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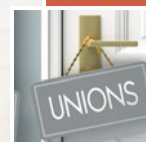
CLINICAL **cme**

## Yes, You *Can* Manage Low Testosterone in the Urgent Care Center

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# Once You're in Court, Your Documentation May Be All That Can Save You

■ SAL D'ALLURA, DO, FAAFP

*"It's lonely being the defendant in a medical malpractice case."*

Truer words were never spoken. At some point in our careers, the majority of us will be named in a medical negligence case. The unfortunate reality is that medicolegal issues will arise as a part of our professional lives along with a multitude of negative emotions (which inevitably spill over into our *personal* lives) when we stand accused. These negative feelings, thankfully, can be avoided altogether with a proper understanding of how best to avoid—or at least prepare for—a malpractice case before it even occurs.

The lessons I've learned have come from both personal experience as a defendant in two malpractice cases very early in my career (both of which were dismissed during discovery), as well as subsequently providing expert review of numerous cases for attorneys. Through this I've realized the most important factor for a viable defense is clear documentation of your thoughts, especially in the medical decision-making (MDM) component of the medical record.

Now, you may be thinking: *We've heard this before. – If it's not written, it wasn't done.* However, I cannot state emphatically enough how often poor documentation has led to settlements that could have been avoided had the provider's thought process been explicitly charted and not assumed.

The sad reality is that once you are put in the position of having to defend your medical decisions in court, you will realize just how much weight is placed on your documentation. The process of having to defend your medical decisions is a somber one. You will feel isolated. It will be difficult to ever



feel at ease while you replay the case over and over in your mind. You won't be allowed to talk to your own experts, and you'll be left with nobody to speak to about any of it except for your attorney.

What are some of the toughest times as a defendant? Certainly, while having to defend your care, the plaintiff will make terrible allegations against you. You'll be called a liar and a falsifier of records, and incompetent. You won't be permitted to tell your story as you would to a colleague; the plaintiff will question you and try to get you to tell the story the way they want. They'll purposely make statements and ask questions they know will be stricken from the record, just so the jury will hear them anyway.

You may begin to have doubts about yourself and your capabilities as a clinician, as well as about the fairness of the legal process all together. Through all this, the only thing you can rely on and that is under your control—long before you're in court—is your own documentation.

This is the major difference for clinicians who are able to go



**Sal D'Allura, DO, FAAFP** practices urgent care medicine with Atrium Health Wake Forest Baptist.

through the process with confidence when named in lawsuits and those left wrecked with stress.

The article *See You in Court: Practice and Documentation Change from a Mock Trial* (JUCM, January 2022), dealt with a mock trial involving an emergency department case with many clinical issues which would have made the medicolegal defense troublesome.<sup>1</sup>

To recap, the patient described presented with symptoms consistent with an acute MI, confirmed by ECG; 49 minutes after presentation and consultation with both an interventional cardiologist and the on-call hospitalist, the patient was admitted to the ICU. During the night, he continued to have chest pain and another ECG was indicative of an anterior STEMI. Subsequently, the patient was finally taken to the cath lab and the culprit left anterior descending (LAD) lesion was stented.

Despite the intervention, the patient progressed to cardiogenic shock.

The simulated trial was viewed by participants ranging from medical students to attending physicians. The attendees heard allegations of “failure to diagnose” and “delay in diagnosis” presented by the plaintiff. Although the vast majority of participants maintained that the defendant in the mock trial met the standard of care, a large percentage also stated that they planned to change both their future medical practice and documentation practices as a result of having viewed the simulation.

What I can say from experience reviewing similar cases is that the plaintiff’s legal team would have many questions regarding the time that elapsed from initial presentation to definitive cardiac intervention, stating emphatically that the delay led to the level of harm that reached the patient. While I did not have the privilege of reviewing the medical record, clearly the outcome of the case would hinge on the clarity of documentation from the interventional cardiologist as to why the patient was not taken to the catheterization lab initially upon presentation.

Questions we could expect to be raised would include:

- Why did almost 6 hours of time lapse from the initial presentation to deterioration before cardiac intervention ensued when the diagnosis was never in question?
- What did the hospitalist do to monitor the patient’s clinical status?
- What did the emergency physician discuss with the cardiologist when he initially spoke to him?

I can also say from experience that the defendant’s legal team will have a much easier case to defend if there are clear answers to these questions contained within their client’s own documentation.

The immediate management of acute coronary syndrome is relatively well established. To briefly review, patients with suspected ACS should be *promptly* evaluated and treated be-

*“If your care in these high-risk scenarios is clearly documented, your case will hold less appeal to would-be plaintiff’s attorneys and you may just save yourself from being named in the lawsuit in the first place.”*

cause the benefits of reperfusion therapy are greatest when initiated quickly. The diagnosis is made based on patient history, ECG, and cardiac biomarkers, which delineate between STEMI and non-STEMI. Rapid reperfusion with primary percutaneous coronary intervention (PCI) is the goal when coronary occlusion is suspected.

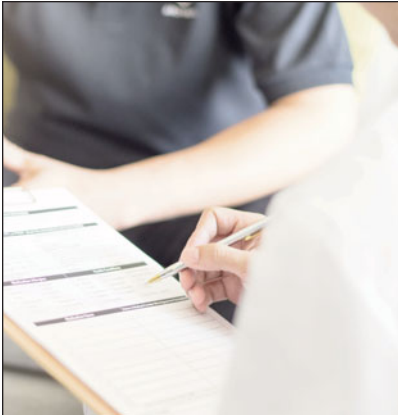
If PCI cannot be performed rapidly, patients with STEMI can be treated with fibrinolytic therapy. Coupled with appropriate medical management, PCI can improve short- and long-term outcomes following acute MI. Post myocardial infarction care should be closely coordinated with a cardiologist to ensure appropriate secondary prevention strategies to prevent recurrence, morbidity, and mortality.<sup>2</sup>

If you have a modicum of acute care experience, this is likely obvious to you. However, if this is not how the patient’s care proceeds and a lawsuit ensues, the explanation for the deviation better be clear in your documentation. It might even be clear to the attorneys who are doing their best to convince the jurors that a poor outcome was all your fault. As far as the jury is concerned though, outside of what was written, it’s just your word against the patient’s (who is someone they can identify with, mind you). Anything you say on the stand often comes off as revisionist rationalization to save your own skin—unless there’s a written, real-time document illustrating that you did everything you were supposed to do at the time, according to your training and the standard of care.

Based on my experience and what I’ve learned about how malpractice attorneys think, I believe this case would have been difficult to defend and likely would have been settled. Certainly without thorough documentation to explain the delays in care the defendants would have little hope. What we all know to be obvious, but which time and time again is deficient in medical records, is clear documentation as to why you are, and why you are not, performing a medical intervention for a patient. As a matter of fact, if your care in these high-risk scenarios is clearly documented, your case will hold less appeal to would-be plaintiff’s attorneys and you may just save yourself from being named in the lawsuit in the first place. ■

**References**

1. Weinstock M, Frost K, Jolliff H, et al. See you in court: practice and documentation change from a mock trial. *J Urgent Care Med.* 2022;16(5):23-27.
2. Switaj TL, Christensen SR, Brewer DM. Acute coronary syndrome: current treatment. *Am Fam Physician.* 2017;95(4):232-240.



## CLINICAL

### 13 Evaluating Decreased Libido: The Lowdown on Low T

Efficient diagnosis of hypogonadism is achievable in the urgent care setting through proper use of hormone level testing and thorough consideration of the patient's stated symptoms and history.

*Lisa O. Iyke, BS and Mark J. Richman, MD, MPH*

## HEALTH LAW AND COMPLIANCE

### 17 Can PAs and NPs Unionize in Urgent Care Settings?



We don't usually consider clinical positions to be "labor" in the same sense as we do factory workers, skilled tradespeople, or even teachers. So, when physician assistants and nurse practitioners talk about unionizing it can raise some eyebrows.

*Alan A. Ayers, MBA, MAcc*

## PEDIATRIC URGENT CARE



### 23 A Million Tests Later: Perspectives on COVID-19 Testing in Pediatric Urgent Care



There are rich data—and invaluable lessons—to be mined from a million pediatric COVID-19 tests. It's even more interesting to see how the picture has evolved through various phases of the pandemic.

*David J. Mathison, MD, MBA*

## CASE REPORT

### 33 Testicular Torsion: The Case of the Dancing Testicle



Delayed diagnosis of testicular torsion is linked to significant physical and psychological morbidity. This is a "can't miss" diagnosis that must be included in the differential for every patient who presents with unilateral testicular pain.

*Jeannette Vaughn-Dotterer, PA-C*

## ORIGINAL RESEARCH

### 35 Reducing Low-Acuity Preventable Emergency Room Visits by Utilizing Urgent Care Center Services via Mobile Health Unit Diversion Program



It's widely accepted that urgent care is the appropriate setting for treating patients with non-emergent complaints. What's less clearly understood is how to ensure they're transported to the appropriate setting to begin with.

*Cesar Mora Jaramillo, MD, FAAFP, FCUCM*

## NEXT MONTH IN JUCM

High-quality imaging is essential in diagnosing (or ruling out) orthopedic injuries. However, there are cases in which those images don't tell the whole story or can mislead altogether. What do you do when what you're seeing on screen appears to be "normal," but it's clear from your examination that there's something afoot? Reading *When X-rays Lie: Important Orthopedic Diagnoses to Consider with Normal Imaging* in our April issue may offer some valuable clues.

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

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A decrease in the amount of testosterone the body produces is a normal part of the aging process. That does not mean that patients won't (or shouldn't) present with complaints of low libido, erectile dysfunction, depression, or other potential signs of hypogonadism, however. And their concerns should be heard and taken seriously, as testosterone is important to the patient's physical, mental, and emotional health. Further, there could be other acute and chronic conditions afoot.

This month's cover article, Evaluating Decreased Libido: the Lowdown on Low T (page 13) by **Lisa O. Iyeke, BS** and **Mark J. Richman, MD, MPH** uses the case of a 46-year-old male as the starting point for a discussion of the implications of hypogonadism, including the diagnostic process and therapeutic options.

Ms. Iyeke and Dr. Richman are colleagues in the Long Island Jewish Medical Center Department of Emergency Medicine; Dr. Richman is also affiliated with the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell.

Unilateral testicle pain is definitely *not* a normal part of the aging process but is certainly something for which patients will be inclined to seek immediate care. And quick, correct diagnosis is essential to prevent significant physical and psychological morbidity, as detailed in Testicular Torsion: The Case of the Dancing Testicle (page 33). As author **Jeannette Vaughn-Dotterer, PA-C** points out, this is a "can't miss" diagnosis that must be included in the differential diagnosis for every patient who presents with the telltale symptoms. Ms. Vaughn-Dotterer practices at NextCare Urgent Care and is affiliated with the Arizona School of Health Sciences Physician Assistant Program at A.T. Still University.

Actually, that article is a great reminder of the many atypical presentations that can be managed in the urgent care center with no need to refer to a higher-acuity setting—a subject related to a new original research article, Reducing Low-Acuity Preventable Emergency Room Visits by Utilizing Urgent Care Center Services via Mobile Health Unit Diversion Program (page 35) by **Cesar Mora Jaramillo, MD, FAAFP, FCUCM**. In it, Dr. Mora Jaramillo presents data related to creation of a mobile health diversion program to transport low-acuity conditions to urgent care instead of a hospital emergency room. The author practices at Providence (RI) Community Health Centers and is affiliated with the Warren Alpert Medical School, Brown University, and the College of Urgent Care Medicine.

With the COVID-19 pandemic persisting, we're able to start

taking a deeper look not only at its effect on urgent care, but also the role urgent care has played in the community, including with younger patients. A Million Tests Later: Perspectives on COVID-19 Testing in Pediatric Urgent Care (page 23), by **David J. Mathison, MD, MBA** uses data from pediatric urgent care centers to provide insights into the capability of the broader urgent care industry to play a significant role in public health in the United States. Dr. Mathison is vice president, clinical operations, South Atlantic for PM Pediatrics, a pediatric emergency physician, and editor of pediatric content for *JUCM*.

More insights into the current state of the urgent care industry can be gleaned from Can PAs and NPs Unionize in Urgent Care Settings? (page 17), a new Health Law and Compliance article by **Alan A. Ayers, MBA, MAcc**. In it, Mr. Ayers, who is president of Experity Networks and senior editor, practice management for *JUCM*, points out that the workforce has changed from primarily emergency physicians to physician assistants and nurse practitioners—groups perhaps more likely to try to seek the advantages of speaking with one "voice" through organization.

This month's Urgent Perspectives piece focuses on a legal topic, as well. If you're concerned about how you would fair in the event of a malpractice suit—which you should be—Once You're in Court, Your Documentation May Be All That Can Save You by **Sal D'Allura, DO**, FFAFP is essential reading. You'll find it on page 1 of this issue. In addition to practicing urgent care at Atrium Health Wake Forest Baptist, Dr. D'Allura is a frequent peer reviewer for *JUCM*.

As always, we appreciate **Ivan Koay MBChB, FRNZCUC, MD** summarizing articles from across the medical publishing landscape for the urgent care community. This month, he shares the most essential points of articles on handlebar injuries, the role of corticosteroids in asthma as well as antibiotics in pediatric community-acquired pneumonia, and more. Dr. Koay is an urgent care physician; Royal New Zealand College of Urgent Care examiner; education faculty for the RCSI Fellowship of Urgent Care Medicine; and head of faculty, na hÉireann RNZCUC. Abstracts in Urgent Care starts on page 29.

Finally, 3 months into the year we're still trying to unpack all the changes that affect urgent care billing and coding practices. Thankfully, there's no one better able to do that than **Monte Sandler**, executive vice president, revenue cycle management, for Experity, as evidenced in his Revenue Cycle Management column, What Else is New in 2022? (page 47). ■

# 2022 Annual Convention

April 30 - May 4, 2022  
Caesars Palace, Las Vegas



we're getting the band

# back together

And we can't wait to see you

## New this year

- More challenging classes and deep-dives
- Multiple daily mock clinics
- Built-in time for collaboration and connection
- Past, Present and Future of Urgent Care Panel Discussion
- Solutions Expo Hall
- All-Day Access to UCA's Accreditation Surveyors



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# Then and Now

■ LOU ELLEN HORWITZ, MA

UCA's *Benchmarking Survey and Report* is back! We are so happy that the pandemic is settling down enough that you are able to look forward and are asking for data to help you do that.

In 2020 and 2021 we had to improvise our benchmarking, and we learned a few things along the way:

- Quarterly surveys and reports are preferred
- You really want to benchmark against each other vs more generalized national data
- Your needs have grown into a desire for deeper dives on data

Before we look at what's next, I want to thank the industry partners that helped us with data for 2021: Experity, Medline, MedTrainer, National Urgent Care Realty, Socius, Solv, Sorensen, Wilder & Associates, and give a shout out to the staff who found a way to keep the data flowing—Jami Kral, Jackie Stasch, and Todd Windley.

For 2022 we are keeping the quarterly schedule, adding back data collection surveys, and focusing each report on a single(ish) topic. Our first report will be on Staffing & Compensation—the number-one issue in urgent care today. It should be available by May. If you contributed to the survey and are a UCA/CUCM organizational member, we are bringing back the benefit of a free copy.

Also new for 2022 are the ways we are going to help you learn and connect to resources and each other. Let's start with in-person experiences. We've shifted the entire Annual Convention away from the fundamentals of urgent care. If you need those, we've got you covered with lots of free webinars. For the Convention in Las Vegas, April 30–May 4, 2022, we are focusing on the trickier diagnoses, the thornier operations problems, the more complicated relationships, the newest models and ideas. The session topics are narrower and deeper and deal with the finer points of success and happiness in urgent care. And they look forward, not backward.



**Lou Ellen Horwitz, MA** is the chief executive officer of the Urgent Care Association.

*“Because of the shared work of many people over many years and your particular achievements in the past two, we are finally getting invitations to ‘sit at the table.’ And we’re going to make the most of them.”*

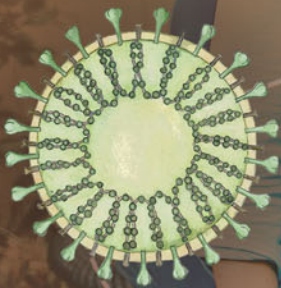
We are shifting our timing a bit, also, to recognize that this may be the first extended, dedicated period you've had for learning and reflection in a very long time. We are giving you extra time and space for absorption and translation of what you hear. Time to talk things over with others from your team, or even your competitors. Time to ask a vendor all of those questions you haven't had been able to get off your list. Time and space to get inspired again. Time and space for absolute silence, or for let-it-all-go laughter.

Looking even further forward, we have been secretly developing brand-new systems for you to easily find the information you are looking for—and filling in gaps for information we've never had. All that is still going on (and will go on forever!), but we'll start unveiling it this summer. We have also been investing in new technology that will make other things easier for you and allow us to easily grow new member benefits, which you'll start seeing in Q4 this year.

Finally, I want to report on the publication of our Advocacy strategy. In November, I said you'd see a summary of those published by the end of the year. Unfortunately, Omicron derailed our efforts for a while as it pulled all of our hard-working volunteer leaders under the tidal wave that swept over all of urgent care, so we did not finish them on time. I am sorry about that. We are putting on the final touches now and will be able begin to share those with the world in April at the latest.

We are very pleased, however, with the considerable strides we have made in our age-old pursuit of a “seat at the table.” Because of the shared work of many people over many years and your particular achievements in the past two, we are finally getting those invitations and we're going to make the most of them. It's still likely to be a long haul, but we've already come a long way. UCA and the College of Urgent Care Medicine are proud to represent you all, and know the best is still yet to come. ■

# With easing restrictions expect increasing respiratory infections.



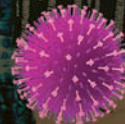
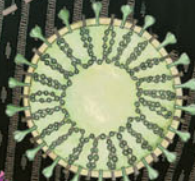
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# CONTINUING MEDICAL EDUCATION

**Release Date:** March 1, 2022

**Expiration Date:** February 28, 2023

## 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 Institute for Medical and Nursing Education (IMNE) and the Institute of Urgent Care Medicine. IMNE is accredited by the ACCME to provide continuing medical education for physicians. The IMNE designates this journal-based CME activity for a maximum of 3 *AMA PRA Category 1 Credits™*.

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### • Joshua W. Russell, MD, MSc, FACEP

*Member reported no financial interest relevant to this activity.*

### • Michael B. Weinstock, MD

*Member reported no financial interest relevant to this activity.*

### • Alan A. Ayers, MBA, MAcc

*Member reported no financial interest relevant to this activity.*

### • Steve Weinman, MSc, RN, CEN, TCRN

*Member reported no financial interest relevant to this activity.*

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# CONTINUING MEDICAL EDUCATION

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## Evaluating Decreased Libido: The Lowdown on Low T (page 13)

- 1. Which of the following conditions has/have been shown to decrease sex hormone binding globulin (SHBG)?**
  - a. Acute sinusitis
  - b. Gastroesophageal reflux disease
  - c. Nephrotic syndrome
  - d. All of the above
- 2. Which of the following is true?**
  - a. All asymptomatic men have normal levels of testosterone
  - b. Not all men with low testosterone levels are symptomatic, and many with low levels are asymptomatic
  - c. Testosterone levels are 100% diagnostic of disease
  - d. All men with low levels of testosterone are symptomatic
- 3. Outside of acute illness, testosterone is best measured:**
  - a. Between 6 am and 8 am
  - b. Between 8 am and 10 am
  - c. Within 1 hour of waking up
  - d. Effective measurement is not time-dependent

## Can PAs and NPs Unionize in Urgent Care Settings? (page 17)

- 1. Historically, urgent care physicians have not been able to unionize because:**
  - a. In the early days of the industry most were owners, not employees
  - b. Physician unions have been discouraged by the American Medical Association
  - c. Physicians are considered “professionals” and not “labor”
  - d. The skills associated with practicing medicine are not a good fit for existing unions
- 2. Urgent care physician assistants and nurse practitioners do have the capability to unionize because:**
  - a. Under the Fair Labor Standards Act (FLSA), PAs can be classified as either salaried employees who are exempt from protections of the FLSA or hourly nonexempt

- a. employees who are entitled to overtime
- b. NPs are closely associated with other classifications of nurses who have always had the capability to unionize
- c. The average PA and NP earns less money than the average physician
- d. None of the above; like physicians, PAs and NPs cannot unionize

## 3. In a Right to Work state, an employee’s “right to refrain” means:

- a. The employee has the right to refrain from working in conditions their union deems unsafe
- b. The employee need not pay union dues if they decide not to join the union
- c. The employee has the right to refrain from working if they have not received a pay increase in 2 years
- d. The “right to refrain” is not recognized in Right to Work states

## Testicular Torsion: The Case of the Dancing Testicle (page 33)

- 1. Unmanaged, testicular torsion can result in which of the following?**
  - a. Ischemia
  - b. Infertility
  - c. Loss of testis
  - d. All of the above
- 2. A high TWIST (Testicular Work-up for Ischemia and Suspected Torsion) score:**
  - a. Indicates consideration of prompt surgery
  - b. Indicates immediate imaging is called for
  - c. Suggests the patient should lie on his side for 30 minutes and then be reevaluated
  - d. Is meaningless, as the TWIST score has not been validated in adults
- 3. The imaging study of choice for testicular torsion is:**
  - a. X-ray
  - b. CT scan
  - c. MRI
  - d. Color flow Doppler

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# Evaluating Decreased Libido: The Lowdown on Low T

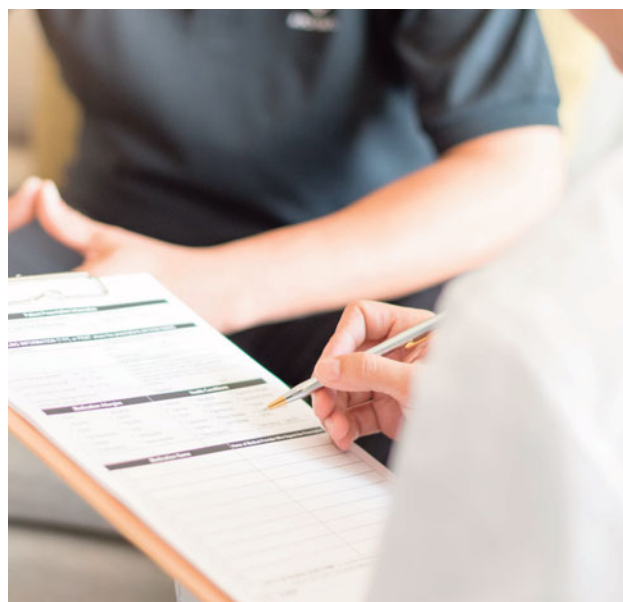
**Urgent message:** Hypogonadism not only impedes biological development, but also negatively impacts a patient's sense of identity and well-being. Prompt diagnosis is achievable through strategic utilization of hormone level testing in conjunction with a patient's stated symptoms and medical history.

LISA O. IYEKE, BS and MARK J. RICHMAN, MD, MPH

Citation: Iyeke LO, Richman MJ. Evaluating decreased libido: the lowdown on low T. *J Urgent Care Med.* 2021; 16(6):33-34.

## Case Presentation

A 46-year-old male with benign prostatic hypertrophy (BPH) presents with complaints of low libido, depression, erectile dysfunction, and no morning erections. He denied other hypogonadism symptoms such as weight gain or diminished energy, cognitive function, or muscle mass; nor did he have other conditions associated with hypogonadism (eg, cardiovascular disease, osteoporosis/low-trauma fractures, or infertility).<sup>1</sup> His medications were finasteride and terazosin. Physical examination revealed a euvolemic patient with body mass index (BMI) of 33.8, clear lungs, normal cardiac examination, no pallor, no palpable thyroid nodules or rash, and normal-size testes.



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## Laboratory Results

Study	Patient Result	Normal
Hemoglobin (gm/dL)	14.1	13.6 to 17.3
Thyroid-stimulating hormone (TSH) (uIU/mL)	0.77	0.55 to 4.78
Total testosterone (TT) (ng/dL), morning, assessed using liquid chromatography/mass spectrometry (LC/MS)	154	250 to 1100*

\*TT and free testosterone (FT) ranges in this article reflect the reference ranges from the author's hospital's send-out lab; there are no national, population-based normative values.<sup>2</sup>

**Author affiliations:** Lisa O. Iyeke, BS, Long Island Jewish Medical Center Department of Emergency Medicine. Mark J. Richman, MD, MPH, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell; Long Island Jewish Medical Center Department of Emergency Medicine. The authors have no relevant financial relationships with any commercial interests.

Table 1. Conditions that Alter SHBG Levels	
<b>Decrease SHBG</b> <ul style="list-style-type: none"> <li>• Hypothyroidism</li> <li>• Nephrotic syndrome</li> <li>• Diabetes mellitus</li> <li>• Use of glucocorticoids, progestins, and androgenic steroids</li> <li>• Moderate/severe obesity (weight loss can increase testosterone)</li> </ul>	<b>Increase SHBG</b> <ul style="list-style-type: none"> <li>• Hyperthyroidism</li> <li>• Aging</li> <li>• Cirrhosis</li> <li>• Hepatitis</li> <li>• Anticonvulsant usage<sup>1</sup></li> </ul>

### Next Steps (?)

Which of the following would be your next step(s) in the diagnosis of hypogonadism?

- A. Measure morning free testosterone (FT)
- B. Repeat morning total testosterone (TT)
- C. Measure sex hormone binding globulin (SHBG) alone
- D. No additional testing is required

The answer is A, measure morning free testosterone (FT).

### Testosterone: Physiological Effects and Test Characteristics

Testosterone is important for physical, mental, and emotional health and secondary sex characteristic development. It is commonly measured to investigate declines in sexual interest/function, strength, mood, concentration, and memory. However, symptoms/signs do not predict testosterone levels, and vice versa<sup>3</sup>; not all symptomatic men have low levels, and many with low levels are asymptomatic.<sup>4</sup>

Considering response to therapy as diagnostic of hypogonadism, one study found 63% sensitivity.<sup>5</sup> Therefore, hypogonadism should be diagnosed by compatible symptoms/signs plus repeatedly low testosterone levels.<sup>1</sup>

Testosterone as a diagnostic test for hypogonadism is complicated by its requirement to be measured at 8–10 AM (outside acute/subacute illness), an incomplete correlation with symptoms/signs, an increasing prevalence of conditions affecting sex hormone-binding globulin (SHBG), and a lack of population-based reference ranges or standardized lab assays and reference values.<sup>2</sup> Accordingly, TT, the recommended screening test,<sup>2</sup> is suboptimal. TT assays vary, though the Centers for Disease Control and Prevention is coordinating standardization via its Hormone Standardization project.<sup>6</sup> Extraction and liquid chromatography/mass spectrometry (LC/MS) assays are more sensitive/specific than immunoassays.<sup>7</sup>

Patients with low initial TT should have a repeat TT; if altered SHBG levels are suspected, FT or bioavailable testosterone should be measured. Of note, there are conditions that decrease SHBG and increase SHBG (Table 1). Consequently, conditions that increase SHBG are also associated with less bioavailable testosterone. Medicare reimburses ~\$35 for measuring FT, TT, and SHBG<sup>8</sup>; laboratories charge \$80/test (~\$200/bundle) or more.

### Next Steps (?) Round 2

Given what you now know about this patient, which of the following would be your next step(s) in the diagnosis of hypogonadism?

- A. Measure morning free testosterone (FT)
- B. Repeat morning total testosterone (TT)
- C. Measure sex hormone binding globulin (SHBG) alone
- D. No additional testing is required

Option A is correct, and B is incorrect. FT should be measured. TT is inaccurate when SHBG levels are altered, which can occur in obesity (as in this patient with BMI = 33.8). Testosterone is loosely bound to SHBG (60%) and tightly bound to albumin (37%). Albumin-bound and free testosterone are bioavailable; however, only the 2% to 3% circulating as FT is bioactive.<sup>1</sup> Because TT consists of SHBG-bound testosterone, albumin-bound testosterone, and FT, conditions altering SHBG produce inaccurate measurements of effective testosterone levels.

Option C is incorrect. While a normal SHBG level increases the likelihood that TT is accurate, TT must be measured concurrently; FT and bioavailable testosterone can be calculated using TT and SHBG.

Option D is incorrect. Owing to daily variation, two testosterone measurements, on separate mornings, outside acute/subacute illness, are required; 30% of men with initially abnormal levels have normal repeat values.<sup>9</sup>

### What Are Alternative Diagnostic Testing Approaches?

Given the above-mentioned challenges in diagnosing hypogonadism, the Endocrine Society has published standard guidelines.<sup>1</sup> Follicle-stimulating hormone (FSH) and luteinizing hormone (LH) levels should have been measured to differentiate primary (high FSH and LH) from secondary (low or normal FSH and LH) hypogonadism.

Primary hypogonadism in patients with small testes should be investigated using a karyotype to evaluate for Klinefelter syndrome; secondary hypogonadism



*“Testosterone is best measured between 8 AM and 10 AM. Given circadian and circannual variation in testosterone level and test inaccuracy, hypogonadism cannot be confirmed with a single testosterone measurement.”*

should be investigated via pituitary MRI.

Asymptomatic patients seeking screening for low T should be informed screening is recommended only for patients at risk for hypogonadism: sellar disease, glucocorticoid or opioid therapy, HIV-associated weight loss, chronic hemodialysis, infertility, or osteoporosis/low-trauma fracture.

### Patient Outcome

Morning FT, assessed using equilibrium dialysis at a reference laboratory (as commercial assays for FT are inaccurate)<sup>10</sup> returned 31.4 pg/mL (normal 35.0 to 155.0 pg/mL), confirming hypogonadism.

Given symptoms and repeatedly low levels, hormone-replacement therapy was started.

Although hypogonadism is associated with cardiovascular events,<sup>11</sup> this patient was relatively young and without cardiovascular risk factors. After initiating therapy, the patient reported improved energy, mood, libido, and erectile function. Repeat testosterone levels had not yet been drawn. The patient’s physicians considered that finasteride and terazosin are associated with hypogonadal symptoms. However, finasteride is not associated with low testosterone, making it unlikely his symptoms and laboratory findings were due to this medication. Finasteride and terazosin were continued, as discontinuation would have adversely affected his quality of life through untreated BPH.

### Clinical Bottom Line

- Testosterone is best measured between 8 AM and 10 AM, outside acute/subacute illness. Given circadian and circannual variation in testosterone level, and test inaccuracy, hypogonadism cannot be confirmed with a single testosterone measurement.
- If initial TT (by LC/MS) is low, patients with suspected or confirmed altered SHBG levels should have bioavailable testosterone or FT (by equilibrium dialysis) measured, rather than repeat TT.

### Take-Home Points

- Testosterone as a diagnostic test for hypogonadism is complicated by:
  - Its requirement to be measured at 8-10 AM (outside acute/subacute illness)
  - An incomplete correlation with symptoms/signs
  - An increasing prevalence of conditions affecting sex hormone-binding globulin (SHBG)
  - A lack of population-based reference ranges or standardized lab assays and reference values
- Extraction and liquid chromatography/mass spectrometry (LC/MS) assays are more sensitive/specific than immunoassays.
- Primary hypogonadism in patients with small testes should be investigated using a karyotype to evaluate for Klinefelter syndrome.
- Secondary hypogonadism should be investigated via pituitary MRI.

- Hypogonadism may be primary (testicular failure) or secondary (hypothalamic/pituitary failure, eating disorders, excessive exercise, chronic opiates, obstructive sleep apnea, glucocorticoids, GnRH analogs, anti-androgens).<sup>1</sup> FSH and LH levels should be included in initial hypogonadism evaluation to distinguish between primary and secondary hypogonadism. ■

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# Can PAs and NPs Unionize in Urgent Care Settings?

**Urgent message:** Urgent care's workforce has changed from primarily emergency physicians to physician assistants and nurse practitioners now making up the bulk of providers. Whereas physicians historically have been excluded from joining a union, recent efforts to organize PAs and NPs have garnered media attention.

ALAN A. AYERS, MBA, MAcc

While just over 10% of U.S. employees belonged to a union in 2019, a number of groups in industries that do not traditionally have a union presence have gone on strike or organized walkouts since the COVID-19 pandemic began.<sup>1</sup> There's also been the failure of high-profile attempts to organize employees at such "employee friendly" companies as Amazon and Tesla.<sup>2</sup>

In 2021, the number of wage and salary workers belonging to unions continued to decline (-241,000, to 14 million).<sup>3</sup> Among healthcare practitioners and technical occupations, of a base of just over 9 million employees, about a million are union members, or roughly 11%.<sup>3</sup>

In fact, there have been a number of recent efforts to unionize PAs and NPs in health system ambulatory practices, including urgent care centers. Union organizers point to COVID as the catalyst for physicians and PAs/NPs to organize.<sup>1</sup> For example, the United Physicians Assistants of Michigan Medicine (UPAMM) gained official recognition from the University of Michigan in June 2020 and has been bargaining for their first contract since September. The contract will govern the working conditions for PAs, from how paid time off is earned and redeemed to how raises are allocated to the handling of grievances.<sup>4</sup>

## A Conundrum in Urgent Care

Historically, physicians have been unable to organize because they're not "labor," but are "professionals." But as the workforce shifts to PAs and NPs, the question looms—are they "labor" or are they "professionals?"



The Fair Labor Standards Act (FLSA) establishes minimum wage, overtime pay, recordkeeping, and youth employment standards that impact employees in the private sector and in federal, state, and local governments.<sup>5</sup> Under the FLSA, PAs can be classified as *either* salaried employees exempt from the protections of FLSA, or hourly (nonexempt) employees who are entitled to overtime of at least time-and-a-half for any hours over 40 worked in one week (or for hospital-employed PAs, 80 hours over 2 weeks).<sup>6</sup> Thus, PAs and NPs have the ability to form a union.

Alan A. Ayers, MBA, MAcc is President of Experity Networks and is Senior Editor, Practice Management of *The Journal of Urgent Care Medicine*. The author has no relevant financial relationships with any commercial interests.

### Unions Representing Healthcare Workers

The total number of unionized healthcare workers is difficult to ascertain. Chapters are organized on a local level and date back to the 1930s. However, workers (especially those in hospital food service and housekeeping) are counted as part of a larger non-healthcare union, such as AFSCME (American Federation of State County and Municipal Workers) or UFCW (United Food and Commercial Workers). The rise of unions targeting those delivering patient care is a phenomenon of the past 15 years.

#### 1. SEIU United Healthcare East

SEIU East claims nearly 450,000 members in homecare, hospitals, nursing home industries, pharmacies, freestanding clinics, and other healthcare settings. SEIU East serves the states of New York, Massachusetts, New Jersey, Florida, Maryland, and the District of Columbia.

#### 2. National Nurses United

Founded in 2009, NNU has close to 185,000 members across all 50 states, making it the largest union and professional association of registered nurses.

#### 3. United Nurses Associations of California/Union of Health Care Professionals

Represents 32,000 registered nurses and healthcare workers in California.

#### 4. National Union of Healthcare Workers

Claims more than 15,000 members, including medical technicians, clerical workers, psychologists, pharmacists, housekeepers, dietary workers, nurses, nursing assistants and drug rehabilitation counselors. The group was founded in 2009.

Source: Becker's Hospital Review.

### What Is Collective Bargaining?

The term *collective bargaining* means the negotiation of employment terms between an employer and a group of workers.<sup>7</sup> Employees are typically represented by a labor union during collective bargaining to negotiate working conditions, salaries and compensation, working hours, and benefits. The objective of the collective bargaining process is to come up with a binding agreement on all terms of employment through a written contract.<sup>7</sup>

Collective bargaining is frequently a long, drawn-out process that can take weeks or even months because the employer and labor union leaders go back and forth with employment terms.

The union leaders must update employees and put the terms to a vote. If employees vote to reject a contract, the negotiating process begins again. In addition, employees and employers may have to take time off

from work in order to negotiate, which can result in productivity losses.<sup>7</sup>

Also, most employees don't realize that they can't be required to become or remain a member of a union as a condition of employment. In Right to Work states,<sup>8,9</sup> an employee's "right to refrain" means they need not pay union dues or even a reduced "financial core fee" to the union. In other states, however, union dues may still be taken from their paycheck even if they choose not to participate.

### What Unionization Means for Employees

For employees, joining a union means they sign away the ability to negotiate with their employer to the union, which can hinder the employer-employee relationship.

If there is a conflict, a worker would seek the help of a union steward, rather than their Human Resources department. As a result, employees are not dealing with the company directly but instead are limited to the internal politics and procedures of the union, which may or may not take up their cause.

Likewise, a union's bylaws may require unyielding allegiance to the "labor movement." By joining a union, a worker is agreeing to be bound by the union's internal rules and regulations; moreover, most employees don't understand that the union's internal rules and regulations often provide the union with the power to: a) issue monetary fines against employees who don't toe the union line and b) sue those same employees in state court to collect those fines.<sup>12,13</sup>

So, if the union decides it's beneficial to march at a political rally or donate money to a specific political candidate or interest group and a union member fails to comply or agree with the action, he or she can be tried in a union court, with possible fines deducted from their paycheck.

### Management's Role

It's critical for owners and operators of urgent care centers to understand what actions and behavior are prohibited by employers with regard to employees exercising their rights in organizing, forming, joining, or assisting a labor organization for collective bargaining purposes, from working together to improve terms and conditions of employment, or refraining from any such activity.<sup>8</sup> This is known as "protected concerted activity."<sup>14,15</sup>

To that end, the National Labor Relations Act (NLRA) forbids employer conduct that violates the law. This includes:

*“A workplace that fosters good relationships between management and employees and addresses employee concerns is much less likely to force employees to union representation for assistance.”*

- Threatening employees with the loss of their position or benefits if they join or vote for a union or engage in protected concerted activity
- Threatening to close the office if employees select a union to represent them
- Questioning employees about their union sympathies or activities in situations that tend to interfere with, restrain, or coerce employees in the exercise of their rights under the NLRA
- Promising benefits to employees to discourage their support of a union
- Transferring, laying off, terminating, or assigning employees more difficult work or otherwise punishing employees because they engaged in union or protected concerted activity
- Transferring, laying off, terminating, assigning employees more difficult work, or otherwise punishing employees because they filed unfair labor practice charges or participated in an investigation conducted by NLRB<sup>8</sup>

### Prohibited Labor Organization Conduct

Note that labor organizations themselves also may not restrain or coerce employees in the exercise of these rights.<sup>16</sup>

Some examples of labor organization conduct that violates the law include the following:

- Threatening employees with job loss unless they support the union
- Seeking the suspension, discharge, or other punishment of an employee for not being a union member even if the employee has paid or offered to pay a lawful initiation fee and periodic fees thereafter
- Refusing to process a grievance because an employee has criticized union officials or because they aren't a member of the union in states where union security clauses aren't permitted
- Fining employees who have validly resigned from the union for engaging in protected concerted activities following their resignation or for crossing an unlawful picket line
- Engaging in picket line misconduct (eg, threatening, assaulting, or barring non-strikers from the employer's premises)

### Differentiated Treatment of Union and Non-Union Employees in Sexual Harassment Allegations

Companies in the past 30 years have made significant efforts in strengthening relationships with employees, assuring a diverse, fair and equitable workplace. Intense competition for labor has pushed up wages and led to a focus on culture and employee experience to attract and retain employees. This is frequently cited as the reason that private sector union membership has declined or why, after years of activism, only 400 of 260,000 employees at Google have unionized.<sup>10</sup>

Many people who sign a union card expecting better wages and benefits don't understand what *rights* they're signing away. Typical verbiage is "I hereby authorize the [union] to represent me and in my behalf to negotiate and conclude all agreement as to hours of labor, wages, and *all other conditions of employment.*"

Consider a case of alleged sexual harassment. Without a union, an employee would report the incident to their human resources department who would handle it according to their employee handbook. If HR fails to respond appropriately, the employee may be able to sue the employer under Title VII of the federal Civil Rights Act.

When a union is present, however, Title VII doesn't apply. The employee will be told by human resources to "take it up with your union steward." That's because harassment of co-workers is covered under the union's Code of Conduct. Before exercising any rights in federal court, a union employee will be required to fully exhaust the union's internal grievance process. This can delay relief for months or years wearing down the "victim" emotionally, physically, and financially.

Depending on the current internal politics of the union, the employee's relationship with the union leaders, the union's relationship with the employer...the victim may get a cold shoulder from the union. Especially if the union doesn't believe the victim or the alleged perpetrator has standing with the union's leadership. In extreme cases, not only has the union not assisted the victim, but it has perpetrated a smear campaign against the victim.<sup>11</sup> That's because, ultimately, it's the union's job to protect the harasser's employment. Even when a company wants to fire an alleged harasser, unions have been known to step in an ask for lesser penalties.

(Adapted from Eisenberg & Baum, LLP. Whose side are they on: unions in sexual harassment claims. August 22, 2019. Available at: <https://www.eandblaw.com/employment-discrimination-blog/2019/08/22/unions-in-sexual-harassment-claims/>. Accessed February 13, 2022.)

- Striking over issues unrelated to employment terms and conditions or coercively engaging neutrals into a labor dispute

*“Regardless of what it promises, a union has no ability to offer employees better pay, benefits, or working conditions. That’s because the union is not the employer. It is merely an intermediary between the employee and employer with its own bureaucracy, budget, rules, and procedures.”*

Union membership looks appealing when employees become dissatisfied with how management treats them and begin to hope the union will make the workplace better. In fact, an organizing campaign typically begins when a small number of disgruntled employees<sup>17</sup> start to influence and turn coworkers against management.

According to the Society for Human Resource Management (SHRM), “while pay and benefits are hot topics in union organizing tactics, employees are most influenced to join a union when the company is perceived to be unfair, unresponsive, or offering substandard working conditions to employees. Employers that minimize employee dissatisfaction can also minimize employees’ desire for union representation.”<sup>18</sup>

According to SHRM, strategies that help discourage union acceptance are:

- Fair and consistent policies and practices
- Open-door management policies
- Competitive pay and benefits
- Employee trust and recognition

A workplace that fosters good relationships between management and employees and addresses employee concerns is much less likely to force employees to union representation for assistance.

### Takeaway

Unions and labor law is a complex subject. Awareness and understanding are crucial, and the best defense is to cultivate a fair and inclusive workplace with a culture that employees find engaging and satisfying. Urgent care owners and operators should consult with an experienced labor law attorney and familiarize themselves with the FLSA, the NLRA, Right to Work, and prohibited employer practices concerning unions. ■

### Summary

- Because PAs can be classified as either salaried employees who are exempt from protections of the Fair Labor Standards Act or as hourly nonexempt employees who are entitled to overtime, PAs and NPs are considered fair game for unionization.
- The "right to refrain" in a Right to Work state means an employee does not have to pay union dues if they decide not to join the union.
- Urgent care operators can ethically and legally discourage unionization by ensuring fair and consistent policies and practices; open-door management policies; competitive pay and benefits; and employee trust and recognition.

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# A Million Tests Later: Perspectives on COVID-19 Testing in Pediatric Urgent Care

**Urgent message:** The depth of COVID-19 testing data specific to the pediatric urgent care market provides insights into the capability of the broader urgent care industry to play a significant role in public health in the United States.

DAVID J. MATHISON, MD, MBA

It's easy to forget how 24 months ago the urgent care industry was amidst one of the worst influenza seasons in recent memory. Then in February 2020, the first cases of COVID-19 were identified in the United States and the subsequent impact of the SARS-CoV-2 virus changed urgent care for the foreseeable future. When many primary care offices shut their doors and EDs were overwhelmed, urgent care stood as a pillar, not only to care for the sick and injured, but also functioning more broadly as community servants, public educators, and leaders in infection containment.

Now 2 years later, UC continues to be at the forefront for access, evaluation, and guidance during the ongoing pandemic. However, the trends and patterns to seek care at UC centers have differed significantly for the pediatric population than for adults. Transmission, time-to-vaccination, return-to-activity, modes of exposure, and severity of disease have all been fundamentally different for children. For both kids and adults, however, COVID testing has been the most powerful driver of UC volume during the pandemic, ebbing from gentle streams to volatile tidal waves.

The following narrative is a reflection on COVID management in pediatric urgent care (PUC), highlighting the social dynamics with this vulnerable population.

## Phase I – Shutdowns, Testing and Virtual Medicine (February – May 2020)

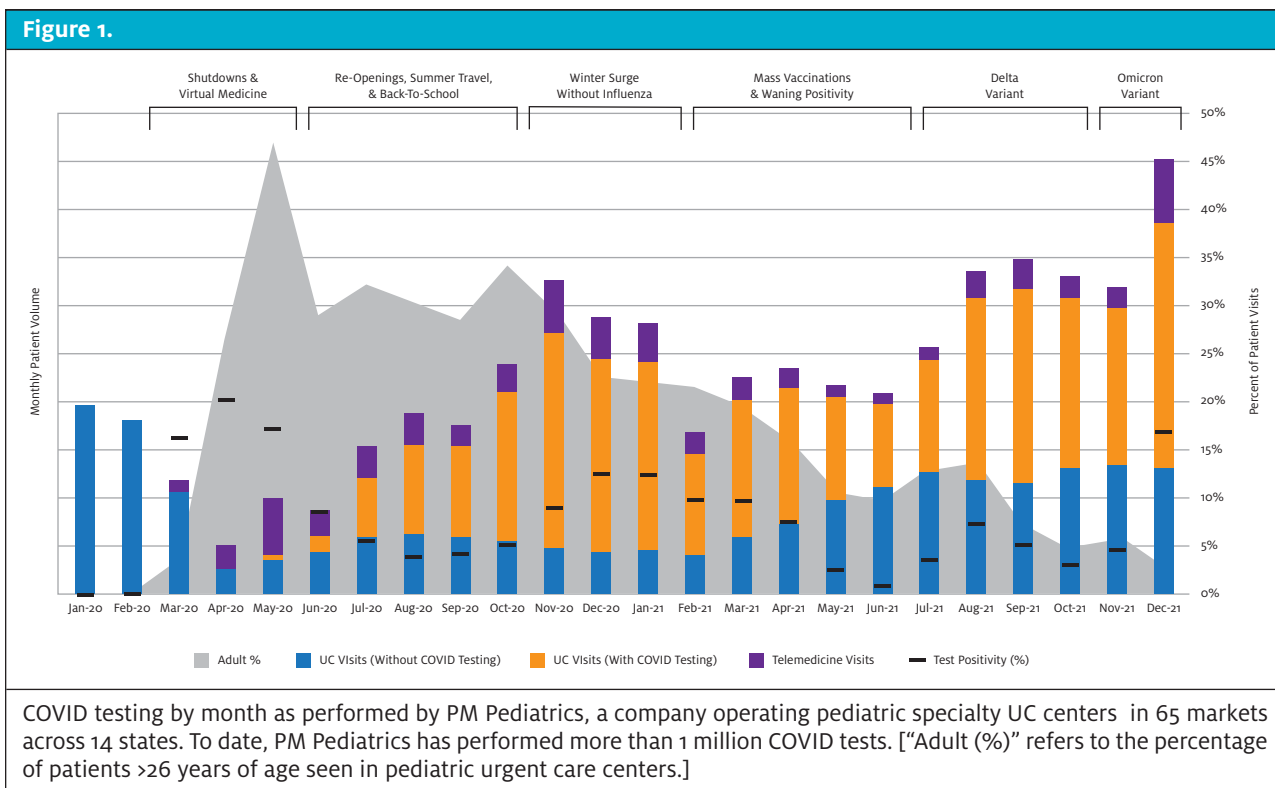
The first pediatric case of COVID-19 was identified in



late February at a Seattle Children's pediatric UC, foreshadowing the role urgent care would play as an access point throughout the pandemic. As cases began to appear in the U.S., demand for testing spiked. Yet, at this time, definitive SARS-CoV-2 testing was offered only through local health departments.

In early March, testing became more widely available through hospitals as well as national labs such as LabCorp and Quest. Soon thereafter, the World Health Or-

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



ganization officially declared the pandemic and the Center for Medicare & Medicaid Services paved the way for expanded use of telehealth. This also marked the introduction of the Coronavirus Aid, Relief, and Economic Security Act (CARES) as stay-at-home orders were initiated in most states. Schools shifted to virtual classrooms and child sports/activities were shut down. By late March, the U.S. already led the world in the number of confirmed cases. Patients with mild flu-like symptoms were advised to home quarantine *without* testing, perhaps underestimating the true prevalence of disease. Many diagnoses of COVID-19 were made clinically via telemedicine as more UC clinicians embraced virtual care as a viable alternative. As essential workers became infected and small businesses reopened, testing demand spiked and molecular nucleic acid amplification testing (NAAT), specifically PCR, became the gold standard.

**What About Children?**

For the pediatric population, the initial testing demand was virtually absent. Without routine child-to-child interactions in school or sports, the transmission of COVID along with other seasonal circulating viruses (that could cause COVID-like symptoms) was extremely limited. Additionally, several studies suggested children were not

as capable of transmission as their adult counterparts.

Many pediatric UCs pivoted to offer limited care for adults not dissimilar to their pediatric hospital counterparts who were offloading adult care from the general EDs. The lack of child illness, injury, and testing demand drove PUC volume down by 80% in some markets, as even true emergencies stayed at home because of apprehension of contagion. Telemedicine flourished and pediatric providers began treating conditions remotely without complete diagnostic assessment, such as otitis externa and urinary tract infections.

As kids spent more time outside in late Spring, injuries started to become more prevalent, though without the aggressive play of competitive sports injuries remained less common than in previous years. Acuity of visits increased as patients often presented with prolonged symptoms and a greater percentage of patients required procedural care.

May 2020 marked a surge in demand for antibody testing, which was appealing for patients who had recent flu-like illnesses or exposures to infected persons at a time when acute testing was unavailable. In June 2020, as some schools concluded their calendar years, children began looking towards a summer season that would be far different than years’ past.

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## Phase II – Reopenings, Summer Travel, and Back-To-School (July-Sept 2020)

As outdoor summer season approached, some stay-at-home orders were lifted, workplaces reopened, and some states discarded mask mandates. Outbreaks began to occur in scattered pockets nationally after the July 4 holiday. While testing was more widely available, would-be patients remained weary to venture into indoor spaces for evaluation or testing. In response, many UC clinics opened drive-up or tent-based testing options.

As social interactions increased and restrictions eased, the COVID positivity rates climbed, spurring testing demand and straining national labs. PCR turnaround times increased significantly and conservative CDC guidelines forced patients to have extended quarantines for mild illness or peripheral exposures.

While local municipalities operated large-scale testing centers, UCs were often preferred because of added convenience, the opportunity for COVID-related counseling, and faster results. Rapid antigen tests gained popularity because of their convenience and large organizations advocated for frequent, even daily, antigen testing as a means to prevent outbreaks within. However, the ability to scale rapid antigen testing in non-healthcare settings was difficult to operationalize because of cost, test availability, staffing, and education required to administer tests effectively. While antigen tests had high sensitivities for symptomatic patients, these tests were shown to be less sensitive for screening asymptomatic patients.

### What About Children?

Nationally, about two-thirds of summer camps were closed and children were forced to adapt to a different sort of summertime recess. The WHO announced that the virus could likely be spread via airborne droplets, which raised concern for children resuming normal activities. Schools evaluated filtration systems and planned for outdoor classrooms to accommodate the continued uncertainty about indoor safety. Cases began to rise in the summer as kids increasingly returned to play, though the overall prevalence was low in total number and percentage relative to adults. A significant portion of pediatric testing was guided by possible exposures to positive adults or for recreational travel, rather than for acute illness.

A new inflammatory disease pattern was recognized, later termed multisystem inflammatory syndrome in children (MIS-C), and was noted to occur most commonly following COVID in children, sometimes even after an initially asymptomatic infections.

In the Fall, many school systems opened virtual-only

or with hybrid models. While some were able to develop surveillance testing strategies, this was not commonplace (especially for large public school systems). PCR was generally the most accepted test for return-to-school clearance after exposures, travel, and other high-risk activities.

## Phase III – Winter Virus Surge Without Influenza (October 2020 – January 2021)

As the workforce returned from home and more states advanced their reopening plans, winter weather set in and indoor gatherings increased, leading to rises in COVID positivity rates nationally. In October 2020, then-President Trump was hospitalized with COVID-19 and the FDA approved monoclonal antibody (mAB) therapy as an option for high-risk infections.

Despite low rates of circulating non-COVID viral disease and almost no influenza, the demand for COVID testing surged. Many states reversed reopening plans because of the rapidly rising numbers of cases. With increased testing demand, turnaround times for PCR tests slowed again, often frustrating families as they tried to navigate holiday travel plans.

In December 2020, vaccine options first became available for essential workers, offering hope for reprieve in the new year.

### What About Children?

Most schools continued hybrid or virtual models. Mask mandates for children who did return to in-person learning were generally stringent and sports were often restricted, which perpetuated limited transmission in children. Cases that did occur in children were most commonly attributable to adult family members or teachers, rather than child-to-child transmissions. The demand for antigen testing increased to assess household risk and guide quarantine planning, especially for parents of young children where separate household quarantines were not an option. Some schools operating in-person or hybrid models developed surveillance testing to screen for prevalence of disease in their specific communities; however, this was difficult to operationalize for many large public school systems that remained virtual throughout the winter.

## Phase IV – Mass Vaccinations and Waning Positivity (February – June 2021)

As multiple vaccination options became available to the general population, COVID rates fell, especially in urban areas. National labs improved COVID PCR turnaround times, allowing for easier decision-making around clearance for work, school, and travel. June

2021 featured the lowest COVID positivity rates (<1% in many areas), prompting optimism for summer.

#### What About Children?

With declining rates, many school districts reopened in Spring for in-person education. Warmer weather saw many sports leagues resume, often omitting mask requirements for outdoor activities. Rates of other circulating viruses continued to be low, although were more prevalent in the daycare groups where children <3 years old were inconsistently able to wear masks. While COVID was on the decline, RSV was on the rise with spikes in activity 5 to 6 months after the typical seasonal pattern. Some schools initiated pooled testing; this allowed for identification of classrooms at risk—an effective strategy when prevalence is low.

In May 2021, vaccines became available for the 12- to 15-year-old population. Injuries and “typical” UC complaints became more frequent, especially for middle and high school students. Camps that were previously closed planned for full seasons with the addition of strict testing protocols. Summer school resumed and school districts planned for full reopenings in the Fall.

#### Phase V – Delta Variant (July – November 2021)

Typical summertime enteroviruses and other respiratory viruses began to circulate with increased social interactions. In July 2021, the Delta variant emerged and began surging around the country. While adults continued to be the most common vectors, child-to-child transmission also increased, particularly among older children and adolescents. Travel and return-to-camp requirements prompted testing spikes. Antigen testing became more generally accepted for workplace clearance in some industries.

In September 2021, President Biden encouraged organizations to require vaccinations. Many hospitals, universities, and large employers listened and began introducing such mandates as did other service-based industries and select school systems. As the weather cooled, rhinovirus and influenza rates increased, particularly in the close quarters of college campuses. In late fall, the Food & Drug Administration recommended booster vaccines for adults.

#### What About Children?

In November 2021, the FDA authorized COVID vaccination for the 5- to 12-year-old population. Most schools reopened for in-person education, often without formal surveillance testing or virtual options. The Massachusetts model to stay-in-school after a masked exposure became

popular and expanded to other jurisdictions. Students could stay in the classroom if the school performed frequent postexposure antigen testing on-site.

While positivity rates generally declined after the August to September spikes, cold weather season and increased participation in sports led to a moderate rise in pediatric COVID rates. A fragile unvaccinated child population remained vulnerable as the country moved to complete reopening without prevention measures necessary to protect children. Children began getting vaccinated in November but were not able to complete a two-vaccine series prior to the surge from the Delta variant. While child-to-child spread was still limited, disease spread became more prevalent in adolescents, especially among those who were unvaccinated.

#### Omicron Variant (December 2021 – January 2022)

In December 2021, the Omicron variant emerged from South Africa and rapidly spread to the U.S. Relative to prior variants, Omicron spread extremely quickly, leading to greater positivity rates than ever. With large scale testing centers mostly retired, the impact on urgent care was overwhelming; this impact was exacerbated by demands for holiday testing. Fears that Omicron was more transmissible were confirmed by several studies, including a Japanese report showing Omicron was 4.2 times more contagious than Delta and more likely to evade the immunity from both infection and vaccination.

Despite its infectivity, Omicron thankfully seemed to cause less severe disease in most, despite unprecedented numbers of hospitalizations in the U.S. By late December 2021, Omicron accounted for the majority of U.S. COVID infections. The FDA continued to further other protection measures, approving the use of an oral medication (eg, molnupiravir) for use in mild-to-moderate COVID disease in adults, and then approving booster vaccinations for adolescents.

#### What About Children?

With infants and toddlers fully unvaccinated and the 5- to 12-year-old population only beginning their series, the school-aged patients were especially susceptible to this surge. Unlike previous SARS-CoV-2 strains, Omicron was noted to cause more disease in the nasopharynx and upper airway, leading to more cases of “COVID croup” in toddlers. In daycares, due to decreased mask use, increased infectivity, and lack of vaccine approval, Omicron spread more readily than previous strains where child-to-child transmission was rare. Despite increases in pediatric hospitalizations, the severity of dis-



ease in children continued to be mild and was similar to other winter-time viral respiratory pathogens.

### WHAT'S NEXT?

The role of COVID testing for PUC centers has been essential. Urgent care-driven testing allows for the benefits of clinician interaction such as counseling on recovery and isolation, evaluation for complications, and treatment of comorbidities. While daycares, schools, and recreational leagues have often created their own (sometimes divergent) policies, UC has been a stalwart in directing consistent, evidence-based management for testing and clearance.

Upcoming years may see a shift from identifying COVID-19 to distinguishing the respiratory pathogens that are truly more dangerous from those associated with lower severity, such as the other coronaviruses. Urgent care's role will be increasingly to help in the diagnostic assessment of respiratory conditions and to mitigate disease spread, whether it be RSV, COVID variants, or the flu, in each community. While home testing has soared in availability, it is not clear how much this will

supplant seeking medical attention in the years to come.

For pediatrics, the downstream effects of the virus are certain to continue. As research focuses on future vaccines and antivirals, the impact on children will likely lag behind the adult population. While the severity of disease in children has been undoubtedly mild, kids could be a vector for transmission and mutation and will therefore be a critical group to attend to if we hope to truly end this pandemic.

For now, new variants are circulating, flu season is underway, and child COVID vaccinations are in their infancy. The coming months will stir ongoing controversy about vaccine mandates, antiviral options, appropriate use of diagnostic testing, lengths of isolation periods, and how to live with endemic COVID-19. For pediatrics, the trends will always be somewhat different from adults because of behavior, regulation, and the effects of the virus itself. It will remain important for urgent care to consider the unique characteristics of the pediatric population in order to make the best decisions both for our individual patients and also the health of the entire population. ■



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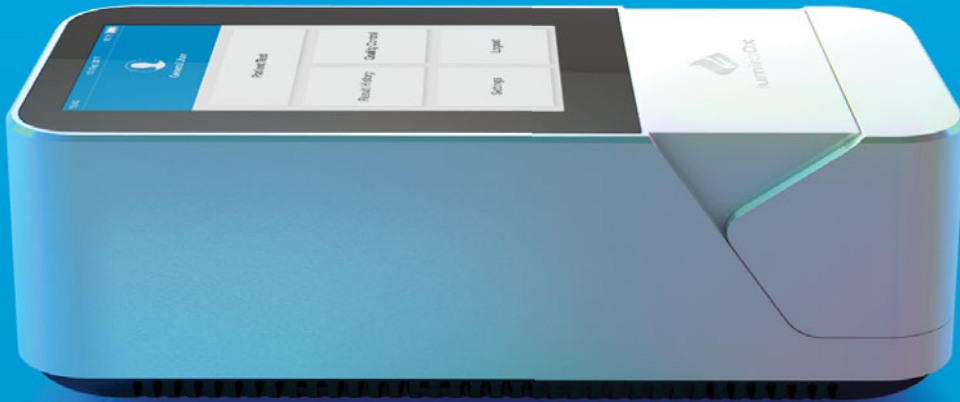
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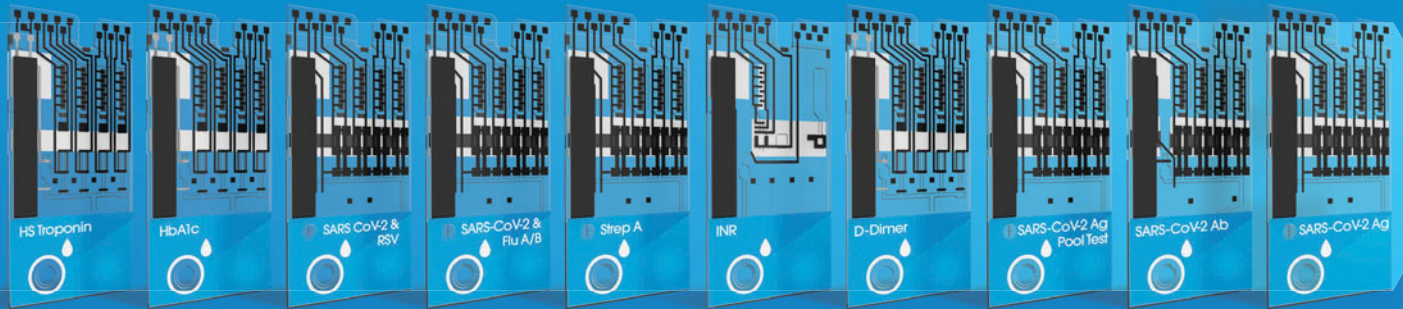
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# ABSTRACTS IN URGENT CARE

- When Handlebar Meets Abdomen
- Corticosteroids and Asthma
- Antibiotics in Pediatric PAC
- Surfactant Use in AOM
- COVID Pneumonia and Disease Progression
- Neutralizing Antibodies in COVID

■ IVAN KOAY MBChB, FRNZCUC, MD

## Pediatric Abdominal Injuries from Handlebars

**Take-home point:** Handlebar impact is a high-risk mechanism for serious intraabdominal injury in children and necessity of operative intervention is common.

**Citation:** Vanderwalle R, Barker S, Raymond J, et. al. Pediatric handlebar injuries: more than meets the abdomen. *Pediatr Emerg Care.* 2021;37(9):e517-e523.

**Relevance:** It is important to appreciate the significance of bicycle handlebar injuries as a unique mechanism when involving the abdomen to avoid missing potentially catastrophic injury.

**Study summary:** This was a retrospective trauma registry review of children presenting to a U.S. pediatric ED after bicycle accidents. The children were divided into two groups: those with and without handlebar injuries. The presence of handlebar injuries was extrapolated from review of the medical record, either from history or physical exam findings. Patients' injuries were further classified into seven anatomical regions and the need for intervention. The regions were abdominal solid organ/nonhollow viscus, abdominal hollow viscus, thoracic (nonskin), head/spine/central nervous system (CNS), face/neck/non-CNS, extremity bone/neurovascular, and thoracoabdominal/extremity soft tissue.

The authors found 385 patients meeting inclusion criteria, with 107 sustaining handlebar injuries and 278 non-handlebar injuries. Injury zone breakdown for handlebar injuries included solid organ (39%), soft tissue (26%), face/neck/non-CNS (12%), hollow organ (11%), thoracic (5%), extremity (5%), and head/

spine/CNS (2%). Among all patients, 38.7% required operative intervention while 13.2% required a nonoperative procedure. Patients with handlebar injuries had slightly lower injury severity scales and lower head abbreviated injury scale, but longer lengths of stay. Extremity injuries were also more frequent in the non-handlebar group. The need for operative intervention across groups was no different.

**Editor's comments:** This study was limited by retrospective methodology and the fact that less severe handlebar injuries may not have been captured in documentation. Regardless, it is clear that such injuries involving translation of the force of a bicycle handlebar are among the highest-risk trauma mechanisms for significant injury. ■

## Prescribing Stewardship of Oral Corticosteroids for Asthma

**Take-home point:** Frequent use of oral corticosteroids (OCS) bursts and ongoing maintenance therapy in the treatment of asthma for adults and adolescents are associated with a multitude of acute and chronic adverse effects.

**Citation:** Blakely J, Chung L, McDonald V, et. al. Oral corticosteroids stewardship for asthma in adults and adolescents: a position paper from the Thoracic Society of Australia and New Zealand. *Respirology.* 2021;26(12):1112-1130.

**Relevance:** The use of OCS is common in the treatment of acute exacerbations of asthma. While often effective at ameliorating asthma symptoms, the potential for adverse effects is commonly underrecognized.

**Study summary:** This was a position statement issued by the Thoracic Society of Australia and New Zealand reviewing the current knowledge pertaining to OCS use in asthma and aimed at delineating principles of OCS stewardship. The authors performed a literature review and issued consensus recommendations.



**Ivan Koay, MBChB, FRNZCUC, MD** is an urgent care physician; RNZCUC Examiner; Education Faculty for the RCSI Fellowship of Urgent Care Medicine; and Head of Faculty on hÉireann RNZCUC.

The authors describe that regular use of inhaled corticosteroids (ICS) reduces the risk of mortality from asthma and severe exacerbations by half in appropriate patients. ICS has been shown to be as effective as low-dose oral prednisolone for maintenance treatment in most patients with asthma.

The use of OCS reduced hospitalization and relapse rates at 7-10 days. A short (5-day) course of nontapered OCS is the preferred treatment for a true acute asthma exacerbation. However, the authors found that OCS use was excessive in relation to asthma severity and that OCS were commonly dispensed to patients with asthma due to suboptimal adherence with ICS treatment. They found that patients taking at least 10 mg per day of prednisolone-equivalent were at higher risk of developing musculoskeletal, metabolic, and psychiatric issues. Patients who had been dispensed >1,000 mg prednisolone-equivalent dose in a lifetime were significantly more likely to suffer from adverse outcomes.

**Editor's comments:** This was a position statement representing an arguable opinion on OCS overprescribing based on the Thoracic Society of Australia and New Zealand's focus groups review of relevant literature. Studies quoted were reliant on variable methodologies to collate data. ■

### Oral Antibiotic Dose and Duration in Pediatric Community-Acquired Pneumonia (CAP)

**Take-home point:** Lower dosage and 3-day duration of amoxicillin was noninferior to higher dosage and 7-day duration treatment.

**Citation:** Beilicki J, Stöhr W, Barratt S, et al. Effect of amoxicillin dose and treatment duration on the need for antibiotic re-treatment in children with community-acquired pneumonia: The CAP-IT Randomized Clinical Trial. *JAMA*. 2021;326(17):1713-1724.

**Relevance:** Antibiotic stewardship involves more than just deciding when to treat with antibiotics. Prescribing the shortest course and lowest dose possible to achieve therapeutic effect also can reduce risk of adverse events.

**Study summary:** This was a multicenter, double-blind, placebo-controlled, randomized trial with a 2 × 2 factorial, noninferiority design, conducted in 29 hospitals in the UK and Ireland, comparing total daily amoxicillin doses (35-50 mg/kg vs 70-90 mg/kg) and duration of therapy (3 vs 7 days) for treatment of CAP in children. Participants were randomized in a 1:1 ratio by dispensing the next sequentially numbered set of trial drug bottles. Nasopharyngeal swabbing for *Streptococcus pneumoniae* carriage and resistance was obtained at enrollment. The primary outcome measured was the need for repeat antibiotic re-

treatment within 28 days of enrollment.

The authors enrolled 814 children. In lower vs higher doses, retreatment rates were 12.6% (lower) and 12.4% (higher) and in the 3- vs 7-day regimen, retreatment rates were 12.5% (shorter) and 12.5% (higher)—both meeting criteria for noninferiority.

Post-hoc analysis of children who took 80% of the medication showed noninferiority for both lower doses and shorter duration course. Resolution of clinical disease was not significantly different between groups by doses or durations of treatment. Forty-two percent of the swabs taken were colonized for *S pneumoniae* with penicillin nonsusceptibility identified in 16.9% of samples.

**Editor's comments:** In this study, it was not possible at enrollment to equivocally identify children who would benefit from antibiotic treatment and it was left to clinician discretion. As most cases of pediatric pneumonia are known to be viral in etiology, it is likely that much of the noninferiority was driven by lack of antibiotic utility for viral infections. ■

### Intranasal Surfactant in the Treatment of Acute Otitis Media (AOM)

**Take-home point:** Artificial surfactant containing dipalmitoyl phosphatidylcholine and cholesteryl palmitate did not improve outcomes in children treated for AOM.

**Citation:** Muniz G, Shope T, Bhatnagar S, et al. Intranasal surfactant for acute otitis media: a randomized trial. *Pediatrics*. 2021;148(6):e2021051703.

**Relevance:** AOM is among the most common pediatric UC presentations. While antibiotics are indicated in many cases, relief of symptoms from even appropriate antibiotic use takes time. This study sought to determine if adjunctive intranasal surfactant can be useful in this task.

**Study summary:** This was a phase 2a, single center, double-blind, randomized, placebo-controlled, parallel group study to assess the safety, tolerability, and efficacy of 20 mg/day of intranasal OPO201, a surfactant-like substance containing dipalmitoyl phosphatidylcholine and cholesteryl palmitate, as adjunct to oral antibiotic treatment for children with AOM. One hundred three children were randomized to receiving intranasal OPO201 or placebo together with amoxicillin-clavulanate 90/6.4 mg/kg per day in two divided doses for 10 days.

The authors found no clinically meaningful differences between treatment groups. The proportion of children with middle-ear effusion was slightly lower among children receiving OPO201; however, this did not meet statistical significance.

**Editor's comments:** The study was underpowered for the outcomes of interest because of early termination due to funding is-

sues. All patients were treated with antibiotics and therefore the utility of intranasal surfactant for serous otitis media or other causes of otalgia cannot be determined from this study. ■



**COVID-19 Abstracts**

**Diagnosing COVID-19 Pneumonia and Disease Progression**

**Take-home point:** Basic vital signs such as heart rate, blood pressure, temperature, respiratory rate, and oxygen saturations have high value in identifying patients with COVID-19 who are experiencing clinical deterioration.

**Citation:** Goyal D, Inada-Kim M, Mansab F, et al. Improving the early identification of COVID-19 pneumonia: a narrative review. *BMJ Open Respiratory Research.* 2021;8: e000911.

**Relevance:** Early identification of COVID-19 pneumonia allows for improved resource utilization while also minimizing associated morbidity and mortality. The use of vitals as inexpensive, quick, and noninvasive clinical data points is explored in this paper.

**Study summary:** This was a narrative review of the relevant literature involving the use of vital signs to identify deteriorating COVID-19 patients in the community. The authors performed a literature search for studies describing vital sign changes in patients with COVID-19 with more severe illness.

The authors noted that symptoms associated with disease progression were dyspnea, confusion, fatigue, dry cough, fever, chest tightness, abdominal pain, diarrhea, and vomiting. Unsurprisingly, elevated heart rate, persistent fever >38°C, respiratory rates of >26/min and oxygen saturations <95% on air were all found to be predictive of disease progression/need for intervention. These indicators were present in patients requiring ICU admission and were associated with higher mortality rates than patients with normal vital signs.

Perhaps most clinically relevant was that identification of patients with hypoxemia was useful in ensuring they were treated early with steroids, which was shown to have benefits for patients with moderate-to-severe disease. Interestingly, C-reactive protein (CRP) was found to be an unreliable biomarker for disease progression. However, CRP levels >150 mg/L were indicative of serious illness with requirements for early invasive ventilation.

**Editor’s comments:** This narrative review affirms the value of home monitoring of vitals to guide patients with COVID-19 on when to seek additional care. Relying on objective data rather than symptoms to prompt reassessment could prove to be a useful strategy in preventing misuse of healthcare resources and to encourage infectious patients to remain in isolation. ■

*“There was an 85% relative risk reduction for hospitalization or death between patients who received sotrovimab vs those who received placebo.”*

**Early Treatment of COVID-19 with Neutralizing Antibodies**

**Take-home point:** In moderate- to high-risk patients, sotrovimab, a neutralizing antibody therapy, reduced the risk of disease progression.

**Citation:** Gupta A, Gonzalez-Rojas Y, Juarez E, et. al. Early treatment for COVID-19 with SARS-CoV-2 neutralizing antibody sotrovimab. *N Engl J Med.* 2021;83:385(21):1941-1950.

**Relevance:** This paper evaluates the efficacy of sotrovimab, a neutralizing monoclonal antibody used in the treatment of COVID-19, on the risk of disease progression.

**Study summary:** This was a phase III, multicenter, randomized, double-blind, placebo-controlled trial, evaluating a single intravenous infusion of sotrovimab (500 mg) for patients with mild-to-moderate COVID-19 but at high risk for progression to serious disease. Patients enrolled had a positive PCR COVID-19 test in the preceding 5 days and were assigned in a 1:1 ratio to sotrovimab or placebo infusion.

Five hundred eighty-three patients were randomized to receive sotrovimab (291 patients) or placebo (292 patients). The authors found three of the 291 sotrovimab patients (1%) compared with 21 of 292 placebo patients (7%) had disease clinically significant disease progression, classified as admission to hospital for >24 hours or any cause or death, which was statistically significant. Secondary analysis revealed no difference in adverse events between the sotrovimab and placebo groups (17% vs 19%). No serious adverse events occurred in either group. There was an 85% relative risk reduction (RRR) for hospitalization or death between patients who received sotrovimab vs those who received placebo.

**Editor’s comments:** This study was sponsored by the pharmaceutical company manufacturing sotrovimab with a small numbers of participants, limiting ability to detect rare adverse events. Baseline antibodies to COVID-19 were not examined in this study and may have accounted for differences between groups. Hospitalization and death were used a composite endpoint, but certainly prevention of mortality is clinically and practically different than avoiding hospitalization. It is unclear how well sotrovimab antibodies may neutralize subsequent variants of SARS-CoV-2. ■



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# Testicular Torsion: The Case of the Dancing Testicle

**Urgent message:** The differential diagnosis for unilateral testicular pain includes testicular torsion; this is a “must not miss” diagnosis, as delayed diagnosis can cause significant morbidity both physically and psychologically.

JEANNETTE VAUGHN-DOTTERER, PA-C

## Case Presentation

**M**L is a 47-year-old male who developed left-sided testicular pain after getting out of bed 2 hours prior. He states that his left testicle appears to be “dancing” and seems to be riding higher than his right testicle. ML states that the pain has been constant and that nothing seems to make it better; conversely, sitting or walking seems to increase the pain. He denies trauma, recent infection, fever, or previous surgery to his testicles. He also denies history of sexually transmitted infections, pain with intercourse, dysuria, penile discharge, or hernias. He states that he felt fine when he went to bed last night. His past medical history includes anxiety and glomerulonephritis. Currently he is taking alprazolam (Xanax), clonazepam (Klonopin), and venlafaxine (Effexor). ML has an allergy to cefuroxime, which causes a rash. He denies illicit drug use or smoking. Previous surgical history includes sinus surgery, appendectomy, and knee arthroscopy.

## Observations and Findings

Evaluation of the patient reveals the following:

- Temp: 98.4°F
- Pulse: 78
- Respiration: 16
- BP: 114/88
- O<sub>2</sub>Sat: 98% RA
- CV: Normal RRR, no murmurs, gallops, or rubs
- Lungs: Clear to auscultation
- Abdomen: Nontender, no guarding, no distention, well-healed surgical scar noted in RLQ, no supra-



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pubic tenderness or masses noted

- Genitourinary: Left testicle is swollen and sitting in a horizontal orientation; it is higher than the right testicle; significant tenderness to palpation is noted to the left testicle

Differential diagnoses were testicular torsion, epididymitis, sexually transmitted infection, symptomatic hydrocele, scrotal hematoma, inguinal hernia, orchitis, and malignancy.

## Course and Treatment

The patient was referred to the emergency department

**Author affiliations:** Jeannette Vaughn-Dotterer, PA-C, NextCare Urgent Care; Arizona School of Health Sciences Physician Assistant Program at A.T. Still University. The author has no relevant financial relationships with any commercial interests.

Table 1. TWIST Scoring System	
Finding	Points
Hard testis	2
Swelling	2
Nausea/vomiting	1
Absent cremasteric reflex	1
High-riding testis	1
0–2 points: Low risk; 3–4 points: Intermediate risk; 5–7 points: Moderate risk	

for further evaluation and to rule out testicular torsion. Scrotal ultrasound confirmed that the patient had a left-sided testicular torsion. The patient opted not to have emergent orchidopexy (fixation of the testicle) so the treating physician manually detorsed the left testicle, providing immediate relief of the patient's pain. Precautions for return to the hospital included return of pain, redness, swelling, and vomiting. He was discharged home with a referral to urology.

## Discussion

Testicular torsion is a condition characterized by the rotation of the testicle around the spermatic cord, causing decreased blood flow to the testicle and possibly resulting in testicular ischemia, infertility, and loss of the testis. Typical presentation includes acute unilateral scrotal pain, with nausea and vomiting, scrotal swelling, a horizontal high-riding testicle, and loss of cremasteric reflex on physical exam.<sup>1</sup>

This is a medical emergency and requires prompt diagnosis and intervention. The urgent care clinician needs to include testicular torsion in the differential any time a patient presents with acute onset of unilateral scrotal pain.

A clinical scoring system can be used in conjunction with a thorough physical exam by the urgent care provider to identify patients at higher risk for a testicular torsion vs those with testicular pain with a different underlying etiology. TWIST (Testicular Work-up for Ischemia and Suspected Torsion) is utilized to determine if the patient is low, intermediate, or high risk for torsion (Table 1).<sup>2</sup> TWIST has been validated only in children, but can be useful in adults; a high TWIST score should prompt a call to the urologist and consideration of taking the patient to the operating room without imaging. The Prehn sign, relief of scrotal pain with elevation, should not be solely used as a predictor for testicular torsion.<sup>3</sup>

Testicular torsion can be caused by genetic predisposition, environmental factors such as cold weather, trauma, and the “bell clapper deformity” where the tu-

nica vaginalis is attached high, allowing the spermatic cord to twist inside causing torsion of the testicle.<sup>4</sup>

Patients who have a low score on the TWIST assessment should have ultrasound performed. Those with a high score, placing them in the moderate risk category, can forgo the ultrasound and go straight to surgery.<sup>3</sup> Doppler ultrasound is the diagnostic imaging study of choice to assess both arterial and venous blood flow and should be performed on both the unaffected and affected testis. Findings will show decreased color or flow in a patient with a testicular torsion.

Testicular torsion is a time-sensitive surgical emergency. Surgical exploration of the scrotum with orchidopexy is the gold standard treatment. A timeframe from testicular torsion to surgical exploration of less than 6 hours of pain has a higher organ salvage rate when compared with a time frame greater than 12 hours of pain.<sup>1,5</sup>

Manual detorsion should be considered when the timeframe for exploration is going to be prolonged. Manual detorsion is performed by grasping the affected testicle by the thumb and middle finger and rotating the testicle medial to lateral. This maneuver may take up to four tries before the patient gets relief. After manual detorsion the patient should have an ultrasound performed to verify adequate blood flow to the testicle. Manual detorsion should be followed by surgical exploration and orchidopexy (fixation of the testicle).<sup>1</sup> Surgical exploration should still be performed followed by orchidopexy or orchiectomy if the testis is necrosed.

## Conclusion

Testicular torsion is a medical emergency affecting approximately a quarter of patients presenting to the emergency room complaining of scrotal pain.<sup>4</sup> Door-to-detorsion time should be less than 6 hours from onset of pain in scrotum, increasing the odds of a favorable outcome. Recognition of patients with a testicular torsion requires a thorough physical exam as well as close attention to presenting symptoms of hard testis, high-riding testis, testicular swelling, nausea/vomiting, and absence of a cremasteric reflex. ■

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# Reducing Low-Acuity Preventable Emergency Room Visits by Utilizing Urgent Care Center Services via Mobile Health Unit Diversion Program

**Urgent message:** Urgent care centers can execute and implement innovative ideas to ameliorate overcrowded emergency rooms. The creation of a mobile health diversion program to transport low-acuity conditions to urgent care instead of a hospital emergency department can improve population health and reduce healthcare cost, providing the opportunity to leverage value-based care by targeting the triple aim (reducing cost, increasing patient satisfaction, and improving outcomes) while freeing up the emergency medical system services.

CESAR MORA JARAMILLO, MD, FAAFP, FCUCM

**Citation:** Jaramillo CM. Reducing low-acuity preventable emergency room visits by utilizing urgent care center services via mobile health unit diversion program. *J Urgent Care Med.* 2022;16(6):35-37.

### Introduction

Volatility and continuously rising costs in the United States healthcare system have created a marketplace in which urgent care centers can play an essential role by helping to reduce cost, increase patient satisfaction, and improve outcomes.

At the same time, overwhelmed emergency departments need help in minimizing low-acuity/unnecessary usage while reducing cost and assisting in health disparities.

According to the Centers for Medicare and Medicaid Services (CMS), healthcare spending is expected to increase to 19.4% from 17.9% in the next 7 years, giving UCCs the opportunity to step up in cost-reducing actions.<sup>1</sup>

Emergency departments are overused in multiple ways—varying levels of severity including acute con-



ditions, acute on chronic illnesses, mental health, substance abuse, and prescription refills, among others.<sup>2</sup>

**Author affiliations:** Cesar Mora Jaramillo, MD, FAAFP, FCUCM, Providence Community Health Centers; Warren Alpert Medical School Brown University; College of Urgent Care Medicine. The author has no relevant financial relationships with any commercial interests.

<b>Table 1. Demographic Characteristics and Analysis Results of Patients Transported to Urgent Care After Calling 911 (N=107)</b>	
<b>Demographic Characteristics and Analysis Results</b>	<b>No. (%)</b>
<b>Sex (n=107)</b>	
Male	38 (35.5%)
Female	69 (64.5%)
<b>Disposition (n=107)</b>	
Emergency room referral	16 (14.95%)
Home	90 (84.11%)
Other	1 (0.94%)
<b>Mental Health Diagnoses (n=107)</b>	
Psychiatric disease and/or substance use	47 (43.9%)
<b>Chief complaint (n=107)</b>	
Pain	47 (43.9%)
Gastrointestinal symptoms	21 (19.6%)
Others	39 (36.5%)
<b>Chief Complaint of Pain (n=47)</b>	
Muscle skeletal pain	28 (59.57%)
Abdominal pain	9 (19.1%)
Others	10 (21.2%)
<b>Medical Diagnosis (n=107)</b>	
Infectious disease	30 (28.03%)
Muscle skeletal/sports medicine	25 (23.3%)
Others	52 (48.8)
<b>Medical Diagnoses of Infections Disease (n=30)</b>	
Gastroenteritis	11 (36.66%)
Influenza	7 (23.3%)

There is evidence showing patients using the emergency room for complaints that could be treated in settings that represent a cost-effective environment (including urgent care or patient-centered medical homes).<sup>3</sup> Initiatives to explore how patients with low-acuity conditions can be transported to a more appropriate setting such as urgent care instead of a hospital ED should be considered. This could reduce ED utilization for non-emergent conditions while also reducing overall health-care cost without affecting patient satisfaction.

**Description**

The Providence (RI) Fire Department receives approximately 33,000 medical-related calls in a year, of which

7,500 are dispatched as basic life support (BLS) and approximately 14,000 are transported and billed as BLS calls. About 39 calls qualified as BLS are received in a period of 24 hours.<sup>4</sup>

The implementation of the Mobile Health Unit initiative provides patients who have non-life-threatening conditions the opportunity to receive immediate care in an appropriate ambulatory care setting (urgent care) while freeing up the EMS system to respond to severe/life-threatening emergencies.

Two lieutenants from the PFD were assigned to the Mobile Health Unit starting late August in 2019. When a patient calling 911 is identified as having a non-emergency condition or complaint, the crew will assess the patient in the field, communicate with a registered nurse at an urgent care center, and may transport the patient to the facility instead of the ED.

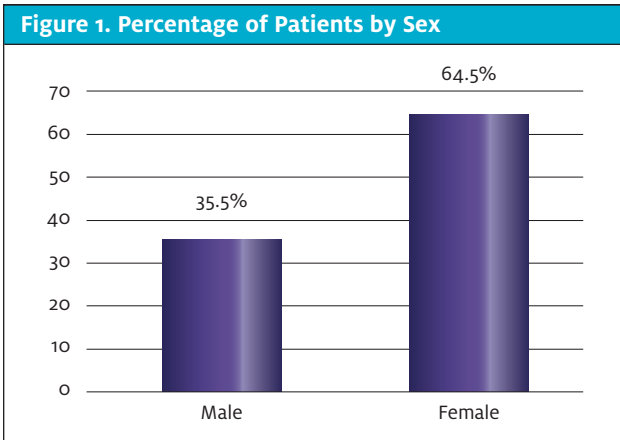
In this article we discuss how an innovative federal qualified health center facility (Providence Community Health Centers) managed to create a program “mobile health unit” in collaboration with state health insurance (Neighborhood Health Plan of RI) and the city fire department. The initiative consisted of transporting low-acuity or BLS calls to immediate appropriate quality care in an urgent care center while ameliorating the EMS system and preventing avoidable ER visits.

The Express Clinic manages close to 25,000 visits a year while the entire organization serves a total of approximately 60,000 patients (seeking primary care), predominantly Hispanic/Latino. The population served by the community health center (CHC) includes 90% of households that are under 200% of the federal poverty level (FPL) and a significant proportion of uninsured patients are undocumented immigrants.

**Methodology**

**Retrospective Descriptive Study**

Data were retrospectively reviewed from the urgent care department of a Federally Qualified Health Center (FQHC) in Providence, RI to determine the percentage of preventable ER visits via the innovative Mobile Health Unit. A query of the electronic medical record database identified 107 patients who were transported to urgent care after calling 911 between August 26, 2019 and March 16, 2020. (The program was put on a hold due to the COVID-19 pandemic.) The data reviewed included age, sex, chief complaint, diagnoses, referral to ED, other referrals/disposition, and diagnoses of any psychiatry condition and/or substance use reported in the visit note, problem list, or the under the diagnosis history prior to the EMS transported visit.



The objective of analyzing the data was to study if the mobile diversion program successfully prevented avoidable ER visits. In addition, data were reviewed to investigate the percentage of any psychiatric conditions and/or substance use within the population studied. The Providence Community Health Centers approved the project.

**Results**

A total of 107 patients were transported to Express (UCC) after calling 911 between August 26, 2019 and March 16, 2020. Of these patients, 69 were female (64.5%). (See **Figure 1**.) The age of the patients seen in urgent care ranged from 16 years to 81 years with a median of 40.

Of those 107 patients, 90 (84.1%) were discharged home and 16 (14.9%) were referred for higher level of care to a local ED. One individual was referred to a detox facility. (See **Figure 2**.)

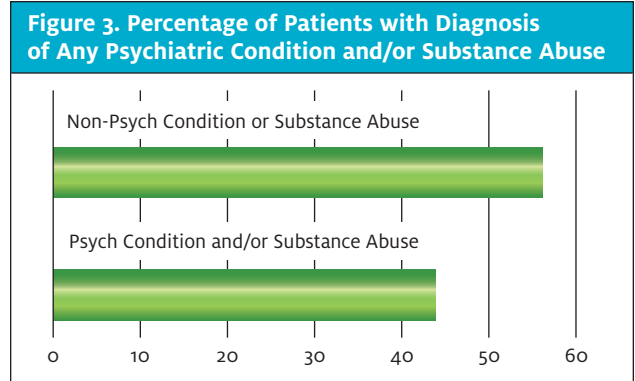
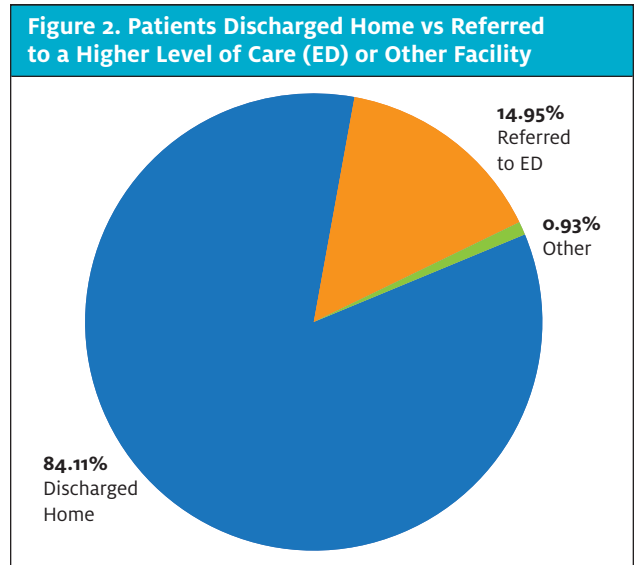
Among the 107 patients transported to the urgent care facility for health services, 47 (43.9%) had a diagnosis of any psychiatric condition and/or substance use. (See **Figure 3**.) Of these patients 19 (40.4%) had a diagnosis of depression and/or other psychiatry condition. In terms of substance use, seven patients (14.8%) of the 47 had a diagnoses of only alcohol use and four (8.5%) of only cannabis use.

The most common chief complaints observed were pain in 47 patients (43.9%) and GI symptoms in 21 patients (19.6%). Pain was identified as musculoskeletal-related in 28 of those 47 patients (59.9%); nine patients (19%) complained of abdominal pain.

Additionally, out of the 107 patients transported to Express via Mobile Health Unit, 30 were diagnosed with infectious diseases (28%).

**Discussion**

An innovative federal qualified health center facility



(Providence Community Health Centers) was successful at executing a program to prevent avoidable emergency room visits while freeing up the EMS system to respond to true emergencies and life-threatening conditions.

In the United States, approximately 13% to 27% of ED visits can be addressed in ambulatory settings (including urgent care centers). Diverting these patients to the appropriate setting for care could decrease health-care costs by \$4.4 billion.<sup>5</sup>

Misuse and/or overuse of 911 calls for nonemergencies can overwhelm the emergency medical system services, threatening to increase ambulance wait time and adding cost to city services. The consequences of such a rise in EMS response time intensifies the risks of serious outcomes or mortality. Organizations should invest in understanding the population/communities and investigate the drivers for patients to seek care in local EDs via 911 calls.

Redirection of nonemergency 911 callers to more appropriate sources of medical care like UCCs can be ac-

complished. During the 26 weeks of the Mobile Health Unit Diversion program, 8.4 out of every 10 patients diverted to a UCC were discharged home—consequently, avoiding an ED visit while patients were treated in a cost-effective setting. This initiative offered an alternative to low-acuity 911 calls or a trip to the ED.

Some of the studied drivers for ED overuse are low incomes/poverty, no health insurance, lack of access to timely care services, and financial and legal obligations by hospitals to treat all patients who arrive in the ED.<sup>2</sup>

A large portion of ED visits fall into the category of “avoidable” use resulting from patients seeking nonurgent care or ED care for conditions that could have been treated and/or prevented in other settings, like UCCs.<sup>2</sup>

While some medical conditions have been associated with ED overuse, this study shows an association of pain, infectious diseases, and mental health with ED usage. In collaboration with key stakeholders, these avoidable visits can be prevented without compromising patient accessibility or quality of care.

Adults with psychiatric conditions and/or substance use issues are more likely to utilize the ED for care for medical conditions in comparison with patients without mental health disorders. The Agency for Healthcare Research and Quality (AHRQ) states that “from 2007 to 2013, the overall rate of emergency department visits with a principal diagnosis related to mental health, alcohol, or substance abuse increased from 1,527.8 to 1,883.0 per 100,000 population nationwide.”<sup>6</sup>

Organizations are stepping up with actions to assist in providing this much-needed help and decrease ER over use. The New Haven Community Health Care Van study (mobile needle exchange–based healthcare delivery system) was associated with a decline of more than 20% in ED visits among injection-drug users.<sup>7</sup>

The Mobile Health Unit study shows a high prevalence of psychiatric conditions and substance use among the patients who were transported to a UCC after calling 911. Approximately 4.3 in 10 patients had a mental health and/or substance use condition. Addressing these risk factors in our communities is paramount to decreasing health costs. Access to integrated behavioral and expanding services (accessibility) are some of the strategies CHCs are implementing to leverage a value-based approach, managing the cost of care for this specific patient population. Thus, a substantial amount of money could be saved annually by eliminating avoidable ED use for mental health conditions.

The struggle of communities to manage the overwhelmed 911 system is evident. Urgent care medicine continues to expand in the United States, offering acces-

sibility, quality, and substantial cost reduction of healthcare services. UCCs are capable of linking patients to greatly needed preventative health services and offer a setting to potentially reduce avoidable ER visits. Furthermore, urgent cares provide other opportunities for engagement and education for patients in a setting other than the ED.

More initiatives and research into programs with focus in diverting patients away from ERs are needed.

## Conclusion

Urgent care centers play an essential role in providing immediate services while offloading overcrowded and high-cost emergency department care. This study shows how UCCs fit in the national value-based care and population health while contributing to an efficient low-cost high-quality healthcare system. UCCs can offer an effective alternative response and prevent unnecessary ED visits by providing care to patients who call 911 with low-acuity complaints.

Patients need (and deserve) access to high-quality care in a timely manner. This includes access to urgent care centers for nonemergent acute conditions. This can be accomplished by intertwining key stakeholders and connecting/transporting patients to appropriate care settings.

The Mobile Health Unit Diversion program supports the idea of a well-designed community/mobile-integrated health intervention that can be effectively executed while ameliorating overcrowded ERs of unnecessary visits and freeing up EMS services to response to severe/life-threatening emergencies. ■

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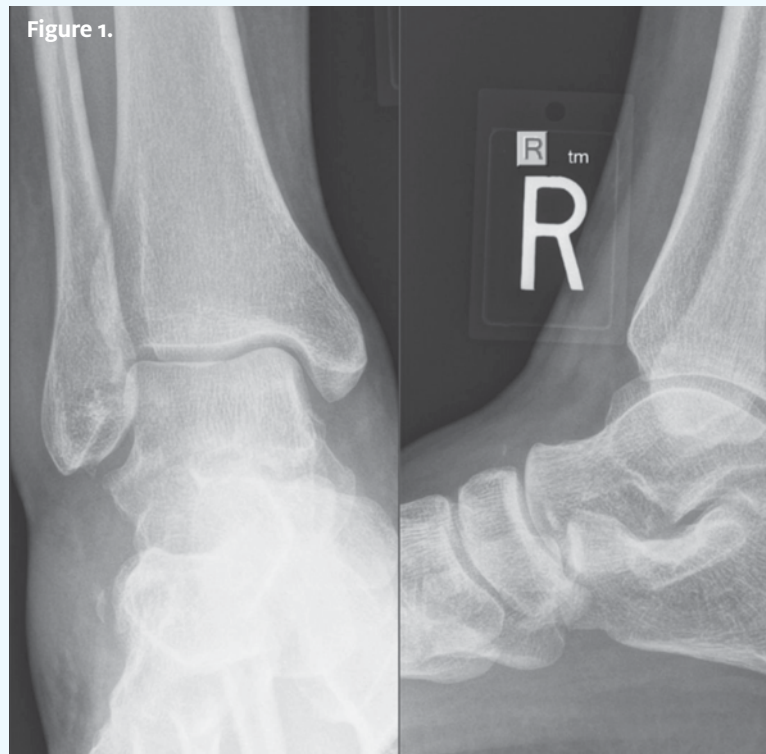
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In each issue, *JUCM* will challenge your diagnostic acumen with a glimpse of x-rays, electrocardiograms, and photographs of conditions that real urgent care patients have presented with.

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

## A 31-Year-Old with Pain After Twisting His Ankle

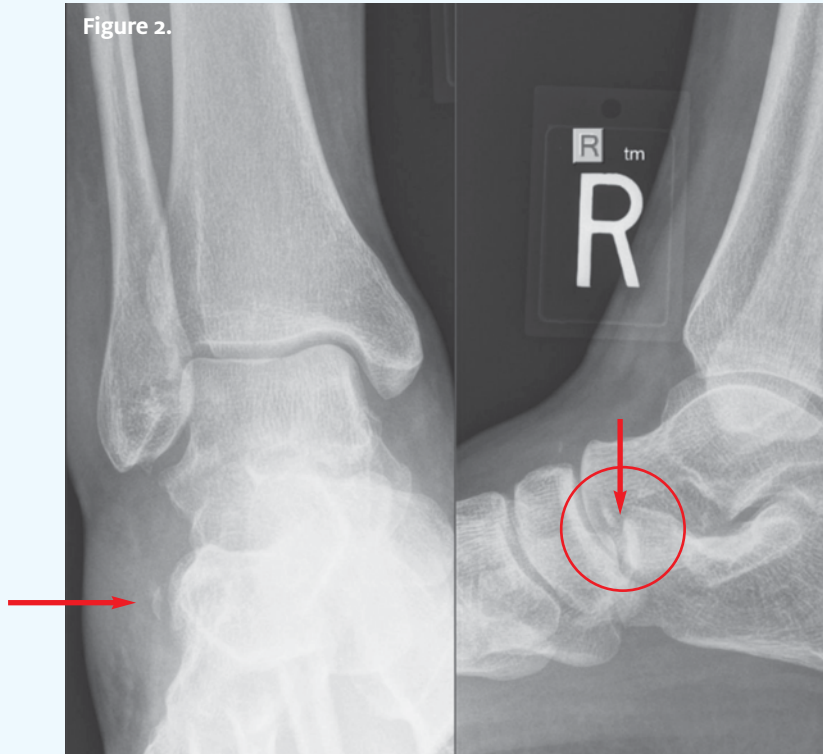


### Case

The patient is a 31-year-old male who presents with lateral ankle pain after an inversion injury during a game of basketball.

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

THE RESOLUTION



**Differential Diagnosis**

- Calcaneus accessorius
- Fracture, anterior process of the calcaneus
- Fracture, dorsal navicular
- Fracture, tuberosity of the calcaneus

**Diagnosis**

This patient was diagnosed with an avulsion fracture of the anterior process of the calcaneus (and also likely of the dorsal navicular).

**Learnings and What to Look for**

- An irregular crescentic bony fragment projects lateral to the foot on the AP view, corresponding to an avulsion of the anterior process of the calcaneus on the lateral view
- These fractures are missed 88% of the time and can lead to nonunion, unrecognized associated ligamentous injuries, and persistent ankle or foot pain

■ Degan classification:

- Type I: Nondisplaced avulsion fractures with no calcaneocuboid joint involvement
- Type II: Displaced fractures but still no calcaneocuboid joint involvement
- Type III: Displaced fractures with calcaneocuboid joint involvement

**Pearls for Urgent Care Management**

- Types 1 and 2 are treated with plaster casting
- Type 3 is managed with open reduction internal fixation due to higher tendency for nonunion

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



## A 60-Year-Old Woman with Dark, Painful Plaques on Her Legs



### Case

The patient is a 60-year-old woman who presents to urgent care after developing dark areas over both legs over the course of the past few days. They are extremely painful. On examination, there were violaceous and dark brown, retiform plaques, some depressed and some crusted, over the legs. The patient has a history of diabetes, hypertension, and chronic renal insufficiency for which she required hemodialysis.

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

*Published online ahead of print November 23, 2021.*

## THE RESOLUTION

**Differential Diagnosis**

- Polyarteritis nodosa
- Calciphylaxis
- Cryoglobulinemia
- Panniculiti

**Diagnosis**

The correct diagnosis is calciphylaxis, also known as calcific uremic arteriolopathy. This is a microvascular occlusion syndrome thought to occur due to diffuse deposition of insoluble calcium salts in cutaneous blood vessels with associated thrombosis. The process may be triggered by chronic hypocalcemia from decreased intestinal absorption of calcium, leading to increased levels of parathyroid hormone and subsequent recruitment of calcium and phosphate from bone. Hypercoagulable states are also thought to play a possible role.

**Learnings/What to Look for**

- Characteristic pathologic findings include progressive medial calcification of cutaneous blood vessels and subsequent ischemic necrosis of the skin
- Warfarin-associated nonuremic calciphylaxis tends to occur on the lower extremities about 2.5 years after warfarin initiation, does not have associated calcium abnormalities
- Early lesions are extremely painful, violaceous retiform patches and plaques, classically on fat-bearing areas such as

the thighs, buttocks, or abdomen. This is followed by necrosis, ulcers, eschar formation, and possibly gangrene. Induration of the surrounding tissues may be present

- Lesions have been reported to be triggered by local trauma, including from insulin or heparin injections, or a skin biopsy
- Incidence of calciphylaxis is increasing and is most commonly associated with chronic renal failure, hemodialysis, and secondary hyperparathyroidism. Other risk factors include female sex, obesity, Northern European descent, and hypoalbuminemia

**Pearls for Urgent Care Management**

- Mortality from calciphylaxis is high (60%-87%) and is largely secondary to sepsis from large, nonhealing ulcers
- A multidisciplinary approach is likely to be necessary and would include wound care, nephrology, dermatology, and pain management
- The most common intervention is off-label use of intravenous sodium thiosulfate<sup>1</sup>
- Other treatments described in case reports include bisphosphonates, low-tissue plasminogen activator infusion, LDL-apheresis, vitamin K, and kidney transplant<sup>1</sup>

**Reference**

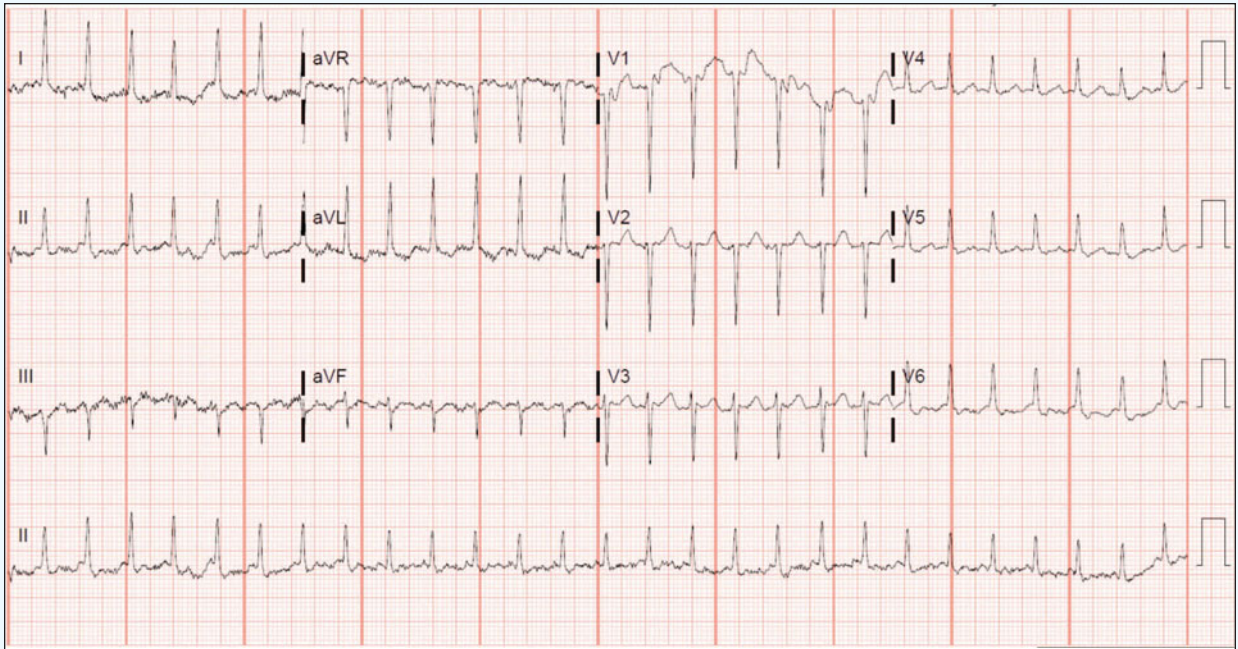
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**Acknowledgment:** Images and case presented by VisualDx ([www.VisualDx.com/JUCM](http://www.VisualDx.com/JUCM)).





# A 46-Year-Old Male Who Presents Due to His Defibrillator Firing



**Figure 1.** Initial ECG.

The patient is a 46-year-old male with a history of hypertension and congestive heart failure who presents complaining of his defibrillator firing—twice yesterday and once today. He denies chest pain, shortness of breath, fever, nausea or vomiting. He ran out of his carvedilol about 1 month ago.

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

*(Case presented by Catherine Reynolds, MD, McGovern Medical School, Department of Emergency Medicine, The University of Texas Health Science Center of Houston.)*

THE RESOLUTION

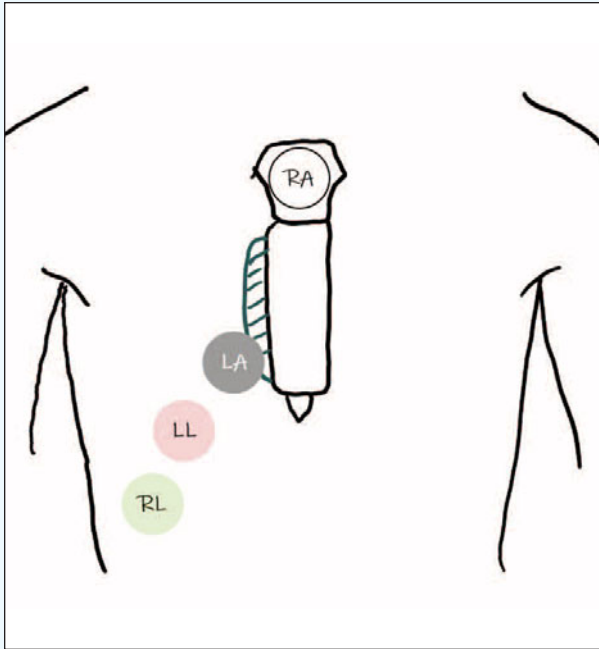


Figure 2. . Electrode placement for Lewis lead.<sup>1</sup> (Used with permission.)

- Atrioventricular nodal reentrant tachycardia (AVNRT)
- Atrioventricular reentrant tachycardia (AVRT)

**Diagnosis**

This patient was diagnosed with atrial flutter with 2:1 conduction. The ECG shows a regular narrow-complex tachycardia with a rate of 160 beats per minute. There is a left axis deviation with left ventricular hypertrophy (as evidenced by the tall R wave in aVL), and T-wave inversions in I and aVL consistent with a left ventricular strain pattern. (See the February 2020 issue of *JUCM* for further clarification of the left ventricular strain pattern).

On initial assessment of this ECG, atrial activity is not readily apparent, making it difficult to distinguish among atrial flutter, sinus tachycardia, and other supraventricular tachycardias such as AVNRT or AVRT. In this case, the astute clinician has two options:

1. A trial of an atrioventricular node blocker (eg, adenosine) will “unmask” atrial activity if present, or
2. A simple strategy to check “the Lewis lead,” which might reveal the underlying rhythm

Developed and described in 1913 by Sir Thomas Lewis, the Lewis lead is a unique configuration of the ECG electrodes over the atrium that allows for the amplification of atrial activity.<sup>2</sup>

To evaluate the Lewis lead on an ECG, move the right arm (RA) electrode to the manubrium, the left arm (LA) electrode to the fifth intercostal space on the right sternal border, and the left leg (LL) electrode to the right lower costal margin (Figure 2). With the electrodes in this position, lead I will best illustrate

**Differential Diagnosis**

- Atrial flutter with 2:1 conduction
- Atrial fibrillation with rapid ventricular response
- Sinus tachycardia

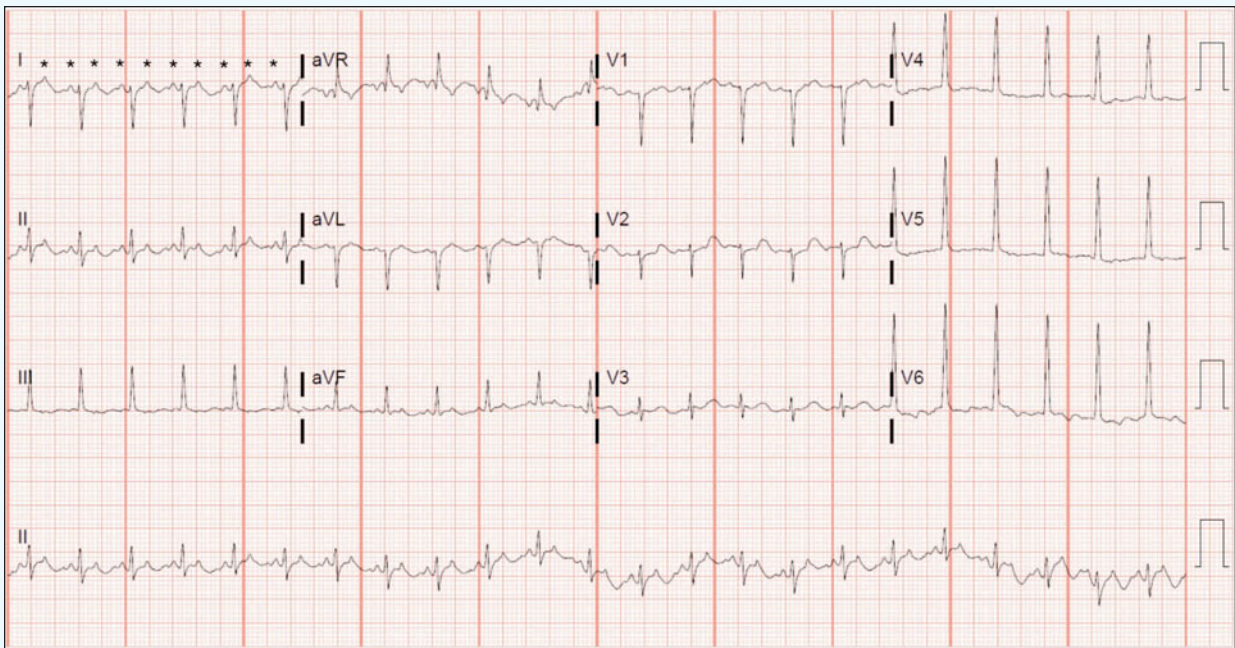


Figure 3. Lewis lead ECG with unmasked flutter waves (\*) in lead I.

THE RESOLUTION

atrial activity.<sup>3,4</sup> This positioning centers lead I over the right atrium, magnifying its activity.

When the Lewis lead was performed in our case, flutter waves were clearly present in lead I (and lead II), cinching the diagnosis of atrial flutter with 2:1 conduction (**Figure 3**).

While this article demonstrates the benefit of a Lewis lead to aid the diagnosis of undifferentiated regular, narrow-complex tachycardias, this technique may also be used with wide-complex tachycardias. In these cases, performing a Lewis lead ECG allows the clinician to identify atrioventricular dissociation and make the diagnosis of ventricular tachycardia in stable patients.<sup>5</sup>

**Learnings/What to Look for**

- Hidden P-waves in regular narrow-complex tachycardias can be unmasked by adenosine or a Lewis lead ECG
- After reorganizing electrodes in the Lewis lead configuration, obtain another ECG and look at lead I for clues about the underlying atrial activity

**Pearls for Urgent Care Management**

- In stable patients with no obvious atrial activity on ECG, a Lewis lead can help you make the diagnosis and treat accordingly
- Patients with atrial flutter with rapid ventricular response typically would benefit from transfer to a facility with cardiology services available, but making the diagnosis and stabilizing before transfer is paramount

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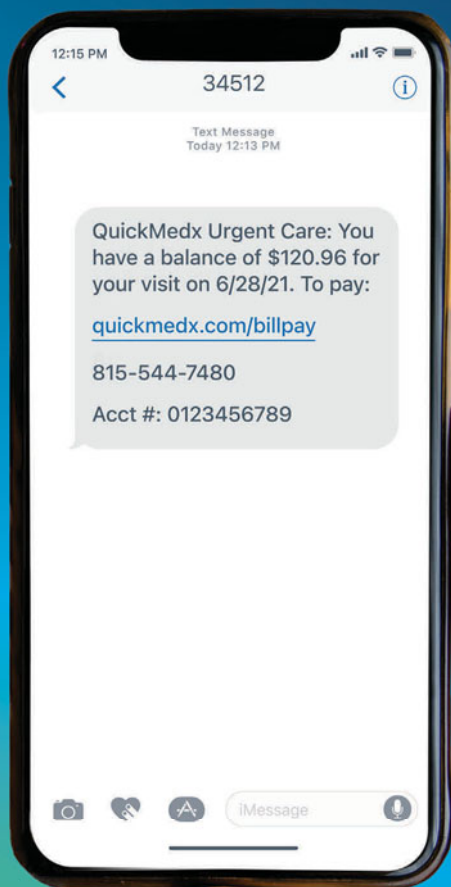
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## What Else Is New in 2022?

■ MONTE SANDLER

**Table 1. Total Relative Value Units and National Allowables, 2021 vs 2022**

Code	2021		2022		Difference in dollars	% difference
	Total RVUs	National allowable	Total RVUs	National allowable		
99202	2.12	\$73.97	2.14	\$74.07	+\$0.10	+0.1%
99203	3.26	\$113.75	3.29	\$113.87	+\$0.12	+0.1%
99204	4.87	\$169.93	4.90	\$169.59	-\$0.34	-0.2%
99205	6.43	\$224.36	6.48	\$224.27	-\$0.09	-0.04%
99212	1.63	\$56.88	1.66	\$57.45	+\$0.57	+1.0%
99213	2.65	\$92.47	2.66	\$92.06	-\$0.41	-0.4%
99214	3.76	\$131.20	3.75	\$129.79	-\$1.41	-1.1%
99215	5.25	\$183.19	5.29	\$183.09	-\$0.10	-0.1%

The Protecting Medicare and American Farmers from Sequester Cuts Act was signed into law on December 10, 2021. This law addresses the reduction in the 2022 Conversion Factor set by the Physician Final Rule, as reported in my December column, increasing the 2022 Conversion Factor by 3%. The new conversion factor becomes \$34.61 compared to \$34.89 in 2021. With the increase in Relative Value Units on most E/M codes, the impact to 2022 rates becomes minimal. (See **Table 1**.)

Without this action by Congress, we would have seen an average reduction in allowables of 3%. The Act also extended the moratorium on the 2% Medicare sequestration cut to March 31, 2022 and reduces the cut to 1% from April 1, 2022 through June 30, 2022.

### New Codes

At the very end of last year, the Centers for Medicare & Medicaid Services added a new Place of Service. New POS 10 is for Telehealth Provided in Patient's Home. The description for POS 02 has been revised to Telehealth Provided Other than in Patient's Home. The new POS will not be available for use until April 1, 2022.

The POS Workgroup created this code, though Medicare has stated that they do not have a use for it. While they will accept it for claims processing because that is required under HIPAA, providers should continue to use the current Medicare billing instructions for telehealth claims.



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

Finally, new modifier 93 (*Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system*) became effective January 1, 2022. This would be used for those payers that want phone calls billed with an E/M code instead of CPT's time-based codes 99441-99443.

There is no payer guidance around the use of this new POS or modifier. While I will continue to monitor responses from private payers, I would not change your current telehealth billing practices until guidance is received from private payers.

Three new ICD-10 codes were also added:

- Z28.310 Unvaccinated for COVID-19
- Z28.311 Partially vaccinated for COVID-19
- Z28.39 Other under-immunization status

Code Z18.310 is assigned when the patient has not received at least one dose of a COVID-19 vaccine. Code Z28.311 may be assigned when the patient has received at least one dose of a multidose COVID-19 vaccine regimen but has not received the full set of doses necessary to meet the Centers for Disease Control and Prevention definition of "fully vaccinated" at the time of the encounter. These new codes should not be used until April 1, 2022.

### Reminders

CMS has increased the allowable to administer influenza, pneumococcal, and hepatitis B virus vaccines to \$30 from an average rate of \$17.63 in 2021. This is for codes G0008 (influenza), G0009 (pneumococcal), and G0010 (hepatitis B). The amount is subject to a geographic adjustment.

Hopefully, private payers will follow their example. I suggest you check your charge amounts as payers adjudicate on the lesser of your charge amount or their allowable. ■

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## In Spite of Turbulence, the Forecast Is Sunny for the Urgent Care Market

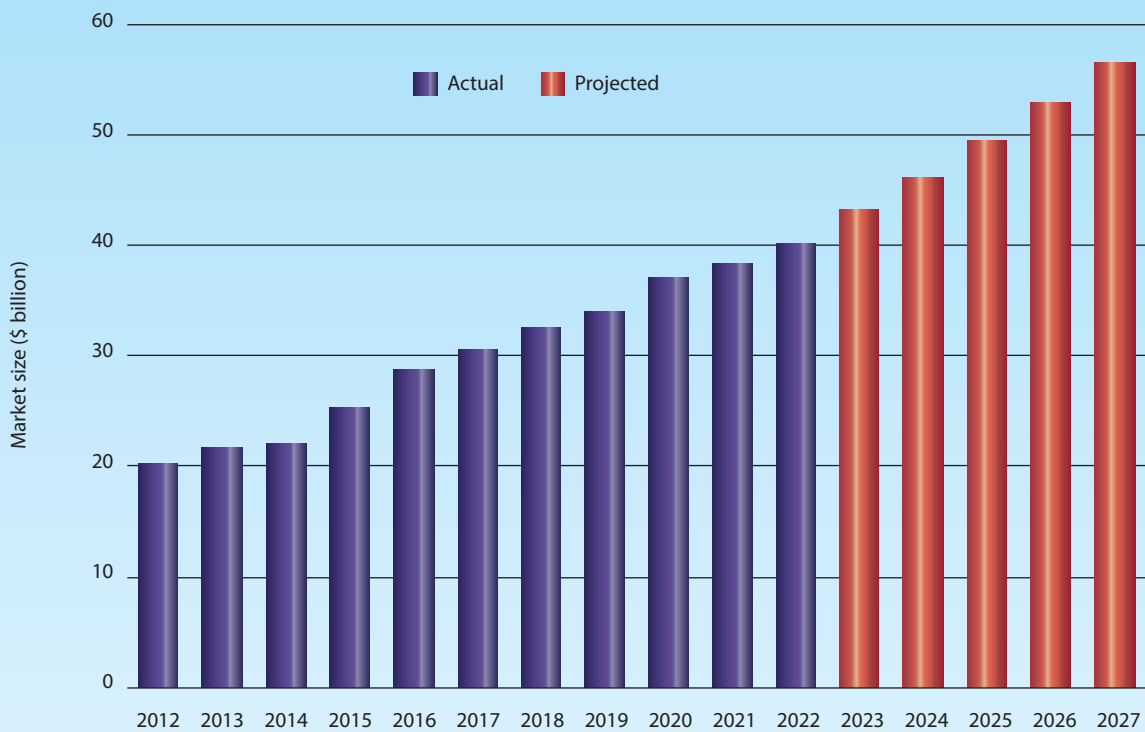
No one would argue that the past 2 years have been easy for urgent care. First many operations were shut out of the running to receive adequate COVID-19 testing supplies. The same occurred in the early days after vaccine approval.

Still, the industry adapted. Once testing supplies were available, operators established new procedures to maximize the number of patients who could get tested safely and efficiently, whether that meant setting up in parking lots or selecting strategically situated centers as testing-only locations (or ded-

icated to helping patients with non-COVID complaints).

Ultimately, through patience and perseverance, things started to turn around—so much so that the international market research firm IBISWorld predicts that the urgent care market will continue its longstanding period of growth, at a clip of 6.9% annually for the next 5 years, in fact. Check out the graph below to get a better sense of where we've been and where we're heading. ■

### URGENT CARE RISING



Adapted from IBISWorld. Urgent care centers in the US – market size 2002-2027. Available at: <https://www.ibisworld.com/industry-statistics/market-size/urgent-care-centers-united-states/>. Accessed February 15, 2022.



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