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LETTER FROM THE EDITOR-IN-CHIEF

A Field Guide to Evaluating Medical Literature



Urgent care medicine is a rapidly evolving discipline. Out of this evolutionary process, scientific skepticism is naturally born. It is the checks and balances of medicine, ensuring that what is purported to be true, is in fact based on evidence, not speculation.

We welcome this inquiry and support the process necessary to lend legitimacy to what has been mere estimation and speculation, thus far, in the development of our discipline.

This is why UCAOA has committed the time and money to support such groundbreaking efforts as the recently announced sampling frame results, and the upcoming benchmarking study. For the first time in the history of urgent care medicine, we will have scientifically validated data to support the contributions of the urgent care industry to the healthcare delivery system. These data will provide the backbone for future study, both clinical and healthcare services research.

But our work is not done. Each of you, as individual practitioners of urgent care medicine, has the same mandate for scientific inquiry.

There are a few basic principles for evaluating clinical studies that may be useful as you evaluate the literature for potential relevance to urgent care. I would like to review those principles here:

- What question is the study trying to answer?
- What is the quality of the evidence?
- How valid are the results?
- What is the relevancy to your practice?

There are several tools available to assist you in evaluation of clinical results. My favorite is the "PP-ICONS"¹ approach developed by Robert Flaherty, MD.

The approach is summarized below:

- **Problem:** What is the clinical condition being studied? This can easily be answered simply by reading the abstract.
- **Patient or population:** Is the group being studied similar to your patient population? This is critically important to the applicability of the results to your practice. Data collected from emergency department patients may not be wholly applicable to urgent care practice.

The same can be said of primary care data. This does not mean there will be no relevancy, but the reader must in-

terpret the data with these population differences in mind.

- **Intervention:** What is the test or treatment being studied? For example: abdominal U/S for evaluation of appendicitis; or antivirals for Bell's palsy.
- **Comparison:** What is the intervention being tested against? In the above examples, this could be abdominal CT, or prednisone alone.
- **Outcome:** We are particularly interested in clinically relevant outcomes. This will limit the relevancy of many articles you see in the scientific literature.
- **Number:** Denotes the "power" of the study. More than 400 patients usually denotes adequate power. Fewer than 100 patients will make it difficult for the authors—and therefore, the readers—to draw conclusions.
- **Statistics:** Review of all statistical terms and their relevance is beyond the scope of this letter, but one of the most clinically useful statistics is the "number needed to treat" (NNT).

Simply, this is the number of patients who must be treated for one person to benefit. If the study does not report a NNT, it can be calculated utilizing the absolute risk reduction ($NNT = 1/ARR$).

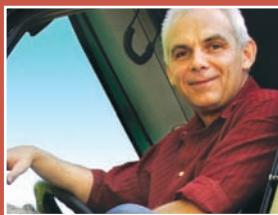
A "good" NNT is dependent on a number of variables, including risk and cost of intervention, but NNTs of 5 to 10 are usually considered reasonable.

I hope this helps you on your journey through the scientific literature. It is imperative for us to critically evaluate the evidence for quality, validity, and relevance to our discipline.

We want *JUCM* to be your forum for this discussion, so please share with us your findings and thoughts. ■

Lee A. Resnick, MD
Editor-in-Chief
JUCM, The Journal of Urgent Care Medicine
President, UCAOA

1. Flaherty RJ. A simple method for evaluating the clinical literature. *Fam Pract Manag*. 2004;11(5):47-52.



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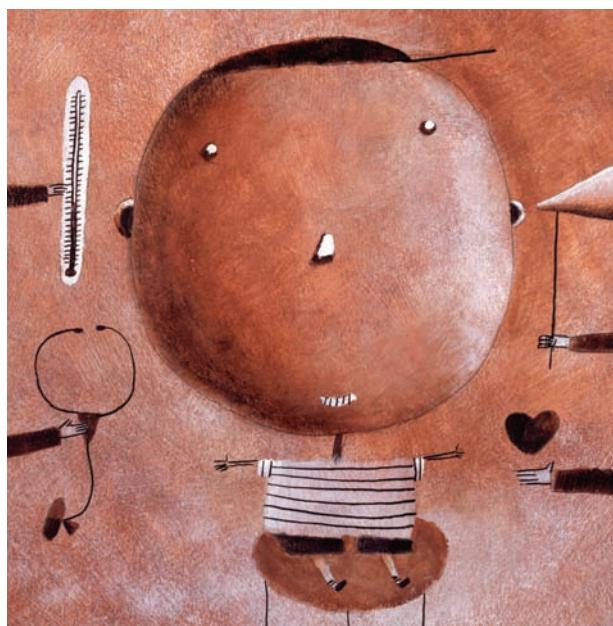
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February 2008

VOLUME 2, NUMBER 5



CLINICAL

11 Integration of Pharmacologic and Non-pharmacologic Techniques to Enhance Pediatric Minor Procedures

Frightened children and worried parents needn't cause you and your staff undue angst. Here are some tips on providing excellent, low-stress care to younger patients.

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Feel like you're already running at full speed? You may be able to rev up earnings without going into overdrive.

By Alan A. Ayers, MBA, MAcc

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Evaluating patients who present to urgent care with head injuries, and how to determine who is at greatest risk for poor outcomes.

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Mission Statement

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, **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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LETTERS TO THE EDITOR

Regarding Constipation as Cause of Acute Abdominal Pain

To the Editor:

Congratulations to the *JUCM* staff for its efforts! The content of the journal is timely, relevant, and needed. As original research in urgent care increases, clinicians will look to *JUCM* as a source for the most important of these studies.

Until then, we must rely on data from many other sources to inform and improve our practice. *JUCM* features like Dr. Nahum Kovalski's Abstracts in Urgent Care Medicine are a most welcome and excellent resource in this regard. We will always have less control over the applicability of knowledge we gain indirectly, and along these lines there was an abstract in the November issue (Constipation as Cause of Acute Abdominal Pain in Children) that deserves some comment.

The abstract pertained to a retrospective study of constipation and abdominal pain in a pediatric practice, with a final conclusion that "constipation was the most common cause of acute abdominal pain in children."

Unfortunately, the evidence in the study does not necessarily pertain to urgent care practice or allow us to make diagnoses or other clinical decisions. Though the Results section of the paper to which the abstract review pertains does distinguish between patients with abdominal pain for less or more than three or four days, the abstracted data include cumulative numbers, and by definition, children with pain for up to two months were considered to have "acute" abdominal pain.

In addition, not mentioned in the abstract but stated in the article is that clinicians, at least sometimes, used enemas in the office and subsequent pain resolution to help with diagnosis. Beyond this, 19% of patients had no diagnosis, and there is no description of further follow-up or evaluation of any patient to determine whether any of the other diagnoses were correct—it seems that they were just assumed to be correct.

These and other methodological problems allow only one take-home point from the study: some of the doctors in that practice thought that some of the children had constipation as

a cause of their abdominal pain. Unfortunately, it is not possible to validly conclude anything more specific than that.

This experience reminds me of two things.

First, we should regard all study results carefully to determine how they pertain to our practice. We should participate in education (we can get CME credit!) that focuses on the basics of analyzing studies using evidence-based medicine techniques.

The specifics and quality of our knowledge will always depend on the specifics and quality of the methods we use to acquire it. We should aspire to the highest quality; our patients deserve it.

Second, in urgent care, we can learn from the emergency medicine approach to caring for patients with acute abdominal pain. In EM, discharging patients with a definite benign diagnosis is typically avoided ("unspecified abdominal pain" is fine), and the evaluation is best explained to patients as a "work-in-progress" which continues after discharge.

Our decision-making should focus on whether a confident diagnosis can be made clinically, whether the patient's presentation is worrisome enough to warrant further tests or consultation soon, or whether it's benign enough wait and see if it resolves fully (which it frequently does), or subsequently declares itself clinically or rises to the level of requiring a work-up.

Constipation is certainly a valid diagnosis in a patient with *these symptoms* as a chief complaint, but in patients with a chief complaint of acute abdominal pain, considering using enemas to relieve the pain prior to discharge (there is no evidence supporting the validity of this approach, but it does seem to make sense), or using the "work-in-progress" approach, with a clear discussion about what to expect and other precautions, seems to be the appropriate fit considering the risk-management and clinical realities in urgent care medicine.

Joe Toscano, MD

Emergency and Urgent Care Medicine Clinician
San Jose, CA

If you have thoughts on an article that appeared in JUCM, The Journal of Urgent Care Medicine (or on issues relevant to urgent care in general), please express them in a Letter to the Editor via e-mail to editor@jucm.com or by "snail mail" to: Editor, JUCM, 2 Split Rock Road, Mahwah NJ 07430.



JUCM CONTRIBUTORS

Children frightened by getting blood drawn, or parents worried about how their child will handle having a wound sutured can add a level of anxiety to an otherwise peaceful practice environment. The right approach to treating younger patients, on the other hand, offers the opportunity to provide outstanding care while boosting the reputation of your practice.

Our February cover article, Integration of Pharmacologic and Non-pharmacologic Techniques to Enhance Pediatric Minor Procedures (page 11), by **Emory Petrack, MD, Lisa S. Perry, CCLS**, and **Kristine Vehar, RN** offers tips on providing excellent care of children while also moving your practice closer to its administrative and financial goals.

As an associate clinical professor of pediatrics at Case Western Reserve University School of Medicine (Cleveland, OH), medical director of the Pediatric Emergency Department at Fairview Hospital in Cleveland, and the president of Petrack Consulting, Inc., Dr. Petrack knows from whence he speaks.

Ms. Perry, a certified child life specialist at Rainbow Babies and Children's Hospital in Cleveland, and Ms. Vehar, a pediatric emergency nursing educator in the Pediatric Emergency Department at Rainbow Babies and Children's Hospital, also bring a wealth of experience and insight to the table. Both work with Dr. Petrack at Petrack Consulting.

Dr. Petrack encourages readers interested in learning more about the techniques recommended in this issue to visit the website for his CalmerKids Training Module (www.GoCalmerKids.com) or to contact him directly at epetrack@petrackconsulting.com. He will also be speaking at the UCAOA's Urgent Care Convention in New Orleans this spring.

In addition, **Drs. Muhammad Waseem, Lalithambal Venugopalan, and Gerard Devas, MD** have contributed a case report that illustrates the importance of quick, thorough evaluation of children presenting with injuries uncommon in their age group (A 4-Year-Old Who Fell from the Slide, page 18). Dr. Waseem is associate professor of emergency medicine (clinical pediatrics) at Weill Medical College of Cornell University in New York City and attending physician in emergency medicine at Lincoln Medical & Mental Health Center in the Bronx, NY, where Dr. Devas is also an attending physician. Dr. Venugopalan is a neonatology Fellow at North Shore Long Island Jewish-Schneider Children's Hospital in New York.



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We are also pleased to present an original article on diversifying your clinical offerings—and adding to your bottom line—without adding undue burden to your existing staff and practice structure (Boosting Revenue by Working Harder—or Smarter?, page 29). The author, **Alan Ayers, MBA, MAcc** is assistant vice president of product development for Concentra Urgent Care, based in Dallas, TX and content advisor to the Urgent Care Association of America. In addition, he has managed urgent care centers for a large hospital system and worked as a consultant to the retail industry with clients such as Wal-Mart and Home Depot. This is the first of several articles Mr. Ayers will contribute, all intended to help you maximize the economic potential of your practice.

This issue also contains new, original contributions from our regular authors: **Nahum Kovalski, BSc, MDCM** reviews abstracts on over-the-counter cough and cold medications, as well as nocturnal cough and sleep quality, among other topics; **John Shufeldt, MD, JD, MBA** offers counsel on how to prevent sexual harassment claims in your practice; **David Stern, MD, CPC** responds to questions on how to translate payor-speak; and **Frank Leone, MBA** explains how mastering a few basic public speaking techniques can enhance your professional standing.



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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FROM THE EXECUTIVE DIRECTOR

Where's the Love?

■ LOU ELLEN HORWITZ, MA

So there you are in your urgent care center, with a full waiting room of cranky, impatient people who don't feel good—kids with head lacerations, teenagers with stomach flu, businesspeople with scratchy throats and body aches, senior citizens feeling weak and dizzy—plus accompanying parents, friends, spouses, children, caretakers...

And no sooner do you get finished taking care of them, bringing all of the skills and talents of your center's staff to bear, that they head right back out your door to get on with their lives.

Where's the love?

They don't see what the insider sees. They don't see the sleepless nights you spent when the center was just getting started, wondering how you were going to make the payroll.

They don't see the hours of glad-handing and hallway politics you had to grit your teeth through just to keep your center in the health system's good graces.

They don't see the agonizing you have done over new hires, nor the time spent training, developing and coaching the physicians or staff.

They don't see the countless reports, contracts, filings, forms, negotiations, trade-offs...they don't see the effort it takes to provide them with the "simple" opportunity to get safe, affordable, quality care without an appointment.

When it comes to "getting the love" it is a two-way street. It's just not necessarily the street we believe it should be.

In healthcare, it is very, very important to get everything right. That's the price of admission and you pay it every day.

But the question here is how you get paid back. If you have been looking to get paid back for all those things that patients don't see, stop looking. That's not where it's at.

As humans—and this includes patients—we respond to things that move us: consideration, respect, compassion, and genuine interest in us as individuals.



Lou Ellen Horwitz is executive director of the Urgent Care Association of America. She may be contacted at lhorwitz@ucaoa.org.

There's a great insurance ad on television that reminds us that the other drivers on the road are not just a car in our way; they are people.

It should be the same way with the patients who visit your practice. They don't think of themselves as patients, but as sons, daughters, fathers, mothers, office managers, teachers, prom queens, and doting grandmothers.

Keep that in mind when you feel a question like, "Are you the mother?" or "Are you the husband?" forming in your mouth. "The mother" is not a generic person. She is *this specific child's* mother, and she is probably tired and worried. She may also be furious at her son for climbing the tree when she told him not to, or stressed out over a presentation at work, or in an abusive situation at home. Or, her life may be perfect except for this small inconvenience.

The right word or sentence—or better yet, some good listening skills—can help you and your staff best understand what this patient situation needs. And it's probably not just stitches or a prescription. Any competent clinician can sew up a cut and quickly get a patient out the door, but to have a meaningful encounter, even if it's quick...that is where it's at. That's where everyone gets a payoff.

There's no mystery here. You get what you give. Give a little of yourself and you'll get a little for yourself. That's where "the love" is; the forms and paperwork and processes are all just necessary props in the grand drama of helping others.

And lest you think this is just a "feel-good" message, let me also remind you of this: it's not sutures and prescriptions that will get people to come back, send their friends, and talk up your center all over town. It's the literal *care* they receive.

That mother tells her fellow playgroup mothers, the businessperson tells his colleagues, the older couple tells their ballroom dancing class, and the teenager...well, let's not push it.

I hope that you all are able to "get some love" in your centers. And don't forget that it applies to your coworkers and employees, as well.

Then, if you still aren't feeling it, call us any time or come see us at the convention in New Orleans in April and we'll give it to you. As long as you give it back. ■



MEET THE JUCM BOARDS

JUCM has been very fortunate to work with committed, highly expert professionals who voluntarily serve on our Editorial Board and Advisory Board.

In order to ensure that each of the boards continues to be a mix of industry authorities with whom we've established ongoing relationships and new members who bring a fresh perspective, we will rotate a handful of members on an off annually.

The following individuals are devoting their time and expertise in support of our mission to provide information that is of high value to you and, by extension, will benefit the entire urgent care community.

JUCM is proud to present them as members of our Editorial Board and Advisory Board.

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Brief Summary (See Package Brochure For Full Prescribing Information)

Rx only for women age 17 and younger

For women age 17 and younger, Plan B® is a prescription-only emergency contraceptive. Plan B® is intended to prevent pregnancy after known or suspected contraceptive failure or unprotected intercourse. Emergency contraceptive pills (like all oral contraceptives) do not protect against infection with HIV (the virus that causes AIDS) and other sexually transmitted diseases.

CONTRAINDICATIONS

Progestin-only contraceptive pills (POPs) are used as a routine method of birth control over longer periods of time, and are contraindicated in some conditions. It is not known whether these same conditions apply to the Plan B® regimen consisting of the emergency use of two progestin pills. POPs however, are not recommended for use in the following conditions:

- Known or suspected pregnancy
- Hypersensitivity to any component of the product

WARNINGS

Plan B® is not recommended for routine use as a contraceptive.

Plan B® is not effective in terminating an existing pregnancy.

Effects on Menses

Menstrual bleeding patterns are often irregular among women using progestin-only oral contraceptives and in clinical studies of levonorgestrel for postcoital and emergency contraceptive use. Some women may experience spotting a few days after taking Plan B®. At the time of expected menses, approximately 75% of women using Plan B® had vaginal bleeding similar to their normal menses, 12-13% bled more than usual, and 12% bled less than usual. The majority of women (87%) had their next menstrual period at the expected time or within \pm 7 days, while 13% had a delay of more than 7 days beyond the anticipated onset of menses. If there is a delay in the onset of menses beyond 1 week, the possibility of pregnancy should be considered.

Ectopic Pregnancy

Ectopic pregnancies account for approximately 2% of reported pregnancies (19.7 per 1,000 reported pregnancies). Up to 10% of pregnancies reported in clinical studies of routine use of progestin-only contraceptives are ectopic. A history of ectopic pregnancy need not be considered a contraindication to use of this emergency contraceptive method. Health providers, however, should be alert to the possibility of an ectopic pregnancy in women who become pregnant or complain of lower abdominal pain after taking Plan B®.

PRECAUTIONS

Pregnancy

Many studies have found no effects on fetal development associated with long-term use of contraceptive doses of oral progestins (POPs). The few studies of infant growth and development that have been conducted with POPs have not demonstrated significant adverse effects.

STD/HIV

Plan B®, like progestin-only contraceptives, does not protect against HIV infection (AIDS) and other sexually transmitted diseases.

Physical Examination and Follow-up

A physical examination is not required prior to prescribing Plan B®. A follow-up physical or pelvic examination, however, is recommended if there is any doubt concerning the general health or pregnancy status of any woman after taking Plan B®.

Carbohydrate Metabolism

The effects of Plan B® on carbohydrate metabolism are unknown. Some users of progestin-only oral contraceptives (POPs) may experience slight deterioration in glucose tolerance, with increases in plasma insulin; however, women with diabetes mellitus who use POPs do not generally experience changes in their insulin requirements. Nonetheless, diabetic women should be monitored while taking Plan B®.

Drug Interactions

Theoretically, the effectiveness of low-dose progestin-only pills is reduced by hepatic enzyme-inducing drugs such as the anticonvulsants phenytoin, carbamazepine, and barbiturates, and the antituberculosis drug rifampin. No significant interaction has been found with broad-

spectrum antibiotics. It is not known whether the efficacy of Plan B® would be affected by these or any other medications.

Nursing Mothers

Small amounts of progestin pass into the breast milk in women taking progestin-only pills for long-term contraception resulting in steroid levels in infant plasma of 1-6% of the levels of maternal plasma. However, no adverse effects due to progestin-only pills have been found on breastfeeding performance, either in the quality or quantity of the milk, or on the health, growth or development of the infant.

Pediatric Use

Safety and efficacy of progestin-only pills have been established in women of reproductive age for long-term contraception. Safety and efficacy are expected to be the same for postpubertal adolescents under the age of 16 and for users 16 years and older. Use of Plan B® emergency contraception before menarche is not indicated.

Fertility Following Discontinuation

The limited available data indicate a rapid return of normal ovulation and fertility following discontinuation of progestin-only pills for emergency contraception and long-term contraception.

ADVERSE REACTIONS

The most common adverse events in the clinical trial for women receiving Plan B® included nausea (23%), abdominal pain (18%), fatigue (17%), headache (17%), and menstrual changes. The table below shows those adverse events that occurred in \geq 5% of Plan B® users.

Table 3: Adverse Events in \geq 5% of Women, by % Frequency

Most Common Adverse Events	Plan B® Levonorgestrel N=977 (%)
Nausea	23.1
Abdominal Pain	17.6
Fatigue	16.9
Headache	16.8
Heavier Menstrual Bleeding	13.8
Lighter Menstrual Bleeding	12.5
Dizziness	11.2
Breast Tenderness	10.7
Other complaints	9.7
Vomiting	5.6
Diarrhea	5.0

Plan B® demonstrated a superior safety profile over the Yuzpe regimen for the following adverse events:

- Nausea: Occurred in 23% of women taking Plan B® (compared to 50% with Yuzpe)
- Vomiting: Occurred in 6% of women taking Plan B® (compared to 19% with Yuzpe)

DRUG ABUSE AND DEPENDENCE

There is no information about dependence associated with the use of Plan B®.

OVERDOSAGE

There are no data on overdosage of Plan B®, although the common adverse event of nausea and its associated vomiting may be anticipated.

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Integration of Pharmacologic and Non-pharmacologic Techniques to Enhance Pediatric Minor Procedures

Urgent message: Integration of various techniques when performing minor procedures on children can enhance clinical care for patients and families while bringing within reach administrative and financial goals.

Emory Petrack, MD, FAAP, FACEP, Lisa S. Perry, CCLS, and Kristine Vehar, RN

Introduction

As the practice of urgent care medicine continues to grow, urgent care centers grapple with several important issues, among them the needs to provide optimal clinical care, reduce medical legal risk, and deliver excellence in customer service; the latter is especially true when centers are located in competitive markets.

Although pediatric care in the urgent care setting has traditionally received relatively little emphasis, it is an area of focus whose time has come; spotlighting child and family-centered care helps urgent care centers enhance clinical care for children and families while also bringing within reach administrative and financial goals.

A plethora of ways exists for enhancing care for families and children in urgent care settings. This article fo-



cuses on but one: improving care for children presenting in need of minor procedures, such as blood draws, IV placements, local wound care, and suturing.

While a variety of pharmacologic and non-pharmacologic techniques for enhancing such pediatric procedures are described in this paper, success in achieving broad care, satisfaction, and business goals is dependent upon the *integration* of techniques.

In other words, each technique alone presents certain benefits to urgent care centers and the children and families they treat, but it is the sum of techniques used together that creates synergy and paints a uniquely positive picture families remember and share with others in the community.

Figure 1, which shows a 4-year-old boy undergoing



repair of a scalp laceration, is an example of what can be achieved when the techniques described here are successfully integrated into an urgent care center's repertoire.

This article will employ a case-based approach to explore a variety of techniques.

Pharmacologic Techniques

IV and Blood Draws

A 6-year-old presents to the urgent care center with significant vomiting and diarrhea, requiring IV rehydration. The child is awake and alert, but is very anxious about the need for an IV, as is the child's mother.

One method that has been around for several years is

the application of a eutectic mixture of lidocaine and prilocaine (EMLA) or lidocaine topical (LMX) 4% cream, which is applied to intact skin to provide anesthesia before needle insertion.

The challenge with such creams, however, is that EMLA takes about an hour to start working; LMX 4% takes 30 to 45 minutes. Frequently, parents do not want to wait, and using these creams significantly reduces throughput time in busy centers.

An alternative to creams is the 70 mg lidocaine/70 mg tetracaine topical (Synera) patch, which is impregnated with lidocaine and tetracaine. When the package is opened, the patch heats up to enhance its effectiveness. This patch is effective in 20 minutes, and is, therefore, much more useful in the emergency- and urgent care setting.

Figure 2 shows a 13-year-old girl, just seconds after an IV line placement. She was extremely anxious about the need for IV placement; the Synera patch and several non-pharmacologic techniques, discussed later in this article, were used before placement.

Yet another alternative will be available in the near future: Zingo, produced by the pharmaceutical company Anesiva. Zingo is a device that delivers powdered lidocaine, which is injected into the epidermis with compressed air. Delivery is painless, and analgesia is achieved in one to three minutes. An important benefit of this method is that the analgesia becomes part of the procedure itself, not requiring significant additional time.

Although uncommon in the urgent care setting, the need to place an IV or draw blood in young infants does arise occasionally. Concentrated sucrose solution has been shown to reduce pain in infants less than 2 months old.

A 24% sucrose and water solution (Sweet-Ease) is available for this purpose. Placing 0.5 ml directly on the tongue one minute before the procedure leads to endogenous endorphin release and pain reduction. Offering a pacifier after the sucrose solution may help further soothe the infant.

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Suturing

A 4-year-old comes to the urgent care center after running into the corner of a dresser. The child had no loss of consciousness, but did sustain a 2 cm laceration to the forehead.

Although dermal glue is considered for closure, a decision is made to suture due to the wound's depth and abraded edges. The family, naturally, is very concerned about how the child will handle the suturing.

Lidocaine-epinephrine-tetracaine (LET) gel is this author's method of choice for lacerations requiring suturing, as it provides complete anesthesia for suturing in 30 minutes for approximately 60% to 80% of patients. In other children, it can reduce the pain of a subsequent lidocaine injection.

LET gel tends to work best on the scalp and face, but provides variable anesthesia in the extremities, as well. This treatment requires preparation by a pharmacist and is not commercially available.

It is important to note that less-than-complete anesthesia may result from improper use.

For proper pain control, the gel is applied generously into the laceration. A small piece of cotton is also inserted and liberally saturated with additional gel. A small gauze pad is applied over the wound.

After 30 minutes, the gauze and cotton are removed, and the wound can be tested for pain with a small gauge needle. Additional buffered lidocaine anesthesia may also be offered if needed.

Non-Pharmacologic Techniques

Establishing Trust

Urgent care centers have at their disposal a variety of non-pharmacologic techniques to improve the experience of

children who require minor procedures. At the foundation of each technique is the establishment of trust with the child and family.

To children who are in pain or sick, being in an urgent care center is like being in a foreign country. They are unfamiliar with the environment and do not understand what is happening and being said around them.

When in such a state, children who need invasive procedures, especially if restrained, often "fight for their lives." When this happens, physicians and other medical staff unwittingly contribute to potential psychological trauma that can lead to difficulties with future medical encounters and procedures.

Some physicians and staff still prefer parents to step out of the room during a procedure. From the child's perspective, this can be traumatic, as the child cannot understand why the parent would turn them over to a stranger who then causes pain and anxiety.

To the child, the parent is the foundation of all trusting relationships. It is almost always better to allow the parent to remain with the child at all times.

Language and communication form the cornerstone on which trust is built. Urgent care professionals should address the child's feelings honestly and ask if he or she is scared. The parent should be permitted to touch the child and to help him or her through the experience.

While nothing short of general anesthesia can guarantee that a child will not cry and become upset, techniques such as these may minimize the intensity and duration of crying, as well as the amount of restraint needed.

Children learn to trust when they feel a sense of control. This is why, whenever possible, urgent care providers should allow children presenting for minor procedures the ability to choose among options.

Such options include the choice of position for older children, the choice to watch or look away, or the choice of distractions, discussed later in this article. Children may also be asked to help hold themselves still.

A parent can play a supporting role by helping to hold or position the child. Staff can also acknowledge parental anxiety while helping parents calm down and focus on the needs of the child.

Positioning Techniques

Children are commonly restrained during minor procedures, as movement often leads to poor outcomes and even safety issues. However, children move less if they feel a sense of control and if restraint is used only as much as is absolutely necessary.

This is especially true if a parent does most of the

holding. Using good positioning techniques can further reduce the need for papoose boards or other restraints.

Infants can be positioned with the parent holding or partially holding them. Infants may also be placed on a stretcher, with the parent's face right next to the infant's face to provide comfort [Additional images, including one that illustrates this point, can be found at www.jucm.com.]. The infant may be offered a pacifier and the parent encouraged to speak to the child, as a parent's voice can be very soothing. Parents may also be asked to pick up a baby immediately after a procedure for quick calming.

Ideally, toddlers should be sitting in the caregiver's lap for procedures. Alternatively, child and parent may sit chest to chest, with the child's arm extended on the table for IV placement or suturing of an extremity.

School-aged children can also sit comfortably in a parent's lap. Children need less restraint if they are being held by someone they trust.

Teens and older children do best when given choices, enabling them to maintain as much control as possible.

Adolescents may be offered a choice of positions, such as sitting or lying down, and care should be taken to respect their privacy.

Preparation and Distraction Techniques

Once trust has been established and an appropriate positioning technique chosen, the child is prepared to cope during the actual procedure.

Language alone can turn an experience from positive to negative—very quickly.

For example, the phrase "don't move" instantly evokes fear in children and creates unnecessary anxiety. A better choice of language might be "do your best to hold yourself still so I can help you better."

For the best possible experience, children should be told what to do, rather than what *not* to do.

Words like "pinch" for IV placement, and "pressure" or "pushing" for sutures or staples are far less scary, and therefore far more comforting.

The child should also know that although they will not feel pain during suturing, they will feel a sensation of pushing or pulling on the skin.

If children really want to watch during a procedure, it is best to allow them to do so. Forcing children to look away increases anxiety and erodes the trust that has been established.

Children older than 3 or 4 should be told what will happen at each step before any action is performed, preferably by showing and telling what can be expected.

Children may be shown the instruments and allowed to feel the suture material, which can be referred to as "string bandaids."

A demonstration set of non-sterile equipment can be kept on hand for this purpose. If the child is too young to understand, a touch of the parent's body where the laceration is located will encourage positive modeling in the child. Combining appropriate language with visualization of what will be happening leads to less anxiety on the part of both patient and caregiver.

For intravenous placement, it helps to refer to the IV as a "straw" through which fluids and medicines can be given. Children may also be comforted in the knowledge that by using the straw, no further needles

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will be needed later. The needle can be referred to as a "helper" to get the straw under the skin into the vein. Providers can also demonstrate how the tourniquet is used and how the area is cleaned before it is actually done.

Once the child is appropriately prepared for the procedure, distraction techniques can further improve the experience as the procedure is accomplished.

While several modalities exist for different developmental ages, it is important to understand that no technique will be as effective if the preceding methods are not adequately applied. Establishing trust, choosing the best position, and preparing the child for the procedure creates the foundation for the consistent and effective use of later distraction techniques.

Bubble blowing is an excellent distraction technique for children 3 years of age and older who are undergoing a procedure. Older children may be asked if they prefer to blow away the pinch of an IV into the air—or into the bubbles. This technique gives the child choice and control and helps them to develop better coping skills. Alternatively, the child could squeeze a parent's hand or a rubber ball to focus their energy elsewhere and enhance distraction.

Reading developmentally appropriate books is an excellent distraction for children undergoing minor procedures.

Likewise, with an inexpensive CD player and headphones, different kinds of music appropriate for different developmental ages can also be made available.

Storytelling is another distraction alternative, one in which parents can often be counted on to participate.

Simple toys also work to distract younger children through play.

The key to successful distraction is to engage the patient and/or caregiver in choosing the best technique for each individual child.

Integration of Pharmacologic and Non-pharmacologic Techniques

Pharmacologic and non-pharmacologic techniques can each be used to improve the experience of children requiring minor procedures in the urgent care setting. The real power, however, comes when the provider is able to fully integrate these seemingly diverse approaches.

Most providers are familiar with the pharmacologic approach. It makes sense to start a discussion with a parent and older child about pharmacologic options. Providers should consider using some of the newer options, such as the Synera patch for IV placement. LET gel, while not

necessarily eliminating the need for lidocaine infiltration, works very well when used correctly, and should always be considered for laceration repair.

Once a decision is made about which pharmacologic agent to use, the provider should consider how the agent will be integrated with non-pharmacologic techniques. This decision is based on the specific procedure, the developmental age of the child, and discussions with the child and/or caregiver.

Typically, it takes less than five to 10 minutes to establish trust, decide how to best position the child, prepare the child, and incorporate a distraction technique into the procedure.

This is time well spent, and will result in much better experience for both the child and the family.

Summary

The reality is that few urgent care centers focus on the specific needs of children; even fewer do so well and consistently.

The good news is that clinical care can be significantly enhanced by paying attention to the needs of children requiring minor procedures.

In addition, as families in the community learn that a specific urgent care center attends well to the needs of children and families, word will spread. Thus, enhancing care for children is an excellent business practice and marketing strategy in competitive markets.■

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Case Report

A 4-Year-Old Who Fell from the Slide

Urgent message: Injuries sustained in playground falls are common presentations to emergency departments and urgent care centers alike. The urgent care physician should be alert to the keys to evaluation and management of traumatic neck pain.

Muhammad Waseem, MD, Lalithambal Venugopalan, MD, and Gerard Devas, MD

Introduction

Cervical spine (C-spine) injuries occur infrequently in children. This is especially true for fractures of atlas vertebra, which is a rare injury in children. Its diagnosis may easily be missed due to inconclusive C-spine radiographs and absence of neurological signs.

Here, the authors present an illustrative case of a patient with, and a review of, a fracture of atlas vertebra.

Case

A 4-year-old presented with neck pain one day after he fell from a slide onto the top of his head. He was complaining of pain in the back of his neck. There was no history of loss of consciousness, headache, or vomiting. He was immediately placed in a rigid cervical collar.

In the emergency department, he was alert and awake. His Glasgow coma scale was 15. His vital signs were as follows:

Temperature: 98.4°F

Heart rate: 119 beats/minute

Respiration: 22 breaths/minute

Oxygen saturation: 99%

The patient did not have any difficulty of breathing but complained of diffuse neck pain.

On physical examination, he had torticollis and diffuse tenderness over the back of his neck. There was no subcutaneous emphysema. The pupils were equal and reactive. There was no hemotympanum or cerebrospinal



Figure 1. Lateral neck radiograph showing pre-vertebral soft tissue swelling of the upper cervical spine with reversal of normal spine curvature.

fluid leak from his ears. His chest was clear, with bilateral symmetric breath sounds. The abdomen was soft and non tender. His neurologic examination was unremarkable.

Radiographs of the cervical spine (AP and lateral views done in erect posture) showed pre-vertebral soft tissue swelling of the upper cervical spine with reversal of normal spine curvature (**Figure 1**).

Because of the persistent pain and indirect signs of injury on the plain radiograph, a cervical collar was applied and the patient underwent computed tomography scan of the upper cervical spine, which showed a fracture in the right anterior arch of the C1 vertebra with a 9 mm separation (**Figure 2**). This fracture was considered stable and managed with immobilization. He improved and was well at follow-up.

Discussion

Cervical spine injuries are serious but relatively uncommon in children, with a reported incidence of 1% to 2%.¹ The typical mechanism of cervical spine injury is either a fall onto the top of head or motor vehicle accident.

The fall onto the head causes the body weight to be transmitted to the atlas, resulting in axial loading.

Identification of the fractures of the cervical spine by plain radiograph is difficult and, therefore, can be missed on plain radiographs.^{2,3} This is especially true for upper cervical vertebrae—including atlas, as most fractures of the atlas, particularly the anterior aspect, may remain occult.⁴

In addition, the open-mouth view, which is usually pathognomonic for the diagnosis, is often inadequate or not obtained.⁵ An open-mouth view is helpful to visualize the displacement of lateral masses of atlas, but may not demonstrate the site of fracture.

It is also important to look for any indirect signs of injury, such as pre-vertebral soft-tissue swelling, air in the pre-vertebral space, an increased width of the anterior atlantodental interval, and overriding of the C1-C2 joint on one side.⁶ Presence of any indirect signs of injury on plain radiograph warrants a CT scan to confirm the presence of fracture of C-spine.

Younger children have a predilection for C-spine injuries at the higher level, which may be related to the biomechanical and anatomic features of the immature pediatric C-spine.⁷ The

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child's spine is more flexible and mobile⁸ and, because of higher mobility and elasticity of the spine and a lower body mass in children, spinal injuries are relatively uncommon.⁹

It is especially rare in fractures of the atlas, as fracture of the ring increases the space that is available for the dural sac and, therefore, is unlikely to cause compression.¹⁰

Atlas fractures may be associated with other cervical fractures, with odontoid fracture being the most common associated fracture.

Management

The initial assessment of the patient must include maintenance of the airway, breathing, and circulation.

A non-displaced fracture of atlas is considered stable.¹¹

Stable fractures usually heal within eight to 12 weeks.

Isolated stable fracture of the atlas can be treated effectively with a rigid cervical collar alone for that period.¹² A Philadelphia collar may provide sufficient immobilization.

Generally, all displaced fractures are considered unstable; more rigid or surgical stabilization is recommended in unstable injuries in patients with displaced fractures.¹³

Another option is halo-vest immobilization for a period of 12 weeks.

Typically, cervical immobilization is sufficient for an isolated fracture of the atlas with an intact transverse atlantal ligament. However, cervical immobilization with surgical fixation and fusion will be required if transverse atlantal ligament is disrupted.¹⁴ The reported long-term outcome from the fracture of atlas is good.¹⁵

Disposition of Case

The patient described in this case report was treated conservatively with cervicothoracic brace; he recovered without any neurological abnormalities.

In most reports, rigid collars, sternal occipital, mandibular immobilizer, or "SOMI", braces and halo ring-vest orthoses have all been used for a period of eight to 12 weeks with good results.

No evidence has been reported favoring use of one of these devices over the other.

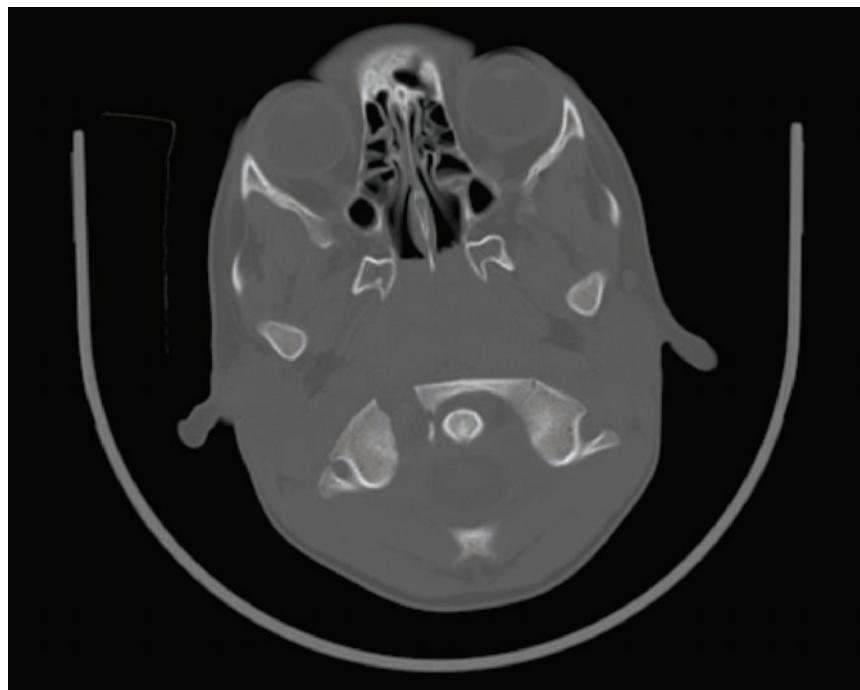


Figure 2. CT scan of cervical spine shows a diastatic fracture of right anterior ring of C₁, with approximately 9 mm of separation.

Conclusion

It is important to consider fracture of the cervical spine in a child with significant neck pain and neck tilt after a fall on the top of the head. The presence of indirect signs of injury on plain films, especially in the presence of neck pain, should be taken seriously and followed with a CT scan. ■

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Tussionex® Pennkinetic®



(hydrocodone polistirex and chlorpheniramine polistirex)

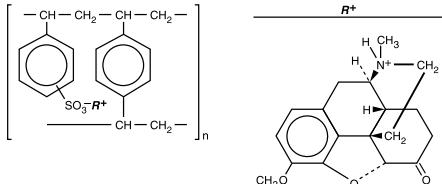
Extended-Release Suspension

Rx Only

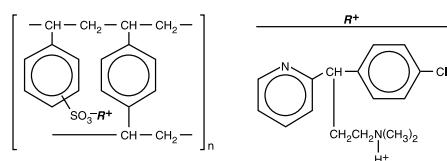
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DESCRIPTION: Each teaspoonful (5 mL) of TUSSIONEX Pennkinetic Extended-Release Suspension contains hydrocodone polistirex equivalent to 10 mg of hydrocodone bitartrate and chlorpheniramine polistirex equivalent to 8 mg of chlorpheniramine maleate. TUSSIONEX Pennkinetic Extended-Release Suspension provides up to 12-hour relief per dose. Hydrocodone is a centrally-acting narcotic antitussive. Chlorpheniramine is an antihistamine. TUSSIONEX Pennkinetic Extended-Release Suspension is for oral use only.

Hydrocodone Polistirex: Sulfonated styrene-divinylbenzene copolymer complex with 4,5α-epoxy-3-methoxy-17-methylmorphinan-6-one.



Chlorpheniramine Polistirex: Sulfonated styrene-divinylbenzene copolymer complex with 2-[β-chloro-α-[2-(dimethylamino)ethyl]-benzyl]pyridine.



Inactive Ingredients: Ascorbic acid, D&C Yellow No. 10, ethylcellulose, FD&C Yellow No. 6, flavor, high fructose corn syrup, methylparaben, polyethylene glycol 3350, polysorbate 80, pregelatinized starch, propylene glycol, propylparaben, purified water, sucrose, vegetable oil, xanthan gum.

CLINICAL PHARMACOLOGY: Hydrocodone is a semisynthetic narcotic antitussive and analgesic with multiple actions qualitatively similar to those of codeine. The precise mechanism of action of hydrocodone and other opiates is not known; however, hydrocodone is believed to act directly on the cough center. In excessive doses, hydrocodone, like other opium derivatives, will depress respiration. The effects of hydrocodone in therapeutic doses on the cardiovascular system are insignificant. Hydrocodone can produce miosis, euphoria, and physical and psychological dependence.

Chlorpheniramine is an antihistamine drug (H₁ receptor antagonist) that also possesses anticholinergic and sedative activity. It prevents released histamine from dilating capillaries and causing edema of the respiratory mucosa.

Hydrocodone release from TUSSIONEX Pennkinetic Extended-Release Suspension is controlled by the Pennkinetic System, an extended-release drug delivery system, which combines an ion-exchange polymer matrix with a diffusion rate-limiting permeable coating. Chlorpheniramine release is prolonged by use of an ion-exchange polymer system.

Following multiple dosing with TUSSIONEX Pennkinetic Extended-Release Suspension, hydrocodone mean (S.D.) peak plasma concentrations of 22.8 (5.9) ng/mL occurred at 3.4 hours. Chlorpheniramine mean (S.D.) peak plasma concentrations of 58.4 (14.7) ng/mL occurred at 6.3 hours following multiple dosing. Peak plasma levels obtained with an immediate-release syrup occurred at approximately 1.5 hours for hydrocodone and 2.8 hours for chlorpheniramine. The plasma half-lives of hydrocodone and chlorpheniramine have been reported to be approximately 4 and 16 hours, respectively.

INDICATIONS AND USAGE: TUSSIONEX Pennkinetic Extended-Release Suspension is indicated for relief of cough and upper respiratory symptoms associated with allergy or a cold in adults and children 6 years of age and older.

CONTRAINdications: TUSSIONEX Pennkinetic Extended-Release Suspension is contraindicated in patients with a known allergy or sensitivity to hydrocodone or chlorpheniramine.

The use of TUSSIONEX Pennkinetic Extended-Release Suspension is contraindicated in children less than 6 years of age.

WARNINGS: Respiratory Depression: As with all narcotics, TUSSIONEX Pennkinetic Extended-Release Suspension produces dose-related respiratory depression by directly acting on brain stem respiratory centers. Hydrocodone affects the center that controls respiratory rhythm and may produce irregular and periodic breathing. Caution should be exercised when TUSSIONEX Pennkinetic Extended-Release Suspension is used postoperatively and in patients with pulmonary disease, or whenever ventilatory function is depressed. If respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride and other supportive measures when indicated (see OVERDOSAGE).

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions, which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

Obstructive Bowel Disease: Chronic use of narcotics may result in obstructive bowel disease especially in patients with underlying intestinal motility disorder.

Pediatric Use: In pediatric patients, as well as adults, the respiratory center is sensitive to the depressant action of narcotic cough suppressants in a dose-dependent manner. Benefit to risk ratio should be carefully considered, especially in pediatric patients with respiratory embarrassment (e.g., croup) (see PRECAUTIONS).

PRECAUTIONS: General: Caution is advised when prescribing this drug to patients with narrow-angle glaucoma, asthma, or prostate hypertrophy.

Special Risk Patients: As with any narcotic agent, TUSSIONEX Pennkinetic Extended-Release Suspension should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy, or urethral stricture. The usual precautions should be observed and the possibility of respiratory depression should be kept in mind.

Information for Patients: As with all narcotics, TUSSIONEX Pennkinetic Extended-Release Suspension may produce marked drowsiness and impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly. TUSSIONEX Pennkinetic Extended-Release Suspension must not be diluted with fluids or mixed with other drugs as this may alter the resin-binding and change the absorption rate, possibly increasing the toxicity.

Keep out of the reach of children.

Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when TUSSIONEX Pennkinetic Extended-Release Suspension is used postoperatively, and in patients with pulmonary disease.

Drug Interactions: Patients receiving narcotics, antihistamines, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with TUSSIONEX Pennkinetic Extended-Release Suspension may exhibit an additive CNS depression. When combined therapy is contemplated, the dose of one or both agents should be reduced.

The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone.

The concurrent use of other anticholinergics with hydrocodone may produce paralytic ileus.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenicity, mutagenicity, and reproductive studies have not been conducted with TUSSIONEX Pennkinetic Extended-Release Suspension.

Pregnancy: Teratogenic Effects – Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. TUSSIONEX Pennkinetic Extended-Release Suspension should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.

Labor and Delivery: As with all narcotics, administration of TUSSIONEX Pennkinetic Extended-Release Suspension to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from TUSSIONEX Pennkinetic Extended-Release Suspension, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness of TUSSIONEX Pennkinetic Extended-Release Suspension in pediatric patients under six have not been established (see WARNINGS).

Geriatric Use: Clinical studies of TUSSIONEX did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosage range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

This drug is known to be substantially excreted by the kidney, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function.

ADVERSE REACTIONS: Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, euphoria, dizziness, psychic dependence, mood changes.

Dermatologic System: Rash, pruritis.

Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of TUSSIONEX Pennkinetic Extended-Release Suspension may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters, and urinary retention have been reported with opiates.

Respiratory Depression: TUSSIONEX Pennkinetic Extended-Release Suspension may produce dose-related respiratory depression by acting directly on brain stem respiratory centers (see OVERDOSAGE).

Respiratory System: Dryness of the pharynx, occasional tightness of the chest.

DRUG ABUSE AND DEPENDENCE: TUSSIONEX Pennkinetic Extended-Release Suspension is a Schedule III narcotic. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, TUSSIONEX Pennkinetic Extended-Release Suspension should be prescribed and administered with caution. However, psychic dependence is unlikely to develop when TUSSIONEX Pennkinetic Extended-Release Suspension is used for a short time for the treatment of cough. Physical dependence, the condition in which continued administration of the drug is required to prevent the appearance of a withdrawal syndrome, assumes clinically significant proportions only after several weeks of continued oral narcotic use, although some mild degree of physical dependence may develop after a few days of narcotic therapy.

OVERDOSAGE: Signs and Symptoms: Serious overdosage with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. Although miosis is characteristic of narcotic overdose, mydriasis may occur in terminal narcosis or severe hypoxia. In severe overdosage apnea, circulatory collapse, cardiac arrest and death may occur. The manifestations of chlorpheniramine overdosage may vary from central nervous system depression to stimulation.

Treatment: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and the institution of assisted or controlled ventilation. The narcotic antagonist naloxone hydrochloride is a specific antidote for respiratory depression which may result from overdosage or unusual sensitivity to narcotics including hydrocodone. Therefore, an appropriate dose of naloxone hydrochloride should be administered, preferably by the intravenous route, simultaneously with efforts at respiratory resuscitation. Since the duration of action of hydrocodone in this formulation may exceed that of the antagonist, the patient should be kept under continued surveillance and repeated doses of the antagonist should be administered as needed to maintain adequate respiration. For further information, see full prescribing information for naloxone hydrochloride. An antagonist should not be administered in the absence of clinically significant respiratory depression. Oxygen, intravenous fluids, vasopressors and other supportive measures should be employed as indicated. Gastric emptying may be useful in removing unabsorbed drug.

DOSAGE AND ADMINISTRATION

Shake well before using.

Adults and Adolescents ≥ 13 Years of Age
5 mL (1 teaspoonful) every 12 hours; do not exceed 10 mL (2 teaspoonsfuls) in 24 hours.

Children 6-12 Years of Age
2.5 mL (1/2 teaspoonful) every 12 hours; do not exceed 5 mL (1 teaspoonful) in 24 hours.

It is important that TUSSIONEX be measured accurately. A household teaspoonful is not an accurate measuring device and could lead to overdosage, especially when half a teaspoon is to be measured. It is strongly recommended that an accurate measuring device be used. A pharmacist can provide an appropriate measuring device and can provide instructions for measuring the correct dose. Please ask a pharmacist for advice.

This medicine is not intended for children under 6 years of age (see CONTRAINDICATIONS).

HOW SUPPLIED: TUSSIONEX Pennkinetic (hydrocodone polistirex and chlorpheniramine polistirex) Extended-Release Suspension is a gold-colored suspension.

NDC 53014-548-67 473 mL bottle

For Medical Information

Contact: Medical Affairs Department
Phone: (866) 822-0068
Fax: (770) 970-8859

Storage:

Shake well. Dispense in a well-closed container.

Store at 20-25°C (68-77°F); excursions permitted to 15-30°C (59-86°F)
[see USP Controlled Room Temperature].

TUSSIONEX Pennkinetic Extended-Release Suspension

Manufactured for:

UCB, Inc.

Smyrna, GA 30080



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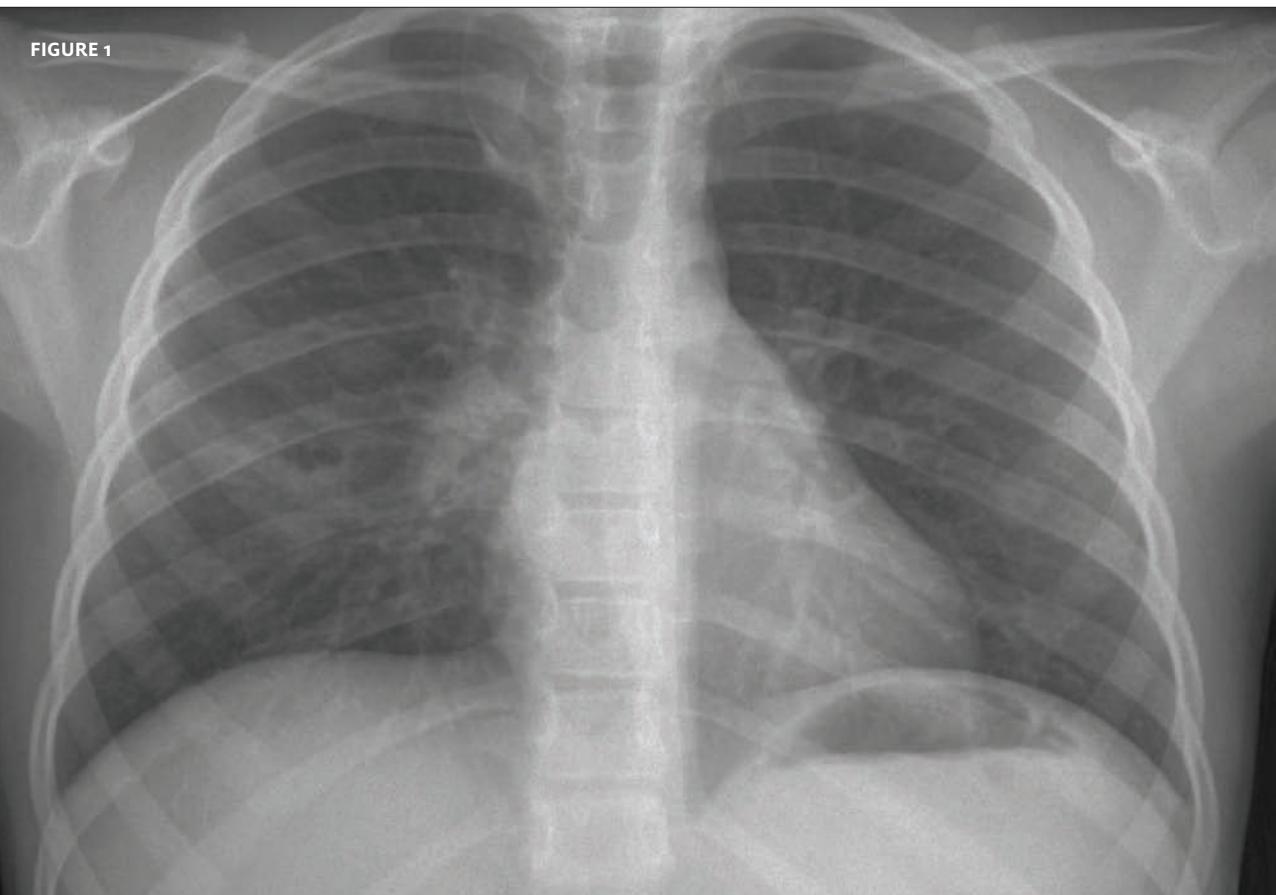
INSIGHTS IN IMAGES

CLINICAL CHALLENGE: CASE 1

In each issue, *JUCM* will challenge your diagnostic acumen with a glimpse of x-rays, electrocardiograms, and photographs of dermatologic 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.

FIGURE 1



The patient is a 9-year-old girl who fell and received a blow to her right chest.

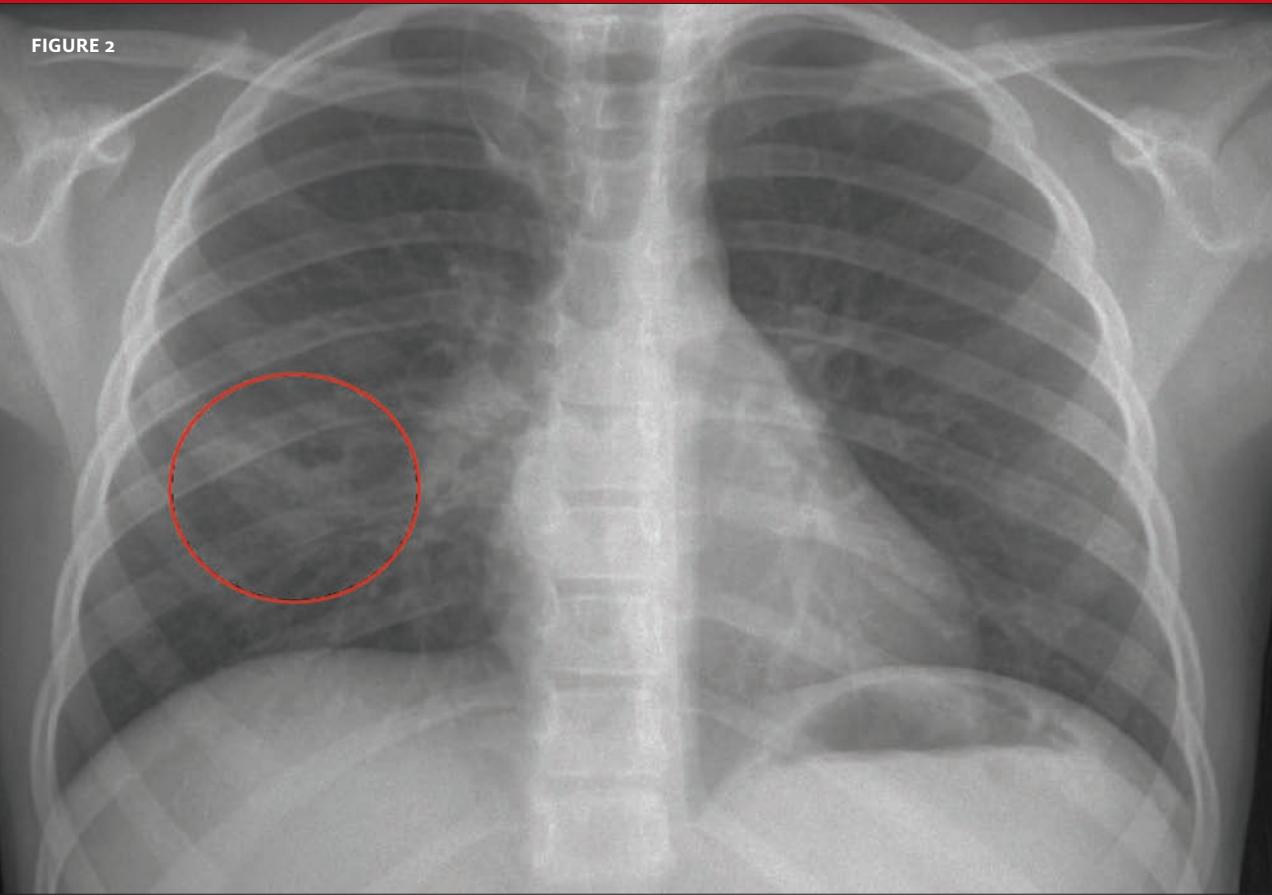
A few hours later, she presented to urgent care complaining of pain on deep breathing.

On exam, you find a pulse of 103, and SAT of 96. She is not in respiratory distress; her chest exam was clear and she has an abrasion over her right chest. She is generally healthy, is on no medications, and has no significant past medical history.

View the x-ray taken (**Figure 1**) and consider what your diagnosis and next steps would be. Resolution of the case is described on the next page.

THE RESOLUTION

FIGURE 2



The x-ray shows increased markings in the right mid-lung, which may be the first signs of a pulmonary contusion. This patient needs close follow-up.

The film reveals infiltrate in middle of right lung field suggestive of hematoma; no rib fracture was perceived.

The patient was discharged home with instructions to:

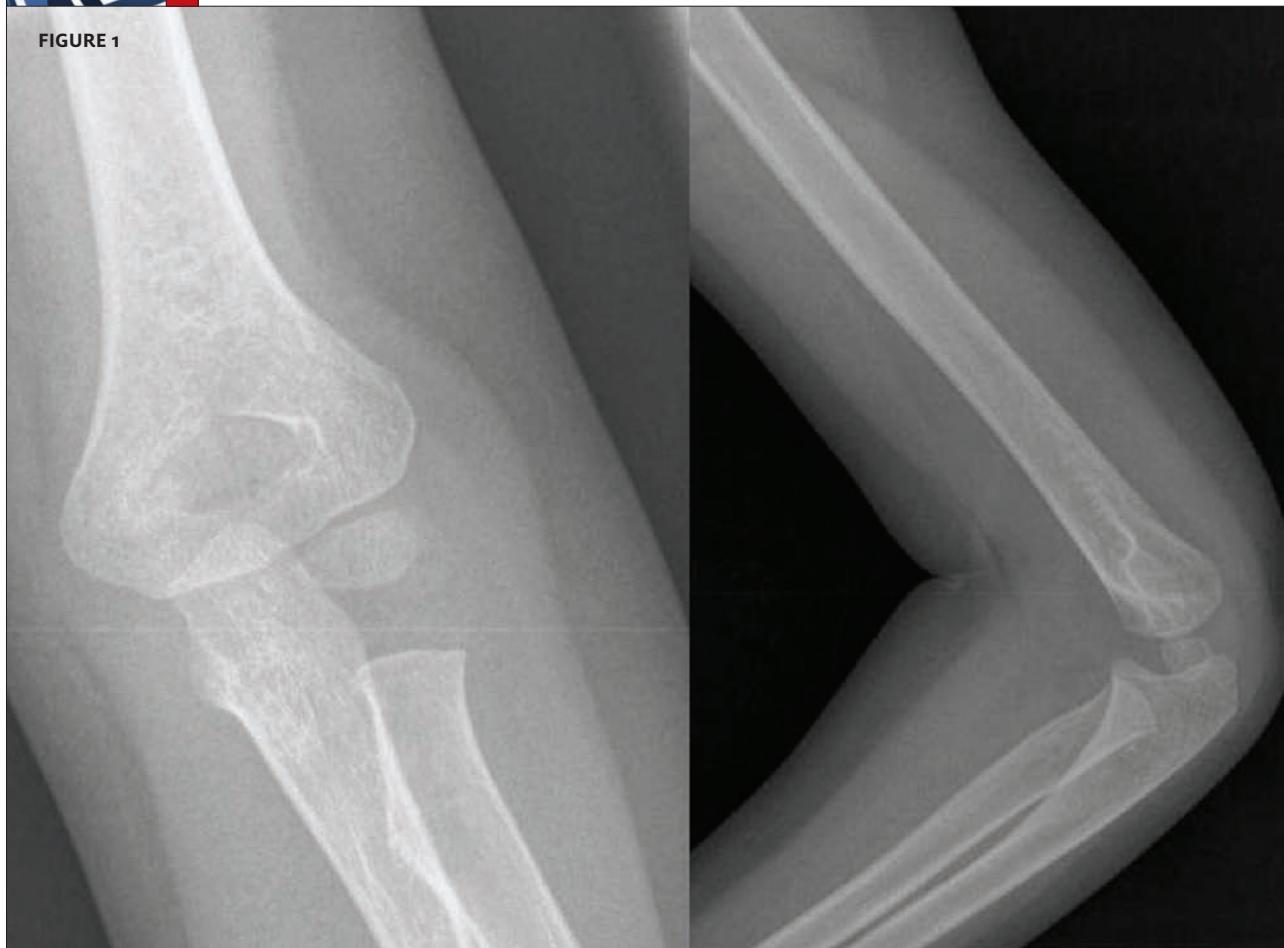
- rest
- follow up with her family physician the next day
- r/u CXR to recheck status of x-ray finding
- return immediately in the event of increased chest pain or dyspnea.

Acknowledgment: Case presented by Nahum Kovalski, BSc, MDCM.



CLINICAL CHALLENGE: CASE 2

FIGURE 1



The patient is a 3 ½-year-old girl who fell from a bicycle, receiving a blow to the elbow a short time before presentation. She had marked swelling and local tenderness over the elbow.

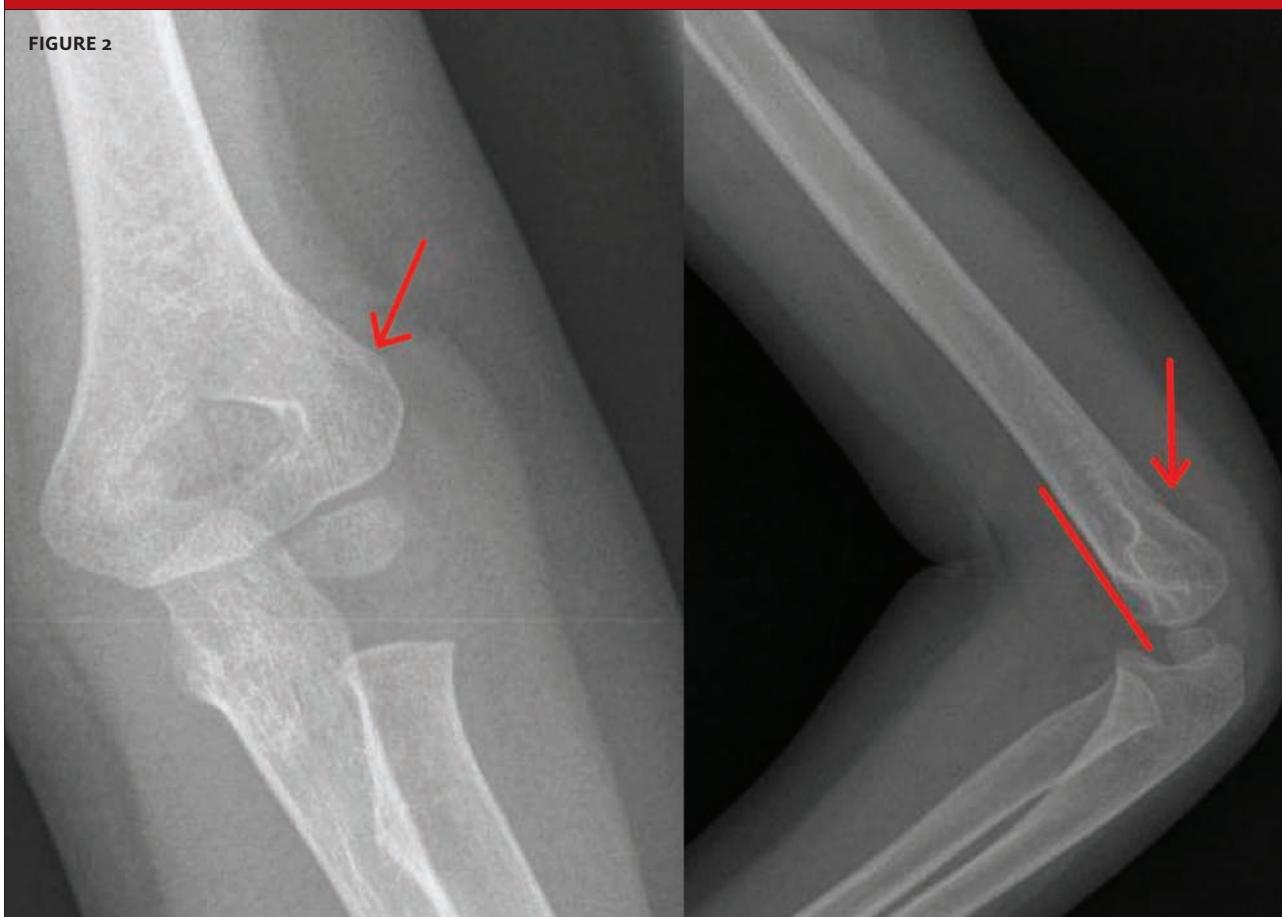
The only other remarkable finding was a pulse of 132.

View the x-ray taken (Figure 1) and consider what your diagnosis and next steps would be. Resolution of the case is described on the next page.

INSIGHTS IN IMAGES: CLINICAL CHALLENGE

THE RESOLUTION

FIGURE 2



The AP film is suggestive of a supracondylar fracture.

On the lateral, one sees a straightening of the distal humerus, as well as a discontinuity in the posterior humerus and increased fat pads.

This is a stable fracture that required a posterior plaster splint from upper arm to wrist, with orthopedic follow-up the next day.

Acknowledgment: Case presented by Nahum Kovalski, BSc, MDCM.



ABSTRACTS IN URGENT CARE

On OTC Cough-and-Cold Meds, Nocturnal Cough and Sleep Quality, Prescribing Trends in Acute Otitis Media, and Diagnosing Bloodstream Infection

■ NAHUM KOVALSKI, BSC, MDCM

Each month, Dr. Nahum Kovalski reviews a handful of abstracts from, or relevant to, urgent care practices and practitioners. For the full reports, go to the source cited under each title.

Over the Counter but No Longer Under the Radar—Pediatric Cough and Cold Medications

Key point: Since 1985, all six controlled studies of cough/cold preparations in children have not shown a positive effect. Over the last 7 years, poison-control centers have reported more than 750,000 calls

Citation: Sharfstein JM, North M, Serwint JR. *N Engl J Med.* 2007;357(23):2321-2324.

In recent weeks, over-the-counter cough and cold medications for children have received unprecedented attention from regulators, physicians, the media, and parents.

This scrutiny represents a long-overdue reassessment of products that were purchased by 39% of U.S. households during the past three years. It also reflects an important evolution in the standard of evidence for medications used in children.

OTC cough and cold preparations include various combinations of antihistamines, decongestants, antitussives, and expectorants. There is no standard for defining these products; two prod-

ucts marketed similarly may have different types of ingredients.

Since 1985, none of the six randomized, placebo-controlled studies of the use of cough and cold preparations in children under 12 years of age have shown any meaningful differences between the active drugs and placebo.

In 1997, the American Academy of Pediatrics noted in a policy statement on cough medications that "indications for their use in children have not been established." In 2006, the American College of Chest Physicians found that "literature regarding over-the-counter cough medications does not support the efficacy of such products in the pediatric age group."

Meanwhile, poison-control centers have reported more than 750,000 calls of concern related to cough and cold products since January 2000. A recent report from the Centers for Disease Control and Prevention identified more than 1,500 emergency room visits in 2004 and 2005 for children under 2 years of age who had been given cough or cold products.

Among other concerns are findings in children under 6 linking decongestants to cardiac arrhythmias and other cardiovascular events, antihistamines to hallucinations, and antitussives to depressed levels of consciousness and encephalopathy. A review by the FDA identified 123 deaths related to the use of such products in children under 6 during the past several decades. Serious adverse effects have been associated with accidental overdose, inadvertent misuse, and drug-drug or drug-host interactions in children given standard doses.



Nahum Kovalski is an urgent care practitioner and assistant medical director/CIO at Terem Immediate Medical Care in Jerusalem, Israel.

ABSTRACTS IN URGENT CARE

Direct-to-consumer advertisements assert that preparations are safe and effective, and many state that ingredients are "pediatrician-recommended." ■

Effect of Honey, Dextromethorphan, and No Treatment on Nocturnal Cough and Sleep Quality for Coughing Children and Their Parents

Key point: Parents rated honey most favorably for symptomatic relief of their child's nocturnal cough and sleep difficulty.

Citation: Paul IM, Beiler J, McMonagle A, et al. *Arch Pediatr Adolesc Med.* 2007;161(12):1140-1146.

A survey was administered to parents on two consecutive days—first on the day of presentation when no medication had been given the prior evening and then the next day when buckwheat honey, honey-flavored dextromethorphan (DM), or no treatment had been given prior to bedtime according to a partially double-blinded randomization scheme.

One hundred five children aged 2 to 18 years with upper respiratory tract infections, nocturnal symptoms, and illness duration of seven days or less were included. The intervention was a single dose of buckwheat honey, honey-flavored DM, or no treatment administered 30 minutes prior to bedtime.

Significant differences in symptom improvement were detected between treatment groups; honey scored best consistently, with the no treatment group scoring the worst.

In paired comparisons, honey was significantly superior to no treatment for cough frequency and the combined score, but DM was not better than no treatment for any outcome. Comparison of honey with DM revealed no significant differences.

In a comparison of honey, DM, and no treatment, parents rated honey most favorably for symptomatic relief of their child's nocturnal cough and sleep difficulty due to upper respiratory tract infection. Honey may be a preferable treatment for the cough-and-sleep difficulty associated with childhood upper respiratory tract infection. ■

National Trends in Emergency Department Antibiotic Prescribing for Children with Acute Otitis Media, 1996–2005

Key point: There was no change in the patterns of prescribing antibiotics for OM even in the face of newer recommendations.

Citation: Fischer T, Singer AJ, Lee C, et al. *Acad Emerg Med.* 2007;14(12):1172-1175.

Withholding antibiotics in nontoxic children with acute otitis media (AOM) is now recommended to reduce bacterial resistance rates. Using the National Hospital Ambulatory Medical Care Survey (NHAMCS), the authors describe the national trends for prescribing antibiotics in children with AOM presenting to emer-

gency departments in the United States over the past decade.

The authors hypothesized that the rates of prescribing antibiotics would decline over time.

This was a retrospective study of NHAMCS databases. A national sampling of ED visits for 1996–2005 was used to identify trends in ED prescription of antibiotics to patients with AOM. The National Drug Code Directory Drug Classes were used to identify type of antibiotic prescribed.

There were 2.6 million and 2.1 million ED visits for AOM during the first and last years of the study, respectively. Children 2 to 12 years of age accounted for about 40% of all ED visits for AOM, with another 40% in the <2 years age group and 20% in the >12 years of age group.

During the first and last year of the study, 79.2% and 91.3% of the patients with AOM were prescribed antibiotics, respectively. There was a slight increasing trend in the proportion prescribed antibiotics over time ($p=0.02$). The rates of use of antibiotics for AOM were similar in all three age groups.

There was a slight increase in the percentage of children with AOM who were prescribed antibiotics in the ED between 1996 and 2005. In addition, there was no change in the patterns of prescribing antibiotics. ■

Diagnosing Bloodstream Infection: How Many Cultures?

Key point: Up to four sets of blood cultures may be needed to detect bloodstream infections in adults.

Citation: Lee A, Mirrett S, Reller LB, et al. Detection of bloodstream infections in adults: How many blood cultures are needed? *J Clin Microbiol.* 2007;45:3546-3548.

Previous studies have suggested that obtaining two or three sets of blood cultures within a 24-hour period is sufficient to detect almost all bloodstream infections (BSIs) in adults. However, blood-culture systems have evolved substantially since many of these studies were performed. Now, investigators from two academic medical centers have examined the performance of two modern blood-culture systems (BACTEC 9240 and BacT/ALERT).

From January 2004 through December 2005, the investigators enrolled all patients with positive blood cultures that they judged to represent true infection (rather than contamination). They included only patients from whom three or more blood cultures were obtained during a 24-hour period.

Among 629 unimicrobial BSI episodes during the study period, 460 (73.1%) were detected with the first blood culture, 564 (89.7%) with the first two, 618 (98.3%) with the first three, and 628 (99.8%) with the first four. Among the 351 BSI episodes for which four or more blood cultures were obtained, the corresponding cumulative detection rates were 73.2%, 87.7%, 96.9%, and 99.7%, respectively. [Published in *J Watch Infect Dis*, December 5, 2007—Daniel J. Diekema, MD, MS.] ■

Practice Management

Boosting Revenue by Working Harder—or Smarter?

Urgent message: With careful consideration and disciplined planning, ancillary services can add to your bottom line without significantly adding to your workload.

Alan A. Ayers, MBA, MAcc

"It was the best of times, it was the worst of times..."

Could Charles Dickens' discourse provide a better depiction of the urgent care business today? Unprecedented growth in recent years proves the value of a healthcare delivery model like urgent care, based on consumer needs for affordability and convenience.

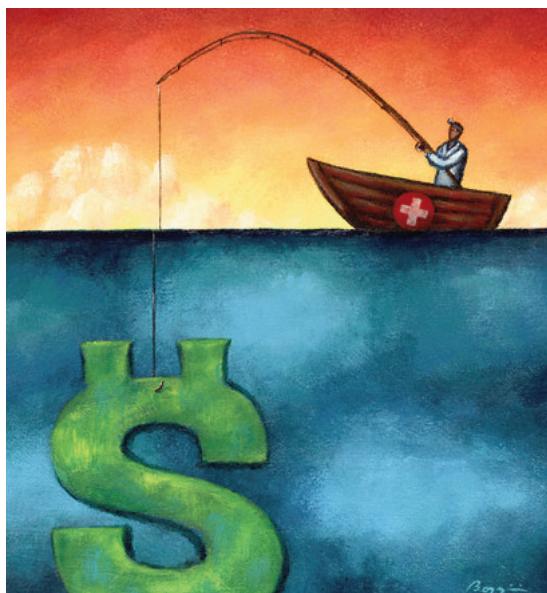
But urgent care is not immune from challenges facing every other medical provider—e.g., declining third-party reimbursement and rising operating expenses.

Falling margins leave providers with just two options—to work harder or to work smarter.

As you well know, urgent care providers are already working hard, seeing more patients per hour than ever and working longer hours to maintain their incomes.

Working *smarter* involves diversifying income streams with high-margin services beyond the core business of walk-in care for illness and injury.

It sounds easy enough, but successful implementation requires careful consideration and disciplined planning.



Lessons from the Retail Industry

Wal-Mart and Nordstrom are both profitable companies, but they attain their profitability in very different ways.

Wal-Mart and other mass retailers focus on volume; their profit is mere pennies on the dollar but they know that low prices will sell more merchandise, resulting in a higher net income.

A challenge for urgent care is that when third-party payors set prices for medical services and offer network participation on "take it or leave it" terms, a provider must lower his or her operating costs to remain profitable.

Because most costs in urgent care are fixed, the provider can be forced into a volume strategy of seeing more patients and working longer hours.

By contrast, Nordstrom and other specialty retailers focus on margin—limiting their appeal to a segment of consumers willing to pay more for personalized attention and unique merchandise. Nordstrom serves fewer customers than Wal-Mart, but makes more money on each sale.

Likewise, urgent care providers who add high-

margin ancillary services can make more money by serving fewer patients.

A Structured and Disciplined Approach

All too often, entrepreneurial physicians succumb to a sales presentation to buy the latest and greatest equipment without a fully developed business case, only to be disappointed by a lack of volume.

Similarly, the decision to diversify revenue through ancillary services cannot be made by emotion; rather, it requires a structured and disciplined approach that includes understanding consumer needs and expectations; analysis of financial, legal, and operational implications; and a plan to execute and measure success.

Brainstorm

The best first step is a brainstorming session. Write down all of the potential services that could be offered in an urgent care setting (some examples are provided in **Table 1**). Be creative, drawing from needs expressed by your patients and what you've seen done elsewhere.

At this point, nothing should be off limits—do not exclude opportunities because of financing, training, or facility constraints. Those will be addressed later.

When it is time to evaluate your list of ideas, ask yourself whether each opportunity is consistent with your interests, strategy, or values. If you don't have a good "gut feeling" about an opportunity, strike it from the list.

Demand

The next step is to evaluate demand.

Demand for any service derives from consumer needs and desires. Before a retailer adds any product to its stores, it asks basic questions such as:

- Is this a product consumers want?
- How much will consumers pay?

TABLE 1.
Common Ancillary Services in Urgent Care

Primary care
Imaging services
Laboratory services
Physical therapy and rehabilitation
Occupational medicine services
Sports medicine services
Diabetes and weight management
Wellness centers
Retail product sales
Anti-aging services
Aesthetic laser and medical spa services
Anti-addiction and psychotherapy services
Immigration medical services
Medical review and expert testimony
Travel medicine services
Pain management services
Medical discount card programs

■ Will consumers buy this product from me instead of from my competitors?

The same questions should be asked of an urgent care provider when considering ancillary services.

For example, a provider interested in adding "medical spa" offerings such as treatment of facial lines and laser hair removal should first understand the target market (what is their age, where do they live, how much disposable income do they have...?), as well as the intrinsic and social needs that drive those people to improve their appearance.

In the case of these services, the provider may find that the market is largely female, middle income, single or divorced, and driven by a perceived need to "ex-

tend youth," boost their self-esteem, and become more appealing to the opposite sex.

Now, ask yourself this: Is this a market already served in your urgent care center, or would it be a new market you would have to attract? Selling additional products and services to existing customers is generally a more successful and less expensive strategy than marketing to an entire new group of consumers, particularly if the service is in response to an unmet need you know and understand.

Supply

After analyzing demand, it's important to consider supply.

To continue our medical spa example, competitive analysis may uncover a host of providers at different price points, including dermatology and plastic surgery physician offices, day spas and destination resorts with nurses on site, and, in some states, podiatry and dental offices.

Low barriers to entry, such as vendor financing and weekend training, have made it easy for a variety of professionals to offer these services. As you identify competitors, ask how their facilities and other ameni-

ties compare to yours. Are they meeting consumer expectations?

If the consumers you're trying to reach expect to receive medical spa services at an upscale facility with a full range of beauty products, it may be necessary to invest in fixtures and renovations to create an atmosphere more reminiscent of a "spa experience"—as some urgent care centers that successfully offer aesthetic services have done. Otherwise, your market could be limited to price-conscious consumers who don't care about frills, and to compete you'd have to adopt a volume strategy by offering the lowest price.

Adding ancillary services is more than purchasing equipment, being trained, and running an ad, however. A thorough understanding of consumer expectations and local competition is required.

Low barriers to entry and high competition almost always necessitate a volume strategy. To attain high margins, a practice needs to offer something unique, which may be as simple as added convenience to existing customers.

The higher the initial investment to get started or the presence of regulatory hurdles that limit the number of providers in an area, the more able a practice will be to capture and defend high margins.

Business Plan Development

Once a plausible opportunity has been identified, a business case should be developed that documents expected revenues, projected expenses, and any impact on existing operations.

Projected revenue should include future trends in pricing and demand. Expenses should include capital expenditures for equipment, facility enhancements, staff training, and start-up marketing campaigns.

These data are used to create pro-forma financial statements and will demonstrate future effects on productivity and cash flow. As with starting a new urgent care center, losses should be expected until volume is sufficient to achieve profitability.

Five Questions to Consider When Evaluating the Wisdom of Offering Ancillary Services

1. Are the services medically appropriate and consistent with good patient care?
2. Is there consumer demand or a community need for the service?
3. Do medical personnel have the appropriate training, skill, and professional competence to administer the service?
4. Will consumers utilize an urgent care center for the service and will changes be required to existing operations and facilities?
5. Will the service be provided in compliance with applicable laws and standards?

In addition to the pro-forma, you should create a formal business plan that evaluates competition, legal and regulatory hurdles (including Stark Laws, Medicare regulations and state/local restrictions), marketing plans, and integration with current operational processes and systems.

While many people treat the business plan as a formality to attain financing, when done correctly it assures that all of the

required analysis has taken place prior to investing.

Short cuts, such as applying someone else's business plan, can often lead to disastrous results because what is true of one market, location, or provider may not be true of another.

In fact, if the business planning process is followed correctly, many times the final decision will be to *not* proceed with a project.

There are many great examples of urgent care practices that have successfully implemented the services in **Table 1** and increased their bottom lines while better serving their patients.

A structured and disciplined approach to identifying, evaluating, and planning ancillary services can assure that your revenue diversification efforts result in the "best of times" and not the "worst." ■

TAKE-HOME POINTS

- "Working smarter" involves diversifying income streams with high-margin services.
- Brainstorm fresh ideas and "borrow" good ideas that have been successful elsewhere.
- Give due consideration to the basic economic principles of supply and demand.
- Create a business plan with a sense of purpose, not simply as an exercise or a task to be completed.
- Careful analysis may lead you to conclude that a given service is not a good fit for your practice.



Insulating Your Practice from Sexual Harassment Claims

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

Merriam-Webster's Dictionary of Law describes *sexual harassment* as a form of employment discrimination consisting of unwelcome verbal or physical conduct directed at an employee because of his or her sex.

Quid pro quo sexual harassment occurs when a condition of future or current employment is predicated upon fulfilling sexual demands.

Finally, *hostile environment sexual harassment* occurs when the harassment has the effect of interfering with the victim's work performance or creates an intimidating, hostile, or offensive environment that affects the victim's psychological well-being.

Sexual harassment claims and lawsuits are among the most challenging and devastating claims affecting providers both in their capacity as an employer and as a healthcare professional because no matter how unsubstantiated the claim is, the aftermath can have significant recriminations both personally and professionally.

As with medical liability issues, you can help insulate yourself and your practice from sexual harassment claims by taking a few simple steps.

Sexual Harassment Policy

Most important, ensure that your office has a sexual harassment policy; every multiperson office should have one—in writing.

The document should delineate a zero-tolerance policy toward the offensive conduct and should instruct the victim to report any instances of misconduct immediately to their supervisor or to you. The policy should be part of the new-hire handbook and should be kept up to date.

Consult an attorney who specializes in employment law to



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ensure your policy contains the necessary information. Post literature detailing the laws and policies about sexual harassment and discrimination on the law in the employee break room.

Also, provide handouts about sexual harassment to your employees.

These actions will help you defend against a sexual harassment claim which the claimant believes occurred in your office.

Under federal law, an employer is strictly liable for sexual harassment committed by the supervisor or manager of the claimant.

Essentially, this means that the employer is liable in a sexual harassment claim decided against a manager or supervisor. Strict liability of the employer can also occur when one coworker sexually harasses another coworker if the employer is aware of it and does not take appropriate action.

Therefore, as the employer, you must investigate and document in writing all reports of sexual harassment. The documentation should include the findings of your investigation and what, if any, corrective action you will be taking.

It is often a challenge to maintain a professional working environment in a close-knit, high-stress environment. You will open yourself up to significant liability if the culture of your office permits or encourages off-color jokes, sexually suggestive comments or photos, or access to adult-content Internet sites.

Sexual harassment claims can also arise from allowing employees to work in an environment that is both objectively and subjectively offensive to a person of reasonable and ordinary sensitivity. This will become a problem if a disgruntled employee decides to make it an issue.

Workplace Romance

Given the amount of time spent at work, office romances are not an uncommon occurrence. Persistent demands for a date or relationship made by one employee which are not favorably received by another, however, are frequently the genesis of sexual harassment claims.

HEALTH LAW

A single inquiry by a physician to an employee would probably not constitute sexual harassment; however, the working relationship may become permanently impaired after the overture. The bottom line is to avoid office romances, particularly if you are in a position of authority or if the individual is in your direct reporting chain.

Having a sexual relationship with a patient is a sure-fire way to end up in front of your state medical board and/or in civil court if the relationship goes sour.

State medical boards generally forbid sexual encounters with current patients. Check your state medical practice act to determine the amount of time that must lapse after you have discharged a patient from your practice before you can see him or her romantically.

I know of one instance where a bitter ex-wife informed the state medical board that 18 years earlier, when she and her physician ex-husband started dating, she was still his patient.

Suffice it to say, the state medical board's response was less than positive about his relationship despite the fact that it was 18 years ago.

Know Your Insurance Policy

Understanding your insurance policy is of paramount importance in defending your practice against claims of sexual harassment.

A typical office will have two kinds of insurance: a general liability policy which covers slip and falls and events unrelated to the professional rendering of medical care, and malpractice or medical liability insurance which relates to claims arising in the professional rendering of medical services.

Many general liability and medical liability insurances exclude coverage of claims which allege sexual harassment, discrimination, or other types of sexual misconduct. If you get named in a sexual harassment suit and your policies exclude that class of claims, you will have to pay the cost of mounting a defense and whatever adverse judgment is awarded against you or your practice.

In summary, an ounce of prevention is worth a pound of cure insulating your practice against claims of sexual harassment, and there are many ways to protect yourself and your office against these very damaging claims.

In the end, following a few guidelines will lower your risk:

- Avoid office romances.
- Do not have romantic relationships with patients.
- Don't tolerate a sexually charged office atmosphere.
- Investigate and document claims of sexual harassment.
- Distribute sexual harassment information, including your policy, to your employees.
- Keep your policies and procedures up to date. ■



Call for Articles

The *Journal of Urgent Care Medicine* (JUCM), the Official Publication of the Urgent Care Association of America, is looking for a few good authors.

Physicians, physician assistants, and nurse practitioners, whether practicing in an urgent care, primary care, hospital, or office environment, are invited to submit a review article or original research for publication in a forthcoming issue.

Submissions on clinical or practice management topics, ranging in length from 2,500 to 3,500 words are welcome. The key requirement is that the article address a topic relevant to the real-world practice of medicine in the urgent care setting.

Please e-mail your idea to

JUCM Editor-in-Chief
Lee Resnick, MD at
editor@jucm.com.

He will be happy to discuss it with you.



Public Speaking Skills Enhance Professional Standing and Proficiency

■ FRANK H. LEONE, MBA, MPH

Whether you are a clinician or a sales professional—or both, as is often the case in the urgent care occupational medicine arena—it is likely that you will find yourself in front of an audience giving a talk at some point.

The topic may be a clinical one or something intended to get the audience to employ your professional services; either way, proficiency as a public speaker will greatly improve your chance of making the most of the opportunity.

Following are some key ingredients to a successful talk:

- **Practice.** The best way to become an outstanding public speaker is to do it over and over again. Seek out every opportunity, whether the group is related to your profession or not, and work on your skills.

It need not be a large audience or especially formal setting, either; local Rotary Clubs always need speakers for their weekly meetings, for example.

- **Prepare.** Always take more time than seems necessary to refine and practice your talk. You should know your material so well that you can give it without the aid of notes or audiovisuals.

- **Structure.** As Mark Twain famously advised: "Tell 'em what you're going to tell 'em, then tell 'em, then tell 'em what you told 'em." Let your audience know where you are taking them and offer a crisp summary at the end.

- **Involve.** Assume that your audience is tight, unmotivated, and lackadaisical. You need to thaw this frost from the "get go" and to get them involved. Your audience needs to be engaged both physically and mentally.



Frank Leone is president and CEO of RYAN Associates and executive director of the National Association of Occupational Health Professionals. Mr. Leone is the author of numerous sales and marketing texts and periodicals, and has considerable experience training medical professionals on sales and marketing techniques. E-mail him at fleone@naohp.com.

I ask an audience to stand up to get their blood flowing. At the same time I like to get them to start thinking about the subject at hand. With a larger audience, ask a simple question, such as "What's the greatest challenge you face in dealing with the workers' comp system?" and have them share their answer with their neighbors.

- **Be yourself.** Many speakers think that humor has to be part of any public talk. If you are particularly funny, go for it. On the other hand, if your personality is of the more no-nonsense, business-first variety, do not try to be a comedian.

- **Monitor your movements.** Beware of two extremes: the Wooden Indian and the Energizer Bunny.

The former hides behind a podium and maintains a rigid posture (no wonder their audience usually finds their talk boring!). The latter tends to race back and forth across the stage. Your audience would likely find such a technique forced and distracting.

- **Speak from the heart.** So many talks seem canned and come off as insincere. Incorporate a "from the heart" segment into your presentation. When using phrases such as, "Let me speak from the heart for a moment," markedly slow down your pace and delivery.

- **Minimize audiovisuals.** I tend to refrain from audiovisual support during major presentations. Eye contact with an audience is crucial and the use of audiovisuals inevitably compromises such contact.

Further, audiovisuals can be a distraction; you will be tempted to turn toward the screen, read words that are plainly seen by your audience, and periodically have to address errors in the audiovisuals or equipment.

- **Offer a challenge.** Make your audience think. Ask questions that are associated with your next thought (e.g.,

Continued on page 36.



Deciphering Payor Language and Other Challenges

■ DAVID STERN, MD, CPC

Q. Many procedures, such as injections and fracture care, are reported to patients as "surgery." Patients sometimes accuse us of false billing, as they don't consider these procedures to be a "surgery." How can we fix this problem?

A. All third-party payors have installed computer software programs that have code descriptions loaded for each CPT code. Many of these code descriptions are hard to understand, and sometimes they are not truly accurate.

Getting payors to come up with more accurate and patient-friendly code descriptions is likely to take many years. When patients express concern, you will need to educate them to them on this issue.

You may want to give your staff a script to follow. An example script might be, "Although many procedures are not accurately described as 'surgeries,' the insurance company may have that word loaded into their software program. They often use the term 'surgery' for many procedures that do not involve a trip to an operating room nor a skin incision."

You may even offer to read or mail the patient the actual description from the CPT manual, as published by the AMA.

Q. My new urgent care will be performing multiple procedures, including suturing lacerations, conscious sedation, and casting fractures. Since I am not a specialist, should I use different codes to report procedures performed in an urgent care center?

A. All physicians use the same CPT, ICD-9, and HCPCS codes for the same procedures, diagnoses, and supplies.

However, some payors do pay more for the same proce-

dure—or even the same evaluation-and-management (E/M) codes—if the procedure (or E/M) is performed by specialty physicians. Medicare pays the same amounts for a procedure, regardless of the specialty the physician. With other payors, it is not uncommon to offer a fee schedule at a 20% to 30% premium for specialty physicians.

Some urgent care centers have become accredited through UCAOA and have been able to obtain contracts as physicians specializing in urgent care medicine. However, they often encounter significant obstacles in receiving recognition as specialty physicians by payors.

Q. Do I have to use a preventive-care E/M code for a patient visit when the patient does not have a chief complaint? An example would be a patient who has hypertension but does not have any symptoms.

A. A chief complaint is required for physician office E/M codes (99201-99205). For the asymptomatic patient, you can simply note the problem; for example, "Patient presents for a chief complaint of hypertension...."

Q. How would I document a history of present illness (HPI) for a patient who has an asymptomatic problem, such as hypertension or elevated blood sugar? How could I document the duration, location, modifying factors, associated symptoms, quality, timing, context, and severity?

A. Per the 1995 or 1997 E/M coding guidelines, you can note when the problem first started (i.e., duration); under the associated symptoms, you could note that the problem is currently asymptomatic.

Under 1997 E/M coding guidelines, you can get credit toward the HPI in past medical history under the chronic/inactive problems. If you note one chronic/inactive problem and its status, you get credit toward a brief HPI. If you note at least three chronic/inactive problems and the status of at least three

Continued on page 36.



David Stern is a partner in Physicians Immediate Care, with nine urgent care centers in Illinois and Oklahoma, and chief executive officer of Practice Velocity (www.practicevelocity.com), a provider of charting, coding and billing software for urgent care. He may be contacted at dstern@practicevelocity.com.

CODING Q & A

chronic/inactive problems, you get credit toward an extended HPI.

Q. Can I use the established patient E/M code 99211 for medication refills performed by a nurse?

A. A medication refill by itself is not a separately coded service. If you only provide a simple medication refill, then no E/M code is appropriate. If the clinical staff provides an additional, medically necessary E/M service beyond the medication refill, you may use code 99211.

Make sure that the clinical staff documents the actual E/M service in the chart. A simple note with the patient vitals and documentation of the refill is not adequate, as you must specify the additional E/M service that was provided.

For example, it is appropriate to document side effects of a medication, the clinical staff's discussion with a physician, and the recommendation for follow-up.

Q. Is it ever appropriate to bill a level-IV E/M code for a visit that does not have a documented physical exam?

A. In some circumstances, it may be appropriate to code a 99214 without a physical exam, as an established patient E/M is based on the three elements of the E/M—i.e., history, physical exam, and medical decision-making—but with the established patient E/M, the lowest of the three elements is dropped and the next highest element determines the actual code.

Thus, it is possible to drop the physical exam from the E/M algorithm and document only the history and medical decision-making; the code is determined by the lowest level of the history and medical decision-making.

With a new patient E/M, however, the lowest element is *not* dropped from the algorithm; instead, the lowest element of the history, physical exam, and medical decision-making actually determines the level of code.

In other words, when basing the E/M code on these three elements, it is not possible to compliantly code a level-IV new patient E/M code (99204) without documenting a physical exam.

It may, however, be compliant to code a level-IV new patient (or established patient) E/M without a physical exam if more than half of the total face-to-face time between the patient and the provider involved counseling and/or coordination of care. If coded by time, the total face-to-face time of a 99214 is 25 minutes; the total face-to-face time for a 99204 is 60 minutes.

Make sure that you document the total face-to-face time, and specify that more than half of the time was devoted to counseling and/or coordination of care. In addition, make sure you describe the nature of the counseling. ■

OCCUPATIONAL MEDICINE

"When was the last time that you..." or "What do you think is the best solution to the problem that I just described?").

■ **Show appreciation.** Let your audience know how appreciative you are at both the beginning and end of your presentation. Be certain that the appreciation is stated from the heart (say something like, "I never take for granted that busy people such as yourselves can find the time to hear what I have to say; it means a great deal to me. Thank you.").

Finally, some quick tips to drive these points home:

■ **Rearrange the room if necessary.** Make the room comfortable for you. Rearrange tables, put people closer to one another, narrow your sight line, etc., so the atmosphere supports your objective as a speaker.

■ **Repeat questions from the audience and keep your answers brief.** In addition to ensuring that every member of the audience hears every question, repeating each question gives you time to think. It also clarifies things for your audience. And keep your answers brief; they may be of interest only to the person who asked the question.

■ **Never turn you back to your audience.** Never turn around to look at a screen or walk into an audience to make a point.

■ **Repeat key points.** Key points are far more important than non-key points. Always repeat them.

■ **Don't fear silence.** Nobody likes a motor mouth. Give your audience a chance to catch their breath. Silence is golden.

■ **Alter your pitch.** Audio record and listen to your next presentation. Are there periods in which you speak louder than normal and others softer than normal? There *should* be.

■ **Vary the speed of your delivery.** Likewise, speed should be continuously adjusted throughout a presentation.

■ **Pause before and after important points.** Pauses reinforce what you just said. What better time than before and following key points?

■ **Act and look confident.** If you enjoy speaking and are well prepared, you should be confident. Makes certain that this confidence comes across.

■ **End with an emotional story.** We live in an emotional world in which good deeds vastly outnumber bad ones, even though the bad ones tend to be repeated at least as often as the good ones. Hook on to a positive, emotional story and retell it. ■

Career Opportunities

SEATTLE, WASHINGTON – URGENT CARE
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For further information, contact: Wendy Jones,
Spectrum Health Physician Recruitment,
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NORTH CAROLINA

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Career Opportunities

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Sandy Heeg, Physician Recruitment, Marshfield Clinic
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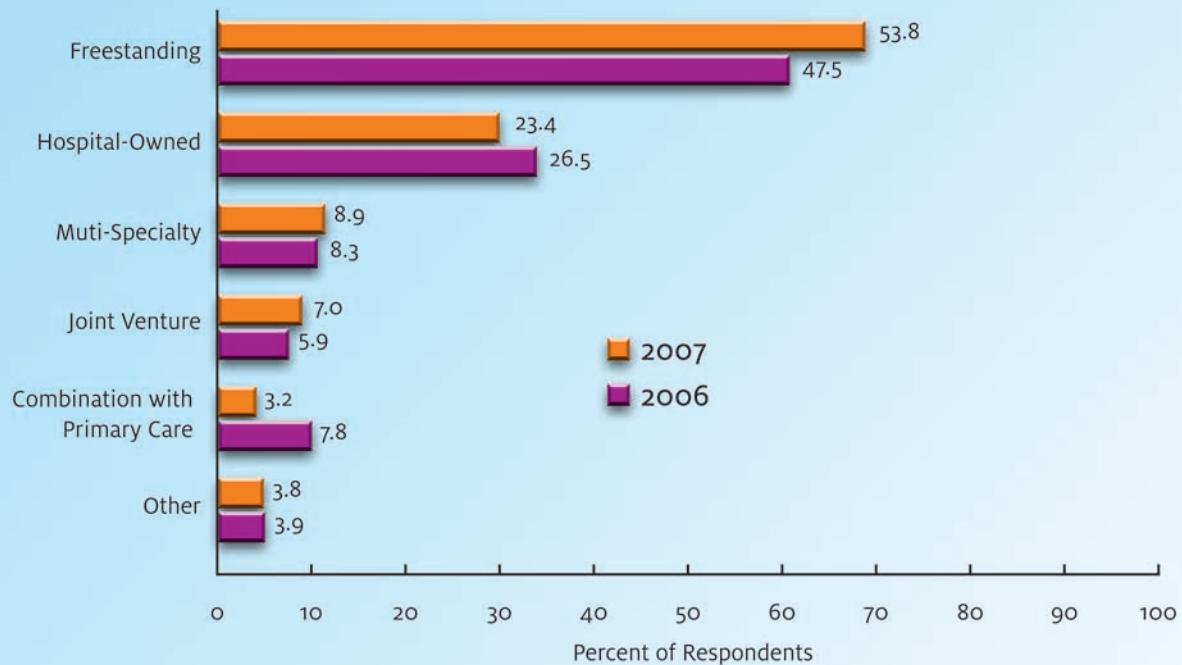
DEVELOPING DATA

As an emerging distinct practice environment, urgent care is in the early stages of building a data set specific to its norms and practices.

In Developing Data, *JUCM* will offer results not only from UCAOA's annual benchmarking surveys, but also from research conducted elsewhere to present an expansive view of the healthcare marketplace in which urgent care seeks to strengthen its presence.

In this issue: How did the corporate structure/organizational models among participants in UCAOA's benchmarking survey change between the 2006 and 2007 reports?

CORPORATE STRUCTURE/ORGANIZATION



Source of data: Benchmarking Your Urgent Care, 2007. Urgent Care Association of America (www.ucaua.org).

While both the 2006 and 2007 reports were products of a relatively small sample, it is interesting to note the movement toward freestanding clinics (from 47.5% of respondents in the 2006 report to 53.8% in the latest edition) at the expense of hospital-owned clinics (which declined from 26.5% to 23.4%) and clinics that exist in combination with primary care practices (from 7.8% to 3.2%).

As noted in previous issues of *JUCM*, UCAOA has embarked on an ambitious new research project in partnership with Harvard University and Massachusetts General Hospital. The report based on those data will be highlighted in a future issue and communicated in depth to UCAOA members by the association.

Are you aware of new data that highlight how urgent care is helping to fill gaps in patient satisfaction, or healthcare in general? Let us know in an e-mail to editor@jucm.com. We'll include them in an upcoming issue and on our website.

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