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VOLUME 14, NUMBER 4

URGENT CARE ASSOCIATION

COLLEGE OF URGENT CARE MEDICINE

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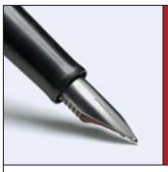

LETTER FROM THE EDITOR-IN-CHIEF

A New Year—and a New Era for *JUCM*

35,000. As I assume the role of editor-in-chief of the journal, this is the number that revolves through my head with rhythmic pops like an old, vinyl record. Cognitive psychologists estimate that that's the number of decisions an average adult makes every day. This number may seem impossibly large at first, to the point of absurdity even. After all, that breaks down to a decision every 2 seconds. But let's pause briefly and examine this.

Pay attention for a moment and you'll realize that you're constantly deciding what you ought to do next. To what stimulus in this hyperstimulating, 2020, "the future is now" existence should you commit your finite attention?

Think about it. At any given instant, you're deciding if you should respond to that email lingering in your inbox, go to the gym, finally start that home improvement project that's been on your to-do list for as long as you can remember, or check your text messages (again).

Throughout all of human history, this dilemma of choice has never been greater. And amongst this sea of options, there you sit—holding this copy of the *Journal of Urgent Care Medicine*—choosing to spend your time pouring over our pages. That means a lot to me.

I greet this opportunity to serve as the journal's editor-in-chief with tremendous enthusiasm. These are exciting times in the story of urgent care as our specialty continues to expand and mature rapidly. And we are all fortunate enough to have a privileged vantage point where we may watch the history of urgent care transpire.

It is my hope that this publication will play an integral role in this story by simultaneously guiding the dialogue and narrative, as well as providing a stage for the plot to unfold. All this, obviously, towards the ultimate goal of improving the quality of care and experience of the growing number of patients who seek attention at urgent care centers each day.

I would also like to acknowledge the hard work that the outgoing editor-in-chief, Dr. Lee Resnick, has done building this journal and steering its content since its inception. A publication that has remained the only peer-reviewed journal in the urgent care world for the past 13 years and counting—this was no small feat.

Dr. Resnick's departure is also importantly telling of a vision of longevity for this journal. As was the case when George Washington announced he would not seek to continue his service as president after his second term, Dr. Resnick's decision to step down after all these years is similarly telling. It is symbolic of a belief that the journal and its readers will benefit from periodic changes in leadership and perspective. From this transition comes an opportunity for the journal to evolve and transform into something new. And I am honored to take the proverbial torch from Dr. Resnick in guiding this process.

And so we come back to the notion of choice because, although the journal has no charge, it certainly is not free. You're paying for it with your valuable and finite attention, even now as you read. Thus, it is my mission and commitment to you, our reader, to print content that's worth your precious time. And I thank you for joining me.

Respectfully,

Joshua W. Russell, MD, MSc, FAAEM, FACEP
Editor-in-Chief, *JUCM, The Journal of Urgent Care Medicine*
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Twitter: @UCPracticeTips

Meet the Editor-in-Chief

Joshua W. Russell, MD, MSc, FAAEM, FACEP is a board-certified emergency physician and a Fellow in the American College of Emergency Physicians and the American Academy of Emergency Medicine. He was previously an associate medical director and continues to serve as a supervisor and educator for Legacy-GoHealth Urgent Care in Oregon and Washington State. He obtained a Masters degree in clinical research and has pursued postgraduate training in the teaching of critical thinking and creative writing. He is also a frequent contributor and editor for the UC:RAP podcast.

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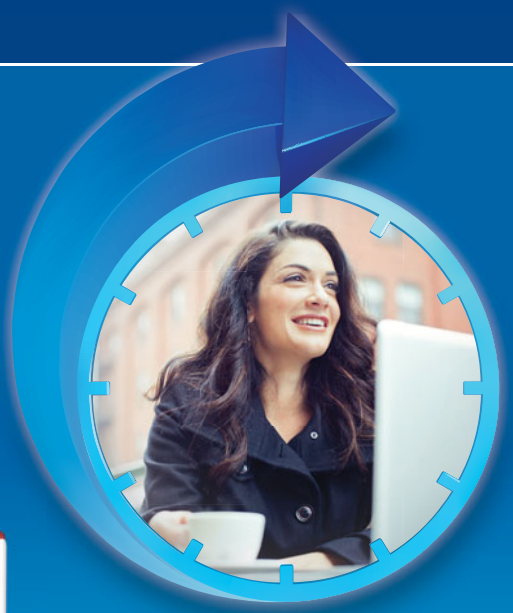

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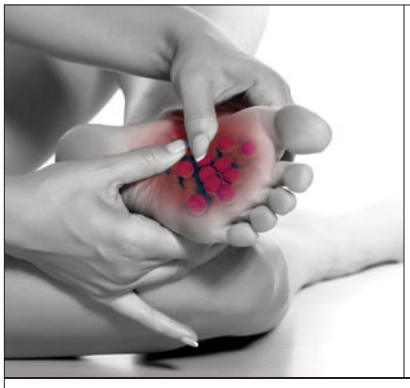

CLINICAL

IN THE NEXT ISSUE OF *JUCM*

Asplenic individuals are at two-to-three times greater risk for severe infection than other patients. As such, postsplenectomy sepsis should be prominent on your radar when patients present with symptoms that are suspect. In the February issue of *JUCM*, we will present an original article to help you know what to look for—and how to respond.

DEPARTMENTS

CLASSIFIEDS

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Mission Statement
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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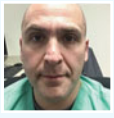
Staphylococcus aureus is at the same time one of the most common and most deadly of organisms. At any given time, according to the Centers for Disease Control and Prevention, 30% of us walking around with it not only right under our noses, but *in* our noses. And we're fine with that—usually. Once infection with *S aureus* takes hold, however, the situation demands more attention. And if the strain proves to be resistant to methicillin... well, you have to move fast and correctly to save the patient.

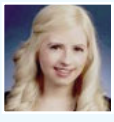
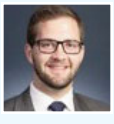
Incidence of infection with methicillin-resistant *S aureus*—better known even to the lay public as MRSA—has decreased over time, thanks to better awareness and subsequent precautions. Unfortunately, however, it's no less threatening for patients who do become infected.

With that in mind, we present Reducing Morbidity and Mortality Due to MRSA in the Urgent Care Setting (page 11) by **Jordan Miller, DO**, and **Ari D. Leib, MD**. Read it for not only a refresher on the essential nature of MRSA, but also understanding of the current, correct approach to treatment. Be sure to take the CME assessment once you're done, too.

Dr. Miller and Dr. Leib both practice at Adena Health System in Ohio.

Kaposi sarcoma, on the other hand, is common only among patients infected with HIV or AIDS. As such, it's not the likeliest of urgent care presentations. That doesn't mean you won't see it, however; in fact, this month's Case Report details the saga of one patient who presented after failed attempts to treat the lesion on his own. See how his assessment and care were handled in Kaposi Sarcoma Presenting in the Urgent Care Setting as a Single Mass Lesion of the Foot, starting on page 23.


Lead author **Brad White, DO** is diagnostic radiology chief resident at Larkin Community Hospital in Miami FL, as well as a Resident and Fellow Section vice president of the Florida Radiological Society. **Susannah Boulet, OMS-IV, William Billari, OMS-IV,** and **Jennifer Lee, OMS-IV** are studying at Lake Eerie College of Osteopathic Medicine in Bradenton, FL.

One of the challenges in treating patients with sexually transmitted infections is that you're only treating one patient, while knowing there's probably another one whose condition may be left unattended. Expedited Partner Therapy, in which a provider can legally give the STI patient a second prescription for their partner to fill, answers some of those concerns. It's not as cut-and-dried as it sounds, though, so be sure you understand the nuances. Reading Legal Considerations for Expedited Partner Therapy in Urgent Care (page 31) will be a good start.

The author of that article, **Alan A. Ayers, MBA, MAcc**, also shares valuable insights into how to protect your business when new competitors open up shop in What to Do if a Competing Urgent Care Opens in Your Community (page 16). With urgent care continuing to grow at a rapid pace, it's a frequent concern. Read it to ensure you're prepared—and get CME credit for your time.

Also in This Issue

Understanding that you can't read every relevant article in every journal (and appreciating that you're reading this one now), we're grateful to **Cornelius O'Leary, Jr., MD** for the time he takes to synopsize content that can help our readers become better clinicians. This month, Abstracts in Urgent Care (page 27) reveals the most essential information from articles on cannabidiol, cluster headaches, tympanostomy, NDMA, and preventing cardiovascular disease. Dr. O'Leary is an urgent care physician with Emergency Care Dynamics.

Finally, with acknowledgment that all the clinical acumen in the world will be for naught if appropriate reimbursement doesn't follow in a timely manner, **Monte Sandler** looks down the road to changes in E/M coding that are designed to let you spend less time on documentation and more time with patients. Revenue Cycle Management starts on page 41. Mr. Sandler is executive vice president, revenue cycle management at Experity.

A Note of Appreciation for 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:

- **Suzanne Alton, DNP, FNP-BC, RN**
- **Barbara Chambers**
- **William Gluckman, DO, MBA, FACEP, CPE, FCUCM**
- **Ben Trotter, DO**
- **Mary Ann Yehl, DO**

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. ■

CONTINUING MEDICAL EDUCATION

Release Date: January 1, 2020
Expiration Date: Decemberr 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.

Planning Committee
- **Joshua W. Russell, MD, MSc, FACEP**
  Member reported no financial interest relevant to this activity.
- **Michael B. Weinstock, MD**
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- **Alan A. Ayers, MBA, MAcc**
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Disclosure Statement
The policy of the Urgent Care Association CME Program (UCA CME) requires that the Activity Director, planning committee members, and all activity faculty (that is, anyone in a position to control the content of the educational activity) disclose to the activity participants all relevant financial relationships with commercial interests. Where disclosures have been made, conflicts of interest, real or apparent, must be resolved. Disclosure will be made to activity participants prior to the commencement of the activity. UCA CME also requires that faculty make clinical recommendations based on the best available scientific evidence and that faculty identify any discussion of "off-label" or investigational use of pharmaceutical products or medical devices.

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CONTINUING MEDICAL EDUCATION

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

Reducing Morbidity and Mortality Due to MRSA in the Urgent Care Setting (page 11)

1. **Which of the following may be present with a MRSA infection?**
   a. A cluster of "pimples" or a large, tender lump that drains pus (a carbuncle)
   b. The area may form a central raised area that oozes purulent material
   c. Single raised red lump that may or may not be tender
   d. All of the above

2. **In 2017, how many people died from MRSA infection in the U.S.?**
   a. 7,000
   b. 12,000
   c. 17,000
   d. 20,000

3. **If a patient with MRSA has a history of sulfa allergy, which of the following is the most acceptable option?**
   a. Penicillin
   b. Amoxicillin
   c. Clindamycin
   d. Cephalexin

What to Do if a Competing Urgent Care Opens in Your Community (page 16)

1. **"SWOT" analysis includes research into a competitor's:**
   a. Strengths, weaknesses, opportunities, and threats
   b. Security, warmth, opportunities, and team
   c. Strengths, weaknesses, ownership, and technology
   d. Signage, windows, ownership, and timeliness

2. **Defending your practice and protecting your market share will require a multitiered strategy towards:**
   a. Understanding what your competitor is offering
   b. Strengthening your weak points
   c. Capitalizing on your advantages
   d. Driving increased awareness of your center
   e. All of the above

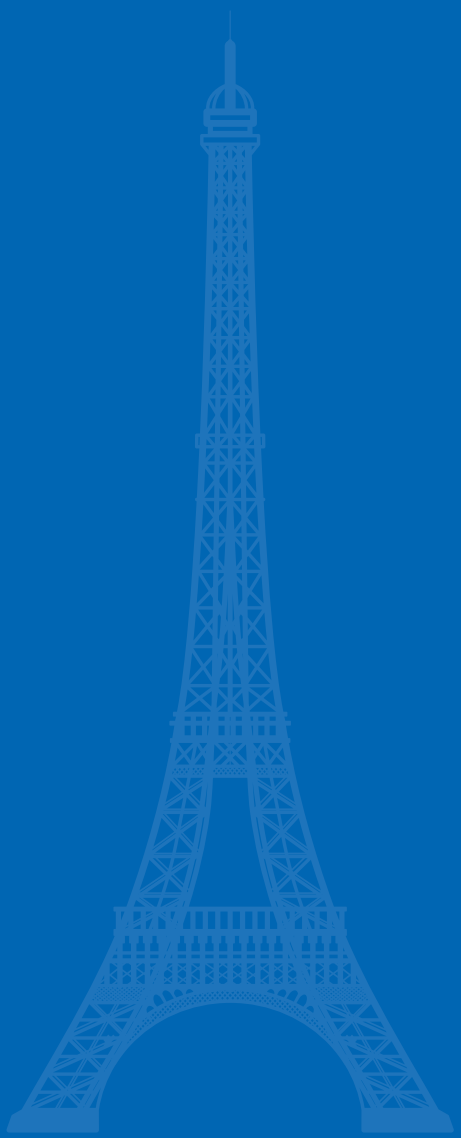
3. **Which of the following tactics has not been suggested as a way to appeal to "soccer moms" looking for a child-friendly urgent care center?**
   a. Addressing the mother as "Mom" during the visit
   b. Creating a section of the waiting room for kids, complete with games and toys
   c. Complimentary lattes
   d. Involve the child in the exam, such as encouraging them to ask questions, where age-appropriate

Kaposi Sarcoma Presenting in the Urgent Care Setting as a Single Mass Lesion of the Foot (page 23)

1. **Which type of Kaposi sarcoma (KS) is the most common tumor arising in HIV-infected individuals?**
   a. Classic KS
   b. Immunosuppressive (iatrogenic) KS
   c. Benign KS
   d. Epidemic KS

2. **Compared with other forms of Kaposi sarcoma, classic KS is thought to:**
   a. Be slower growing
   b. Be more likely to arise in older men of the Mediterranean or Central/Eastern European population
   c. Affect distal extremities, mostly lower legs and feet
   d. All of the above
   e. Present as a vesicle

3. **The differential diagnosis for nodular skin lesions includes each of the following *except*:**
   a. Abscess
   b. Dermatofibroma
   c. Plantar fibroma
   d. Plantar wart
   e. Bullous pemphigoid



UCA 2020 CONVENTION

...and now for something (almost) completely different

What do the VP for Health Transformation at Walmart, an award-winning podcast host, author, and Chief of Clinical Transformation at Atrium, the Chief Transformation Officer from NY-Presbyterian, Chief Strategic Innovation Officer from Dignity, and an internationally renowned violinist have in common?

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Disrupting Your Status Quo: *Kai Kight*
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Thanks to you, UCA's 2019 *Benchmarking Report* is Our Best Ever

LAUREL STOIMENOFF, PT, CHC

The 2019 *Benchmarking Report* publication date is fast approaching. I am predicting that it is going to be the best in the history of the Urgent Care Association (UCA), thanks to participation exceeding our expectations by a wide margin. Data are not only geographically diverse, but also representative of the diversity in urgent care ownership and scope, rendering it credible and downright enlightening.

Myth Busters

This year's report will feature a section that includes some industry myth busters. It is an excellent portrait of a healthcare sector that can be subject to undeserved criticism. And now we can dispel those myths with data. Simply put, speculation is trumped with facts.

Benefits to Advocacy

UCA's mission includes advocating on behalf of the industry. Every letter to congressional representatives and decision-makers includes at least one statistic from the *Benchmarking Report*. It is contemporary information, and this year's participation level makes it all the more compelling. Every edition is also referenced and quoted frequently by the media as they seek resources on this popular consumer healthcare destination.

Benefits to Urgent Care Owners and Operators

Benchmarking one's organization against others is a proactive way to see how one compares with the goal of continuous improvement. The report tells us that many urgent care operators use net promoter scores (NPS) to determine levels of patient satisfaction and loyalty. NPS monitoring allows operators to not only benchmark their performance against the healthcare industry, but also against other sectors including airlines, cable and internet providers, and hospitality. In contrast, UCA's *Benchmarking Report* drills down almost exclusively into the urgent care vertical, peppered with information about other on-demand services and competitors.

This will be the third year that UCA has partnered with Merchant Medicine to augment the data findings with updates on the state of the industry, trends, and technology. Who is growing and who is contracting? You have an opportunity to see what is happening in on-demand medicine with the benefit of their constant surveillance and lens peering into the future.

The esteemed management consultant and author, Peter Drucker, stated, "The only things that evolve by themselves in an organization are disorder, friction, and malperformance." Benchmarking is a way to proactively monitor and adjust performance so we don't become victims of the forces of entropy.

Over a Decade of Data

UCA has been publishing its *Benchmarking Report* since 2008. We are proud to produce yet another snapshot. And with a decade worth of input, it's becoming a full-length motion picture.

I would like to extend my deepest gratitude to those who took the time to contribute their data and responses to this upcoming report. We could not produce this work without your transparency and commitment. The composer Irving Berlin noted, "The toughest thing about success is that you've got to keep on being a success." Urgent care has experienced enormous success, and through ongoing benchmarking we've got our finger on the pulse.

Once the report is published, those who participated in the survey will automatically receive the Benchmarking Report *via email. For all others, the report will be available at* ***ucaoa.org/benchmarking.*** ■

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

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Reducing Morbidity and Mortality Due to MRSA in the Urgent Care Setting

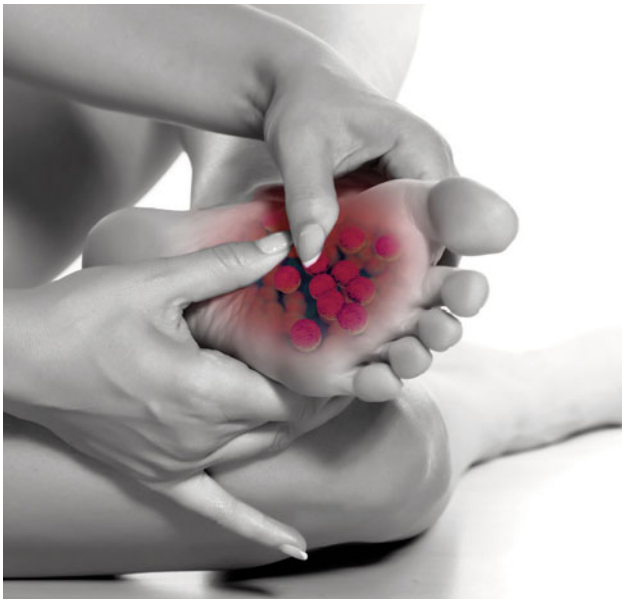
Urgent message: *Staphylococcus aureus* is a common pathogen in the community—one that can lead to a range of infections, including abscess and sepsis. Invasive methicillin-resistant *S aureus* (MRSA) infections have decreased in the healthcare setting; however, community-acquired MRSA infections have increased. Delayed treatment of MRSA infection leads to increases in morbidity and mortality.

JORDAN MILLER, DO and ARI LEIB, MD

An Illustrative Case

A 40-year-old female presented to an urgent care center with the chief complaint of a spider bite on her right foot. She states that she woke up to her foot itching and now had a small area of redness over the dorsal aspect with associated pain over the foot but no associated fevers, chills, or malaise. She denied seeing a spider. She denies a history of intravenous drug use, skin popping, or trauma to the area. She denies recent pedicures in unsanitary conditions or going barefoot; however, she did admit to taking a shower in a tub that had standing water backing up into it.

Physical exam revealed a well-developed female in no significant distress. On exam, there was a small area of erythema over the lateral aspect of the fourth metatarsal with mild tenderness to palpation (See **Figure 1**). Neurovascular exam of the foot was benign.



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Urgent Care Management

The patient was given amoxicillin/clavulanic acid and steroids from the urgent care and was discharged with return precautions.

Outcome

Over the next 2 days, the patient developed extensive swelling over the dorsum of the foot, with fevers and malaise. The erythema transitioned to necrosis with draining tracts. She subsequently presented to the emergency room where bedside incision and drainage revealed extensive purulent material. She was started on

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Figure 1. Patient's foot after "spider bite."

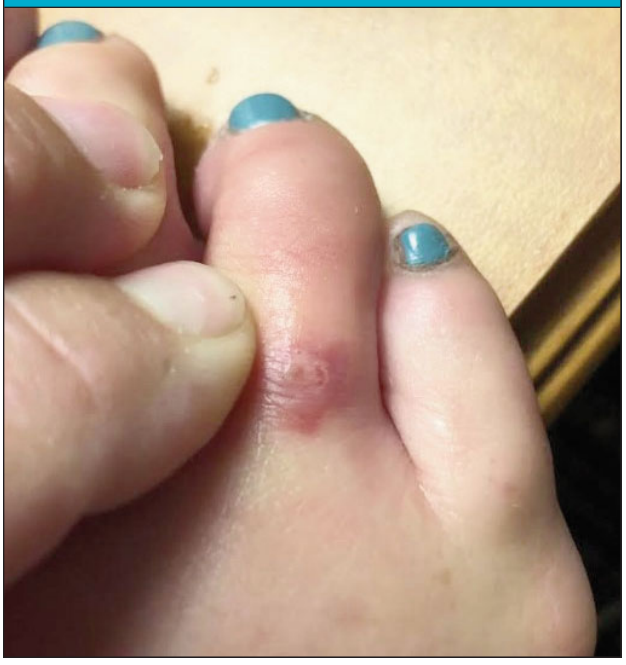
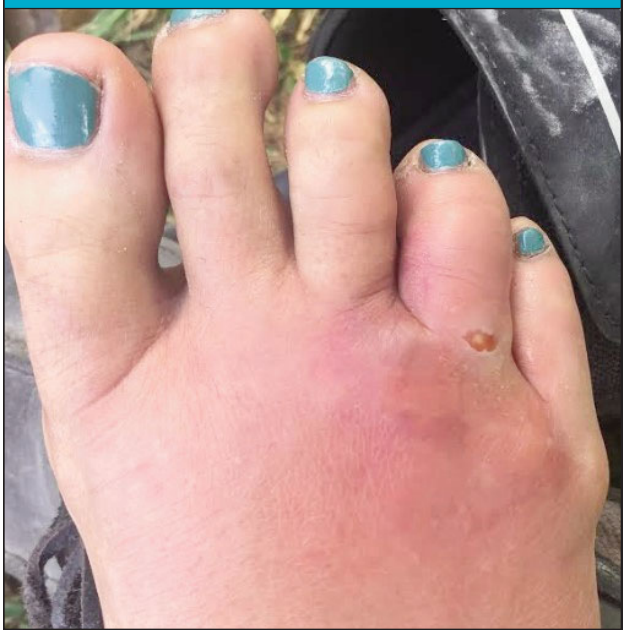


Figure 2. Patient foot prior to starting Augmentin with steroid taper.



intravenous antibiotics (vancomycin and piperacillin-tazobactam).

On admission, the patient was afebrile but had an elevated white blood cell count of 13,000. All other laboratory work was unremarkable. MRI of the right lower extremity was performed but did not show osteomyelitis. Wound cultures returned positive for MRSA and blood cultures were negative. In addition, the patient was diagnosed with cellulitis secondary to MRSA in the emergency room after failed outpatient management; this was thought to be provoked by unsanitary water exposure. After 5 days of IV antibiotics she was discharged home with oral linezolid two times daily for 6 days.

Discussion

Introduction

Staphylococcus aureus is a gram-positive, cocci-shaped bacterium that is catalase-positive, reduces nitrates, and is a facultative anaerobe. It can be a normal part of human flora, commonly found in the upper respiratory tract and on the skin. However, it can also be an opportunistic pathogen that is a common culprit in abscesses, respiratory tract infections (including sinusitis), food poisoning, pneumonia, meningitis, osteomyelitis, endocarditis, toxic shock syndrome, bacteremia, and sepsis.

Though *S aureus* could be treated successfully with penicillin in the 1940s, two decades later resistance began to develop and methicillin emerged as the treatment of choice. The first human case of MRSA was discovered in 1968. The bacteria was found to be resistant to previously successful treatments including penicillin, methicillin, oxacillin, and amoxicillin.

Currently, intravenous vancomycin is the drug of choice for severe MRSA requiring hospitalization, although there have been 13 documented cases of vancomycin-resistant MRSA.[1]

Common symptoms of community-acquired MRSA include:

- A cluster of "pimples" or a large, tender lump that drains pus (a carbuncle)
- The area may form a central raised area that oozes purulent material
- Single raised red lump that may or may not be tender and, with many patients, report of a "spider bite," without actually seeing the spider

Epidemiology

S aureus is implicated in many infections, and infections can progress rapidly.[2] In one study, researchers cultured acute skin or soft tissue infections of 422 patients seen at 11 emergency rooms; 59% were found to be MRSA. Another study revealed that in perianal abscess 34.8% of cases were found to be MRSA positive.[1] The initial

Figure 3. Patient foot on day of admission.

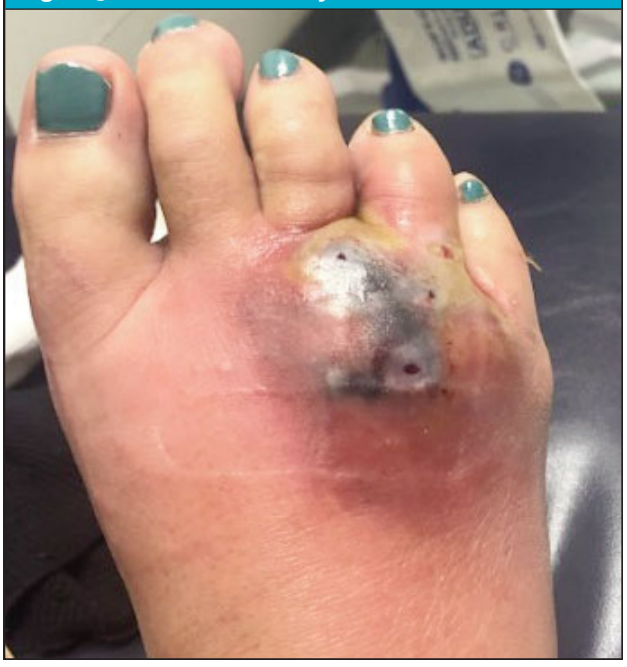
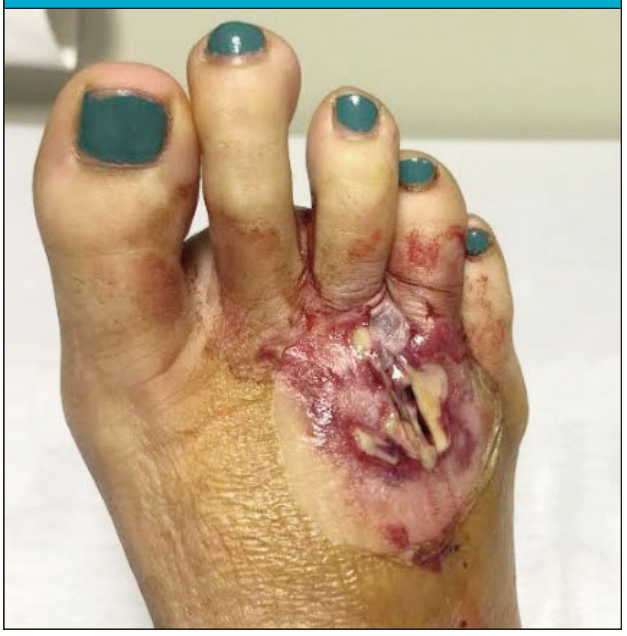


Figure 4. Patient foot after 4 days of IV antibiotics and incision and drainage



area of infection spread hematogenously to the heart valves, bones, joints, lungs, pacemakers, IV lines, or prosthetic joints.

Risk Factors

Risk factors for community-acquired MRSA include skin trauma (burns, cuts, and sores), body hair removal, tattoos, piercings, and sharing of personal equipment (eg, razors, tweezers) that are not cleaned properly. The incidence of MRSA-related hospitalizations ranges from 11.5% to 60% across the nation.[2,3]

MRSA is considered a major pathogen in skin and soft tissue infections. Clinicians should suspect MRSA infection in the following situations:

- Contact with a prisoner or prison facility
- Recent treatment or report of a "spider bite"
- Recurring skin infections, including impetigo and furuncles
- The patient is involved in contact sports or spends time in a sports facility

Cellulitis vs MRSA

Misdiagnosing cellulitis is a common problem in our healthcare system. Inflammatory dermatoses of the lower extremity are often misdiagnosed as cellulitis and treated with antibiotics or hospitalization. One study found that 30.5% of patients were misdiagnosed with cellulitis; of those 259 patients, 52 were admitted for further treatment.[4] Misdiagnosing cellulitis leads to 50,000 to 130,000 unnecessary hospitalizations annually and unwarranted use of antibiotics, which can lead to nosocomial infections, including *Clostridium difficile* and adverse reactions such as anaphylaxis. Correlating exam findings with patient presentation is an important task

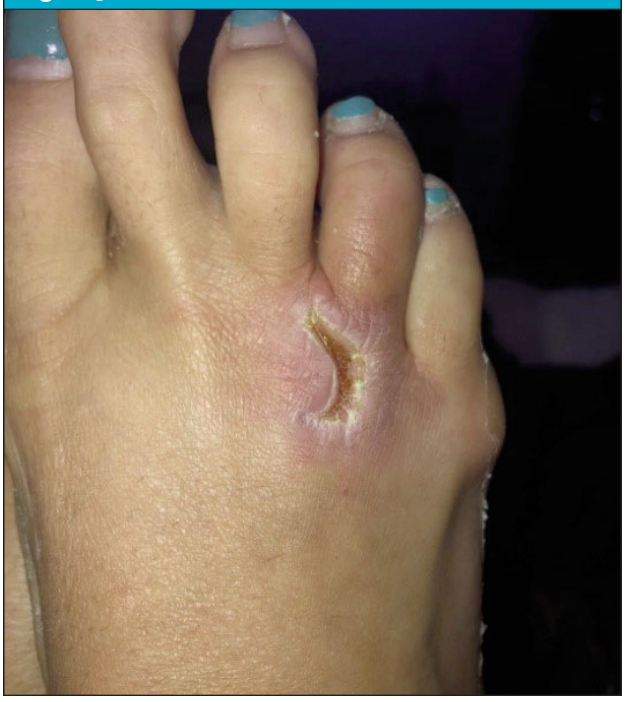
Table 1. Management Options—a Comparison

Trimethoprim-sulfamethoxazole
- Mechanism of action: sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid; trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid
- Pros: low cost
- Cons: photosensitivity, hyperkalemia, renal tubule acidosis, hepatitis, Steven Johnson syndrome

Doxycycline
- Mechanism of action: bacterial protein synthesis inhibitor
- Pros: fecal excretion (good antibiotic choice for ESRD patients)
- Cons: chelation, teratogenic, photosensitivity

Clindamycin
- Mechanism of action: bacterial protein synthesis inhibitor
- Pros: low cost
- Cons: diarrhea; high risk for *Clostridium difficile* infection; potential source for inducible resistance; generally highest rates of resistance

Figure 5. Patient foot 6 weeks after treatment.



for providers to avoid unwanted outcomes for the patient.[4]

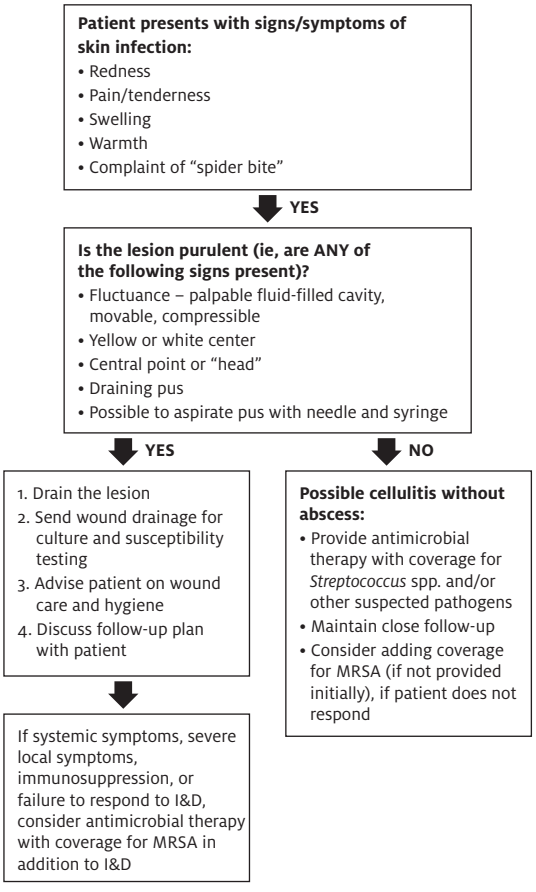
Differentiating simple cellulitis from MRSA infection can be challenging for clinicians. Patients with simple cellulitis often present with redness, swelling, and pain around the site of the skin infection. Purulent lesions with palpable, fluid-filled cavities that are moveable or compressible are more likely to be MRSA. Lesions with draining pus are also more likely to be MRSA. Patients with a history of MRSA infection elsewhere on the body, penetrating trauma, or history of IV drug abuse are more likely to require MRSA coverage.

As streptococci species are also a common cause of cellulitis, many physicians choose to cover for both MRSA and streptococci. Options include using TMP-sulfamethoxazole (Bactrim) or doxycycline with a beta-lactam such as penicillin, cephalexin, or amoxicillin. Current studies have shown that in the absence of abscess, ulcer, or purulent drainage, beta-lactam monotherapy is recommended and that treatment with a beta-lactam such as cefazolin or oxacillin was successful in 96% of patients. Double-blinded studies showed that a combination of TMP-SMX plus cephalexin was no more efficacious than cephalexin alone in pure cellulitis.[4]

Patients with an increased mortality and morbidity due to MRSA include seniors, nursing home patients, and those with organ dysfunction. Patients with end-stage liver disease or renal dysfunction and those admitted to the ICU with MRSA infection have also been found to have increased mortality. Mortality rates range from 5% to 60%, dependent on the site of infection and patient population.[1] In 2017, *S aureus* bloodstream infections accounted for 20,000 deaths in the United States.[5]

The CDC gives specific recommendations for outpatient MRSA follow-up and advises that patients should be clearly instructed to return promptly if they develop systemic symptoms or worsening local symptoms, or if their symptoms do not improve within 48 hours. Patient should have a follow-up visit scheduled within 48 hours of the initial visit to confirm adequate response to therapy.[6]

From the CDC: Outpatient Management of Skin and Soft Tissue Infections



Source: Centers for Disease Control and Prevention. MRSA Provider Brochure. Available at: https://www.cdc.gov/mrsa/pdf/MRSA_ProviderBrochureF.pdf. Accessed December 12, 2019.

Management

Treatment centers around adequate incision and drainage. Use of antibiotics remains controversial, but is generally recommended for all but very small abscesses. If the patient is to be discharged home, options include a 7- to 10-day course of oral trimethoprim-sulfamethoxazole, doxycycline, clindamycin, or minocycline. For those with a history of sulfa allergy where sulfamethoxazole is contraindicated, doxycycline or clindamycin are acceptable options. (Using a local antibiogram can help guide clinicians to select the best empiric antimicrobial therapy in the event of a pending culture and susceptibility result.)

Doxycycline is excreted in fecal material and is also an acceptable option in outpatient treatment of patients with chronic kidney disease.

In pregnant patients and children with a sulfa allergy, clindamycin is the preferred oral agent.

Currently, according to the CDC, cultures are not recommended in cases of cellulitis where there is no purulent drainage or no abscess.

Current recommendations include incision and drainage of simple abscesses and boils. In addition, there are insufficient data to suggest the necessity of antibiotics in these cases. Antibiotics should be given if there are multiple sites of infection or progression of associated cellulitis, signs and symptoms of systemic illness, associated comorbidities or immunosuppression, extremes of age, or in body areas where abscesses are difficult to drain.

Empiric therapy is recommended for 5 to 10 days; a culture should be obtained if there is purulent material. For nonpurulent cases, 5 to 10 days of empiric therapy is recommended. In some departments, irrigation after an incision and drainage is standard of care. Irrigation increases the length of procedure and pain experienced by the patient.

Prevention

Following are tips to help prevent MRSA:[7]

- Avoid sharing personal items such as towels or washcloths
- Perform good handwashing with soap and water
- Clean all exercise machines at gyms
- Avoiding touching others' wounds and sores
- Keeping cuts/scrapes clean and dry with a Band-Aid overtop

Colonization

Most patients who develop MRSA infection have been colonized prior to infection. Approximately 20% of the general population is colonized with *S aureus*, and most frequently it is found it in the anterior nares.[8] In the general population, another 30% is intermittently colonized. Though the reasons are unclear, the remaining 50% do not appear to be susceptible to *S aureus* carriage.[9]

Risk factors for colonization include previous admission to a hospital, the presence of chronic wounds or skin lesions, residing in a long-term care facility, and use of urinary or IV catheters.

One study showed that mupirocin appeared to only be cost-effective as a decolonization agent in patients that were proven nasal carriers. It was concluded that mupirocin as a decolonizing agent is effective in the short-term, and is helpful in decreasing risk for infection in select populations.[1] Mupirocin is not systemically absorbed, which makes it a good choice for decolonization. There has been an increase in resistance to mupirocin when the agent is routinely used as a strategy to control endemic *S aureus* infection and transmission among general inpatient population. ■

Teaching Points

- MRSA infection can progress quickly and be life-threatening if not promptly identified and treated.
- Associated risk factors include contact with prisoners or a prison facility, recurring skin infections, contact sports, and reporting concern for "spider bites" (although true spider bites are uncommon).
- Incision and drainage of abscesses remains the treatment of choice.
- Wound cultures can guide antibiotic therapy.

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What to Do if a Competing Urgent Care Opens in Your Community

Urgent message: As the country's urgent care markets become increasingly saturated, the forward-thinking operator will have a strategic patient-retention strategy ready when a competitor inevitably opens up shop in their community.

ALAN A. AYERS, MBA, MAcc

As the urgent care market continues its yearly growth of around 8%, per the Urgent Care Association's *2018 Benchmarking Report*, many markets around the country are seeing an oversaturation of urgent care centers. According to the *St. Louis Business Journal*, for instance, there are nearly 120 urgent care facilities in the 30 mile-radius of downtown St. Louis, a metropolitan area of 2.8 million people—with the researchers expecting that growth to continue. Similarly, the Washington, DC area has 131 urgent care centers; only seven are in the District of Columbia, leaving over 120 centers in a handful of Maryland and Virginia counties.

This is the reality of the urgent care landscape today: in many cities, competition for urgent care patients is being waged neighborhood by neighborhood, intersection by intersection, with new entrants popping up all the time.

Understanding the Competition

It's important to note that "competitors" aren't always urgent care centers whose capabilities align fully with yours. Retail clinics and pediatric-focused urgent care, for example, are expanding their footprints, disrupting markets, and offering patients additional on-demand care options. There is a great chance, therefore, that if you've yet to face a competing urgent care popping up in your market, it's likely to happen soon. And given that there are a finite number of urgent care patients in any one community, you may wonder what made that competitor decide to put a stake down in your market.

There are a few common reasons, several of which may have indeed factored into your own decision-making when you chose to open your center:

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- The competitor has done a thorough *strengths, weaknesses, opportunities, and threats* (SWOT) analysis in your market. If the SWOT analysis shows the competitor that the incumbent (you) is strongly positioned in the market with a loyal patient base, they'll usually look elsewhere. However, if the competitor sees that the incumbent urgent care has weaknesses and vulnerabilities in its model, adver-

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tising, or service delivery, then they've likely decided that they can offer a better option and attract your patients to their center.

- Urgent care industry leaders maintain that despite the burgeoning number of on-demand care options, emergency rooms are still seeing and treating an abundance of nonemergency patients. They reason, therefore, that there is still room for more urgent care centers in some communities to educate and better serve those additional patients, with your competitors thinking likewise.
- A competitor that understands the urgent care demographic and their habits has spotted a specific opportunity in your market. For example, if they see an area (like a strip mall) with no urgent care nearby, but note there is a PetSmart, Target, or Kohl's , then they know those retailers target the same demographic as urgent care (working women ages 25 to 55 with children). The competitor has leveraged the research other retailers have done on the demographic and figures they can out-position the incumbent if they build an urgent care center near those strong retail draws.
- Former providers or employees see the success of your practice, have learned your operating model and processes, think they have a loyal following of your patients who will follow them, and believe they can make more money opening a competing business than working for you.

What to Do if a Competitor Opens Nearby

There are a dwindling number of communities that have large-enough patient bases to support a bunch of urgent care centers in close proximity to one another. But for the most part, oversaturated markets dictate that any new entrants must siphon off your patient base and erode your market share. And since the urgent care space doesn't have strong brand differentiation among the main players and operators, you can't rely on brand loyalty to keep your patients and fend off competitors. Rather, defending your practice and protecting your market share will require you to implement and execute a multitiered strategy towards:

- Understanding what your competitor is offering
- Strengthening your weak points
- Capitalizing on your advantages
- Driving increased awareness of your center
- Showing patients your center is the best option

To that end, we'll examine critical points of emphasis, why they matter, key factors to consider, and takeaways towards focusing your efforts and resources on fortifying your practice and strengthening your market position.

Point of Emphasis #1: Conduct Competitive Analysis

Why it matters: Your competitor has likely done a competitive analysis on you, so you must do the same. It's the first step in understanding where you stand in relation to the competition, how they tend to out position you, and how their strengths and weaknesses stack up.

Key Factors to Consider

- The retail trade area – What's the size of your retail trade area, wherein your urgent care draws the majority of its customers? Trade area is commonly evaluated by determining drive times and the population within a certain radius. For urgent care, depending on the population density, we consider a 12-15-minute drivetime. That could mean a 2-mile drive in an urban area with heavy traffic, or a 10-mile drive in a sparsely populated rural area. A competitor is a *competitor* if they inhabit the same retail trade area as your center.
- Which center has the best location – Who has the best major retail draws that create "flow-through" traffic? Retail draws include the aforementioned Kohl's, Target, and PetSmart, as well as Lowes, and Walmart. Major grocery chains, Starbucks locations, banks, restaurants, and pharmacies are solid retail anchors, as well.
- The competitor's operating model – What type of facility and operating hours? What is their scope of services and technology? Do they have lab and x-ray capabilities onsite? What's their staffing model? What marketing tactics are they employing? What is their website and social media presence like? How do their offerings differ from yours? Lastly, how well do they execute these factors in comparison to your urgent care center?
- The first-person experience of utilizing the competitor's center – Making a secret shopper-type visit to your competitor may be the most insightful method to gaining a complete view of the patient experience. You'll see firsthand the interior of the facility, the clinical flow, and the registration processes. You'll also experience the culture of the center, the competence of the providers, and the customer service orientation. Be mindful of signage, too; for example, does the competitor post a self-pay menu? It's important to use discretion while secret-shopping so the staff acts naturally and is not defensive

to an obvious spying competitor. Consider that the competitor may have done likewise and sent a "secret shopper" to your urgent care.

Takeaway: A thorough competitive analysis will be more detailed and in-depth than the above brief example. It remains a good starting point, however, to gain a grasp of how your competitor plans to operate in your market, and for your center to begin developing its defensive strategy.

Point of Emphasis #2 – Upgrade the Curb Appeal and Interior of Your Center

Why it matters: Experience and anecdote have taught us that patients aren't typically knowledgeable enough to discern the clinical quality of their encounter, so they instead use the cleanliness and appearance of an urgent care center as a proxy for clinical expertise. Maintaining an attractive and pristine exterior, therefore, becomes a huge differentiator in the face of competition.

Key Factors to Consider

- The exterior – Well-lit, prominent signage. Maintained shrubbery, grass, walkways, and parking areas. Clean, pleasing aesthetics. Consider spending on upgraded signage along with an exterior makeover if necessary.
- No signs of center "fatigue" – All visible equipment should be functional. From a patient's perspective, seeing equipment in a corridor with an "Out of Order" or "Do Not Use" label affixed to chairs or even vending machines creates a negative perception. We've seen negative, one-star Yelp reviews of urgent cares that caution about "broken and dirty" equipment.
- Cleanliness of all interior areas – Waiting area/lobby, corridors, restrooms, and exams rooms should be uncluttered and clean. Restrooms, in particular, should be checked often, as an unpleasant restroom experience is a major turnoff that could send your patient to your competitor.
- Awareness of patient needs – Even with a short wait, patients may be drawn to an urgent care center whose operators anticipate their needs before they can be seen. Free Wi-Fi and device-charging stations may seem unnecessary, but will be appreciated by patients who need them.

Takeaway: Appearance is critical to patient perceptions of an urgent care center, often beyond the clinical outcome. Developing and adhering faithfully to a facility checklist is key to keeping patients happy with your center and avoiding negative online reviews that could give your competitors an advantage.

Point of Emphasis #3 – Ensure that Your Center Is Mom- and Kid-Friendly

Why it matters: Pediatric-focused urgent care centers are disrupting the market and, in the eyes of the coveted "soccer mom" demographic, are much "better" than conventional urgent cares for treating their kids. Your competitor could very well be a new pediatric urgent care, so you'll need to ensure on-the-fence patients that your center is likewise mom- and kid- friendly.

Key Factors to Consider

- Pediatric urgent care is considered worth the extra effort – Focus group anecdote has shown that because of the perception that pediatric urgent care offers superior care option for kids, moms will make the extra drive beyond the local conventional urgent care to utilize them.
- A kid-friendly environment – A section of the lobby should be designated for kids. Offering games, tablets, stuffed animals, and toys helps distract the child from their pain/illness, reduces their perceived wait time, and sets a positive tone for the visit.
- Borrow from pediatric urgent care and address the mother as "mom" throughout the visit; this deference and respect to the mother who drives the healing and recovering process has been shown to greatly appeal to "mom."
- Let the child participate – Where age-appropriate, explain the procedure to the child, encourage them to ask questions, offer options when appropriate, and show them equipment and supplies. You don't want to slow down throughput by overly explaining everything, but it will appeal to the mom to see that your staff is making an effort to ease their sick or injured child's anxiety and take their mind off their discomfort.

Takeaway: The goal for your center is not to dominate the pediatric niche, but to retain patients who would otherwise spend the extra time and effort to drive to a further away pediatric urgent care. By clearly demonstrating that your service delivery caters to kids and moms, your center can remain competitive against new pediatric urgent care entrants.

Point of Emphasis #4 – Make Sure You're Competing for Patients in Digital Channels

Why it matters: Consumer-driven companies are all leveraging technology to reduce the steps and effort involved in time-consuming tasks; in other words, they strive to reduce "friction" in using their products and services. Consumers expect the same in their healthcare providers; hence, leveraging technology to reduce the friction in utilizing your urgent gives you a competitive advantage.

Key Factors to Consider

- Perceived wait time – When evaluating your center against a competitor, a patient will definitely factor in wait time. By leveraging technology that allows them to reserve a spot online and receive text alerts when their time is approaching, the patient's perceived wait time is drastically reduced since most of it is occurring away from the center.
- GPS apps – Especially in densely packed urban areas with heavy traffic, creating an account with a GPS app provider such as Waze allows patients to locate the center on their phone, better time their trips, and avoid traffic delays by discovering alternate routes. You could even pay for Waze ads to target nearby drivers to your urgent care.
- Online SEO – Google reports that the key phrase "urgent care near me" is surging in online searches. When someone has an urgent care need, they don't go for the Yellow Pages anymore; they search on their phone. Ensuring that you allocate marketing dollars to your SEO so that your center shows in Google's "local three-pack" gives you the competitive advantage of placing your urgent care "front and center" in online searches.

Takeaway: There are a ton of additional technology-based and digital-marketing tactics your center can employ to get in front of your patients where they spend much of their time—online. Research the popular ones, determine which tactics fit your marketing budget, and employ them as soon as possible since there's a good chance your competitor is doing the same.

Point of Emphasis #5 – Increase Your Marketing Spend

Why it matters: Based on experience we know that a new urgent care center will spend upwards of $50,000 its first year on marketing, whereas an established center would spend around half of that. Meaning, unless your center matches their marketing spend, the competing urgent care could be gaining a marketing advantage.

"Be diligent in asking patients for feedback about their service or concerns before they leave your urgent care, or shortly thereafter with a survey. Any negative comments or concerns should be followed up on immediately before the patient goes online to post a bad review."

Key Factors to Consider

- Marketing channels the competitor is using – Where is the new urgent care focusing its marketing spend? Are their commercials on the radio? Are they advertising on the sides of buses? Do they have billboards around town? Can you tie up the desirable billboard locations? Is your current marketing in those channels strong or weak?
- Market strategically – It's not about simply outspending the new urgent care competitor. Your center should be strategic in where and how you allocate your marketing dollars. Have your staff and patients noticed the competitor's advertising? If so, where and which channel? Would it make more sense to spread your budget evenly among several channels, or focus on an important few?

Takeaway: Your urgent care competitor is spending thousands to achieve top-of-mind status and get your patients familiar with their offering as an alternative to you. Even if you're top-of-mind currently, you'll have to roll up your sleeves and examine your and their entire marketing initiative if you want to stay on top.

Point of Emphasis #6 – Ensure You're In-Network with the Most Payers

Why it matters: A new competitor will be out-of-network with payers until they can complete the contracting and credentialing process to accept insurance.

Key Factors to Consider

- New patients of the competing center may be hit with out-of-network penalties or fees before the credentialing is completed, making them more likely

to stay with your center because its credentialing is already established.
- Spend the time and effort to ensure that your center is in-network with as many additional payers as possible. Of course you'll need to negotiate the best rates so your center is not losing money on a bad contract, but the fact that you take more insurance providers than your competitor will be a clear advantage.

Takeaway: Credentialing can be a confusing and time-consuming process, but the effort will be worth it in the end. Hire an expert to help you through the process if necessary, as that competitive advantage cannot be overstated.

Point of Emphasis #7 – Build a Strong Network of Cross-Referrals with Local PCPs

Why it matters: Although urgent care could be seen as a competitor to PCPs, building a mutually beneficial cross-referral relationship (called *comanagement agreements* by some operators) means the PCP will steer their patients toward your practice and not your competitor.

Key Factor to Consider

- Look for areas of collaboration and referrals. Introduce yourself to local PCPs and, for those that are receptive, point out how a relationship could be mutually beneficial. For example, you could agree to steer your patients to the PCP office for follow-ups, specialty visits, and consultations that your urgent care doesn't handle, and the PCP could refer their patients to your urgent care for low-acuity issues when their office is closed or there is a lengthy appointment wait.

Takeaway: Not every PCP will be receptive to your center's offer, with some actively steering their patients away from your practice. The ones who do recognize the mutually beneficial relationship, however, can provide you with a source of patient referrals that your competitor doesn't have.

Point of Emphasis #8 – Closely Manage Your Online Reputation

Why it matters: In online searches, your competitor's urgent care center is likely placed right next to yours. The center with the most positive (and the fewest negative) reviews might be the deciding factor to which option a patient chooses.

Key Factors to Consider:

- Ensure that your urgent care is registered with Google My Business, then strive to get your center into the Google "local three-pack" (when a patient types in a keyword like "urgent care near me" into Google, the top three results shows first). If your center is among the first three results, its average star rating and the number of reviews it has are prominently displayed. When the searcher clicks your urgent care listing, another page opens to reveal more detailed information such as address, hours, phone, questions and answers, and a summary of your reviews and star rating average.
- The aforementioned UCA *Benchmarking Report* indicates that 96% of urgent care centers use social media in its advertising. The most popular social media channel for urgent care is Facebook Business Pages, which includes a section for reviews and star ratings as well.
- The competing urgent care will have their families and friends provide them 5-star reviews and will have reviews promoting their short wait times since they are a start-up with a small patient base.
- Maintaining the all-important positive reviews requires a proactive approach. Your center's staff must be diligent in asking patients for feedback about their service or concerns before they leave your urgent care, or shortly thereafter with a survey. Any negative comments or concerns should be followed up on immediately before the patient goes online to post a bad review. Also keep in mind that 95% of people will return to a business if their issue is quickly resolved.

Takeaway: There are numerous examples online of upset patients pulling out their phone and going online to post a negative review—as they sit in the lobby of your urgent care. It's much easier to prevent a negative rating than to try to get one removed later, provided there is a strong emphasis on continually checking with patients to make sure they are happy with your service delivery. The negative reviewers will not come back to your center, but they will try out the new urgent care that just opened down the road.

Point of Emphasis #9 – Strengthen Your Community Relationships

Why it matters: In addition to being medical care providers, urgent care operators are also retailers who must aggressively market to draw in the necessary new

business to stay ahead of competitors. This often means getting involved in the local community to provide patient education about urgent care, support other businesses and organizations, and to drive awareness to their center.

Key Factors to Consider

- See if you can get "exclusives" on certain community sponsorships – Work out arrangements with receptive community organizations that will allow your urgent care to be their "exclusive" sponsor.
- Expand your pre-existing community relationships. Depending on your marketing budget, there are a number of community organizations that your urgent care can get involved with:
- Churches/religious congregations
- Athletic boosters
- Chamber of commerce
- Local parks and recreation
- Volunteer/service organizations
- Local 5k runs
- Advocacy organizations
- Community event organizers

Takeaway: Having a stronger community presence than your local competitors is an advantage that can reap huge dividends insofar as creating loyalty and top-of-mind awareness. When there is a choice to be made, the local residents will choose the urgent care they have an affiliation with.

How Would Your Urgent Care Center Measure Up vs New Competitors in Patient Satisfaction?

As noted, the Net Promoter Score—a measure of patient loyalty—for urgent care centers was 68.1 in GMR Web Team's January-to-June 2018 survey period. Other insights from the company's *Urgent Care Patient Satisfaction Survey* may offer a glimpse into how patients perceive the urgent care market overall—and give you context for assessing how you measure up.

- 92.1% of patients gave *positive* ratings about their visit to urgent care centers in January-June 2018; 1% rated their experience as neutral.
- Of the 4,023 patients who made up the sample population, 80.9% were promoters (patients likely to refer a specific practice/physician to a friend or family member); 12.7% were "passives" (likely not to take any action in referring a specific practice/physician); 6.4% were considered detractors (likely to deter others from choosing a specific practice/physician).
- Key words used frequently by patients who rated an urgent care experience as positive included *friendly*, *helpful*, and *professional*. Think—honestly—about whether those attributes apply to the staff who interact with patients in your urgent care center. If you find it hard to be objective, you might want to consider bringing in a secret-shopper of your own.

Data source: GMR Web Team Urgent Care Patients Satisfaction Survey. Available at: https://www.gmrwebteam.com/urgent-care-patient-satisfaction-survey-december-2018. Accessed December 12, 2019.

Point of Emphasis #10 – Focus on Improving Your Net Promoter Score (NPS)

Why it matters: The NPS score is one of the most reliable measures of patient satisfaction (or dissatisfaction) with your urgent care. Striving to ensure that your NPS is as high as possible will help keep your patients from having a dissatisfying experience that could steer them to your competitors.

Key Factors to Consider

- Long wait times are the #1 detractor to patient satisfaction and result in lower NPS scores; implement measures at every opportunity to shorten wait times in your center (as long as they don't sacrifice clinical quality). In addition to the aforementioned "save your spot in line" and text alerts that offload the wait from the lobby to their home, consider implementing standing orders to expedite patient care through the clinical workflow. Take care to implement standing orders judiciously, though, to avoid any chance of liability.
- Place a renewed emphasis on culture – Studies show that the vast majority of online complaints and negative reviews are customer-service related. A compassionate, caring, customer-facing staff has an outsized impact on the perceptions of your center, and warm, positive interactions can boost your NPS scores.
- Make the interaction feel personal to increase NPS scores – Train your staff to introduce themselves during every patient encounter and use the patient's name whenever possible. This practice not only shows respect for the patient, but it increases the likelihood that they will express their concerns on the spot, rather than going to social media to post a negative review.

Takeaway: Healthcare marketing agency GMR Web Team has stated that in the January-June 2018 survey period the average NPS score for urgent care was 68.1 (out of a 4,736-clinic sample). If your center works diligently to boost your NPS beyond that number into at least the 80s, you stand well-positioned to maintain and ever grow your patient base.

Point of Emphasis #11 – Don't Bad Mouth Your Competitor

Why it matters: There have been recent legal cases where rival urgent care providers became embroiled in lawsuits over a perceived defamation of one center of another. This underscores the importance of being careful when making a statement about another urgent care center.

Key Factors to Consider

- Think twice before making a disparaging or inaccurate claim about a competitor online. This behavior can result in unneeded liability and expensive litigation. It's best to play it safe and err on the side of caution.
- Consider what it says about your practice if you're disparaging the competition – Is your center unable to stand on its own reputation of high-quality service, having to resort to attempts to tarnish another businesses reputation? Taking the high road always casts your center in the most favorable light and demonstrates that your business operates with the kind of integrity that engenders loyalty and patient retention.

Takeaway: Always double-check the facts before saying anything that can be perceived as a negative by a competitor. And even when something is factually correct, carefully weigh the benefits and drawbacks before repeating it.

Point of Emphasis #12 – Consider A Grand Reopening

Why it matters: Just because a competing urgent care center is opening nearby doesn't mean they're entitled to all the local buzz. A strategic grand reopening can steal some of that buzz and draw attention to your center.

Key Factors to Consider

- Capitalize on any significant development – Has your urgent care brought in new providers? Updated the lobby or exterior? Hit a company milestone? Added new service offerings? Any significant change, development, or upgrade could be an occasion for a grand reopening.
- The grand reopening gets people talking about your urgent care and can attract new patients. Advertising the grand opening can help neutralize the "newness" and novelty of the competitor and keep your center top-of-mind.
- Get the word out – Use social media, create an advertisement online, or have a press release created to let the entire community know about your exciting re-launch. You can also add temporary signage like sail flags and building banners, or hire a sign flipper (all subject to municipal codes) to increase your site's visibility amid the re-launch.

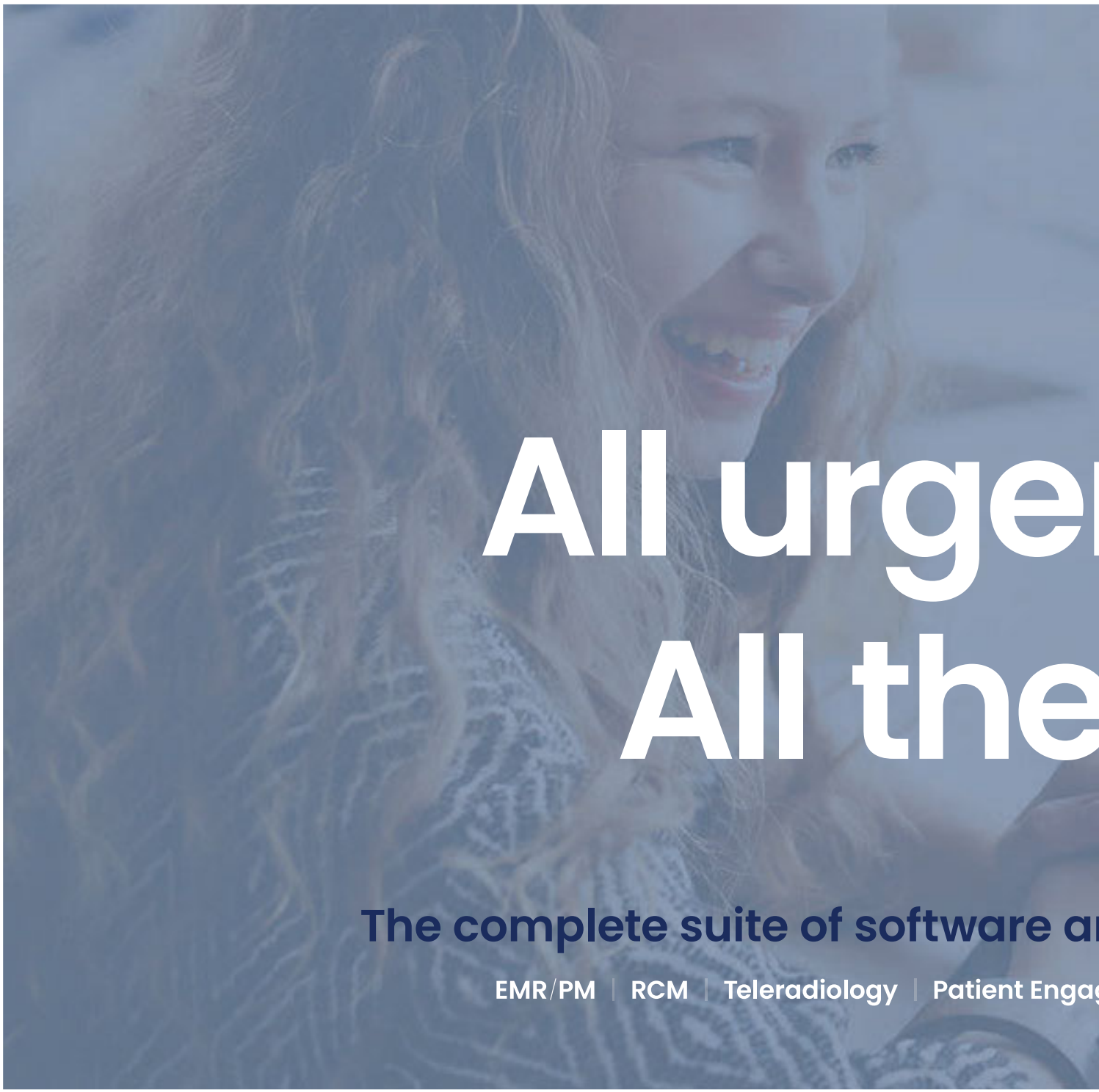
Takeaway: A grand reopening shows the community that your center is continually improving and innovating your service model to provide the best patient care in your city. Your center doesn't have to sit idly by and watch the new competitor grab all the headlines.

Recap: Points of Emphasis for Fortifying Your Practice and Strengthening Your Market Position

1. Conduct competitive analysis.
2. Upgrade the curb appeal and interior of your center.
3. Ensure your center is mom- and kid-friendly.
4. Make sure you're competing for patients in digital channels.
5. Increase your marketing spend.
6. Ensure you're in-network with the most payers.
7. Build a strong network of cross-referrals with local primary care providers.
8. Closely manage your online reputation.
9. Strengthen your community relationships.

Conclusion

Amid increasing competition from rival urgent care centers and other disruptive entrants, urgent care operators must mobilize on all fronts to retain their patients and stave off aggressive competitors. Urgent care markets, like most others, tend to self-regulate—meaning that the smartest operators who can provide the best service at the lowest costs are the ones who will remain profitable. In the end, it will come down to the urgent care operator who fine-tunes their entire business model the best, keeps their finger on the pulse of the industry, and provides their patients with highest-quality experience. ■



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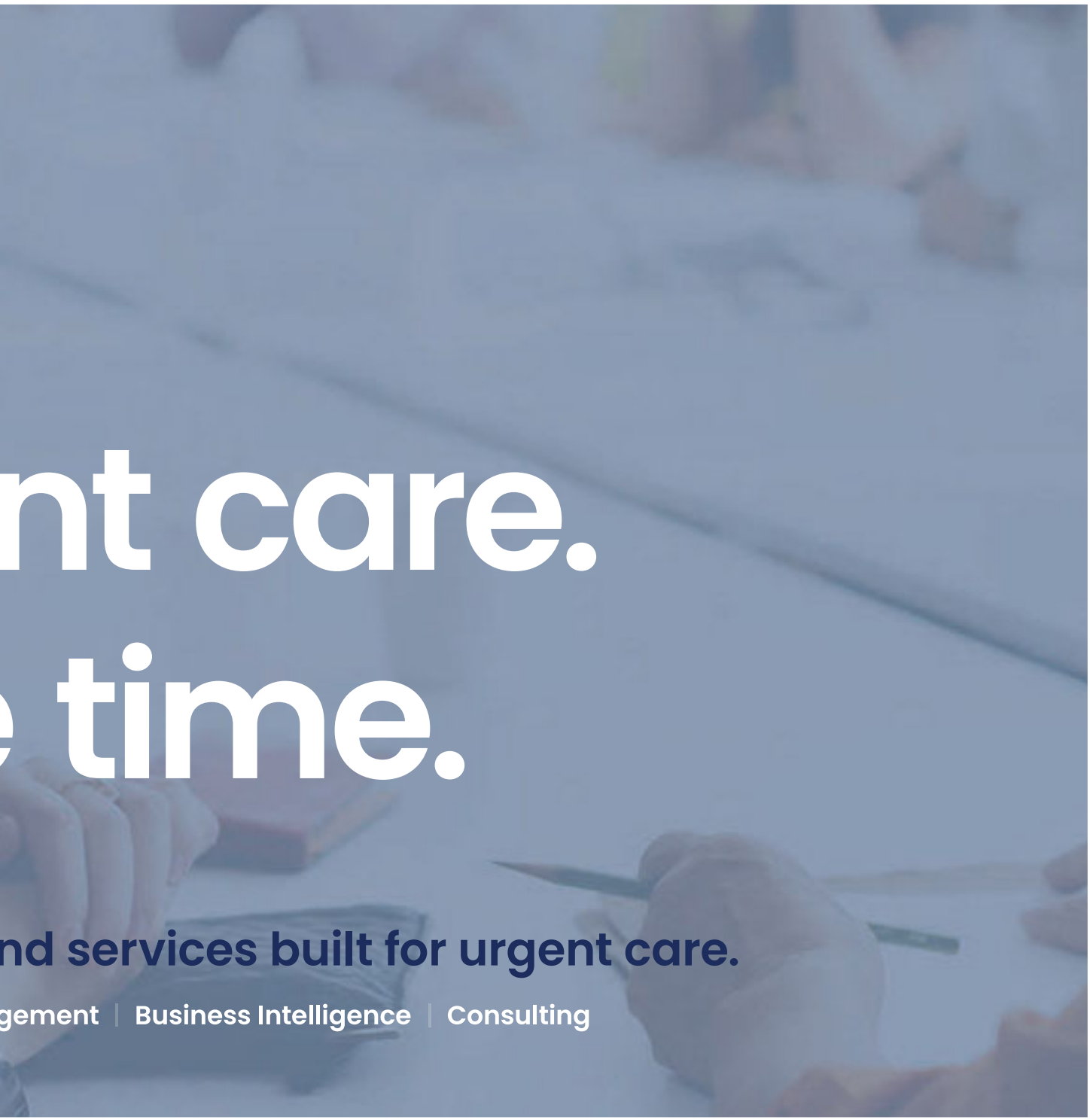

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CME: This article is offered for *AMA PRA Category 1 Credit*.™
See **CME Quiz Questions** on page 7.

Kaposi Sarcoma Presenting in the Urgent Care Setting as a Single Mass Lesion of the Foot

Urgent message: Kaposi sarcoma is considered an AIDS-defining illness with variable locations of presentation. Proper diagnosis of lesions can allow patients to seek out necessary care for potentially serious pathologies.

BRAD WHITE, DO, SUSANNAH BOULET, OMS-IV, WILLIAM BILLARI, OMS-IV, and JENNIFER LEE, OMS-IV

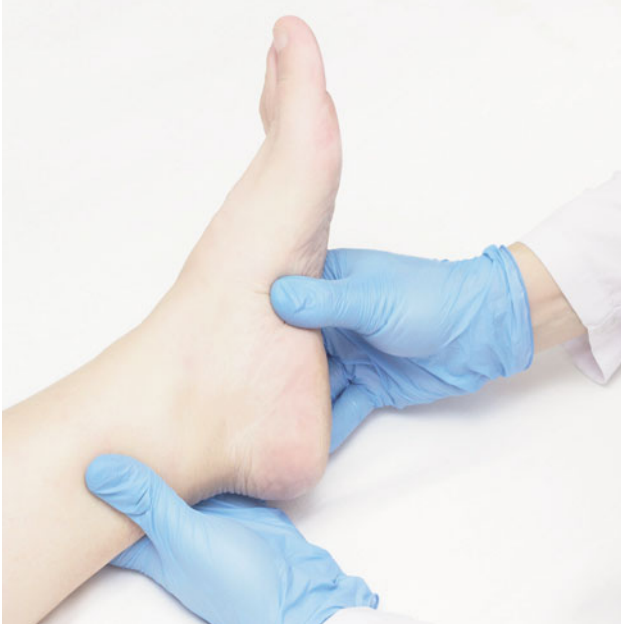
Introduction

Skin lesions and abscesses are common and often relatively benign findings that a physician may not deem serious enough for further investigation. However, as first-line providers, it is critical for urgent care physicians to identify and biopsy any lesions that are irregular in appearance, location, or both, as they could be harbingers of serious disease. Here, we present the case of a 54-year-old man diagnosed with Kaposi sarcoma, which presented as a fungating mass on the plantar surface of his right foot.

Case Presentation

History

A 54-year-old Hispanic male with no significant past medical history presented to the urgent care center with intermittent, radiating pain of the right lower foot of 2 weeks duration. He rated the pain at 7 on a 10-point scale. The patient reported that he initially noticed a rapidly enlarging black lesion on the bottom of his right foot with edema and erythema present. He also reported applying methylene blue to the lesion with no improvement. He is a construction worker and denied any injury or trauma to the extremity. He related that the pain was alleviated while wearing a shoe, and exacerbated when the shoe is off. He denied any fever, muscle cramps or spasms, swollen lymph nodes, shortness of breath, or chest pain, but admitted to bleeding that was controlled.



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Physical exam

Vital signs and physical exam were unremarkable except for a 2 x 1.5 cm fungating mass on the plantar surface

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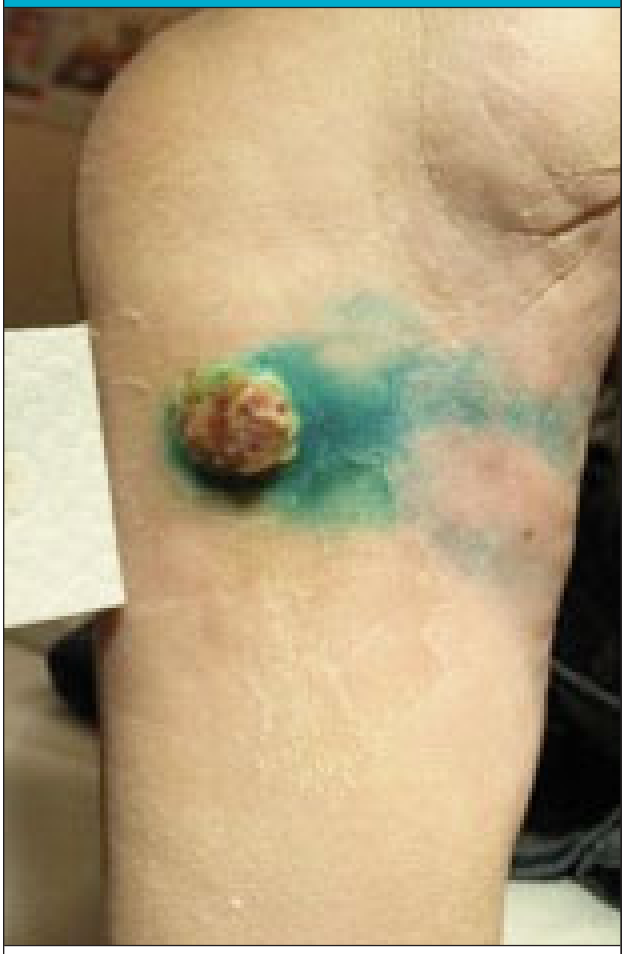
Figure 1.



A lesion of Kaposi sarcoma on the plantar surface of the right foot; artificially dyed by methylene blue.

of the right foot. A pocket of demarcation was present between the mass and normal surrounding tissue, with approximately 0.5 cm of probable depth. Blue, artificially dyed skin surrounding the lesion and a small amount of purulent material were observed.

Differential diagnosis

The differential for nodular skin lesions includes, but is not limited to, abscess, dermatofibroma, plantar wart, epidermal inclusion cyst, plantar fibroma, Kaposi sarcoma, squamous cell carcinoma, bacillary angiomatosis, pyogenic granuloma, and hemangioma.

Testing and treatment

The patient was prescribed cephalexin (Keflex) and bacitracin. A culture of the lesion was obtained via punch biopsy, which was performed in the urgent care center and sent to pathology. Pathology report of the biopsy returned with diagnosis of Kaposi sarcoma of the skin. An additional section stained with HHV8 was reviewed and supported the diagnosis. Histology reported a bland spindle cell proliferation around the superficial vascular and periadnexal plexuses with formation of slit-like spaces filled with extravasated erythrocytes. Scattered inflammatory infiltrate of lymphocytes and plasma cells were present.

"If biopsied, the lesions can be processed through polymerase chain reaction to detect amplified human herpes virus 8 (HHV-8) DNA sequences."

Follow-Up

The patient was contacted twice and informed that an urgent follow-up visit was advised regarding a potentially serious diagnosis. The patient declined both times and reported that he had an appointment with his primary care provider and a specialist.

Discussion

Kaposi sarcoma (KS) is an angioproliferative malignancy, which can further be sorted into four types based on the clinical conditions and presentation in which it arises. These four types include: classic; endemic; immunosuppressive (iatrogenic); and the most common, epidemic (AIDS-related) Kaposi sarcoma.[1]

The microscopic presentation is consistent between the four types of KS, displaying evidence of angiogenesis, inflammation, and spindle cell proliferation.[2-4] There are many clinical variants of KS, including telangiectatic, ecchymotic, keloidal, hyperkeratotic, micronodular, pyogenic granuloma-like, and intravascular.[2,5] These lesions can rupture, bleed, grow rapidly in size, or even remain unchanged for several years. If biopsied, the lesions can be processed through polymerase chain reaction to detect amplified human herpes virus 8 (HHV-8) DNA sequences. Immunohistochemical staining can also be used to detect the presence of HHV-8 latent antigen within the spindle cells.[4]

Classic Kaposi sarcoma (CKS) is thought to be slower growing, arises in older men of the Mediterranean or Central/Eastern European population, and affects the

distal extremities, mostly lower legs and feet.[6]

Endemic (African) KS is most commonly found in Central and Eastern Africa in those less than 40 years of age, including women and children. Factors such as malnutrition and malaria are thought to contribute to its development.

CKS was the most common form of KS in Africa prior to the AIDS epidemic.

Immunosuppressive (Iatrogenic) KS is found in renal allograft recipients, other transplant recipients, and those on immunosuppressant therapy. Cessation or lowered dosage of the immunosuppressive drugs often resolves or reduces the size of KS lesions.[1,7]

Epidemic (AIDS-associated) KS is the most common tumor arising in HIV-infected individuals and is considered an AIDS-defining illness by the Centers for Disease Control and Prevention. This disease has been found among all demographics associated with increased risk for HIV infection, most commonly homosexual or bisexual men. Although less common, epidemic KS may also be present in intravenous drug users and transfusion recipients. In these patients, the CD4 count plays an important factor in the incidence of KS.[8,9]

"As an AIDS-defining illness, KS should lead the urgent care provider to seek out further workup and proper follow-up."

The cutaneous lesions of KS are aggressive and can be found most often on the lower extremities, face, oral mucosa, and genitalia.

Noncutaneous sites of disease most commonly include the oral cavity, gastrointestinal tract, and respiratory system.[1]

Due to our patient's age, ethnicity, geographic location, and lack of any significant past medical history, epidemic KS was suspected. Urgent follow-up was highly recommended in order to determine if the patient was infected with AIDS, so he could receive the best care possible for his condition.

Other AIDS-Related Dermatologic Conditions

Physicians should also be aware of other dermatologic conditions associated with AIDS, including esophageal candidiasis, herpes simplex with chronic ulcerations, varicella zoster in a younger patient, seborrheic dermatitis, condyloma acuminata, oral hairy leukoplakia, molluscum contagiosum, psoriasis, and dermatophyte infections, among others. Any of these suspicious skin disorders warrant further investigation by the urgent care physician, as they could be signs of significant disease.

Differential Diagnosis for Nodular Skin Lesions

• Abscess	• Kaposi sarcoma
• Dermatofibroma	• Squamous cell carcinoma
• Plantar wart	• Bacillary angiomatosis
• Epidermal inclusion cyst	• Pyogenic granuloma
• Plantar fibroma	• Hemangioma

Conclusion

Physicians working in an urgent care setting are often the first-line providers for patients who may harbor potentially serious pathologies. Thus, good clinical judgment and relevant workup are essential in proper diagnosis, no matter the presenting complaint. Kaposi sarcoma is a serious disease, and as an AIDS-defining illness it should lead the urgent care provider to seek out further workup and proper follow-up.

AIDS is a treatable, but fatal, condition; therefore, the presentation of irregular-appearing lesions on the skin should always be appropriately investigated (as highlighted by this case, when the initial manifestation of KS arose on the plantar surface of the foot). Prompt and accurate diagnosis allows the potentially AIDS-infected patient to seek out further diagnosis and treatment crucial to improving both duration and quality of life. ■

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ABSTRACTS IN URGENT CARE

- The FDA on Cannabidiol
- Improving Diagnosis of Cluster Headache
- Making Tympanostomy Tube Placement Office-Friendly
- Nothing to Fear from NDMA?
- Counseling Patients on Preventing Cardiovascular Disease

CORNELIUS O'LEARY JR, MD

FDA Delves Deeper into Use of CBD Products

***Key point:** The FDA is working to answer questions about the science, safety, and quality of products containing cannabis and cannabis-derived compounds, particularly CBD.*

Citation: U.S. Food & Drug Administration. What you need to know (and what we're working to find out) about products containing cannabis or cannabis-derived compounds, including cannabidiol (CBD). Available at: https://www.fda.gov/consumers/consumer-updates/what-you-need-know-and-what-were-working-find-out-about-products-containing-cannabis-or-cannabis. Accessed December 9, 2019.

Aware there is a common belief among cannabidiol (CBD) users that trying the compound "can't hurt," the FDA has evaluated (and seeks to educate the public on) potential dangers associated with its use. The likelihood of experimenting with CBD may be enhanced by seeing celebrities promote or support its use. This is especially relevant in the urgent care setting, where patients may have suggested to you that CBD is "the only thing that works" for their pain. Now the FDA has published information for both physicians and the public to understand the risks, as well as the benefits, of cannabis and cannabis-derived compounds, including CBD.

The FDA states they have only approved one CBD product, Epidiolex, to treat two rare forms of epilepsy. It is illegal for companies to market CBD by adding CBD to food or labeling it as a "dietary supplement."

At this point, there are limited data on CBD and its safety when being taken for any reason. The FDA published the following information for the public with regard to CBD:

1. CBD has the potential to harm you, and harm can happen to you before you are aware of it.
   a. CBD can cause liver injury (as identified by the FDA when studying Epidiolex for rare forms of epilepsy).
   b. CBD can affect the metabolism of other drugs, causing serious side effects.
   c. Use of CBD with alcohol or other CNS depressants increases the risk of sedation or drowsiness, which can lead to injuries.
   d. CBD may cause male reproductive toxicity. The FDA identified possible changes in male reproductive fertility during animal studies while developing Epidiolex, including effects in the male offspring of females exposed to CBD. These findings were only in animals, but affected testicular size and sperm count and the public should be aware this is a possible side effect.
2. CBD can cause side effects that you do notice. These side effects should improve if one stops using CBD, or the amount of CBD ingested or used is decreased. Such side effects include:
   a. Changes in alertness (most commonly experienced as somnolence)
   b. Gastrointestinal distress (most commonly experienced as diarrhea and/or decreased appetite)
   c. Changes in mood (irritability or agitation)

The FDA also warns that there are many important aspects of CBD use that have not been studied at this point. These include the effects of long-term use, or the effects on the developing brain if used during pregnancy or breastfeeding, or when children take CBD. Further, we do not know how or if CBD interacts with herbs/botanicals or prescription medications, but there is an inherent risk of interactions.

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The FDA continues its efforts to block unproven claims made by CBD companies and to determine unknown risks to the public. ■

Moving Toward More Efficient Diagnosis of Cluster Headaches

Key point: Cluster headaches are as hard for the clinician to diagnose as they are unpleasant for the patient to experience. Improving both the quality and timeliness of care hinges on making earlier, and more distinct, diagnosis.

Citation: Martin V. Making the diagnosis of cluster headache. *J Fam Pract*. 2019;68(8):S39-S42.

The very nature of cluster headaches, and the diverse ways in which patients experience them, make timely, precise diagnosis (and subsequent treatment) challenging. Studies show an average delay in diagnosis of 6 to 8 *years*. In this article published in the *Journal of Family Practice*, the author notes that cluster headaches tend to occur in a "cluster period" or "bout" that can last from weeks to months. Further, patients with cluster headaches may experience periods of remission lasting from months to years; 25% of patients are thought to have only one cluster period in their lifetime.

The author also notes, however, that cluster headaches tend to follow a circadian as well as a circannual pattern (meaning they tend to occur at the same time of year, particularly during spring and fall).

The *International Classification of Headache Disorders*, 3rd edition (ICHD-3), describes cluster headache attacks of severe, strictly unilateral pain which is:

- Orbital, supraorbital, temporal, or any combination of these sites
- Lasting 15 to 180 minutes
- Occurring from daily up to eight times per day
- Associated with one or more autonomic signs or symptoms ipsilateral to the headache
- Described as excruciating in intensity, to the extent that patients are usually unable to to lie down and relax, and characteristically pace the floor

Cluster periods or bouts may be precipitated by alcohol, histamine, nitroglycerin, changes in weather, odors, and bright or flashing lights.

First- and second-line relatives of patients with cluster headaches are more likely to be similarly afflicted than the general population. Further, the U.S. Cluster Headache Survey showed a history of head trauma in 18% of patients who subsequently developed cluster headaches. In over 75% of male patients with head trauma preceding CH, the average time interval between head trauma and CH was 10.1 years, suggesting the possibility that there was no causal association, only correlation.

ICHD-3 diagnostic criteria for cluster headaches are outlined in **Table 1**. ■

Table 1. ICHD-3 Diagnostic Criteria for Cluster Headaches

A. At least five attacks fulfilling criteria B–D
B. Severe or very severe unilateral orbital, supraorbital and/or temporal pain lasting 15-180 minutes when untreated
C. Either or both of the following:
  1. At least one of the following symptoms or signs, ipsilateral to the headache:
    a. Conjunctival injection or lacrimation
    b. Nasal congestion or rhinorrhea
    c. Eyelid edema
    d. Forehead and facial sweating
    e. Miosis and /or ptosis
  2. A sense of restlessness or agitation
D. Occurring with a frequency between one every other day and eight per day
E. Not better accounted for by another ICHD-3 diagnosis

Diagnosis of cluster headache is clinical, based on a detailed history and neurological examination. Laboratory tests are usually not useful. MRI can be useful to rule out other disorders. In cluster headaches, MRI tends to show enlargement of anterior hypothalamic gray matter ipsilateral to the headache side compared with controls. Functional MRI has shown cerebral activation in ipsilateral hypothalamic gray matter during an attack.

Cluster headache attacks are unilateral, affecting peri- and retro-orbital regions and the temple, sometimes involving the teeth. Some patients have compared the sensation, per the author, with being poked in the eye with a hot needle or knife. During an attack, patients experience one or more cranial autonomic symptoms ipsilateral to the pain. These include:

- Lacrimation
- Eye redness
- Eye discomfort
- Nasal congestion
- Rhinorrhea
- Aural fullness
- Throat swelling
- Flushing ■

General Anesthesia No Longer a Necessity for Placement of Ear Tubes

Key point: A new "breakthrough device" facilitates placement of ear tubes under local anesthesia.

Citation: U.S. Food and Drug Administration. News release. FDA approves system for the delivery of ear tubes under local anesthesia to treat ear infection. November 25, 2019. Available at: https://www.fda.gov/news-events/press-announcements/fda-approves-system-delivery-ear-tubes-under-local-anesthesia-treat-ear-infection. Accessed December 9, 2019.

The U.S. Food and Drug Administration has approved use of a new system for delivering local anesthesia in children undergoing placement of tympanostomy tubes. The Tubes Under Local Anesthesia system (Tula) consists of the anesthetic Tymbion, Tusker Medical Tympanostomy Tubes, and several devices needed for delivery of the anesthetic and ear tubes into the eardrum. The benefit to the patient—and, potentially, to the urgent care provider—is that tubes will be able to be placed in a physician's office with minimal discomfort to the patient, according to the FDA. According to the National Institute of Deafness and Other Communication Disorders, five out of every six children will have at least one ear infection before the age of 3 years. The Tula system uses an electric current to deliver a local anesthetic to the patient prior to the placement of tympanostomy tubes, thus avoiding the use of general anesthesia. This system can be used in infants as young as 6 months of age, as well as in adults. Tula is not for use in patients with allergies to local anesthetics or preexisting problems with their eardrums, such as a perforated eardrum. The most common problem was lack of adequate anesthesia during the procedure. The FDA also granted Breakthrough Device status to Tula; that designation is reserved for devices that treat a life-threatening or permanently debilitating condition and meets one of the following criteria: the device is in the best interest of patients; there are no cleared or approved alternatives; or the device shows significant advantage over cleared and approved alternatives. ■

Deflating Fear of Products Containing NDMA

Key point: Some mainstream media reports have created warrantless uneasiness among patients who take certain medications falsely perceived to be unsafe due to the presence of the substance NDMA.

Citation: U.S. Food and Drug Administration. Statement from Janet Woodcock, MD, director of FDA's Center for Drug Evaluation and Research, on impurities found in diabetes drugs outside the U.S. December 05, 2019. Available at: https://www.fda.gov/news-events/press-announcements/statement-janet-woodcock-md-director-fdas-center-drug-evaluation-and-research-impurities-found. Accessed December 9, 2019.

The FDA has investigated several drugs for genotoxic impurities including the substance NDMA over the past few years. Certain

drugs, including angiotensin II receptor blockers (ARBs) and ranitidine, have been found to have small amounts of the substance, sometimes compared with amounts that may be found in charred beef. Consequently, the FDA has announced efforts to ensure that U.S. drug supply meets strict quality standards. One example: There are some reports that metformin has been found to have low levels of NDMA or other nitrosamines in other countries. Again, these levels are tantamount to those contained in food and water naturally.

NDMA is found in dairy products, seafood, cured and grilled meats, and even vegetables. Everyone is exposed to some level of NDMA. It may be most helpful to counsel your patients on these facts. The international scientific community and FDA do not expect NDMA or nitrosamines to cause damage when ingested at low levels. ■

Counseling Patients on Reducing Risk for Cardiovascular Disease

Key points: The AHA and ACC have boiled down their latest guidelines update into a "Top 10" list to facilitate discussion with patients.

Citation: Arnett DK, Blumenthal RS, Albert MA, et al. 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: A report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *Circulation*. 2019;140(11):e596-e646.

The latest guidelines update issued by the American Heart Association and American College of Cardiology features a list of the Top 10 Take-Home Messages for the Primary Prevention of Cardiovascular Disease. Given that patients may present to urgent care centers with questions on reducing their own risk for CVD, this is of great relevance to the urgent care provider. The top 10 topics urgent care clinicians should consider discussing with patients include:

1. Prevention of atherosclerotic vascular disease (ASCVD), heart failure, and atrial fibrillation through healthy lifestyle
2. A team-based care approach that evaluates social determinants of health that affect individuals to inform treatment decisions.
3. A 10-year ASCVD risk estimation for patients between 40 and 75 years of age, including a clinician-patient risk discussion before starting on pharmacological therapy (eg, antihypertensive therapy, a statin, or aspirin). In addition, assessing for other risk enhancing factors can help guide decisions about preventative interventions in select individuals, as can coronary artery calcium scanning.
4. All adults should consume a healthy diet that emphasizes the intake of vegetables, fruits, nuts, whole grains, lean vegetable or animal protein, and fish and minimizes the intake of trans fats, red meat and processed meats, refined carbohydrates, and sugar-sweetened beverages. For adults with overweight/obesity, counseling and caloric restriction are recommended for achieving and maintaining weight loss.

"Nonpharmacological interventions are recommended for adults with elevated blood pressure or hypertension. For those requiring pharmacological therapy, the target blood pressure should generally be <130/80 mmHg."

5. Engaging in at least 150 minutes per week of accumulated moderate-intensity physical activity or 75 minutes per week of vigorous-intensity physical activity.
6. For adults with type 2 diabetes mellitus, lifestyle changes, such as improving dietary habits and achieving exercise recommendations. If medication is indicated, metformin is a first-line therapy, followed by consideration of a sodium-glucose cotransporter 2 inhibitor (SGLT2 inhibitor) or a glucagon-like peptide-1 receptor agonist (GLP-1 receptor agonist).
7. Assessment of tobacco use at every visit; those who use tobacco should be assisted and strongly advised to quit.
8. Advice that aspirin should be used infrequently in the routine primary prevention of ASCVD because of lack of net benefit.
9. Statin therapy is first-line treatment for primary prevention of ASCVD in patient with elevated low-density lipoprotein cholesterol levels (>190 mg/dL); those with diabetes mellitus; who are 40 to 75 years of age; and those determined to be at sufficient ASCVD risk after a clinician-patient risk discussion.
10. Nonpharmacological interventions are recommended for all adults with elevated blood pressure or hypertension. For those requiring pharmacological therapy, the target blood pressure should generally be <130/80 mmHg.

In addition to the top 10 take-home messages, the ACC/AHA highlight additional risk factors that are key points for clinician-patient risk discussions and high-complexity clinical decision-making. Among the "risk-enhancing factors" recommended for discussion with patients are family history of premature ASCVD (males, age <55; females, age <65); primary hypercholesterolemia (LDL-C, 160-189 mg/dL [4.1-4.8 mmol/L]); non-HDL 190-219 mg/dL [4.9-5.6 mmol/L]; metabolic syndrome; chronic kidney disease; chronic inflammatory conditions (eg, psoriasis, rheumatoid arthritis, systemic lupus erythematosus); history of premature menopause (prior to age 40); being of a high-risk face (eg, South Asian ancestry); lipids/biomarkers associated with ASCVD risk. ■

Legal Considerations for Expedited Partner Therapy in Urgent Care

Urgent message: Expedited Partner Therapy enables a provider, when treating a patient for a sexually transmitted infection, to give a second prescription for the patient's partner without having to examine the partner.

ALAN A. AYERS, MBA, MAcc

Introduction

Expedited Partner Therapy (EPT) is the clinical practice of treating the sex partners of patients diagnosed with sexually transmitted diseases by providing prescriptions to the patient for his or her partner without the healthcare provider first examining the partner.[1]

Initially developed to help control syphilis, EPT became widely recognized to treat gonorrhea, chlamydial infection, and, most recently, human immunodeficiency virus (HIV) infection.[2] The CDC reviewed multiple studies on EPT and concluded that EPT is a "useful option" to further partner treatment, particularly for male partners of women with chlamydia or gonorrhea.[2] To that end, in August 2006 the CDC recommended the practice of EPT for certain populations and specific conditions; the CDC continues to recommend it in *Sexually Transmitted Diseases Treatment Guidelines, 2010*.[3]

Here, we discuss the legal considerations when issuing a script to a patient a provider has never examined.

Legal Issues

The CDC has stated that the legal status of EPT remains an area of uncertainty.[4] At the same time, the CDC has attempted to assist state and local STD programs in their efforts to implement EPT as an additional partner services tool, and has collaborated with the Center for Law and the Public's Health at Georgetown University and Johns Hopkins University to assess the legal framework concerning EPT across all 50 states and other jurisdictions.[4]

Expedited Partner Therapy is permissible in 44 states, and *potentially* allowable in five states (Alabama, Kansas, New Jersey, Oklahoma, and South Dakota).[1] It is prohibited in one state (South Carolina).[4]

Given this broad spectrum of application of EPT, there will be specific requirements in each state that permits this practice, as the regulation of these programs is at the state level.

Record keeping

Questions may arise concerning what is required for charting the prescription since the physician never examined the partner. For example, in Wisconsin, a 2009 law permits the prescription to be written in the partner's name—which is preferred—or with "Expedited Partner Therapy" or "EPT" in place of a name when the patient doesn't know or won't divulge the partner's name. The law also requires that written materials be developed by the Department of Health Services and be distributed to the patient by the medical provider, for use by the partner(s) receiving EPT.[5]

In Maine, pharmacists should document patient EPT prescriptions like any other noncontrolled substances prescriptions.[6] New York has the same requirements, and a separate prescription must be provided for each partner, but providers shouldn't

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Table 1. Policy Statements on Expedited Partner Therapy

Centers for Disease Control and Prevention https://www.cdc.gov/std/ept/default.htm	CDC has concluded that EPT is a useful option to facilitate partner management, particularly for treatment of male partners of women with chlamydial infection or gonorrhea. Although ongoing evaluation will be needed to define when and how EPT can be best utilized, the evidence indicates that EPT should be available to clinicians as an option for partner treatment. EPT represents an additional strategy for partner management that does not replace other strategies such as provider-assisted referral, when available.
American Academy of Family Physicians https://www.aafp.org/about/policies/all/partner-therapy.html	The American Academy of Family Physicians (AAFP) supports EPT according to current CDC recommendations. Clinicians should determine state law requirements for EPT. (2012 COD) (2017 COD).
Society for Adolescent Medicine and American Academy of Pediatrics https://www.jahonline.org/article/S1054-139X(09)00205-5/fulltext	The Society for Adolescent Medicine (SAM) recommends that providers who care for adolescents should do the following: use EPT as an option for STI care among chlamydia- or gonorrhea-infected heterosexual males and females who are unlikely or unable to otherwise receive treatment; through SAM and AAP chapters, collaborate with policy makers to remove EPT legal barriers and facilitate reimbursement; and collaborate with health departments for implementation assistance.
American Bar Association https://www.cdc.gov/std/ept/onehundredsixteena.authcheckdam.pdf	RESOLVED, that the American Bar Association urges states, territories, and tribes to support the removal of legal barriers to the appropriate use by healthcare providers of EPT, applied as specified in protocols promulgated by the U.S. Centers for Disease Control and Prevention, in the treatment of those sexually transmitted diseases identified in the evidence-based recommendations of the CDC and the policy statements of the American Medical Association (adopted June 2006).

prescribe treatment for a partner by adding extra doses of medication to an index (original) patient's prescription.[4]

New York law also stipulates that healthcare providers or pharmacists who prescribe or dispense drugs in accordance with the state's EPT law and regulations won't be held legally or professionally liable.[7] Wisconsin has a similar protection.[5]

Common exemptions or limitations

In New York City, EPT may not be given if the index patient is coinfected with gonorrhea or syphilis because the medication used doesn't adequately treat gonorrhea or syphilis. The Department of Health states that "coinfected partners could be mistakenly reassured by treatment and not seek care for these other infections."[8] That agency prohibits EPT when the index patient is coinfected with HIV, and it is not recommended for men who have sex with men.[7,8] Also, in New York City, EPT is not recommended if it would put the index patient's or partner's safety at increased risk.[8]

Notification requirements

As with all aspects of EPT, individual states have the legal authority for the notification and referral of partners of persons with STDs. Typically, there is no change to the reporting requirements for healthcare providers. In New York State, physicians are still required by law to report cases to the local health officer[9] and cooperate with state and local health officials' efforts to determine the source and to control the spread of sexually transmitted disease.[10,11] New York City advises physicians when reporting to specify whether EPT was used to treat the partners of the reported case, and if so, the number of partners for whom medication was dispensed or prescriptions written.[4] The department also says that partner names should not be provided.[4]

HIPAA

The requirements of the Health Insurance Portability and Accountability Act of 1996 will apply to healthcare providers who practice EPT. For example, Wisconsin states that a pharmacist is a "healthcare provider" as defined in Wis. Stats. § 146.81(1) and is required to comply with state laws regarding confidentiality of patient healthcare records.[12]

Some states have no limit to the number of partners that can receive EPT for a given index patient. In Wisconsin, the EPT program allows for the treatment of all of a patient's partners. The rationale behind this is that the "[t]reatment of all affected partners will reduce the risk of transmission and re-infection."[12] However, New York limits doses to the number of known sex partners in the previous 60 days.[7]

The only appellate-level case concerning EPT found in

researching this article comes from Connecticut, where the Supreme Court held that a physician who mistakenly informed the patient that he did not have herpes could be held liable in ordinary negligence to the patient's exclusive sexual partner for her resulting injuries. The Court opined that because the physician knew that the patient sought testing and treatment for the express benefit of that partner, he owed a duty of care to the partner even though she was not his patient.[13]

Takeaway

EPT has been found to be an effective and practical strategy for treating the sex partners of individuals with certain sexually transmitted diseases. EPT programs and their eligibility requirements are regulated by the states. Check with your state department of health and licensing boards for specific rules in your jurisdiction. ■

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INSIGHTS IN IMAGES

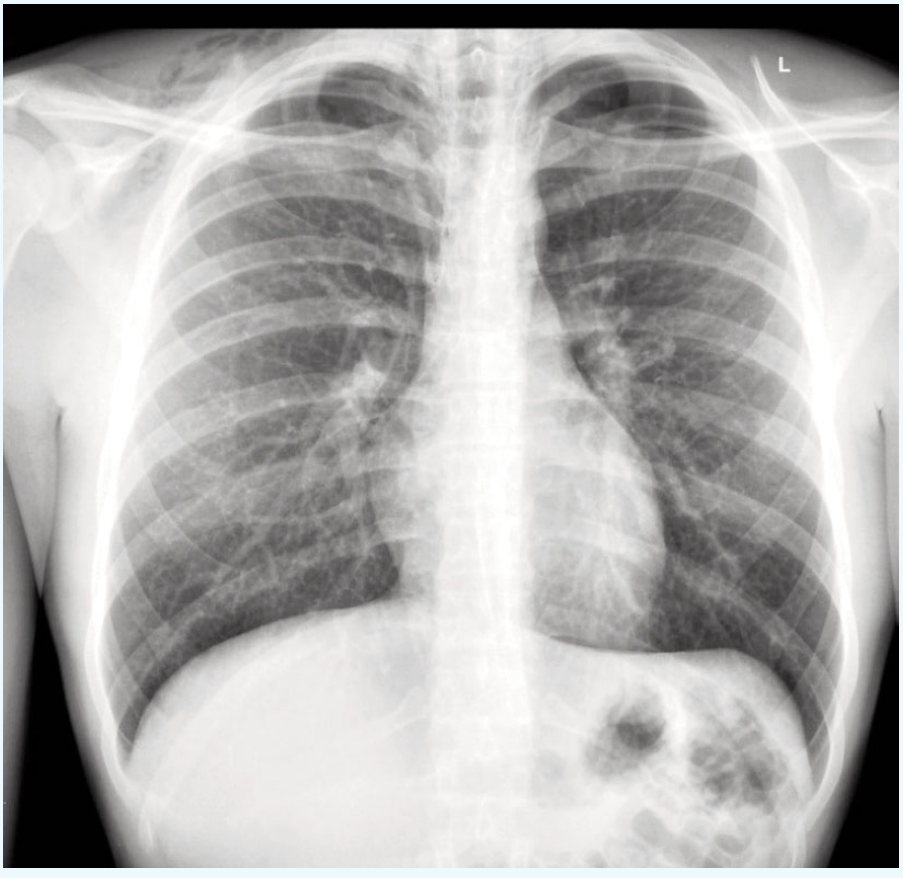
CLINICAL CHALLENGE: CASE 1

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

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

An 18-Year-Old Male with Shortness of Breath and 'Tightness' in His Chest

Figure 1.



Case

The patient is an 18-year-old male who presents to urgent care complaining of 1-day history of intermittent shortness of breath, as well as a sore throat. He reports that he woke up with "chest tightness" and "discomfort." He is unable to take a deep breath.

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

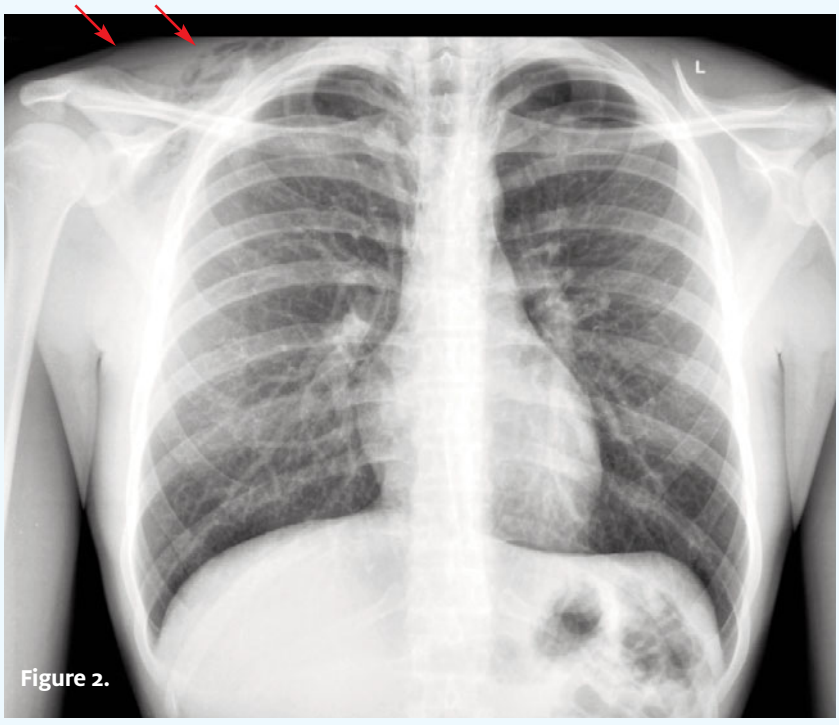


Figure 2.

Differential Diagnosis

- Acute coronary syndrome
- Boerhaave syndrome
- Pneumomediastinum
- Pneumothorax
- Pulmonary embolism

Diagnosis

Subcutaneous foci of air are noted in the right supraclavicular region. Air is seen tracking along the paratracheal regions and the mediastinum.

This patient was diagnosed with pneumomediastinum and subcutaneous emphysema.

Learnings/What to Look for

- Pneumomediastinum is the presence of extraluminal gas within the mediastinum. Gas may originate from the lungs, trachea, central bronchi, esophagus, and peritoneal cavity and track from the mediastinum to the neck or abdomen
- Causes include chest trauma, neck, thoracic, or retroperitoneal surgery, esophageal perforation, tracheobronchial perforation, vigorous exercise (childbirth, weightlifting, Valsalva), asthma, barotrauma, infection (tuberculosis, histoplasmosis, dental, or retropharyngeal infection, mediastinitis), interstitial lung disease, connective tissue disorders, interstitial lung disease, or may be idiopathic
- Rarely, tension pneumomediastinum may occur due to elevated mediastinal pressure which leads to diminished cardiac output from direct cardiac compression or reduced venous return
- When extensive subcutaneous and mediastinal gas is present, airway compression may also occur

Pearls for Urgent Care Management and Considerations for Transfer

- Patients with new-onset pneumomediastinum should be transferred for evaluation of the etiology and management
- If there is respiratory distress place oxygen and an IV while awaiting transport

Acknowledgment: *Images and case provided by Experity Teleradiology. (www.experityhealth.cm/teleradiology)*

CLINICAL CHALLENGE: CASE 2

A 50-Year-Old Male with Several Chronic Conditions and Foot Pain at an Amputation Site

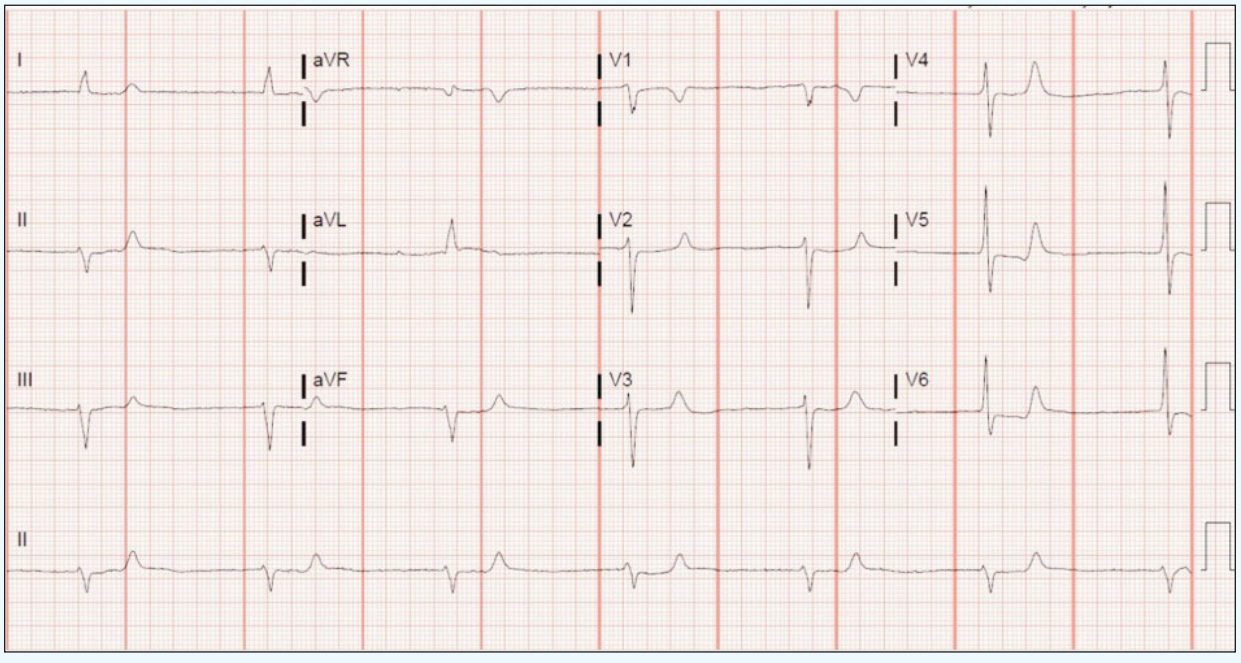


Figure 1.

Case

The patient is a 50-year-old man who presents with foot pain at the site of a right-foot amputation. He has a history of chronic renal disease, diabetes mellitus, and hypertension.

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

THE RESOLUTION

Differential Diagnosis

- Normal sinus rhythm
- Sinus bradycardia
- Anterior ischemia
- Junctional rhythm due to hyperkalemia
- Complete heart block

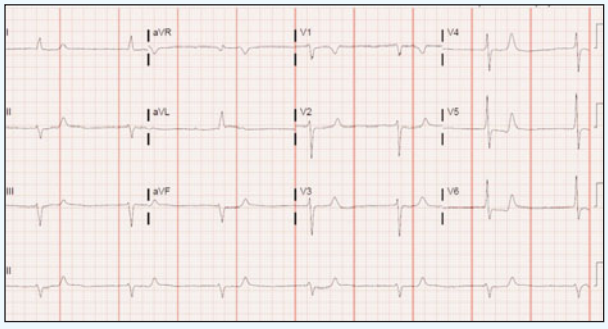
Diagnosis

This patient was diagnosed with hyperkalemia. This ECG shows a rate of 42 BPM, which is bradycardic. There are no discernable P waves, and the typical junctional rate is between 40 and 60 BPM, so this is consistent with a junctional rhythm. Additionally, notice that the T waves appear peaked, a sign of hyperkalemia. These should be differentiated from tall hyperacute T waves of ischemia, which produce a broader base.

Hyperkalemia can cause many electrocardiographic changes, but hyperacute T waves, absence or flattening of P waves, bradycardia, and QRS widening are a few.

Case Resolution

This patient's potassium returned at 7.9 meq/L. He was treated with 4 g IV calcium gluconate, 10 mg albuterol, and 5 units of insulin with an ampule of D50W—after which the following ECG was obtained:



(Note that in the post-treatment ECG, P waves have appeared, the rate is faster, and the QRS is narrower.)

Hyperkalemia is a cardiac membrane destabilizer, and recognition of its electrocardiographic findings is paramount to avoid deterioration into a more unstable rhythm like complete heart block or ventricular fibrillation. Three electrocardiographic findings have been demonstrated to predict short-term adverse outcomes: bradycardia <50 BPM, QRS widening >110 msec, and the presence of a junctional rhythm.

This patient's ECG demonstrated all three. Classic electrocardiographic changes are shown in the following table, but it important to recognize that hyperkalemia is implicated in all kinds of electrocardiographic changes (not limited to those in the table).

Serum Potassium	Potential ECG Changes
5.5-6.5 mEq/L	Tall, peaked T waves with narrow base QT interval shortening ST-segment depression
6.5-8.0 mEq/L	Peaked T waves PR-interval prolongation P wave decreased amplitude or disappearance QRS widening R-wave amplification
> 8.0 mEq/L	P-wave absence QRS widening Intraventricular/fascicular/bundle branch blocks Sine wave

Learnings/What to Look for

- Always obtain an ECG if hyperkalemia is suspected (ie, when dialysis is missed)
- Typical electrocardiographic findings of hyperkalemia include peaked T waves, flattening or absent P waves, and QRS widening
- If unrecognized and untreated, hyperkalemia can deteriorate into ventricular fibrillation
- Three electrocardiographic findings predict short-term adverse events: bradycardia < 50 BPM, QRS widening >110 msec, and the presence of a junctional rhythm

Pearls for Urgent Care Management and Considerations for Transfer

- Hyperkalemia can be treated with membrane stabilizers like intravenous calcium gluconate (or calcium chloride if unstable), potassium shifters like beta agonists and insulin, and potassium excreters like furosemide and oral polystyrene sulfonate
- Patients with hyperkalemia should be transferred to an emergency department for consideration of emergent dialysis, but if resources are available, consider the above treatments prior to transfer

Acknowledgment: *Images and case provided by Benjamin Cooper, MD, FACEP, assistant professor and associate program director, McGovern Medical School, Department of Emergency Medicine, The University of Texas Health Science Center at Houston.*

An 8-Year-Old Girl with Persistent Sore Throat and Fever

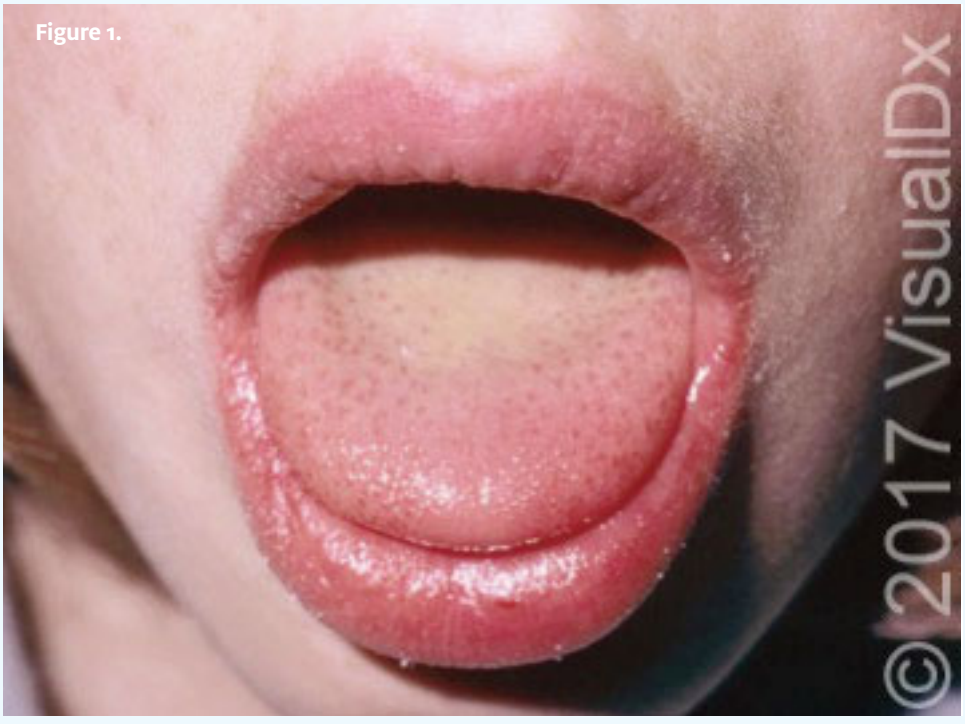


Figure 1.

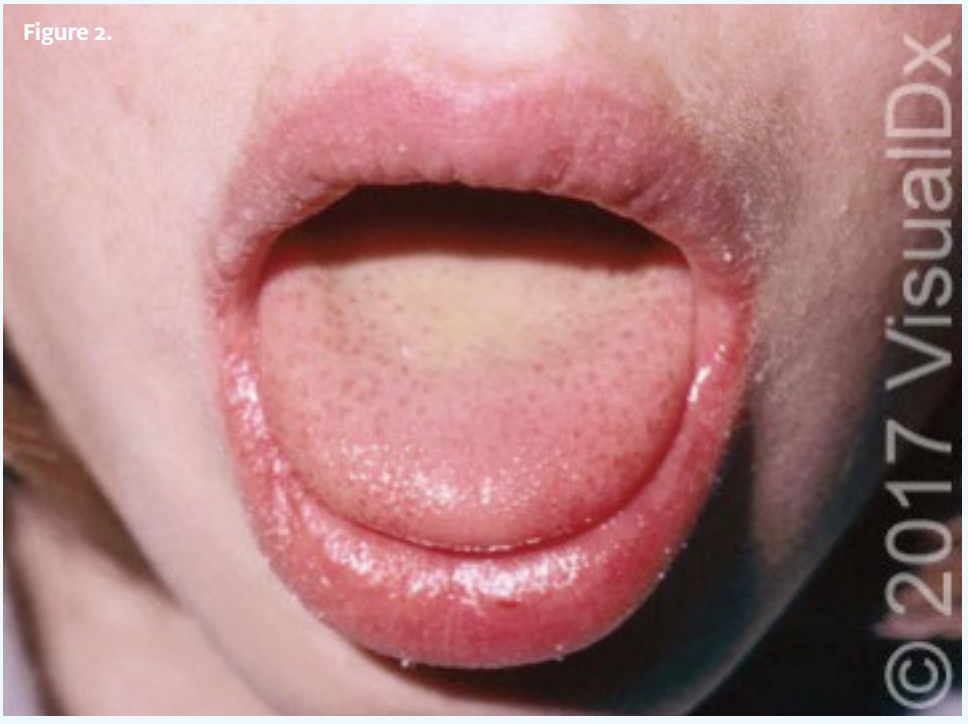
Case

The patient is an 8-year-old girl who is brought to your urgent care center by her father, who reports his daughter has had a sore throat and a fever for "a few days." Most recently, a petechial rash has appeared, spreading from her head and neck down to her torso. She also started complaining of nausea. The father also observes that her tongue appears redder than usual.

View the image taken and consider what your diagnosis and next steps would be.

THE RESOLUTION

Figure 2.



Differential Diagnosis

- Toxic shock syndrome
- Kawasaki disease
- Scarlet fever
- Mononucleosis

Diagnosis

The patient was diagnosed with scarlet fever, an acute toxin-mediated disease caused by infection with group A beta-hemolytic streptococci (*Streptococcus pyogenes*), and most common in children under 10 years of age.

Learnings/What to Look for

- The characteristic rash associated with scarlet fever begins within 12 to 48 hours of fever onset
- Associated prodromal symptoms include fever and malaise
- Sore throat and swollen, tender anterior cervical lymph nodes are typical
- Abdominal pain, nausea, and vomiting are common in younger children
- Petechiae may be present on the soft palate

Pearls for Urgent Care Management and Considerations for Transfer

- Penicillin or amoxicillin is considered first-line treatment for scarlet fever
- In patients who are allergic to penicillin, a narrow-spectrum cephalosporin, clindamycin, azithromycin, or clarithromycin would be appropriate

Acknowledgment: *Images and case courtesy of VisualDx (www.VisualDx.com/JUCM).*

Already Looking Forward to 2021—and (Hopefully) Smoother Sailing with E/M Coding

MONTE SANDLER

On November 1, 2019, the Centers for Medicare & Medicaid Services (CMS) confirmed with the final rule for 2020 that they have accepted all of the American Medical Associations (AMA) recommendations for coding of office and outpatient evaluation and management (E/M) services starting in 2021.

This will offer some documentation relief for providers who have been held to dated 1995 and 1997 guidelines that were written before the use of electronic medical records. However, these guidelines should still be used for any code sets that require them outside of CPTs 99202-99215 (eg, hospital and home visits).

Since these changes are part of the CPT code set, they will apply to all private payers required by HIPAA to use the standard code set. Workers' compensation can be an exception. The AMA will be working with stakeholders across the industry on implementing the new E/M coding login.

The new coding guidelines can be found in the CPT Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes published by the AMA.

Effective January 1, 2021, CPT codes for office visits will be selected by either medical decision making (MDM) or the total time spent on the visit. The AMA revised all descriptions for CPTs 99202-99215 for 2021. CPT 99201 will be deleted, as the MDM is the same as 99202. All code descriptors state a "medically appropriate" history and/or examination and MDM (meaning, the level of history and exam performed and documented will be up to the provider. It will not be a consideration in code selection).

Monte Sandler is Executive Vice President, Revenue Cycle Management of Experity (formerly DocuTAP and Practice Velocity).

The requirements for the level of MDM for each code remains the same (ie, *straightforward*, *low*, *moderate*, or *high*). The definition of these levels is different, however. All codes state a total time spent on the date of encounter. The times are similar to the current code descriptors, with the addition of a specific range to remove any ambiguity.

No guidelines have been set for CPT 99211. This is still a valid code to be used for minimal services if the requirements for a higher level of visit are not met.

MDM

The AMA removed vague terms, such as *mild*, and defined other concepts like the type of problem addressed (eg, self-limited or minor problem, stable, chronic illness, and acute, uncomplicated illness or injury).

All of this has been consolidated into one table that will be used when audits are performed after January 1, 2021. (See **Table 1**.)

Guidelines are the same whether the patient is new or established. The level will continue to be based on two out of three elements, though the requirements have changed.

- *Number and complexity of problems addressed:* The term "problems addressed" is defined in the new guidelines, and must be comprised of those conditions that are clinically relevant.
- *Amount and/or complexity of data to be reviewed and analyzed:* Emphasis was given to clinically important activities over the number of documents, and accounted for clinically important activities over the number of documents.
- *Risk of complications and/or morbidity or mortality of patient management:* Includes possible management options selected and those considered but not selected, and addresses risks associated with social determinants of health. Those examples not office-oriented were removed.

Table 1. CPT E/M Office Revisions: Level of Medical Decision-Making (MDM)

		Elements of Medical Decision-Making		
Code	*Level of MDM (based on 2 out of 3 elements of MDM)*	*Number and complexity of problems addressed*	*Amount and/or complexity of data to be reviewed and analyzed (each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below)*	*Risk of complications and/or morbidity or mortality of patient management*
99211	n/a	n/a	n/a	n/a
99202 99212	Straight-forward	Minimal 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low • 2 or more self-limited or minor problems, *or* • 1 stable chronic illness, *or* • 1 acute, uncomplicated illness or injury	Limited (must meet the requirements of at least 1 of the 2 categories) Category 1: Tests and documents • Any combination of 2 from the following: – Review of prior external note(s) from each unique source – Review of the result(s) of each unique source – Ordering of each unique test Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see *moderate* or *high*)	Low risk of morbidity from additional diagnostic testing or treatment
99204 99214	Moderate	Moderate • 1 or more chronic illness with exacerbation, progression, or side effects of treatment, *or* • 2 or more stable chronic illnesses, *or* • 1 undiagnosed new problem with uncertain prognosis, *or* • 1 acute illness with systemic symptoms, *or* • 1 acute complicated injury	Moderate (must meet the requirements of at least 1 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: – Review of prior external note(s) from each unique source – Review of the results(s) of each unique test – Ordering of each unique test – Assessment requiring an independent historian(s) • Category 2: Independent interpretation of tests – Independent interpretation of a test performed by another physician/other qualified healthcare professional (not separately reported) • Category 3: Discussion of management or test interpretation – Discussion of management or test performed by another physician/other qualified healthcare professional/appropriate source (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment
99205 99215	High	High • 1 or more chronic illnesses with severe exacerbation, progression, or side effect of treatment, or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive (must meet the requirements of at least 2 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: – Review of prior external note(s) from each unique source – Review of the results of each unique test – Ordering each unique test – Assessment requiring an independent historian(s) • Category 2: Independent interpretation of tests – Independent interpretation of a test performed by another physician/other qualified healthcare professional (not separately reported) • Category 3: Discussion of management or test interpretation – Discussion of management or test interpretation with external physician/other qualified healthcare professional/appropriate source (not separately reported	High risk of morbidity from additional diagnostic testing or treatment

Adapted from: CPT Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes. Available at: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf. Accessed December 5, 2019.

Time

Time is defined as the total time spent by the "reporting" practitioner on the day of the visit (including face-to-face and non–face-to-face time). This is not limited to the time the patient is physically in the office. Examples of non-face-to-face time include reviewing of tests to prepare to see the patient; ordering medications, tests, and procedures; and documenting the service in the EMR.

Spending 50% of the visit in counseling and coordination of care is no longer a concept for this category of codes.

Per the AMA, when both a physician and a nonphysician provider see the patient, the total time for both providers should be combined to determine the correct code. Time spent by clinical staff (eg, nurses) and time spent on a procedure should be excluded from the total time calculation.

If the visit goes 15 minutes more than the time stated for 99205 and 99215, the add-on code 99XXX can be reported for each additional 15 minutes. It must be a *complete* 15 minutes to report this code–no rounding up. For your reference:

99XXX Prolonged outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)

CMS has stated they would only expect to see billing by time on higher-level visits where extra time is spent on history and exam or coordination of care. Payers may monitor for higher-level visits with diagnoses for minor conditions and excessive time spent on a given day (eg, total time billed for a date is 25 hours). Time is expected to be a target area across the payer market due to risk of abuse.

Additionally, providers were warned that total revenue will ultimately be less when billing by time, as either levels will be lower or fewer patients will be seen.

Whether coding by MDM or time, stress was given to documentation being sufficient for a subsequent provider treating the patient and a proper legal defense. ■

PHYSICIANS WANTED

Most Urgent Care Centers Give Immunization a Shot—of One Type or Another

If you haven't noticed, it's flu season. In fact, it's been flu season longer than usual for this point compared with past years, thanks to an unexpectedly early arrival. With months to go, though, there's still time for patients who have not been immunized to reap the benefits of getting a flu shot.

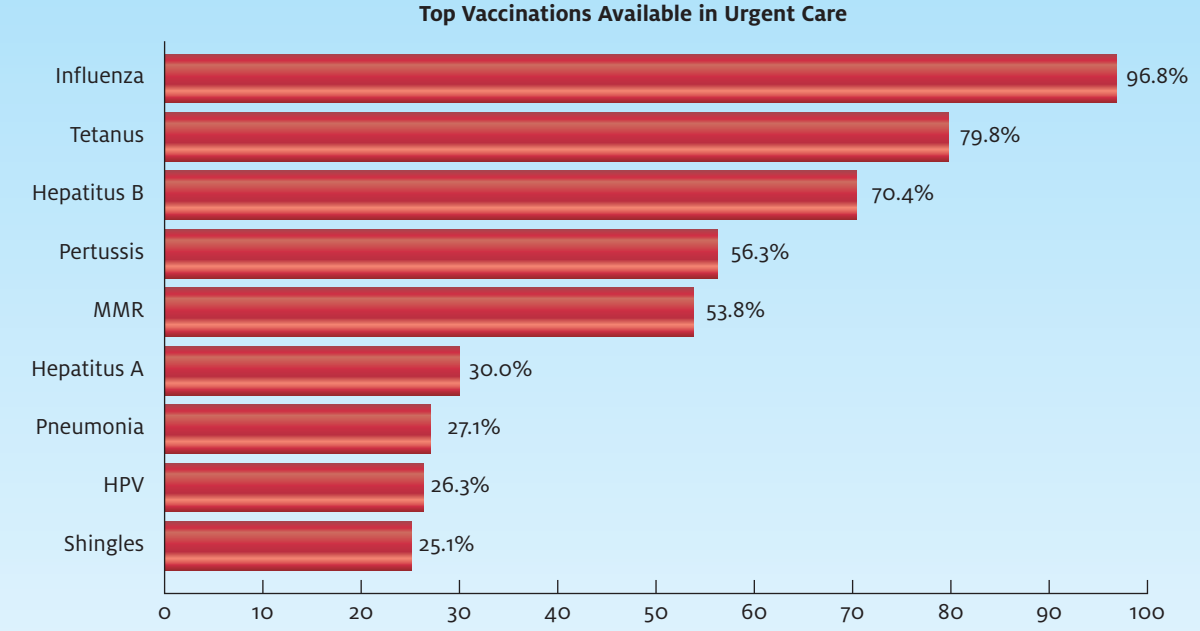
This is not to say that influenza is the only immunization patients need. With reports of measles also beginning to climb as we go to press, unprotected people of all ages need to ensure they're up to date on their MMR vaccine.

Both those vaccinations are likely to be available in the closes urgent care center. In fact, flu shots are the most common immunization offered in urgent care, according to data in the Urgent Care Association's 2018 *Benchmarking Report*. (MMR is the fifth most common.)

Interestingly, according to the report, commercial payers often exclude wellness services such as immunizations in urgent care centers. "We can speculate that the payers assume that wellness services are delivered via the patient's medical home," the report conjectures, "yet survey respondents indicate that 35% of patients seeking care in their centers are unaffiliated with a PCP."

The graph below, featuring data from the UCA report, can tell you whether your vaccine offerings put you at a competitive advantage—or a disadvantage—vs other urgent care locations in your area. ■

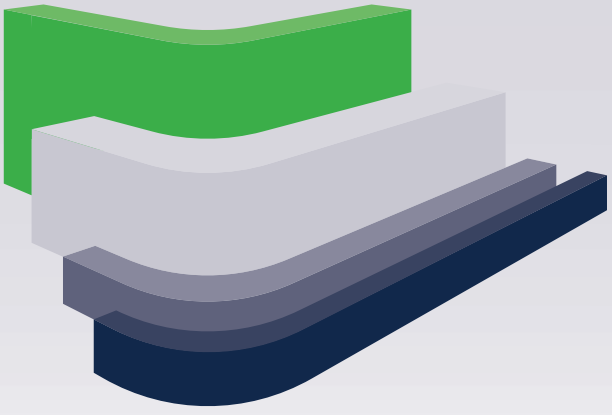
IMMUNIZATION SERVICES OFFERED BY URGENT CARE CENTERS



Adapted with permission from the Urgent Care Association 2018 *Benchmarking Report*. ©2019 UCA.

Get the Data

An Analysis of the Impact of Radiology in the Urgent Care Industry



Urgent Care Quarterly

Get the latest information about radiology's impact on the urgent care industry.

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