortunately, may persist or even originate in the postpartum period, occurring up to 4 weeks after delivery.<sup>67</sup> In one study, 2/3 of patients had no antecedent diagnosis of hypertensive disease in the recent pregnancy, and most cases occurred in the week after delivery.<sup>68</sup> The most common presenting symptom is headache, and if there are notably elevated blood pressures the possibility of postpartum preeclampsia should be considered.

As with preeclampsia during gestation, evaluation for proteinuria and edema can be done at the urgent care center. Uric acid and liver function tests can be performed, as well, if you have that capability. If you have an onsite lab that can do spot urine protein, diagnosis of preeclampsia prior to obtaining 24-hour urine protein collection is now possible in the urgent care utilizing the ratio of urine protein and creatinine. These values can be placed in a calculator (such as one on the website perinatology.com). At the very least, a dipstick determination of 1+ or more is suspicious.<sup>69</sup> As there is the possibility of progression to eclampsia or HELLP syndrome, immediate referral is warranted.

### Mastitis

Mastitis is a relatively common problem, occurring in approximately 10% of breastfeeding mothers, most commonly in the second and third weeks postpartum.<sup>70</sup> Clinically, it can present as localized breast tenderness with erythema to a septic picture with pain, malaise, myalgia, and high fevers. While local culture or milk culture can be obtained, the organism most frequently implicated is *Staphylococcus aureus*.<sup>70</sup> Cephalixin or dicloxacillin are good first-line choices for most patients, but other common choices include amoxicillin/clavulanate, clindamycin (especially if MRSA is suspected). Bactrim is not recommended in women breastfeeding infants <2 months due to risks of kernicterus, but extensive review of sulfonamides near term and during breast feeding found no adverse reactions.<sup>71</sup> Breastfeeding with good drainage of the breast is encouraged during treatment. Establishment of improved breast feeding technique might require referral to a lactation consultant.

## General Health Considerations and Complaints Postpartum

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>• Postpartum preeclampsia</li> <li>• Mastitis</li> </ul> | <ul style="list-style-type: none"> <li>• Postpartum hemorrhage</li> <li>• Postpartum depression</li> </ul> |
|---|--|

### Postpartum Hemorrhage

Postpartum hemorrhage (PPH) is defined as either primary or secondary, depending on whether it happens in the first 24 hours after delivery. In the urgent care setting, it would seem more likely to see secondary PPH, which can present up to 12 weeks postpartum and in somewhere around 1% of pregnancies.<sup>72</sup> Following delivery, most women will have a period of lochia, a musty-smelling dark discharge which lightens in the weeks after delivery. A patient may present with sudden bleeding after lochia has tapered, but bleeding can be occult so patients may present with hypotension, tachycardia, lightheadedness, and other signs of near or overt syncope. Uterine atony would be less an issue after the initial postpartum period, so more likely causes of increased may include retained placental tissue, infection, and vascular anomalies.

A history of primary PPH is often present.<sup>73</sup> Depending on your comfort level, speculum exam may reveal retained placenta or other tissue in the os. Because of the varied causes and management options, ranging from conservative care to uterine evacuation, and the potential need for advanced imaging or labs, referral to the ED after determining or securing hemodynamic stability, or immediately to an obstetrician is warranted for the patient with acute worsening of post part bleeding.

### Postpartum Depression

Recognizing a presentation of increased sadness, poor sleep, and other mood changes in the postpartum period should prompt close follow-up and referral.

The most commonly recommended validated tool is the Edinburgh Postnatal Depression Scale.<sup>74</sup> The EPDS is 10 questions and therefore probably beyond the scope of most urgent care centers, but awareness of three key components of the scale—self-blame, anxiety, and fearfulness<sup>74</sup>—might prompt a provider to consider the diagnosis and refer appropriately. PPD is generally treated with psychological support and other nonpharmacologic interventions.<sup>75</sup> ■

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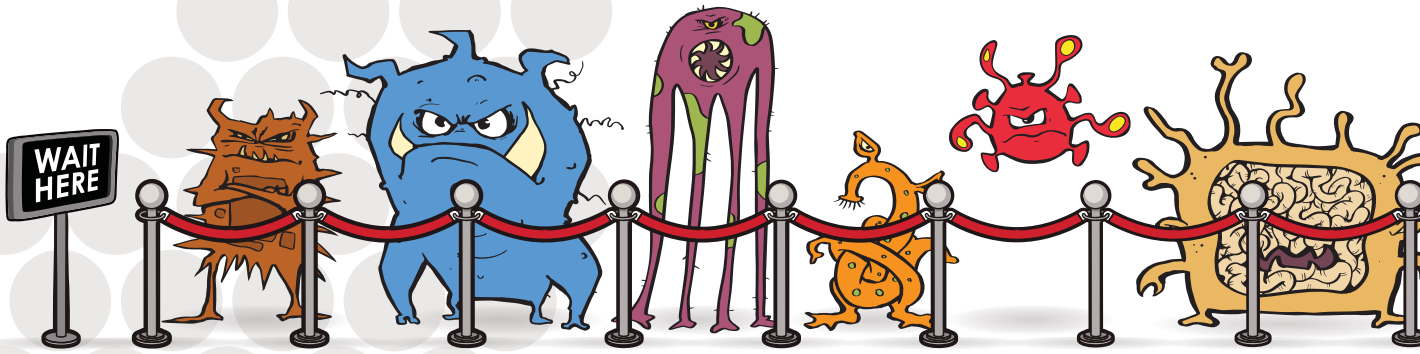
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# An 11-Year-Old Girl with Red, Itchy Rash

**Urgent message:** Urticaria from cold exposure should be considered to prevent future anaphylaxis and angioedema with re-exposure.

KELSEY REED, MSN, APRN, FNP-C

## Case Presentation

An 11-year-old girl presents to urgent care with complaints of repetitive episodes of sudden onset of itchy red rash with ill-defined borders which has occurred three times in the past 1.5 weeks following exposure to cold water. Twice, the hives occurred after swimming in a pool and once in a local lake.

The mother states that her daughter is experiencing “giant hives” that are getting progressively worse with each exposure. The patient states that the rash itches and is red, but denies any throat or neck swelling, drooling, wheezing, shortness of breath, vesicles, nausea, vomiting, diarrhea, palpitations. The mother states that the hives spontaneously resolve after the patient gets out of the water and warms up, but immediately reoccur when the patient reenters the water or is exposed to cold objects. The mother states that she did administer 50 mg of Benadryl prior to the urgent care visit. She denies any new household products, personal products, food exposure, animal exposure, medications, or prior episodes.

In taking the history, you learn:

- Past medical history: Seasonal allergies
- Allergies: NKDA
- Medications: None
- Social history: Noncontributory
- Family history: Mother has seasonal allergies

## Physical Examination

- Vital signs: 36.4° C, pulse 96, respirations 20, O<sub>2</sub> saturation 99%
- Height: 5 feet
- Weight: 45 kg
- General appearance: Alert and oriented x 3, no



- acute distress, able to have a conversation with provider
- Skin: Warm, dry, pink. No evidence of urticarial lesions, rash, redness, swelling, streaking
- Eyes: PERRL
- ENMT: TM’s clear, oral mucosa moist, no pharyngeal erythema or exudate, no lesions, no Ludwig’s angina, no angioedema
- Neck: supple, midline trachea, no tenderness
- Cardiovascular: regular rate and rhythm, no murmur, normal peripheral perfusion

Kelsey Reed is an APRN for the state of Illinois. The author has no relevant financial relationships with any commercial interests.

### Cold Urticaria

#### Signs and Symptoms

- Temporary reddish, itchy welts (hives) on the area of skin that was exposed to cold
- Worsening of the reaction as the skin warms
- Swelling of hands while holding cold objects
- Swelling of lips from consuming cold food or drink

#### Severe Reactions

- Whole-body response (anaphylaxis), which can cause fainting, racing heart, swelling of limbs or torso, and shock
- Swelling of the tongue and throat, which can make it difficult to breathe

Adapted from: Cold Urticaria. Mayo Clinic. Available at: <https://www.mayoclinic.org/diseases-conditions/cold-urticaria/symptoms-causes/syc-20371046>. Accessed October 13, 2019.

- Respiratory: Lungs CTA, non-labored respirations, breath sounds equal
- Gastrointestinal: Soft, non-tender, non-distended, normal bowel sounds
- Neurological: Alert and oriented x 3, no focal neuro deficits

#### Differential Diagnoses

- Allergic reaction (food, medication, household or personal product)
- Viral-induced urticaria
- Irritant contact dermatitis
- Pityriasis rosea
- Urticarial vasculitis
- Other forms of urticaria

#### Cold Contact Stimulation Test: The Ice Cube Challenge

The provider placed a mixed bag of ice and a small amount of water on the volar aspect of the left lower arm for 5 minutes. After 5 minutes, the patient developed an urticarial wheal, which was not present on the opposite arm. Evaluation at 10 minutes postremoval of the ice cube indicated the hives were still present, but reduced. (This technique is known as a cold contact stimulation test, specifically the "ice cube challenge.")

#### Diagnosis

The patient was diagnosed with cold urticaria. She was given prescriptions for Loratadine and an epinephrine pen.

*“Cold-induced urticaria can easily be reproduced in the office setting. Missing the diagnosis could have deadly consequences due to the possibility of repetitive exposure and increasing chance of anaphylactic reaction.”*

#### Discussion

##### Epidemiology

Cold-induced urticaria can affect people across the lifespan and can be acquired or follow an autosomal-dominant familial transmission pattern.<sup>1</sup> Commonly adolescents, as well as younger children, are more likely to be affected by sudden onset of cold-induced urticaria. However, this does not exclude adults nor the geriatric population.<sup>2,3</sup> Gender does not seem to play a role in occurrence. If the reaction occurs in youth and has a genetic component, the condition is likely to last a lifetime (whereas an acquired case may spontaneously resolve in approximately 5 years).<sup>1</sup>

When a reaction occurs, a localized response of classic urticaria or wheal and flare pattern may initially present with exposure to cold weather, liquids, foods, or chilled objects due to a systemic histamine, leukotriene, and mast cell response.<sup>1</sup> Severe reactions may also cause systemic response involving angioedema and anaphylaxis.

Escalation of response with each exposure should be expected; therefore, prevention and treatment strategies must be initiated as soon as cold-induced urticaria is suspected, as respiratory shock and failure can occur.

Preventive measures, on which patients should be counseled, include taking an antihistamine before expected cold exposure; taking all medications as directed; protecting skin from cold or sudden changes in temperature; avoiding ice-cold drinks and foods; and keeping an epinephrine pen, if prescribed, close at hand to prevent serious reactions.<sup>4</sup>

##### History

A diagnosis of cold urticaria should be considered in any patient with sudden onset of wheals or angioedema following exposure to a cold object, fluid, or food should be considered for possible diagnosis of cold urticaria. Patients may present with first-episode responses, or may complain of continued reactions post cold exposure.



## Physical Examination

### Differential diagnosis

Differential diagnoses must be considered in any case presentation; for cold urticaria, they include, but are not limited to, familial cold autoinflammatory syndrome, cold-induced urticarial vasculitis, serum protein disorders, and differentiation between types of cold-induced urticaria.<sup>5</sup>

Types of cold-induced urticaria include: delayed response, familial atypical cold urticaria, cold-induced cholinergic urticaria, systemic cold urticaria, localized cold urticaria, and food-dependent cold urticaria.

While it's outside the scope of this case, awareness of cold urticaria syndromes may help inform decisions relating to treatment, referral, and patient counseling in the urgent care setting. See **Table 1**.

### Diagnosis

Diagnostic pearls include the use of algorithms for diagnosing patients with recurrent wheals or angioedema.<sup>6</sup> Simple testing such as the “ice cube test” or “cold stimulation challenge” can provide insight as to whether or not the response is reproducible by applying an ice cube to the patient's forearm for 5 minutes, removing, and observing for formation of a wheal approximately 5 minutes after removal.<sup>7</sup>

### Management

If the test is positive, then treatment should begin with H<sub>2</sub> antihistamines and nonsedating antihistamines while in the urgent care setting.<sup>8</sup> These treatments have been shown to reduce the severity of the reaction, but may not prevent future reactions.<sup>8</sup>

Epinephrine auto injectors were also recommended in all cases due to risk of continued worsening with exposure, and risk for anaphylaxis due to cold foods.<sup>9</sup> While urgent care plays a role in attempting to prevent further episodes, complete management in this setting is not appropriate. Primary care providers should follow the patient and make referral to immunology, allergists, dermatologists, and vascular specialists as needed. Treatment then can be tailored to each individual patient and may include management of acute exacerbations, refractory symptoms, and cold desensitization therapy.

### Conclusion

Cold-induced urticaria can be difficult to diagnose. When a patient presents with spontaneous urticaria, a thorough history should be obtained to determine any possible exposures. Cold-induced urticaria can easily be

**Table 1. Diagnostic Classification of Cold Urticaria Syndromes**

Syndromes with positive cold-contact stimulation test	Atypical syndromes (ie, atypical responses to cold-contact stimulation test)
<ul style="list-style-type: none"> <li>• Primary</li> <li>• Secondary               <ul style="list-style-type: none"> <li>– Cryoglobulinemia</li> <li>• Primary</li> <li>• Secondary                   <ul style="list-style-type: none"> <li>■ Chronic lymphocytic leukemia</li> <li>■ Lymphosarcoma</li> <li>■ Leukocytoclastic vasculitis</li> <li>■ Angioimmunoblastic lymphadenopathy</li> </ul> </li> </ul> </li> <li>– Leukocytoclastic vasculitis</li> <li>– Infectious diseases               <ul style="list-style-type: none"> <li>• Mononucleosis</li> <li>• Syphilis</li> <li>• Others</li> </ul> </li> <li>– Cold agglutinins</li> <li>– Cold hemolysins</li> <li>– Cold fibrinogens</li> <li>– Other factors</li> </ul>	<ul style="list-style-type: none"> <li>• Systemic atypical</li> <li>• Cold-dependent dermatographism</li> <li>• Cold-induced cholinergic urticaria</li> <li>• Delayed cold urticaria</li> <li>• Localized cold-reflex urticaria</li> </ul>
<p>Adapted from: Wanderer AA. Cold urticaria syndromes: historical background, diagnostic classification, clinical and laboratory characteristics, pathogenesis, and management. <i>J Allerg Clin Immunol</i>. 1986;85(6):965-981.</p>	

reproduced in the office setting. Missing the diagnosis could have deadly consequences due to the possibility of repetitive exposure and increasing chance of anaphylactic reaction. ■

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## ABSTRACTS IN URGENT CARE

- What's New in Flu Vaccine Information
- New First-in-Class Pleuromutilin Antibiotic for CAP
- Abdominal Pain in Patients with IUDs—Watch Out for Ectopic Pregnancy
- Cancer-Causing Chemical Found in Ranitidine
- Measles Cases and Outbreaks
- Cooling Pediatric Burns
- Occ Med: Severe Silicosis in Stone Fabrication Workers

■ CORNELIUS O'LEARY JR, MD

### An Update on Vaccine for the 2019-2020 Flu Season

**Key points:** The CDC recommends annual influenza vaccination for everyone 6 months of age and older, with any licensed influenza vaccine that is appropriate for the recipient's age and health status (IIV, RIV4, or LAIV4) with no preference expressed for any one vaccine over another. All regular dose vaccines are quadrivalent this year. Fluzone (high-dose trivalent vaccine) may provide more protection to those ages 65 and up, but is not preferred in this population by the CDC. Doses for first-time recipients can be found on the CDC website.

Citation: Food and Drug Administration. Influenza Vaccine for the 2019-2020 Season. Available at: <https://www.fda.gov/vaccines-blood-biologics/lot-release/influenza-vaccine-2019-2020-season>. Accessed October 9, 2019.

The FDA's Vaccines and Related Biologic Products Advisory Committee met in Silver Spring, MD to determine the composition of this season's influenza vaccines. The agency noted that the investigators reviewed and evaluated surveillance data on the epidemiologic and antigenic characteristics of recent influenza isolates, serologic data showing response to last year's vaccine, and the availability of strains and reagents to make this year's vaccine. All regular dose seasonal influenza vaccines are quadrivalent this year.

The committee decided that this year's trivalent vaccine would contain:

- an A/Brisbane/02/2018 (H1N1)pdm09-like virus



**Cornelius O'Leary Jr, MD** is an urgent care physician with Emergency Care Dynamics, San Diego, CA.

- an A/Kansas/14/2017 (H3N2)-like virus
  - a B/Colorado/06/2017-like virus (B/Victoria lineage)
- The committee also decided that the quadrivalent vaccine would get the above three strains and a B/Phuket/3073/2013-like Virus (Yamagata lineage). ■

### A New Antibiotic for Community-Acquired Bacterial Pneumonia

**Key point:** Xenleta (lefamulin) is a first-in-class pleuromutilin antibiotic for the treatment of community-acquired pneumonia (CAP). A recent stage III clinical trial published in JAMA showed it to be noninferior to moxifloxacin (Avelox), though it is more expensive and with a higher amount of gastrointestinal severe adverse events.

Citation: FDA. FDA Approves New Antibiotic to Treat Community-Acquired Pneumonia. Available at: <https://www.fda.gov/news-events/press-announcements/fda-approves-new-antibiotic-treat-community-acquired-bacterial-pneumonia>. Accessed October 9, 2019.

The FDA approved a new oral and IV antibiotic, lefamulin (Xenleta), for the treatment of adults with community-acquired pneumonia. The agent will not cover MRSA or *Pseudomonas*. Lefamulin is a first-in-class new drug in the novel class of pleuromutilins made by Nabriva therapeutics.

The Nabriva website reports pleuromutilins were discovered in 1950. They disrupt bacterial ribosomal protein synthesis by binding to the 50s subunit of bacterial ribosomes. Ed Cox, MD, MPH, director of FDA's Office of Antimicrobial Products said the new approval is indicative of the agency's commitment to developing new antibiotics in this age of resistance.

The authors noted that a pivotal clinical trial tested the safety and efficacy of lefamulin head-to-head vs moxifloxacin with or without linezolid in 1,289 patients with CABP. When administered

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orally or intravenously, lefamulin achieved clinical success similar to moxifloxacin with or without linezolid during these studies.

Lefamulin requires no dose adjustment in renal failure. Oral and IV adjustments are made in moderate to severe hepatic impairment. The most common side effects were diarrhea, vomiting, injection-site reaction, transaminitis, and QT prolongation. Women who may become pregnant are advised to use contraception until 2 days after the last dose. Based on findings of fetal harm in animal studies pregnant women or women who may become pregnant should be advised of potential risks. ■

### Don't Let Birth Control Dissuade You from Considering Ectopic Pregnancy

*Key point: Providers should maintain a high index of clinical suspicion for ectopic pregnancy in women of reproductive age, even in the setting of highly effective birth control.*

*Citation: Neth MR, Thompson MA, Gibson CB, et al. Ruptured ectopic pregnancy in the presence of an intrauterine device. Clin Pract Cases Emerg Med. 2019;3(1):51–54.*

The patient in this case was a 34-year-old woman with no past medical history who presented with acute-onset suprapubic pain. The pain was moderate to severe, nonradiating, with rebound abdominal tenderness and guarding. Review of systems was significant for nausea and vomiting. The patient had a copper IUD placed 3 years prior. She was afebrile, with stable vital signs: 98.1° F, BP 140/81, HR 96 beats per minute, RR 20 respirations. She denied history of PID or ectopic pregnancy, any vaginal bleeding or spotting, or vaginal discharge.

The authors noted that a urine pregnancy test was ordered promptly; however, the patient had a syncopal episode on the way to the restroom which led to prompt point-of-care ultrasound (POCUS) showing free fluid in Morrison's pouch, an intact IUD with no signs of intrauterine pregnancy, and marked hypervascularity in the left adnexa (ring of fire sign) and fetal cardiac activity. Along with a positive pregnancy test, a live ectopic pregnancy was diagnosed. The patient was taken emergently to the operating room where a ruptured left tubal ectopic pregnancy and a 1 L hemoperitoneum were found. After salpingectomy, the patient was hemodynamically stable and discharged.

A syncopal episode in this patient illustrates the importance of advocacy for safe ambulance transport to the ED.

The authors report that ruptured ectopic pregnancy is the leading cause of first-trimester maternal mortality. It is a medical emergency that should be considered in women presenting with abdominal pain, vaginal bleeding, or even syncope. This study shows that intrauterine devices protect women from intrauterine pregnancy, but do not protect from ectopic pregnancy in the setting of IUD failure. This case report discusses a patient who presented with ruptured ectopic pregnancy and hemoperitoneum despite a correctly positioned IUD.

With regard to ectopic pregnancy, the authors note that factors affecting fallopian tube function, such as a prior surgical procedure, instrumentation, or infection (such as from pelvic inflammatory disease) can increase the chance of ectopic pregnancy. They further highlight that use of an IUD for birth control increases the probability that women presenting with abdominal pain are experiencing ectopic pregnancy.

IUDs decrease the overall incidence of pregnancy, including ectopic pregnancy. However, in the instance of IUD failure (unintended pregnancy), the pregnancy is more likely to be an ectopic or ruptured ectopic pregnancy.

Studies show that IUDs have a 1-year failure rate of 0.8–0.1 unintended pregnancies per 100 women. In the setting of IUD failure, the risk of ectopic pregnancy rises from 2% in the general population to between 15% and 27%.

The overall incidence of ectopic pregnancy is 2%, but is much higher in patients who present to the ED (and also to the urgent care setting). Women with IUDs commonly report to the urgent care practitioner that pregnancy is impossible, and that they recently had an IUD check with their PCP.

This case report should reinforce in the mind of the urgent care practitioner the possibility of ectopic pregnancy in patients with correctly placed IUDs. Point-of-care ultrasound (POCUS) is important in the timely diagnosis of these patients. Alternative diagnoses such as ovarian torsion or ruptured ovarian cyst require the same timely transfer to the ED for ultrasound evaluation. This clinical scenario illustrates the potential for a skilled urgent care practitioner experienced in ultrasound to confirm this diagnosis prior to transfer. Confirmation of this diagnosis increases the likelihood the patient will accept safe transfer by ambulance to the ED. ■

### Be Mindful of Warnings Regarding Ranitidine-Containing Medications

*Key point: Providers should consider prescribing alternatives to ranitidine during the current testing and recall of contaminated products by the FDA.*

*Citation: FDA. Zantac (ranitidine): Safety Information—NDMA Found in Samples of Some Ranitidine Medicines. Available at: <https://www.fda.gov/safety/medical-product-safety-information/zantac-ranitidine-safety-information-ndma-found-samples-some-ranitidine-medicines>. Accessed October 9, 2019.*

The FDA announced that trace amounts of N-Nitrosodimethylamine (NDMA) have been found in some ranitidine-containing medications, including the brand name drug Zantac. NDMA is a probable human carcinogen, the FDA noted, and is a known environmental contaminant that is sometimes present in water and in food such as dairy products, meat, and vegetables.

The FDA is not advising patients to stop taking ranitidine at

this time. However, urgent care providers should be prepared to discuss the situation with patients because the agency is recommending that those who want to stop taking it discuss alternatives with their healthcare provider. Patients taking OTC ranitidine should consider various other OTC options, according to the FDA. (The FDA subsequently announced the recall of Zantac and several other ranitidine containing products due to the potential for contamination.) ■

### Measles Cases and Outbreaks

**Key points:** As of September 26, 2019, 1,243 known cases of measles have been confirmed in the U.S. Of note:

- 75% are related to the outbreak of measles in New York
- The majority of cases occur in previously unvaccinated patients
- 131 cases were hospitalized, with 65 patients reporting severe sequelae such as pneumonia and encephalitis

**Citation:** Centers for Disease Control and Prevention. Measles cases in 2019. Available at: <https://www.cdc.gov/measles/cases-outbreaks.html>. Accessed October 9, 2019.

The CDC reports there are two current outbreaks of measles occurring in the United States—both of them in New York. The two outbreaks are identified as New York #1 (Rockland County) and New York #2 (non-Rockland County). The date of two maximal incubation periods (42 days) without further cases was September 30 for the Rockland County outbreak. The CDC reports that outbreak is related to international travelers coming from countries such as Israel, Ukraine, and the Philippines, where outbreaks continue to be active. ■

### New Data Validate Optimal First Aid for Burns in Children

**Key point:** Adequate first aid for burns includes 20 minutes of running water within the first 3 hours after thermal injury. Adequate duration of running water therapy may improve outcomes in pediatric burns.

**Citation:** Griffin BR, Frear CC, Babl F, et al. Cool running water first aid decreases skin grafting requirements in pediatric burns: a cohort study of two thousand four hundred ninety-five children. *Ann Emerg Med*. Available at: [www.annemergmed.com/article/S0196-0644\(19\)30538-4/abstract](http://www.annemergmed.com/article/S0196-0644(19)30538-4/abstract). Accessed October 9, 2019.

The objective of this study was to study the adequacy of first aid with respect to running water duration on pediatric burn outcomes. This was a prospective cohort study of 2,495 children who presented to a tertiary children's hospital for burn care. The study examined duration of first aid with respect to the primary outcome of skin grafting, and secondary outcomes of time to re-epithelialization, wound depth, operative interven-

*"Engineered stone contains much higher silica levels than natural stone, and the popularity of engineered quartz surfaces has resulted in an 800% increase in the use of such materials over the past several years. Silicosis causes approximately 100 deaths per year in the U.S. "*

tion, admission, and hospital stay.

Multivariate logistic regression models were used to study the relationship between first aid and the requirement for skin grafting. Approximately 91% of children were given first aid with running water, however only 71% were given the adequate duration of 20 minutes.

Approximately 10% of children required skin grafting. When adequate first aid with 20 minutes of running water was administered, the study noted:

- Odds ratio (OR) for decreased risk of skin grafting was 0.6 [95% Confidence Interval (CI) 0.4-0.8]
- Reduction in full thickness depth of the burn OR was 0.4 [95% CI 0.2-0.6]
- Decrease in hospital admissions OR 0.7 [95% CI 0.3-0.9]
- Decrease in operating room interventions OR 0.7 [95% CI 0.5-0.9]
- Twenty minutes of running water had no effect on hospital stay duration

The researchers concluded that adequate prehospital first aid should be prioritized, particularly with respect to the provision of 20 minutes of running water within 3 hours of injury, to improve outcomes in pediatric burns. ■

### Severe Silicosis in Engineered Stone Fabrication Workers — California, Colorado, Texas, and Washington, 2017–2019

**Key point:** Silicosis is a rare, incurable lung disease that occurs after the inhalation of silica dust. It should be considered in symptomatic occupational health patients who work in stone fabrication.

**Citation:** *MMWR*. 2019;68(38):813–818.

Silicosis causes approximately 100 deaths per year in the U.S. The CDC identified two deaths in young stone fabrication workers that were attributable to their work with silica-containing compounds. With regard to the occupational health patient from stone fabrication, keep this diagnosis in mind. Keep this diagnosis in your differential if appropriate (such as in occupational medicine patients engaged in stone fabrication and in urgent care patients with exposures to dust/silica). Some of the



most important information we give to patients is to follow up with their physician if their symptoms do not improve.

According to the CHEST Foundation, there are three types of silicosis:

- Acute, in which patients experience cough, weight loss, and fatigue within a few years after exposure. Severe pulmonary inflammation may occur, leading to dyspnea and desaturation
- Chronic, which can occur 10 to 30 years after exposure, noted by extensive scarring, and may involve apical lungs. This may cause distinct areas of scarring and involve lymph nodes
- Accelerated, within 10 years of high-level exposure, noteworthy for scarring/inflammation and symptoms progress faster than in acute silicosis

Silicosis cannot be cured, but it can be prevented. Engineered stone contains much higher silica levels than natural stone, and the popularity of engineered quartz surfaces has resulted in an 800% increase in the use of such materials over the past several years.

From a medical perspective, these cases describe 18 mostly

Hispanic stone fabrication workers who presented with upper respiratory symptoms and had severe, accelerate, progressive disease. Two of the patients were concomitantly diagnosed with autoimmune disease, scleroderma and rheumatoid arthritis.

All patients had CT findings consistent with silicosis and pulmonary function tests showing restrictive disease. Several of these patients had lung biopsies prior to referral to occupational health.

The diagnosis of silicosis involves a full history and physical exam. Furthermore, work-up involves:

- Radiographs
- CT scan
- Referral to pulmonology
- Bronchoscopy
- Lung biopsy
- Sputum examination for associated diseases such as tuberculosis

In addition, the treatment of silicosis may initially involve steroids, inhaled steroids, or bronchodilators. In severe cases, a lung transplant may be considered. ■



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# Urgent Care Looks to Find its Identity through Gen Z and Millennials

**Urgent message:** Younger consumers' healthcare preferences are significantly different than those of older consumers. Urgent care providers have a prime opportunity to meet the needs of Gen Z and Millennials by creating a new healthcare experience.

DAN STANEK

## Introduction

As everyday healthcare begins to deviate from the classic primary care model, the competition is just beginning in regard to which alternative provider will best suit consumers' needs. Urgent care may be the current provider type with the biggest opportunity. While the term "urgent" tends to make new and potential consumers believe they can only visit urgent care providers if they have a critical issue (similar to an emergency department), many urgent care centers offer services comparable to a PCP and can often do so without an appointment. Consumers, especially young and healthy ones, are taking notice and causing healthcare professionals to question their current model as the desire for convenient, cost-efficient care is expanding.

With this in mind, the consulting firm WD Partners undertook research into considerations healthcare decision makers take into account when making everyday decisions.

## Purpose

We start with the presumption that healthcare systems will continue to move away from monolithic hospital settings in an attempt to become more convenient for their customers. As healthcare moves closer to where people work and live and creates more consumer-friendly settings, this is an opportune time to learn the preferences of healthcare decision makers when it comes to everyday care.

The WD Partners' study, *Healthcare: Who Survives?* found clear indications that consumers, especially Gen



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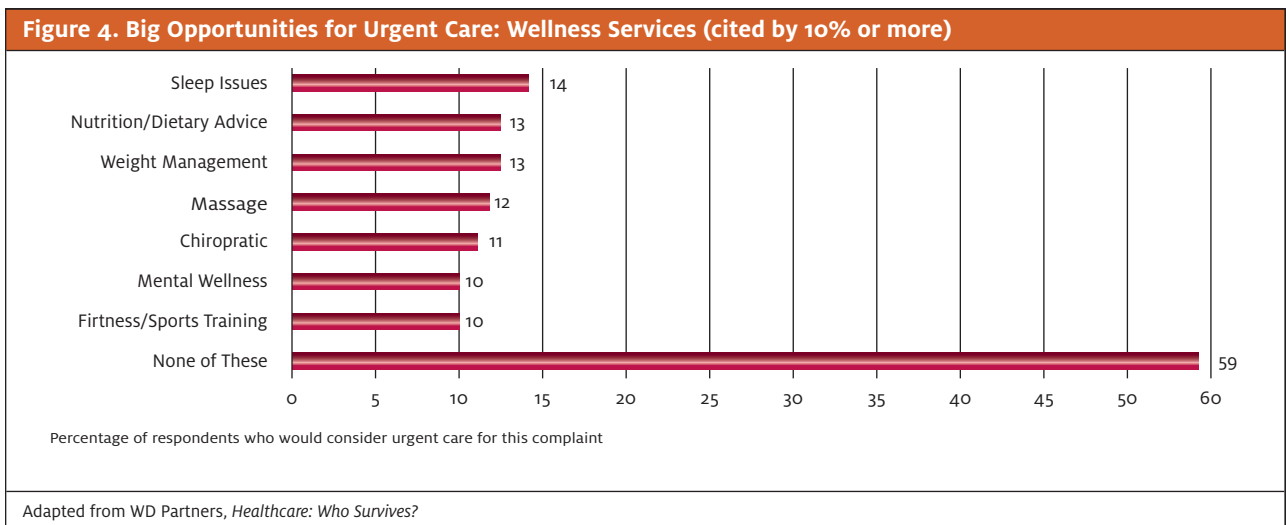
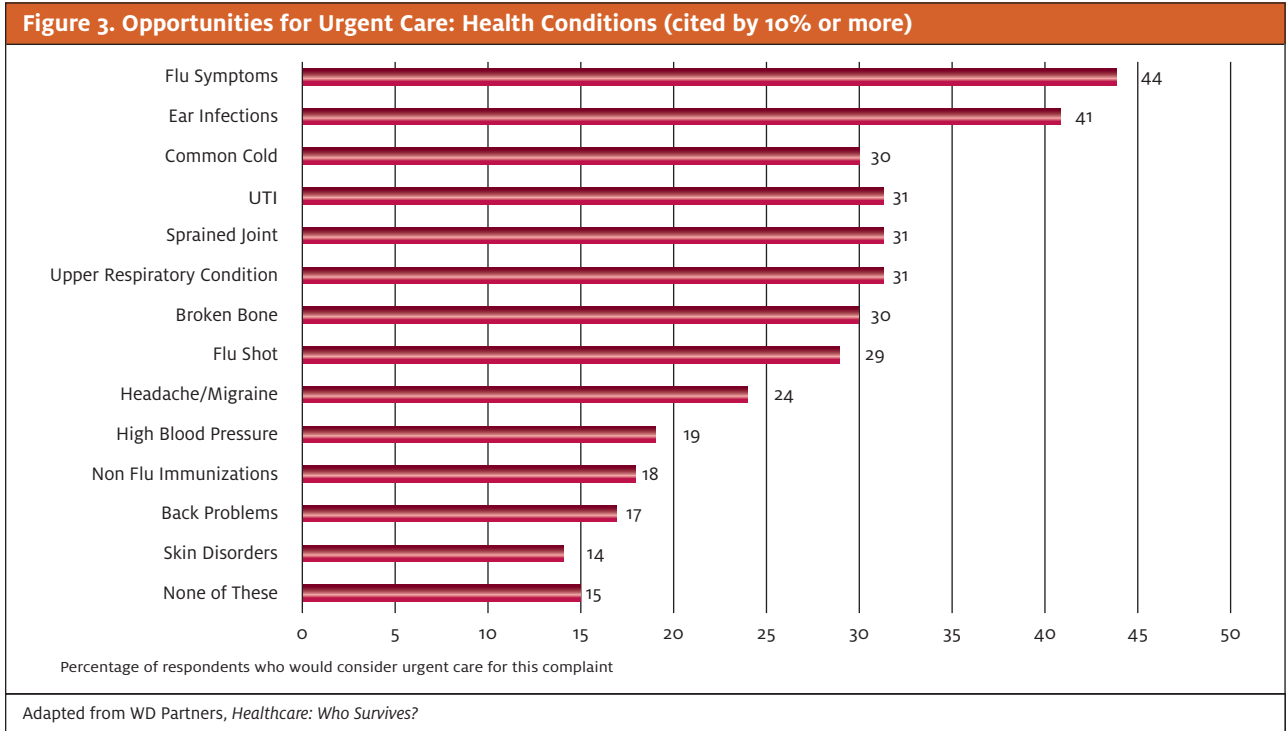
Z and Millennials (those between the ages of 18 and 38, combined), are increasingly looking to move away from the PCP's office and toward more accessible, low-cost options. This movement is prominent among the factors that have prompted the everyday healthcare landscape to reconfigure, generating two new alternatives that better suit the public's evolving needs: retail clinics and urgent care facilities. These new facilities are offering a more accessible approach to care, especially today as the number of available PCPs dwindles. The industry has long positioned PCPs as the gatekeeper for medical treatment, but with urgent care on the rise as a promi-

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Dan Stanek is Executive Vice President of the consulting firm WD Partners. The author receives a salary from WD Partners.



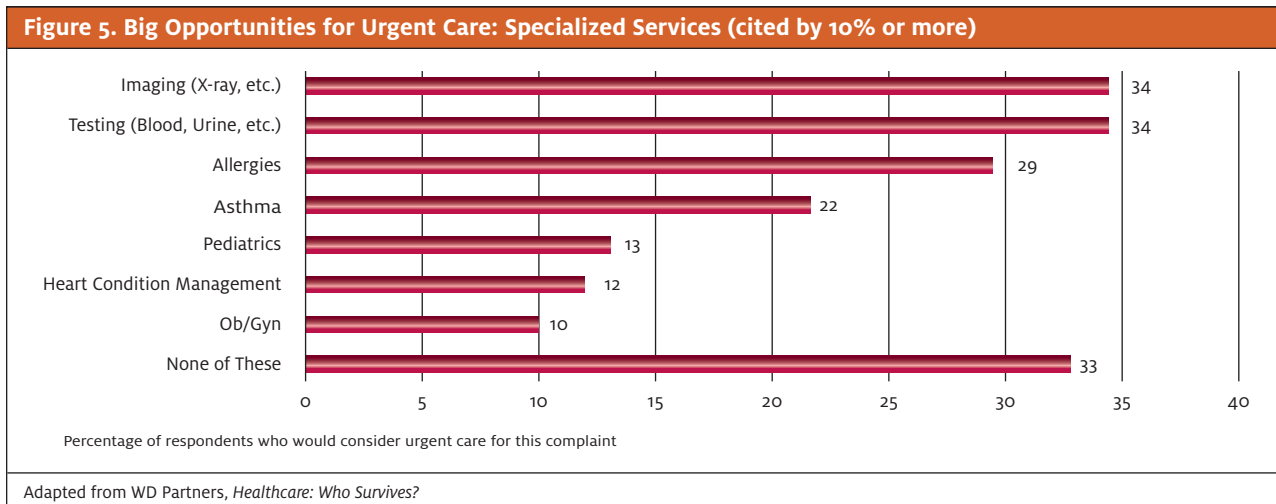




These disparities in urgent care utilization ultimately lead us to conclude that for younger generations, urgent care providers are essentially becoming their version of the PCP. Only 11% of our respondents overall claimed that urgent care centers were their most frequent provider; however, that number jumped to 21% for members of Gen Z, while the number fell to around 5% for both of the older generational groups.

The younger the consumer, the less likely they are to have established a PCP.

In the case of older consumers, familiarity breeds loyalty. Baby Boomers and the Silent Generation value longtime PCP loyalty, and for good reason: they have more complicated medical histories and typically need more extensive care. Gen Z and Millennials, on the other hand, look to convenience, speed, and ease of



access, all of which are characteristics attributed to urgent care facilities.

Roughly 80% of Boomers and Silent Generation consumers reported being happy with their healthcare, while only 54% of Gen Z respondents shared their affection. This explains why younger respondents' net promoter scores for PCPs are so low when compared with older consumers—which means they are more likely to use (and recommend) other providers. Evidently, these younger demographics are increasingly dissatisfied with primary care, and have no issue with looking for the alternative that will meet their needs. Enter urgent care facilities.

### What Are the Opportunities?

Based on our findings, there are three big opportunities for urgent care facilities:

- Expand services.** Respondents reported that they would consider urgent care facilities for a variety of services. The most common reasons consumers claimed that they would consider this provider for add-on care were for the treatment of health conditions like flu symptoms (44%) and ear infections (41%). For specialized services, the top add-ons are imaging and testing (34%). The most popular wellness service that they would consider at urgent care were for the treatment of sleep issues (14%), but overall, 59% of respondents reported that they would not consider an urgent care facility for their wellness needs. The interesting story related to wellness needs started when we looked at sleep issues by age. Looking at Gen Z, 23% would consider urgent care for sleep issues compared to only 8% of Baby Boomers. When it comes to specialty care,

39% of Gen Z would consider urgent care for allergy treatment compared to only 25% of Boomers. This creates an opportunity for urgent cares to establish a value proposition that reinforces the perception of trust, quality and professional competence in order to show that they are capable of providing significantly more types of care. (See **Figures 3, 4, and 5.**)

- Reverse negatives.** Urgent care providers are seen as strong in quality when it comes to grading them against their PCP counterparts, but lack in the familiarity department; the most common reason consumers reported not visiting these facilities is because they are not familiar with their working healthcare professionals. Unfamiliarity was the top reason that Boomers (44%) and members of the Silent Generation (50%) reported not considering urgent care facilities for services. This factor is still important to younger consumers, but far less than their older counterparts; only 8% of Gen Z and 20% of Millennials' cited this as an urgent care deterrent. Seeking more ways to develop relationships and tie in EHR (electronic health records) will help foster the sense of familiarity offered by PCPs. The current market is saturated with independent urgent care centers that aren't widely trusted by consumers due to their lack of brand recognition. Adding more urgent care locations in health system/PCP environments can counteract this element by using their established brand name to prove that they are a trustworthy care source.

The second and third most cited reasons for not visiting urgent care facilities were the service prices

and extended time spent in waiting rooms. Twenty-eight percent of Gen Z respondents said that they didn't consider an urgent care because of wait times in treatment rooms, and their second most cited reason was because of long waiting room times (as compared to 5% of Boomers). Twenty-eight percent of Millennials' top reason for not considering urgent care facilities was because of high costs, which starkly contrasts the 5% of Silent Generation consumers who said the same. Younger generations appreciate shortened wait times and more price-conscious care, so improving those areas will prompt increased popularity among this group of consumers.

- **Focus on younger demographics.** Our research shows that younger healthcare consumers are seeking a replacement for the traditional PCP model. Urgent care or the next generation of urgent care centers can become that go-to provider, if they truly develop an offering that capitalizes on Gen Z's and Millennials' distinct preferences.

It doesn't hurt that improvements in the areas of quality, familiarity, and cost will appeal to all generations *and* position them as the go-to provider of younger generations (because, let's face it: as the population of older patients who are established with PCPs begins to die, the proportion of convenience-driven, younger consumers will replace their numbers). To be sustainable, a healthcare service must capture new customers and develop relationships with them that are satisfied and loyal. The best way to do this is to hold the attention of those using them most (Millennials and Gen Z) and place a direct focus on getting them to become repeat visitors.

Urgent care facilities have the ability to meet that criteria, so long as they continue to grow, evolve, and offer consumers more clarity on exactly the types of services they can provide.

### What's Next? Threats to Consider

Urgent care facilities need to establish and, potentially, rebrand themselves as the on-demand PCP. One way would be to move away from the term "urgent," which places the industry conceptually near an emergency department. This "identity crisis" could be detrimental to the provider's growth; rather, showing consumers that urgent care is the best one-stop-shop for all their drop-in healthcare needs will increase their usage.

Urgent care facilities have a great deal of potential to build on their "middle ground"—that is, they are per-

*"In our consumer-driven marketplace, we must recognize a significant opportunity to make seismic changes in our industry. Today's young healthcare decision makers have spoken."*

ceived as providing convenience and efficiency without as much of the quality-of-care sacrifice that is currently hurting the reputation of retail clinics. The key, however, is to build on that middle ground and become a leader by providing a clear offering and improving quality-of-care perception.

Considering all of this, we know that urgent care facilities have a strong base setting them up for success. But they may be facing some competition when it comes to younger consumers; telemedicine is rising in popularity and could become urgent care's biggest threat. Conversely, though it has been slow to catch on, some urgent care operators are starting to be successful by offering telemedicine as one of their services. Fact: 31% of all survey respondents claimed that if they could avoid going to the doctor's office and complete their visits using technology, they would. And that percentage rises even higher for Gen Z (40%) and Millennials (42%), while it plummets for Boomers (15%) and the Silent Generation (9%). The number of consumers favoring this option will only continue to climb as telemedicine begins to improve.

In our consumer-driven marketplace, we must recognize a significant opportunity to make seismic changes in our industry. Today's young healthcare decision makers have spoken. It's time for healthcare providers to adapt to their needs in order to lead the industry into the future. ■

#### About WD Partners

WD Partners is a consulting firm that advises its clients on strategy, design, operations, architecture, engineering, and construction services with the intent of driving and shaping the customer experience. While those experiences include numerous retail and consumer brands, the company has also begun focusing more on consumer-driven practices in a health and wellness industry that is transitioning to consumerism.



## The Top 15 Occ Med Key Performance Indicators for Your Urgent Care Center

**Urgent message:** Every medical practice follows certain key performance indicators. Here, we offer 15 that are essential to running a profitable occupational medicine business within an urgent care operation.

■ MAX LEBOW, MD, MPH, FACEP, FACPM

There are a number of important key performance indicators (KPIs) that every urgent care, or any medical practice, follows—the most important being the bank balance at the end of the month. Most also follow basic practice measures such as total patient volume, accounts receivable, and aging reports.

While most urgent care practices that offer occupational medicine services will not follow all the benchmarks discussed here (categorized by Population Indicators, Ancillary Services, Patient Throughput, Financial Indicators, and Provider), understanding their importance will help urgent care managers and administrators choose the benchmarks that are most important to them and the financial well-being of their particular clinic.

### Population Indicators

**KPI #1: Percentage of Occ Med Visits of Total Patient Volume**  
According to the *Urgent Care Association 2018 Benchmark Study*, the average urgent care center surveyed showed occupational medicine making up 16.4% of total patient volume; by payer type, 8.4% is classified as Occupational Health and 6.2% as Workers Comp. If your volume exceeds these UCA benchmarks, your clinic may consider marketing your practice more aggressively to increase your volume even more.

### KPI #2: Occ Med Visits as a Ratio of Occupational Health:Workers Comp

The *UCA 2018 Benchmark Study* shows the ratio of occupational health (OH):Workers Compensation (WC) to be 1.35:1, or OH=58% vs WC=42%. OH is defined as pre-offer or pre-employment physicals, drug screens, fit-for-duty exams, DOT exams, respiratory fit tests, hearing tests, etc. WC, referring to workplace injuries and illness, are more desirable because total reimbursement is higher. However, some companies may send their OH to one urgent care, while they send their WC to another. Comparing these two figures may alert you that there are additional opportunities for WC volume, and the company was sending only OH.

### Use of Ancillary Services

**KPI #3: Percentage of New Injuries Recordable vs First Aid**  
There are no published benchmarks on the percentage of new injuries considered to be first aid. In our experience, we have seen metrics showing up to 30% of new injuries being classified as first aid. However, first aid percentage will change based on the type of industry and degree of workplace safety of an individual company. It must be observed for variance across the practice and by individual providers to make sure there are no changes that cannot be explained. Variance can be introduced into a practice if providers are not following definitions even after having been trained properly. Also, first aid injuries will generally require fewer services that help clinic planners determine staffing level, then estimate reimbursement.



**Max Lebow, MD, MPH, FACEP, FACPM** is board certified in Emergency Medicine and Preventive/Occupational Medicine, and is President and Medical Director of Reliant Immediate Care Medical Group, Inc.

**KPI #4: Ratio of New Injuries to Follow-Up Visits**

This is the ratio of total new injuries vs the total number of Workers Comp follow-up visits. Like first aid, this number will vary based on the type of injuries and type of companies that are being serviced. This number also varies by location. For example, repetitive strain injuries and cumulative trauma cases tend to have a high number of follow-up visits. In California, these kinds of injuries are increasing rapidly. At the other end of the spectrum, a simple laceration may have two follow-up visits. It is important to follow this number to identify changes early. This ratio affects staffing levels and other utilization within the clinic.

**KPI #5: Ratio of New Injuries to Physical Therapy Sessions**

This is important for clinics that also provide physical therapy as a service line. It assures that physical therapy is being neither underutilized nor overutilized. Each clinic should establish policies and protocols to help guide providers as to when to order physical therapy.

**KPI #6: Ratio of New Injuries to Durable Medical Equipment Utilization**

This is important to measure if your clinic dispenses and charges for durable medical equipment.

**Patient Throughput**

Patient throughput is an especially sensitive issue in occupational medicine. The reason—besides the usual patient satisfaction issues that impact any visit—is, in most cases, the employee will be “on the clock” while at the clinic. So, without compromising care, the total time should be as short as possible.

**KPI #7: Total Turnaround Time for the Patient**

The UCA benchmark report notes nearly 85% of patient encounters reportedly taking 1 hour or less. For occupational medicine, based on the reasons listed above, the total throughput time, door-to-door, becomes the most important metric. Employers are not much interested in pre-paperwork or post-paperwork times; they are looking for the total time that their employee is away from the job site.

**KPI #8: Variance Between Follow-Up Appointment Time and Actual Time the Patient Was Seen by the Provider**

For urgent care clinics that are not currently doing online appointments, Workers Comp follow-up visits may be the only actual scheduled patients the clinic sees. Like any practice, it is important that when the practice gives a patient an appointment time, they will endeavor to see that patient at the time given. Again, not only do patients become upset when they are told to come in at one time and not seen promptly, but the employer is also upset.

You should set your own goal, but seeing the patient within 15 minutes of their appointment is a reasonable place to start.

**Financial Indicators**

We should discuss financial metrics that are specific to occupational medicine. The indicators we suggest here are actionable, yet easy to collect and follow.

**KPI #9: Total Charges Per New Injury**

Because of the intensity of service, the charges on the first visit for a new work-related injury or illness will be higher than the average urgent care visit. New Workers Comp injuries will have higher rates of x-ray, be more likely to involve procedures such as suturing or casting, more likely to involve DME in dispensing of medications (if appropriate for your state), and tend to be at a higher level of care. Establishing your clinic benchmarks will allow you to observe any variance that occurs.

**KPI #10: Total Charges Per Workers Comp Follow-Up Appointment**

Because these visits involve fewer x-rays, procedures, or other billable activities, the charges rest primarily on the level of service that can be charged. This, in turn, is based primarily on documentation. Low or decreasing reimbursement per Workers Comp follow-up indicates that the providers are not documenting properly and may need coaching and instruction.

**KPI #11: Total Collection Per New Injury and Follow-Up Visit**

Workers Comp reimbursement is generally mandated by each state by a Workers Comp fee schedule. With proper documentation, the clinic should expect reimbursement rates over 80% of charges. Any number lower than this may indicate there is billing of nonreimbursable codes or inappropriate down-coding. In any event, this should be followed and investigated by your practice management and billing company.

**Key Performance Indicators By Provider**

Many of the KPIs discussed above can be measured both for the clinic at large and by individual providers. Tracking individual provider metrics allows for the identification of outliers, and serves as an early warning system to ensure that the group as a whole are performing up to expectations.

The rationale for these has already been discussed in the course of describing KPIs, but it let's call them out here:

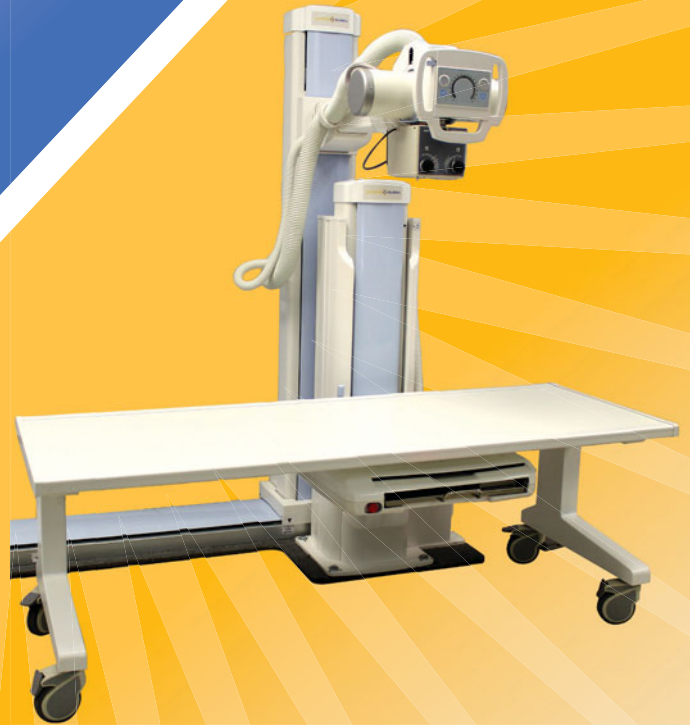
- **KPI #12: Percentage of New Injuries That Are Recordable Versus First Aid by Provider**
- **KPI #13: Ratio of New Injuries to Durable Medical Equipment/DME Utilization by Provider**
- **KPI #14: Total Charges Per New Injury by Provider**
- **KPI #15: Total Charges Per Work Comp Follow-Up Appointment by Provider** ■



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

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

## A 13-Year-Old Boy with Hip and Groin Pain After a Soccer Game

Figure 1.



### Case

The patient is a 13-year-old boy who complains of pain in his right hip and groin after playing soccer. His mother says she didn't see what happened, but reports that she looked up from a magazine she was reading to see him limping suddenly.

View the image taken and consider what the diagnosis and next steps would be. Resolution of the case is described on the next page.

## THE RESOLUTION



Figure 1.

**Differential Diagnosis**

- Avulsion fracture of the anterior inferior iliac spine
- Extra-articular femoroacetabular impingement
- Muscle strain
- Rectus femoris muscle tear

**Diagnosis**

The x-ray shows a displaced fracture of the anterior inferior iliac spine, with separation by 5 mm. There is also a rectus femoris muscle tear at the insertion site.

Rectus femoris is a hip flexor muscle and has two origins from the anterior inferior iliac spine and the supra acetabular ilium. Distally, it inserts on the patella and patellar ligament. Avulsion tear of the muscle and accompanying fracture of the anterior inferior iliac spine are common in boys 14-to-17 years of age, when the ratio of muscular strength to the physical strength is greatest. Rectus femoris tears are usually associated with athletic activity, including sprinting and competitive kicking sports. A sudden forceful pull of the rectus femoris muscle during a forceful extension of the hip and flexion of the knee is the mechanism of the injury. A loud popping sound followed by severe groin pain and inability to move the limb are common clinical presenting features. Clinical findings

include localized groin tenderness, painful active flexion and forceful extension.

MRI findings include a displaced fracture, soft tissue edema, hemorrhage and retracted rectus femoris muscle.

**Learnings/What to Look for**

- Diagnosis is usually made on plain x-rays, CT, or MRI
- Plain x-rays and CT reveal a displaced fracture of the anterior inferior iliac spine, with accompanying soft tissue swelling and hemorrhage

**Pearls for Urgent Care Management and Considerations for Transfer**

- Usual treatment is conservative with rest, analgesia, and physical therapy. Lack of treatment results in chronically painful groin which could be career limiting for the athletes
- Surgical repair/internal fixation is usually reserved for fractures with more than 2 cm separation, failed conservative treatment, and nonunion of fracture and in athletes to facilitate early recovery

**Acknowledgment:** Images and case provided by Experity Teleradiology ([www.experityhealth.com/teleradiology](http://www.experityhealth.com/teleradiology)).



# A 78-Year-Old with Dizziness and No Chest Pain, Shortness of Breath, or Diaphoresis

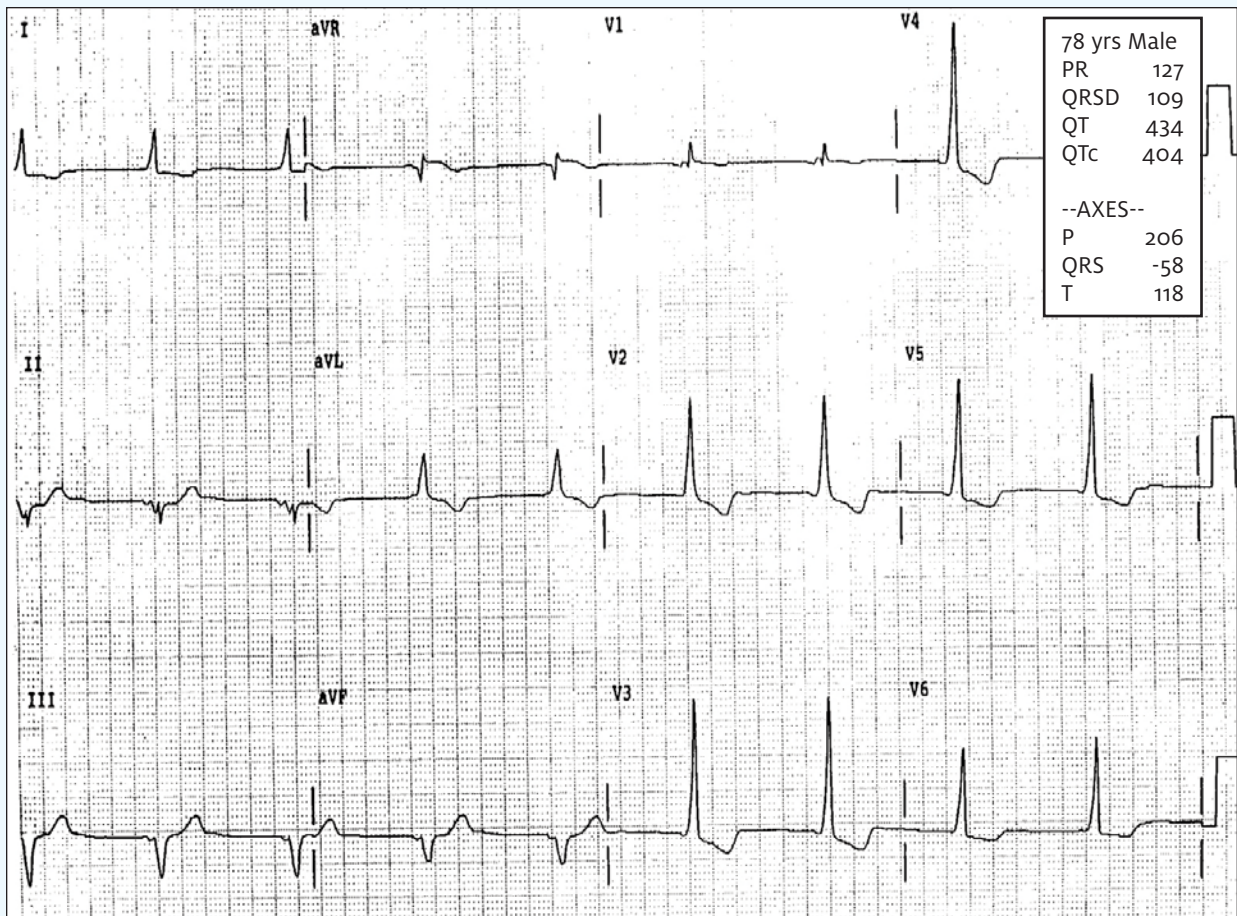


Figure 1.

### Case

The patient is a 78-year-old man who says he has felt dizzy for several hours. He denies chest pain, shortness of breath, or diaphoresis.

Upon exam, you find:

- **General:** Alert and oriented; breathing comfortably
- **Lungs:** Clear bilaterally
- **Cardiovascular:** RRR without m/r/g

- **Abdomen:** Soft and nontender, no pulsatile mass
  - **Extremities:** No pain or swelling, pulses normal and equal in all 4 extremities
- Review the ECG and consider what your diagnosis and next steps would be. Resolution of the case is described on the next page.



## THE RESOLUTION

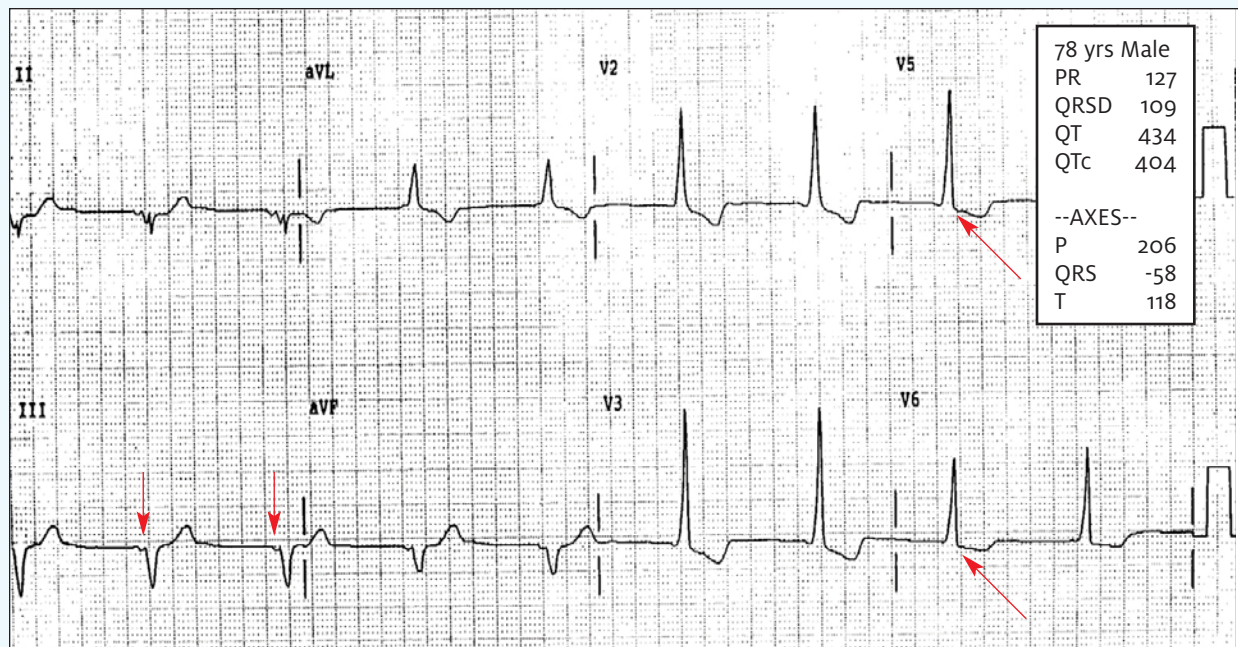


Figure 2.

**Differential Diagnosis**

- Junctional bradycardia
- Atrial fibrillation
- Bradycardia with Wolff-Parkinson-White syndrome
- Brugada syndrome
- Third-degree heart block

**Diagnosis:** The patient is experiencing bradycardia with Wolff-Parkinson-White syndrome (WPW).

Though this is a bradycardic rhythm, there is evidence of P waves before the QRS complexes (see downward arrows at lead III), so it is not a junctional bradycardia (no P waves).

The rhythm is regular, and not irregularly irregular as in atrial fibrillation.

Brugada syndrome is important to recognize, as it may degrade into a terminal rhythm; it is diagnosed by the presence of incomplete right bundle branch block and ST elevation in leads V1 and V2, but is not present on this ECG.

Third-degree heart block results in a bradycardic rate, but usually with a rate in the 30s; additionally, in this ECG a P wave precedes the QRS complexes, while in third-degree (complete) heart block there is complete dissociation between the P waves and the QRS complexes.

This ECG shows bradycardia with WPW. Note the short PR interval and the upsloping “delta” waves in the V5 and V6 (upward arrows).

**Learnings/What to Look for**

- WPW is a supraventricular re-entrant rhythm
- Patients may be asymptomatic, with the WPW being found incidentally, or may include complaints of anxiety, palpitations, dizziness, chest discomfort, or shortness of breath
- ECG findings include a short PR interval, a delta wave (upsloping initial portion of the QRS complex), and a prolonged QRS complex

**Pearls for Urgent Care Management and Considerations for Transfer**

- Compare to previous ECG if available
- If found incidentally, the patient does not require transfer and outpatient referral is appropriate
- The patient should be transported emergently to the emergency department via EMS if symptomatic with chest discomfort, shortness of breath, tachycardia, hypotension, hypoxemia, or altered mental status
- Note that WPW may occur with atrial fibrillation and reveal an irregular tachycardic rhythm with a wide complex QRS. Do not use calcium channel blockers, adenosine, beta blockers, or digoxin, as these may precipitate ventricular fibrillation and death. WPW may occur with atrial fibrillation is managed medically with procainamide or electrically with cardioversion





## A Teenage Girl Who Suddenly Bruises Easily



### Case

A 17-year-old girl presents to urgent care complaining of easy bruising, especially on her legs. She couldn't recall having any injuries, even minor bumps, that might have caused the red and purple ecchymoses that had appeared. She insisted no one else had caused her harm. She also complained of headache and nausea. A high school student, she was about to complete her final exams and was concerned she would have bruises on her legs during graduation.

View the image and consider what your diagnosis and next steps would be. Resolution of the case is described on the next page.

## THE RESOLUTION

**Differential Diagnosis**

- Cryoglobulinemia
- Autoerythrocyte sensitization
- Vitamin K deficiency
- Ehlers-Danlos syndrome

**Diagnosis**

The correct diagnosis is autoerythrocyte sensitization, also known as Gardner-Diamond syndrome or psychogenic purpura. This disorder is characterized by bruising without clear precipitating causes or definite trauma.

**Learnings/What to Look for**

- Autoerythrocyte sensitization has been associated with psychiatric illness, sometimes subtle and without initial obvious symptoms
- Bruises are painful, vary in size, and may have peculiar or geometric shapes

- Associated symptoms include abdominal pain, nausea, vomiting, diarrhea, and headache
- Prodromal symptoms such as pain, warmth, or itching at the site prior to the bruising have been described

**Pearls for Urgent Care Management and Considerations for Transfer**

- Diagnosis is by history, physical examination, and laboratory tests to rule out bleeding disorders
- Onset may follow a traumatic event or in the context of severe psychosocial stress. Associated psychiatric abnormalities include depression and anxiety, borderline personality disorder, and obsessive-compulsive disorder
- Once other, physical disorders have been ruled out, referral for psychiatric therapy is warranted

**Acknowledgment:** Images courtesy of VisualDx ([www.VisualDx.com/JUCM](http://www.VisualDx.com/JUCM)).



## What Use Restrictions Can Landlords Impose on Urgent Care Facilities?

**Urgent message:** Lease “exclusivity of use” provisions prohibiting competing urgent care centers, walk-in medical clinics, primary care offices, etc. are often used in leases to protect an urgent care center, but there are implications for both landlord and tenant.

■ ALAN A. AYERS, MBA, MAcc

“Landlord agrees that no other space in the Fairland Center Building will be leased to anyone who will compete directly with Wedgewood Urgent Care, LLC.”<sup>1</sup>

It’s not uncommon for an urgent care center to request their landlord to provide use restrictions prohibiting other urgent care centers, primary care offices, chiropractors, podiatric offices—and, in some states, medical marijuana businesses—from being housed in the same building, strip shopping center, or retail development as the urgent care.

The rationale behind such a request is that urgent care volume is driven by potential clients who see a convenient urgent care location and note to use it if an unexpected illness or injury occurs. Since location is a critical component of an urgent care center’s livelihood, an owner may pay a premium for prime retail signage and building visibility to enjoy heavy traffic. To protect that premium investment, an owner may ask for guarantees that the landlord won’t lease to another medical business in close proximity, typically in the same strip mall or office building.<sup>2</sup>

The urgent care wants to be the “only game in town” in that location and will cry *Foul!* if another urgent care center opens across the parking lot.

The way an urgent care owner can protect her business from unwanted competition is to negotiate terms into her lease that restrict what types of business can open in the same location. Here, we discuss how restrictive covenants, such as exclusivity, use, and noncompete provisions in a commercial lease can protect an urgent care owner’s business.

### Restrictions in a Commercial Lease

An *exclusive* or *exclusivity clause* is a term in a lease that creates an obligation by the landlord to restrict further rentals of any business that engages in the same type of business. It’s common that this benefit is given to only powerful “anchor” tenants, such as a large supermarket chain, department store, or health club.<sup>3</sup> In this context, it may include prohibitions of specific services rather than a type of business, such as diagnostic imaging, drug screening, or physical therapy. Again, a powerful large tenant such as Walgreens or CVS may ask that all medical businesses are excluded from a development.<sup>4</sup> And a landlord may ask for higher rent in exchange for giving up its right to rent to whomever he wants.

The landlord must incorporate the prohibition from offering urgent care services into future leases with new tenants so these tenants don’t violate the landlord’s promise to the exiting urgent care.<sup>5</sup>

### Restrictive vs permissive use clauses

There are two types of use clauses: restrictive and permissive. A *restrictive use clause* states what a tenant can’t do during the duration of the agreement.<sup>6</sup> In effect, a tenant can do anything



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*“It’s advisable to work with an experienced business attorney to help you negotiate an exclusivity clause. In addition to drafting a binding clause to your benefit, they will make certain that the lease also contains the terms of enforcing that clause and spell out the remedies for the landlord’s breach.”*

that’s *not* on the list. It’s best for an urgent care owner faced with the prospect of a restrictive use clause to negotiate the broadest rights to use the space or that prohibits only a few activities.<sup>2</sup>

On the other hand, a *permissive use clause* details the types of activities that are permitted; anything not included in the clause is prohibited.

A permissive use clause isn’t recommended for urgent care owners because the onus is on the owner to list every conceivable use in which her business may possibly want to engage when signing the lease. There are differences among urgent care operators as to the exact scope of services that constitutes “urgent care.” If an owner subsequently decides to offer an ancillary or specialty service at her urgent care—such as medicine dispensing, weight management, or physical therapy—she would be forbidden from doing this. Again, an owner should be reluctant to entertain this type of use clause because it can be very disadvantageous and severely narrow her potential business opportunities.<sup>2</sup>

A second tenant may want the landlord to reimburse it for any capital cost to replicate, lost business, and relocation expenses in the event that a valid exclusivity claim is made and enforced by another tenant on the landlord. However, the smarter course of action may be to avoid such an entanglement altogether and select a location where that company can be the first and only of its kind and to negotiate its own exclusivity term in its lease.

### Contract Enforcement

Getting the terms you want into your lease may be a tough fight; however, once they’re included, seeing that they’re enforced may be more than half the battle. The Connecticut Supreme Court stated that in construing a written lease, three basic principles must be considered:

1. The intention of the parties is controlling and must be gathered from the language of the lease in the light of

the circumstances surrounding the parties at the execution of the agreement

2. The language must be given its ordinary meaning unless a technical or special meaning is clearly intended
3. The lease must be construed as a whole and in such a manner as to give effect to every provision, if reasonably possible<sup>7</sup>

In addition, another court has explained that a commercial tenant trying to enforce an exclusivity restriction in a lease must show that “the activity which allegedly infringes on its exclusivity provision falls clearly within the specific terms of the covenant.”<sup>8</sup>

When a violation occurs, and the landlord leases space to a second urgent care or perhaps a Walgreens with a health clinic next to its pharmacy, the first urgent care owner must bring a legal action for breach of contract. The owner may also request injunctive relief, which would stop the landlord from leasing to the second urgent care and be a more immediate remedy.

As part of the negotiation process, an urgent care owner should also include what would happen in this situation. The lease should list the remedies available to the owner.

### Real-life examples

Again, it must be emphasized that in court, these provisions are interpreted narrowly and with plain meaning. For instance, a local children’s hospital operates a multispecialty facility in a landlord’s retail space. The hospital has a use exclusivity clause in its lease for “pediatric urgent care,” “pediatric diagnostic imaging,” “pediatric physical therapy,” and anything similar. If an urgent care operator wants to lease space in the same location and caters to all ages, it may run into a conflict with the hospital. The “all-ages” urgent care is not by definition a “pediatric urgent care” (and is a different business model defined by the Urgent Care Association).<sup>9,10</sup> However, if a court interprets this pediatric restriction literally and verbatim, the all-ages urgent care couldn’t see children if this restrictive covenant was enforced.

While the landlord looking to fill its space assures the all-ages urgent care that it has nothing to worry about because it’s not a pediatric urgent care, the owner of the urgent care has reason to be concerned in that it may not be able to treat children (ie, administer urgent care to a pediatric patient) if the prohibition were taken literally and enforced as such.

The New Jersey Supreme Court applied a series of reasonableness factors in deciding whether to give effect to anticompetitive clauses in contracts generally. Those factors include:

1. whether the covenant had an effect on the considerations exchanged when the covenant was originally signed
2. whether the covenant clearly and expressly sets forth the restrictions
3. whether the covenant was in writing and recorded
4. whether the covenant is reasonable concerning area,

time, or duration<sup>11</sup>

Finally, in a different state, a lawsuit was brought against the landlord where an urgent care went out of business. The urgent care owner sued the landlord for his business failure because the tenant alleged that the landlord allowed a primary care office to open in a more visible part of the strip center, which diverted patients who would otherwise have used the plaintiff's center. The urgent care tenant in that case wouldn't have any standing to sue the second tenant. The plaintiff's action is in contract against the landlord.

#### *What if your urgent care is the second tenant?*

The issue may arise when an urgent care owner signs a lease for space where there already is a competitor or other business that may decrease its traffic. Ideally, this urgent care owner has done her due diligence and researched the location prior to even entering into contract negotiations. If so, she will have seen the drugstore clinic or medical office that is presently leasing space at the location and will look elsewhere.

If this owner fails to conduct due diligence, hopefully she has negotiated an exclusivity clause into her lease. This would give her some protection to sue the landlord for renting to her when the landlord knew that it already had competing tenants and that the second owner would not be the exclusive provider of urgent care services. A judge may void that lease and award damages to the urgent care owner; however, the landlord may claim that she failed to mitigate her damages by not conducting her own due diligence. This situation is more of a 50-50 proposition in court, and the best plan is to avoid it altogether. In addition, the landlord may have to defend another lawsuit from the original tenant if its lease contained an exclusivity clause.

Note that in some states, such as Rhode Island, restrictive covenants are not favored by the law.<sup>12</sup> As a result, these provisions will be "strictly construed in favor of the free alienability of land while still respecting the purposes for which the restriction was established."<sup>13</sup> Further, the courts in Rhode Island have held that restrictive covenants and exclusivity provisions are enforceable "only if the terms are reasonable in light of the circumstances surrounding the agreement and do not extend beyond what is necessary to protect the beneficiary."<sup>13</sup>

#### **Takeaway**

Work with an experienced business attorney to help you negotiate an exclusivity clause. In addition to drafting a binding clause to your benefit, he or she will make certain that the lease also contains the terms of enforcing that clause and spell out the remedies for the landlord's breach.

Also, your attorney will want to add an established amount of monetary damages into the lease so you don't have to prove you lost profits and actual damages. This can save you time and expenses if this unfortunate situation arises.<sup>14,15</sup> ■

#### **Know the regulations in your state.**

- The New Jersey Supreme Court applied a series of reasonableness factors to contracts, including whether the covenant had an effect on the considerations exchanged when the covenant was originally signed; whether the covenant clearly and expressly sets forth the restrictions; whether the covenant was in writing and recorded; and whether the covenant is reasonable concerning area, time, or duration.
- In Rhode Island, restrictive covenants and exclusivity provisions are enforceable "only if the terms are reasonable in light of the circumstances surrounding the agreement and do not extend beyond what is necessary to protect the beneficiary."
- The Connecticut Supreme Court stated that in construing a written lease, three basic principles must be considered: 1) The intention of the parties is controlling and must be gathered from the language of the lease in the light of the circumstances surrounding the parties at the execution of the agreement; 2) the language must be given its ordinary meaning unless a technical or special meaning is clearly intended; and 3) the lease must be construed as a whole and in such a manner as to give effect to every provision, if reasonably possible.

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## Keeping Up with CMS Policies on Medicare Cards and Flu Vaccine Reimbursements

■ DAVID E. STERN, MD

### New Medicare Card Transition Period Ends December 31, 2019

As a result of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), in 2018 the Centers for Medicare and Medicaid Services (CMS) began issuing new Medicare cards to all beneficiaries; unlike the previously existing cards, the new cards do not display the beneficiary's Social Security number. CMS set up a schedule to mail out the new cards based on regions, to be completed by April 2019. The project is now complete and all Medicare beneficiaries should have received their new cards.

Has your front desk staff been diligent in asking Medicare patients for their new Medicare card and updating your system accordingly? As of January 1, 2020, claims billed to Medicare must have the new Medicare Beneficiary Identifier (MBI); claims sent with the Health Insurance Claim Number (HICN) will be rejected after December 31, 2019.

CMS also states that when billing the MBI, no hyphens or spaces should be used or the claim will be rejected. Thus, it is important to educate your staff to enter the number in your billing system correctly to avoid reworking the claims and payment delays, or update your electronic data interchange (EDI) program to automatically remove them.

Medicare has been including the MBI on remittance advices to help billers find and familiarize themselves with it. They also offer a lookup tool for billers, as well as patients. You can direct your staff to the MLN Matters article SE18006 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18006.pdf> for specific

details regarding the new cards. The article offers links to handouts that staff can give to patients, instructing them on how to obtain their new card if they have not received one yet. It also offers a sign-up link to your specific Medicare Administrative Contractor (MAC) that your staff can use to look up the MBI when the card is not available.

### 2019-2020 Influenza Vaccinations

CMS also has announced their reimbursement schedule for the 2019-2020 flu season:

Code	Vaccine Name	Reimbursement
90653	Fluad	\$59.530
90662	Fluzone High-Dose	\$56.006
90672	FluMist Quadrivalent	\$26.876
90674	Flucelvax Quadrivalent (0.5 mL), Preservative Free	\$28.130
90682	Flublok Quadrivalent	\$56.006
90685	Fluzone and Afluria, (0.25 mL) Quadrivalent, Preservative Free	\$20.343
90686	Fluarix, Flulaval, Fluzone, Afluria, (0.5 mL), Quadrivalent, Preservative Free	\$19.032
90687	Fluzone and Afluria, (0.25 mL) Quadrivalent	\$9.403
90688	Flulaval and Afluria, Quadrivalent (0.5 mL)	\$17.835
90756	Flucelvax Quadrivalent, (0.5 mL), antibiotic free	\$26.657

When providing services for the influenza vaccine, remember to document and bill for the administration of the vaccine, as well. Use Healthcare Common Procedure Coding System (HCPCS) Level II code G0008 to bill Medicare for the administration of the flu vaccine for adults over 18 years old. If the Medicare patient is



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under 18 years old and vaccine counseling was also provided, refer to Current Procedural Terminology (CPT) codes:

- 90460, "Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered"
- 90461, "...each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)"

Medicare also recognizes the administration codes for intranasal and oral vaccines using the following CPT codes:

- 90473, "Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)"
- 90474, "...each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)"

- Use 90474 in conjunction with 90460, 90471, and 90473

The Medicare national average rate of reimbursement is \$16.94 for HCPCS code G0008 and CPT codes 90460 and 90473, and \$12.97 for CPT codes 90461 and 90474.

When billing to commercial payers, unless otherwise directed by a specific payer, bill the appropriate CPT codes shown in the list above, or from the following list:

- 90471, "Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)"
- 90472, "...each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)"

- Use 90472 in conjunction with 90460, 90471, and 90473

Medicare waives the patient copay for the influenza vaccine. You can find the influenza updates on the Medicare's Seasonal Vaccines Pricing website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-drugs/McrPartBDrugAvgSalePrice/VaccinesPricing.html>.

Consult Medicare's Physician Fee Schedule at <https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=o&T=o&HT=o&CT=3&H1=90473&M=5> for reimbursement information. ■



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- MRI/CT
- Ultrasound
- Bone Densitometry
- Mammography





# Urgent Care Is on the Rise, Hospitals on the Decline in Searching for Clinical Hires

This is an interesting time to be in the healthcare field. We keep hearing (and are starting to see the effects of) a serious shortage in available physicians across multiple settings, but most direly in primary care. To compensate, many practices are relying more on the skills and high-level training of nurse practitioners and physician assistants, now known collectively as advanced practice providers (APPs).

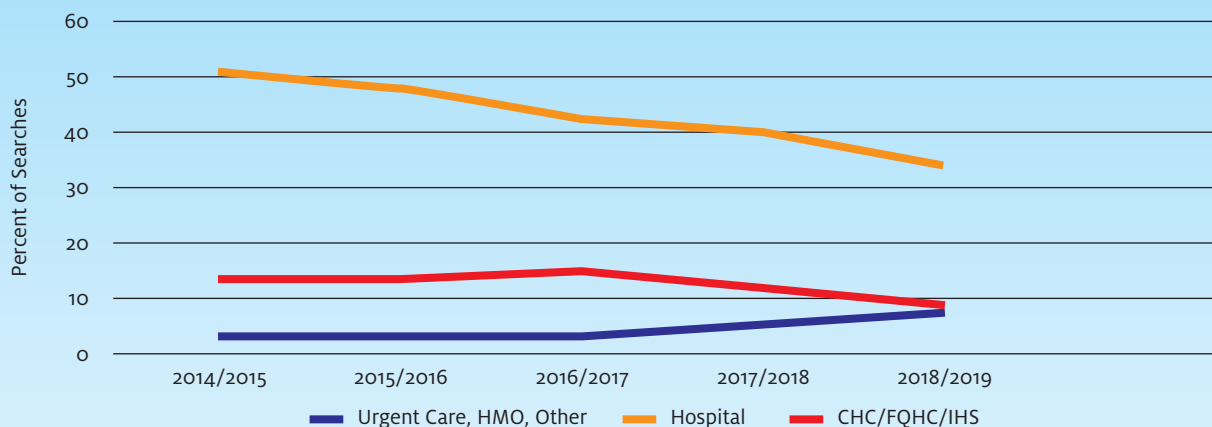
At the same time, consumers continue to demonstrate a growing preference for walk-in care facilities where they don't necessarily have an ongoing relationship with a clinician. What's more, they clearly don't want to be tied down to one location. They want to decide where they're going when they need to go, and they prefer to not be inconvenienced by driving across town or having to hop from one office to another.

Further, hospital systems and venture capitalists are recognizing the economic value to be found in these growing sectors. Viewing it from 30,000 feet, it looks like the convergence of

several factors that are extremely favorable to urgent care. And it appears the job market is following suit.

According to Merritt Hawkins' 2019 Review of Physician and Advanced Practitioner Recruiting Incentives, which reflects research into urgent care centers, hospitals, medical groups, federally qualified health centers, academic centers, and "others," most organizations engaged in recruiting physicians today are employing physicians outright rather than placing them in private practices. The question, given consolidation among disparate practice settings, is where are they employing them? The Merritt Hawkins paper clearly states that hospitals are still the most prevalent setting when it comes to physician search assignments. It's equally clear, however, that the hospital figures are dropping. So are those for community health centers, federally qualified health centers, and Indian Health Services—while urgent care and HMO numbers are increasing. (See the graph below). ■

### TRENDS IN SEARCHING FOR CLINICIANS, BY SETTING



CHC, community health center; FQHC, federally qualified health centers; IHS, Indian Health Service

Data source: 2019 Review of Physician and Advanced Practitioner Recruiting Incentives. Merritt Hawkins. Available at: <https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2019/UHG-Avoidable-ED-Visits.pdf>. Accessed August 2, 2019.



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