JUCM™

MARCH 2013
VOLUME 7, NUMBER 6

Urgent Care Association of America

THE JOURNAL OF URGENT CARE MEDICINE®

www.jucm.com The Official Publication of the UCAOA and UCCOP

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Strategies for Avoiding Drug–Drug Interactions in Urgent Care

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CLINICAL

9 Strategies for Avoiding Drug-Drug Interactions in Urgent Care

With the increasing number of drugs on the market, patients are more and more likely to be taking multiple medications. Urgent care providers need to be alert for potential interactions when changing or adding to a patient's drug therapy.

Maya Heck, MS1, and John Shufeldt, MD, JD, MBA, FACEP

PRACTICE MANAGEMENT

22 Chronic Exertional Compartment Syndrome

Runners who train too much too soon risk serious injury. Prompt and thorough evaluation is necessary to spot CECS masquerading as "shin splints."

Matthew Speer and John Shufeldt, MD, JD, MBA, FACEP

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Cultivating trust requires good communication and if a language barrier stands between patient and provider, not only are clinical outcomes jeopardized, but the urgent care operation can be subject to legal liability.

Alan A. Ayers, MBA, MAcc

IN THE NEXT ISSUE OF *JUCM*

According to one study, 91% of parents suffer from "fever phobia"—the erroneous belief that fever alone could hurt their child. It's not surprising, then, that fever is one of the most common chief complaints in pediatric patients presenting at urgent care centers. In the vast majority of these cases, the source of the fever will be discovered on physical exam or the explanation will be a self-limited viral illness. The challenge for urgent care providers is to identify the pediatric patient with fever who is at high risk of a serious bacterial infection (SBI) such as urinary tract infection, pneumonia, bacteremia, or meningitis. Next month's cover story offers recommendations for an age-based approach to laboratory testing that is rigorous yet ensures prompt identification of the "not well" pediatric patient with fever and appropriate evaluation of the "well" pediatric patient to rule out any possible SBIs.

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JUCM *The Journal of Urgent Care Medicine* supports the evolution of urgent care medicine by creating content that addresses both the clinical practice of urgent care medicine and the practice management challenges of keeping pace with an ever-changing healthcare marketplace. As the Official Publication of the Urgent Care Association of America and the Urgent Care College of Physicians, *JUCM* seeks to provide a forum for the exchange of ideas and to expand on the core competencies of urgent care medicine as they apply to physicians, physician assistants, and nurse practitioners.

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JUCM (ISSN 1938-002X) printed edition is published monthly except for August for $50.00 by Braveheart Group LLC, 120 N. Central Avenue, Ste 1N, Ramsey NJ 07446. Periodical postage paid at Mahwah, NJ and at additional mailing offices. POSTMASTER: Send address changes to Braveheart Group LLC, 120 N. Central Avenue, Ste 1N, Ramsey, NJ 07446.

JUCM The Journal of Urgent Care Medicine *(www.jucm.com) is published through a partnership between Braveheart Publishing (www.braveheart-group.com) and the Urgent Care Association of America (www.ucaoa.org).*

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With use of multiple drug therapies becoming more common and patients' medication lists growing longer, the number cases of drug-drug interactions seen by urgent care providers is increasing. Nineteen percent of all hospitals injuries are caused by adverse drug events, most of which involve common medications and many of which are drug-drug interactions. This month's cover story, by Maya Heck, MD, and John Shufeldt, MD, JD, MBA, FACEP, reviews the risk factors for drug interactions with warfarin, antibiotics, oral contraceptives, statins, and selective serotonin reuptake inhibitors. It's not possible for an urgent care provider to remember all potential drug interactions but it is crucial to maintain a high level of suspicion when making changes or additions to a patient's medications, and to thoroughly review existing medications when prescribing something new.

Ms. Heck is a first year medical student at Oregon Health & Sciences University in Portland, Oregon. Dr. Shufeldt is principal of Shufeldt Consulting and sits on the Editorial Board of *JUCM*.

Millions of people worldwide run as a form of exercise and training for competitive events from 5K races to ultramarathons is no longer unusual. Half of regular runners find themselves injured each year and many such complaints are a result of overexertion or overuse. In this month's case report, Matthew Speer and John Shufeldt, MD, JD, MBA, FACEP, underscore the importance of prompt and thorough evaluation of even the most physically fit, young patient who presents with complaints associated with running. Those "shin splints" may be chronic exertional compartment syndrome (CECS) caused by repetitive microtrauma. Without appropriate treatment, CECS can cause complications that would put an abrupt end to a patient's running career.

Mr. Speer is a second year pre-med student at Arizona State University. Dr. Shufeldt is principal of Shufeldt Consulting and sits on the Editorial Board of *JUCM*.

Offering medical interpretation services is a requirement for urgent care centers that treat patients whose health care is covered by federally funded programs or who are hearing- or vision-impaired. Several methods of reliable medical interpretation are available, each of which can affect the quality of the patient experience and clinical outcomes. As Alan A. Ayers, MBA, MAcc, describes in this month's practice management article, some types of medical interpretation are quicker, whereas as others are more accurate, and still others are more expensive. How to choose? The author counsels taking into consideration the frequency or likelihood of non-English-speaking patients, the diversity of languages presenting, and the language skills and training of providers and staff.

Mr. Ayers is Associate Editor, Practice Management, *JUCM*, Content Advisor, Urgent Care Association of America, and Vice President, Concentra Urgent Care.

Also in this issue:

John Shufeldt, MD, JD, MBA, FACEP, discusses employee theft. The key message here is to not let blind loyalty lull you into a false sense of security.

Nahum Kovalski, BSc, MDCM, reviews new abstracts on literature germane to the urgent care clinician, including studies of statins in prevention of urinary tract infection, pediatric appendicitis, and panic disorder and atrial fibrillation.

In Coding Q&A, **David Stern, MD, CPC**, discusses modifier -25 and urgent care codes.

Our Developing Data end piece this month looks at incentives to urgent care providers other than salary and benefits. ■

To Submit an Article to *JUCM*

JUCM, *The Journal of Urgent Care Medicine* encourages you to submit articles in support of our goal to provide practical, up-to-date clinical and practice management information to our readers—the nation's urgent care clinicians. Articles submitted for publication in ***JUCM*** should provide practical advice, dealing with clinical and practice management problems commonly encountered in day-to-day practice.

Manuscripts on clinical or practice management topics should be 2,600–3,200 words in length, plus tables, figures, pictures, and references. Articles that are longer than this will, in most cases, need to be cut during editing.

We prefer submissions by e-mail, sent as Word file attachments (with tables created in Word, in multicolumn format) to *editor@jucm.com*. The first page should include the title of the article, author names in the order they are to appear, and the name, address, and contact information (mailing address, phone, fax, e-mail) for each author.

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Practice Management

Language Interpretation Services in the Urgent Care Center

Urgent message: Cultivating trust requires good communication and if a language barrier stands between patient and provider, not only are clinical outcomes jeopardized, but the urgent care operation can be subject to legal liability.

ALAN A. AYERS, MBA, MAcc

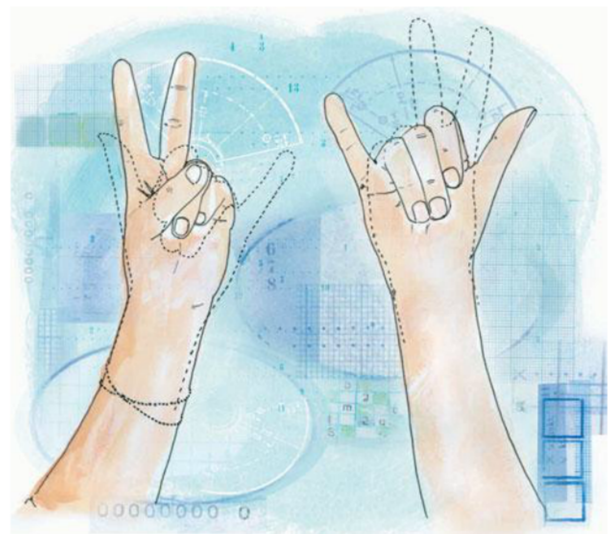
The demographics of the United States are rapidly changing. Today a language other than English is spoken in 55 million households, 67% of which speak Spanish, and an estimated 19% of Americans have Limited English Proficiency (LEP).[1,2] In places like Southern California, over 200 languages are spoken and nationally, 1 in every 10 business transactions occurs in a language other than English.[3] Over 1.2 million immigrants, both documented and undocumented, move into the United States each year, and children born to immigrants account for over 70% of population increases.[4] Considering the proliferation of non-English speakers who require healthcare in the United States, it should come as no surprise that the availability of medical interpretation services is required by law.[5]

Legal Considerations for Urgent Care Operators

While medical interpretation services have been shown to enhance patient compliance and follow-up while significantly reducing chances for misdiagnosis, two federal regulations affect how urgent care centers treat patients with limited English proficiency or who have hearing or sight difficulties:

- Title VI of the Civil Rights Act; and
- Title III of the Americans with Disabilities Act (ADA).

If an urgent care center receives any funds from Medicare, Medicaid, Tricare or any other federal health program, Title VI of the Civil Rights Act of 1964 requires that center to provide “equal access to treatment” in a way that is “meaningfully understood by patients”—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Alan Ayers is Content Advisor, Urgent Care Association of America, Associate Editor—Practice Management, *Journal of Urgent Care Medicine*, and Vice President, Concentra Urgent Care.

both of which have been defined as including accommodation for limited English proficiency as well as for physical impairment.

Executive Order 13166, issued by President Clinton in 2000, stipulates, "Any health facility that receives federal monies must provide competent interpreter services for all limited English proficient patients. In case of refusal to provide this service, federal monies can be denied the facility."[6]

In 2000, then President Bill Clinton emphasized the importance of "meaningful understanding" in medical settings when his Executive Order 13166 expanded the protections of Title VI to people with limited ability to understand English. In 2002, the Department of Health and Human Services (HHS) followed up with its own guidance regarding "meaningful access"[7] that considers it discriminatory to deny services in a healthcare setting to beneficiaries of federal health care programs. "Effective communication is critical for necessary health and human services," said HHS, and "in many cases, LEP individuals form a substantial portion of those encountered in federally assisted programs."

Further, according to Title III of the ADA,[8] "no individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations…and that discrimination includes a failure to make reasonable modifications in policies, practices, or procedures when such modifications are necessary to afford such goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the entity can demonstrate that making such modification would fundamentally alter the nature of such goods, services, facilities, privileges, advantages, or accommodations." The definition of public accommodation *specifically* includes the "professional office of a health care professional," 42 U.S.C. §12181(7)(F).[9] Under the ADA, urgent care centers must provide *equal access* to their services and one must assume that *includes patient communication*.

Steps to Offering Medical Interpretation Services

Urgent care operators have several options for meeting the requirement to communicate with patients in a way they understand. If a center sees a large number of patients speaking the same non-English language, the most convenient and perhaps most cost-effective is to use the center's staff to translate. This requires hiring bilingual receptionists, technicians and medical assistants but even better are bilingual nurses and doctors who can treat patients without using a mediator. According to the International Medical Interpreters Association (IMIA), bilingual staff are an *investment* in the patient experience with "language discordant" patients 61 percent more likely to rate their providers as "fair" or "poor" compared with language-concordant patients."[10]

However, bilingual clinicians are often difficult to find and a full-time medical interpreter can earn $40,000 or more per year—a heavy expense burden, even if also supporting the center as a receptionist or medical assistant. And what happens when, say, a clinic in South Florida that employs providers and staff who are fluent in Spanish encounters a French-, Portuguese-, or Russian-speaking patient, which is common in Miami?

Because the interpreter will be speaking back and forth between two communicators, the most important skill is to have fluency in both languages.

As a substitute for bilingual providers and staff, most large cities have companies that can provide on-site face-to-face medical interpretation services in any number of languages. A trained medical interpreter is someone who has been formally educated in medical interpretation and is not only sensitive to cultural nuances but also educated in medical terminology. More often than not, medical interpreters are native speakers. The advantages of an in-person, experienced medical interpreter include patient satisfaction, assurance that truthful information is being conveyed, better understanding on behalf of both the patient and caregiver, decreased costs of diagnostic testing, and fewer preventable medical errors.[11]

Sign language interpreters help their clients a bit differently than do spoken language interpreters. They have fluency in both English and American Sign Language (ASL), which has its own grammar. ASL is composed of signing, finger spelling, and specific body language. People with hearing difficulties may read speakers lips. Interpreters help lip-readers use oral interpretation, which is mouthing the words carefully and distinctly so that the person who is lip reading can understand more easily. They may use "cued speech" – hand shapes near their mouth to give lip readers more information. They can also use body language and facial expressions to communicate. For patients who are both sight- and hearing-impaired, the interpreter will use "tactical signing"—signing into the patient's hand so that he/she can feel the communication.[12]

When an On-Site Interpreter Isn't Possible

While the advantages of using "professional interpreters" cannot be disputed, the on-demand nature of

urgent care and ebbs and flows in walk-in volume make it impractical to have an interpreter physically present. And when family members and other non-professionals (such as community activists or church representatives who arrive with the patient) are relied upon, there can be an inherent lack of familiarity with medical terminology, word substitution or editing, or emotions added by the interpreter, which contribute to confusion, miscommunication, and medical mistakes.[13] Introducing non-professionals to the patient encounter can also jeopardize patient privacy.

Depending on an urgent care center's location, it may see limited English proficiency patients several times a day, once or twice a week, or once or twice a year. The frequency with which a center encounters the need for medical translation plays a large role in determining which translation options balance demand, cost, and efficacy.

Given the impossibility of having bilingual staff to meet every need that could arise at an urgent care center, the most practical methods of interpretation are flash cards containing common signs, telephonic, and video services.

First off, research casts doubt on the efficacy of flash cards for medical interpretation purposes. The odds of miscommunication using flash cards are high because pointing to images lacks the specificity of spoken language and can convey any number of meanings. Based on studies that trained interpreters are 70% less likely to err than untrained interpreters,[14] the most effective solution is the use of technology to "bring" a trained interpreter into the clinic.

Telephonic medical interpretation has been the fastest growing, and according to the IMIA,[15] this method was touted for use in facilities that dealt with many languages, had infrequent need for translation services, or that were located in outlying areas. Because encounters can be conducted in an exam room with the clinician, patient and a speakerphone—telephonic translation preserves patient confidentiality. Service providers are available 24 hours a day, 7 days a week, and support almost every language and dialect.

Telephone interpretation can be useful with patients who speak uncommon languages or in emergencies when an in-person interpreter cannot be arranged. But the telephone interpreter cannot monitor and evaluate the patient's body language and facial expressions. Communication is more than words; patients lack medical lexicon so consider someone pointing to a body part to indicate where their pain originates or how it travels.[16] Using Internet technology, telephonic interpretation can be coupled with a video feed, providing both words and gestures to the interpreter. Allowing for visual cues not only improves the accuracy of translation, but it can accommodate communication for the deaf and hearing-impaired patients because sign language is easily communicated via video connection.

For most urgent care centers, a subscription to a telephonic or video medical interpretation service is a low cost way to ensure compliance and preparedness, should a non-English-speaking or hearing-impaired patient show up and require services.

Conclusion

Urgent care centers are required to offer interpretation for patients who are using federally funded programs to pay for health care services as well as those who are hearing- or vision-impaired. To identify the best interpretation method for your center, consider the frequency or likelihood of non-English-speaking patients, the diversity of languages presenting, and the language skills and training of providers and staff. ■

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