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IN THIS ISSUE

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Rx Drug Abuse and the Drug-Seeking Patient

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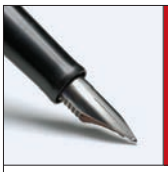

LETTER FROM THE EDITOR-IN-CHIEF

Rekindling the Doctor-Patient Relationship

The joy of practice is two-fold: Intellectual and Relational.

The intellectual side of us thrives on the challenge of complex medical decision-making and computational fact-finding. Understanding and applying pathophysiology is what we trained for, and what most of us consider to be a joyful brain exercise.

However, since we do not practice medicine in a vacuum, the relational side of patient care is equally important to job satisfaction. It is, without doubt, the more challenging and frustrating part of practice. The desire to provide "care" to those in need was, for most of us, an overwhelming reason for entering the medical field. Yet, we had little training and preparation for just how to go about this in the most productive way.

The extensive demands on our time make this task even more difficult. The emotional drain of "difficult patients," "difficult colleagues," and a dysfunctional healthcare system add to the burden. However, if we don't find ways to produce positive relational encounters with our patients, we will find ourselves feeling half-empty of the joy of practice.

I'd like to share a few methods I have learned over the years that will enhance your patient relationships, ensure positive patient encounters, and, subsequently, support years of joyful practice.

We all know that a positive doctor-patient relationship is built on trust. In urgent care it is very difficult to build trust with a patient we don't know in the 10 minutes we have per encounter. It is critical to understand, however, that trust between patient and doctor determines every outcome from that encounter. Trust ensures compliance, risk management, patient satisfaction, and perception of quality. Trust also ensures that the physician gets accurate and useful information which he/she uses to provide optimal clinical care. Additionally, trust ensures an efficient patient encounter, a much overlooked fact.

So what builds trust? Empathy. Patients want you to make them feel like you care.

Take, for example, the hysterical patient, a challenging and emotionally draining encounter for most.

Ask yourself: "What is it that this patient needs?" Answer: Attention.

"Why is this patient screaming so loudly?" Answer: Because no one will listen to them.

Despite gut tendencies to react otherwise, give this patient a little attention and let them know you "hear" them. Consider saying this: "Wow, that must make it really difficult to get out of bed in the morning." *Nothing* changes the tone of this type of encounter faster. Patients invariably cooperate and let you control the rest of the encounter. End result: Quality, efficient care without the emotional strain.

Consider the mother of three with four days of a flu-like illness. Most physicians will assume she is just here for an antibiotic. If I give her an antibiotic, she'll be happy; if I don't, she'll be angry.

There are two things at play here: "Caregiver" as "patient" and an underestimation of the severity of influenza. Let her know how awful the flu is. Show lots of empathy. Then give her permission to be the patient for once. "You can't always be the caregiver." You will be surprised how many leave grateful, with no antibiotic at all.

So what undermines trust? Judgements. Remember, patients come to the doctor to be *cared* for, not judged.

I will address common scenarios that lead to dangerous and inaccurate judgements in a future column. Until then, lay your hand on a patient's shoulder, look them in the eye and say, "I am sorry that you've had to go through this," and see how it changes your day. ■

Lee A. Resnick, MD
Editor-in-Chief
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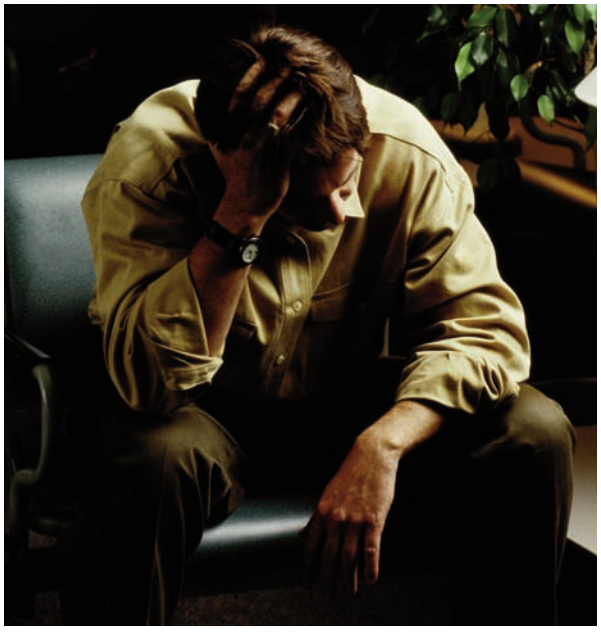


CLINICAL

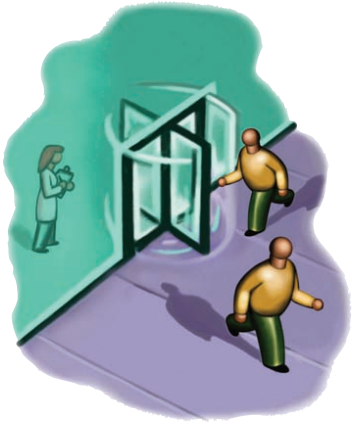
11 Prescription Drug Abuse and the Drug-Seeking Patient

Urgent care centers are perceived as fertile ground for substance abusers looking for illicit subscriptions. Are you confident that you can tell the difference between a patient in real need and an addict in the brief time you have to spend with a patient?

By Marcelina Behnam, MD and Mark Rogers, MD

BOUNCEBACKS

23 The Case of a 71-Year-Old Man with Back Pain



Back pain is a common presenting complaint in urgent care. That doesn't necessarily mean its etiology is a common diagnosis, however.

By Michael B. Weinstock, MD and Ryan Longstreth, MD, FACEP

***Next month in* JUCM:** *Diabetes is on the rise in the U.S. Is your practice prepared to provide immediate, potentially life-saving care to patients with glycemic emergencies?*

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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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Recently, the mainstream media have reported on the growing problem of prescription drug abuse and addiction. The news tends to focus more on statistics than the deeper issues of who these patients are, how they go about feeding their addiction, or—most importantly—what the medical profession can do to curb the trend and ensure substance abusers get the help they need.

Our cover article this month, Prescription Drug Abuse and the Drug-Seeking Patient (page 11), by **Marcelina Behnam, MD** and **Mark Rogers, MD** looks at this issue from an urgent care perspective, offering tips on how to identify drug seekers, the best ways to deflect their attempts to gain illicit prescriptions, and an explanation of why they view acute care settings as ripe for the picking.

In addition to being the medical director of the urgent care facility, Dr. Rogers is an assistant professor for the Department of Emergency Medicine at West Virginia University. He also has a particular interest in drug abuse and addiction management in the urgent care and emergency department settings.

Dr. Behnam is a second-year resident in the Department of Emergency Medicine at WVU, having previously attended the University of Virginia School of Medicine. She has an avid interest in international medicine.

Looking beyond the surface of a patient's presenting complaint is also the subject of the latest installment of Bouncebacks (page 23) by **Michael B. Weinstock, MD** and **Ryan Longstreth, MD, FACEP**. The subject is a patient who presented to an emergency department with acute back pain. That's common enough, but the ultimate diagnosis might surprise you, and was overlooked during the patient's first visit to the ED.

Drs. Weinstock and Longstreth are colleagues at Mt. Carmel St. Ann's Emergency Department in Columbus, OH. In addition, Dr. Weinstock is clinical assistant professor of emergency medicine at The Ohio State University College of Medicine.

In addition, **Nahum Kovalski, BSc**, **MDCM** reviews new abstracts highly relevant to your practice (page 29); **David Stern, MD, CPC** answers coding questions posed by *JUCM* readers (page 31); **John Shufeldt, MD, JD, MBA, FACEP** discusses issues, legal and otherwise, that prevent some start-up practices from succeeding (page 33); and **Frank Leone, MBA, MPH** offers advice on how to use a clinic visit to close the deal with a new occupational medicine client (page 34).

At press time, Drs. Rogers, Weinstock, Stern, and Shufeldt, as well as Mr. Leone, were all scheduled to participate in the recently completed UCAOA National Convention in New Orleans. In addition, Dr. Stern and Mr. Leone will present a program entitled Urgent Care: 40 Ways to Increase Profitability on July 25 in Tampa, FL and July 26 in Boca Raton, FL. For more information on that program, call 1-800-666-7926, extension 13.

If you have an idea for an article, or thoughts about an article you've read in this issue, send an e-mail to Editor-in-Chief **Lee A. Resnick, MD** at *editor@jucm.com*. Your participation will help us ensure that *JUCM* continues to presents topics of high interest to urgent care practitioners in an urgent care voice.

To Submit an Article to *JUCM*

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

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

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

Before submitting, we recommend reading "Instructions for Authors," available at *www.jucm.com*.

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LETTERS TO THE EDITOR

To the Editor:
The article discussing minor traumatic brain injury in the March 2008 *JUCM* is outstanding. My only concern is with the way post-TBI vomiting is mentioned.

We all know that it is quite common for a patient to experience nausea following TBI. The patient can have nausea/vomiting from being emotionally distraught alone. The vomiting that is much more clinically significant is projectile in nature.

I am not suggesting that post-TBI vomiting is only significant if projectile in nature, but the clinical sign of vomiting should be expanded upon further.

Raul Ruelas, PA
Magan Medical Clinic Urgent Care, Covina, CA

Dr. Toscano responds: Thanks for the kind words. With the focus of urgent care being different than other specialties in many ways—sometimes only subtly but often importantly—we need to reframe many of the things we've learned in school, training, and practice.

As far as being more specific about vomiting, we do know, from both the Canadian Head CT Rule and NEXUS-II Rule, that it seems safe to use the absence of *repeated* vomiting in decision-making. Unfortunately, none of the studies I cited or reviewed for the article examined projectile vomiting specifically, so it's impossible to know its true sensitivity or utility.

It is nearly always true that the more restrictively an important variable is defined (e.g., "severe or worsening headache" rather than just simply "headache"), the more specific, but less sensitive it becomes. Using projectile vomiting as a reason to observe or evaluate a patient further would be rational, but basing a decision *not* to proceed further just because any vomiting is not projectile would be expected to lead to some misses.

Lastly, related to the typical design of these studies: the researchers are seeking to define a group of clinical variables for which, when all are absent, the chance of a bad outcome is extremely low. That's not, however, the same as saying that the presence of any variable guarantees a bad outcome. This middle ground is precisely where clinical acumen and experience are necessary! ■

Unsung Heroes

LOU ELLEN HORWITZ, MA

"There is no limit to what a man can do so long as he does not care a straw who gets the credit for it."

C.E. (Charles Edward) Montague (1867–1928)

Of all the columns I've written, none have elicited more e-mails and phone calls than "Where's the Love?" (*JUCM*, February 2008). It seems there is just not enough praise in this world, and it's too easy for us to forget to do it—and consequently we all feel at least a little underappreciated.

For a few people, I'd like to end that here.

These people have worked mostly in the shadows, for all of our benefit, for several years, with no compensation outside of the satisfaction of contributing to something they believe in. They have put in long hours *after* their day jobs, including countless marathon conference calls and meetings, and their "sweat equity" in the outcome is substantial. They have fought and argued. They have negotiated and cajoled. They have flown many miles and spent many nights away from their families. They have invested their time and their intellect and their passion.

You probably don't even know most of their names.

I am speaking (perhaps you have guessed) about UCAOA's founding Board of Directors. Not only did they create the Association, but they nurtured it closely through its early years, and without their incredible contributions, this journal, the convention in New Orleans this month, the Fellowships, the website resources...none of it would have been possible.

I doubt many of us have ever thanked them. So let's do it now.

On behalf of everyone who has and will benefit from your original efforts, we thank you:

Don Kilgore
John Koehler, MD
Dan Konow, PA-C
William Meadows, MD
Lee Resnick, MD
Marge Simat
David Stern, MD, CPC

Since that founding, there have been four elections bringing in several new Directors who have added their own contributions: **Kathy Crampton**, **Dr. Jim Gore**, **Dr. Ken Palestrant**, **Amy Tecosky**, **Cindi Lang**, **Dr. Marc Salzberg**—and the five newest members still to be determined as of this writing, but whose identities will be known by the time this column is in your hands (and will be announced on *www.ucaoa.org*).

Last, but certainly not least, I'd like to recognize the staff and collaborators who make UCAOA work every day.

They are the people you talk to when you call us, who help you find what you are looking for, take your registrations, change your address, plan the conferences, line up our exhibitors, publish *JUCM*—and love doing it for you.

Becky Mendez (who has been here since the beginning), **Colleen Richter**, and **Karlo Castro** make up our full-time staff, **Alan Ayers** and **Dr. Philip Disraeli** provide consultation and program development on a regular basis. It's a team that loves working together, and I hope it shows in your interactions with us.

As you have read this, no doubt there are those in your own professional and personal life who have come to mind, that you have either never shined a spotlight on or it has been far too long. I hope this will encourage you to find a way. ■

Since this column must be submitted a few weeks before the New Orleans National Convention, a full report of the "happenings" will have to wait until June. However, we will be sending a "Live Report" by e-mail, so if you have not done so yet, please join our mailing list (you can visit *www.ucaoa.org* or e-mail *info@ucaoa.org*) and add UCAOA to your list of "safe senders."

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

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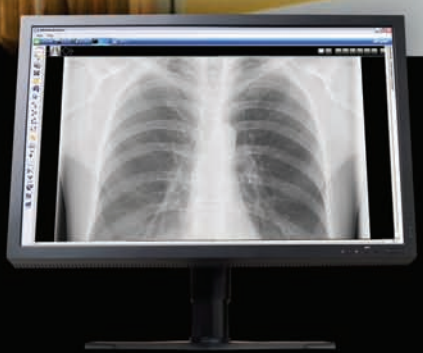

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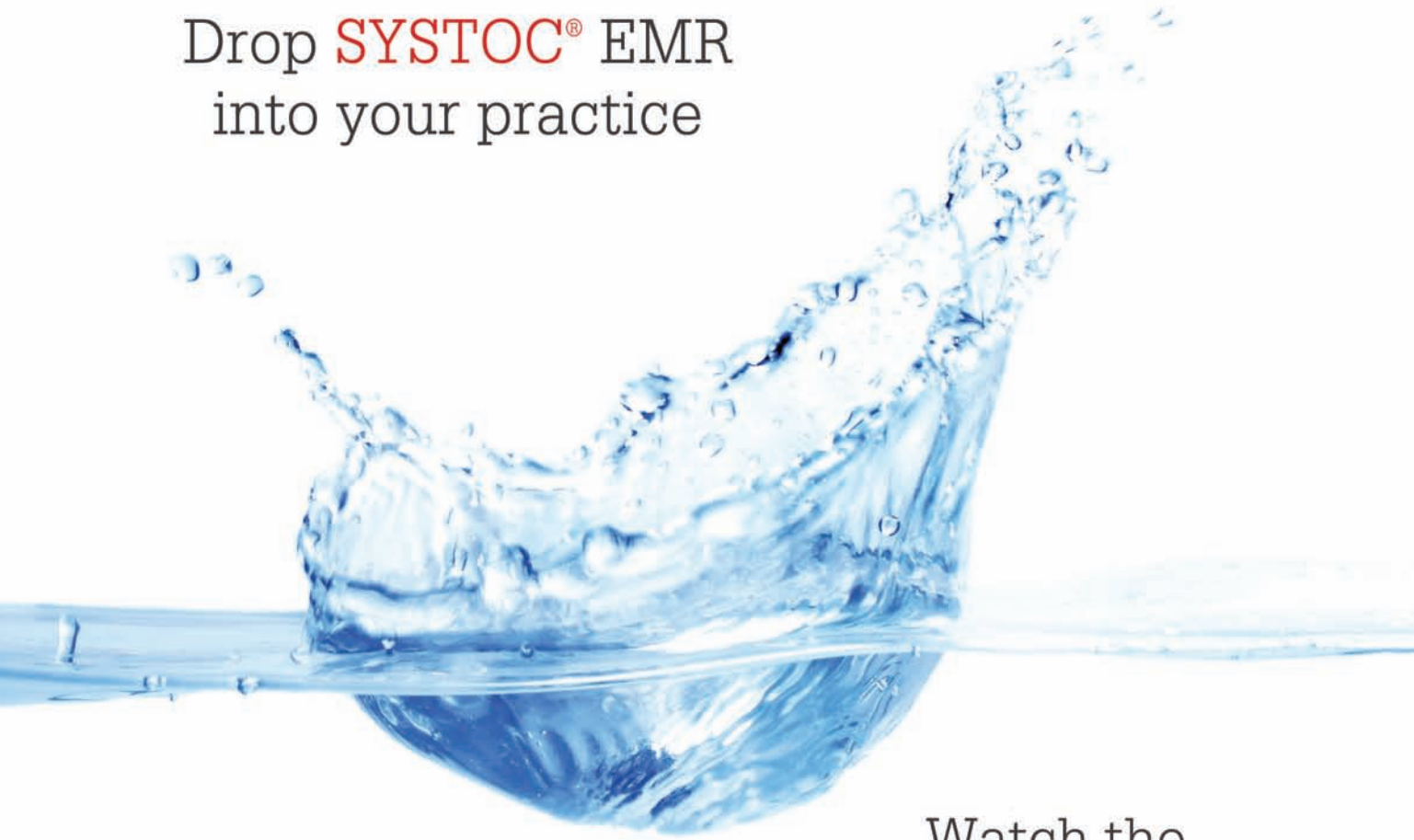

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Prescription Drug Abuse and the Drug-Seeking Patient

Urgent message: The urgent care clinic is a prime target for prescription drug abusers seeking possibly inappropriate prescriptions. Clinicians must be vigilant to screen, intervene, and refer such patients.

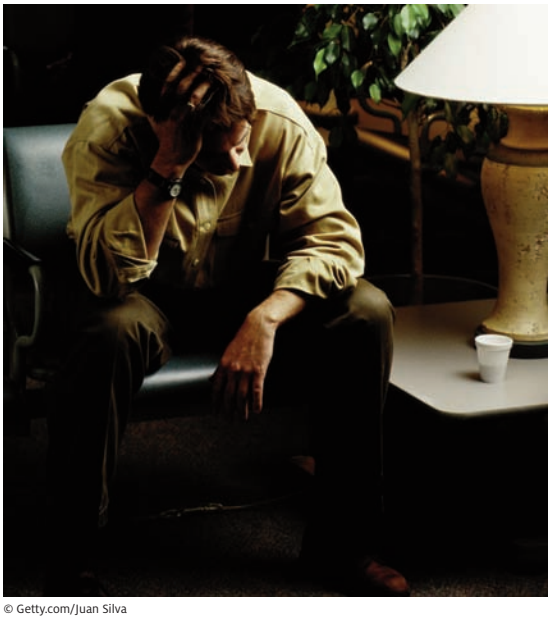
Marcelina Behnam, MD and Mark Rogers, MD

Introduction

Over the past several years, prescription drug abuse has become a problem of epidemic proportions for urgent care centers and emergency departments around the country. There has been an increase both in visits related to the acquisition of these medications, and in emergency department visits related to the misuse of prescription drugs.[1,2]

In response to this epidemic, new government legislation has been enacted and intervention and treatment centers developed.

This review article discusses the current problems of prescription drug abuse and substance use disorders (SUDs), as well as measures being implemented to address them.



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Rise of Prescription Drug Abuse

Within the past decade, there has been a substantial rise in prescription drug use and abuse.

Drugs of abuse are classified both by abuse potential and pharmacologic action, the latter of which is broken down into three main categories: stimulants, opioids, and CNS depressants. Each of these categories has seen a rise in use and abuse in the past several years, with opiates being the most commonly abused.[1]

According to a 2004 national survey on drug use and health published by the Substance Abuse and Mental Health Services Administration (SAMHSA), 19.1 million Americans were current illicit drug users. Among those 19.1 million, the largest segment (2.4 million) was populated with those engaging in non-medical (i.e., recreational) use of prescription pain relievers.

In 2005, according to the National Survey on Drug Use and Health (NSDUH), 6.4 million Americans over the age of 12 reported using a prescription drug for a non-medical purpose within the past month. Of those:

- 4.7 million used narcotic pain relievers
- 1.8 million used tranquilizers
- 1.1 million used stimulants (including methamphetamine)
- 272,000 used sedatives.[2]

Opiate abuse accounts for more than 50% of prescription drug abuse. Between 2004 and 2005, the Drug Abuse Warning Network (DAWN) reported that emergency department visits involving non-medical use for

Definitions

Drug abuse
Drug abuse, as defined by the DSM-IV, is characterized by one or more of the following signs:
- failure to fulfill major obligations
- use when physically hazardous
- recurrent legal problems
- recurrent social or interpersonal problems

Addiction/SUDs
Drug addiction and substance abuse disorders are characterized by preoccupation with the drug, tolerance, escalating use of the drug, withdrawal symptoms, and drug use associated with interference with daily functions.

Doctor shopping
"Doctor shopping" refers to an action whereby patients actively seek to obtain from multiple physicians the same or similar prescription within a brief period of time, e.g., 30 days.

opiate pain meds increased 24% overall.[2]

The Drug Enforcement Agency (DEA) diversion drug trend report identified hydrocodone as the most commonly diverted and abused controlled substance in the United States.

Hydrocodone is also one of the most commonly used drugs in the U.S., period. In 2004, this country used 99% of the global hydrocodone supply.[1] In 2005, hydrocodone outpaced Lipitor to be the most-prescribed drug here.[1,2]

Compounding the situation, there has been an increase in deaths and ED visits related to misuse and abuse of opiates. Opioid-related deaths increased 91% between 1999 and 2002, and by the end of 2002 opioid-related deaths outnumbered deaths related to heroin or cocaine.[3] In 2004, according to DAWN, there were 1.3 million ED visits related to opioid misuse and abuse. It all added up an estimated $181 billion in healthcare and social costs.[1]

Why EDs and Urgent Care?

Lack of patient-provider continuity makes it relatively easy for drug seekers to obtain prescriptions; hence, abuse of prescription drugs tends to be more prevalent in the emergency and urgent care settings.

In fact, prescription drugs are relatively easy to abuse in most practice settings for a variety of fairly logical reasons. Among them:
- Prescription drugs are perceived to be more socially acceptable and easy to obtain than other illicit drugs like heroin or cocaine.
- There is good quality control in their production.
- They are often paid for by insurance companies and are sold on the Internet.

There may also be a mistaken impression among the general public that prescription drugs are less dangerous than other drugs of abuse; in 2005, the NSDUH showed that 60% of prescription drugs were given to the user by a friend or relative for free.[2] And in June 2006 the national Center on Addiction and Substance Abuse (CASA) report found 185 Internet sites selling prescription drugs, 89% of which did not require a prescription.[2]

Other factors that may contribute to the rise of prescription drug abuse include the perception by both physicians and patients that pain is undertreated. Patient advocates have voiced concerns that the war on drugs has made physicians afraid to treat pain.[4] Paradoxically, this may facilitate drug seekers playing on a physician's sympathies to get prescriptions for pain medications.

Striking a balance between good pain treatment and facilitating SUDs is difficult. The Joint Commission's regulations mandate the monitoring and relief of pain. Physicians are challenged with demands for pain control and the feasibility of chronic pain management.[3]

Overall, the ready availability of prescription drugs in the U.S. has led to increased popularity compared with their illegal counterparts. Abusers of prescription drugs have developed various modes of diversion through which to obtain medications. Doctor shopping, Internet sales, theft, improper prescribing on the part of the physician, and sharing among family and friends are some of the most-often cited.[3]

Characteristics of a Drug-seeking Patient

Familiarity with some of the characteristics common among drug-seeking patients is particularly important in urgent care and other acute-care settings, where clinicians often encounter patients with whom they have no previous experience.

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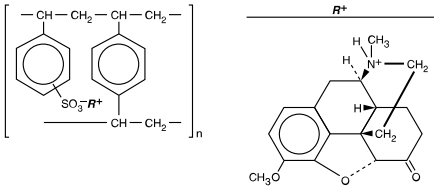

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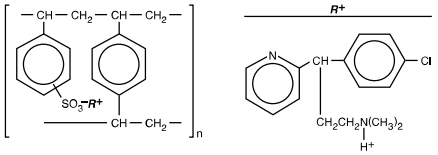

Inactive Ingredients: Ascorbic acid, D&C Yellow No. 10, ethylcellulose, FD&C Yellow No. 6, flavor, high fructose corn syrup, methylparaben, polyethylene glycol 3350, polysorbate 80, pregelatinized starch, propylene glycol, propylparaben, purified water, sucrose, vegetable oil, xanthan gum.

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

Chlorpheniramine is an antihistamine drug (H_1 receptor antagonist) that also possesses anticholinergic and sedative activity. It prevents released histamine from dilating capillaries and causing edema of the respiratory mucosa.

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

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

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

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

The use of TUSSIONEX Pennkinetic Extended-Release Suspension is contraindicated in children less than 6 years of age due to the risk of fatal respiratory depression.

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

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

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

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

Pediatric Use: The use of TUSSIONEX Pennkinetic Extended-Release Suspension is contraindicated in children less than 6 years of age (see CONTRAINDICATIONS).

In pediatric patients, as well as adults, the respiratory center is sensitive to the depressant action of narcotic cough suppressants in a dose-dependent manner. Caution should be exercised when administering TUSSIONEX Pennkinetic Extended-Release Suspension to pediatric patients 6 years of age and older. Overdose or concomitant administration of TUSSIONEX Pennkinetic Extended-Release Suspension with other respiratory depressants may increase the risk of respiratory depression in pediatric patients. Benefit to risk ratio should be carefully considered, especially in pediatric patients with respiratory embarrassment (e.g., croup) (see PRECAUTIONS).

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

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

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

Patients should be advised to measure TUSSIONEX Pennkinetic Extended-Release Suspension with an accurate measuring device. A household teaspoon is not an accurate measuring device and could lead to overdosage, especially when a half a teaspoon is measured. A pharmacist can recommend an appropriate measuring device and can provide instructions for measuring the correct dose.

Shake well before using.

Keep out of the reach of children.

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

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

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

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

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

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

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

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

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

Pediatric Use: The use of TUSSIONEX Pennkinetic Extended-Release Suspension is contraindicated in children less than 6 years of age (see CONTRAINDICATIONS and ADVERSE REACTIONS, Respiratory, Thoracic and Mediastinal Disorders).

TUSSIONEX Pennkinetic Extended-Release Suspension should be used with caution in pediatric patients 6 years of age and older (see WARNINGS, Pediatric Use).

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

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

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

General Disorders and Administration Site Conditions: Death

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

Renal and Urinary Disorders: Ureteral spasm, spasm of vesical sphincters, and urinary retention have been reported with opiates.

Respiratory, Thoracic and Mediastinal Disorders: Dryness of the pharynx, occasional tightness of the chest, and respiratory depression (see CONTRAINDICATIONS).

TUSSIONEX Pennkinetic Extended-Release Suspension may produce dose-related respiratory depression by acting directly on brain stem respiratory centers (see OVERDOSAGE). Use of TUSSIONEX Pennkinetic Extended-Release Suspension in children less than 6 years of age has been associated with fatal respiratory depression. Overdose with TUSSIONEX Pennkinetic Extended-Release Suspension in children 6 years of age and older, in adolescents, and in adults has been associated with fatal respiratory depression.

Skin and Subcutaneous Tissue Disorders: Rash, pruritus.

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

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

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

DOSAGE AND ADMINISTRATION: *It is important that TUSSIONEX is measured with an accurate measuring device* (see PRECAUTIONS, Information for Patients). A household teaspoon is not an accurate measuring device and could lead to overdosage, especially when half a teaspoon is to be measured. It is strongly recommended that an accurate measuring device be used. A pharmacist can provide an appropriate measuring device and can provide instructions for measuring the correct dose.

Shake well before using.

Adults and Children 12 Years and Older: 5 mL (1 teaspoonful) every 12 hours; do not exceed 10 mL (2 teaspoonfuls) in 24 hours.

Children 6-11 Years of Age: 2.5 mL (1/2 teaspoonful) every 12 hours; do not exceed 5 mL (1 teaspoonful) in 24 hours.

This medicine is contraindicated in children under 6 years of age (see CONTRAINDICATIONS).

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

NDC 53014-548-67 473 mL bottle

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

Storage: Shake well. Dispense in a well-closed container.

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

TUSSIONEX Pennkinetic Extended-Release Suspension
Manufactured for:
UCB, Inc.
Smyrna, GA 30080

Rev. 01/2008 TU1186-0308 1E

For example, drug-seeking patients:

- are often described as exhibiting "coercive behavior" and may request a specific drug for their pain, with some experts believing that coercive behavior may be pathognomonic of drug-seeking patients
- are often noted to have escalating use of the drug
- often report that they "lost" their prescriptions
- may partake in "doctor shopping"
- may report multiple drug allergies, especially to analgesics with low abuse potential.

A call to the patient's primary care physician's office may reveal multiple missed appointments, more reports of lost prescriptions, and deceptive behavior. However, drug-seeking patients are often reluctant to identify a primary care physician or may claim that their physician is out of town.

Such patients may also falsify symptoms, as well as medical examination tests, in order to deceive providers.[5]

One example is a patient who was known to repeatedly visit the emergency department with complaints of kidney stones, and who had a history of particularly manipulative behavior. Despite multiple negative CT scans, this patient often received narcotics based on complaints of flank pain and hematuria—that latter of which, as eventually witnessed by a nurse, was manufactured by the patient pricking his finger in order to contaminate the urine sample.

Drug-seeking patients are likely to have a history of substance or alcohol abuse. Look for cutaneous signs of drug abuse, such as needle tracks. They are also more likely to suffer from mood disorders.

A 2005 study looked at characteristics of drug-seeking patients and found that opioid abusers were characteristically more likely to be young men who have a past history of alcohol abuse, cocaine abuse, or have a previous drug or DUI conviction.[6]

Table 1. The CAGE Questionnaire

The CAGE questionnaire may be helpful in establishing alcoholism which, in turn, may inform decisions on whether to prescribe a medication that might be abused. The acronym, as shown below, notes that the questions focus on cutting down, annoyance over being criticized for drinking, feelings of guilt, and the need for an eye-opener (i.e., a drink first thing in the morning).

A caveat: The value of the quiz is only as good as the patient's willingness to answer the questions honestly.

1. Have you ever felt you should cut down on your drinking?
2. Have people annoyed you by criticizing your drinking?
3. Have you ever felt bad or guilty about your drinking?
4. Have you ever had an eye-opener—a drink first thing in the morning to steady your nerves or get rid of a hangover?

Approach to the Drug-seeking Patient

Assessment of drug addiction/abuse

It is important to evaluate the patient on a clinical basis and not to dismiss complaints of pain out of hand. Key steps in this evaluation include establishing the initial diagnosis, the medical necessity for pain medication, and weighing the risk-benefit ratio of prescribing pain medications in the evaluation of a suspected drug abuser.[3]

Patients should be evaluated for signs and symptoms of drug abuse and withdrawal. A discussion with patients regarding past or present alcohol and recreational drug use should always take place whenever one considers prescribing a potentially addictive medication.

The CAGE questionnaire (**Table 1**) is useful for determining alcohol abuse and SUDs, which is a useful predictor for prescription drug abuse. It can also be modified to query patients about prescription drug addiction and abuse.

Other surveys have been devised, such as the prescription drug use questionnaire, which consists of 39 items evaluating five different domains. This tool is helpful in identifying addiction risk.[5,7]

One major limitation to extensive questionnaire use is the feasibility in an urgent care setting. Other modes of evaluating for SUDs and abuse of prescription drugs include a review of the patient's chart and, in certain states, a prescription monitoring program.

Alternatives to drugs of abuse

If SUDs or recreational use of prescription drugs is suspected with a particular patient but you still feel that patient has a legitimate need, consider prescribing something other than a medication that could be abused by the patient (**Table 2**).

Drugs with partial opiate receptor activity such as tramadol, for example, have become a popular alternative

Table 2. Pharmacologic Alternatives to Controlled Drugs in Patients with SUDs[8]

Diagnosis	Alternative to controlled drugs
Anxiety disorders	Antidepressants (most) Buspirone (Buspar) Anticonvulsants (valproic acid [Depakene], gabapentin [Neurontin]) Selected antihypertensives (beta-blockers) Atypical neuroleptics (olanzapine [Zyprexa], quetiapine [Seroquel], risperidone [Risperdal])
Insomnia	Sedating antidepressants Trazodone (Desyrel) Doxepin (Sinequan) Amitriptyline (Elavil) Nefazodone (Serzone) Mirtazepine (Remeron) Zolpidem (Ambien)* Antihistamines
Attention-deficit disorder	Pemoline (Cylert) Bupropion (Wellbutrin) Desipramine (Norpramin) Venlafaxine (Effexor) Clonidine (Catapres) Selective serotonin reuptake inhibitors
Pain	Nonsteroidal anti-inflammatory drugs Acetaminophen Antidepressants Anticonvulsants Steroids Muscle relaxants

*While this drug has been marketed with claims of having low abuse potential, there have been some reports of abuse.

to opiate analgesics. These agents are commonly believed to be non-addictive and are often prescribed to addiction-prone patients, though there have been multiple reports of addiction to these substances, as well, with an increased prevalence in their abuse. A 2004 survey by the NSDUH found that 1.3 million Americans used tramadol for non-medical purposes. The DAWN 2004 study cited 2,984 ED visits related to tramadol overdose.[1]

When prescribing these medications, consider the possibility for abuse in those patients with a history of SUDs or drug abuse.

Strategies for dealing with difficult patients

Practice caution when dealing with coercive patients. Avoid feeling compelled to oblige the patient's requests. If discussion of treatment options escalates to a confrontation with a patient who is requesting a controlled substance, try to do the following:

- Remain calm.
- Explain to the patient that what he or she requested is not an option.
- Say no.
- Offer the patient an alternative.
- Demonstrate genuine concern for the patient's distress, and avoid raising your voice. Also, try to avoid using judgmental phrases or tones.
- Create room for discussion by showing concern and interest for the patient's wellbeing.

Documentation

From a medical/legal standpoint, it is important to document these discussions with the patient in the patient chart.[5] In addition, if you suspect that the patient has exhibited repetitive drug-seeking behavior, doctor shopping, or other modes of diversion, make notes of this in the patient's chart.

This should be done with caution, however, to avoid "labeling" the patient and causing undue harm and bias between the patient and future providers. For this reason, objective language should be used with specific situational references.

Cite in a patient note the nature of the visit, the past prescriptions obtained, what the interaction with the patient was, and an objective description of the patient's behaviors. It is also important to cite what alternative treatments have been offered to the patient.

Treatment

Finally, if feasible and deemed appropriate in your opinion, direct the patient toward resources to aid in treatment.

Current treatment for SUDs is multifaceted. Medical therapy usually involves a combination of pharmaceuticals aimed at reducing the side effects of opiate withdrawal (e.g., clonidine [Catapres], loperamide [Imodium]) and others reducing the craving for the drug itself (e.g., methadone, buprenorphine hydrochloride/naloxone hydrochloride [Suboxone].

There are a variety of resources available for treatment

(**Table 3**). For example, SAMHSA offers an online Substance Abuse Treatment Facility Locator covering more than 12,000 treatment centers.[9] Other resources include the National Institute on Drug Abuse (NIDA) and the Office of National Drug Control Policy (ONDCP).

Preventive Strategies

Prevention of prescription drug abuse is a multidisciplinary task which involves both public and physician awareness. Education through the media, government agencies, and local campaigns combine to raise public awareness of prescription drug abuse.

As clinicians who are likely to see our fair share of drug-seeking patients, urgent care practitioners are in a good position to contribute to public awareness by educating patients and patients' families on the dangers of addiction and the potential for overdose of controlled substances.

Awareness of which drugs are most likely to be abused helps to facilitate education.

Medications with high potential for abuse tend to have several properties in common, notably:

- rapid onset
- high potency
- brief duration

The formulation of the substance also affects its abuse potential. Water-soluble medications are prone to intravenous use; volatile substances may be smoked.

Also, some controlled substances that are manufactured for a slow, time-release delivery may be tampered with (e.g., crushed) so that the entire amount of the active ingredient is absorbed immediately upon ingestion.

Prescriber responsibility and training

There is also concern that the abuse of prescription drugs is due to overprescribing on the part of the prescriber. This may be due, in part, to the fact that many clinicians lack education and training on drug-seeking patients. They may not know how to identify drug-seeking behaviors, or they may be unaware of the signs and symptoms of SUDs. They also may not have strategies to deal with coercive patients, which may lead to trouble saying "no" to patients.[3]

Research indicates that, as a whole, physicians lack education on prescription drug abuse. For example:[2]

- Only 19% of physicians report receiving training in prescription drug diversion.
- An underwhelming 40% had any previous medical school training in identifying prescription drug abuse and SUDs.

Table 3. Substance Abuse and Treatment Resources

Organization	Website
Agency for Healthcare Research and Quality	*www.ahrq.gov*
American Academy of Family Physicians	*www.aafp.org*
The Buprenorphine Bibliograph	*www.coretext.org*
Center on Addiction and Substance Abuse (CASA)	*www.casacolumbia.org*
Central East Addiction Technology Transfer Center	*www.ceattc.org*
Department of Health and Human Services (DHHS)	*www.hhs.gov*
Drug Abuse Warning Network (DAWN)	*www.dawninfo.samhsa.gov*
Drug Enforcement Agency	*www.usdoj.gov/dea*
Narcotics Anonymous	*www.na.org*
National Alliance of Methadone Advocates	*www.methadone.org*
National Institute on Drug Abuse (NIDA)	*www.nida.nih.gov*
Office of National Drug Control Policy (ONDCP)	*www.whitehousedrugpolicy.gov*
Substance Abuse and Mental Health Services Administration (SAMHSA)	*www.samhsa.gov*
Substance Abuse Treatment Facility Locator	*www.findtreatment.samhsa.gov*
U.S. Department of Health and Human Resources Health Resources and Services Administration	*www.hrsa.gov*

- As many as one third do not regularly call or obtain records from the patient's previous physician before prescribing controlled drugs on a long-term basis.

Educational seminars and training designed to increase awareness among physicians and patients is needed. ONDCP, NIDA, DEA, SAMHSA, and the Department of Health and Human Services (DHHS) all offer education on prescription drug abuse.

Institutional Policies

In many instances, institutional policies are overshadowed by state and national regulations. In some institutions, hospital committees can help to identify drug-seeking patients and assign these patients to a primary provider.

Other institutions have developed "patient alert lists." A community-wide system in Calgary, Canada encompasses a group of local hospitals toward this end. Such institutional surveillance may not be feasible in the U.S. due to HIPAA and other federal regulations, however.

Private insurers and Medicaid have adopted policies to combat prescription drug diversion, as well.

Private insurance companies use drug utilization reviews to address whether drugs are being prescribed appropriately.

Medicaid has an abuse drug audit system that identifies doctor shoppers and assigns a single primary care physician and pharmacy to these patients.

Prescription monitoring programs

On both state and federal levels, there are programs which monitor the distribution of prescription drugs.

The Kentucky All Schedule Prescription Electronic Reporting (KASPER) system, developed in 1998, archives relevant information into a database that can be accessed in real time by practitioners. The limitations to this system are that drug-seeking patients can go to bordering states that do not use a prescription monitoring system.

In an attempt to remedy this problem, in 2003 the Department of Justice initiated the Harold Rogers Prescription Drug Monitoring Program, sponsored by the DEA and Congressman Harold Rogers (R-KY). This initiative was aimed at improving prescription drug monitoring programs among individual states.

Two years later, the National All Schedules Prescription Electronic Reporting Act (NASPER) passed, continuing the funding of state monitoring programs and authorizing spending to improve the communication between the different state programs. While funding has been an issue for these projects, as of 2006 there were 27 states with prescription drug monitoring programs, of which 18 monitored schedule IV drugs and 20 monitored schedule III drugs.[2]

Prescription drug monitoring programs are a benefit in the states that have these programs. However, at this time there is little communication between neighboring states, and work still needs to be done to make this a national system.

Doctor shopping laws

The National Alliance of Model State Drug Laws is a resource for legislators and other professionals to help develop laws with the intent to address alcohol and drug abuse. Specifically, they cite the number of individual

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Table 4. State Doctor Shopping Law[10]

State	Citation
Connecticut	CONN. GEN. STAT. ANN. § 21a-266 (West 2006).
Florida	FLA. STAT. ANN. § 893.13(7)(a).8 (West 2006).
Georgia	GA. CODE ANN. § 16-13-43(a)(6) (2005).
Hawaii	HAW. REV. STAT. ANN. § 329-46 (Michie 2005).
Maine	ME. REV. STAT. ANN. Tit. 17-A, § 1108 (West 2006).
Nevada	NEV. REV. STAT. ANN. 453.391 (Michie 2005).
New Hampshire	N.H. REV. STAT. ANN. § 318-B:2.XII-a (2006).
South Carolina	S.C. CODE ANN. § 44-53-395(A)(3) (Law. Co-op 2005).zz
Utah	UTAH CODE ANN. § 58-37-8(3)(a)(ii) (2006).
West Virginia	W. VA. CODE ANN. § 60A-4-410 (Michie 2006).

states with doctor shopping laws.

As of 2006, only 10 states had specific laws against doctor shopping (**Table 4**).

Treatment legislation

Congress passed the Federal Controlled Substance Act, the government's initial response to the abuse of prescription medications, in 1970. This act classifies drugs of abuse and provides criminal statutes for inappropriate use of controlled substances.

Under the Federal Controlled Substance Act, it is illegal for physicians to prescribe controlled substances to individuals who are known to have an abuse or addiction problem—including those for the treatment of withdrawal symptoms.

The Drug Addiction and Treatment Act of 2000 addressed the issue of treatment of individuals who are addicted to controlled substances. Currently, buprenorphine HCl (Subutex) and buprenorphine HCl/naloxone HCl (Suboxone) are the only Schedule III, Schedule IV, or Schedule V drugs with FDA approval to treat individuals who are addicted to controlled substances with opiates, or agents with partial opiate receptor activity. This treatment is facilitated through specialty clinics.

Summary

With the implementation of strategies aimed at reducing the diversion of controlled substances, the abuse of prescriptions drugs can decrease. One study identified frequent users in an emergency department, denied them narcotic prescriptions, provided supportive and addiction counseling, and limited them to one pharmacy. This resulted in a 72% decrease in the use of the emergency department by these frequent users without increased use of other hospitals.[4]

Prescription drug abuse has grown to epidemic proportions in the past 10 years. One of the challenges in the identification and prevention of prescription drug abuse is the fear of inadequately treating someone's pain. It is often difficult to discriminate between true disease pathology and drug-seeking behavior.

However, with increased awareness and experience, urgent care providers can help to control prescription drug abuse by identifying drug-seeking patients through the recognition of their behaviors and diversion techniques. This will allow the provider to treat all patients appropriately and responsibly. ■

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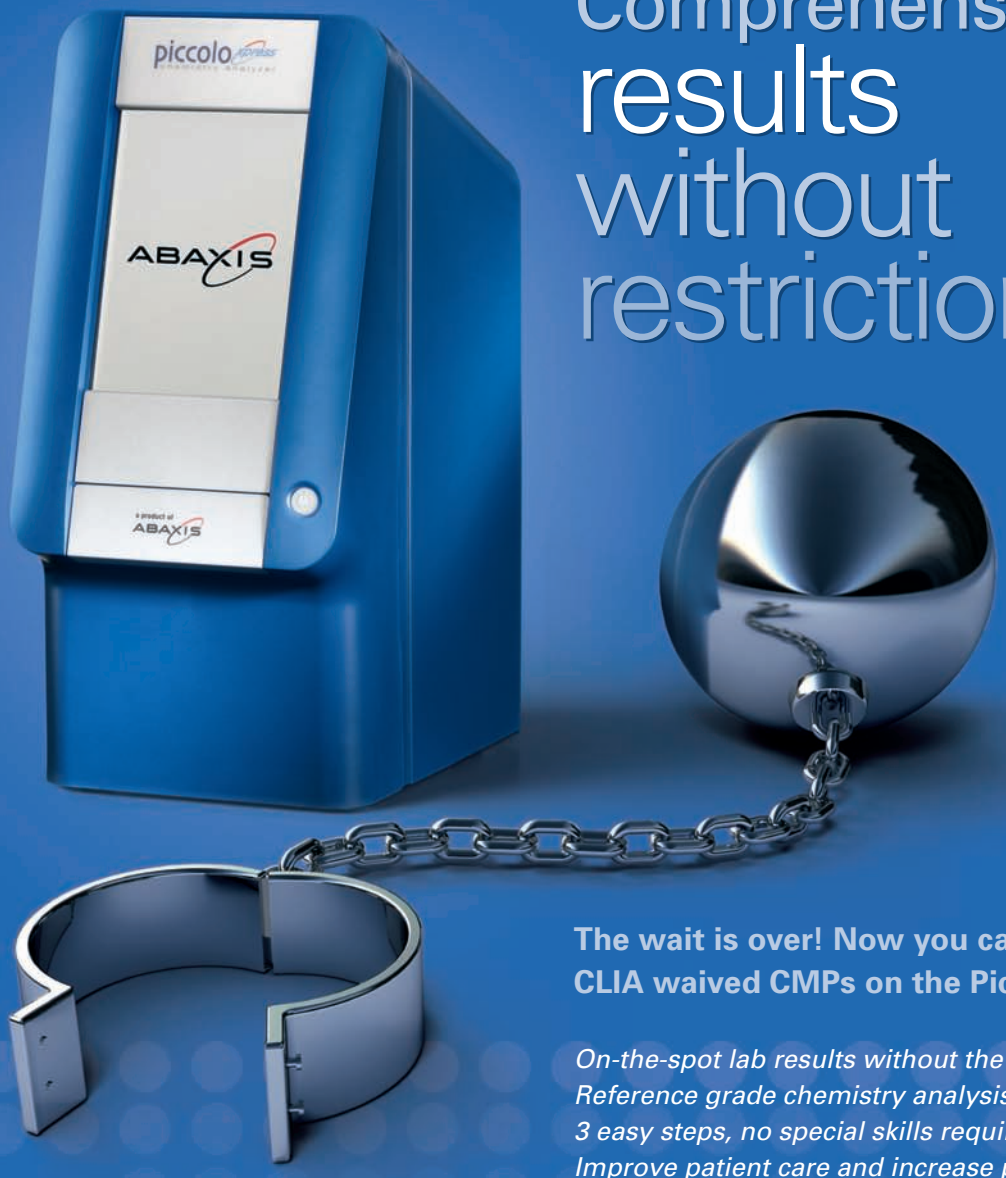

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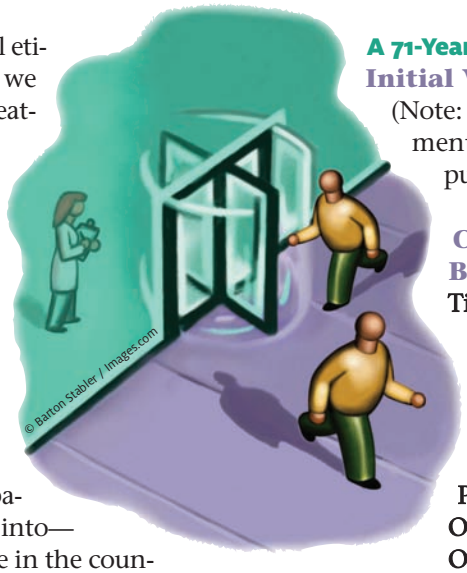
The Case of a 71-Year-Old Man with Back Pain

Bouncebacks *appears semi-monthly in JUCM. Case presentations on each patient, along with case-by-case risk management commentary by Gregory L. Henry, past president of The American College of Emergency Physicians, and discussions by other nationally recognized experts are detailed in the book* **Bouncebacks! Emergency Department Cases: ED Returns** *(2006, Anadem Publishing, www.anadem.com; also available at amazon.com and www.acep.org).*

Michael B. Weinstock, MD and Ryan Longstreth, MD, FACEP

Though it is easy to predict the usual etiology of common complaints, we need to be able to exclude life-threatening causes of symptoms.

In law, we are innocent until proven guilty. In medicine, we are required to prove certain diseases are *not* occurring; we are, in a sense, guilty until proven innocent: A 50-year-old man with chest pain and diaphoresis has an MI until proven otherwise. A 22-year-old woman with lower abdominal pain has an ectopic pregnancy until proven otherwise.



Our case this month involves a patient with back pain. He could walk into—and out of—any urgent care practice in the country *unless* the provider has an index of suspicion for potential life-threatening causes of his symptoms.

An easy way to put this principle into practice is to complete the history and physical, then to revisit the symptoms with a "back door" approach by specifically evaluating for the life-threatening causes of the symptoms.

For example, if a patient has a headache, subarachnoid hemorrhage and meningitis need to be considered. After the provider has obtained information on the character of the pain, onset, duration, and exacerbating factors, specific questions can be asked to exclude these important diagnoses.

A 71-Year-Old Man with Back Pain

Initial Visit

(Note: The following is the actual documentation of the providers, including punctuation and spelling errors.)

CHIEF COMPLAINT (at 20:36):
Back pain

Time	20:48	00:11
Temp (F)	97.1	
Pulse	72	71
Resp	20	16
Syst	140	113
Diast	80	67
POS	L	S
O2 sat		98
O2%		RA
Pain scale	6	2

HISTORY OF PRESENT ILLNESS (at 21:09):
71yo WM with h/o HTN reports was watching the game and it had just started overtime when felt a spasm and pain in left lower back. Denies any twisting/turning/lifting/trauma to the back. Reports lay down on the hard floor to help the pain, took 2 advil from his wife and placed a cool cloth on the back. Still with spasm and unable to get up off the floor, so called 911 for assistance to ED. Denies any known recent back injury. No prior illness. No cough/rhinorrhea/chest pain/ear ache/sore throat/dysuria/

hematuria/urinary incontinence/numbness or tingling down extremities/bowel or bladder dysfunction/weakness in legs. Denies chest pain/abd. p., fever

PAST MEDICAL HISTORY/TRIAGE:

Triage nurse: Pain started spontaneously while at home watching TV. Pain is a stabbing, pressure in the left lower back that does not radiate. Denies trauma. Denies pain, or burning with urination.

Medication, common allergies: Morphine (nausea)
Current meds: Prinivil
PMH: Hypertension, kidney stones
PSH: Lobectomy for TB in the 1960's

EXAM (at 21:10)

General: Alert and oriented X3, well-appearing WM in no acute distress; lying flat on his back on the bed; unable to sit upright, but can roll over on his side

Head: Normocephalic; atraumatic.

Resp: Normal chest excursion with respiration; breath sounds clear and equal bilaterally; no wheezes, rhonchi, or rales

Card: Regular rhythm, without murmurs, rub or gallop

Abd: Non-distended; Patient has some tenderness to palpation in left upper quadrant without guarding or rebound

Back: No c/t/l midline tenderness; +tenderness to palpation over left paraspinous area in lumbar region

Ext: 5/5 strength DF/PF at ankles/IS/HS/quads; nl sensation to light touch; patellar DTR's 2+ and symmetric bilaterally; neg SLR bilaterally; 2+ DP pulses bilaterally

Skin: Normal for age and race; warm and dry; no apparent lesions

ORDERS:

At 21:00: Demerol 50 mg IVP, Phenergan 12.5 mg IVP, .9NS – 1L bolus

At 23:39: Vicodin 2 PO, Vicodin 2 PO to go

RESULTS (Reviewed at 21:58):

Test	Value	Units	Ref. Range
WBC	15.3	K/uL	4.6-10.2
HGB	13.2	G/DL	13.5-17.5
PLT	175	K/uL	142-424
NA	135	MMOL/L	135-144
K	5.1	MMOL/L	3.5-5.1
CL	102	MMOL/L	98-107
CO2	26	MMOL/L	22-29
BUN	22	MG/DL	7-18
CREAT	1.3	MG/DL	0.6-1.3

LFT's amylase/lipase: WNL
Urine dip stick: Protein; Results: Trace

PROGRESS NOTES (at 23:39):

Abdominal exam benign with palpation although reports that abdomen sore with palpation of lower left side and upper left side. Still with some muscle spasm in the lower back, but able to walk and desires to go home. Counseled patient to return immediately for worsening abdominal pain, fevers, etc.

DIAGNOSIS:

Spasm - muscle, back

DISPOSITION:

The patient was discharged to Home ambulatory. Follow-up with primary care physician in 2 days. Prescriptions: Vicodin 5mg Twenty (20). Take 1-2 by mouth every 4-6 hours as needed. Released from the ED at 00:19.

Discussion of Documentation and Risk Management Issues at Initial Visit

Error 1

Error: Abdominal pain was mentioned in the progress note but not discussed in the history of present illness.

Discussion: Concomitant abdominal *and* back pain in a 71-year-old significantly changes the differential diagnosis. There are many entities which cause both abdominal and back pain, including pancreatitis, peptic ulcer disease, aortic aneurysm, ureterolithiasis, pyelonephritis, mass, and diverticulitis.

The HOPI states patient denies abdominal pain. Just as discrepancies in the physician and nurses notes are difficult to defend, the physicians note needs to be consistent.

Teaching point: Subsequent findings often require the provider to revisit the history to further quantify these symptoms.

Error 2

Error: The patient required a significant amount of pain medication, possibly indicating a more serious underlying etiology of his symptoms.

Discussion: He initially received IV narcotics, then additional PO narcotics were ordered at the same time as documentation of a progress note saying he had improved. These incongruous events make the progress note hard to believe. If he was feeling so much better, then why did he require Vicodin on top of Demerol?

Teaching point: Repeated doses of narcotic meds in a 71-year-old man without a history of back pain is a red flag for more serious illness.

Error 3

Error: Over-reliance on normal urine.

Discussion: The urine does not show blood in 20% to 25% of patients with ureterolithiasis/kidney stones. The urine may show blood with a ruptured aortic aneurysm. With such concerning symptoms, it is important that a normal urine result not lead the doctor astray.

Teaching point: A test with low specificity and sensitivity is only marginally helpful.

Error 4

Error: Diagnosis is not consistent with symptoms.

Discussion: Why would a 71-year-old man without history of back pain suddenly have a spasm so severe that it causes him to call the paramedics? Our patient had no mechanism for his pain; it started as he was sitting watching TV and was so severe it brought him to the floor. After he had received two doses of narcotic pain medications, he stood up, said he felt better, and wanted to go home.

A physician needs to consider serious disease even if the patient attempts to talk him out of this possibility.

Teaching point: The onus is on the physician to exclude life-threatening etiologies of symptoms.

Bounceback Visit—ED Return Two Days Later

Shortly after 8 p.m. two nights later, the patient has sudden onset of abdominal pain radiating to the back. He calls his primary care physician, who does not return the call in 15 minutes. The patient's wife again calls 911.

When paramedics have the patient stand up to transfer to cart, he has a syncopal episode.

21:09 Presents per squad. Chief complaint of abdominal pain. Pulse 122, blood pressure 96/49, O2 sat 100%

21:13 *Physician documentation*: Severe abdominal and back pain. Has associated shortness of breath. No chest pain, blood in urine or stool.

Physical exam: The abdomen does have voluntary guarding and is moderately distended. He does have a pulsatile mass palpated in the left side of the abdomen. Femoral pulses both present but slightly decreased. Palpebral conjunctiva pale. Skin is moist. His mental status was alert and oriented, although he did keep closing his eyes during the history

21:16 Empiric diagnosis of ruptured aortic aneurysm. Vascular surgeon is paged and immediately calls back. Agrees to come in immediately for emergency surgery

21:27 Systolic BP decreases to 80. Hb returns at 6.5, indicating severe anemia. Pt. taken to surgery where ruptured aortic aneurysm is found. Surgery includes aorto-bi-iliac bypass with reimplantation of inferior mesenteric artery.

Pt. makes good recovery and leaves the hospital in good condition.

Unless a specific life-threatening entity is considered in the differential diagnosis, it will not be found.

Discussion of Ruptured Aortic Aneurysm and Risk-Management Principles

This patient presented initially, as do many patients, with ruptured abdominal aortic aneurysm (AAA); he had atypical symptoms which were mistakenly attributed to another disease entity.

The triad of ruptured aortic aneurysm is hypotension, back pain, and pulsatile abdominal mass, but less than half of patients present with all three symptoms. Almost a quarter of patients with AAA are initially misdiagnosed with renal colic.

The incidence of AAA is 1% in men over the age of 65 and is the cause of death in 15,000 patients per year. Most asymptomatic aneurysms are found incidentally on a CT or ultrasound of the abdomen.

Frequent presenting symptoms in patients with AAA are syncope, abdominal pain, hypotension, or back pain. Sudden death may also occur. Risk factors include hypertension, tobacco use, and age. If diagnosis is delayed until rupture, mortality skyrockets to 75%.

Physical examination can be misleading. Peripheral pulses may be normal, even in cases of rupture. Cullen (periumbilical ecchymosis) and Grey Turner's signs (flank ecchymosis) indicating retroperitoneal hematoma occur only rarely. Pulsatile abdominal mass in unreliable.

The diagnosis in an unstable, hypotensive patient is clinical, as occurred when our patient returned. He was taken to the operating room based on symptoms and physical exam findings. If he had been taken to the CT scanner while so unstable, he likely would have "crashed" there and the outcome may have been different.

Labs with acute rupture will be normal, as was the case at the initial visit; the patient did not have anemia until he returned. CT is almost 100% accurate, but the risk in the acute-care setting is that an unstable patient will need to be transferred. US is good at determining if there is an aneurysm, but CT is better at determining rupture. A bedside ultrasound, if available, can be performed rapidly and is almost 100% sensitive. There is no role for plain x-ray in diagnosis of AAA; if suspected, US or CT should be emergently performed.

In 1994, Michael Kefer published a study in the *Annals of Emergency Medicine* entitled Death After Discharge from the ED. The endpoint was death within seven days of ED visit. The researchers found nine patients who had been discharged and subsequently died from a medical error; interestingly, three of the nine died from ruptured AAA.

Unless a specific life-threatening entity is considered in the differential diagnosis, it will not be found.

Risk Management Principles

The main lesson to learn from this case is, when faced with an unusual presentation in a patient with risk factors for a potential life-threatening illness, the life-threatening causes need to be excluded.

Our patient had no mechanism for a back strain/spasm and had an unusual presentation; he was sitting in a chair watching TV when his pain started. He did have some pain with palpation of the back, but the physical exam was not definitive evidence that a more serious etiology was occurring. Abdominal pain was mentioned, but not adequately pursued. In addition, he had two significant risk factors for AAA: age and hypertension. It is rare for a 71-year-old to present to the ED with the first episode of back pain in his life. ■

Suggested Readings

- Venkatasubramaniam AK, Mehta T, Chetter IC, et al. The value of abdominal examination in the diagnosis of abdominal aortic aneurysm. *Eur J Vasc Endovasc Surg*. 2004;27(1):56-60.
- Fink HA, Lederle FA, Roth CS, et al. The accuracy of physical examination to detect abdominal aortic aneurysm. *Arch Intern Med*. 2000;160:833-836.
- Norman PE, Jamrozik K, Lawrence-Brown MM, et al. Population based randomized controlled trial on impact of screening on mortality from abdominal aortic aneurysm. *BMJ*. 2004;329(7477):1259.
- Rogers RL, McCormack R. Aortic Disasters. *Emerg Med Clin North Am*. 2004;22(4):887-908.
- Prisant LM, Mondy JS 3rd. Abdominal aortic aneurysm. *J Clin Hypertens (Greenwich)*. 2004;(2):85-89.
- Salen P, Melanson S, Buro D. ED screening to identify abdominal aortic aneurysms in asymptomatic geriatric patients. *Am J Emerg Med*. 2003;21(2):133-135.

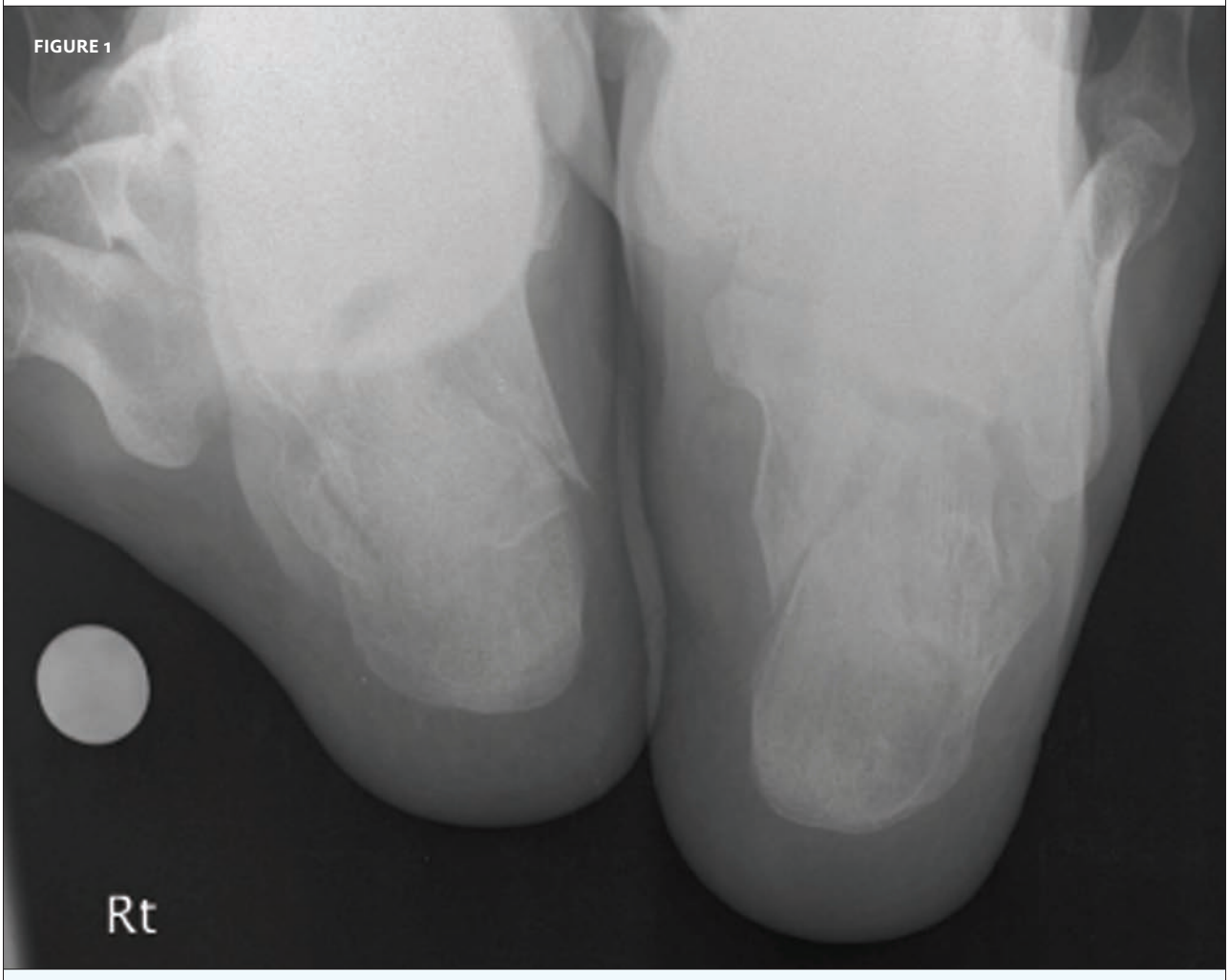
INSIGHTS IN IMAGES

CLINICAL CHALLENGE

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

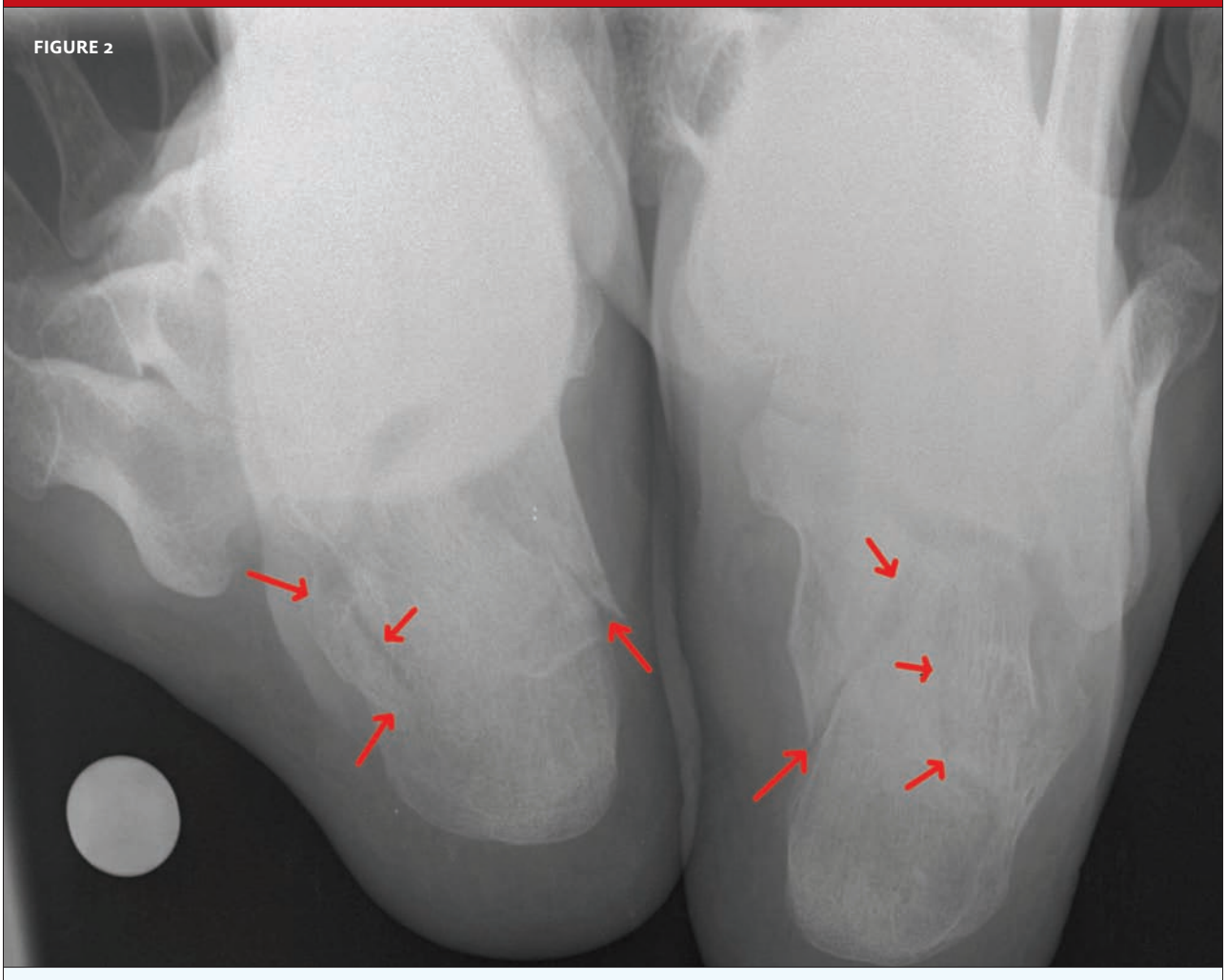


This male patient presents to urgent care after, he claims, falling from a ladder. He refuses to give further details, except to say that the distance he fell was "not high."

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

THE RESOLUTION

FIGURE 2



The obvious diagnosis is calcaneal fracture. However, it is important to note that as many as 7% of patients with calcaneal fracture may have fracture of the contralateral heel.

Given the appropriate mechanism of injury (i.e., a fall from an adequate height), care must be taken to thoroughly examine both lower extremities to exclude the presence of bilateral injuries.

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

On Children with Pyelonephritis, CPR Protocols, and Expenditures for Spine Problems

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.

Duration of IV Antibiotic Treatment for Children with Pyelonephritis

Key point: **Rates of renal scarring were similar in children who received long- or short-course IV antibiotics.**

Citation: Bouissou F, Munzer C, Decramer S, et al. Prospective, randomized trial comparing short and long intravenous antibiotic treatment of acute pyelonephritis in children: Dimercaptosuccinic acid scintigraphic evaluation at 9 months. *Pediatrics*. 2008;121:e553-e560.

Whether the mode and duration of antibiotic treatment prevent development of renal scars in children with pyelonephritis remains controversial. In this multisite, prospective study, French investigators analyzed data from 383 children (age range, 3 months to 16 years; mean age, 34 months) with first acute episodes of pyelonephritis; they were randomized to receive either intravenous antibiotics for eight days or IV antibiotics for three days followed by five days of oral antibiotics.

Children with grade 4 or grade 5 vesicoureteral reflux (VUR) or evidence of renal hypoplasia were excluded. Children underwent dimercaptosuccinic acid scintigraphies at six to nine months after enrollment to assess the incidence of renal scars.

The percentage of children with renal scars was similar in the long- and short-duration IV treatment groups (17% vs. 13%, respectively). Risk factors significantly associated with renal scarring included grade 3 VUR (odds ratio, 4.61) and enlarged kidney on initial ultrasound (OR, 3.19).

These results confirm that the duration of IV antibiotics does not affect development of renal scars in children with pyelonephritis and that oral and IV antibiotics are equivalent (*J Watch Pediatr and Adolesc Med*, April 8, 2005). However, the effect of antibiotic treatment on children with grade 4 or grade 5 VUR is unclear because these children were excluded from the study. Although grade 4 or grade 5 VUR is unlikely in children with normal prenatal ultrasounds, voiding cystography often is not performed for weeks after pyelonephritis diagnosis and after decisions about antibiotic treatment have been made. [Published in *J Watch Pediatrics and Adolesc Med*, March 26, 2008—Howard Bauchner, MD.] ■

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

New CPR Protocol

Key point: **Survival to discharge increased from 1.8% before minimally interrupted cardiac resuscitation training to 5.4% afterwards.**

Bobrow BJ, Clark LL, Ewy GA, et al. Minimally interrupted car-

diac resuscitation by emergency medical services for out-of-hospital cardiac arrest. *JAMA*. 2008;299:1158-1165.

Patients with out-of-hospital cardiac arrest have a dismal chance of survival. In this study, investigators sought to determine whether survival of such patients would improve with minimally interrupted cardiac resuscitation (MICR). This novel approach, aimed at maximizing cerebral perfusion, involves:

- an initial series of 200 uninterrupted chest compressions
- rhythm analysis, with a single defibrillator shock if indicated
- 200 immediate post-shock chest compressions before pulse check or rhythm reanalysis
- administration of epinephrine as soon as possible, repeated with each cycle of compressions and rhythm analysis
- delay of intubation until after three cycles of chest compression and rhythm analysis.

The researchers trained emergency medical services staff in two Arizona metropolitan areas to perform MICR. They then assessed records for patients with out-of-hospital cardiac arrest before and after the training.

In a separate analysis that included data from 60 additional Arizona fire departments, they also compared outcomes in patients who received MICR according to the protocol with those in patients who did not.

The main outcome of interest in both analyses was survival to hospital discharge.

A total of 886 patients with cardiac arrest from January 2005 through June 2007 were included in the two-city analysis. Survival-to-hospital discharge increased significantly, from 1.8% before MICR training to 5.4% after training (odds ratio, 3.0).

In 174 patients with witnessed arrest and ventricular fibrillation, survival rates increased from 4.7% to 17.6% (OR, 8.6). The rate of compliance with the MICR protocol was 61%.

In the larger analysis, involving 2,460 patients with cardiac arrest between January 1, 2005, and November 22, 2007, survival to discharge was significantly better in patients who received MICR than in those who did not (9.1% vs. 3.8%; OR, 2.7).

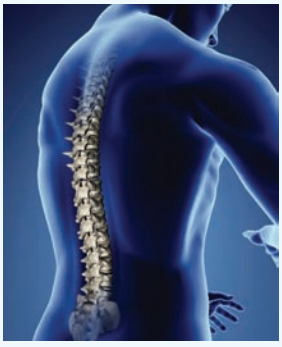
Minimally interrupted cardiac resuscitation was associated with improved survival-to-hospital discharge in patients with out-of-hospital cardiac arrest.

Encouraging as these results are, the study is limited by its observational design and by the possibility of the Hawthorne effect, whereby a short-term improvement is caused by observing worker performance. These findings are quite promising, but need validation before being adopted into practice. [Published in *J Watch Cardiol*, March 11, 2008—JoAnne M. Foody, MD. ■

Healthcare Expenditures for Spine Problems Have Increased

Key point: **Expenditures are up, but patient functioning has decreased.**

Citation: Martin BI, Deyo RA, Mirza SK, et al. Expenditures and health status among adults with back and neck problems. *JAMA*. 2008; 299:656-664.



Neck and back problems are prevalent in the U.S., yet little is known about national trends in healthcare expenditures for them or whether newer diagnostic and treatment methods improve outcomes. To address these issues, researchers analyzed data from the nationally representative Medical Expenditure Panel Survey of adults (>17 years) from 1997 through 2005.

Neck or back problems were reported by 13.6% of 23,045 respondents in 1997 and by 14.3% of 22,258 respondents in 2005. Mean age-, sex-, and inflation-adjusted medical expenditures among respondents with spine problems were significantly greater in 2005 than in 1997, both per respondent (US $6,096 vs. $4,695) and in total ($85.9 billion vs. $52.1 billion); total expenditures increased 65%.

Self-reported measures of mental health, physical functioning, and work, school, and social limitations among respondents with spine problems were worse in 2005 than in 1997. From 1997 through 2005, pharmacy expenditures for spine problems increased 171%, outpatient expenditures increased 74%, emergency department expenditures increased 46%, and inpatient expenditures increased 25%.

In the U.S., only healthcare expenditures for heart disease plus stroke substantially exceed those for spine problems. One disturbing finding of this study is that costs for spine problems increased sharply during less than a decade.

This change can be attributed to factors such as greater use of expensive new drugs, imaging studies, and surgery, as well as high patient expectations.

Even more disturbing is that dysfunction related to spine problems has worsened while costs have increased.

Spine problems represent an enormous opportunity, both generally and in the ED, to reduce healthcare expenditures without detriment to patient outcomes. [Published in *J Watch Emerg Med*, February 29, 2008—John A. Marx, MD, FAAEM, FACEP.] ■

CODING Q&A

Coding for Services Attempted But Not Completed, and Other Reader Queries

DAVID STERN, MD, CPC

Q. I can't find any documentation that tells us specifically how we should code when a provider tries to remove a foreign body, but is not successful and decides that the patient should go to the ER. Do we just code for an office visit or do we also code for the removal of the foreign body since the provider did try, albeit unsuccessfully, and decided the patient needed to be seen at the hospital?

– *Question submitted by both Nancy Wilkes, UCI Medical Affiliates, Columbia, SC and Alexis Adams, Louisiana Urgent Care, New Orleans, LA*

A. You may code both:

- the E/M (if one was documented and performed) with modifier -25
- and the procedure code (with a separate and identifiable procedure note) with modifier -53 (discontinued procedure).

A payor may discount the procedure because of the modifier, but you should bill out at full rate. Medicare does not reduce payment for CPT codes with modifier -53 appended.

Do not use modifier -53 for procedures that were planned but never actually performed.

Neither modifier -53 nor modifier -52 (reduced services) should ever be reported with an E/M service. Rather, you should report the actual level of service performed.

In the case of a patient visit for an emergency condition (under 1997 CMS E/M coding guidelines), if the physician is unable to take a full history because of the emergency nature of a visit (example: full review of systems was not performed because of emergency visit), you may indicate this reason for an incomplete history on the chart and take credit for a comprehensive history.

David Stern is a partner in Physicians Immediate Care and chief executive officer of Practice Velocity. Dr. Stern and Frank H. Leone, MBA, MPH, are scheduled to speak at a pair of half-day seminars, Urgent Care: 40 Ways to Increase Profitability, in Tampa and Boca Raton, FL July 25 and 26. For more information about the seminars, call Megan Montana at (800) 666-7926, extension 13. Dr. Stern may be contacted at *dstern@practicevelocity.com*.

Note: This only applies to the history part of the E/M documentation. On the physical exam, credit is given only for the actual exam elements and systems that were examined and documented on the chart. No credit should be given for any exam elements that were omitted because of the emergent nature of the visit. ■

Q. Is it better to use add-on S9088 or the global code S9083 for urgent care at a primary care facility with extended hours for walk-in patients?

– *Question submitted by Susan Nation, Camp Creek Urgent and Family Care Center, Atlanta, GA*

A. First: These codes are *only for true urgent care centers*. They should not be used by primary care offices that operate extended hours where they take walk-in patients. Abuse of these codes by practices that do not operate true urgent care centers (defined as those that provide significant extended hours, advertise themselves as providing services to the public on a walk-in basis, have x-ray on site and allow walk-in visits during all open hours) creates problems for everyone in the industry.

Second: You will need to use the proper codes, *based on your contracts with third-party payors*:

- Use S9083 if you have flat-rate per visit contracts.
- Use S9088 if a specific payor agrees to reimburse this code.
- Never use either code for Medicare. ■

Q. We are a urology practice that offers daily "on call" services in which patients can be seen on an urgent basis. What are the requirements of being able to bill as an "urgent care" center and/or state licensing requirements?

– *Question submitted by Patricia Williams, Urological Associates, Davenport, IA*

A. You would qualify as an urgent care if:

- your office advertises walk-in services to the public
- your office operates a center that offers walk-in care to patients at all times that you are open

- you operate x-ray on site
- you offer all basic CLIA-waved labs (urinalysis, *Strep* screen, rapid flu, urine pregnancy, etc.)
- *and* you offer significant hours beyond 9-5 (Monday through Friday).

If you meet all of these criteria, you may qualify for using the POS -20 and for using the only two codes (S9088 and S9083) that are unique to urgent care.

However, if you simply offer walk-in services to a small number of patients each day, this would simply be a case of open scheduling, as seeing a few walk-in patients each day is typical for physician offices. It would not make a physician office an urgent care center.

State licensing is required for urgent care centers in Arizona, but licensing is not required (or even available) in most other states. ■

Q. In a recent column, you stated that CMS allows one to "double dip" with the HPI and ROS. Where does CMS state that one can count the same item in both the history of present illness (HPI) section and the review-of-system (ROS) section?

– *Question submitted by Alex Trimpe, St. Vincent Health, Carmel, IN*

A. The traditional interpretation that one may count an item of history in both the HPI and ROS was documented in 1997 in a letter from the chief medical officer of the Department of Health and Human Services. You can read the letter on this website: *www.ercoder.com/Downloads/CMS%20letters%20re%20HPI-ROS.pdf.*

Even though CMS has not released any official statement changing this position, the issue is still not fully settled. This issue remains confusing because many, often contradictory, oral statements on the issue have been made by officials of CMS and individual carriers; it has become very carrier-specific.

Some carriers are using the previous method and giving physicians credit as described.

Some carriers seem to be requiring "further development" (whatever that means) in order to count in the ROS.

The payors, however, do seem to read *JUCM*. Since the *JUCM* column you cite was published (October 2006, available at *www.jucm.com/2006-oct/coding.shtml*), one carrier—Trailblazer, in Virginia, Maryland, Delaware, Texas, and Washington, DC—has noted in an audio conference that it will not allow this type of "double dipping" (see Trailblazer Audit Template for E/M, available at *www.ouhsc.edu/bc/WatchingtheNews.asp*). ■

Q. Is it compliant for our urgent care center to code as a facility with place-of-service (POS) -22 to Medicare and as non-facility POS -11 to commercial carriers? Note: Our urgent care center is operated on a hospital campus, so it is fully compliant for us to code the POS -22. Can you define the place of service, depending upon the carrier?

You are probably wondering why anyone would do that. Bluntly, to maximize reimbursement from Medicare while remaining competitive with commercial payors and other free-standing urgent cares. My gut says, "No," but I have searched the Medicare website and did not come up with an answer. Is there a specific OIC or CMS ruling on this issue?

– ***Name withheld, Idaho***

A. I do think that your "gut" feeling is probably correct. I am unaware of any specific ruling on this specific POS coding method, but I suspect that an enterprising OIG investigator might deem it as violating CMS rules. The reasoning might be that you are billing in such a way to cause Medicare to pay more than other payors for the same service.

CMS has a most-favored-nation status for billings to Medicare, i.e., you may not bill Medicare more than you bill other payors. The specific regulations, interpreting Section 1128(b)(6)(A) of the Social Security Act, are available at *http://edocket.access.gpo.gov/2007/E7-11663.htm*.

They state, in part, that the OIG may exclude an individual or entity that has "[s]ubmitted, or caused to be submitted, bills or requests for payments under Medicare or any of the State health care programs *containing charges or costs for items or services furnished that are substantially in excess of such individual's or entity's usual charges* or costs for such items or services."

One can infer the intent of the existing rule from the OIG statement in the preamble to the September 15, 2003 proposed (but not implemented) rule: "When market forces cause a provider's usual charge to most of its customers to drop substantially below the Medicare fee schedule allowance, some providers continue to charge Medicare at least the fee schedule amount. In this situation, *the provider creates a two-tier pricing structure with Medicare paying more than other customers.* Unless the price differential can be justified by costs that are uniquely associated with the Medicare program, the provider is simply overcharging Medicare. In such circumstances, section 1128(b)(6)(A) of *the Act obligates providers to either charge Medicare and Medicaid approximately the same amount as they usually charge their other purchasers for the same items or services or risk exclusion from all Federal health care programs*."

This statement would seem to ban the POS coding method that you describe. After releasing this proposed rule for feedback, however, the OIG decided not to implement this rule. Thus, we are left without a clear ruling on the subject. ■

There Will be Blood: Key Reasons That Start-ups Fail

JOHN SHUFELDT, MD, JD, MBA, FACEP

In the movie *There Will be Blood*, character Henry Brands says, "That part of me is gone...working and not succeeding—all my failures has [sic] left me....I just don't... care."

At the end, after the struggles, "I don't care" is a common aphorism of the wanton entrepreneur. Maybe it is uttered during the futile death throes of the dying business. Or, maybe after leaving the bank president's office. I suppose it really doesn't matter where it is said; the goal is to never find yourself in the position where your best retort is, "I just don't care."

Here are some common reasons that new businesses fail, and what you can do to decrease your risk of failure.

1. Wrong business form. There are many different ways to set up your business: S-Corp., Limited Liability Corporation, Partnership, C-Corp., and Limited Liability Partnership to name the most common. Using the wrong business form probably will not hurt you at the start; however, it may make your exit strategy more challenging.

Also, if the business entity is sued, the plaintiff may try to pierce the corporate veil and attempt to sue you personally. For example, if you chose a C-Corp. and did not ensure that it was set up properly, your personal assets could be at risk.

a. Solution: Find a healthcare business attorney who understands the urgent care space and who can advise you on what business form to use and how to protect yourself from individuals attempting to pierce the corporate veil.

2. Undercapitalization. One way that a plaintiff can pierce the corporate veil is to prove that the business was undercapitalized at the inception. Also, in all new businesses, cash is king and starting a business without adequate cash reserves to get you through the first 18 months is akin to walking the tightrope without a net, ala Karl Wallenda.

a. Solution: Wait to start the venture until you are adequately capitalized. I have known a number of physicians who have squandered their entire savings trying to get to the break-even patient volume only to run out of cash during the home stretch.

3. Waning momentum. At the beginning, it will seem like there are not enough hours in the day to accomplish all that you need to operationalize the urgent care. It will also seem like you have an unlimited supply of energy to accomplish these tasks. However, as time goes on, the energy dissipates and as B.B. King sang, "The Thrill is Gone."

a. Solution: Take baby steps every day toward the goal. The energy needed to take the operation from start-up through its first year is significant. Remember, it is a marathon and not a sprint. I have known a number of physicians who make it through their first year only to run out of emotional steam before they hit their second anniversary.

4. Losing your vision. Remember the movie *Castaway* ("Wilsooooooooon")? Tom Hanks is stranded on a deserted island for an unknown period of time. He never truly gave up all hope and he always did what he needed to do to survive. Surviving the start-up phase until the clinic hits a break-even volume is crucial.

a. Solution: Don't lose sight of the goal. Do what it takes to win by finding creative directions to ensure the business can make it through the lean years, even if it's not pretty or not what you bargained for. If you have to go work at the prison doing new inmate cavity checks (I had to do that once), so be it.

5. Isolationism. No man is an island. A common mistake many entrepreneurs make is to not enlist help or solicit advice. The common adage among physicians goes something like this: "I survived medical school, how hard can this be?" Business is different than medicine, though, and success in the latter does not guarantee success in the former. It is a

Continued on page 35.

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

Perfecting the Clinic Visit as a Closing Technique

FRANK H. LEONE, MBA, MPH

Inviting would-be employer clients to visit your urgent care clinic is an increasingly common and effective marketing tool. Yet, most such visits are done with insufficient forethought.

The majority of occupational health closes are "soft" commitments—that is, there is no guarantee that the prospect will use your urgent care clinic. Hence, some type of follow-up to most sales calls is advisable. Further, it is best to actually *involve* the prospect in some manner, as prospect involvement is often the key to closing a sale.

A visit to your clinic is an excellent way to instill both a psychological and actual sense of commitment.

In addition, such a visit provides you with an opportunity to meet with a prospect on your own turf, as well as an opportunity to refine numerous processes that are likely to save your staff time down the road.

Rule #1: Schedule two clinic tours every week. For example, you might make Thursday afternoon clinic tour day and schedule two tours every Thursday at 2:00 and 3:45 p.m. Strive to fill your open slots rather than inviting prospects only as opportunities arise. Two tours per week equates to 100 tours per year—a sure fire way to bring in large volumes of new employer clients.

Rule #2: Schedule tours on days and during hours that make sense. You do not want your weekly tours to take place during busy times (e.g., Monday mornings) or usually quiet times (e.g., Friday afternoon). While it is impossible to predict the volume of walk-in patients with certainty, if your schedulers know that every Thursday afternoon is clinic tour day, they can set up planned appointments accordingly.

Frank Leone is president and CEO of RYAN Associates and executive director of the National Association of Occupational Health Professionals. Mr. Leone and David Stern, MD, CPC are scheduled to speak at a pair of half-day seminars, Urgent Care: 40 Ways to Increase Profitability, in Tampa and Boca Raton, FL July 25 and 26. For more information about the seminars, call Megan Montana at (800) 666-7926, extension 13. Mr. Leone may be contacted at *fleone@naohp.com*.

Rule #3: Make it easy for the prospect. Once a tour has been arranged, routinely e-mail prospects confirmation of the time, date, and location of the visit, where and how to park (with parking passes as appropriate), and a map and/or basic written directions to your clinic.

Cancellations are less likely if the prospect understands that you have set up an itinerary and blocked out your time. Include a basic "itinerary" of their visit so they would know what to expect.

Rule #4: Turn the prospect over to your clinic director, if possible. The clinic visit is an excellent time to introduce the prospect/new client to your clinic director, who would then conduct the actual clinic tour.

Rule #5: Establish a routine tour. Every moment of the tour should be carefully orchestrated. For example, you should provide a soup-to-nuts walk-through to demonstrate typical patient flow. Always associate a "why" with a "what" and make sure that the why implies value. Do not simply say that you have six exam rooms; say that you have six exam rooms, which expedites patient flow and offers patients more privacy, which leads to greater satisfaction.

Rule #6: Ensure that key conversations are planned. Your clinic director should be briefed on the prospect's hot buttons and focus his/her conversation on these issues (i.e., "I understand that you are concerned with excessive waiting time. We attempt to address this concern by..."). Minimize chitchat or reciting the obvious ("this is an exam room") and focus on the prospective "win-win" relationship.

Rule #7: Make staff introductions meaningful. Go beyond simply introducing staff by training staff members to ask the "right" questions and script the "right" answers. Your physicians and clinical staff should always ask something like, "Tell me a little about your company. What seems to be your

greatest health and safety problem?"

By going this extra step, the prospect will sense that you and/or your physicians genuinely care about their company, and are capable of providing customized services.

Likewise, registration desk personnel should be instructed to mention the same thing (or ask the same question) regarding registration processes. What you know is a carefully orchestrated (yet easy to instill) process will be perceived by the prospect as a highly organized, efficient operation.

A well-executed tour is an exceptional way to move a near-close to a real close.

Rule #8: Involve your prospect. Try to involve prospects in some type of hands-on activity. For example, have them complete a prototype registration, ask them to complete a patient satisfaction form, offer them a complimentary cholesterol check, or have them "try" a physical therapy modality. Let them "feel" your team in action.

Rule #9: Complete your paperwork and client prep. Use your clinic tour to review and/or complete all required information (e.g., "client profile forms") necessary to expedite communication and information flow. Introduce the prospect to a liaison in billing and have them exchange critical information to facilitate subsequent billing processes. Provide prospects with handout material, including maps and appointment cards, which in turn can be distributed at their workplace.

Rule #10: End on a high note. Walk the prospect to their car and summarize your visit. Show them that extra level of respect by "staying with them" until they drive off. Remember that the most important thing you say to someone is usually as they are leaving, so you must be certain to summarize the new relationship as you part company.

A carefully planned and well-executed clinic tour is an exceptional way to move a near-close to a real close, develop mechanisms that will smooth the way once the prospect moves to client status, and cross-sell additional services as multiple members of your team become better acquainted with the prospect.

Viable clinic tours occur too infrequently and, when provided, usually fail to fully capture the moment. Incorporating the tips here into your next visit is likely to help you make the most of the opportunity. ■

completely different skill set, and survival by relaying on your gut is fraught with danger.

a. Solution: Enlist the help of consultants or others who have tread the same path. Don't be penny wise and pound foolish by refusing to pay a consultant in order to save a few dollars when the advice they give could save you thousands. Another alternative is to find someone who can support you as a mentor. Identifying someone who has "been there and done that" in the business world is extraordinarily useful.

6. Not hiring help. A mistake I made early-on was to be so caught up working *in* the business that I was unable to work *on* the business. I could have saved myself thousands of dollars and years of trial and error if I had hired some talented people at the outset and been able to spend time on business strategy, as opposed to operations.

a. Solution: Even if you can only afford someone a few hours a day (or less) make sure you have time to be strategic. The return on investment for that small amount of strategy-time will be huge!

7. Wrong motivation. When I was just out of residency and wanted to start a business, a close friend of mine who was already a very successful entrepreneur offered this sage advice: At the end of the day, if you simply spent your time working and earning wages (for me it was in emergency department) and compared that to all the debt you will incur in a start-up venture, along with lost wages and the time you will spend, you would probably be better off simply practicing medicine—particularly if your goal is merely to make money.

a. Solution: Be honest with yourself about what you hope to gain. If you love all the different aspects of running the business and all the challenges that go along with it, then opening a business is a great adventure. However, if it is simply the money you are after, there are probably better ways to maximize your return on investment.

8. Failing to support the community. Your business, and you as founder, must be good corporate citizens. This means you should help with projects important to your community (i.e., school, town, or place of worship). People will identify the good deeds with your enterprise and, consequently, your business will prosper from your involvement with other not-for-profit ventures.

a. Solution: Get involved in local not-for-profit organizations. It is a great way to form lasting business contacts and derive pleasure from your philanthropic endeavors!

A wise person learns from their mistakes, a brilliant one from the mistakes of others. Starting a business is fraught with challenges and risks. However, many of the risks can be mitigated by proper planning and execution, coupled with partnering with others who have trodden the same path. ■

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To learn more about this exciting opportunity, please contact:
Barb Hilborn, Manager, Physician Recruitment
Sparrow Health System
1210 West Saginaw, Lansing, MI 48915
Phone: 800-968-3225 • Fax: 517-364-6266
e-mail: barbara.hilborn@sparrow.org

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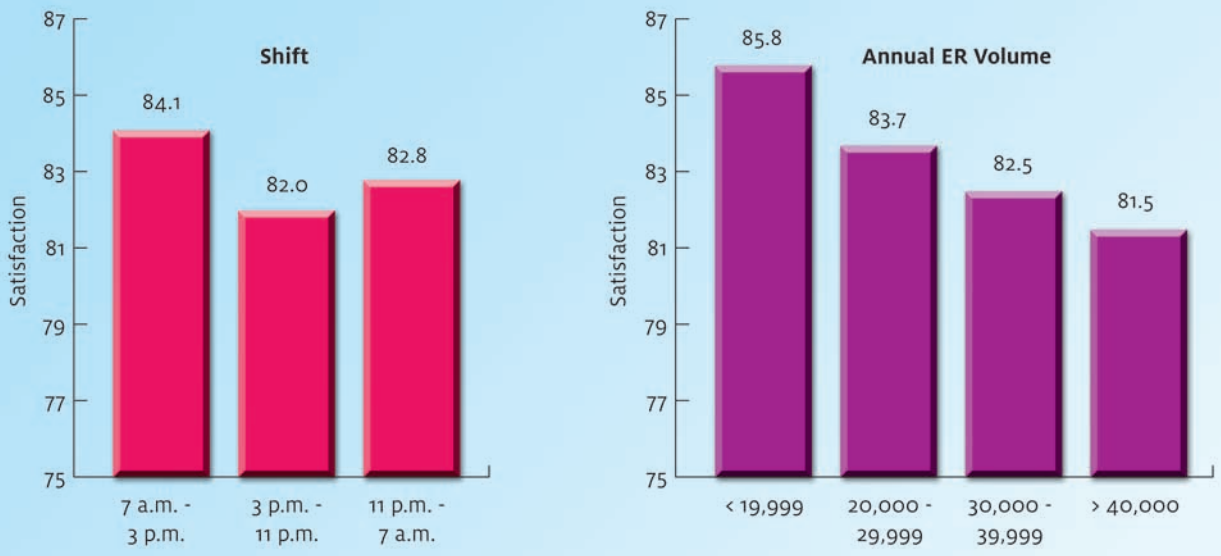
DEVELOPING DATA

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

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

In this issue: Among patients visiting emergency rooms in the U.S., how is overall satisfaction affected by time of day and the total annual visits to that ER?

PATIENT SATISFACTION BY ER SHIFT AND ANNUAL VOLUME



Source: *Emergency Department Pulse Report 2007. Patient Perspectives on American Health Care.* ©2007 by Press Ganey, Inc. Based on a population of 1.5 million patients who visited 1,552 U.S. hospitals in 2006.

Recognizing the factors that affect patient satisfaction can be of enormous value in crafting your marketing message and making decisions on staffing in an existing practice or location in a practice that is just starting out or expanding.

These data indicate that patients tend to be *least* satisfied with the care they receive in the ER between 3 p.m. and 11 p.m., and in hospitals with more than 40,000 annual ER visits.

The question, then, is how can your practice fill the perceived gap in patient satisfaction?

Future issues of *JUCM* will present new data from the third—and, to date, the most ambitious—UCAOA benchmarking survey.

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

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