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Extend the Differential for Back Pain Diagnoses Beyond the Back

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It's Time to Think Differently about Follow-up



In the macro and “dot phrase” era, there are many refrains that appear in the electronic medical record (EMR) with such regularity that we don’t even notice them anymore. Statements like *All questions were answered prior to discharge*,

The patient verbalizes understanding and is comfortable with the plan, and *Symptomatic care and over-the-counter treatments discussed* are so commonly tacked onto charts that our eyes have been trained to gloss over them.

When was the last time one of these statements rose to a meaningful level of consciousness for you?

Such comments do not add much (if any) value for communicating the course of care or our thought processes with other healthcare personnel. Rather, they’re inserted because, like a seatbelt on an airplane, they offer a modicum of comfort and (mostly) an illusion of protection. We sleep a little easier knowing that such phrases reside at the end of our notes because we believe that, should we ever have the misfortune to learn our chart is under the scrutiny of a plaintiff’s attorney, they’ll keep us safe from litigation.

Other than contributing to “note bloat”—a significant, but largely unavoidable nuisance of modern medicine—these overly general, protective statements are mostly harmless. However, when templated, generic instructions infiltrate our patients’ follow-up plan and aftercare instructions, their effects can become decidedly more pernicious.

The most common example of this lies in the instructions and timeline recommended for ongoing care after the patient is discharged from clinic. “Follow-up with your primary care provider (PCP) in 2-3 days,” is the mantra I’ve seen appear with the greatest frequency.

This recommendation may soothe us because it’s concise, expedient to include (it’s usually just part of a template), and theoretically protective. The issue is that it’s rarely practical within the confines of the current U.S. healthcare landscape and, even if achievable, it would almost always be bad medical advice. What’s most unfortunate, though, is that many patients actually still trust us and, therefore, take this recommendation seriously.

On initial appraisal, this statement may seem perfectly

appropriate. After all, it does cover the important aspects of a good follow-up plan in that it is both time-specific and action-specific. “Follow-up with your PCP in 2-3 days.” It tells the patient who to see and when. This makes the advice more actionable than the still-oft used “Follow-up with your PCP” or highly enigmatic “Return if worse.” The vagueness of these statements renders them nonspecific to the point of meaninglessness. But, the perniciousness of directing patients precisely towards a 2–3-day primary care revisit lies mostly in the fact that it is just specific enough to be taken seriously, while simultaneously being highly impractical and medically inappropriate most of the time.

Let’s begin with the impracticality aspect because it’s most obvious.

In a bygone era, before smartphones and DVRs, most Americans had a primary care doctor. They knew their doctor and their doctor knew them. Their doctor could be reached by phone (and even appreciated the call) when their patient came to urgent care in the evening hours. If their patient came in over the weekend, the PCP would make time to see them on Monday morning.

Things are different now. The most recent study addressing the topic found that 25% of U.S. adults did not even have a PCP.¹ However, this paper examined data from 2015, and personal experience from anyone providing episodic care in the post-COVID age would suggest that this figure is almost certainly considerably higher. Furthermore, this study didn’t delve into the quality of patient-PCP relationships, and I’ve certainly found that the proportion of patients with nominal PCPs whom they’ve never met seems to be growing rapidly and continuously.

In recent years, largely due to secondary effects of the pandemic, the rates of healthcare providers leaving medicine have risen sharply. In 2020-21 alone, 30% of U.S. medical personnel left their positions.² In fact, 117,000 doctors—nearly 15% of the U.S. physician workforce—left their jobs in 2021.³ An additional 20% of American healthcare workers, according to a survey published in the Mayo Clinic Proceedings in 2021, stated that they intended to leave their current employer.⁴ This is the so-called “Great Resignation” and, if you haven’t been part of it, you’ve

“Asking a patient to return before the time of expected natural resolution does nothing but increase the collective frustration of all parties.”

undoubtedly felt its effects—and so have our patients. I see multiple patients each shift presenting with requests for refills of long-term medications for conditions like high blood pressure and hypothyroidism because their PCP has retired or moved on. The waitlist to see a new PCP in my healthcare system is currently longer than 6 months. I’d wager that your experience is similar. And with 45% of physicians aged 55 and older, this problem is unlikely to improve anytime soon.⁵

Furthermore, this turnover creates illusory PCP-patient relationships even for the patients who have one. I hear story after story of patients waiting weeks or months to be seen at their primary care clinic only to be greeted by a new or cross-covering provider who they’ve never met.

In essence, the foundation of primary care—continuity in clinician-patient relationship—has largely gone the way of the 8-track and cassette tape. So, not only is it laughable to imagine currently that most patients can be seen by a PCP they know within 2-3 days, but asking patients to even try suggests we are oblivious to the current crisis affecting the U.S. healthcare system. Proposing that a patient attempt this Herculean task simply furthers frustrations and disillusionment with the entire medical establishment.

More importantly, with the knowledge of the accessibility crisis, it’s worth being honest with ourselves about how many (or rather, how few) of our patients actually *need* follow-up within this time frame, if at all.

When pondering this question, it’s worthwhile to consider why we have patients with acute issues follow up in the first place. As a guiding principle, the timeline for re-checks for acute problems should be guided by the natural history of whatever concerning conditions remain in our differential diagnosis at the time of discharge. This should be coupled with consideration for the relative likelihood of these disease entities (which hopefully is low if we are discharging the patient), as well as the consequences of these diagnoses, if missed, for the patient’s morbidity and mortality.

To unpack this, let’s consider a few everyday examples.

When we evaluate a child with vomiting, we (hopefully) realize that, while it’s almost always gastroenteritis, a small fraction of these children may be vomiting as an early manifestation of appendicitis. The natural history of gastroenteritis, however, is spontaneous recovery over several days. For the cases in which this pattern of recovery

unfolds as expected, why would we compel an exhausted parent to take more time off work and take their now recovered child out of school again to see a pediatrician? Keep in mind the pediatrician is likely struggling to find time to keep up with their essential role as a PCP for their patient panel. The parent, child, pediatrician, and the pediatrician’s other patients are all adversely affected if this recommendation is followed.

Conversely, the natural history of appendicitis involves a relatively rapid progression towards rupture, which then proceeds to peritonitis, sepsis, and death. Beginning at 36 hours after symptom onset, the risk of rupture increases by around 5% every 12 hours.⁶ So, if we are telling parents to get rechecked in 3 days and it turns out that their child has appendicitis, we are telling them to wait until it may be too late.

In neither of these hypothetical cases does mandatory follow-up in 2-3 days serve the patient or the subsequent clinician.

Another common example where this advice is problematic can be seen in the follow-up recommendations for most simple orthopedic injuries, such as knee and ankle sprains. These tend to improve over weeks-to-months in most patients without treatment. Occasionally, however, they don’t improve, and patients do require advanced imaging, physical therapy, or even surgery. However, if a patient shows up at their PCP’s office 48 hours after being seen in UC for a knee sprain, not much will have changed and it will still be far too early in the natural history of recovery to determine if the patient is going to need specialist attention or an MRI. If such a visit does miraculously occur, several things tend to happen, and none of them represent high-value or high-quality care.

First, the patient is likely to expect something more to be done (eg, orthopedics referral, prescription analgesics, etc.). Secondly, the PCP is likely to believe that the patient is expecting something more to be done (even if they’re not). If either of these conditions is true, then unnecessary and potentially harmful testing or treatment is a likely result. After all, it’s hard to improve on quality or value by doing more for patients with self-limited conditions.

Perhaps the most common, and consequently frustrating, example of unnecessary short-term follow-up concerns the case of a lingering upper respiratory infection (URI).

It probably won’t be hard for you to remember a time when this happened to you: a patient who was seen by a colleague for 4-5 days of cold symptoms returns 2 days later because they’re “still coughing.” This can occur simply because the patient has unrealistic expectations or didn’t get the antibiotic they thought they needed at the first visit. However, more often, patients return because the

provider who saw them initially recommended a recheck in several days and the frustrated, still-ill patient simply followed their advice.

The natural history for URIs, which we are all hopefully intimately familiar with, involves at least 2 to 3 weeks of cough in many cases.⁷ Asking a patient to return for re-evaluation before the time of expected natural resolution does nothing but increase the collective frustration of all parties and further crowd clinics with cases of contagious disease.

Now, I'm not dismissing the value of follow-up care entirely; it certainly is appropriate and necessary in the right context. When considering chronic disease care (think diabetes and blood pressure management), regular follow-up with some specific cadence is critical. This is because these are long-term, if not lifelong, conditions and patients usually are treated with an indefinite regimen of daily medications. For example, patients with refractory hypertension and diabetes who are being treated with an ACE-inhibitor and insulin should be regularly reviewing blood glucose and blood pressure logs with their provider and having labs like renal function and hemoglobin A1c checked on a scheduled basis to evaluate the effectiveness and tolerability of treatment.

Compare this with the acute, episodic care of mostly self-limited conditions that we deliver in UC. Patients usually present to UC because of a minor injury or new symptoms. In doing so, they've demonstrated that they're comfortable seeking out care if they have health concerns. Therefore, since we know they're reliable, it makes the most sense to simply ask them to return or go to the emergency department if things don't proceed according to the expected natural history of the condition we've diagnosed. As long as our instructions are time-specific and action-specific (eg, return here or go to the ED immediately) and we communicate diagnostic uncertainty and the possibility of things not going as planned, these statements offer the most practical guidance.

As a general rule, a good framework for provisional follow-up instructions should take the form of "if/then" statements. For a URI, this may be something like, "I believe you have a viral URI. Recovery commonly takes up to 3 weeks. If your symptoms persist longer than this, return to UC or see your PCP for further evaluation. If you develop shortness of breath, fevers >101°F, pass out, or have other new or significantly worsening symptoms, then seek care immediately in the emergency department." Adding "If you think you're having an emergency then call 911" doesn't hurt either and, while trite, is much better advice than telling a patient with a back strain or sore throat to see their PCP in 2-3 days.

As a final note, it's worth mentioning that there are certainly some cases where short-term, mandatory follow-up is highly advisable, if not obligatory. Occasionally, it's because patients need specific procedures like casting or suture removal. There are also higher-risk conditions, like chest pain and serious hand injuries, where close/rapid specialist follow-up is protective for both the patient and ourselves. This group, however, is a small minority of the patients we see.

In most situations, we are sparing patients, PCPs, and our colleagues the stress and risks of likely unnecessary care by foregoing mandatory, short-term follow-up recommendations for most acute issues we see in UC.

This is especially true in the wake of the pandemic and consequent healthcare access crisis. In fact, putting this advice in the EMR and communicating it to patients furthers frustrations and the other issues perpetuating the crisis.

Our patients have proven that they know how to access care if they feel the need by virtue of simply showing up in our UC centers in the first place. So when we discharge them, let's give them practical and personalized guidance about where and when they should be seen next. This fosters trust and appreciation, which are far more protective than whatever impersonal and generic follow-up recommendations we might be tempted to plaster on the bottom of our discharge instructions. ■



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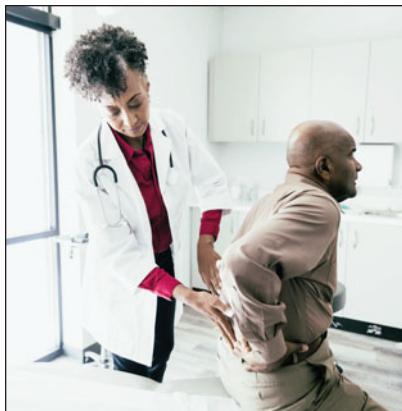
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CLINICAL

13 Back Pain, an Urgent Care Visit— and a Devastating Outcome

As self-evident as it may sound, you only get one chance to get your documentation correct. If you don't, an adverse outcome could have devastating consequences not just for the patient, but also for the provider and the entire urgent care operation.

Lyndsie Pfeifer, DO; Marta Fratzcak, Kinkela Harkins, and Michael Weinstock, MD

CASE REPORT

19 No Butts About it: Approaching Anorectal Abscesses in the Urgent Care Center



Anorectal abscesses carry a high risk for systemic involvement. Maximizing the prospect for a positive outcome begins with a thorough assessment and understanding of risk factors by the urgent care provider.

Cameron W. Galbreath, MSN, FNP-C and Christina Gardner, DHSc, MBA, PA-C

HEALTH LAW

34 Are Urgent Care Providers Liable if They Don't Test Patients for COVID?



Whether due to pandemic fatigue or over-reliance on reports that newer strains of SARS-CoV-2 are less severe than others, some providers and patients have become less vigilant about COVID-19. Are there legal ramifications for failing to test for the virus, though?

Alan Ayers, MBA, MAcc

IN THE JUNE ISSUE OF JUCM

Providing proper care in the urgent care center is only half of the battle. As the medical record grows in prominence, so, too does the importance of accurate, thorough charting. It is essential to recognize how your documentation may appear to the many different parties who could view those records, such as colleagues providing care—or a judge and jury in a courtroom. Professionalism and competence are the bare minimum requirements, as explained in Six Tips to Bulletproof Your Chart: Lessons from the Exam Room and the Court Room next month in *JUCM*.

PRACTICE MANAGEMENT

31 The X-Waiver Is No More: What This Means for Urgent Care



The recently passed Mainstreaming Addiction Treatment Act could give any urgent care provider with a standard DEA controlled-medication license the authority to prescribe buprenorphine. A good measure of preparedness is advised.

Alan Ayers, MBA, MAcc

ORIGINAL RESEARCH

39 Assessing Urgent Care Clinics' Readiness to Manage a Lip Laceration



It may be surprising to learn that some operators discourage patients with lip lacerations from seeking care in their urgent care centers. The solution to this problem, a hallmark of acuity degradation, lies within the reasons they give for doing so, however.

David T. Ford, MD; Patrick M. O'Malley, MD; and Brantley Dick, MD

DEPARTMENTS

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If *JUCM*'s own proprietary research is any indication, for every 100 patients who walk through your door, one or two will be there with a primary complaint of back pain. Based on your experience and what you've read, depending on how the patient describes their pain, your mind might go to lumbar strain, trauma, or a disk problem. At the other end of the spectrum, various cancers or inflammatory bowel disease could be the issue.

If your mind *didn't* lead you to consider acute coronary syndrome, you're not alone—but it's possible that such an oversight could have led to a catastrophic outcome, as was the case with an actual patient described in this issue's cover article. In Back Pain, an Urgent Care Visit—and a Devastating Outcome (page 13), authors **Lyndsie Pfeifer, DO, Marta Fraczak, Kinkela Harkins, and Michael Weinstock, MD** reveal not only red flags that could have hinted at the actual cause of the patient's symptoms, but also elements of the documentation that could prove essential in legal proceedings likely to occur when a life-threatening diagnosis is missed.

Drs. Pfeifer and Weinstock are colleagues at Adena Health System, with Dr. Weinstock also affiliated with The Ohio State University Department of Emergency Medicine, the Ohio Dominican University Physician Assistant Studies Program, and *JUCM*. Ms. Fraczak and Ms. Harkins are at the Ohio University Heritage College of Osteopathic Medicine.

Potential liability can result not only from diagnoses that are missed, but also from missed opportunities to pursue diagnosis with the appropriate, available tools. The question posed in this month's health law article is, Are Urgent Care Providers Liable if They Don't Test Patients for COVID? The answer can be found starting on page 34. We appreciate the efforts of **Alan A. Ayers, MBA, MAcc**, president of Experity Consulting and senior editor, practice management for *JUCM* to explain the nuances.

Mr. Ayers also employed his expertise in delving into the urgent care implications of removal of federal caps that pave the way for any healthcare provider with a standard DEA controlled-medicine license to prescribe buprenorphine. The X-Waiver Is No More: What This Means for Urgent Care starts on page 31.

An urgent care provider's expertise should include the ability to repair lacerations of the lip. Unfortunately, however, some urgent care operators are likely to defer patients who present with lacerations as a matter of course. We know this because that's exactly what the authors of Assessing Urgent Care Clinics' Readiness to Manage a Lip Laceration (page 39) found when they called up 100 urgent

care centers posing as a hypothetical patient. As **David T. Ford, MD; Patrick M. O'Malley, MD; and Brantley Dick, MD** point out, however, awareness of this issue presents an opportunity to continue the fight against acuity degradation in our industry.

Drs. Ford and Dick are affiliated with Prisma Health Richland/University of South Carolina School of Medicine – Department of Emergency Medicine and Dr. O'Malley with Newberry County Memorial Hospital.

When patients present with what is ultimately identified as anorectal abscesses, the essential task for the urgent care provider is to identify risk factors that could be red flags for systemic involvement and fistula development. **Cameron W. Galbreath, MSN, FNP-C** and **Christina Gardner, DHSc, MBA, PA-C** describe such a case in No Butts About it: Approaching Anorectal Abscesses in the Urgent Care Center (page 19). The authors are both affiliated with VelocityCare; Dr. Gardner is also director, Carilion Clinic Advanced ACP Fellowship in Urgent Care and Rural Health, and the Carilion Department of Family and Community Medicine ACP Liaison.

With COVID-19 no longer the extreme threat it was at the height of the pandemic, regulations put in place in an attempt to protect the public are no longer necessary. So, some are being allowed to expire. While this clearly is a good sign, there could be pitfalls in the "new normal" for urgent care providers. **Monte Sandler** addresses some of them in End of the Public Health Emergency: What's Next?, starting on page 50. Mr. Sandler is chief operating officer for Experity.

Finally, **Ivan Koay MBChB, MRCS, FRNZCUC, MD** again clues us in on urgent care-relevant articles that have been published in other journals recently. In this month's Abstracts in Urgent Care (page 25), he presents highlights of papers on testicular torsion, preventing RSV in young patients, lactational mastitis, cephalexin in cellulitis, understanding pain in children, and post-COVID smell dysfunction. Dr. Koay is an urgent care physician and medical lead, Kings College Hospital Urgent Treatment Centre, London, UK; convenor faculty na hÉireann and United Kingdom Royal New Zealand College of Urgent Care; and Independent Assessor, European Reference Network, Andalusian Agency for Healthcare Quality. ■

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The Best Time to Plant a Tree

■ LOU ELLEN HORWITZ, MA

Urgent Care is definitely ready to start Driving Change again. The pandemic taught us how to be in crisis-response mode all day every day, to roll with wave after wave after wave of external changes, to constantly pivot and adapt, to maintain a furious pace because our communities needed us to. It also diminished opportunities to improve other skills—longer-term thinking, broader-scope planning, finer-tuning on quality improvement, better team development, and deeper understanding of where Urgent Care should be going.

If we want to get back to Driving Change—we have to get all of those skills back. Everyone we got to talk to at the Urgent Care Convention last month is more than ready to get out of response mode and back behind the wheel, and so are all of us in the UCA family who support you.

I mentioned in April's column that we have hired McDermott+ as our lobbying firm and I am pleased to say that not only is our strategy mapped out, but it aligns overall with UCA's strategic plan, so the path is laid for all of our efforts to be in concert. UCA's core purpose is to ensure the advancement and long-term success of Urgent Care, so I'd like to spend this column sharing how we are working on the latter half.

We are starting our lobbying strategy at the federal level, with CMS and Place of Service 20. It's not the flashiest of starting points, but it *is* where all of the payment structures specific to Urgent Care in the United States begin—so that's where we will begin. Take a look at the current definition of POS 20. It's extremely deficient in reflecting the full capabilities of Urgent Care, and makes us look not-at-all-special compared to a regular provider office or even a retail clinic. It's hard to argue that certain providers should get paid more appropriately to their scope of service when you can't even show what that scope is.

The other reason we are starting here is that ultimately



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

“Make sure everyone knows the full extent of what Urgent Care is capable of!”

payment systems are mechanical things. Somewhere a machine has to look at a fee schedule that is built following certain rules and say, “We pay this provider based on this rule.” Passionate arguments may work for some of our members some of the time, but if we want to change this on a national scale (and we do) we have to do better than just negotiation. We have to change the rules.

Changing the rules means first defining who the new rules will apply to, so the rules can be written properly for that group. So that's where we begin...but do know that the ultimate goal *is* for us to have our own codes with fee schedules that are appropriate to the contributions we've been making to healthcare for two plus decades.

As our team begins to work, we may have to adjust our approach. There are many things that influence when and how and whether things get done at this level. We are happy to have McDermott+ working for us and appreciate all the contributions through your membership or contributions to the \$100 for \$1 Million campaign (which is open until we get to \$1M!) that have made it possible to hire a firm of this caliber.

While we work on the elements of this federal strategy, you also have a role, and that is to *positively connect* with the lawmakers and societies and healthcare coalitions and community groups and media (social and traditional) in your local and state areas. Invite them to your centers for a tour and photo-op. Make sure *everyone* knows the full extent of what Urgent Care is capable of (stage that photo-op in your x-ray room or lab!). Then, someday, when something lands on their desk that can go toward the good of Urgent Care or to our harm, they will choose the good.

There's a Chinese proverb that suits this moment for all of us: “The best time to plant a tree was 20 years ago. The second best time is now.” Did you start building relationships with your state and local and federal leaders in 2003? Let's not kick ourselves in 2043. ■



CONTINUING MEDICAL EDUCATION

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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
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Member reported no financial interest relevant to this activity.

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Member reported no financial interest relevant to this activity.

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Member reported no financial interest relevant to this activity.

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Member reported no financial interest relevant to this activity.

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Back Pain, an Urgent Care Visit—and a Devastating Outcome (page 13)

1. In a patient presenting with back pain, physical exam documentation should include:

- a. Palpation
- b. Percussion for CVA tenderness
- c. Inspection
- d. All of the above

2. Which of the following is considered a nonmechanical cause of low back pain?

- a. Renal cell neoplasia
- b. Muscular strain
- c. Discitis
- d. Herniated disc

3. Which of the following is a nonclassic presentation of acute coronary syndrome?

- a. Arm pain
- b. Epigastric pain
- c. Back pain
- d. All of the above

No Butts About It: Approaching Anorectal Abscesses in the Urgent Care Center (page 19)

1. What percentage of patients with Crohn’s disease will spontaneously develop a pelvic or abdominal abscess at some point in their illness?

- a. Up to 5%
- b. Up to 30%
- c. Up to 45%
- d. Up to 50%

2. Which of the following is a common risk factor for anorectal abscess?

- a. Sexually transmitted infection
- b. Medications
- c. Obesity
- d. All of the above

3. If intravenous antibiotic monotherapy is deemed appropriate for a patient with anorectal abscess, which of the following would be the most likely

choice?

- a. Ampicillin/sulbactam
- b. Ciprofloxacin
- c. Clindamycin
- d. Metronidazole

Are Urgent Care Providers Liable if They Don’t Test Patients for COVID? (page 34)

1. The Centers for Disease Control and Prevention has estimated that what percentage of Americans 16 and older have acquired some level of immunity against COVID-19?

- a. 56%
- b. 68%
- c. 80%
- d. 95%

2. The intent of the Coronavirus Aid, Relief and Economic Security Act (CARES Act) was to provide additional federal liability protections for which of the following during the COVID-19 emergency response?

- a. Public health facilities
- b. Office-based physician practices
- c. All licensed healthcare providers
- d. Volunteer healthcare professionals

3. Under the 2005 Public Readiness and Emergency Preparedness (PREP) Act, the Secretary of Health and Human Services has the authority to grant immunity from liability to which of the following “for loss covered by, arising out of, relating to, or resulting from the administration to or the use by an individual of a covered countermeasure” during a declared disease-related public health emergency?

- a. Any nonvolunteer healthcare professional
- b. A qualified person who prescribes, administers, or dispenses such countermeasures
- c. Any nonphysician acting on the orders of a supervising physician
- d. Physicians following accepted guidelines for treatment

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Back Pain, an Urgent Care Visit—and a Devastating Outcome

Urgent message: By the time an adverse outcome occurs in the urgent care center, it's too late to go back and ensure the documentation reflects the care the patient received.

Lyndsie Pfeifer, DO; Marta Fratzcak, Kinkela Harkins, and Michael Weinstock, MD

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Key words: back pain, documentation

Introduction

It's easy to let our guard down when it comes to common complaints, such as back pain. Conversely, sometimes we complete a thorough evaluation—but our excellent data-gathering is not reflected in the documentation.

Discussion of the evaluation and documentation of patients with back pain is framed around the following case, with actual documentation reflected below.

The Patient's Story

A 42-year-old man sees his luck begin to turn when he is granted permission to immigrate to America. Having escaped the hardships of war and endured 8 months in a Somali refugee camp, Mohammed is ready to start his journey toward a new and improved life.

In America, he succeeds in finding a job at a distribution center, securing a yearly salary, health benefits, and a newfound sense of accomplishment. In spite of settling into a better life, however, old habits and hobbies begin to return, including playing soccer and, unfortunately, drug use. With increased exertion during soccer games, back pain begins to slow Mohammed down. Running on the field alongside teammates, Mo-



ammed's pain grows until he finally decides to make a visit to the urgent care clinic.¹

The Urgent Care Visit

(See **Figure 1**; this is the actual documentation of the chart.)

Differential Diagnosis of Back Pain

Back pain is a common presentation in the urgent care clinic; pain relief is often difficult to attain and finding

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the definitive cause proves to be even more elusive. In addition to common mechanical causes such as a strain, back pain can be the result of referred pain, originating from another area of the body.

A complaint-specific evaluation including a differential-based history and physical exam may shed light on serious underlying causes. The lifetime worldwide prevalence of low back pain is approximately 39%, with women 40 to 80 years of age being the highest-affected demographic group.² Problems with ligaments, muscles, and joints are often responsible for chronic back pain. The differential diagnosis can be divided into two categories: mechanical and nonmechanical.

Mechanical causes of back pain

Low back pain is due to a mechanical cause 97% of the time, with lumbar strain accounting for 70% of cases.³ Originating from simple everyday overuse to traumatic injuries, lumbar strains and sprains often present with pain worse on movement, improvement with rest, and muscle tenderness. Other causes of mechanical back pain include degenerative disk and facet disease, fol-

lowed by osteoporotic compression fractures, and spondylolisthesis; less than 1% of cases are due to traumatic fractures, congenital diseases, and spondylosis.³

Nonmechanical causes of low back pain

Nonmechanical conditions of the spine claim 1% of low back pain, with the most common condition being neoplasia.³ A broad categorization for low back pain includes hip problems, prostatitis and endometriosis, vascular disease such as an abdominal aortic aneurysm (AAA), or a systemic cause.⁴

Illnesses such as multiple myeloma, metastatic carcinoma, lymphoma and leukemia, spinal cord tumors, retroperitoneal tumors, and primary vertebral tumors account for 0.7% of nonmechanical low back pain cases. Inflammatory causes (specifically due to HLA-B27) make up 0.3% of low back pain presentations and include ankylosing spondylitis, psoriatic spondylitis, Reiter’s syndrome, inflammatory bowel disease, Scheuermann’s disease, and Paget’s disease of the bone.³

Red flags such as unexplained weight loss, immunocompromised state, intravenous drug use (IVDU), history

of cancer or trauma, and long-term glucocorticoid use are associated with serious causes of back pain.⁴ At times, pain may be referred from other areas of the body—for example, the heart or aorta—and present as back pain.

Documentation of Patients with Back Pain

In training, a common teaching is to inquire about different elements of the chief complaint. A common mnemonic is OLD CAAARS:

- O – Onset
- L – Location
- D – Duration
- C – Character
- A – Alleviating/aggravating factors
- A – Associated symptoms (eg, dyspnea, diaphoresis, nausea/vomiting)
- A – Activity at onset
- R – Radiation
- S – Severity

However, this doesn't always translate to our history-taking or documentation; sometimes, a history this extensive is unnecessary (for example, when we walk into the room and see grouped vesicles on an erythematous base in a dermatomal distribution). In a busy urgent care, inquiring about all these elements after the pathognomonic rash is visualized may be unnecessary. On the other hand, sometimes simply documenting each of these elements will be inadequate; consider a patient with a headache from carbon monoxide toxicity: we are not able to consider this problem until we gather additional documentation in a "diagnosis-specific" fashion (ie, asking about others with headache—*Yes, my children also have headaches*), when the headache occurs (worse in the morning and on weekends), and even the social history (a trailer heated with a generator located near a window).

The Front-Door, Back-Door Approach

We propose data gathering first in a symptom-based fashion; consider the chief complaint and proceed down the OLD CAAARS pathway.

Next, consider the differential and ask questions in a "diagnosis-specific" fashion to specifically exclude "can't-miss" diagnoses. In other words, before leaving the room consider serious diagnoses, and make sure adequate data have been gathered to exclude them.

In the case above, neither of these approaches was used. Almost all of documentation was either omitted or extremely vague. With cases of back pain, we should attempt to exclude life-threatening causes of back pain, while ruling in a likely diagnosis.

In our patient, the most likely diagnosis was a muscle strain; we are not paid to be "usually right," however. After the evaluation was completed and the patient discharged, life-threatening causes of back pain still included thoracic aortic dissection, pulmonary embolism, spinal cord compression from both infectious (our patient had a history of IVDU) and cancer-causing etiologies, ureteral stone, and acute coronary syndrome (ACS).

Back to Our Case: How Would the Front Door, Back Door Approach Have Helped the Clinician to an Accurate Diagnosis?

Front door (a symptom-based history):

O – Onset: Arguably, onset (the first component of the OLD CAAARS mnemonic) would have helped to either increase or decrease the suspicion of a "muscle spasm" (one of the diagnoses). If the pain started suddenly while playing soccer or with lifting/pushing/pulling then a muscular etiology would be more likely. If it started during exertion, such as when climbing the stairs or walking/jogging, then a cardiac etiology could be considered.

L - Location: If the pain was midline, then a more concerning etiology such as a spinal epidural abscess (SEA)⁵ or thoracic aortic dissection (TAD)⁶ could be considered, but if lateral at the site of a muscle, such as the trapezoid, then a more benign muscular etiology would be more likely.

D – Duration: If present for just a few days and if started with a burning/hyperesthesia feeling, consider herpes zoster. If present for years, a TAD or ACS is much less likely. Correlating the duration with the onset might help to exclude entities such as SEA, which would be more likely to manifest within several days and have a gradual onset.

C – Character: A sharp pain would make ACS less likely and increase the suspicion for musculoskeletal or pulmonary embolism (PE).

A – Alleviating/aggravating factors: Pain worse with range of motion suggests musculoskeletal, not simply from a muscle strain, but could also be from discitis, osteomyelitis, fracture (with history of trauma) or SEA.

A – Associated symptoms: A very important part of our evaluation is the question; back pain and:

Back pain and fever increase suspicion of osteomye-

litis, SEA, and pyelonephritis

Back pain and shortness of breath and/or sweating increase concern for ACS

Back pain and weight loss would increase the risk of malignancy

Back pain and history of IVDU (as was the case in our patient) increase the risk of osteomyelitis and SEA as well as pulmonary abscess and endocarditis

A – Activity at onset: Our patient played soccer, but did the pain start with a particularly rigorous kick of the soccer ball, or with the exertion of running up and down the field?

R – Radiation

Summary

Reading through the HPI again (the actual documentation from the chart) we see that almost none of these elements are explored. It is certainly hard to make a diagnosis when there are not adequate data to evaluate. With back pain, diagnosing a strain/spasm is usually right—but “usually right” is not even close to good enough for our urgent care patients!

Back door (a diagnosis-based history)

After we explore the chief complaint of back pain as above (OLD CAAARS or other memory aide), but before the patient leaves the urgent care, we need to consider which “can’t miss” diagnoses could still be occurring. Formulating this differential will help us to consider diagnoses which would not be considered simply by gathering more data on back pain. For example, we might get a lot of info on back pain, but never really consider ACS until we think about an expanded differential as the pain from coronary ischemia can certainly be referred to the back, neck, arm, and jaw. Following is a list of possible diagnoses for our patient:

1. Thoracic aortic dissection
2. Pulmonary embolism
3. Spinal epidural abscess
4. Malignancy (renal cancer or lung cancer)
5. Osteolytic lesion
6. Ureteral stone
7. Pyelonephritis
8. Pneumonia
9. Acute coronary syndrome

It does not seem as though the treating clinician considered many (or any) of these diagnoses. Not only does their history and exam lack evaluation for serious causes

of back pain, but these are not detailed in a medical decision-making (MDM) note.

The Physical Exam

The physical exam documentation should include skin findings, palpation, percussion, and range-of-motion if applicable. Because so many internal organ systems coalesce in the thorax and nervous innervation can be radiated to the back, the differential is extensive (as noted previously). Looking at the chart, we do not see that these were done—in fact, despite a chief complaint of back pain, there was not even documentation of a cursory back exam.

Medical Decision-Making

In the primary care setting, ruling out life-threatening diagnoses buys you one thing: time. Time to utilize treatment of the likely diagnosis (back strain) and to have the patient return or follow up with a primary care clinician if the symptoms do not resolve or if they change or worsen. However, when in the urgent care setting, follow-up may be less defined, and most patients are not known to the clinician, as would be the case with a primary care patient who has been receiving care for years or decades.

This is why knowledge of the life-threatening causes of back pain (differential) and how to rule them out (bedside evaluation and possibly testing) is the best way to keep patients safe; and this should be reflected in the MDM. Using the MDM as a “hard stop” can allow for consideration of serious causes before the patient leaves the urgent care; after completion of the MDM, note whether “can’t miss” causes have been considered and evaluated for and excluded to a high degree of likelihood. If not, return to the bedside for further data gathering.

For example, if a patient’s history denies any loss of ability to control bowel or bladder, and there are no gluteal or lower extremity paresthesias, it is unlikely that cauda equina syndrome is present. In a patient with back pain who does not have a fever or a history of IVDU, there is even more support that this diagnosis is unlikely and an MRI is not necessary to be done emergently.

In our patient, we lack the data or cauda equina symptoms—and he did have increased risk with history of IVDU. Unfortunately, the clinician did not explain why they thought this was not occurring. Additionally, considering the diagnosis of ACS, there is no mention of exertional pain, diaphoresis, or radiation, and there was no ECG, imaging, or other evaluation of a serious cause of pain. Whether a mental or physical list is made, the top differentials and how to rule them out are para-

mount to making a diagnosis and treating the patient.

Outcome of the Case

Two hours after his urgent care visit, Mohammed arrives at the emergency department by EMS following witnessed cardiac arrest. EMS reports police were performing CPR at the scene and the patient has been going in and out of ventricular tachycardia and pulseless electrical activity. The patient has undergone multiple defibrillations alongside multiple administrations of epinephrine, amiodarone, and atropine.

Once in the ED, CPR continues and he is intubated. After two more rounds of epinephrine and defibrillation for ventricular fibrillation, a sinus rhythm is seen and a femoral pulse is able to be palpated. Respiratory metabolic acidosis is found and treated with mechanical hyper-ventilation and sodium bicarbonate. Cardiology is consulted and the patient undergoes cardiac catheterization.

Following catheterization, he is found to have a complete occlusion of the proximal left anterior descending coronary artery. Despite rescue percutaneous intervention and drug-eluting stent placement, neurology and the intensive care unit are consulted for anoxic injury. Mohammed is later pronounced brain dead and life support is withdrawn with no palpable pulses, cardiac activity, or spontaneous respirations.¹

Discussion of Acute Coronary Syndrome and Unusual Presentations

While as few as 10% out of more than 8 million patients per year will be diagnosed with ACS after presenting to the ED with acute chest pain, it is important to include ACS in the differential.⁷

Classic cardiac chest pain is considered to be a retrosternal, left anterior chest-crushing, squeezing, tightness, or pressure accompanied by radiation to the arms, neck or jaw; diaphoresis; dyspnea; and nausea or vomiting with the pain being worsened by exertion and relieved by rest with a duration of 2 to 10 minutes for anginal pain, 10 to 30 minutes for unstable anginal pain, and greater than 30 minutes for acute myocardial infarction pain.⁸ However, this presentation is widely affected by sex, race, age, and concurrent medical conditions.⁸⁻¹⁰

Nonclassic presentations are surprisingly common, with up to 33% of ACS patients presenting without chest pain; these nonclassical complaints include chest pain lasting for seconds instead of minutes to hours or constant pains that are not relieved by rest and aggravated by exertion, burning pain described as similar to heartburn, epigastric pain, and back pain.¹¹

Additional unusual complaints are chest pain wor-

sened by specific body movements or positions, such as twisting and turning of the thorax. In stark contrast to the typical description of pressure or tightness of the chest, 22% of patients with acute myocardial infarction described their chest pain as sharp or stabbing.⁵ It is important to be aware that unusual presentations of ACS occur more frequently in patients who are genetically female, racial minorities, the elderly, diabetics, or present with altered mental status.^{10,12}

With so many factors altering the likelihood of classical symptoms, it is clear that ACS cannot be ruled out with confidence on the basis of their absence.¹³ In maintaining a high clinical suspicion for ACS with uncommon presentations, we can work toward missing fewer cases that lead to devastating consequences for patient's, and their family's, lives such as in Mohammed's story.

In summary, back pain is a very common ailment we see frequently and that can seem rather simple to diagnose and treat. As providers, we need to keep a broad differential, know the red flag warning signs, and know how to identify those in patients efficiently and accurately. Patient's lives like Mohammed depend on it. ■

(This article has been adapted from a case published in *Bouncebacks! Critical Care*. Columbus, OH: Anadem Publishing; 2021.)

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No Butts About It: Approaching Anorectal Abscesses in the Urgent Care Center

Urgent message: Given the high rate of systemic involvement in patients with anorectal abscess, it is essential for urgent care providers to identify patients with risk factors and, when indicated, ensure those patients receive incision and drainage and appropriate follow-up care.

Cameron W. Galbreath, MSN, FNP-C and Christina Gardner, DHSc, MBA, PA-C

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Key words: anorectal abscess, urgent care, escalation of care, general surgery

Abstract

A 60-year-old male presented to urgent care with a 2-day history of buttock and rectal pain. He was noted to have several risk factors for anorectal abscess with a concern for systemic involvement. He was escalated to the emergency department where an anorectal abscess was discovered on CT. He later developed a fistula, despite receiving an incision and drainage (I&D) by general surgery in the OR.

There is a high complication rate of systemic involvement and fistula development, even with appropriate treatment and follow-up. It is important for urgent care providers to readily recognize an anorectal abscess and ensure patients receive I&D and appropriate follow-up care due to these complications. This often requires escalation of care to the ED to facilitate timely general surgery consultation and treatment.

Introduction

Much of providing care in an urgent care setting involves



determining a safe and appropriate disposition for the patient. Many patients are safe to be treated and sent home with appropriate follow-up parameters. However, there will be some instances that require escalation of care to the emergency department. Anorectal abscesses or suspicion thereof are one clinical instance that should

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“If there are exam findings suspicious of an anorectal abscess, regardless of spontaneous drainage, the patient should be evaluated by general surgery due to high fistula occurrence rates.”

prompt the clinician to strongly consider escalation of care.

The goal of this case report is to help clinicians identify potential anorectal abscesses in patients and discuss the reasoning as to why escalation to the ED may be prudent. This case will cover topics such as common presentations and symptoms, risk factors, complications, and treatment of anorectal abscesses, and highlight the rationale for escalation of care.

The Case

History of Present Illness

A 60-year-old male presents to urgent care with a chief complaint of right buttock pain for 2 days. He does note pain and discomfort continuously and mentions he thinks there is a “boil” there. He denies any drainage from the area, prior history of methicillin-resistant *Staphylococcus aureus* or abscess, testicular pain, or swelling. He does have associated malaise and chills but does not report any subjective or objective fever. His pertinent past medical history includes insulin-dependent type 2 diabetes mellitus, coronary artery disease, and a current daily cigarette smoker of one pack per day. No known history of inflammatory bowel disease. Of note, his most recent A1C was 10.2 but this was last checked 12 months prior. He also reports a positive test for COVID-19 2 weeks prior and that he had episodes of diarrhea for approximately 7 days leading up to this visit. He is sexually active, in a monogamous heterosexual relationship, and denies anal penetration.

Physical Exam

BP: 139/67

Pulse: 128

Temperature: 97.6°F (36.4°C)

Respirations: 18

Height: 1.803 m (5' 11")

Weight: 91.6 kg (202 lb)

BMI: 28.17 kg/m²

SpO₂: 97%

Constitutional: He is not in acute distress. He is not diaphoretic.

Genitourinary: Erythema approximately 8 cm to the right gluteal cleft tracking to the anus. There is induration present measuring approximately 2 cm without appreciable fluctuance. It is significantly tender to palpation. Cardiac, pulmonary, gastrointestinal, neurologic, and psychiatric exams were all within normal limits.

Clinical Course

The patient was transferred to the ED for further evaluation given uncontrolled diabetes, tachycardia, diarrhea, and concern for anorectal involvement. This is supported by erythema tracking to the anus and no appreciable fluctuance on exam. Diabetes, smoking, and male gender are supporting risk factors for anorectal involvement.

As addressed throughout this writing, this patient exhibits several risk factors and a clinical presentation consistent with anorectal involvement. The presence of tachycardia, constitutional symptoms, and poorly controlled diabetes triggered concern for potential systemic involvement.

Additionally, anorectal abscesses have a high instance of complications, and a general surgery consult was deemed necessary. This is best facilitated through the emergency department given the noted additional findings.

If the clinician does not suspect systemic involvement, there are fewer risk factors present, and the patient is a well-controlled diabetic, outpatient referral to general surgery could be considered if available within 24-48 hours. This will be a very select group of patients that requires the ability and resources for close follow-up.

The clinician should not start antibiotic therapy alone without a plan for I&D.

If the abscess has already spontaneously drained, the clinician could also consider close outpatient follow-up if the patient is reliable to follow-up.

If there are exam findings suspicious of an anorectal abscess, regardless of spontaneous drainage, the patient should be evaluated by general surgery due to high fistula occurrence rates.

Initial ED Evaluation

Pertinent labs in the ED include negative blood cultures, WBC 20.7, absolute neutrophils elevated at 16.6, absolute monocytes elevated at 1.7, glucose 570, A1C 13.6, lactic acid 2.5, CRP 4.49, sedimentation rate 39, ferritin 438.7. A CT of the pelvis with contrast showed a moderate-sized cellulitis and a possible small area of fluid collection. General surgery consultation was placed and noted it was unamenable to I&D. The patient was admitted for 2 days and received IV clindamycin and transitioned to oral clindamycin at discharge. No I&D was performed due to clinical improvement. A COVID-19 rapid antigen test was completed and was positive. He did not receive any specific therapy for COVID as part of his course.

Return to ED

The patient re-presented to the ED 4 days after discharge with persistent pain and erythema. Pertinent labs include negative blood cultures, lactic acid 3.0, glucose 384, WBC 19.5 up from 18.3 compared with 5 days prior, absolute neutrophils elevated at 16.0, absolute monocytes elevated at 1.7.

At discharge 5 days prior, his absolute neutrophils were 12.9 and absolute monocytes were 1.6.

General surgery consultation was placed, the patient was admitted, and I&D in the OR was performed. He was empirically treated with cefepime, vancomycin, and metronidazole. His culture results showed two strains of *Lactobacillus* and were negative for *Neisseria gonorrhoeae*. Infectious disease was consulted and his antibiotics were narrowed to amoxicillin-clavulanic acid and doxycycline. The patient was discharged home a few days later with home health in stable condition.

Home care and complications

At his follow-up with general surgery, there was concern for an anal fistula given poor healing progress. An MRI of the pelvis with and without contrast showed a patent fistula tract from the anal verge to the skin opening, as well as a tract to the base of the scrotum with a small abscess.

The patient was referred to colorectal surgery and was scheduled for a rectal exam under anesthesia, anal placement of seton, and anal fistulotomy. However, he was followed by wound care who achieved successful wound closure while awaiting surgery. His surgery was subsequently canceled, and he obtained full healing.

The Clinical Entity

Abscesses and cellulitis are common presentations in

“Recurrence of an anorectal abscess and/or fistula is a potential complication that should be considered by the clinician and can be elucidated through a thorough review of the patient’s history.”

the urgent care setting, and many can be treated without the need of escalation of care. However, any concern for an anorectal abscess should warrant the clinician to pursue escalation of care to the emergency department.

The most common presentation of an anorectal abscess is pain in the perianal region, erythema, fluctuance, and swelling.¹ Not all of these may be present. Systemic signs such as high fever, chills, tachycardia, or leukocytosis should warrant a high suspicion for more significant involvement.

There are associated complications with anorectal abscesses that often require extensive follow-up and resources that would be outside the bounds of urgent care. Many of the risk factors discussed in this writing also contribute to the complicated clinical course that often accompanies an anorectal abscess. One study showed fistula development in 45% of participants treated with I&D.² Additionally, up to 30% of patients with Crohn’s disease will spontaneously develop a pelvic or abdominal abscess at some point in their illness.³

Etiology and Epidemiology

Anorectal abscesses occur because of infection of the anal crypt.¹ The anatomic makeup of the anal crypt makes it a susceptible area for obstruction and subsequent infection.

Additionally, the proximity to the internal and external sphincters is another important factor when considering the prevalence of fistula development.⁴

Men have a higher risk than women (2.4:1) and patients with Crohn’s disease, diabetes, and obesity also have a higher incidence.⁵

Approximately 68,000 to 96,000 cases of anorectal abscesses occur in the United States per year.⁶ The actual occurrence is likely higher given likelihood of underreporting, attributing symptoms to alternative diagnoses,

“This case is an example of how a common complaint in the UC setting can lead to some clinicians overlooking the possibility of a more serious entity and potentially performing an I&D that would best be reserved for general surgery.”

and spontaneous resolution.

Risk Factors

The most common risk factors for developing an anorectal abscess are diabetes, inflammatory bowel disease, pregnancy, sexually transmitted infection, medications such as chemotherapy, immunosuppression, foreign objects in the rectum, male gender assigned at birth, smoking, and obesity. Males are more likely to develop diabetes and more likely to smoke tobacco than females and thus more likely to have multifactorial risk components. Anal penetration is another important factor to consider.

Complications

There are several potential complications of an anorectal abscess. One third of patients will develop a fistula.³ Some studies have shown the prevalence of fistula to be as high as 50%.⁴ Many patients may already have an underlying fistula at initial presentation; it may or may not be evident on the clinical exam.

Fistula occurrence is high, even with optimal I&D technique and appropriate antibiotic therapy. The management of a fistula often requires surgical intervention and extensive follow-up with the potential for recurrence.

Sepsis is another potentially serious complication that should be considered in these patients. Many of the risk factors for developing an anorectal abscess can also contribute to the development of sepsis in the clinical course. Systemic involvement warrants a low threshold for escalation of care and can help differentiate between a simple buttock abscess and an anorectal abscess.⁴

Pain is also very common with anorectal abscesses and can be difficult to manage.

Lastly, recurrence of an anorectal abscess and/or fistula is a potential complication that should be considered by the clinician and can be elucidated through a thorough review of the patient’s history. In the case of recurrent anorectal abscesses, the clinician should consider an underlying cause such as inflammatory bowel disease.⁷

Differential Diagnosis

There are many differential diagnoses to consider. The clinical presentation may support a simple buttock abscess without anorectal involvement. Cellulitis of the buttock may develop without abscess development. A more localized cellulitis not extending to the anus and no induration would support a simple buttock abscess but does not definitively rule out anorectal involvement.

Depending on the region and season, a tick bite should also be considered with careful evaluation for erythema migrans. A recent history of being outdoors may support this.

Hemorrhoids are another common presentation and may mimic many symptoms of an anorectal abscesses, including anorectal pain. A prior history of hemorrhoids, bleeding with defecation, and clinical findings of hemorrhoids on exam help distinguish a thrombosed hemorrhoid from anorectal abscess. This highlights the importance of a rectal exam. Hemorrhoids are also not accompanied by systemic signs of infection and typically do not have purulent drainage.

Proctitis and sexually transmitted infections should also be considered. A good sexual history as well as appropriate STI testing when indicated is useful. Other considerations for proctitis include food-borne illnesses, anal penetration, and inflammatory bowel disease history that can be obtained via a thorough history.

Many of these differential diagnoses can be appropriately treated in the urgent care setting. This creates a challenge in deciding when escalation of care is appropriate. It is important to do a thorough clinical exam and have a low threshold for escalation of care with any concern for anorectal or systemic involvement.

Treatment

Treatment of an anorectal abscess will require an I&D with or without antibiotic therapy. Antibiotic therapy without I&D is not an effective treatment.⁸ There is no standardized antibiotic regimen for treatment and studies widely vary in antibiotic selection and duration.

The American Society of Colon and Rectal Surgeons recommends antibiotic therapy only in patients who have associated cellulitis, evidence of systemic involvement, or immunosuppression.⁹ However, this rec-

ommendation is given a 2B grade based on moderate-quality evidence. Additionally, most patients presenting for care will likely have one of these clinical criteria.

If antibiotics are deemed necessary, treatment should include broad-spectrum coverage with anaerobic and gram-negative coverage.

Intravenous antibiotics may be warranted if systemic symptoms are present. An intravenous regimen utilizing ampicillin/sulbactam or second-generation cephalosporin in combination with metronidazole or ciprofloxacin or clindamycin would provide appropriate coverage.

If an oral regimen is appropriate, amoxicillin-clavulanic acid or ciprofloxacin in combination with metronidazole are good options.⁴

A duration of 5 to 10 days of therapy has been shown to decrease fistula occurrence in otherwise healthy patients, although based on weaker heterogeneous evidence.¹⁰

Wound cultures are not routinely recommended but can be helpful in cases of recurrence or delayed healing.⁹

There are several I&D techniques proposed to try and minimize fistula development, but a fistula often develops or is already present regardless. This is a supporting reason for escalation of care to allow for imaging, a potential consult with general surgery, and a consult to colorectal surgery if warranted. An anorectal exam under anesthesia may also be needed if a fistula is suspected.

Conclusion

This case is an example of how a common complaint in the urgent care setting can lead to some clinicians overlooking the possibility of a more serious entity and potentially performing an I&D that would best be reserved for general surgery. Additionally, this case was not deemed necessary for I&D at initial presentation and was treated with antibiotic therapy alone. The patient re-presented for care and an I&D was done at that point. This highlights the importance of I&D in the care of these patients and the lack of efficacy of antibiotic therapy alone.

1. The focus of this writing is to help clinicians identify anorectal abscesses and recognize the high likelihood of complications in this population. Complications are common and often require extensive treatment, follow-up, and multidisciplinary resources.
2. Clinicians should have a high index of suspicion in patients with risk factors and look for these in patients presenting with a gluteal abscess or cellulitis. Systemic involvement warrants a low thresh-

hold for escalation of care and can help differentiate between a simple buttock abscess and an anorectal abscess. Clinicians should consider escalation of care to the ED when an anorectal abscess is suspected. These patients often require evaluation, treatment, and follow-up beyond the urgent care scope.

3. It can be worse than what it appears. There is not always an obvious abscess adjacent to the anus. Physical exam showed cellulitis with induration but no fluctuance and tachycardia in the case patient. The patient was afebrile both in the urgent care and the ED.
4. If this is a recurrent issue, consider underlying etiology such as undiagnosed Crohn's or ulcerative colitis.
5. Was COVID-19 a contributor? This patient reported diarrhea as his predominant symptom. Additional research would be required to fully evaluate this. ■

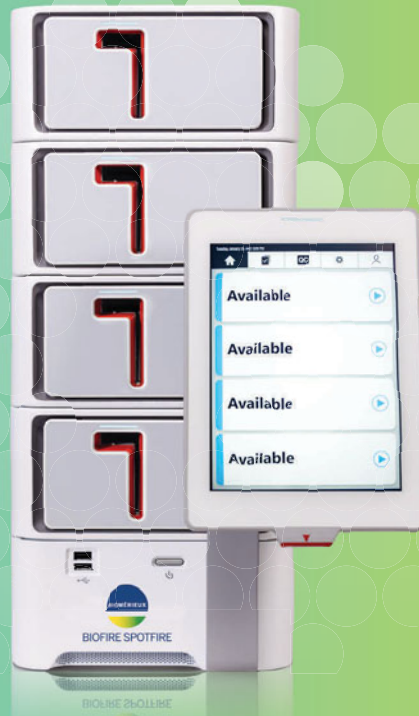
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ABSTRACTS IN URGENT CARE

- Telltale Signs of Testicular Torsion
- Preventing RSV in Young Patients
- Lactational Mastitis

■ IVAN KOAY, MBChB, FRNZCUC, MD

- Cephalexin in Cellulitis
- Understanding Pain in Children
- Post-COVID Smell Dysfunction

Does My Patient Have a Testicular Torsion?

Take-home point: Symptoms most suggestive for testicular torsion (TT) are adolescent/pubertal age, palpated hard testicle, and the presence of nausea and vomiting associated with acute scrotal pain.

Citation: Lukosiute-Urboniene A, Nekrosius D, Dekeryte I, et al. Clinical risk factors for testicular torsion and a warning against falsely reassuring ultrasound scans: a 10-year single-centre experience. *Emerg Med J.* 2023;40:134–139.

Relevance: As symptoms of TT can be mimicked by other causes of acute scrotal syndrome (ASS), it is important to know which characteristics are most indicative of torsion to speed up diagnosis and facilitate appropriate treatment.

Study summary: This retrospective observational study was conducted in the largest tertiary healthcare institution in Lithuania. Medical records from the ED and pediatric surgical department were used. Patients were categorized into two groups: those with TT and those with other acute scrotal syndrome causes—testicular appendage torsion (TAT), trauma, and acute epididymo-orchitis (EO).

The authors identified 555 children (0–17 years of age) with acute scrotal syndrome who were included in the study: TT 196 (35%); TAT 228 (41%); EO 97 (18%); and testicular trauma 34 (6%). TT had the highest incidence in the age group of 13–17 years (OR 8.39) while other acute

scrotal pain causes were mostly observed in the age group of 7–12 years ($p < 0.001$). Patients in the TT group more commonly presented with nausea/vomiting ($p < 0.001$), abdominal or groin pain ($p < 0.001$ and $p = 0.009$, respectively), hard testis ($p < 0.001$), and scrotal edema ($p = 0.001$). Palpable torsed testicular appendage ($p < 0.001$), blue dot sign ($p < 0.001$), and scrotal erythema ($p = 0.001$) were more frequently observed in the other ASS causes group. Ultrasound with Doppler was notably unreliable with normal testicular blood flow noted in 75 cases (41.7%) of TT. Hypoechoic zones were found more often in patients with TT diagnosis ($p < 0.001$)

Editor's comments: This study was retrospective and only examined patients <18 years of age. It is noteworthy that, among associated symptoms, nausea and vomiting were most suggestive of torsion. Additionally, scrotal ultrasound was “normal” in over 40% of cases of TT. It is important to note that ultrasound technology has improved and interpretation of US is radiologist-dependent. ■

Use of Monoclonal Antibodies to Prevent RSV Infection in Infants and Children

Take-home point: In this study, motavizumab, nirsevimab, and palivizumab were associated with substantial benefits in the prevention of respiratory syncytial virus (RSV) infection-associated morbidity.

Citation: Sun M, Lai H, Na F, et al. Monoclonal antibody for the prevention of respiratory syncytial virus in infants and children: a systematic review and network meta-analysis. *JAMA Network Open.* 2023;6(2):e230023.

Relevance: Finding effective prevention and treatment for common viral upper respiratory infections remains an on-



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“Inflammatory breast cancer is rare, but should be considered as a potential diagnosis in patients with persistent mastitis as the diagnosis may be delayed during lactation.”

going clinical challenge. This paper highlights several options for the prevention of RSV infections.

Study summary: This was a systemic review and meta-analysis following the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) reporting guidelines. Eligible studies were identified from the PubMed, Embase, CENTRAL, and ClinicalTrials.gov databases. The review focused on the use of monoclonal antibodies (mAbs) and the prevention of various clinical outcomes, including all-cause mortality, rate and duration of RSV-related hospitalization, rate of RSV infection, drug-related adverse events, duration of intensive care unit admission, use of supplemental oxygen, and use of mechanical ventilation (MV) use.

The authors included 15 randomized controlled trials (RCTs), involving 18,395 participants with a mean age of 4 months in the meta-analysis. They found moderate-to-high certainty that motavizumab, nirsevimab, and palivizumab were associated with reducing the rate of RSV and RSV-related hospitalizations compared with placebo. Motavizumab and palivizumab were associated with reduced risk of ICU admission. There was no significant difference in all-cause mortality or adverse drug-related events.

Editor’s comments: There were insufficient data to perform subgroup analyses for individual comorbidities (eg, bronchopulmonary dysplasia, congenital heart disease, or chronic lung disease). No change in overall mortality was seen, which is not unexpected given the effectiveness of supportive care; however, for high-risk infants, mAbs may hold promise in preventing serious illness and hospitalization.

It is unlikely these treatments will be available in the urgent care setting; however, it would be worth informing the parents of infants with cardiopulmonary disease of these treatments during RSV season. ■

An Evidence Review of Lactational Mastitis

Take-home point: Use of over-the-counter nonsteroidal and analgesic medications can reduce antibiotic overuse and improve outcomes for women who are breastfeeding and their children.

Citation: Louis-Jacques A, Berwick M, Mitchell K. Risk factors, symptoms, and treatment of lactational mastitis. *JAMA*. 2023;;329(7):588-589.

Relevance: Breastfeeding is associated with better health outcomes for both mother and child. Improved understanding of lactational physiology has led to change in guidelines regarding the management of mastitis with a growing emphasis on conservative and nonpharmaceutical interventions.

Study summary: This was an educational overview of lactational mastitis. The authors reviewed the anatomy and physiology of the human mammary gland, as well as the symptoms, risk factors, and treatment of mastitis in the setting of breastfeeding. Lactational mastitis may be infectious or noninfectious. Women typically present with unilateral breast pain, warmth, and erythema, which may be localized or involve the whole breast. The most common systemic symptoms of lactational mastitis are malaise (87%), fever (82%), and chills (78%).

Accumulating evidence suggests that immediate initiation of antibiotics may not be necessary for some patients. Patients eligible for a trial of conservative treatment are those with mild systemic symptoms, focal breast findings, and improvement without antibiotic therapy during a 24- to 48-hour period of observation. Conservative treatment consists of rest, continuing physiologic breastfeeding/milk expression, and over-the-counter nonsteroidal and analgesic medications. Physiologic breastfeeding consists of feeding on cue or otherwise expressing the volume of milk that the child needs. Excessive use of breast pumps can result in nipple trauma and should be avoided. Cold pack application can provide symptomatic relief and reduce edema, hyperemia, and inflammation.

Those with more severe initial presentation or who do not improve with conservative measures should be treated with antibiotics. The first-line antibiotic regimens include dicloxacillin or cephalexin for 10 to 14 days. Breastfeeding and/or milk expression is safe during treatment.

Inflammatory breast cancer is rare, but should be considered as a potential diagnosis in patients with persistent mastitis as the diagnosis may be delayed during lactation. Abscess is an additional consideration for cases that do not respond to antibiotics. Abscess is confirmed by ultrasound and treated via percutaneous drainage in most instances. Operative incision and drainage should be avoided as this can cause persistent wounds and fistulae.

Editor’s comments: This was an educational review based on available evidence. Recommendations provided are based on the authors interpretation of the materials re-

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viewed. ■

Does High-Dose Cephalexin in Cellulitis Reduce Treatment Failure?

Take-home point: High-dose cephalexin had fewer treatment failures but also was associated with higher rates of adverse effects, which were mostly minor.

Citation: Yadav K, Eagles D, Perry J, et al. High-dose cephalexin for cellulitis: a pilot randomized controlled trial. *CJEM*. 2023 Jan;25(1):22-30.

Relevance: Cellulitis treatment failure rates approach 20% with standard antibiotic regimens.

Study summary: This was a parallel arm, double-blind randomized controlled pilot trial at the Ottawa Hospital, Canada. Adult patients presenting to the ED with nonpurulent cellulitis and determined by the treating emergency physician to be eligible for outpatient management with oral antibiotics were recruited. Participants randomized to the experimental group received a 7-day prescription of cephalexin 1000 mg four times daily, while the control group received a 7-day course of cephalexin 500 mg four times daily plus oral placebo. Patients were assessed for worsening infection criteria at day 3 and day 7 follow-up.

Thirty-three participants were randomized into each study arm. Oral antibiotic treatment failure occurred in four patients (12.9%) in the standard-dose arm vs one patient (3.2%) in the high-dose arm with similar clinical response at day 3.

A greater proportion of participants had complete clinical cure at day 7 (16.1% vs 6.5%) and day 14 (45.2% vs 38.7%) in the high-dose arm vs the standard-dose arm.

A greater percentage of participants in the high-dose arm had adverse events (38.7% vs 25.8%); these were predominantly nausea/vomiting (9.7% vs 3.2%) or diarrhea (16.1% vs 6.5%). No patients stopped their antibiotic treatment due to adverse effects.

Editor's comments: This study is limited by small size and by use of a single oral antibiotic agent. It was conducted in an ED population, which would bias to more severe cases of cellulitis. It is useful to note that clinical cure was achieved in the minority of patients by 14 days despite treatment with both standard and high-dose cephalexin. Clinicians might prepare patients for the likelihood that complete resolution of skin findings by the time of antibiotic completion may not occur and does not necessarily suggest treatment failure. ■

Parents May Feel Their Child's Pain, but Do They Understand It?

Take-home point: A considerable percentage of parents hold misconceptions about how children express pain.

Citation: Escobar-Castellanos M, Míguez-Navarro M, García-Mancebo J, et al. How much do parents know about pain in their children? *Pediatr Emerg Care*. 2023;39(1):40-44.

Relevance: Adequate analgesia is important when treating pediatric patients. However, this relies on the parent's appropriate understanding of their child's pain. It would be useful to help parents to identify and correctly treat pain in their children.

Study summary: This was a descriptive, cross-sectional, single-center survey performed in the pediatric emergency department (PED) of a tertiary referral hospital in Madrid, Spain. A two-part questionnaire was administered to parents, covering demographic variables followed by 14 questions/affirmations evaluating the parents' attitudes towards pain expression and pain management in children. To study parents' knowledge of pain expression and pain management, a previously validated survey, Parental Pain Expression Perceptions (PPEP) was used.

The authors included 453 parental questionnaires. They found around half of the answers (53.2%) were correct. Many parents had misconceptions regarding how children express pain. The most common misconceptions were that "children in pain have trouble sleeping" and "children always tell their parents when they are in pain." Parents with a higher level of education obtained 1.04 more correct answers for each level of education ($\beta=1.04$; 95% CI, 0.76–1.32; $p<0.001$).

Editor's comments: The study was based in a tertiary pediatric ED in Spain, which limits generalizability. Cultural perceptions of pain were not included in the study. Educating parents about pain evaluation and encouragement of a short duration of scheduled dosing of over-the-counter analgesics in the setting of obviously painful conditions (eg, acute fractures) may reduce oligoanalgesia in children.



COVID-19 Abstract Enduring Loss of Smell with COVID-19: Is There a Solution?

Take-home point: A combination of local corticosteroids and antihistamines had a superior effect over antihistamines alone or nasal saline for the treatment of postCOVID-19 smell dysfunction.

Citation: Mohamad S, Badawi A, El-Sabaa R, et al. Study of different local treatments of post covid-19 smell dysfunction. *Iranian J Otorhinolaryngol.* 2022;34(6), Serial No.125.

Relevance: Enduring olfactory disturbances in patients with COVID-19 are common despite recovery. Treatment options to help with these symptoms are limited.

Study summary: This was a single-center, active placebo-controlled study based in Tehran, Iran. Patients were randomly assigned to one of four parallel groups in a 1:1:1:1 ratio by computer randomization. Patients received either a combination of topical corticosteroids and antihistamine nasal spray (azelastine base/fluticasone propionate) 125 µg/50 µg/25 mL actuation nasal spray (G1), topical corticosteroids (fluticasone propionate to the nasal mucosa using a metered atomizing spray pump) (G2), antihistamine (azelastine HCl nasal spray containing 125 µg of azelastine base) one puff in each nostril twice daily (G3), or 0.2% normal saline spray (one puff in each nostril every 4h) as the control group (G4).

The primary outcome evaluated was the patients' sense of smell, which was assessed using the butanol threshold

and discrimination tests. All patients were initially evaluated after their recovery from COVID-19 and were followed for 3 weeks.

The authors enrolled 240 participants and found significant improvement in the test's scores in G1 and G2 after 3 weeks of treatment. Treatment with corticosteroids in combination with antihistamines resulted in the greatest improvement (G1), followed by steroids alone (G2), antihistamines alone (G3), and finally the saline group. These differences were statistically significant in the first and third weeks. All groups exhibited improvement in olfaction during the treatment period.

Editor's comments: The study population was comprised predominantly of male participants (84%). There was no true control group (ie, no treatment), which is current practice in most settings, so it is unclear how much recovery may have been seen without any treatment. Smell dysfunction is a particularly disconcerting symptom for many patients recovering from COVID-19 and offering nasal steroids (with or without nasal antihistamine) is a low-risk intervention that may help restore olfaction. ■



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The X-Waiver Is No More: What This Means for Urgent Care

Urgent message: In December 2022, Congress passed the Mainstreaming Addiction Treatment Act, which would remove federal patient caps and allow any healthcare provider with a standard DEA controlled-medication license to prescribe buprenorphine.

Alan A. Ayers, MBA, MAcc

For over a decade, the question of whether or not to prescribe buprenorphine/naloxone (Suboxone) products in urgent care has resurfaced with regularity. With the announcement of this new legislation, I was asked by a couple of urgent care providers whether they should consider adding a medication-assisted treatment (MAT) program to their urgent care offerings.

As a bit of background, U.S. opioid-related deaths have risen sharply in recent years from approximately 20,000 in 2010 to more than 80,000 in 2021.¹ Opioid-use disorder (OUD) is a chronic disease defined by frequent relapses. Patients who receive MAT have much fewer relapses and lower mortality.²

Buprenorphine is a partial opioid agonist that exists in multiple formulations and routes of delivery (ie, buccal, transdermal, depot injection, oral tablet) and is variably combined with naloxone to reduce abuse potential.³

Data about the benefits of buprenorphine for MAT are unambiguously positive. For example, the number needed to treat (NNT) for buprenorphine/naloxone to achieve abstinence from opioids for 5 years is only three, making MAT with buprenorphine/naloxone the most medically effective therapy that exists in all of medicine.⁴

In the past, federal limitations on the number of buprenorphine/naloxone patients a provider could treat (panel) created a supply/demand imbalance, which meant that offering the service would almost guarantee patients would show up.

In 2021, the revised regulation which expanded prescribing authority to nurse practitioners and physician



assistants required 8 hours of training for a panel of 30 patients or 24 hours of training or a panel of 100 patients. Certification and good standing with DEA regulations was indicated with an “X” added to the provider’s DEA number. Activists bemoaned that these time-consuming training and registration requirements created barriers which reduced access to what could be lifesaving medications for addicts.

Prior to this announcement, my feedback to the urgent care operator considering offering this treatment would have been:

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The provision recently passed in the 2023 Consolidated Appropriations Act has entirely eliminated the X-Waiver requirement. In turn, any healthcare provider with a standard DEA controlled medication license can now prescribe buprenorphine, subject to state requirements, without any federal patient caps.

1. For an independent, physician-run, urgent care this could be a viable ancillary business— though not without challenges, including:
 - Reimbursement including billing “behavioral health” insurance or Medicaid, prior authorization, and concurrent enrollment in counselling required by some insurances (but not covered under conventional “urgent care” contracts)
 - Checking state-controlled substance registries to identify patients receiving potentially unsafe quantities and combinations of prescribed medications and abiding by other state laws, including adherence to treatment strictly according to ICD-10 diagnostic criteria for “opioid abuse disorder”
 - Urine drug testing to assure buprenorphine is not being diverted or combined with other drugs of abuse
 - First-dose observation when patients are beginning to experience opioid withdrawal
 - Willingness to work with a very complex patient population who are generally underinsured, underemployed, and have other behavioral health and social issues that complicate care
 - The fact that patients suffering from addiction and dependence often have tumultuous social situations (eg, unstable transportation, housing, employment) and comorbid mental health disorders that often complicate the plan of care
2. For a corporately owned, scaled, multisite operation, MAT could bring significant challenges in staffing, processes, oversight, and liability and thus would probably not be a good fit with the operating model.

In 2007, when running seven urgent care centers in Central Ohio—near the epicenter of the Appalachian

Crisis of prescription abuse—I was involved with setting up an MAT program. It was born when one of the urgent care doctors began offering primary care one day a week at a local inpatient drug rehabilitation facility and quickly realized the potential benefits of offering buprenorphine to this population who were affected by OUD with tragic frequency.

So, I created an LLC, submitted applications for the doctors, and launched our “rehabilitation care” service. Once we were registered on the SAMHSA (Substance Abuse and Mental Health Services) website, patients showed up in the urgent care for treatment.

Although the doctors had argued with skeptical staff that the “addicts” who they’d be treating were grandmas, nurses, and lawyers whose paths to addiction were largely accidental (eg, after receiving a short course of oxycodone following surgery), demand from the beginning was overwhelming from other patients—the more commonly stereotype of an injection heroin user. It wasn’t long before we experienced confrontations in the waiting room and front desk with the above-mentioned patient population, so we moved the MAT clinic to a discreet urban location off a bus line away from the mothers waiting with their children who regularly came to our urgent care center.

Sixteen years later, that dedicated treatment clinic in Columbus, OH still exists.

Multiple venture capital (VC) and private equity (PE)-backed groups have since established chains of similarly positioned, discreet, storefronts that advertise heavily on the web and social media. Some vendors, like construction and supply companies, that have served urgent care in the past have even become involved in building up these MAT “chains.” So, there’s even competition in this marketplace now, including from non-profit and county addiction and mental health agencies.

The addiction business, however, is not without risk. Robert Lesslie, MD of Rock Hill, SC sold his urgent care and occupational medicine centers to a national chain but continued to serve patients, including those suffering from chronic pain, in his private practice. Tragically, he and his family, as well as a repairman working in the clinic, were killed allegedly by a patient suffering from addiction who was cut-off from ongoing prescription opioids.⁵ This is an important consideration. When thinking about opening an MAT/buprenorphine service line, it’s important to also consider if you are prepared to deal with discharging or turning away patients for nonadherence, nonpayment, or disruptive and abusive behaviors.

So, when asked my opinion in light of this recent

legislative change, I would give this advice:

- Remember that urgent care is episodic. Addiction and dependence are chronic conditions
- Patients suffering from addiction frequently have complex social and psychological needs, which often results in the need for intensive care coordination
- Individuals who inject drugs have multiple comorbidities and are at risk for serious health issues such as endocarditis, spinal epidural abscess, HIV, and viral hepatitis
- While the federal law may enable prescription solely for addiction, state Medicaid managed care programs can have more specific requirements that point to a “primary care” relationship being required for MAT⁶

Therefore, despite strong evidence on the need for more access to buprenorphine/MAT and its clear benefit in mitigating rising mortality related to OUD, the decision to use urgent care as a space for an MAT service line should be pursued with caution. OUD is a chronic condition best managed with a longitudinal primary care type relationship. This certainly could include a physician-owned and operated urgent care that also provides primary care services. However, outside of this,

I would ask urgent care operators if they are up to the challenges described above when considering whether an MAT program will work within their center. ■

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Are Urgent Care Providers Liable if They Don't Test Patients for COVID?

Urgent message: As the severity of newer strains of SARS-CoV-2 has decreased, many patients and providers have become less vigilant about COVID-19. Yet COVID-19 remains among the top 10 causes of death in the U.S. Failure to diagnose and, if eligible, treat patients with COVID-19 may result in significant harm. Professional liability is less likely, however, given the current governmental protections in place.

Alan A. Ayers, MBA, MAcc

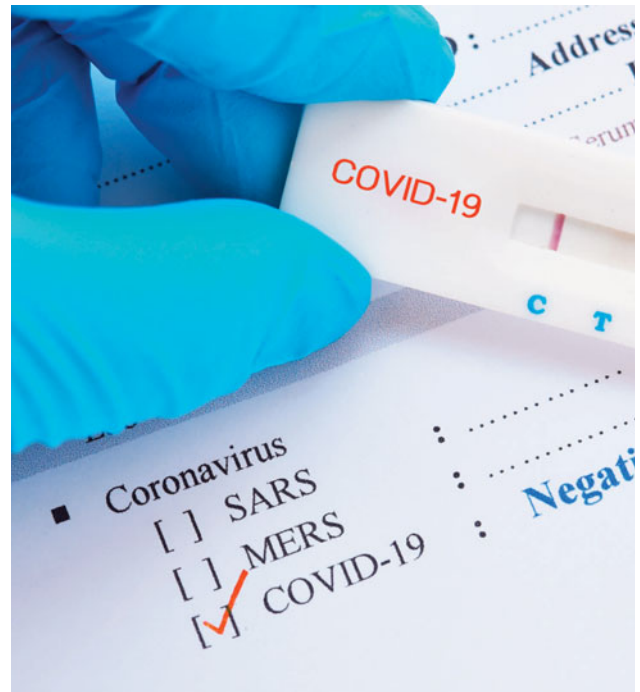
Certainly, the COVID-19 pandemic brought about changes in how we live our lives. This included times of uncertainty, modified daily routines, financial stress, and social isolation. Today in urgent care centers, visits by patients with a COVID test (symptomatic patients) or diagnosis make up less than 33% of visits, which is a decrease from roughly 2/3 in 2020.¹ Nonetheless, with these numbers, it's likely that patients may present to UC initially with an ultimately fatal COVID-19 infection.²

Urgent Care Providers Growing Complacent With COVID Testing

Anecdotally, on the Urgent Care Association listserv, many providers discuss a rising complacency among patients and other UC providers surrounding COVID testing and/or prescription of potentially indicated antiviral medications.

This falls under the umbrella of what might be termed “pandemic apathy.”³ The virus has now evolved into a less virulent form, and COVID vaccines are readily available. Add to this the fact that many of the COVID-positive patients that urgent care professionals see—including those with risk factors for serious illness—look less sick than the patients with influenza.

Another factor is that people can get free at-home kits from the government and very inexpensive test kits from any pharmacy. Every U.S. household is eligible to order four free at-home COVID-19 tests.⁴



The Centers for Disease Control and Prevention has estimated that 95% of Americans 16 and older have acquired some level of immunity against the virus.⁵ Thus, the question that arises is, what is the medical malpractice liability risk by *not* performing a COVID test if indicated?

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Discussion

Urgent care owners and operators may question their providers' duty when they know a patient is symptomatic.⁶ First, on March 27, 2020, the Coronavirus Aid, Relief and Economic Security Act (CARES Act) was signed into law. The legislation provides additional federal liability protections for volunteer healthcare professionals during the COVID-19 emergency response.⁷

While the CARES Act provision only protects volunteers, another provision for treatment offered to COVID-19 patients is found in the 2005 Public Readiness and Emergency Preparedness (PREP) Act.⁸ This law grants authority to the Secretary of Health and Human Services (HHS) to provide that a "covered person," including a qualified person who prescribes, administers, or dispenses "pandemic countermeasures," "shall be immune from suit and liability under Federal and State law with respect to all claims for loss covered by, arising out of, relating to, or resulting from the administration to or the use by an individual of a covered countermeasure" during a declared disease-related public health emergency.⁹

With that in mind, multiple states have followed suit and enacted similar laws to protect healthcare providers.^{10,11} For example, under Michigan law, a physician would not have a traditional physician-patient relationship based on ordering or conducting a screening test. There is no explicit or implicit contractual arrangement for performing COVID-19 testing, for example.¹²

The "Limited Physician-Patient Relationship"

The Michigan Supreme Court looks to have created what it terms a "limited physician-patient relationship" in *Dyer v Trachtman*.¹³ While that case concerned an independent medical examination (IME) where the examining physician aggravated the plaintiff's injury, the Supreme Court found that:

"...an IME physician has a limited physician-patient relationship with the examinee that gives rise to *limited duties* to exercise professional care....The limited relationship imposes fewer duties on the examining physician than does a traditional physician-patient relationship. But it still requires that the examiner conduct the examination in such a way as not to cause harm."¹³

And in *Paul v Glendale Neurological Associates, P.C.*,¹⁴ the Michigan Court of Appeals, citing *Dyer*, held that "...this duty does not constitute a duty to diagnose or

"In Texas, a person who in good faith administers emergency care is not liable for civil damages for an act performed during the emergency, unless the act is willfully or wantonly negligent."

treat an examinee's medical conditions."¹⁴ And while lab testing is quite distinguishable from an IME, it is difficult to contemplate a sufficient factual scenario to satisfy the elements of the medical liability standard. In that case, another state statute also provides protection for local public health officials.¹⁵

In Michigan, doctors have benefit from this precedent and the qualified immunity it creates under state law. A patient would be required to show gross negligence to overcome the immunity. This would be nearly impossible in the testing context.¹⁶ Again, under Michigan law, a physician:

"...is not liable for an injury sustained by a person by reason of those services, regardless of how or under what circumstances or by what cause those injuries are sustained. The immunity granted by this subsection does not apply in the event of an act or omission that is willful or gross negligence. If a civil action for malpractice is filed alleging an act or omission that is willful or gross negligence resulting in injuries, the services rendered that resulted in those injuries shall be judged according to the standards required of persons licensed in this state to perform those services."¹⁷

Other states have enacted similar legislation and governors have signed executive orders seeking additional protections.

In Virginia, for instance, a state statute applicable to "disasters" provides liability protection to healthcare providers during state or local emergencies, where the exigencies of the emergency "render the health care provider unable to provide the level or manner of care that otherwise would have been required in the absence of the emergency...."¹⁸ Similar to Michigan's law, immunity is not applicable to cases involving gross negligence or willful misconduct.

In Tennessee, the governor is empowered to declare through Executive Order "limited liability protection to healthcare providers, including hospitals and community mental health centers" providing care to "vic-

tims” of an emergency.¹⁹ Likewise, the protection immunity is inapplicable to claims found to involve gross negligence or willful misconduct.¹⁹

In Texas, a person who in good faith administers emergency care is not liable for civil damages for an act performed during the emergency, unless the act is willfully or wantonly negligent. However, this law does not apply to care administered for or in expectation of remuneration.²⁰

Maryland Public Safety § 14-3A-06 states that “[a] health care provider is immune from civil or criminal liability if the health care provider acts in good faith and under a catastrophic health emergency proclamation.”²¹

Kentucky provides civil immunity for care provided to a COVID-19 patient.²² The law, signed into law on March 30, 2020, states:

“A health care provider who in good faith renders care or treatment of a COVID-19 patient during the state of emergency shall have a defense to civil liability for ordinary negligence for any personal injury resulting from said care or treatment, or from any act or failure to act in providing or arranging further medical treatment, if the health care provider acts as an ordinary, reasonable, and prudent health care provider would have acted under the same or similar circumstances.”²²

Finally, Connecticut Executive Order No. 7U states:

“[I]n order to encourage maximum participation in efforts to expeditiously expand Connecticut’s health care workforce and facilities capacity, there exists a compelling state interest in affording such professionals and facilities protection against liability for good faith actions taken in the course of their significant efforts to assist in the state’s response to the current public health and civil preparedness emergency.”²³

It is clear that multiple states and the federal government have contemplated possible liability for the care of patients infected during the COVID-19 pandemic. Deciding whether to test or not test can be added by analogy if not specific statutory language.

What About Prescribing Antivirals?

Many proposed treatments have been put forth as potential therapies to limit COVID-related morbidity and mortality over the past 3 years.

“The pandemic created extraordinary conditions, and most laws and regulations reflect an attempt to provide healthcare professionals with a great deal of insulation from lawsuits when they demonstrate good faith efforts and reasonable care in their decisions to treat COVID-19.”

Currently, the most promising option for outpatient treatment of patients at risk for serious disease is nirmatrelvir/ritonavir (Paxlovid). Nirmatrelvir/ritonavir is a combination of two prescription antivirals which have been shown to reduce the risk of hospitalization and death among outpatients with COVID-19 infection.²⁴

In November 2022, the CDC reported on a real-world study that showed adults at high risk of serious outcomes who took nirmatrelvir/ritonavir within 5 days of a COVID-19 onset had an 88% lower rate of hospitalization or death than those who were not given the drug.²⁵ The drug has been authorized for emergency use by the FDA under an emergency use authorization (EUA) for the treatment of mild-to-moderate COVID-19 in outpatients aged 12 and older with positive results of direct SARS-CoV-2 viral testing, and who are at high risk for progression to severe COVID-19, including hospitalization or death.²⁵

However, the results of a 109,000-patient study may renew questions about the U.S. government’s use of nirmatrelvir/ritonavir, “which has become the go-to treatment for COVID-19 due to its at-home convenience.”²⁶

Israeli researchers found that nirmatrelvir/ritonavir reduced hospitalizations among people 65 and older by roughly 75% when given shortly after infection, which is consistent with earlier results used to authorize the drug in the U.S. and other nations.²⁷ However, people between the ages of 40 and 65 saw *no measurable benefit*, according to the analysis of medical records.²⁸

Conclusion

The pandemic created extraordinary conditions, and most laws and regulations reflect an attempt to provide healthcare professionals with a great deal of insulation from lawsuits when they demonstrate good faith efforts and reasonable care in their decisions to treat COVID-19.

A provider, weighing all factors, may point to this

evidence as well as limitations in the urgent care delivery model, such as the absence of renal function testing, as reasons not to prescribe nirmatrelvir/ritonavir to qualifying patients. Additionally, a provider would be required to review hundreds of potential medication interactions, which can also be quite time-consuming. These factors provide enough disincentive to obviate some UC clinicians from even considering antiviral prescribing in their practice.

However, COVID-19 remains a leading cause of mortality and certainly the primary condition with significant risk of short-term mortality for which patients are likely to present initially to urgent care.

If urgent care is going to play a role in mitigating COVID-related mortality, it is incumbent upon UC providers to remain vigilant in counseling, testing, and treatment among patients with risk factors for serious illness. Even if UC clinicians are shielded (temporarily at least) from liability, they are also usually best positioned to protect these vulnerable patients from the worst of possible outcomes. ■

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TAKE-HOME POINTS

- The Centers for Disease Control and Prevention has estimated that 95% of Americans 16 and older have acquired some level of immunity against COVID-19.
- The intent of the Coronavirus Aid, Relief and Economic Security Act (CARES Act) was to provide additional federal liability protections for volunteer healthcare professionals during the COVID-19 emergency response.
- Under the 2005 Public Readiness and Emergency Preparedness (PREP) Act, the Secretary of Health and Human Services has the authority to grant immunity from liability to a qualified person who prescribes, administers, or dispenses such countermeasures “for loss covered by, arising out of, relating to, or resulting from the administration to or the use by an individual of a covered countermeasure” during a declared disease-related public health emergency.
- If urgent care is going to play a role in mitigating COVID-related mortality, UC providers must remain vigilant in counseling, testing, and treating patients with risk factors for serious illness. Even if UC clinicians are shielded at least temporarily from liability, they are also usually best positioned to protect these vulnerable patients from the worst outcomes.

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Assessing Urgent Care Clinics' Readiness to Manage a Lip Laceration

Urgent message: Lacerations are a common reason for patients to present to urgent care. Data suggest not all providers are comfortable managing lacerations, however. Clinicians who need additional training should be afforded such in order to reduce acuity degradation and unnecessary referrals to the emergency room.

David T. Ford, MD; Patrick M. O'Malley, MD; and Brantley Dick, MD

Citation: Ford DT, O'Malley PM, Dick B. Urgent care clinics' readiness to manage a lip laceration. *J Urgent Care Med.* 2023;17(8):39-41.

Key words: *urgent care, laceration, research*

Abstract

Acuity degradation—generally, the practice of referring patients who theoretically could be treated in an urgent care center to an emergency room or other setting due to on-site providers' inexperience or discomfort with performing a given procedure—is a growing concern in the urgent care industry. A telephone survey was devised to assess how common it would be for an urgent care center to suggest an alternate setting to a “patient” who called to inquire about being seen for a lip laceration.

Introduction

It is common for patients to present to an urgent care clinic for assessment and treatment of lacerations. However, not all urgent care providers are comfortable managing lacerations, and patients are subsequently sent to an emergency room for repair.

A speaker at a national urgent care conference brought this issue to light when he called an urgent care center live, from the lectern, and asked if they could repair his simple laceration; he was told that they could not, and that he would “need to go to the ED.”



Image courtesy of Patrick O'Malley, MD and with patient consent.

The issue of acuity degradation is an important one that needs to be addressed. It is felt by many in the urgent care world that UC clinicians should be expected to handle straightforward lacerations.¹

One possible reason could be a pragmatic one: consider that flat-fee reimbursement may lead UC operators to refer procedures that take time and require costly medical products/devices to manage them.²

However, the inability or declination to manage simple lacerations has several ramifications. When a patient

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Table 1. Free-Text Answers from "Maybe" Respondents

- Have to come in and let the physician evaluate it
- Clinician has to look at it in order to determine
- Provider discretion, may need to see facial plastic surgeon
- If it crosses the lip line, probably won't do it, just have to look at it and see
- Would have to see it, but normally handle lacs
- Can do face, just have to see it first

presents with a simple laceration and is told that the UC clinician is unable to address their need, there is a loss of revenue, patient confidence in the clinician, and a decrease in the chance that they will return to that UCC in the future.

Over time, many UCCs have become staffed by some clinicians with less training in procedural skills. Whereas physicians who go through a residency program are required to develop a high level of procedural skills, other providers may be less likely to have the same level of training and experience. This can include both advanced-practice providers and some physicians who may not have had much experience managing lacerations during their training, as well.

When UCCs refer patients with relatively simple lacerations to the ED, this ties up staff and resources that could have been devoted to patients with truly emergent complaints. There is also a strong economic factor, as the cost of managing a laceration in the ED is higher than in a UCC.³

This survey was developed to further evaluate how frequently a hypothetical patient with a laceration would be redirected to another setting, such as an ED.

Methods

A list of UCCs in every state was obtained, with two clinics from each state randomly chosen and combined into a master list. Three physicians called each of these clinics, posing as a theoretical patient with a lip laceration, and followed a standard script: "Hi, my name is Sam. I cut my face on a door frame. I have a 1 inch cut to my upper lip and skin. Is this something that you can repair there?"

Calls were placed several hours prior to closing to ensure that impending close of day was not a factor in any decision. If the provided phone number was incorrect or disconnected, another clinic was found randomly in the database, to ensure that 100 clinics, two from each state, were contacted in order to provide a

good representation of trends across the country.

If "Sam" was told that the a given UCC could treat his laceration, he simply replied, "Thank you" and ended the conversation. If the answer was "No," he would ask if they were able to repair lacerations in general, with the hopes of gathering any additional details as to that UCC's ability in this capacity. The researcher posing as Sam also inquired about where he should go for this laceration repair. Some UCCs answered "Maybe" to the subject question, explaining that the clinician on-site would have to evaluate the wound before making a determination, so this was included as an option. Answers and free-text information were entered into a spreadsheet for analysis.

Results

Of the 100 clinics that were contacted and provided with the scenario described, 38 (38%) told our mock patient "Yes," they could handle the laceration. Seventeen clinics (17%) answered "Maybe," and 45 (45%) of the clinics said "No".

Of the 45 UCCs that said they would not do the repair, four said they do not manage lacerations at all; 42 told the mock patient to go to the ED; and two provided the name of another UCC or ED. One provided the name of another urgent care only.

Discussion and Limitations

One of the limitations of our study was that we did not inquire on any policies that a given UCC had on whether a provider was allowed to repair facial lacerations, ahead of time. We also did not break down the UCCs with regard to how many were staffed by physicians vs advanced-practice providers, or a mix of physicians and APPs.

We chose a lip laceration for our mock patient's injury as this would raise the possibility of cosmetic concern and perceived complexity because of involvement of the vermilion border of the lip. The results show that nearly half of surveyed UCCs do not feel comfortable managing what is felt by most to be a simple laceration on the face.

The free text/additional responses warrant deeper evaluation. As it is understood that the person answering the phone cannot see the injury and may not be in a clinical position, the answer was frequently expanded with them stating, "It depends, the clinician must evaluate it first in order to decide" or something similar to this. Seventeen percent of surveyed UCCs answered in this way, which the authors feel is a very reasonable response in the sense that they are at least willing to eval-

Table 2. Free-Text Responses from "No" Respondents

- Have to ask the physician, concerned about how deep it was
- Not on the face
- We do cuts on the hands, arms, and legs, but not the face
- Clinic policy that we do not do sutures on the face
- Had to go ask provider. Says they would look at it but that "they can't do it if it goes onto the lip inside the mouth because those always come undone"
- Will need a plastic surgeon, we don't touch the face
- Can do stitches but not "cosmetic"
- It's a sensitive area. Go to the ER where they have surgeons. We have a lot of new providers, PAs and NPs who aren't comfortable with suturing
- Don't feel comfortable doing the lip line or the eyebrow
- Not with it going all the way through, "go to the ER to get a good stitch job"
- Nothing on the face, will repair lacs elsewhere
- Nothing that will "leave a scar on the face"
- Aren't doing stitches right now "due to COVID"
- Can't do stitches on the neck and up
- Do not repair lacs on the face
- Won't do it if it touches the lip
- Would have to see it. Probably not, may need plastics because it "needs to come out perfect"
- Nothing on face; needs plastic surgery

uate the injury in order to make a decision. See **Table 1** for more detail.

For the clinics that said "no" the reasons given were varied, and our mock patient tried to get further statements and justifications. See **Table 2** for a list of responses provided.

It is interesting to note that many who said "no" answered this way because they felt closure required plastic surgery in the ED—likely unaware that getting a plastic surgeon to come to the emergency department to repair a simple laceration is not likely to happen, and that such a wound will be managed by an emergency physician, PA, or NP. Also, it is often unnecessary and not beneficial to have simple lacerations repaired by a plastic surgeon as this often offers no patient satisfaction benefit but does increase ED length of stay.

It should be noted that *clinic* staff who answered the call may not have been *clinical* staff, and the clinician on duty may not have been asked directly. As such, if a clinic can handle lacerations it is imperative that this vital information be passed along to those who answer

the phones so patients receive accurate information. An interesting follow-up study would consist of calling these same clinics and speaking directly to the clinician on duty to see if there is a disconnect between what the clinician can do and the information that the staff answering the phone provide.

This study raises several important questions. Should UCCs be able to handle lacerations like this? If so, why does it appear from our limited survey that so many patients are being referred away? Is it lack of communication between clinicians and staff answering the phone? Should protocols be devised whereby patient calls should be transferred directly to the UC clinician? Is it lack of training, education, and comfort level of clinicians?

Anecdotal experience of the authors brings to light the possibility that front-office staff answering the phones may not actually be asking the clinician if they can, in fact, manage a particular patient.

For example, the ED clinician may call the urgent care center to discuss a patient who was referred by urgent care, with the urgent care clinician unaware that the patient was referred away. While they may voice frustration with this, the situation could have been avoided had there been better lines of internal communication.

Urgent care clinicians should be expected to manage most lacerations on ambulatory patients. Not doing so puts an undue burden on emergency departments that are already overwhelmed. UCCs should identify clinicians who need help with this basic skill set and then fill that knowledge and skill gap.

The biggest burden is on the patients, who likely will experience much longer wait times and incur much higher charges in the ED. We estimate that this happens tens, if not hundreds of times a day in urgent care centers across the country. It is not known, and it was not asked, whether or not the patient would be charged for having the patient come in and allowing the clinician to evaluate and make an assessment. This would serve as an interesting follow-up study. ■

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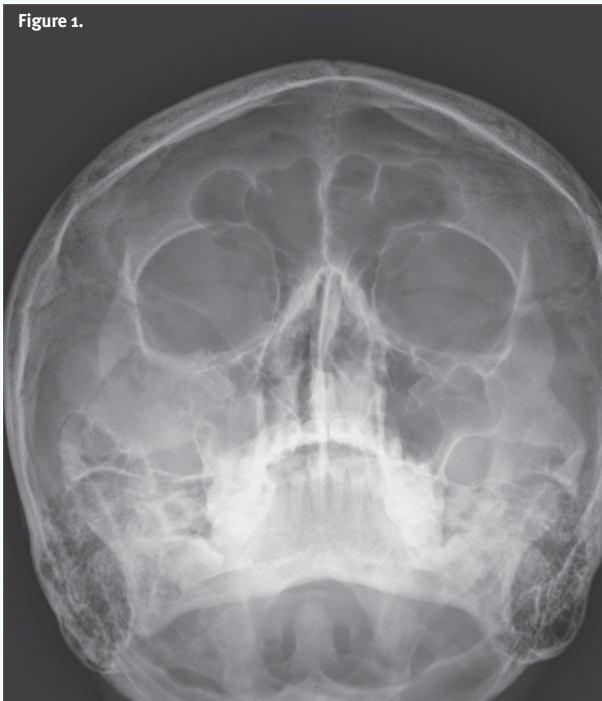


In each issue, *JUCM* will challenge your diagnostic acumen with a glimpse of x-rays, electrocardiograms, and photographs of conditions that real urgent care patients have presented with.

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

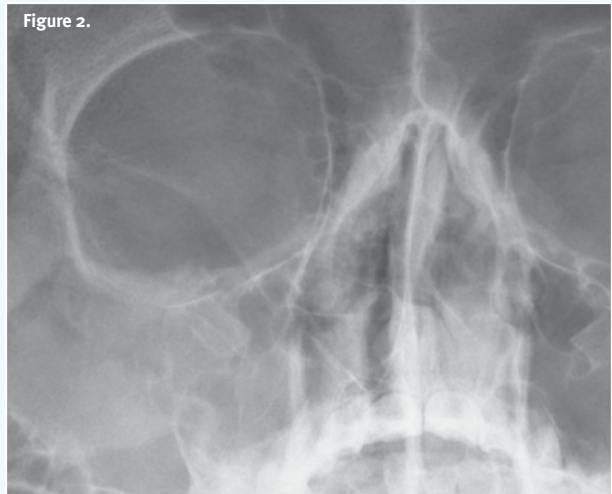
A 40-Year-Old with Swelling After a Direct Blow to the Eye

Figure 1.



A 40-year-old male presents with pain and swelling in his right eye after being struck by a foul ball while coaching his daughter's softball game.

Figure 2.



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

Figure 3.

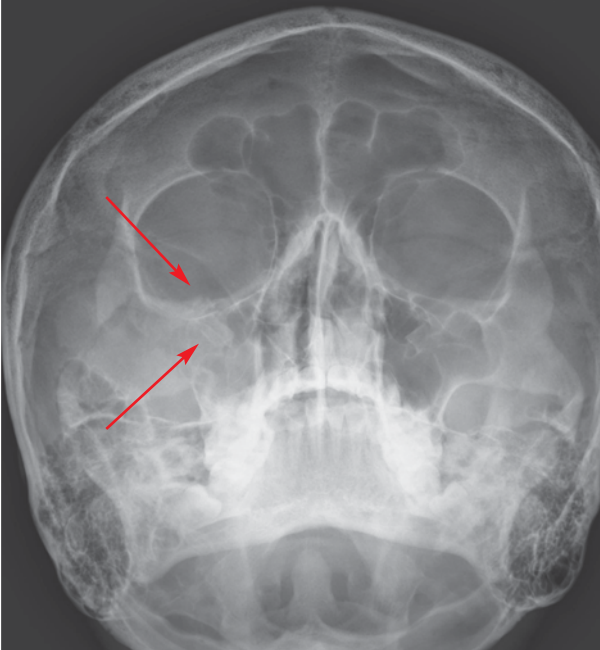
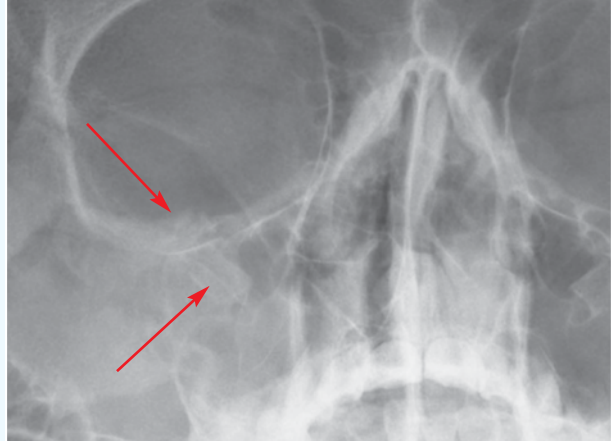


Figure 4.



Differential Diagnosis

- Orbital floor fracture
- Soft tissue edema secondary to trauma
- Traumatic diplopia
- Trochlear nerve palsy

Diagnosis

This patient had a right orbital floor fracture. Findings include partial opacification of the right maxillary sinus, an irregularity on the inferior orbital rim, and a subtle discontinuity on the orbital floor. The most common mechanism is a direct blow to the central orbit from a fist or ball.

Findings/What to Look for

- Orbital fractures can involve any wall of the orbit (medial, lateral, superior or inferior), the orbital rim, or both
- The inferior wall is the most common fractured

Clinical findings can include:

- Enophthalmos (sunken eyes)
- Diplopia (double vision due to extraocular muscle entrapment)
- Orbital emphysema, especially when the fracture is into an adjacent sinus
- Malar region numbness (due to injury to the infraorbital nerve)
- Hypoglobus (affected eye is lower than unaffected eye)

Pearls for Urgent Care Management

- Cold packs should be applied to reduce swelling
- Referral for ophthalmologic or surgical evaluation is needed
- Surgery may be indicated if there is nerve incarceration, acute enophthalmos or hypoglobus, and limitation of gaze

Acknowledgement: Images and case provided by Experity Teleradiology (www.experityhealth.com/teleradiology).



A 46-Year-Old with Evolving Sores on Her Hand and Arm



A 46-year-old female presents with an evolving eruption that developed on her right hand and spread to her forearm over the past several weeks. She is an immunocompetent commercial landscaper who lives in Brazil, and she does not recall any specific injury. She is regularly exposed to toxic plants and sustains minor scratches and cuts at work. She also suspects that she could have experienced bug bites.

She appears well and is without systemic symptoms. On examination, you note smooth, scaly, and crusted, erythematous nodules in a linear configuration on her dorsal hand and forearm.

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



Differential Diagnosis

- Rocky Mountain spotted fever
- Sporotrichosis
- Mycetoma
- Melioidosis

Diagnosis

The correct diagnosis is sporotrichosis, a disease caused by the dimorphic fungus *Sporothrix schenckii*, found worldwide but more commonly in tropical and subtropical climates. The organism resides in decaying vegetation, plants, and soil. Cutaneous infection usually results from traumatic inoculation. Sporotrichosis is the most common and least severe of the deep mycoses.

Learnings/What to Look for

- The lesions of sporotrichosis may present in three different patterns:
 - Lymphocutaneous or sporotrichoid pattern—as seen above, 75% of cases
 - Fixed cutaneous—no lymphatic dissemination; may be more likely to develop in patients previously sensitized to *S schenckii*
 - Disseminated cutaneous—occurs with systemic in-

volvement, is rare and usually in the context of severe immunosuppressed states

- Thorny plants, such as barberry and rose bushes, are the most common source of cutaneous inoculation of sporotrichosis. Other plant exposures include sphagnum moss, straw, hay, soil, and mine timbers
- Occupational exposures include farmers, florists, gardeners, and forestry workers

Pearls for Urgent Care Management

- Untreated cutaneous sporotrichosis usually waxes and wanes over months to years without systemic manifestations
- Antifungal treatment is the standard of care
- Topical heat to lesions may be beneficial in strains that cause cutaneous or lymphocutaneous sporotrichosis

Acknowledgment: Image and case presented by VisualDx (www.VisualDx.com/jucm).



A 69-Year-Old Male with Left-Sided Chest Pain and Dyspnea for 3 Days

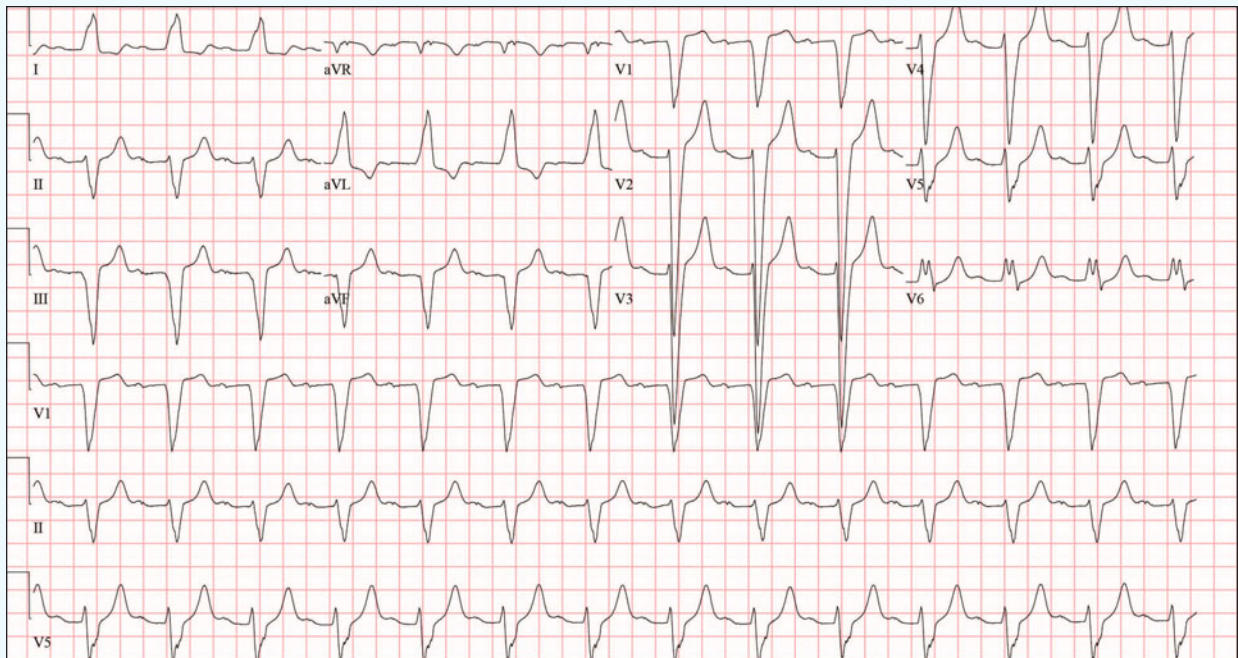


Figure 1. Initial ECG

The patient is a 69-year-old male who presents to urgent care complaining of left-sided chest pain and dyspnea for 3 days. The patient has no known cardiac history.

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

(Case presented by Benjamin Cooper, MD, MEd, FACEP, Department of Emergency Medicine, McGovern Medical School at UTHealth Houston.)

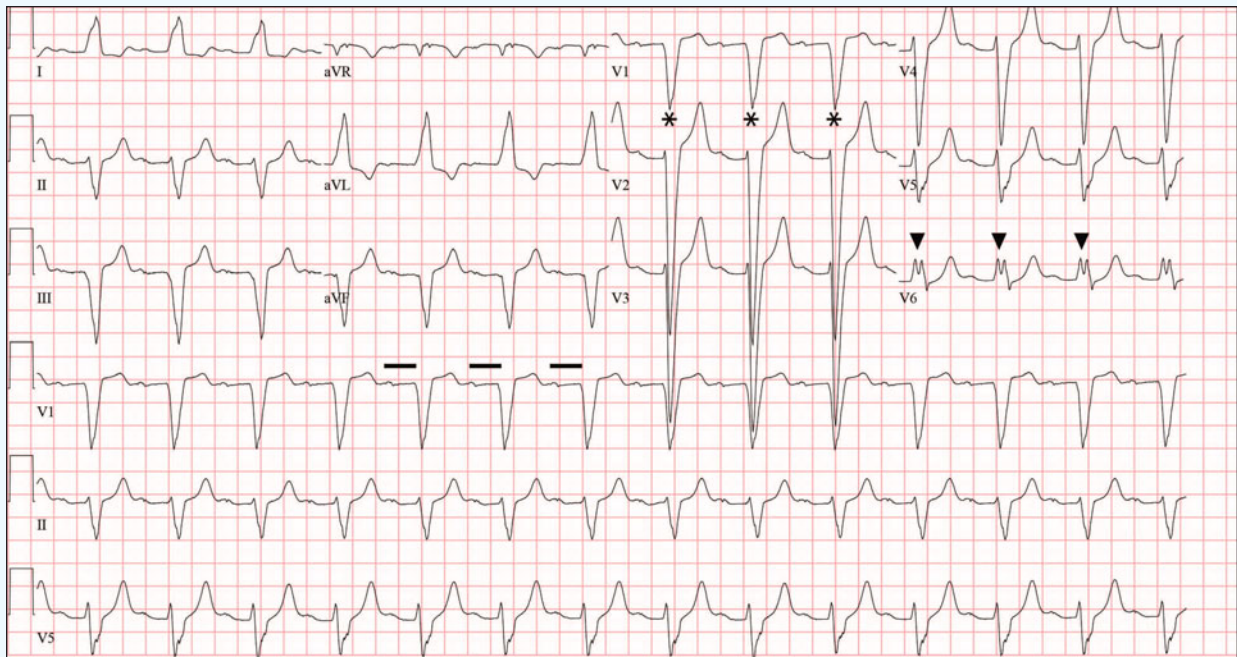


Figure 2: The wide QRS (>120 msec), dominant S wave in V₁ (asterisks), broad notched R wave in V₆ (arrowheads) and absent q waves in lead I, V₅, and V₆ indicates the presence of a left bundle branch block. The PR interval is prolonged (horizontal line).

Differential Diagnosis

- ST-elevation MI (STEMI)
- Left ventricular hypertrophy (LVH) with strain
- Hyperkalemia
- Left bundle branch block (LBBB)
- Ventricular tachycardia

Diagnosis

The ECG reveals a regular, wide-complex, sinus rhythm at a rate of 84 beats per minute. The wide QRS complex (>120 msec), dominant S wave in V₁, broad notched R wave in the lateral leads (I, aVL, V₆), and left axis deviation indicate the presence of a left bundle branch block (LBBB). The prolonged PR interval represents a first-degree atrioventricular block.

Our understanding of the trifascicular framework of the intraventricular conduction system comes from the seminal work of Rosenbaum, et al from 1969 to 1973.

These works elucidated three conduction terminals—one in the right ventricle (the right bundle) and two in the left ventricle (the anterior and posterior divisions of the left bundle).¹⁻³

Conduction disturbances of any or all three conduction terminals may result from structural abnormalities of the His-Purkinje system caused by necrosis, fibrosis, calcification, infiltrative disease, electrolyte disturbances, or im-

Table 1. Abbreviated electrocardiographic criteria for complete LBBB⁴

Dominant S wave in V₁ QRS duration greater than or equal to 120 ms in adults

Broad notched or slurred R wave in leads I, aVL, V₅, and V₆

Absent q waves in leads I, V₅, and V₆, but in the lead aVL, a narrow q wave may be present in the absence of myocardial pathology

R peak time greater than 60 ms in leads V₅ and V₆ but normal in leads V₁, V₂, and V₃

Associated features:

ST and T waves usually opposite in direction to QRS
Left axis deviation

paired vascular supply.⁴

When conduction is impaired to both left ventricular terminals, the result is an LBBB. **Table 1** lists the established electrocardiographic criteria for the diagnosis of LBBB.

Historically, LBBB was thought to prevent accurate recognition of acute myocardial infarction, resulting in poor allocation of reperfusion therapy.⁵ In fact, for many years (until 2013), new or presumed new LBBB was considered equivalent to an ST-elevation myocardial infarction.⁶

The Sgarbossa/modified Sgarbossa criteria can help to

Table 2. Modified Sgarbossa criteria for determining myocardial infarction in the presence of a LBBB⁷

ST-segment elevation ≥ 1 mm and concordant with the QRS in at least 1 lead

ST-segment depression ≥ 1 mm in any of leads V₁–V₃
Excessively discordant ST-segment elevation in any one lead

Defined by most negative ratio of ST/S and at least 1 mm of STE

Cut point for ST/S ratio < -0.25

Note that the presence of any one of the three criteria rules in for myocardial infarction.

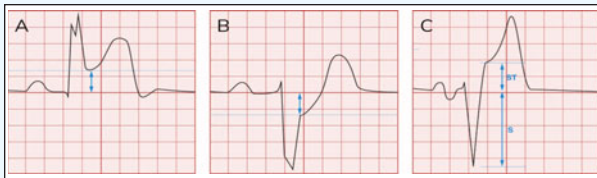


Figure 3. Panel A shows concordant ST-segment elevation. Panel B shows concordant ST-segment depression in leads V₁, V₂, or V₃. Panel C shows excessively discordant ST-segment elevation. Images used with permission from ddxof.com.

identify underlying myocardial infarction in patients with symptoms of acute coronary syndrome in the setting of a LBBB (Table 2 and Figure 3).

Our patient does not meet Sgarbossa criteria, but the presence of an LBBB and a first-degree atrioventricular block does indicate significant pathologic conduction disease.

The symptomatic patient with an LBBB should be transferred to a catheterization-capable facility for further work-up. The ECG Stampede glossary at www.ecgstampede.com/glossary includes additional examples.

Learnings/What to Look for

- Electrocardiographic findings of left bundle branch blocks include a wide QRS, a dominant S wave in V₁,

and a notched or slurred R wave in leads I, aVL, V₅, and V₆

- Apply the modified Sgarbossa criteria for consideration of myocardial infarction in patients with symptoms of acute coronary syndrome with a left bundle branch block
- Always compare with prior ECGs when available

Pearls for Urgent Care Management

- Patients with symptoms concerning for acute coronary syndrome should be transferred to catheterization-capable facility for evaluation
- A new left bundle branch block, in and of itself, does not indicate the need for emergent reperfusion; however, the provider must always consider the entire clinical picture

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Case courtesy of ECG Stampede (www.ecgstampede.com).

ECG STAMPEDE



End of the Public Health Emergency: What's Next?

■ MONTE SANDLER

With expiration of the national Public Health Emergency (PHE) as of May 11, the revenue cycle management (RCM) industry has to adjust to the “new normal.” Some emergency declarations were tied to the end of the PHE and others are not. While not a comprehensive list, I’ve outlined some of the most urgent care-relevant changes below.

Payers Coverage for COVID-19 Testing, Treatments, and Vaccines

During the PHE, federally regulated health plans were mandated to cover COVID-19-related services, often without cost-sharing (ie, patient responsibility). This includes deductibles, co-insurance, and copays.

For private health insurance (eg, BCBS), the following changes will take place with the expiration of the PHE:

- Group health plans and individual health insurance plans will no longer *be required* to cover COVID-19 tests and testing-related services without cost-sharing or prior authorization or other medical management requirements. This includes over-the-counter (OTC) COVID-19 tests.
- Group health plans and individual health insurance (including grandfathered plans) will no longer *be required* to cover out-of-network (OON) providers for tests and related services when the patient has OON coverage.
- Plans and issuers will not be mandated to cover COVID-19 vaccines without cost-sharing even when provided by out-of-network providers.

None of this means coverage *must* change. It just means it is not mandated.

For Medicaid and Medicaid-managed care plans, coverage of coronavirus testing, including at-home, and



COVID-19 treatment services without cost-sharing ends the last day of the first calendar quarter beginning 1 year after the end of the PHE (ie, September 30, 2024).

Beneficiaries in traditional Medicare and Medicare Advantage currently pay no cost-sharing for COVID-19 at-home testing, testing-related services, and certain treatments, including oral antiviral drugs like Paxlovid (nirmatrelvir tablets; ritonavir tablets). This all ends with the expiration of the PHE.

The government may continue to distribute free COVID-19 tests from the Strategic National Stockpile through the United States Postal Service, states, and other community partners while supplies last.

Medicaid Eligibility Ending

The Families First Coronavirus Response Act (FFCRA) prevented states from involuntarily removing anyone from coverage. To accomplish this, Congress boosted states’ federal Medicaid match rates by 6.2 percentage points. While this was initially tied to the PHE, lawmakers changed that as part of the federal spending bill that passed in December.

As of April 1, 2023, states are able to start processing Medicaid redeterminations and disenrolling residents who no longer qualify for Medicaid. The plans will have 14 months to review the eligibility of their beneficiaries.

More than 92 million Americans were enrolled in Medicaid in December 2022. This is an increase of 31% since



Monte Sandler is Chief Operating Officer of Experity.

February 2020, according to the most recent data available from the Centers for Medicare and Medicaid Services. A total of roughly 15 million people could be dropped from Medicaid when the continuous enrollment requirement ends, according to an analysis the Department of Health and Human Services released in August.

Here are examples of how two states will address this:

- Virginia Medicaid will send letters in the mail to current Medicaid members. These letters will contain information regarding their current health plan and, depending on their status, they may need to take further action. Medicaid members will need to update their mailing address and contact information.
- Texas Medicaid will handle this through an online portal. Medicaid members will receive a notice by mail, or email if they signed up to go paperless. The letter is from the Texas Health and Human Services Commission. It will be in a yellow envelope with the words ACTION REQUIRED in red. Beneficiaries will need to follow through on eligibility renewal instructions by visiting YourTexasBenefits.com.

Failure to complete these actions will result in loss of coverage. Temporary losses in coverage will occur. We should expect increased denials. It is imperative that practices check eligibility at time of service and make payment arrangements when appropriate. Patients may not be aware that they lost their coverage.

Telehealth

The Consolidated Appropriations Act, 2023 (CAA) extended expanded coverage for telehealth services through December 31, 2024. For Medicare and Medicare Advantage plans, these flexibilities include:

- Coverage in any geographic area, rather than patient's living in rural areas only.
- Patients can remain in their homes for telehealth, rather than needing to travel to a healthcare facility.
- Telehealth visits can be delivered via smartphone in lieu of equipment with both audio and video capability.
- The expanded list of Medicare-covered services that can be provided via telehealth will continue.
- Rural health clinics (RHC) can provide telehealth services as a distant site provider, rather than being limited to an originating site.

During the PHE, coverage and/or access to telehealth services were expanded for Medicaid and Medicaid Managed Plans in all 50 states and the District of Columbia (DC). States have broad authority to cover telehealth without federal approval, including flexibilities for allowable populations, services and payment rates, providers, technology, and managed care requirements. Changes will

“Medicare never priced the CPT code and gave it a status of Bundled Code, so it was rarely paid. The elimination of its use should have no impact on urgent care.”

vary by state. Some may be tied to either the federal and/or state PHE. Most states have made, or plan to make, some Medicaid telehealth flexibilities permanent.

All states and DC temporarily waived some aspects of state licensure requirements, so that providers with equivalent licenses in other states could practice via telehealth.

Changes to these waivers will also vary by state. In some states, these waivers are still active and tied to the end of the PHE; in others, they have expired. Some states have made allowances for long-term or permanent interstate telemedicine.

During the PHE, the U.S. Department of Health & Human Services waived penalties for HIPAA violations against healthcare providers who serve patients in good faith through everyday communications. This allowed for widely accessible services like FaceTime or Skype to be used for telemedicine purposes, even if the service is not related to COVID-19. This ends with the expiration of the PHE.

Also ending with the PHE is the ability of providers registered with the Drug Enforcement Administration to use telemedicine to issue prescriptions for controlled substances to patients without an in-person evaluation, if they meet certain conditions.

Emergency Use Authorizations (EUA)

An EUA is a mechanism to facilitate availability and use of medical countermeasures that are determined to be safe and effective but have not yet been formally approved by the U.S. Food and Drug Administration. This allowed for expedited availability of laboratory tests, vaccines, and treatments related to COVID-19. This emergency declaration remains in effect until terminated by the Secretary of the Department of HHS (ie, not May 11, 2023, with the other declarations). So, the use of those tests, vaccines, and treatments that have not yet been officially approved may continue.

A declaration under the Public Readiness and Emergency Preparedness (PREP) Act provided liability immunity for activities related to the administration of covered

COVID-19 medical countermeasures, except for claims involving “willful misconduct.” For a PREP Act emergency determination, HHS must specify an end date which, in this case, will be October 1, 2024, in most cases.

Coding

Any coding changes will be based on the date of service, so adjustments may be needed.

Requirements to report modifier CS will also no longer exist when the PHE ends.

CS Cost-sharing waived for specified COVID-19 testing-related services that result in an order for, or administration of, a COVID-19 test and/or used for cost-sharing waived preventive services furnished via telehealth in Rural Health Clinics and Federally Qualified Health Centers *during the COVID-19 public health emergency.*

This modifier should no longer be appended to evaluation and management codes starting May 12, 2023.

CPT 99072 will still be an active code but, with the end of the pandemic, the elements of the description of the code will not be met so it is no longer billable.

99072 Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other nonfacility service(s), when performed *during a Public Health Emergency*, as defined by law, due to respiratory-transmitted infectious disease

Medicare never priced the CPT code and gave it a status of Bundled Code, so it was rarely paid. The elimination of its use should have no impact on urgent care.

While the changes above stand as of this writing, Congress and states are considering legislation that may impact the dates quoted. Variances can be expected across states and health plans similar to 2020.

Let’s hope the end of the PHE is easier than the beginning. ■



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The 10-Year Trend on UC Claim Lines Is Strong—in the City and in the Country

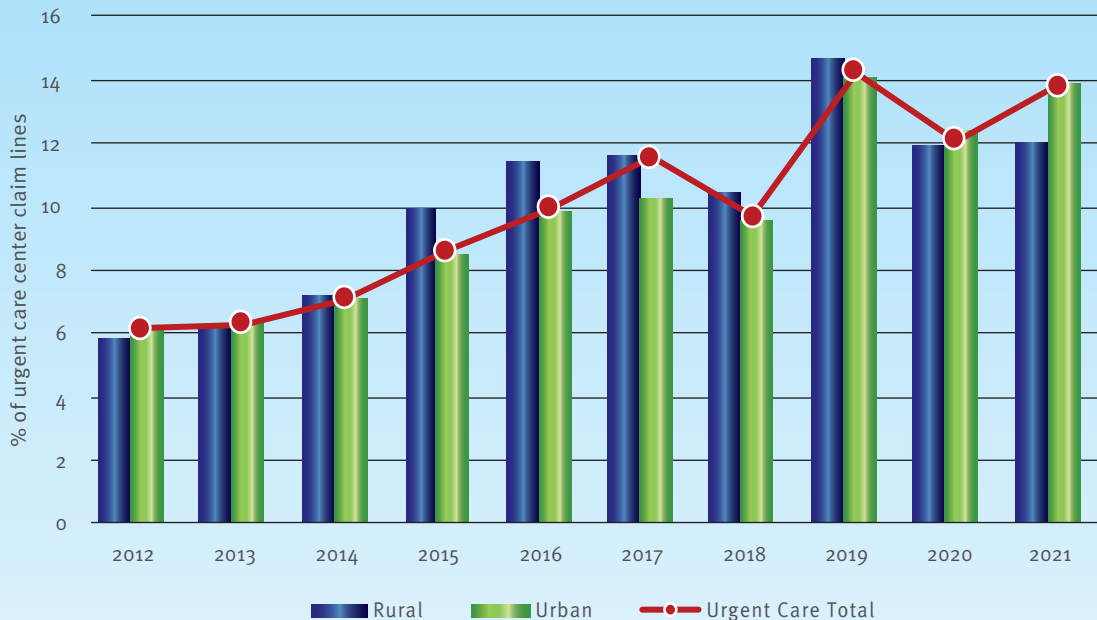
Believe it or not, just a decade ago urgent care accounted for barely 6% of all claim lines in the United States. There was little difference between rural and urban settings, too. New research from FAIR Health¹ shows that the picture changed dramatically in 2015, though, as the percentage of claim lines attributed to urgent care jumped nearly 5% in a single year and rural claims started to outpace urban claims as a portion of the whole data set. The last 3 years of the period tracked in the research (and the graph below) illustrate the industry's resilience, as a couple of minor stumbles, one of which clearly was attributable to the COVID-19

pandemic, were followed by strong recoveries—the last of which shows urgent care accounting for nearly 14% of claim lines overall, with urban holding nearly 2% more of the claim lines than rural. The steady, balanced growth and relative equanimity between rural and urban settings speak not only to urgent care's increasing popularity among healthcare consumers, but also its viability as a growth industry among diverse communities.

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CLAIM LINES WITH UCC USAGE BY RURAL, URBAN, AND NATIONAL SETTINGS



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