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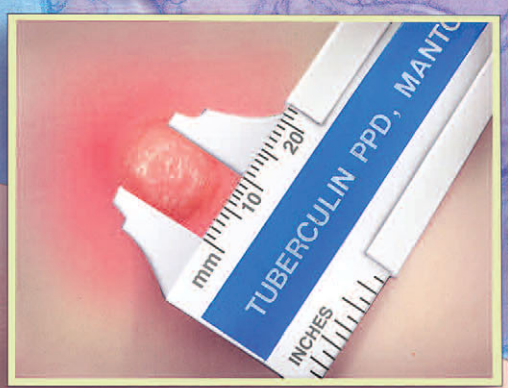
Tuberculosis Screening in Urgent Care Medicine



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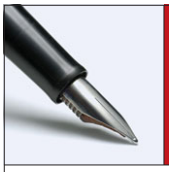

LETTER FROM THE EDITOR-IN-CHIEF

Healthcare's Title Bout: Free Market Economics KOs Reform

At the risk of oversimplifying, the healthcare "crisis"—and subsequent attempts to "reform" it—really boils down to a coverage crisis and a cost crisis. The two, of course, are inextricably linked. And every attempt to solve one seems to exacerbate the other.

Our healthcare delivery system has essentially failed to manage cost *and* manage coverage simultaneously. The teeter-totter is perpetually imbalanced.

The problem with reform efforts to date is complex. However, the root of the problem is simple: The people don't want it. Reform requires individual sacrifice—pooled risk and pooled resources in some way rationed and/or managed for the greater good.

Americans are not culturally wired for this. We want to eat what we want, say what we want, and do what we want. This is the American way. We are a society of individuals operating in a free market that only reforms itself in a crisis. We simply do not have a societal commitment to being proactive and preventative. We impose rules for banks after they cheat us, impose environmental regulations after disasters, and we won't really fix healthcare until the free market demands it, which will not happen until access to adequate healthcare is restricted to a voting majority.

Until then, there is simply no political or social will to act otherwise.

Here's a look at a few underlying features of the American social and political psyche that create barriers to reform:

Consumerism. Consumerism is in direct conflict with sacrifice. Freedom of choice, information technology, and relative economic prosperity have driven over-consumption for decades. We are a society without an "off" button, addicted to everything from food to medicine...a little is good, but more is better. Healthcare consumption is a status symbol. Getting an MRI for a sprained knee is a sign of powerful influence. We are hesitant to give up this influence for the sake of the public good, and are even willing to ignore evidence of potential harm.

Intervention=care. A physician willing to intervene on a patient's behalf is revered, even when the intervention has unproven benefit. Willingness to intervene is somehow equated with quality of care. *Quantity* of care still reigns supreme in the eyes of the American people.

Politics. As The Kinks advised, "Give the People What They Want!" Public will drives political inertia. To date, the general public has been unwilling to make the access and choice sacrifices necessary to make real heath reform work. The majority of Americans have access to adequate, reasonably priced healthcare. The "healthcare crisis" is not a crisis at all for the majority of Americans. That would have to change significantly to affect the will of the people. There simply aren't enough uninsured people. And from within the "insured class," there just isn't enough support for a more socialized healthcare system to tip the scales in reform's favor. A political price will be paid by those who fight the will of the people.

Decision-making power. Who will decide who gets what? There is almost zero support for giving this power to government or health insurance companies. The only plausible decision-makers are physicians. However, utilization management is entirely disincentivized in the current system. Until the public frees the physician of the burden of liability, physicians will prove incapable of managing resources. In addition, the current payment system encourages "utilization" (procedures, admissions, testing) *and* discourages "management" and "prevention." As such, with incentives misaligned, the one group capable of contributing to real healthcare reform is handcuffed.

Healthcare, despite layers of regulations and a multitude of power-brokers, is a veritable free market; as such, it must be responsive to the economic will of the majority of its consumers.

The "healthcare crisis" as it stands today is, at most, an intellectual crisis to the majority of Americans. While teetering on the precipice of sustainability, it will require a market crash on the order of the Great Depression to generate enough public will for change. It's the American way. ■

Lee A. Resnick, MD
Editor-in-Chief
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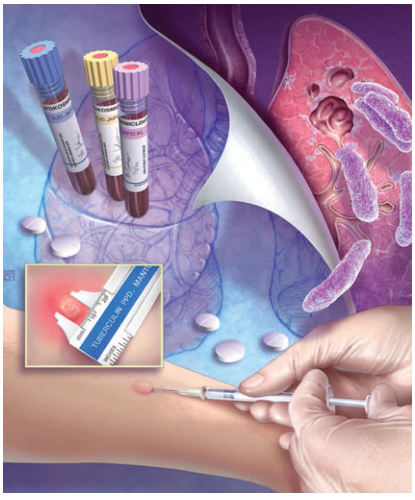

CLINICAL

9 Tuberculosis Screening in Urgent Care Medicine

Urgent care clinicians—particularly those whose work includes occupational medicine—are often called upon to screen for infectious disease. Familiarity with procedures for tuberculosis testing is essential.

By Jacqualine Dancy, PA-C, MPAS

PRACTICE MANAGEMENT

27 Agencies Can Extend Clinical Recruiting and Staffing Capabilities

Recruiting and hiring duties can stretch busy urgent care owners and managers to the max. Staffing agencies can be an invaluable resource. What do you need to know before engaging one?

By Alan A. Ayers, MBA, MAcc

IN THE NEXT ISSUE OF *JUCM*

The Department of Transportation's responsibility to ensure that commercial drivers are physically qualified to operate in interstate commerce can mean new revenue for urgent care providers who qualify to perform certification exams.

WEB EXCLUSIVE

In the Beginning

What lessons can be learned from entrepreneurs who have thrown open the doors of a new urgent care center? This new series, which will appear periodically in the digital version of *JUCM*, explores the inevitable ups and downs. The first installment spotlights Medical Express Care in Dunmore, PA. Available only at *www.jucm.com*.

By Sally Michael

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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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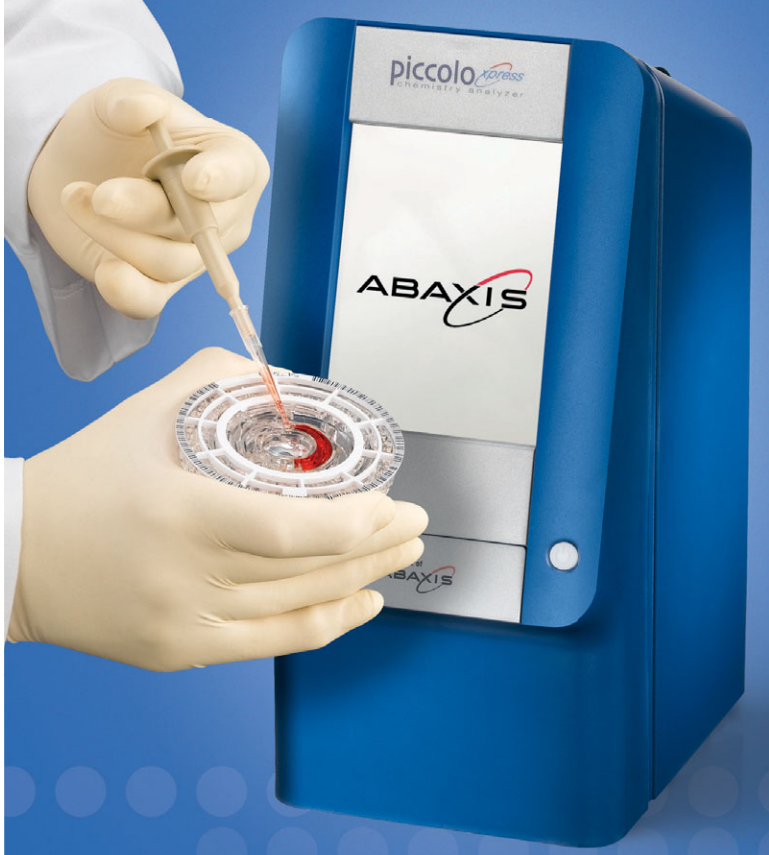

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Count Me In

LOU ELLEN HORWITZ, MA

Sometimes, it's hard to stand up for what you believe in—especially if you are standing alone. Hopefully, you all know that feeling of (perhaps metaphorically) putting your hands on the seat of your chair and pushing yourself somewhat reluctantly, somewhat proudly, to your feet. Or letting your hand creep high above your shoulder in a crowded room to show your support—or lack thereof—for something. It's hard to take a stand, and a bit scary.

It would follow, then, that it's much easier to stand up and support something when everyone else in the room is doing the same, to jump to your feet with your neighbors and burst into thunderous applause: "Touchdown!"

All this makes you wonder why urgent care is so quiet. Why so few of us actively seek each other out to bond together and *shout* about our industry.

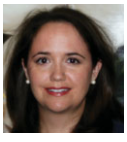
Do you know that UCAOA, as successful as we have been, represents (via membership) only about 1,500 different urgent care organizations? That's a good number and we are thankful for every one of you, but it's curious why more of your brethren have not joined us.

During the convention in Orlando in May, I was doing a talk about the Certified Urgent Care designation. One of the questions that came up was, effectively, "Why should we do this? What's in it for me?"

I think that question speaks to the heart of what is hindering us from becoming the industry we can be.

If we are going to bother to "associate" at all, our thinking needs to shift from "What's in it for me?" to "What's in it for *us*?" Otherwise, you are just passing by, taking what you can get, and moving on—and that never builds greatness. What builds greatness is, well…building! And that takes a lot of bricks and at least a modest level of dedication from the bricklayers (i.e., you).

I'm not asking everyone to give the time to be a committee chair or a board member, or even to come to every conference we have. I am asking you, at the very least, to become a member and support the activities and efforts of others who are laying bricks on your behalf every single day. Think of what we could build together if every urgent care professional reading this (that means you) participated even a little bit.



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

"Be the change you want to see in the world."

- Mohandas Gandhi

For 1,700 of you, an up-close and personal opportunity is already in your lap. You hold the log-in and password to your site's participation in the UCAOA Benchmarking Survey. Have you used it? Are you sending in your own data to add to the collective so we can answer the questions you all have for us, and the questions that legislators and payors and patients have for us?

This is your chance to be heard—and, more importantly, for your industry to be heard.

In January, I wrote a column (primarily for the solo urgent care owner) about not being alone, and how there are thousands of urgent care owners just like you across the country, going through the same things. That's true of every biller, coder, physician, practice manager, registrar, x-ray tech, nurse…all of you. But if you don't come together and support each other, you may as well actually be alone.

Gandhi said it well: "Be the change you want to see in the world." It's not going to happen without you. It's not going to happen just because you wish it would or think it should. It's going to happen because you make it happen. Become a member. Give us your benchmarking data. Answer a question on UConnect. Come to a conference. Share the industry talking points.

Be the change you want to see. We're building it—and I hope you will come. It's going to be awfully lonely without you, and honestly, not nearly as much will get done. ■

JUCM CONTRIBUTORS

Exactly what array of services defines an urgent care center continues to be something of a mystery among the media and general public (though the Urgent Care Association of America continues to set that standard through a variety of initiatives).

Owing to the entrepreneurial nature of urgent care, though, there is a broad range of potential ancillary services that can not only bring new revenue into a center, but also introduce the concept of urgent care to a whole new patient population. Infectious disease screenings, such as those conducted as part of pre-employment physicals, are a prime example.

In Tuberculosis Screening in Urgent Care Medicine (page 9), **Jacqualine Dancy, PA-C, MPAS**, explains why familiarity with the proper procedures for testing for TB is of paramount importance in the urgent care setting, especially if occupational medicine is a priority.

In addition to her responsibilities as a physician assistant, Ms. Dancy serves as compliance officer and clinical staff educator at Med+Stop Urgent Care Centers in San Luis Obispo, CA. She is a graduate of the University of Nebraska School of Medicine, with a specialization in urgent care medicine, and received training at the University of California–Davis School of Medicine.

As if keeping the operation running smoothly and profitably isn't daunting enough, what happens when you find your clinical staff buckling under the weight of increasing patient visits? More and more operators are turning to agencies that specialize in matching practice with practitioner.

Agencies Can Extend Clinical Recruiting and Staffing Capabilities (page 27), by **Alan Ayers, MBA, MAcc** presents sound advice on what you need to know before engaging an agency to help in your search.

Mr. Ayers is content advisor to the Urgent Care Association of America and vice president of strategy and execution, Concentra Urgent Care in Dallas, TX.

We're excited to introduce a new, web-exclusive series this month, as well. In the Beginning will offer a view of the ups and downs of starting an urgent care center. Author **Sally Michael** will recount the trials and triumphs of select urgent care centers with an eye toward illuminating their evolution from idea to viable business. The first installment, which focuses on Medical Express Care in Dunmore, PA is available now, exclusively at *www.jucm.com*.

Ms. Michael is vice president for administration at The Lohman Group, Inc. in Falls Church, VA. A life-long communications professional, she also directed the largest HIV/AIDS program in Virginia in the late 1990s.

Also in this issue:

Nahum Kovalski, BSc, MDCM reviews new abstracts on stroke risk after transient ischemic attack, children with periorbital swelling, and children with suspected gastroenteritis.

John Shufeldt, MD, JD, MBA, FACEP draws parallels between the preparation for and experience of competing in a triathlon with running a successful business—and career.

David Stern, MD, CPC responds to reader queries on coding for splints, modifier—QW, and other issues.

Frank Leone, MBA, MPH referees the debate over whether urgent care occupational medicine services are better sold as a commodity or a relationship.

If you'd like to contribute, as well, drop a note to Editor-in-Chief **Lee A. Resnick**, MD, at *editor@jucm.com*. ■

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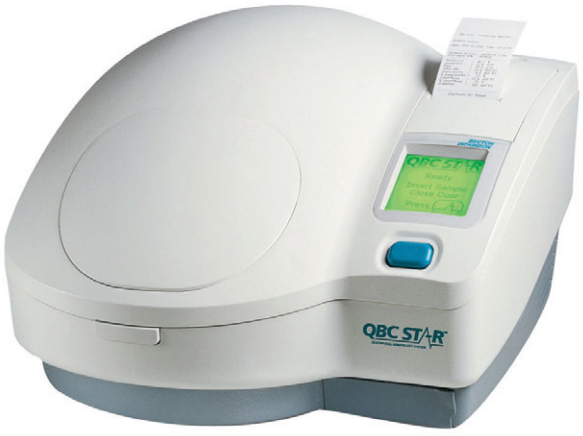

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Tuberculosis Screening in Urgent Care Medicine

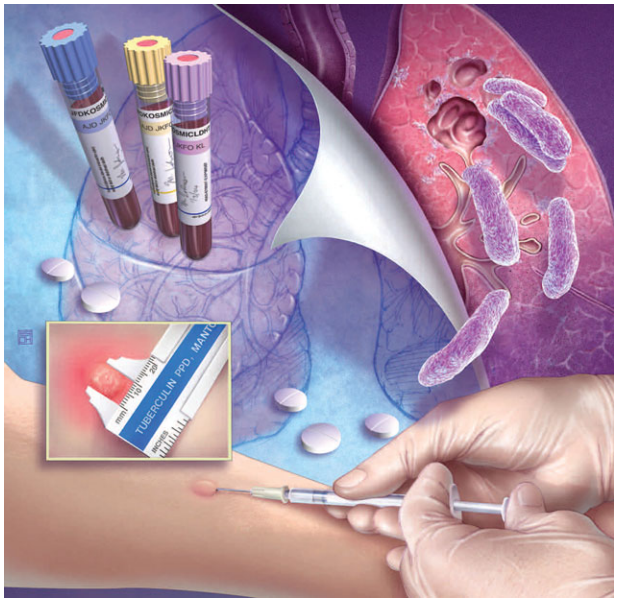
Urgent message: Often placed in the role of first-line clinicians with respect to testing for and treating infectious disease, urgent care practitioners are ideally suited to provide screening services for tuberculosis.

Jacqualine Dancy, PA-C, MPAS

Introduction

In addition to urgent care services, many of us also offer occupational medicine and provide post-offer/pre-employment evaluations. As such, urgent care clinicians play a key role in screening for tuberculosis (TB). In fact, understanding the complexity of the screening process is essential to our specialty.

This article will provide an overview of screening tests and clinical assessment of TB.



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Disease Overview

Tuberculosis is a communicable disease caused by the bacteria *Mycobacterium tuberculosis*. While this bacterium most often attacks the lungs, TB can infect many areas in the body, such as the kidneys, spine, and brain.

Tuberculosis is spread primarily by aerosol droplets person-to-person.

The clinical spectrum ranges from non-infectious, asymptomatic, latent TB infection (LTBI) to highly contagious pulmonary infections with significant morbidity and even death.

For the purpose of this article, we will focus on pulmonary tuberculosis.

According to the Centers for Disease Control, the incidence of TB in the United States has declined over the past 50 years from 63,534 in 1958 to 12,906 in 2008.

Similarly, the number of deaths from TB has also declined dramatically; in 1958, 12,417 Americans died from TB. Mortality in 2006, the last year for which deaths have been reported, was 644 people. Continuing to increase understanding of the disease process and appropriate screening tools can only help this trend continue.

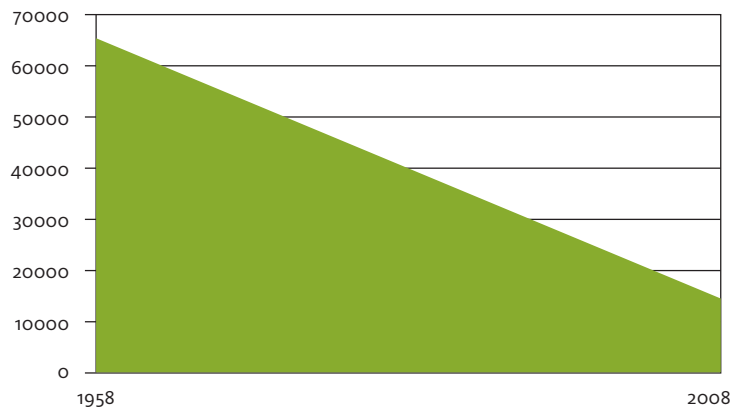
Active vs. Latent Tuberculosis

We will focus our discussion on two disease states: active TB and latent tuberculosis infection (LTBI).

In active TB infection, the bacteria multiply, and the patient will eventually demonstrate signs of active disease. The most common signs and symptoms of active TB include:

- anorexia

U.S. Incidence of TB



Source of data: Centers for Disease Control and Prevention.

Table 1. Interpreting TST Tests

Induration of	is classified as a positive in patients
≥5 mm	• who are HIV positive (especially with AIDS and a low CD4 count) • who have had a recent close contact with a known or suspected TB-infected person • who have had an organ transplant and other immunosuppressed patients (the equivalent of 15 mg/day of prednisone/day or more for >1 month is considered immunosuppressed) • who are receiving specialized treatment for rheumatologic or immunological disease • with fibrotic changes and calcific changes on chest x-ray consistent with old TB.
≥10 mm	• who do not meet the any of the above criteria, but belong to one or more of the following groups having moderate risk for TB: – who are foreign-born, recently arrived to U.S. (i.e., within 5 years) from area with high incidence of TB – who inject illicit drugs – who reside or, who work in high-risk congregate settings: prison and jails, nursing homes, long-term care facilities for the elderly and the young (<4-years-old), healthcare facilities and homeless shelters – who are mycobacteriology laboratory personnel – who have medical conditions known to increase the risk for progressing from LTBI to active TB infection; these medical conditions include: diabetes, silicosis, prolonged corticosteroid therapy, other immunosuppressive therapy, cancer of the head/neck, hematological and reticuloendothelial disease, end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption, or weight of more than 10% below ideal body weight – <4-years-old, or children and adolescents exposed to adults in high-risk categories.
≥15 mm	who do not meet any of the above criteria.

- weight loss
- malaise
- fevers
- chills
- night sweats
- cough (which may include hemoptysis and pleuritic chest pain).

Affected patients often have an abnormal chest radiograph and a positive acid-fast bacilli sputum stain and culture in addition to, often, a positive tuberculin skin test (TST).

The patient diagnosed with active tuberculosis must be considered contagious and needs antibiotics, along with public health intervention to minimize the spread of disease.

In cases of LTBI, the patient usually has a positive TST but does not exhibit any signs or symptoms of illness. These patients are not contagious. The bacteria live in the host, whose immune system has been able to halt the bacterial replication process (at least temporarily). Should these LTBI patients become immunocompromised, the bacteria may begin to replicate and cause active TB disease.

Treatment of LTBI is intended to lessen the chance of subsequent conversion to active disease. Among the many drugs currently available to treat tuberculosis are:

- isoniazid
- rifampin
- rifabutin
- rifapentine
- pyrazinamide
- ethambutol
- cycloserine
- ethionamide
- streptomycin
- capreomycin
- p-aminosalicylic acid
- the fluoroquinolone class.

We will focus on screening for, rather than treating, active and latent tuberculosis.

Screening Tests

The TST is the most widely used screening test for tuberculosis infections. It cannot differentiate between active and latent in-

Whether she's a future Olympian or just wants to make a splash, she deserves the #1 choice.[1]

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Ciprofloxacin, a fluoroquinolone is available as the monohydrochloride monohydrate salt of 1-cyclopropyl-6-fluoro-1,4-dihydro-4-oxo-7-(1-piperazinyl)-3-quinolinecarboxylic acid. The empirical formula is $C_{17}H_{18}FN_3O_3 \cdot HCl \cdot H_2O$. Dexamethasone, 9-fluoro-11(beta),17,21-trihydroxy-16(alpha)-methylpregna-1, 4-diene-3,20-dione, is an anti-inflammatory corticosteroid. The empirical formula is $C_{22}H_{29}FO_5$.

CLINICAL PHARMACOLOGY

Pharmacokinetics: Following a single bilateral 4-drop (total dose = 0.28 mL, 0.84 mg ciprofloxacin, 0.28 mg dexamethasone) topical otic dose of CIPRODEX® Otic to pediatric patients after tympanostomy tube insertion, measurable plasma concentrations of ciprofloxacin and dexamethasone were observed at 6 hours following administration in 2 of 9 patients and 5 of 9 patients, respectively.

Mean ± SD peak plasma concentrations of ciprofloxacin were 1.39 ± 0.880 ng/mL (n=9). Peak plasma concentrations ranged from 0.543 ng/mL to 3.45 ng/mL and were on average approximately 0.1% of peak plasma concentrations achieved with an oral dose of 250-mg [4]. Peak plasma concentrations of ciprofloxacin were observed within 15 minutes to 2 hours post dose application. Mean ± SD peak plasma concentrations of dexamethasone were 1.14 ± 1.54 ng/mL (n=9). Peak plasma concentrations ranged from 0.135 ng/mL to 5.10 ng/mL and were on average approximately 14% of peak concentrations reported in the literature following an oral 0.5-mg tablet dose[5]. Peak plasma concentrations of dexamethasone were observed within 15 minutes to 2 hours post dose application. Dexamethasone has been added to aid in the resolution of the inflammatory response accompanying bacterial infection (such as otorrhea in pediatric patients with AOM with tympanostomy tubes).

Microbiology: Ciprofloxacin has *in vitro* activity against a wide range of gram-positive and gram-negative microorganisms. The bactericidal action of ciprofloxacin results from interference with the enzyme, DNA gyrase, which is needed for the synthesis of bacterial DNA. Cross-resistance has been observed between ciprofloxacin and other fluoroquinolones. There is generally no cross-resistance between ciprofloxacin and other classes of antibacterial agents such as beta-lactams or aminoglycosides.

Ciprofloxacin has been shown to be active against most isolates of the following microorganisms, both *in vitro* and clinically in otic infections as described in the **INDICATIONS AND USAGE** section.

Aerobic and facultative gram-positive microorganisms: *Staphylococcus aureus, Streptococcus pneumoniae.* **Aerobic and facultative gram-negative microorganisms:** *Haemophilus influenzae, Moraxella catarrhalis, Pseudomonas aeruginosa.*

INDICATIONS AND USAGE: CIPRODEX® Otic is indicated for the treatment of infections caused by susceptible isolates of the designated microorganisms in the specific conditions listed below: **Acute Otitis Media** in pediatric patients (age 6 months and older) with tympanostomy tubes due to *Staphylococcus aureus, Streptococcus pneumoniae, Haemophilus influenzae, Moraxella catarrhalis*, and *Pseudomonas aeruginosa.* **Acute Otitis Externa** in pediatric (age 6 months and older), adult and elderly patients due to *Staphylococcus aureus* and *Pseudomonas aeruginosa.*

CONTRAINDICATIONS

CIPRODEX® Otic is contraindicated in patients with a history of hypersensitivity to ciprofloxacin, to other quinolones, or to any of the components in this medication. Use of this product is contraindicated in viral infections of the external canal including herpes simplex infections.

WARNINGS

FOR OTIC USE ONLY (This product is not approved for ophthalmic use.) **NOT FOR INJECTION**

CIPRODEX® Otic should be discontinued at the first appearance of a skin rash or any other sign of hypersensitivity. Serious and occasionally fatal hypersensitivity (anaphylactic) reactions, some following the first dose, have been reported in patients receiving systemic quinolones. Serious acute hypersensitivity reactions may require immediate emergency treatment.

PRECAUTIONS

General: As with other antibacterial preparations, use of this product may result in overgrowth of nonsusceptible organisms, including yeast and fungi. If the infection is not improved after one week of treatment, cultures should be obtained to guide further treatment. If otorrhea persists after a full course of therapy, or if two or more episodes of otorrhea occur within six months, further evaluation is recommended to exclude an underlying condition such as cholesteatoma, foreign body, or a tumor. The systemic administration of quinolones, including ciprofloxacin at doses much higher than given or absorbed by the otic route, has led to lesions or erosions of the cartilage in weight-bearing joints and other signs of arthropathy in immature animals of various species. Guinea pigs dosed in the middle ear with CIPRODEX® Otic for one month exhibited no drug-related structural or functional changes of the cochlear hair cells and no lesions in the ossicles. CIPRODEX® Otic was also shown to lack dermal sensitizing potential in the guinea pig when tested according to the method of Buehler. No signs of local irritation were found when CIPRODEX® Otic was applied topically in the rabbit eye. **Information for Patients:** For otic use only. (This product is not approved for use in the eye.) Warm the bottle in your hand for one to two minutes prior to use and shake well immediately before using. Avoid contaminating the tip with material from the ear, fingers, or other sources. Protect from light. If rash or allergic reaction occurs, discontinue use immediately and contact your physician. It is very important to use the ear drops for as long as the doctor has instructed, **even if the symptoms improve**. Discard unused portion after therapy is completed. **Acute Otitis Media in pediatric patients with tympanostomy tubes:** Prior to administration of CIPRODEX® Otic in patients (6 months and older) with acute otitis media through tympanostomy tubes, the solution should be warmed by holding the bottle in the hand for one or two minutes to avoid dizziness which may result from the instillation of a cold solution. The patient should lie with the affected ear upward, and then the drops should be instilled. The tragus should then be pumped 5 times by pushing inward to facilitate penetration of the drops into the middle ear. This position should be maintained for 60 seconds. Repeat, if necessary, for the opposite ear (see **DOSAGE AND ADMINISTRATION**). **Acute Otitis Externa:** Prior to administration of CIPRODEX® Otic in patients with acute otitis externa, the solution should be warmed by holding the bottle in the hand for one or two minutes to avoid dizziness which may result from the instillation of a cold solution. The patient should lie with the affected ear upward, and then the drops should be instilled. This position should be maintained for 60 seconds to facilitate penetration of the drops into the ear canal. Repeat, if necessary, for the opposite ear (see **DOSAGE AND ADMINISTRATION**).

Drug Interactions: Specific drug interaction studies have not been conducted with CIPRODEX® Otic. **Carcinogenesis, Mutagenesis, Impairment of Fertility:** Long-term carcinogenicity studies in mice and rats have been completed for ciprofloxacin. After daily oral doses of 750 mg/kg (mice) and 250 mg/kg (rats) were administered for up to 2 years, there was no evidence that ciprofloxacin had any carcinogenic or tumorigenic effects in these species. No long term studies of CIPRODEX® Otic have been performed to evaluate carcinogenic potential. Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin, and the test results are listed below: *Salmonella*/Microsome Test (Negative), *E. coli* DNA Repair Assay (Negative), Mouse Lymphoma Cell Forward Mutation Assay (Positive), Chinese Hamster V79 Cell HGPRT Test (Negative), Syrian Hamster Embryo Cell Transformation Assay (Negative), *Saccharomyces cerevisiae* Point Mutation Assay (Negative), *Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative), Rat Hepatocyte DNA Repair Assay (Positive). Thus, 2 of the 8 tests were positive, but results of the following 3 *in vivo* test systems gave negative results: Rat Hepatocyte DNA Repair Assay, Micronucleus Test (Mice), Dominant Lethal Test (Mice). Fertility studies performed in rats at oral doses of ciprofloxacin up to 100 mg/kg/day revealed no evidence of impairment. This would be over 100 times the maximum recommended clinical dose of ototopical ciprofloxacin based upon body surface area, assuming total absorption of ciprofloxacin from the ear of a patient treated with CIPRODEX® Otic twice per day according to label directions. Long term studies have not been performed to evaluate the carcinogenic potential of topical otic dexamethasone. Dexamethasone has been tested for *in vitro* and *in vivo* genotoxic potential and shown to be positive in the following assays: chromosomal aberrations, sister-chromatid exchange in human lymphocytes and micronuclei and sister-chromatid exchanges in mouse bone marrow. However, the Ames/Salmonella assay, both with and without S9 mix, did not show any increase in His+ revertants. The effect of dexamethasone on fertility has not been investigated following topical otic application. However, the lowest toxic dose of dexamethasone identified following topical dermal application was 1.802 mg/kg in a 26-week study in male rats and resulted in changes to the testes, epididymis, sperm duct, prostate, seminal vessicle, Cowper's gland and accessory glands. The relevance of this study for short term topical otic use is unknown.

Pregnancy

Teratogenic Effects. Pregnancy Category C: Reproduction studies have been performed in rats and mice using oral doses of up to 100 mg/kg and IV doses up to 30 mg/kg and have revealed no evidence of harm to the fetus as a result of ciprofloxacin. In rabbits, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion, but no teratogenicity was observed at either dose. After intravenous administration of doses up to 20 mg/kg, no maternal toxicity was produced in the rabbit, and no embryotoxicity or teratogenicity was observed. Corticosteroids are generally teratogenic in laboratory animals when administered systemically at relatively low dosage levels. The more potent corticosteroids have been shown to be teratogenic after dermal application in laboratory animals. Animal reproduction studies have not been conducted with CIPRODEX® Otic. No adequate and well controlled studies have been performed in pregnant women. Caution should be exercised when CIPRODEX® Otic is used by a pregnant woman.

Nursing Mothers: Ciprofloxacin and corticosteroids, as a class, appear in milk following oral administration. Dexamethasone in breast milk could suppress growth, interfere with endogenous corticosteroid production, or cause other untoward effects. It is not known whether topical otic administration of ciprofloxacin or dexamethasone could result in sufficient systemic absorption to produce detectable quantities in human milk. Because of the potential for unwanted effects in nursing infants, 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: The safety and efficacy of CIPRODEX® Otic have been established in pediatric patients 6 months and older (937 patients) in adequate and well-controlled clinical trials. Although no data are available on patients less than age 6 months, there are no known safety concerns or differences in the disease process in this population that would preclude use of this product. (See **DOSAGE AND ADMINISTRATION**.) No clinically relevant changes in hearing function were observed in 69 pediatric patients (age 4 to 12 years) treated with CIPRODEX® Otic and tested for audiometric parameters.

ADVERSE REACTIONS

In Phases II and III clinical trials, a total of 937 patients were treated with CIPRODEX® Otic. This included 400 patients with acute otitis media with tympanostomy tubes and 537 patients with acute otitis externa. The reported treatment-related adverse events are listed below:

Acute Otitis Media in pediatric patients with tympanostomy tubes: The following treatment-related adverse events occurred in 0.5% or more of the patients with non-intact tympanic membranes.

Adverse Event	Incidence (N=400)
Ear discomfort	3.0%
Ear pain	2.3%
Ear precipitate (residue)	0.5%
Irritability	0.5%
Taste perversion	0.5%

The following treatment-related adverse events were each reported in a single patient: tympanostomy tube blockage; ear pruritus; tinnitus; oral moniliasis; crying; dizziness; and erythema. **Acute Otitis Externa:** The following treatment-related adverse events occurred in 0.4% or more of the patients with intact tympanic membranes.

Adverse Event	Incidence (N=537)
Ear pruritus	1.5%
Ear debris	0.6%
Superimposed ear infection	0.6%
Ear congestion	0.4%
Ear pain	0.4%
Erythema	0.4%

The following treatment-related adverse events were each reported in a single patient: ear discomfort; decreased hearing; and ear disorder (tingling).

DOSAGE AND ADMINISTRATION

CIPRODEX® OTIC SHOULD BE SHAKEN WELL IMMEDIATELY BEFORE USE

CIPRODEX® Otic contains 3 mg/mL (3000 µg/mL) ciprofloxacin and 1 mg/mL dexamethasone.

Acute Otitis Media in pediatric patients with tympanostomy tubes: The recommended dosage regimen for the treatment of acute otitis media in pediatric patients (age 6 months and older) through tympanostomy tubes is: Four drops (0.14 mL, 0.42 mg ciprofloxacin, 0.14 mg dexamethasone) instilled into the affected ear twice daily for seven days. The solution should be warmed by holding the bottle in the hand for one or two minutes to avoid dizziness, which may result from the instillation of a cold solution. The patient should lie with the affected ear upward, and then the drops should be instilled. The tragus should then be pumped 5 times by pushing inward to facilitate penetration of the drops into the middle ear. This position should be maintained for 60 seconds. Repeat, if necessary, for the opposite ear. Discard unused portion after therapy is completed. **Acute Otitis Externa:** The recommended dosage regimen for the treatment of acute otitis externa is: For patients (age 6 months and older): Four drops (0.14 mL, 0.42 mg ciprofloxacin, 0.14 mg dexamethasone) instilled into the affected ear twice daily for seven days. The solution should be warmed by holding the bottle in the hand for one or two minutes to avoid dizziness, which may result from the instillation of a cold solution. The patient should lie with the affected ear upward, and then the drops should be instilled. This position should be maintained for 60 seconds to facilitate penetration of the drops into the ear canal. Repeat, if necessary, for the opposite ear. Discard unused portion after therapy is completed.

HOW SUPPLIED

CIPRODEX® (ciprofloxacin 0.3% and dexamethasone 0.1%) Sterile Otic Suspension is supplied as follows: 5 mL fill and 7.5 mL fill in a DROP-TAINER® system. The DROP-TAINER® system consists of a natural polyethylene bottle and natural plug, with a white polypropylene closure. Tamper evidence is provided with a shrink band around the closure and neck area of the package. NDC 0065-8533-01, 5 mL fill; NDC 0065-8533-02, 7.5 mL fill. **Storage:** Store at controlled room temperature, 15°C to 30°C (59°F to 86°F). Avoid freezing. Protect from light.

Clinical Studies: In a randomized, multicenter, controlled clinical trial, CIPRODEX® Otic dosed 2 times per day for 7 days demonstrated clinical cures in the per protocol analysis in 86% of AOMT patients compared to 79% for ofloxacin solution, 0.3%, dosed 2 times per day for 10 days. Among culture positive patients, clinical cures were 90% for CIPRODEX® Otic compared to 79% for ofloxacin solution, 0.3%. Microbiological eradication rates for these patients in the same clinical trial were 91% for CIPRODEX® Otic compared to 82% for ofloxacin solution, 0.3%. In 2 randomized multicenter, controlled clinical trials, CIPRODEX® Otic dosed 2 times per day for 7 days demonstrated clinical cures in 87% and 94% of per protocol evaluable AOE patients, respectively, compared to 84% and 89%, respectively, for otic suspension containing neomycin 0.35%, polymyxin B 10,000 IU/mL, and hydrocortisone 1.0% (neo/poly/HC). Among culture positive patients clinical cures were 86% and 92% for CIPRODEX® Otic compared to 84% and 89%, respectively, for neo/poly/HC. Microbiological eradication rates for these patients in the same clinical trials were 86% and 92% for CIPRODEX® Otic compared to 85% and 85%, respectively, for neo/poly/HC.

U.S. Patent Nos. 4,844,902; 6,284,804; 6,359,016
Licensed to Alcon, Inc. by Bayer HealthCare AG.

Manufactured by Alcon Laboratories, Inc.
Rx Only
Revision date: 17 July 2003

References: 1. Wolters Kluwer Health, Source® Pharmaceutical Audit Suite, January 2009 – December 2009. **2.** CIPRODEX® Otic package insert.

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fections, however. Rather, its purpose is to identify patients who have been infected with TB.

The test can also be used to monitor for potential infection in those exposed to TB; the usual recommendation is to test two and six weeks after exposure. Interpretation can be difficult if there is not an established history of a negative TST, however.

The most commonly used screening tool in the United States is the Mantoux tuberculin skin test, commonly referred to as purified protein derivative (PPD). This test is performed by injecting 0.1 ml of solution intradermally on the volar aspect of the forearm. The test is interpreted between 48 to 72 hours after the injection.

Interpretation is based on induration, not erythema; the indurated area is measured transversely to the long axis of the forearm. Diagnostic criteria are detailed in **Table 1**.

Who Should Be Screened—and How Often

Anyone at risk for developing tuberculosis should be screened with a TST. Such candidates for TST screening include:

- recent immigrants
- injection drug users
- residents and employees of prison and jails
- healthcare workers, including part-time volunteers
- children <4-years-old
- people with chronic disease
- people entering a group living situation.

Establishing a baseline before entering a high-risk employment or residential situation is of particular value. The frequency of subsequent screening for tuberculosis is usually annually or biannually, depending on risk stratification.

Two-step TST

The two-step TST is used to identify people who have had tuberculosis in the past and who now have diminished immune response and skin test reactivity. This procedure is designed to reduce the likelihood that a booster reaction, also called the "booster phenomenon," is later interpreted as a new infection.

The two-step technique is employed as the initial TST for adults who will be retested periodically (e.g., healthcare workers). This helps ensure that any future positive TST can be interpreted as being caused by a new infection rather than simply a boosted reaction to an old infection.

The procedure for the two-step is as follows:

Step 1
Place PPD and read within 48-72 hours.
If *positive,* consider the person infected.
If *negative*, proceed to step 2.

Step 2
Place a second PPD one to three weeks later and read within 48-72 hours.
If *positive*, consider the person *previously* infected.
If *negative,* consider the person uninfected.

Potential Errors with TST

The TST is not a true gold standard. The sensitivity is about 95% in healthy patients; however, it can be as low as 80% in immunocompromised patients. The 20% false-negative rate is due to a combination of factors causing immunosuppression. This, in turn, may be due to an acute illness, poor nutrition, medications, or underlying disease.

False negatives

False-negative reactions occur when a patient is immunologically compromised—even secondary to a highly active tuberculosis infection. The immune system needs to be competent to mount a response to the purified protein derived in the TST. Anytime the immune system is significantly strained, a false-negative TST test may occur.

Some scenarios in which higher rates of false-negative TST results might be most likely to occur include:

- patients <6 months or >70 years of age
- leukocytosis
- fever
- irradiation
- live viral vaccine
- viral infections
- sarcoidosis and any other immune-compromising disease process.

False positives

False-positive reactions occur when a patient has been infected with a non-tuberculosis mycobacterium (e.g., mycobacterium avium complex) or by previous administration of the bacille Calmette-Guerin (BCG) vaccine. Highly sensitive people may react to the PPD as a hypersensitive "foreign protein" reaction without an identifiable cause.

Special Testing

Special tuberculin blood tests include interferon-gamma

Table 2. Screening Tool: Assessing Risk of Active Disease

Answer Yes, No, or Unknown to each of the following questions:

Past Medical History
History of positive TB test?
History of TB/treatment?
History of TB exposure?
History of BCG vaccine?
Immune-suppressing disease?
Immune-suppressing therapy?
Pulmonary (lung) problems?
Family history of TB?

Review of Systems
Recurrent fevers?
Night sweats?
Weight loss?
Hemoptysis?
Pleuritic chest pain?

Social Risk Factors
Homeless/shelter?
Institutionalized/prison?
Nursing home?
Alcohol or drug abuse?
Contact with TB patient?
Significant foreign travel?

release assays (IGRAs) that the Federal Drug Administration approved in 2005. This blood test detects the release of interferon-gamma from sensitized persons when incubated with two proteins in *M tuberculosis*. IGRAs provide greater specificity than is possible with tests using purified protein derivative.

These tests are considered by some to be more accurate than the TST test and measure how the immune system reacts to two of the proteins in the bacteria causing tuberculosis. The superiority over TST is well established with active TB when measured against the gold standard of sputum culture.

In LTBI, there is no gold standard and there is only indirect evidence that it is better than TST. Accurate measures of the sensitivity and specificity of IGRAs are not available with LTBI.

The IGRA tests can be used in all circumstances in which TST is used. Many practitioners feel these serological tests are particularly helpful in patients with a positive TST who have received the BCG vaccine (to be discussed).

The commercially available IGRA tests are the QuantiFERON-TB test (QFT-G) and QuantiFeron-TB Gold (QFT-Gold). These tests may also be helpful in patients with dermatological conditions, a probable false-positive, or apparent allergic reactions to PPD.

The results of the IGRAs are qualitative, and a positive result indicates that an infection with *M tuberculosis* is likely; inversely, a negative result indicates that a tuberculosis infection is not likely.

One could consider replacing TST with IGRA testing; however, the value added is not well established and the increased costs are significant, currently.

Diagnostic Testing

Chest radiographs

In patients who have their first positive TST after known negatives (also known as converters), a one-view anterior-posterior chest radiograph should be performed to assess if there is radiographic evidence of active tuberculosis. Chest x-ray is also indicated if the first known TST is positive.

There have been no reliable, evidence-based studies to establish the value of subsequent screening chest radiographs. Annual screening chest x-rays for patients with known positive TSTs have not been shown to be of significant value in the absence of known TB exposures and symptoms or findings consistent with active TB. The cumulative radiation when employed as an annual screening test is noteworthy.

The clinician should evaluate each individual patient and make a thoughtful recommendation based on a focused history and physical to assess the risk of active disease. An example of the screening tool used in our urgent care center is shown in **Table 2**.

Any positive response requires further consideration about risk.

Acid-fast Bacilli (AFB) sputum examination

The gold standard for TB diagnosis is a sputum culture; however, it can be expensive and time-consuming.

Pulmonary tuberculosis can be diagnosed adequately in the right clinical setting using a chest x-ray and identifying AFB on sputum smear before isolating the organism in a culture. Large quantities of sputum and first morning expectorant may yield higher diagnostic accuracy. Sputum is usually collected over three consecutive days. AFB sputum examination can be used in patients where the diagnosis of active TB should be established before culture results are available.

Special considerations: BCG vaccine

BCG is a vaccine used to prevent tuberculosis. Many foreign-born people, especially those from areas endemic with tuberculosis, have received the vaccine.

The BCG vaccine can interfere with TSTs, causing a

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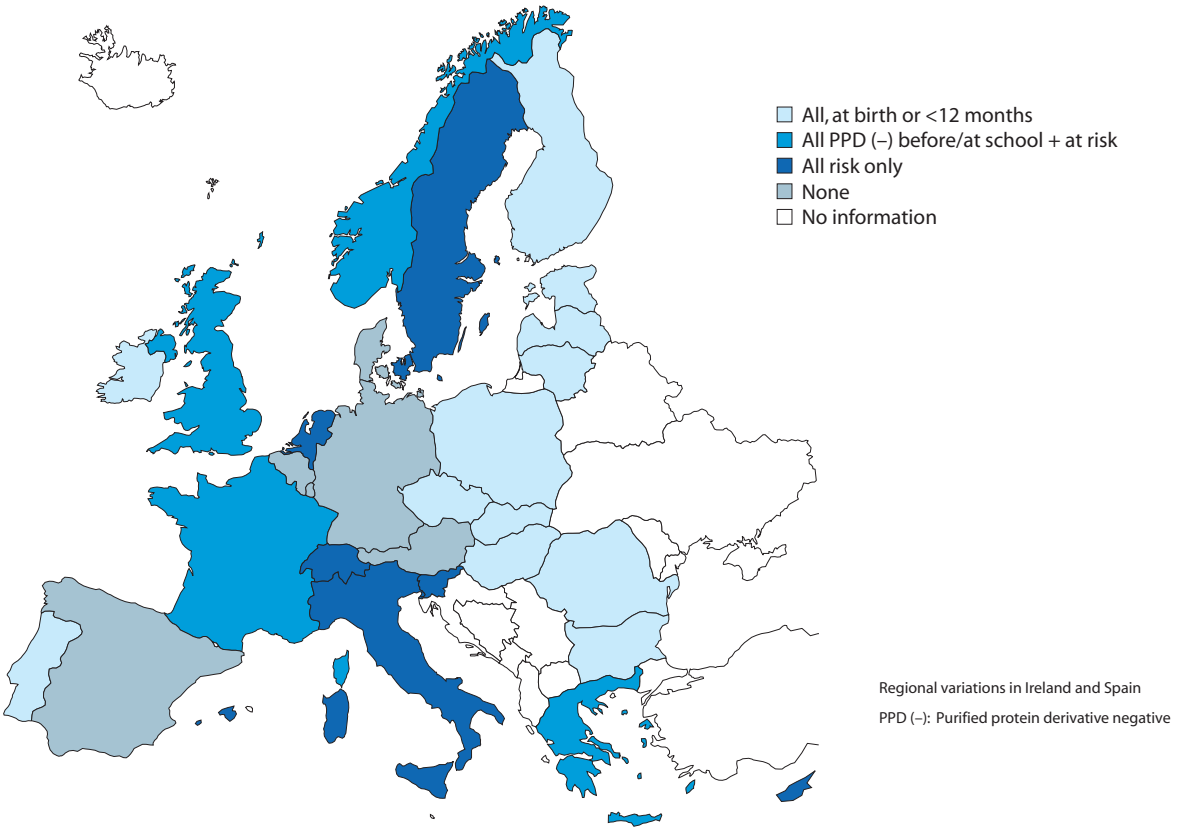
Figure 1. Groups of Children Target for BCG in National Recommendations*, in Europe 2005



false-positive test result.

The fact that BCG vaccine is used in areas with high prevalence of TB makes interpretation of a positive TST problematic. A positive TST may represent a true positive or a vaccine-associated false positive.

Serological IGRA testing is not affected by prior BCG vaccination and is the screening test of choice in a patient with a positive PPD and a history (known or presumed) of BCG vaccination. It need only be done once.

Some of the TB-endemic areas that use the BCG vaccine include: Latin America, Caribbean, Africa, Asia, Eastern Europe, and Russia (**Figure 1** and **Table 3**).

BCG vaccine is usually administered in the first year of life. Currently, revaccination is not widely used, employed only in some areas with higher prevalence of disease.

One study from the pulmonary journal *Chest*, published in 2007, evaluated more than 1,000 Canadian aboriginal children vaccinated with BCG before 1 year of age and found that after four years the effect on TSTs was minimal; after 10 years, the vaccine had no demonstrable effect on TSTs.

IGRA serology testing can be useful in assessment of a positive PPD in a person with a history of BCG vaccine. IGRA testing can be expensive, however, which may be a prohibitive factor in this diagnostic strategy.

Some institutions, such as Brown University Health Services, do not consider BCG vaccine history when interpreting a TST reaction; they assume a positive TST is a true positive and then assess for active versus latent disease.

In a 2004 article published in *Clinical Medicine & Research*, Ayub, et al, write that the majority of TSTs in persons previously BCG-vaccinated are negative—92% of the time. This was particularly prevalent in subjects who received the vaccine in infancy or early childhood. The recommendation is that a previous history of BCG vaccine be ignored when interpreting tuberculin skin test results.

Given the lack of high-quality data on the effect of BCG vaccine on TST results over time for a patient with a history of BCG vaccination and a positive PPD, in our

Table 3. TB Notification Rates Per 100,000, BCG Recommendations in Children, and BCG Coverage in Europe

	TB notification rates, 2003			Groups of children targeted for BCG vaccination, 2005						BCG coverage	
Country	Overall	Children	Rate ratio (adults: children)	All, at birth or <12 months	All, older age	Parents from/birth in high incidence areas	Travel to high incidence areas	Family history of contact with TB case	No systematic use	%	Year
Bulgaria	41.3	16.1	2.8	x*						n/a	–
Czech Republic	11.3	0.7	18.9	x*						98.8	2003
Estonia	47.1	1.9	29.3	x						92.0	2004
Finland	8.0	0.4	24.0	x						98.0	2002
Hungary	27.8	0.6	15.0	x						99.5	2003
Ireland	10.6	2.8	4.5	x	x (r)	x (r)	x (r)	x (r)		90.2	2004
Latvia	74.8	30.3	2.7	x						99.3	2004
Lithuania	81.9	20.3	4.7	x						96.9	2004
Poland	26.2	1.5	20.0	x*						95.0	2003
Portugal	41.1	5.0	8.0	x						83.0	2003
Romania	41.6	43.3	3.7	x						95.6	2003
Slovakia	18.2	2.1	10.3	x*						98.1	2003
Malta	3.8	3.3	3.5	x						87.0	2004
France	9.8	2.7	4.3	x						85.0	1997
Norway	7.5	2.0	4.4	x	x	x				>94.0	2002
United Kingdom	12.3	3.4	4.2	x	x					75.0	n/a
Greece	5.6	1.1	6.5	x		x				31.3	2003
Sweden	4.6	1.1	4.9		x	x	x			88.0	2004
Netherlands	8.2	2.0	4.8	x	x					60-90	2000-04
Slovenia	14.8	3.1	5.4							70-90	2004
Switzerland	8.7	2.1	4.7		x					n/a	–
Cyprus	4.4	0.0	*			x				n/a	–
Italy	7.9	2.2	3.9			x				n/a	–
Andorra	32.6	0.8	-			x				–	–
Austria	32.1	3.2	4.3			x				–	–
Belgium	10.9	4.0	3.1						x	–	–
Denmark	7.3	3.3	2.5			x				–	–
Germany	8.7	2.3	4.3			x				–	–
Luxembourg	11.9	1.2	12.0			x				–	–
Spain	18.2	8.2	2.4	x (r)			x			–	–

(r), regional policy; n/a, not available, *revaccination also recommended

clinic we recommend IGRA serology testing for clarification, when possible.

If the IGRA is positive, we assume a true positive TST.

If the IGRA is negative, we assume the TST was a false positive.

If IGRA testing is not a viable option, consider the BCG-vaccinated patient with a new or first positive PPD as a *new* converter and proceed clinically.

Continued on page 20

On Stroke Risk and TIA, Children with Periorbital Swelling, and Suspected Gastroenteritis in Children

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.

Validation of the ABCD² Score for Predicting Stroke Risk After Transient Ischemic Attack

Key point: An ABCD² score >2 is associated with significantly increased risk for stroke within 90 days.

Citation: Tsivgoulis G, Stamboulis E, Sharma VK, et al. Multicenter external validation of the ABCD² score in triaging TIA patients. *Neurology*. 2010;74(17):1351-1357.

The ABCD² score has been endorsed internationally as a simple method for identifying patients with transient ischemic attack (TIA) who are at high risk for early stroke and require admission, yet multiple external validation studies have demonstrated mixed results.

In a multicenter case series study, investigators prospectively applied the score to 148 consecutive patients with TIA at three hospitals in Greece and Singapore.

The seven-point ABCD² score is based on the following:

- Age ≥60=1 point
- Blood pressure at presentation ≥140/90 mm Hg=1 point
- Clinical features: unilateral weakness=2 points; speech disturbance without weakness=1 point
- Duration of symptoms: 10–59 minutes=1 point; ≥60 minutes=2 points
- Diabetes mellitus=1 point

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

Patients with higher ABCD² scores had significantly higher incidences of stroke at seven days and 90 days. The score accurately predicted high seven-day and 90-day stroke risk (area under the receiver operating characteristic curve, 0.72 and 0.75, respectively).

Patients with scores >2 were five times more likely to suffer stroke at 90 days than those with lower scores.

This study supports the clinical use of the ABCD² score.

[Published in *J Watch Emerg Med*, May 14, 2010—Richard D. Zane, MD, FAAEM.] ■

Evaluation of Children with Periorbital Swelling

Key point: Classic signs of proptosis, ophthalmoplegia, and pain with external ocular movements were absent in 50% of children with orbital infections.

Citation: Rudloe TF, Harper MB, Prabhu SP, et al. Acute periorbital infections: Who needs emergent imaging? *Pediatrics*. 2010;125(4):e719-726.

Rapid diagnosis and treatment of children with orbital abscess can prevent serious sequelae. In a retrospective review of 918 children who presented to an emergency department with periorbital swelling, investigators identified predictors of orbital abscess.

Of 298 children who underwent computed tomography (CT), 111 (12% overall; median age, 7.3 years) had an orbital abscess, and only half of these patients had the three common presenting signs of proptosis, ophthalmoplegia, and pain with external ocular movements.

Children who did not undergo CT were assumed to not have

orbital cellulitis.

Other variables significantly associated with orbital abscess on CT included edema beyond the eyelid, absolute neutrophil count (ANC) 10,000 cells/µL, age 3 years, and recent treatment with antibiotics. A recursive partitioning model based on all 918 patients identified edema beyond the eyelid as a strong predictor of orbital abscess.

Among children without the three common presenting signs, 20% of children with edema beyond the eyelid had an orbital abscess vs. 3.5% of those without.

This study would have been improved if all children who presented with periorbital swelling had undergone CT, and if the investigators had prospectively assessed variables associated with orbital abscess. Nonetheless, the results suggest that classic signs, such as proptosis, are absent in a substantial percentage of children with orbital infections. In addition, edema beyond the eyelid seems to be an important sign of orbital cellulitis.

[Published in *Journal Watch Pediatrics and Adolescent Medicine*, May 12, 2010—Howard Bauchner, MD.] ■

Does Ondansetron Mask Alternative Diagnoses in Children with Suspected Gastroenteritis?

***Key point:** Children who received ondansetron were more likely to return and to be admitted at the return visit but were not more likely to be given alternative diagnoses*

Citation: Sturm JJ, Hirsh DA, Schweickert A, et al. Ondansetron use in the pediatric emergency department and effects on hospitalization and return rates: Are we masking alternative diagnoses? *Ann Emerg Med*. 2010;55(5):415-422.

Does use of ondansetron in children with suspected gastroenteritis affect likelihood of admission, return visits, or alternative diagnoses? To find out, investigators conducted a retrospective chart review of 34,117 patients (age range, 3 months to 18 years) who received diagnoses of vomiting or gastroenteritis at two tertiary care pediatric emergency departments over a three-year period. Fifty-eight percent of them received ondansetron.

In logistic regression analyses, patients who received ondansetron were significantly less likely than those who did not receive ondansetron to be admitted on the initial visit, but were significantly *more* likely to return within 72 hours and to be admitted on the return visit. Overall, patients who received ondansetron were significantly less likely to be admitted during the initial or return visit (5.3% vs. 7.3%).

Of 443 patients who returned and were admitted, 17% received alternative diagnoses, most often appendicitis (4%), intussusception (2%), bacteremia (2%), or pyelonephritis (1%). The likelihood of an alternative diagnosis was not associated with ondansetron use, but was significantly associated with documented abdominal pain on the initial visit.

This large study provides convincing evidence that ondansetron does not usually mask alternative diagnoses in children with suspected gastroenteritis. Therefore, physicians should feel comfortable using this effective antiemetic, but continue to consider etiologies of vomiting other than gastroenteritis and provide clear instructions regarding when to return to the ED.

[Published in *J Watch Emerg Med*, May 21, 2010—Katherine Bakes, MD.] ■

Public Health Concerns

In most areas of the United States, it is mandatory and appropriate to notify the Public Health Department of potentially active TB. Refer the patient to an appropriate treatment center, which may be your public health department.

Conclusion

It is imperative that the urgent care clinician become an expert on tuberculosis screening to maintain the health and safety of our patients and communities. Interpreting the current recommendations on TB screening and applying them to our diverse pool of patients can be challenging, as there are few comprehensive guidelines available. We must be well informed, diligent in our focused evaluations, and able to interpret a wide spectrum of data. Tuberculosis screening is a patient-specific paradigm.

Summary

BCG vaccine and effect on TST

- Given in countries with high incidence of tuberculosis
- Can affect TST
- TST effect wanes over time (when vaccine given before 1 year of life, the BCG effect on TST is usually gone in 10 years)
- If positive history of BCG vaccine and a positive TST consider IGRA testing **OR** treat as a new converter

New converters (patients with a positive TST)

- Complete a focused history and physical for symptoms and signs of tuberculosis
- Obtain a one-view chest x-ray
- Assess for radiographic evidence of tuberculosis
  - If asymptomatic with a negative x-ray or findings consistent with "old" non- active TB, treat as latent TB and refer them to their primary care provider for further evaluation of LTBI and treatment options.
  - If symptomatic and an X-ray with findings that could represent active TB, obtain a sputum for AFB stain and culture and arrange for evaluation and treatment of potentially active TB.
  - If chest x-ray is completely negative, refer patient to their primary care provider for evaluation of a positive TST.

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What do you think of this article (or any other article or column in this issue)? Do you have anything to add? Let us know with a letter to the editor; you can e-mail us at *editor@jucm.com*.

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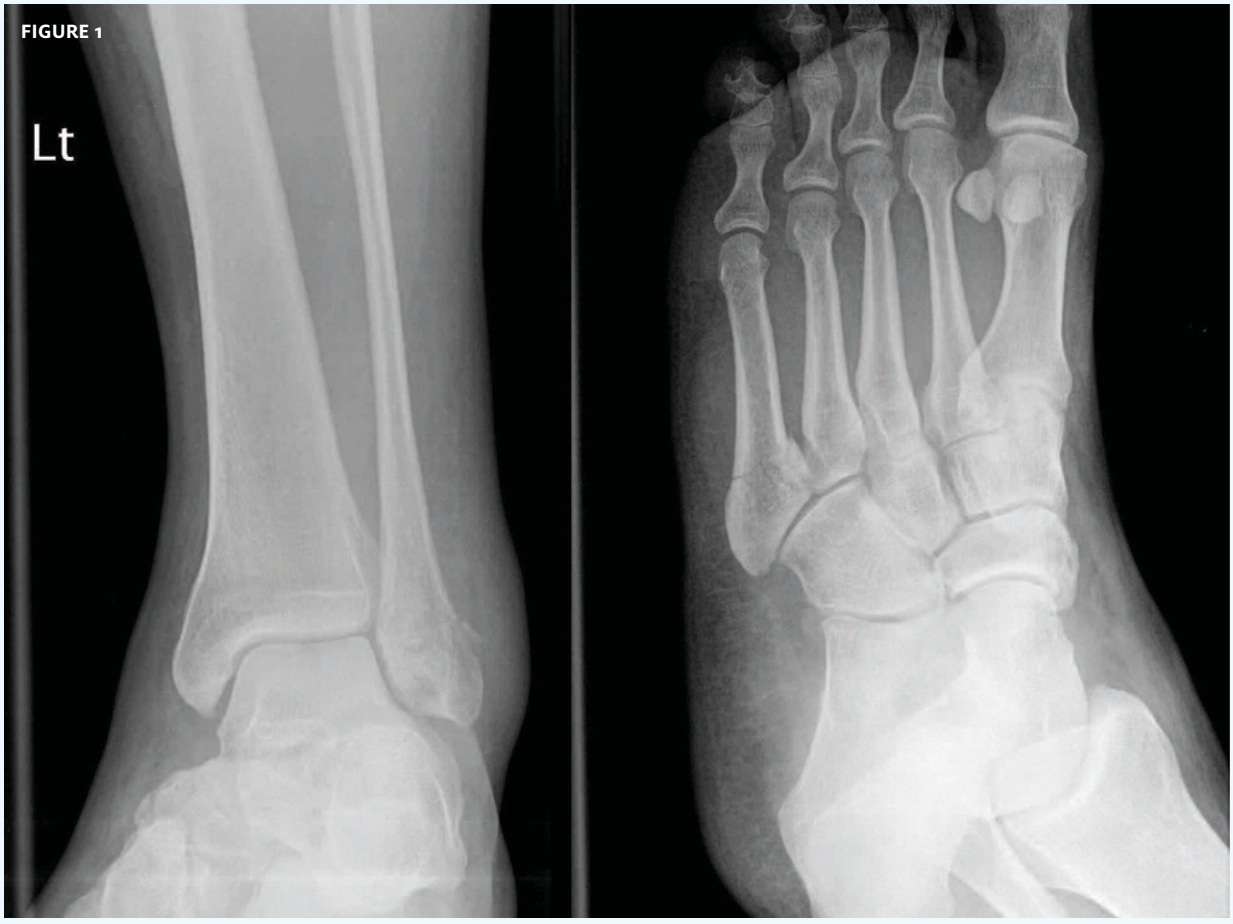
INSIGHTS IN IMAGE

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



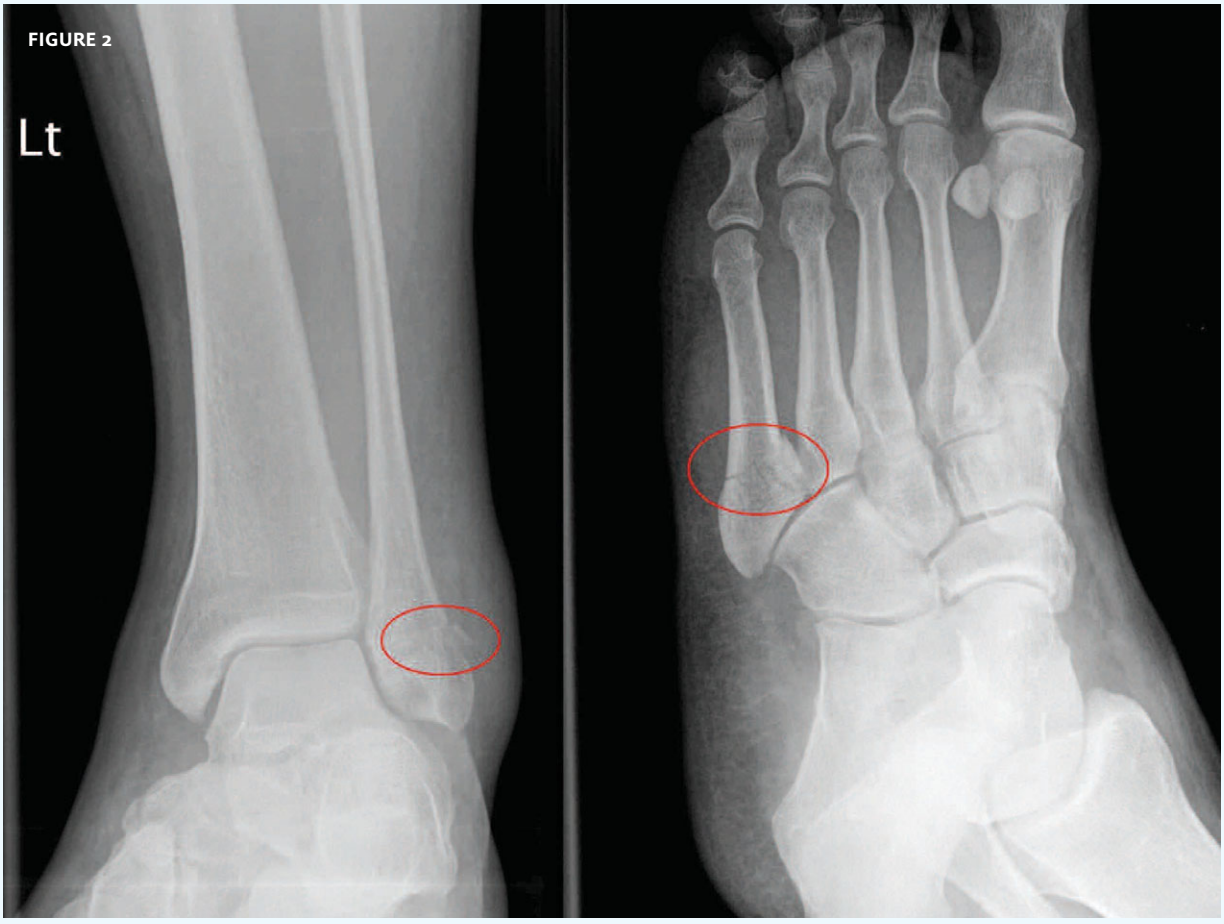
The patient is a 42-year-old who presents to urgent care after "twisting" her left foot.

The patient is able to bear weight on the foot, though it is painful.

View the image 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



The x-rays reveal fractures of both the distal fibula and proximal fifth metatarsal. A cast splint was applied and the patient was instructed to follow up with an orthopedist.

More specifically, the film on the left shows a transverse proximal fifth metatarsal shaft fracture; this is an unstable injury (Jones facture). Malunion is common, and orthopedic follow-up is urgent.

Fractures through the tuberosity of the proximal fifth metatarsal that do not involve the shaft are stable fractures (pseudo-Jones) and can be treated with a post-op shoe.

Acknowledgment: Case presented by Nahum Kovalski, BSc, MDCM, Terem Emergency Medical Centers, Jerusalem, Israel.

INSIGHTS IN IMAGES

CLINICAL CHALLENGE CASE 2

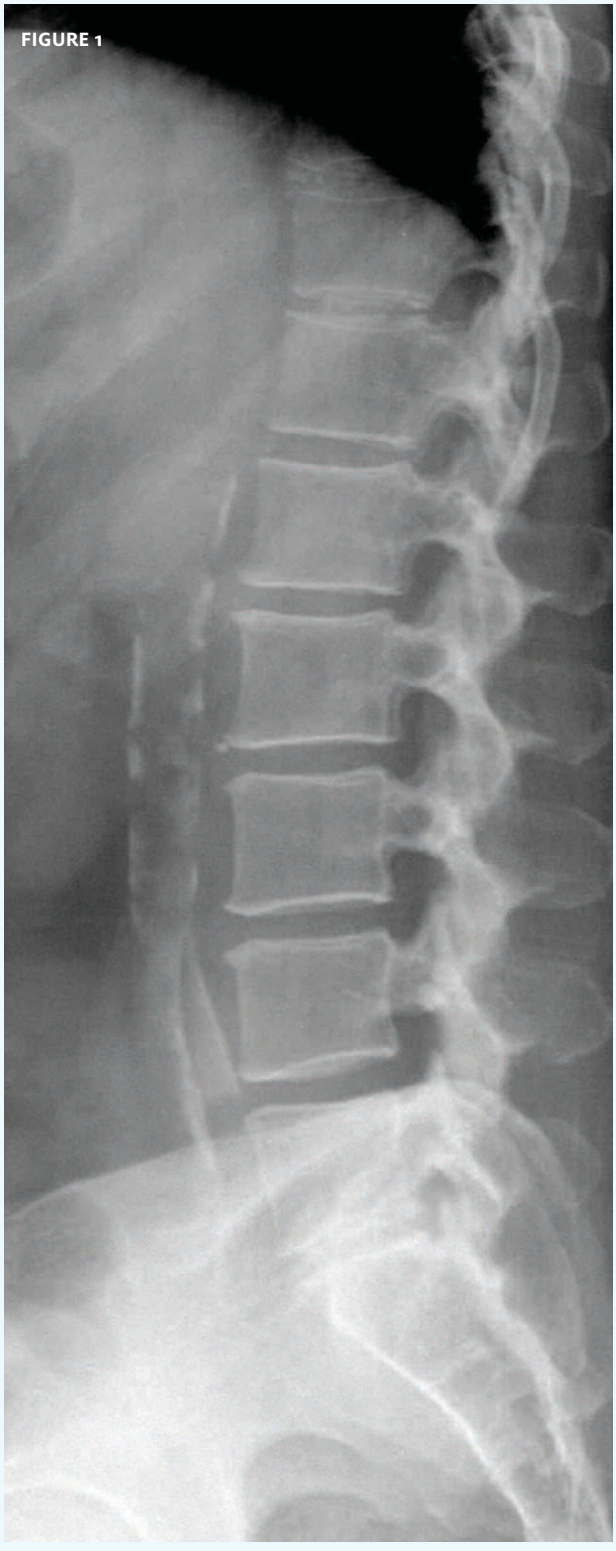


FIGURE 1

The patient is a 61-year-old male who presents with back pain.

The patient's abdomen is soft. Vitals are stable.

View the image 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

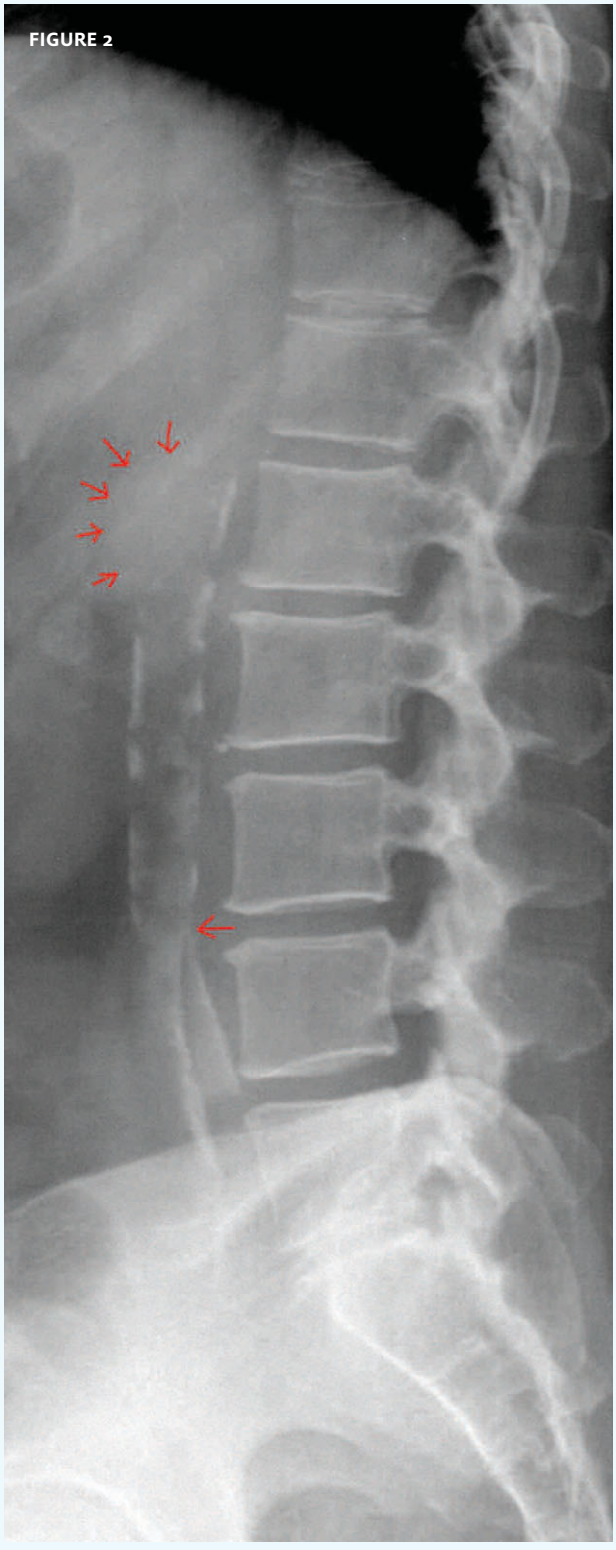


FIGURE 2

This patient had an aortic aneurysm.

This is quite a dramatic example of calcification of the aorta. At the top end, one sees an aneurismal dilatation of the aorta; at the lower end, one sees the iliac bifurcation.

This patient was referred back to his physician with clear instructions to further evaluate the aneurysm.

Given the patient's complaint of back pain, additional evaluation with computed axial tomography or ultrasound should be considered.

Acknowledgment: Case presented by Nahum Kovalski, BSc, MDCM, Terem Emergency Medical Centers, Jerusalem, Israel.

These cases are among hundreds that can be found in Terem's online X-ray Teaching File, with more being added daily. Free access to the file is available at https://www2.teremi.com/xrayteach/.
A no-cost, brief registration is required.

Agencies Can Extend Clinical Recruiting and Staffing Capabilities

Urgent message: Medical staffing agencies extend an urgent care center's recruiting and staffing capabilities with solutions to fill all operating hours with qualified providers.

Alan A. Ayers, MBA, MAcc

Introduction

The United States faces a shortage of primary care and emergency medicine physicians—the provider force feeding urgent care today.

When an urgent care center has an insufficient number of providers to adequately cover its schedule, the patient experience suffers due to extended wait times, being turned away without receiving treatment, and poor service from providers who have become tired and frustrated with their inability to keep pace with an ever-increasing workload.

© Laughing Stock/Corbis

As the adverse effects of provider shortages escalate, overworked physicians leave for better working environments—leading to more unfilled shifts and management's time consumed by recruiting and staffing tasks.

Medical staffing agencies enable urgent care operators to stay focused on day-to-day operations by finding qualified locum tenens (temporary) and permanent providers for the center.

Locum Tenens: A Ready Solution to Scheduling Shortfalls

Medical providers are subject to periods of absence due to personal or family illness, vacation, continuing medical education, or unexpected events.

Urgent care centers are also subject to increased provider turnover due to greater family mobility, "baby boomers" approaching retirement age, and market demand for providers leading to better job opportunities. And even when a center is fully staffed, ebbs and flows in patient volume may lead to occasions (such as flu season) in which permanent providers cannot keep pace.

But unlike front office and medical support staff that can easily cover the workload of a missing colleague, en-

Table 1. Benefits and Drawbacks of Utilizing Locum Tenens Providers in Urgent Care

Benefits	Drawbacks
• Allows uninterrupted treatment of patients and retention of patient revenue during a provider's absence. • Provides extra help for after-hours coverage or during periods of increased demand, such as flu season. • Improves provider retention and job satisfaction by preventing burnout of existing staff. • Minimizes the risk of extending hours or testing new service lines that might otherwise require a full-time permanent provider. • Credentialing, licensing, privileging, and other administrative tasks are performed by the staffing agency. • Medical malpractice insurance coverage is provided by the staffing agency.	• Hourly rates may be higher than permanent provider salaries, as they include the staffing company's operating costs and profit margin. • There is a steep "learning curve" for each new provider that includes the center's policies, procedures, workflow, equipment, and systems. • Locum tenens are not "vested" in the assigned practice, which can manifest in poor bedside manner, hurried or sloppy documentation, and lack of attention to coding. • Learning curve and lack of vesting may result in less productivity (fewer procedures performed or patients treated per day) and lower gross charges than with permanent providers. • Locum tenens are not vested in the assigned practice, which can manifest in poor bedside manner, hurried or sloppy documentation, and lack of attention to coding. • Locum tenens may not assimilate into a center's culture, leading to patient and/or staff perceptions they are "transient" or "lower quality" doctors.

Table 2. Value of Utilizing Locum Tenens Providers in Urgent Care

Lost revenue due to inability to treat patients
+ diminished brand equity due to patients seeking care elsewhere
– daily or hourly cost of locum tenens provider
– differential in productivity (number of patients seen, gross charges entered)
– differential in quality of clinical care delivered
– differential in quality of patient experience (bedside manner, quality and continuity of care)
= value retained by locum tenens provider

trepreneurial urgent care centers rarely have a "bench" of underutilized medical providers to step up to the plate.

Locum tenens—temporary, substitute providers—enable urgent care centers to remain open and continue generating revenue when permanent providers are away from the center, while searching for a permanent provider, or to augment providers during busy seasons.

Table 1 compares the benefits and drawbacks of locum tenens in urgent care.

Locum tenens providers are, typically, independent contractors who enter into an agreement to perform pre-defined services for a set period of time at a fixed daily or hourly rate. Although practices usually reimburse direct expenses related to transportation, meals, and lodging—and staffing agencies typically provide the malpractice insurance coverage—as independent contractors, locum tenens providers are not employees of the practice or staffing agency and are therefore responsible for their own benefits, taxes, unemployment, and workers compensation coverage.

Urgent care operators can expect to pay between $95 and $125 per hour for locum tenens coverage, depending on the scope of practice (e.g., urgent care, occupational medicine, and/or primary care), the volume and acuity of patients, required board certifications or procedural training, and the location of the assignment.

Randy Sparks, regional vice president of Irving, Texas-based StaffCare, explains that "The more detailed the requirements for a locum, the less available matching candidates will be, and therefore, the greater effort by the agency in finding a good fit. Pricing is also highly regionalized because not only must a provider be licensed in a state—and the supply of providers varies by state—but some work locations are just more appealing to prospective candidates than others."

Ultimately, as **Table 2** illustrates, the value of locum tenens to an urgent care center is the difference between lost revenue and goodwill due to uncovered shifts, the direct and indirect costs paid for the locum, and differentials in productivity and quality between locums and staff providers.

Although an urgent care center can directly recruit and contract with a locum tenens provider without outside assistance, there are advantages to utilizing an agency, including a "bench" of qualified candidates to choose from, medical malpractice coverage arranged by the

agency and included in the hourly rate, and agency support of medical credentialing and licensure processes. In addition, many agencies arrange for the travel and housing needs of temporary providers.

The downside is that fees charged include the agency's operating expenses and profit margin—typically resulting in a higher hourly rate than hiring providers directly.

Locum Tenens from a Provider's Point of View

Medical practice has been evolving rapidly over the last 10 to 15 years, as many providers move away from the traditional full-time, private practice model to other modes of practice, including hospital employment, part-time practice, concierge medicine, and locum tenens.

When locum tenens providers first came into use, their quality sometimes was questioned. Colleagues, administrators and patients might ask, "Is there a *reason* they're *on the move*?"

Today, locum tenens practice has become widely accepted as a "lifestyle" choice—appealing to older physicians who have retired from private practice but want to stay active in their licensure, young parents desiring to spend time at home but also retain their clinical skills, and transitional providers who want to "try out" a certain practice type or geographical area without long-term commitment. **Table 3** outlines the benefits and drawbacks for the provider doing locum tenens work.

Locum tenens providers vary widely in terms of medical practice experience, although the majority are tenured physicians who see temporary assignments as a way to augment their income. According to Sparks, 67% have 21 years or more experience as physicians while less than 7% have been in practice fewer than six years. This includes veteran physicians who "moonlight" during evenings, weekends, or vacation—including many who cover the extended operating hours of urgent care centers.

Because locum tenens providers are independent contractors, they can negotiate all terms of their assignments,

"Few entrepreneurial UCCs have the scale to employ a full-time recruiter."

including location and pay. Physicians can find locum tenens engagements on their own—through the Internet or by contacting urgent care centers directly—or they may work with one or more locum tenens agencies.

The leading reasons that physicians choose one agency over another include:

- number and location of practice opportunities
- pay rate (including malpractice coverage and benefits)
- quality of service offered (including logistics and travel)
- reputation and/or name recognition.

When a medical provider expresses interest in doing locums work, staffing agencies typically start by discussing the provider's objectives, experience, and availability. The staffing agency also begins credentialing the provider—verifying education and licensure—and securing malpractice coverage. Once the provider is qualified to work locums, the staffing agency reviews available opportunities and circulates the provider's credentials to those that seem most appealing.

The following are questions that a locum tenens provider might ask when considering a particular assignment:

- What is the location of the opportunity?
- What is the length of the assignment?
- What is the type of facility, how large is it, and how many (and what type of) providers work there?
- What shifts are included and how long is each shift?
- What is the average patient load and acuity per shift?
- What accommodations and/or reimbursement for travel expenses will be provided?
- What is the availability and quality of equipment and supplies?
- Which charting/billing systems are used and what training/orientation will be provided?
- What is the pay rate?

When an opportunity appears to be a good match for both the provider and the practice, the staffing company negotiates the terms of the assignment and coordinates travel details with the provider. Once engaged,

Table 3. Benefits and Drawbacks to Providers Working Locum Tenens

Benefits	Drawbacks
• The ability to choose among temporary assignments leads to greater scheduling flexibility and freedom to pursue personal interests. • Working locum tenens provides an escape from politics and other "hassle factors" of practice ownership, such as having to pay high premiums for malpractice insurance (which is typically provided by the staffing agencies). • Working locum tenens provides an opportunity to travel and work in new and interesting places while living on an expense account. • The pay rate for locum tenens is often competitive with full-time permanent practice, with supplemental pay for travel and/or extended assignments. • Working in a variety of practices contributes to professional development through a diversity of experiences while providing a low-risk mechanism for "trying out" different practice types and geographical locations. • Being an independent contractor, locums can deduct from their taxes the cost of a home office and the business portion of telephone, computer, automobile, and other expenses. • Locums practice often leads to a permanent position, as both the practice and provider can assess whether the provider is a good "fit."	• Being away from family and friends can lead to loneliness and isolation. • Many locums find they are unable to schedule assignments as continuously as they would like—resulting in extended unpaid periods "on the bench." • As independent contractors, locums must arrange for their own employee benefits, including health insurance and retirement savings. They must also cover self-employment, unemployment, workers compensation, and other taxes. • The quality of an assignment may not be what the provider expected, or there may be differences between the practice style of the locum and the engagement.

the provider submits a log of hours worked to the staffing agency, which bills the practice and issues a paycheck to the provider.

Permanent Placement: Outsourcing the Recruiting Function

Few entrepreneurial urgent care centers have sufficient scale to employ a full-time physician recruiter. Using a medical staffing company, an urgent care center may "outsource" this vital capability—supporting the entire process of recruiting, hiring, and on-boarding.

The advantages of using a medical staffing company for permanent placement include:

- time and attention focused on finding the "right" candidate for a practice (without distraction of day-to-day operations of the center)
- consulting assistance in outlining job responsibilities, setting compensation, and defining benefits (to assure the center is competitive in the employer market)
- ability to conduct a national candidate sourcing campaign through multiple channels (including recruiting at conferences, capturing referrals from previous placements, and direct Internet and media job postings)
- thorough screening of prospective applicants through background searches, technical skill evaluations, and pre-interviews (saving time by "weeding out" unsuitable candidates)
- ability to "try out" prospective permanent hires through "temporary to permanent" programs or service guarantees such as professional fees refunded if a placement does not work out
- support with physician licensure, credentialing, and hospital privileging
- relocation assistance, including moving, housing, childcare, and even job placement for spouses. Some staffing agencies also handle immigration-related issues for international medical graduates.

The cost of utilizing a staffing agency for permanent placement of an urgent care physician averages $15,000 to $20,000, depending on the location of the center, the scope of work, provider qualifications, and other factors affecting how many providers meeting the criteria are available in the marketplace.

The cost of bringing a locum tenens physician from temporary to permanent can be even higher—around $25,000—because the staffing agency is losing a provider it previously expected to have available for locum assignments.

Likewise, a staffing agency may require payment of its fee in whole if a practice identifies and hires a physician on its own without the agency's assistance—the rationale being that the staffing agency still incurred recruiting and screening efforts.

Just as the nation's provider shortage affects the ability of urgent care centers to attract and retain qualified candidates, some professional recruiters are having increased difficulty finding viable candidates for their

Table 4. Factors to Consider When Evaluating Medical Staffing Companies

- What is the staffing company's size? How many facilities and physicians do they represent?
  - Larger staffing companies should attract a greater pool of applicants but may also be focused on serving larger, key accounts with greater ongoing staffing needs than small independent centers making one-time hires.
  - Smaller staffing agencies may put more time and effort into placement for a single client but may be working from a smaller pool of applicants, meaning they have to work harder to find a provider who is a "good match."
- How big is the account manager or search consultant's portfolio? What is his/her workload?
  - Does the staffing company's representative have the time and resources to provide appropriate attention to each account? An overloaded staffing professional may focus disproportionately on the "easiest to fill" positions, neglecting rural or out-of-market clients.
  - A staffing professional with a large portfolio may steer a prospective provider that may be a good fit for a small practice to larger accounts that pay greater commissions.
- What is the staffing company's geographic footprint?
  - Out-of-market staffing agencies may present candidates requiring relocation—a costly proposition that raises stakes if the placement does not work out.
  - Local staffing agencies may have difficulty attracting qualified applicants within a limited market.
- What is the staffing company's scope of services?
  - Does the firm specialize in permanent placement, locum tenens, physicians only, or nurses, administrators, and physical therapists? Some firms try to position themselves as a "one-stop shop" while others develop deep expertise within a discipline or specialty.
  - A firm specializing in permanent placement will attract providers looking for a full-time job; using such a firm to search for locum tenens may yield providers who become dissatisfied with continual short-term assignments.
- What is the longevity and exclusivity of the agency's locum tenens provider base?
  - Providers who have a long tenure with a staffing company may be more willing to assure clients are satisfied with their experience than providers who approach assignments as a "one-time deal" or work with multiple agencies simultaneously.
- What is the staffing company's reputation?
  - Ask a medical staffing company to provide references, and follow up with those references on the quality of providers, the fairness of contracts and pricing, and the level of service received.
  - Conduct Internet research to identify any past or pending lawsuits or sanctions.
- How are fees and contracts structured? When is payment due?
  - Permanent placements may be billed as a fixed fee for each placement, a percentage of the starting salary, or an hourly fee. The staffing company may incur expenses associated with the search (such as Internet ads and telephone calls), or these items may be billed back to the urgent care center.
  - Many placement agency contracts require payment of a placement fee—regardless of whether they find a candidate. This means that once contracted, if the urgent care center hires a provider through any other method (including a physician who approaches the practice directly), the center is obligated to pay the agency's fee.
  - Some agencies require a deposit or retainer up front, while others will work flexible payment arrangements with percentages of the placement fee due after the provider is with the practice after set intervals.
  - It's important to remember that all fees and contract terms are subject to negotiation. For example, many staffing agencies will provide discounts for filling multiple positions simultaneously or for long-term loyalty.
- What guarantees or service level agreements do they offer?
  - Staffing agencies that are willing to put some of their fees "at risk" for filling positions within a certain period of time—or to refund fees if a hire does not work out—may be less likely to accept searches they cannot fill while working harder to assure the right candidate for each search they accept.
  - Some staffing agencies will allow fees to be rolled over into future searches if the practice hires from another source before the agency fills the opening.

clients. As a result, many urgent care centers choose to utilize several different search firms, staffing agencies, or recruiting channels to find qualified providers. **Table 4** outlines factors to consider when evaluating a medical staffing company.

Conclusion

Urgent care centers are differentiated by extended evening and weekend hours, with seasonal ebbs and flows in patient volume. A national shortage of qualified providers creates challenges for urgent care centers to appropriately match staffing levels to demand during all operating hours.

In addition, tasks related to provider recruiting and staffing can distract urgent care operators from managing the day-to-day business.

Medical staffing agencies are a resource available to urgent care operators—on a one-time or ongoing basis—to augment their own capabilities and assure all slots on the provider schedule are filled. ■

Transitions

JOHN SHUFELDT, MD, JD, MBA, FACEP

I participated in my first triathlon in 18 years last weekend in a town named for a card game. Show Low sits at 6,412 feet at the base of the White Mountains in northern Arizona.

Remember the first scene in *Chariots of Fire*, where a group of men are running barefoot, effortlessly through the crashing waves on a beautiful beach with the orchestra playing an inspiring melody in the background? It wasn't like that.

In complete contradistinction to *Chariots*, I staggered out of the water in the back of the pack. Once on the bike, I decided to pass everyone I could see who was ahead of me. I set my sights on a cyclist about 300 yards in front.

The words of the legendary multi-distance runner Steve "Pre" Prefontaine echoed in my mind: "A lot of people run a race to see who is fastest. I run to see who has the most guts, who can punish himself into exhausting pace, and then at the end, punish himself even more."

I peddled faster. Hunched on the aero bars, I looked up and knew that I could pass him. As I got closer, I realized something wasn't right. His bike looked different, he looked different, but I did not care; I was gaining on him and that was all that mattered.

I zoomed past him feeling pretty damn good about myself. It was then I noticed: he only had one leg. Instantly, I knew who had more guts.

A triathlete and close friend of mine once told me, "a little pain now, less pain later." The truth was, in my preparation, I hadn't endured enough pain. It showed.

There is one area, however, in which I was well prepared: transitions. Transitions are what occur between the swim and the bike and the bike and the run. In the broader sense, transitions are periods of change. Transitions are an inevitable, fun, and dynamic part of life.

Unfortunately, transitions are an area in which many individuals find themselves ill-prepared. I was lucky; my son Michael is a superb triathlete and gave me lots of tips about how to prepare for the transitions. Here is what he taught me:

1. Collect all the necessary equipment.
2. Learn how to use it and how to fix it when it breaks.
3. Expertly organize your area.
4. Prepare for the unknown.
5. Keep moving.

Such preparation applies equally well to practicing medicine, running a business, or generally managing all the transitions that are part of life.

Collect All the Necessary Equipment

In triathlons, this means a wet suit, goggles which will stay on your head, glide stuff to prevent chafing and to make your wetsuit come off easier, a watch which measures your pace and speed, biking and running shoes, a bike with aero bars, a device to measure your pedal cadence, cool sunglasses, and a hat worn backwards (allegedly to be more aerodynamic).

In life, it's a bit more complicated. The "equipment" may be additional training, another degree, expertise in an area which few others possess. Simply stated, it is the knowledge, training, or devices which set you apart from the pack and ensure that during times of change you are better prepared than the next person.

For example, I know someone who worked at the same company for 25 years. He was in middle management and was fairly successful. Unfortunately, when the company experienced a downturn he was one of the first to be let go.

Never once in his 25 years did he think "what if?". Never once did he seek additional training or go back for an advanced degree. He simply existed, and when he was laid off, he had nothing to fall back upon. He did not stand out, nor was he viewed as action-oriented.

Basically, he was screwed, or as he says now, "Would you like fries with your meal?"

Now is the time to prepare. Assemble the tools, training, and tactics you will need to have when the chips are down and pray that you will never need to rely upon them. At the end of the day, this exercise alone will improve your game.

Continued on page 35

John Shufeldt is the founder of the Shufeldt Law Firm, as well as the chairman of the board of NextCare, Inc., and sits on the Editorial Board of *JUCM*. He may be contacted at *JJS@shufeldtlaw.com*.

CODING Q&A

Coding for Splints, Modifier–QW, Routine Rechecks, and Language Barriers to Efficient Coding

DAVID STERN, MD, CPC

Q. For splinting, our physicians use Ortho-Glass. At one time we billed out by the inch for it, but now some are saying that you cannot bill for it, as it is included in the E/M level charge. This does not make sense to me, so we're looking for an expert opinion. Can you help me with this coding dilemma or point me in the right direction?

– Question submitted by Carlene Cox, Genesis FirstCare, Ohio

A. There are specific codes for both splint application and splint supplies. Neither is included in the E/M code.

For example, if the doctor applies a short-arm fiberglass splint to an adult, then you should code:

- Q4022: Cast supplies, short-arm splint, adult (11 years +), fiberglass
- 29125: Application of short-arm splint (forearm to hand); static

Fracture care: If the splint is applied as the definitive care for a fracture, then you should use the CPT code for the fracture care; you should not code the CPT code for splint application, as the initial splint or cast application is included in the code for fracture care.

If the doctor is only splinting the fracture prior to providing definitive care for the fracture, then you should code for the splint application and splint supplies. ■

Q. My question relates to CPT code 87880-QW (CLIA-waived rapid strep test). When coding for a pediatric urgent care center, is it appropriate to bill 87880 with the QW modifier for claims that are not sent to Medicaid or Medicare? It is my understanding that if box 23 is complete and includes the CLIA Certificate number, then this is appropriate to code utilizing the QW modifier. Please understand that when I code a chart, I am not aware of the specific payor to which the claim will be sent.

– Question submitted by Diane McKenna, CCS, Holbrook, New York

A. As a general rule, modifier-QW should only be used for CLIA-waived tests when billed to Medicare, Medicaid and Tricare. In order to code accurately, you should modify your processes to allow you to see the payor at the time of coding, as many coding issues (not just modifiers) are specific to payors.

If your billing software automatically strips off modifier –QW when the payor does not accept this modifier, then you may be able to code this issue without being aware of the primary payor. In general, however, coding without knowledge of the payor will result in significant numbers of avoidable denials. ■

Q. We had a patient come into our hospital-affiliated urgent care center a week ago for a left forearm abscess. The physician who initially saw the patient cleaned, packed, and cultured the wound.

Yesterday, the patient came for a recheck and was seen by a different physician in our practice. The physician had to examine and repack the wound.

Are we able to charge for the physician visit, or is that an inclusive charge from the original visit? If we cannot charge for the physician visit, how do we bill for supplies?

– Question submitted by Meg Bickel, ExpressCare

A. The answer to your question is quite simple, but not very satisfactory. Routine rechecks (including time and supplies for repacking) are included in the initial fee for the incision and drainage of the abscess. You should not add an E/M

David E. Stern, MD, CPC is a certified professional coder. He is a partner in Physicians Immediate Care, operating 12 urgent care centers in Oklahoma and Illinois. Stern serves on the Board of Directors of the Urgent Care Association of America and speaks frequently at urgent care conferences. He is CEO of Practice Velocity (*www.practicevelocity.com*), providing urgent care software solutions to more than 500 urgent care centers. He welcomes your questions about coding in urgent care.

CODING Q & A

for the professional services of the physician. Hospital-affiliated urgent care centers that bill separately on a UB-04 form for the facility may bill for supplies on the UB-04, even during the global period for a code billed on the CMS-1500. ■

Q. My question is which code we could use for urgent care centre while patient has chest pain and facility perform EKG?
– Name withheld

A. Yes, this is the actual question that was sent by e-mail. I get scores of similar questions from people—mostly workers in foreign nations—who are actively coding for urgent care centers in the U.S.

If you have outsourced your billing to a coder who is unaware of the correct code for an EKG, you can be sure that your center is losing thousands of dollars due to poor coding in many other areas. Be very careful. ■

HEALTH LAW

Learn How to Use the Equipment and Fix It When It Breaks

On one of my first rides, I stupidly made the comment, "I don't believe in karma, I won't get a flat tire." Within about 30 minutes, I had *two* flat tires. Fortunately, the person with whom I was riding not only had the equipment, he knew how to use it and taught me how to quickly change a tire (twice).

It is simply not enough to have initials after your name. The pursuit of additional training or an advanced degree is not a means to an end. The value is in the knowledge base which comes with the degree or training. You have to understand how to apply what you have learned in the real world and how to use this knowledge when things break or do not go as planned.

Expertly Organize Your Area

I thought I was pretty organized until I watched Michael prepare all of his gear. There was clearly a rationale to his methodology. His race times and transition times were fractions of some of the other elite racers. He simply out-organized many of them.

Individuals who are organized seem to effortlessly accomplish more than their peer group. I work with an amazing woman who has every document and every necessary management detail at her fingertips. She is not obsessive-compulsive; she is simply very organized and accomplishes more than anyone else in a shorter time period because she is so prepared. She does not have to waste time looking for information because she makes the effort to organize prospectively, as opposed to haphazardly searching retrospectively.

Prepare for the Unknown

Extra socks, another set of goggles, an extra inner tube, etc., etc...all things to help you deal with potential impediments to finishing the race. (For me, an extra set of lungs, O_2 and blood doping may have helped.) Save for my lack of talent, thanks to Michael, I had it dialed in. The only thing I was unprepared for was being eaten by Jaws or Nessie, neither of which made an appearance. (Although, at one point during the swim, I thought I saw a killer dolphin. Since I was in a lake in Arizona, it was probably simply a hypoxia-induced hallucination or a fat guy with a big nose in a wetsuit.)

No one expects to lose their job or suffer some untoward event. Those who are prepared in advance can weather the squall and emerge tougher, smarter, and ready for the next challenge. I simply look at this as the human version of a credit default swap; understand the risks and mitigate them by hedging your bet.

This preparation takes guts and determination. In other words, it takes your best. Others won't understand why you need more training or education or why you seem to continually choose the harder road. Hopefully, they will never need to know.

Keep Moving

During this race, to keep moving was very challenging for me. After seeing the "killer dolphin" and beating the one-legged man, the run portion of the triathlon appeared the most daunting. Fortunately for me, Michael was off his personal record pace and decided to wait for me so that we could run together. He convinced me to just keep moving forward. It worked. I finished the race and, most importantly, learned where I was deficient for future races.

Nothing comes to those who wait for gifts to land on their doorstep. Simply stated, action equals results. Sometimes the actions are misguided and lead to negative results. Personally, I have learned more from missteps then I have ever learned from successes.

Just keep moving and the goal that was just over the horizon becomes achievable. Approach these challenges as gifts which test your resolve and watch them become achievable.

As Pre said, "To give anything less than your best is to sacrifice the gift." ■

Learn How to Articulate What You Are Really Selling

FRANK H. LEONE, MBA, MPH

Remember the old Miller Lite commercial, "Tastes great!" "Less filling!" "Tastes great!" "Less filing..."? Occupational health has its own Miller Lite-style debate: "It's a commodity!" "No, it's a relationship!" "No, it's a commodity!", etc.

Most savvy professionals tout occupational health sales as *relationship* selling; your urgent care clinic provides an integrated series of services to support optimal workplace health and safety management.

Commodity sales tend to be the norm in occupational health sales, however.

For starters, commodity sales is easier—you revert back to sales 101, tell your prospect what your clinic has to offer, and wait for positive buying signals.

Commodity sales tend to be concrete, whereas relationship sales are more complex and invariably require a more lengthy sales cycle.

At the end of the day, are occupational health sales more commodity-based or relationship-based? I believe that it depends, and usually involves a little of both.

The Product

Several variables drive how you will define your product: the vision and purpose of your clinic's occupational health initiative, the nature of the relationship with a given sales prospect, and the actual service itself.

One constant remains: the core definition of occupational health.

A clinic's mission should involve everything you can do to ensure optimal workplace health and safety for the companies your clinic serves. The mission should include both a commitment to injury/illness management *and* appropriate environmental interventions to minimize incidence in the first place.

Sadly, many occupational health "professionals" fail to recognize or acknowledge this definition and simply sell a discrete series of services.

The starting point for your sales initiative is to understand the duality of your product, rather than viewing your occupational health services as just another component of your urgent care clinic.

The Commodity/Relationship Continuum

Once you understand your product, you need to determine how to present the product. This is where the commodity vs. relationship issue kicks in.

In a world that is often more gray than black and white, the line that separates commodity from relationship is blurred. A sales professional will be more oriented to certain prospects or at certain points in the sales process, or by your clinic's position within the market, or in selling certain "products."

Consider each variable:

- *By prospect.* You could endlessly preach "relationship" to certain prospects and they simply will never get it. Others will embrace a broad relationship with your urgent care center. Many others will be somewhere in between.

  The astute sales professional should trial balloon the term "relationship" early in the sales process, assess where the prospect appears to fit on the commodity-relationship continuum, and proceed accordingly

- *During the sales process.* Occupational health often involves a long sales cycle. Such a cycle can begin with name identification marketing, continue with a differentiation campaign, and then involve meetings, follow-ups, and, at times, written proposals.

  The commodity/relationship continuum emphasis may well change several times during this process. And

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the cadence of these changes can vary. For example, your differentiation campaign might emphasize the partnership concept, whereas actual sales calls might zero in on actual commodities. Or, conversely, early marketing might familiarize the universe with your services, with subsequent face-to-face sales placing greater emphasis on how each product is part of an integrated whole.

- *By market position.* The commodity/relationship continuum can also be affected by your urgent care clinic's position in the marketplace. A longstanding program with a stable client base is likely to be more interested in adding new commodities to the client's service mix. In such cases, the sales person is more likely to be commodity-driven; after all, the relationship already exists.

  On the other hand, what if you are a second-tier market challenger in your market and/or a new entry? An emphasis on relationship then becomes more important, as you need to differentiate yourself from better established competitors who may offer similar commodities.

- *By product.* Most occupational health commodities are inherently linked to one another, and some are easier for prospects to digest if presented as commodities. A thorough pre-hire screening process is an appropriate adjunct to health management, but many prospects may see it as nothing more than a commodity. If necessary, you have to sell in that spirit. On the other hand, placing a nurse at the worksite is inherently relationship-oriented and in almost every circumstance should be presented that way.

- *During a sales call.* Bring both your commodity and relationship hats to a sales call, and switch hats as necessary. During certain sales calls you need to emphasize—and sell—both. In others, you learn something about the buyer's view and have to change hats suddenly. In many calls you are best served by first explaining your services as a series of commodities and then explaining why the various commodities should be integrated into a systematic whole that results in a genuine long-term relationship.

Adherence to sales dogma is often a sales professional's downfall; indeed, occupational health sales professionals need to be nimble by adapting to the realities of the moment. You are, at once, selling both a commodity and a relationship. ■

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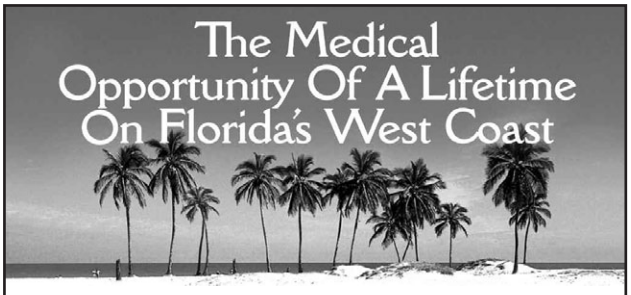

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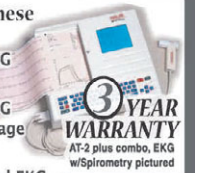

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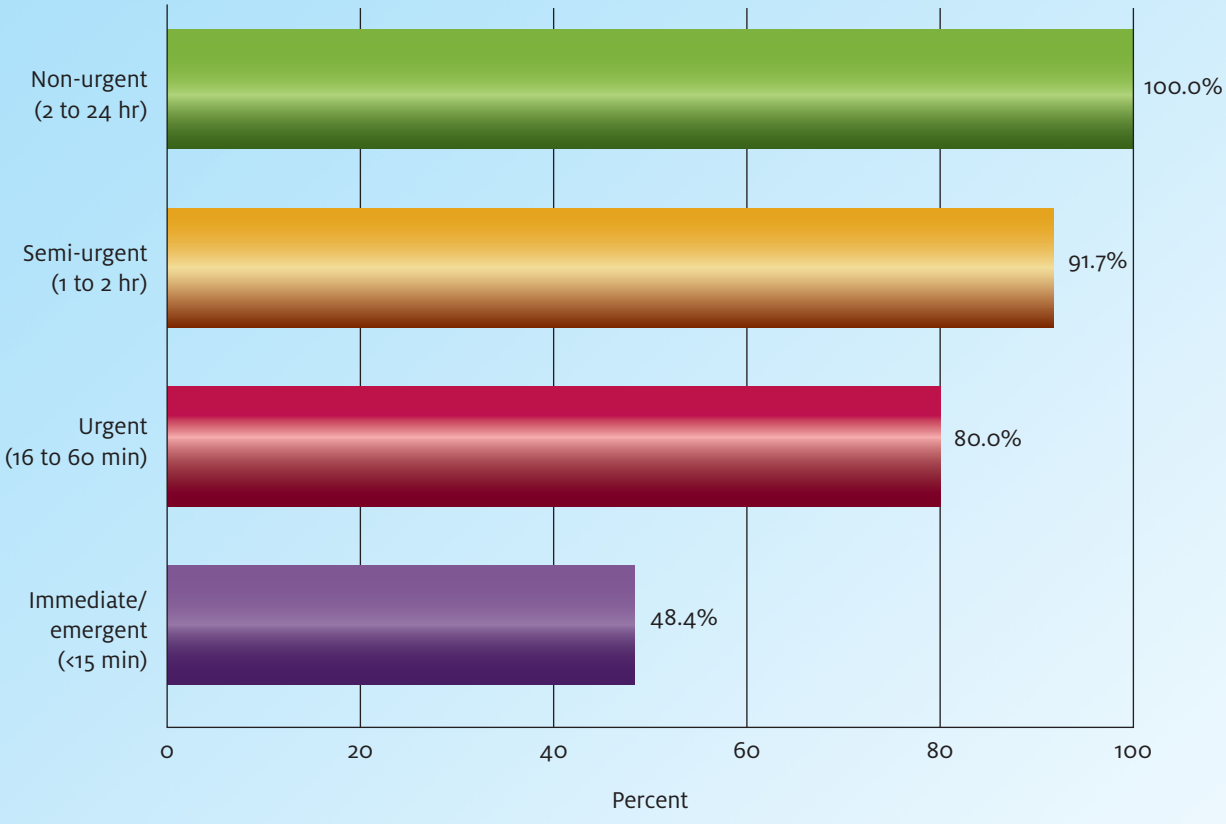
DEVELOPING DATA

In each issue on this page, we report on research from or relevant to the emerging urgent care marketplace. This month, we provide new data relevant to many urgent care providers' marketing messages—namely, hospital performance on wait times during visits to the emergency room.

These data reflect the percentage of visits in which wait times met pre-defined targets.

ED VISITS MEETING TARGET WAIT TIMES (MEDIAN)



Source: Horwitz LI, Green J, Bradley EH. U.S. emergency department performance on wait time and length of visit. *Annals Emerg Med.* 2010;55(2):133-141.

It may be especially noteworthy that patients visiting for "urgent" matters—those with a target wait time of 16 to 60 minutes—were seen within the target time 80% of the time, with performance improving for longer target times at lower acuity levels.

How would your urgent care center's performance stack up against the ED's for similar patient visits?

If you are aware of new data that you've found useful in your practice, let us know via e-mail to *editor@jucm.com*. We'll share your discovery with your colleagues in an upcoming issue of *JUCM*.

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