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LETTER FROM THE EDITOR-IN-CHIEF

The Art of Conflict Management

Urgent cares centers are fertile ground for angry patients. Our patients are often sick and in pain, they often have long waits to be seen, and they are frustrated by an inefficient healthcare system that has landed them in urgent care in the first place.

Additionally, most of our patients are starting a new relationship with us, and they have not yet built any trust. Their prior healthcare experiences are most often lousy at best, and replete with hurdles and aggravation. They are used to being given the run-around, so they’re coming in with “dukes up,” ready to fight. Couple a battle-ready patient with a poorly prepared urgent care staff, and you have all the ingredients for a real scene.

The key to avoiding a full scale war in any conflict is “de-escalation.” De-escalation skills are mature coping skills that most of us have never learned. The majority of us learned our coping skills on the playground at school: “I’m rubber and you’re glue! Everything you say bounces off me and sticks to you!” When someone came after you with fists clenched, you got ready to punch back.

We have translated these playground lessons into our everyday lives as adults. I can freely admit to being ready for a fight every time I walk into the Department of Motor Vehicles. Unfortunately, many of our patients have the same feeling about healthcare institutions, so when they walk through our doors, they are preparing for a battle.

Understanding the root causes of hostility is the first step toward a path of de-escalation. Let’s review a few others here:

- Fear. You may not think you instill fear in your patients, but most people are, in fact, afraid of seeing doctors. In addition, they are often afraid that their condition may be something very dangerous. It may seem obvious to the practitioner that a patient’s chest pain is simply reflux disease, but you can be assured that patient thinks he is having a heart attack and is scared to death about it.
- Pain. Nothing makes for better “anger food” than pain.
- Recall. A patient is coming to your office with a life’s worth of bad experiences in healthcare.
- Confusion. The healthcare-and-insurance maze is one of the most challenging bureaucracies one will ever have to navigate. I have yet to see an insurance bill I understand, and I’m still trying to figure out what all my deductibles, copays and co-insurances mean. I have to laugh when I hear off-duty staff say, “Well, it’s your responsibility to understand your benefits.”

Now that we know the fuel for the hostility fire, let’s discuss tips on how to extinguish:

- Let them “blow off steam.” During the peak of an anger reaction, there is no way you are going to be able to reason with them, so don’t try. Resist the urge to react to everything they are saying. Just stop and listen. Remember, their anger is not directed at you, so don’t take it personally.
- Eventually, the anger runs out of “steam” if it is not provoked.
- Once they slow down, you have an opportunity to get the train back on the tracks. This is where you say something supportive like, “I know how frustrating this must be for you.” This does not mean you agree, but it shows understanding and validates. Nothing works better than validation to diffuse a situation and build trust.
- Once they have calmed down, you have the opportunity to problem solve, which is what everyone really wanted in the first place. If at any point you begin arguing with a patient, the whole process derails and escalation resumes.

Finally, if you feel unable to control a situation, get help from a colleague. Sometimes, a new face and a new pair of ears can be the difference maker. Again, don’t take it personally.

In future columns, I will discuss other tips that help you provide exceptional customer service, even in the most difficult of circumstances.

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

Adapted from the “Hostility Curve” as presented by the American Hospital Association. Teaching Patient Relations in Hospitals: The How’s and Why’s, 1983.
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11 Toward Ensuring Patient Safety in Urgent Care

Risks inherent to the practice of urgent care medicine can be mitigated by building a safety culture that embraces proper medication and lab practices. The first of two parts.

By Phillip Disraeli, MD, FAAFP

31 Putting Patients First: Redefining Quality in the Patient Experience

Patients and clinicians gauge “quality” in different terms. While good care is essential to both, patients also look at themselves as customers and expect to be treated as such. Ignore their perspective at the peril of your business.

By Alan A. Ayers, MBA, MAcc

In the next issue of JUCM: Further discussion of how to foster a culture of safety, including prevention of healthcare-associated infection, proper radiation procedures, and transitioning care from one provider to another. Also, a new installment of Bouncebacks considers the case of a patient with GI symptoms—from that patient’s perspective.
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EDITOR-IN-CHIEF
Lee A. Resnick, MD
editor@jucm.com

EDITOR
J. Harris Fleming, Jr.
hfleming@jucm.com

CONTRIBUTING EDITORS
Nahum Kovalski, BSc, MD
Frank Leone, MBA, MPH
John Shufeldt, MD, JD, MBA, FACEP
David Stern, MD, CPC

ART DIRECTOR
Tom DePrenda
tdeprenda@jucm.com

PUBLISHERS
Peter Murphy
pmurphy@braveheart-group.com
(201) 847-9334

Stuart Williams
swilliams@braveheart-group.com
(201) 529-4004

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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Preventable errors can be catastrophic for patients and have the potential to end a practitioner’s career or put an urgent care center out of business. The good news is that you can be proactive and establish safeguards against patients walking out your door with a prescription for the wrong medication (or the wrong dosing regimen for the right medication, for that matter), or lab results that reflect another patient’s visit.

In Toward Ensuring Patient Safety in Urgent Care (page 11), Phillip H. Disraeli, MD, FAAFP reviews strategies for establishing a culture of safety in your urgent care center. Part 1 of this two-part series focuses on good practices for patient identification, medication safety, and proper procedures for lab and x-ray results.

Dr. Disraeli is a partner in Metro Urgent Care in Frisco, TX, and director of clinical programs for the Urgent Care Association of America. This is the second article he has contributed to JUCM, the first being Managing Foot Fractures in Urgent Care (available in the Past Issues Archives at www.jucm.com).

Patient safety and good medical care may be the hallmarks of a “quality” experience from the clinician’s perspective (and rightly so), but it is also important to recognize that patient expectations may go beyond those factors. As Alan Ayers, MBA, MAcc explains in Putting Patients First: Redefining Quality in the Patient Experience (page 31), patients tend to judge a visit to your urgent care center, at least partially, in the context of the level of service provided, as they might after going to a restaurant.

Mr. Ayers is assistant vice president of product development for Concentra Urgent Care.

Also in this issue:

Nahum Kovalski, BSc, MDCM reviews abstracts on the risk of occult bacteremia in children, the burden of respiratory syncytial virus in younger patients, and how age relates to the likelihood of an orthopedic injury having been caused by child abuse.

Frank Leone, MBA, MPH explains the difference between an “attribute” and a “competitive strength” in the urgent care occupational medicine marketplace and offers a formula for evaluating the strengths of your program.

John Shufeldt, MD, JD, MBA, FACEP draws parallels between safely piloting an airplane and navigating your business through economic turbulence.

David Stern, MD, CPC responds to questions about observation status codes and continues his discussion of established vs. new patients.

We would like to expand our roster of readers who contribute to JUCM. If you have an idea for an article on a clinical topic, a case study to share, or have found new ways to bring revenue into your urgent care center, let us know by sending an e-mail to Editor-in-Chief Lee A. Resnick, MD, at editor@jucm.com.

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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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I don’t have a Blackberry. I do have a cell phone; it makes calls, and can take pictures, and send text messages, but by the time I’ve gotten to about the third word I just get frustrated and call.

I am not a technophobe, I actually love technology—I just don’t necessarily want it following me wherever I go. Which makes you wonder why I have opened a Twitter account for UCAOA.

I got dragged—kicking and screaming—into the “social networking” world about a year ago and have ended up having a marvelous time. So, when someone suggested we get a Twitter site, though it felt like one more step toward becoming a technology fashion victim, I had to look into it.

One of the biggest difficulties we have had at UCAOA is finding ways to get timely information to you in a nonintrusive, yet easy to access, but not overwhelming way. Currently, we have just a few good ways of doing that:

1. The monthly e-mail newsletter (but it only comes out once a month and we don’t want to further clutter your already-full Inbox).
2. The website. We change the front page once a week at least (but you have to go there on your own to see “What’s New” and we know you don’t always think to do that).
3. This column (but it is written weeks in advance of your reading it, so while it’s great for many things, it doesn’t work for many others).

Members have long wanted the Forum e-mails to “push” to them. And they can, but not everyone wants that much content at once; again, that can be overwhelming in the middle of a busy day.

Which brings me back to Twitter. Although all the news about Twitter has been about celebrities and such, turns out it does have possibilities for us (and many other top companies who use it to communicate), so we’ve decided to give it a try and would like you to join us.

“Anytime we hear anything of interest to the urgent care world we will ‘tweet’ a very short, easily digestible message to you.”

For those of you who haven’t jumped on this bandwagon, either (or should I say bandwidth?), here’s what it is and how it works:

Twitter is a service/software/company/thing that lets you “broadcast” short (there’s a 140 character limit) messages to people who want to hear from you, instantly. Those people are called your “followers” in Twitter-speak.

So, if you follow UCAOA on Twitter, anytime we hear anything of interest to the urgent care world we will “tweet” (I’m not making this up) a very short, easily digestible message to you, either on your Twitter page or your cell phone or your Blackberry, to keep you up to date on what’s happening.

You do need a Twitter page to make this work, but it takes literally one minute to set up at www.twitter.com. I know some of you already have Twitter pages (I am already following a few of you!), so tell your friends how easy it is.

Once you have a page, you just find “UCAOA” and click “follow.” That’s it. You don’t ever have to write (sorry, “tweet”) a thing, and the messages will sit on your page until you are ready to read them and catch up. You can get more involved than that, but you don’t have to.

We hope you will give this a try. We don’t post something every day, so don’t be nervous; it should be a good way for us to share some of the “pearls” we pick up along the way and enrich your connection with the rest of urgent care.

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Clinical

Toward Ensuring Patient Safety in Urgent Care

Urgent message: As urgent care’s role in the continuum of care continues to evolve, the practitioner must take steps to create a culture that supports proper patient identification, drug safety, and adherence to lab standards.

Phillip Disraeli MD, FAAFP

In the 1998 report To Err is Human, the Institute of Medicine defined patient safety as “freedom from accidental injury.” The ensuing media coverage focused on the 98,000 deaths that IOM estimated occur each year due to adverse events in U.S. hospitals.

Yet, the report also discussed errors that lead to injury and death across the continuum of healthcare, from medical offices, to pharmacies, home healthcare, and long-term care.

Ten years after the report, urgent care centers are an important component in the continuum of care for patients. As such, we need to evaluate our systems to ensure patient safety.

The purpose of this two-part article is to outline the common areas of risk inherent to the urgent care environment and to discuss concrete recommendations for mitigating that risk.*

Safety Culture in the Urgent Care Center

A culture that emphasizes patient safety should begin with the physicians and administration of the urgent care center.

Physicians can model behavior oriented toward intellectual curiosity, continuous quality improvement, and patient advocacy. Successful practices will use “near misses” as opportunities for learning for the entire staff, and not react by singling out individual staff for blame or ridicule.

In an approach similar to the airline industry’s, sentinel events can spur the practice to perform a root-cause analysis to prevent other medical errors of the same type.

It is helpful to designate a safety officer for the practice—someone responsible for keeping the center up to date on the latest recommendations from reg-

* The majority of the recommendations were adapted from the Joint Commission, with whom the Urgent Care Association of America recently agreed on a voluntary accreditation process for urgent care centers. This article is not intended to be a legally binding guideline. Other useful resources on the topic are the Institute of Medicine, the American Board of Medical Specialties, and the Institute for Safe Medication Practices.
ulatory and accrediting bodies, for annual assessments of potential areas of risk, and for staff and provider education. This need not be a physician, but the individual needs to have the full support and cooperation of the physicians in order to succeed. It may be helpful for the practice to assess its safety preparedness with the Physician Practice Patient Safety Assessment, available at www.physiciansafetytool.org.

Case Example
Mrs. Amy Jones presents to the urgent care center for treatment of cough and a fever. In the triage area, she gives the assistant her list of medications and notes that she is allergic to penicillin. The patient is evaluated by the physician in room 2, has a chest x-ray, and is diagnosed with pneumonia. Her physician decides levofloxacin would be the most appropriate treatment, and leaves to complete the chart and prescriptions.

Meanwhile, Mrs. Charlene Jones is seen by another provider for strep throat in room 3. Her physician reviews her medications and allergies and prescribes a shot of penicillin G benzathine. The order is written on the chart and handed to the nurse for the injection. The nurse sees the room number 2 in the corner of the chart—the wrong room number—and prepares the injection of penicillin and walks into room 2, where Amy Jones is sitting on the exam table. The nurse says, “Hi Mrs. Jones, I have an injection that the doctor ordered for you.” Feeling quite ill, Amy Jones does not question the injection. She is given the penicillin intended for the other Mrs. Jones, next door, and suffers an anaphylactic reaction.

Patient Identification
Both the Joint Commission and the American Board of Medical Specialties (ABMS) recommend that health-care providers utilize two unique patient identifiers before performing any procedure, drawing blood, or administering medications or vaccines.

The most reasonable method is to identify patients by their first and last names and date of birth.

- Nurses should always verify drug allergies prior to administering an injection.
- If a practice has more than one patient with the same or similar names, they can highlight the chart and name to bring the potential confusion to light for staff.

Medication Safety
Medications are the greatest source of adverse events in ambulatory care. One systematic review by Thomsen, et al found that they occur at the rate of 14.9 events per 1,000 person months.

On review, it becomes clear that many of these are preventable. Errors may occur in the ordering, prescribing, administering, refilling, and storing of medications.

Starting with the intake of the patient, the staff should obtain a complete medication and allergy history of every patient for every encounter. This list should include prescription medications, over-the-counter meds, herbal products, and supplements.

Allergies considered should include medications, foods, latex, and contrast agents. The urgent care center should have a system in place to ensure this is done for every encounter and that the provider can rely on the medication list.

Prescription “hygiene”
When prescribing medications, the provider should indicate the full name, dose, route, frequency, duration, and indication for every medication. The prescription must be legible if handwritten, or follow a standardized method in an electronic medical records or electronic prescribing tool.

The support staff needs to be encouraged to ask for clarification for any prescription that is incomplete, illegible, or unclear.

Oral and telephone orders are an area of potential danger for patients. Whenever possible, spoken orders should be avoided within the urgent care center. However, there are occasions when spoken or telephone orders are unavoidable. In these cases, a spoken order should specify the exact medication or procedure, the dose, route, and patient identifiers.

Clinical staff who receive spoken/telephone orders should write the order in the chart or order sheet and read the order back to the prescribing person, who must verify the order.

Clinicians need to be aware of common look-alike
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- FLECTOR® Patch is contraindicated for the treatment of perioperative pain in the setting of coronary artery bypass graft (CABG) surgery

Gastrointestinal (GI) risk
- NSAIDs cause an increased risk of serious GI adverse events at any time during use and without warning symptoms including bleeding, ulceration, and perforation of the stomach or intestines, which can be fatal. Elderly patients are at greater risk for serious GI events
- FLECTOR® Patch is contraindicated in patients with known hypersensitivity to diclofenac. FLECTOR® Patch should not be given to patients who have experienced asthma, urticaria, or allergic-type reactions after taking aspirin or other NSAIDs have been reported in such patients.
- FLECTOR® Patch should not be applied to non-intact or damaged skin resulting from any etiology, e.g., exudative dermatitis, eczema, infected lesion, burns or wounds.
- NSAIDs, including FLECTOR® Patch, can cause new onset or worsening of hypertension, contributing to increased incidence of CV events. Fluid retention and edema have been observed in some patients taking NSAIDs. Use with caution in patients with hypertension, fluid retention or heart failure.

A patient with symptoms and/or signs of liver dysfunction, or with a history of an abnormal liver test, should be monitored for a more severe hepatic reaction and therapy stopped. Anemia is sometimes seen in patients receiving NSAIDs and platelet inhibition has been shown to prolong bleeding times.

Long-term administration of NSAIDs has resulted in renal papillary necrosis and other renal injury. Renal toxicity has also been seen in patients in whom renal prostaglandins have a compensatory role in maintaining renal perfusion. FLECTOR® Patch is not recommended in patients with advanced renal disease.

NSAIDs, including FLECTOR® Patch, can cause serious skin adverse events without warning such as exfoliative dermatitis, Stevens-Johnson Syndrome (SJS), and toxic epidermal necrolysis (TEN), which can be fatal. Patients should be informed about the signs and symptoms of serious skin manifestations and use of the drug should be discontinued at the first appearance of skin rash or any other sign of hypersensitivity.

NSAIDs, including FLECTOR® Patch, can cause serious skin adverse events without warning such as exfoliative dermatitis, Stevens-Johnson Syndrome (SJS), and toxic epidermal necrolysis (TEN), which can be fatal. Patients should be informed about the signs and symptoms of serious skin manifestations and use of the drug should be discontinued at the first appearance of skin rash or any other sign of hypersensitivity.

Overall, the most common adverse events associated with FLECTOR® Patch were skin reactions (pruritus, dermatitis, burning, etc.) at the site of treatment and gastrointestinal disorders (nausea, dysgeusia, dyspepsia, etc.) and nervous system disorders (headache, paresthesia, somnolence, etc.).

In late pregnancy, as with other NSAIDs, FLECTOR® Patch should be avoided because it may cause premature closure of the ductus arteriosus. FLECTOR® Patch is in Pregnancy Category C. Safety and effectiveness in pediatric patients have not been established.

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Overall, the most common adverse reactions were edema, headache, rash, and edema. Flector® Patch should be used in patients with pre-existing asthma or if episodes with or without edema, in patients treated with NSAIDs. Only one in five (20%) patients with pre-existing asthma had adverse events with a maximum intensity of “mild” or “moderate.” The potential of increased adverse effects.

In late pregnancy, as with other NSAIDs, Flector® Patch should be avoided because it may cause fetal hypervolemic, diuresis, and adverse fetal renal function. Flector® Patch is contraindicated in patients with pre-existing renal disease or if abnormal liver tests persist or worsen, Flector® Patch should be discontinued. Clinical studies of Flector® Patch did not include sufficient numbers of patients aged sixty and over to determine whether they responded differently from younger individuals. In late pregnancy, as with other NSAIDs, Flector® Patch should be avoided because it may cause fetal hypervolemic, diuresis, and adverse fetal renal function. Flector® Patch is contraindicated in patients with pre-existing renal disease or if abnormal liver tests persist or worsen, Flector® Patch should be discontinued. Flector® Patch should not be used to treat pre-existing renal disease or if abnormal liver tests persist or worsen, Flector® Patch should be discontinued.

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and sound-alike medications that have been identified as common sources of medication errors. Most of the drugs with similar-sounding names will have different medical indications, so attaching the indication for use to every prescription will help prevent confusion. **Table 1** lists such medications that are used frequently in the urgent care setting.

All clinical personnel need to be aware of these meds so they have a heightened sense of safety when prescribing or refilling them. The urgent care center may even choose to post such a list in the clinical area.

All employees need up-to-date drug references at their fingertips, including accurate pediatric dosing. An online database with a patient education component (such as Epocrates or MD Consult) would allow for clinicians to discuss side effects and provide the patient with a written summary of the information.

**Samples**

Prescription samples are commonly dispensed from the urgent care center. A staff member should be responsible for maintaining the order of the sample closet and purging expired meds.

Again, particular care should be taken with medications that look alike or sound alike; these should not be stored next to each other.

Sample medications should be accepted by the practice only if they are known to be safe and effective, to be useful for common conditions seen in the urgent care center, and to be present on managed care formularies available to patients.

Providers must document the samples dispensed in the medical record in the same manner as normal prescriptions. The dosage and instructions for use need to be included. If the center has an EMR system, it may be possible to search the patient database for samples dispensed in the event of a drug recall or FDA removal.

**Sound decisions based on accurate information**

Physicians should prescribe medications only within the context of the urgent care center. In order to have all the necessary information for an accurate prescription, the clinician needs to have a chart with a full medication and allergy history, past medical history, and accurate demographic information. When clinicians make exceptions to this rule, they are more likely to make an error or encounter a patient who will have a preventable adverse reaction.

This is also true for personnel who are involved in the refilling of meds. They, too, must have access to the full chart. Chart access is improved in the setting of an EMR, because more than one individual may view the chart simultaneously, or even remotely.

It is most helpful when all members of the team utilize standardized protocols for refilling medications, whether electronic, by fax or, by phone. All refills must be documented in the medical record and be accessible as part of the ongoing medication history.

Jenkins, et al cite an anonymously authored article published in the *Journal of the American Medical Association* in reporting that up to one third of physician handwriting is illegible. For this reason and many others, urgent care clinicians are moving toward electronic prescribing and EMRs to enter medication orders and prescriptions. Some of these systems allow for updated drug information, interaction checking, and allergy warnings to prevent errors.

Recently, the Institute of Medicine recommended that all prescriptions be electronic by 2010. For those who have not yet made the transition, safety experts suggest that prescriptions be written carefully, while sitting in a quiet area, to improve legibility.

Abbreviations in prescriptions are especially problematic and prone to error. When writing the prescription, the name and dosing frequency should be indicated in full text, along with the indication for the prescription.

The Joint Commission recommends against using

<table>
<thead>
<tr>
<th>Table 1. Sound-alike and Look-alike Meds</th>
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<tr>
<td>Celebrex and Celexa</td>
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<tr>
<td>Clonidine and Klonopin</td>
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<tr>
<td>Hydromorphone and morphine</td>
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<tr>
<td>Lorazepam and alprazolam</td>
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<tr>
<td>Metformin and metronidazole</td>
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<tr>
<td>Topamax and Toprol XL</td>
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<tr>
<td>Zyprexa and Zyrtec</td>
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<tr>
<td>Advicor and Advair</td>
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<tr>
<td>Darvocet and Percocet</td>
</tr>
<tr>
<td>Hydrocodone and oxycodone</td>
</tr>
<tr>
<td>Prilosec and Prozac</td>
</tr>
<tr>
<td>Zantac and Xanax</td>
</tr>
<tr>
<td>Zestril and Zetia</td>
</tr>
<tr>
<td>Liquid morphine products—many concentra-</td>
</tr>
<tr>
<td>tions available</td>
</tr>
<tr>
<td>Insulin products—numerous confusing pro-</td>
</tr>
<tr>
<td>ducts</td>
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</tbody>
</table>
MOXATAG is indicated for the treatment of tonsillitis and/or pharyngitis secondary to Streptococcus pyogenes (S. pyogenes) in adults and pediatric patients 12 years and older. MOXATAG should be used only to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria. The full 10-day course of therapy should be completed for effective treatment. Patients taking MOXATAG should not chew or crush tablet.

Important Safety Information
Use caution in patients with known serious hypersensitivity to amoxicillin or to other drugs in the same class or patients who have demonstrated anaphylactic reactions to beta-lactams. Serious and occasionally fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. If an allergic reaction occurs, MOXATAG should be discontinued and appropriate therapy instituted. Clostridium difficile Associated Diarrhea (CDAD) has been reported with nearly all antibacterial agents, including

Please see brief summary of Prescribing Information on next page.

Introducing MOXATAG™ — Refining the delivery of amoxicillin therapy with innovative proprietary technology

- Extended-release tablets efficiently deliver amoxicillin using a once-daily dose of 775 mg for 10 days
- Proven efficacy for the treatment of tonsillitis/pharyngitis secondary to *Streptococcus pyogenes*
- Convenient, once-daily dosing potentially leading to improved compliance
- Favorable safety profile with observed minimal GI upset

*New* for the treatment of tonsillitis and/or pharyngitis secondary to *Streptococcus pyogenes*...
**moxatag.**
(amoxicillin extended-release tablets) 775 mg

The following is a brief summary only; see full Prescribing Information for complete product information.

**RX ONLY**

**INDICATIONS AND USAGE**
Moxatag is a once-daily amoxicillin product indicated for the treatment of tonsillitis and/or pharyngitis secondary to *Streptococcus pyogenes* (S. pyogenes), more commonly referred to as ‘strept throat’, in adults and pediatric patients 12 years or older.

To reduce the development of drug-resistant bacteria and maintain the effectiveness of MOXATAG and other antibacterial drugs, MOXATAG should be used only to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria.

**DOSAGE AND ADMINISTRATION**
The recommended dose of MOXATAG is 775 mg once daily taken within 1 hour of finishing a meal for 10 days. MOXATAG should be taken approximately the same time every day. The full 10-day course of therapy should be completed for effective treatment of tonsillitis and/or pharyngitis secondary to *S. pyogenes*.

Do not chew or crush tablet.

**CONTRAINDICATIONS**
MOXATAG is contraindicated in patients with known serious hypersensitivity to amoxicillin or to other drugs in the same class or patients who have demonstrated anaphylactic reactions to beta-lactams.

**WARNINGS AND PRECAUTIONS**

**Anaphylaxis and Hypersensitivity Reactions**
Serious and occasionally fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy, it has occurred in patients on oral penicillins. These reactions are more likely to occur in individuals with a history of penicillin hypersensitivity and/or a history of sensitivity to multiple allergens. There have been reports of individuals with a history of penicillin hypersensitivity who have experienced severe reactions when treated with cephalosporins. Before initiating therapy with MOXATAG, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, or other allergens. If an allergic reaction occurs, MOXATAG should be discontinued and appropriate therapy instituted.

**Clostridium difficile Associated Diarrhea (CDAD)**
Clostridium difficile Associated Diarrhea (CDAD) has been reported with nearly all antibacterial agents, including amoxicillin, and may range in severity from mild diarrhea to fatal colitis. Treatment with antibacterial agents and/or pharyngitis secondary to *S. pyogenes* may range in severity from mild to fatal colitis. Treatment with antibacterial agents and/or pharyngitis secondary to *S. pyogenes* may range in severity from mild to fatal colitis. Treatment with antibacterial agents and/or pharyngitis secondary to *S. pyogenes* may range in severity from mild to fatal colitis.

CDAD must be considered in all patients with present with diarrhea following antibiotic use. Careful medical history is necessary since CDAD has been reported to occur over two months after the administration of antibacterial agents.

If CDAD is suspected or confirmed, ongoing antibiotic use not directed against *C. difficile* may need to be discontinued.

**Superinfections**
The possibility of superinfections with mycotic or bacterial pathogens should be kept in mind during therapy. If superinfections occur, amoxicillin should be discontinued and appropriate therapy instituted.

**Mononucleosis Rash**
A high percentage of patients with mononucleosis who receive ampicillin develop an erythematous skin rash. Thus, ampicillin-class antibiotics should not be administered to patients with mononucleosis.

**Development of Drug-Resistant Bacteria**
Prescribing amoxicillin in the absence of proven or strongly suspected bacterial infection or treating prophylactically is unlikely to provide benefit to the patient and increases the risk of the development of drug-resistant bacteria.

**False-Positive Urinary Glucose Tests**
High urine concentrations of ampicillin may result in false-positive reactions when testing for the presence of glucose in urine using Clinitest® or Benedict’s Solution or Fehling’s Solution. Since this effect may also occur with amoxicillin, it is recommended that glucose tests based on enzymatic glucose oxidase reactions (such as Clinistix®) be used.

**ADVERSE REACTIONS**
In a controlled Phase 3 trial, 302 adult and pediatric patients (12 years) were treated with MOXATAG 775 mg once-daily for 10 days. The most frequently reported adverse reactions (>1%) which were suspected or probably drug-related were:

- Vaginal yeast infection (2.0%)
- Diarrhea (1.7%)
- Nausea (1.3%)
- Headache (1.0%)

**DRUG INTERACTIONS**

**Probenecid**
Probenecid decreases the renal tubular secretion of amoxicillin. Concurrent use of MOXATAG and probenecid may result in increased and prolonged blood levels of amoxicillin.

**Other Antibiotics**
Chloramphenicol, macrolides, sulfonamides, and tetracyclines may interfere with the bacterial effects of penicillin. This has been demonstrated in vitro; however, the clinical significance of this interaction is not well documented.

**Oral Contraceptives**
As with other antibiotics, amoxicillin may affect the gut flora, leading to lower estrogen reabsorption and potentially resulting in reduced efficacy of combined oral estrogen/progesterone contraceptives.

**USE IN SPECIFIC POPULATIONS**

**Pregnancy:** Teratogenic Effects. Pregnancy Category B.
Reproduction studies have been performed in mice and rats at doses up to 2000 mg/kg (12.5 and 25 times the human dose in mg/m²) and have revealed no evidence of impaired fertility or harm to the fetus due to amoxicillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**Labor and Delivery**
It is not known whether use of amoxicillin in humans during labor or delivery has any immediate or delayed adverse effects on the fetus, prolongs the duration of labor, or increases the likelihood that forceps delivery or other obstetrical intervention or resuscitation of the newborn will be necessary.

**Nursing Mothers**
Penicillins have been shown to be excreted in human milk. Amoxicillin use by nursing mothers may lead to sensitization of infants. Caution should be exercised when amoxicillin is administered to a nursing woman.

**Pediatric Use**
The safety and effectiveness of MOXATAG in pediatric patients 12 years of age and older have been established based on results of a clinical trial that included adults and pediatric patients (12 years or older). The safety and effectiveness of MOXATAG in pediatric patients younger than 12 years has not been established.

**Geriatric Use**
This drug is known to be substantially excreted by the kidney, and the risk of adverse 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.

**Renal Impairment**
MOXATAG has not been studied in patients with renal impairment; however, a reduction of amoxicillin dose is generally recommended for patients with severe renal impairment. Therefore, MOXATAG is not recommended for use in patients with severe renal impairment (CrCl < 30 mL/min) or patients on hemodialysis.

**OVERDOSAGE**
In case of overdose, discontinue medication, treat symptomatically, and institute supportive measures as required. If the overdose is very recent and there is no contraindication, an attempt at emesis or other means of removal of drug from the stomach may be performed.

Intestinal nephritis resulting in oliguric renal failure has been reported in a small number of patients after overdosage with amoxicillin.

Crystalluria, in some cases leading to renal failure, has also been reported after amoxicillin overdosage in adult and pediatric patients.

Renal impairment appears to be reversible with cessation of drug administration.

High blood levels may occur more readily in patients with impaired renal function because of decreased renal clearance of amoxicillin.

For additional information about overdose treatment, call a poison control center (1-800-222-1222).

**HOW SUPPLIED/STORAGE AND HANDLING**
Moxatag tablets for oral administration are provided as blue film-coated, oval-shaped tablets that contain 775 mg of amoxicillin. The tablets are printed with “MB-111” on one side in black edible ink. MOXATAG is packaged in bottles as follows:

- Presentation: Bottles of 30
- NDC Code: 11042-142-03
- Storage: Store at 25°C (77°F); excursions permitted to 15–30°C (59–86°F) [See USP Controlled Room Temperature.]

**Middlebrook PHARMACEUTICALS®**
Germantown, Maryland 20876 USA
U.S. Patents 6,544,555; 6,669,948; 6,723,341
Issue Date 02/2009
910-0209-0675
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certain abbreviations (Table 2) and symbols altogether. The entire list is available in PDF form at www.jointcommission.org/PatientSafety/DoNotUseList/.

**Injectables**

Most urgent care centers administer injectable medications and vaccines to patients. There are a number of ways one can reduce the risk of errors in these instances. For example:

- An urgent care center could choose to stock only one concentration of a medication.
- The provider must be very careful to specify the route of administration (IV, oral, SQ, IM).
- Only providers and qualified clinical personnel should administer medications.
- A member of the staff should be responsible for ongoing review of the safety and efficacy of all stocked and administered medications.
- Before administering the medication, the nurse should verify the patient with two identifiers.
- Make certain the correct patient is receiving the correct medication, correct dose, and correct route, and that the med has not expired.
- Liquid medications should be administered only in approved measuring devices. Parenteral syringes used for this purpose have accidentally resulted in aspiration of the syringe tip.
- The members of the clinical team need to be warned when a vital medication is low or out of stock.
- After administration, the center should be prepared to monitor the patient for possible adverse reactions or anaphylaxis, and be equipped to handle a complication, should one arise.

**Storage**

The proper storage of medications is also important. The urgent care center should follow storage instructions specified by the manufacturer. In addition:

- Medications should not be stored in patient areas or exam rooms.
- Medications should be stocked by a standardized inventory, with a specific staff member responsible for purging expired meds at least quarterly.
- Multi-dose vials should be discarded within 30 days of opening (labeling the vial when opened with a date) or changed to single-dose vials to prevent administering expired meds.
- Emergency medications should be available as unit doses and labeled age appropriately. They should be kept separately in a crash cart in ready-to-use formulations.
- Controlled substances need to be kept in another separate locked area, and monitored daily by nursing staff.
- Medications and reagents (e.g., hemoccult developer, eye drops, glucose monitor reagents) designed for external use (i.e., podophyllin, benzoin, phenol) should be labeled “for external use only” and kept separate from other medications.

**When prevention fails**

Despite our best efforts, medication errors and adverse

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**Table 2. Abbreviations to Avoid Using**

<table>
<thead>
<tr>
<th>Do not use</th>
<th>Potential problem</th>
<th>Use instead</th>
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<tbody>
<tr>
<td>U (unit)</td>
<td>Mistaken for “o” (zero), the number 4, or “cc”</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (International Unit)</td>
<td>Mistaken for IV (intravenous) or the number “10”</td>
<td>Write “International Unit”</td>
</tr>
<tr>
<td>Q.D., QD, q.d., qd (daily) Q.O.D. QOD, q.o.d., qod (every other day)</td>
<td>Mistaken for each other Period after the Q mistaken for i and the O mistaken for l</td>
<td>Write “daily” Write “every other day”</td>
</tr>
<tr>
<td>Trailing zero (X.0 mg)* Lack of leading zero (X mg)</td>
<td>Decimal point is missed</td>
<td>Write X mg Write 0.X mg</td>
</tr>
<tr>
<td>MS MSO₄ and MgSO₄</td>
<td>Can mean morphine sulfate or magnesium sulfate Confused for one another</td>
<td>Write “morphine sulfate” Write “magnesium sulfate”</td>
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</tbody>
</table>

*Exception: A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sized. It may not be used in medication orders or other medication-related documentation.
reactions will continue to occur. In such cases, the prescribing physician should always be informed of the reaction. The urgent care center should have a process to perform a root-cause analysis of the error, so problems with the medication system can be corrected.

**Lab Safety and CLIA-waived Testing**
The Clinical Laboratory Improvement Amendments of 1988 (CLIA) classifies lab testing according to four complexity levels:
1. High complexity
2. Moderate complexity
3. Provider-performed microscopy (a subset of moderate complexity)
4. Waived testing

The vast majority of urgent care centers possess a moderate complexity lab or a waived testing lab. Moderate complexity designation carries with it stringent requirements for compliance on personnel qualification, quality assurance, and controls. When followed, these guidelines help protect the patient.

For those urgent care centers following waived testing rules, the Joint Commission requires several elements of performance.
- The urgent care center should have a designated lab director who is identified on the CLIA certificate; even CLIA-waived labs need a certificate.
- A clinical policy and procedure manual for the practice should be created.
- There should be a policy on collecting and proper labeling of specimens. Whenever possible, specimens should be labeled in the presence of the patient to reduce identification errors.
- Test reagents need to be stored and purged according to manufacturers’ instructions.
- Controls on point-of-care tests should be run as indicated.
- There should be quality controls in place for the tests, with guidance for lab personnel when they have an equivocal result. Too often, lab assistants substitute their own judgment when a test is unclear. Instead, they should defer to the provider or repeat the test.
- There needs to be a clear procedure for reporting and documenting the test results, with a separate log of all in-house labs with results to be used as a back-up.
- It is important that lab personnel and the director review manufacturers’ instructions when the vendor is changed or the test is updated.

The other critical component of a safe CLIA-waived lab is the lab personnel. Only designated clinical personnel should be allowed to perform lab tests. They should be identified by job title and description (e.g., certified medical assistants). Only personnel that have been properly oriented to the center’s lab should perform the tests. New hires should be instructed in the proper performance of each test and their competence documented by a supervisor before they operate independently. A checklist for lab competencies would be helpful, and could be updated annually.

**Tracking Lab and X-ray Results**
Another area of concern for patient safety is the tracking of outside test results. This includes outside reference labs, pathology specimens, and imaging. Clinics that send blood, urine and stool tests to outside ref-

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**Table 3. Sample Test Tracking Log**

<table>
<thead>
<tr>
<th>Patient name</th>
<th>Test ordered</th>
<th>Location</th>
<th>Ordering physician</th>
<th>Results received (date, time)</th>
<th>Action plan or no action needed</th>
<th>Follow-up completed (date)</th>
<th>Staff initials</th>
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**Table 3. Sample Test Tracking Log**
In well-controlled clinical trials, CIPRODEX® Otic cured more patients with AOE than CORTISPORIN® Otic† and more patients with AOMT than ofloxacin‡.

The anti-inflammatory agent, dexamethasone, has been added to aid in the resolution of the inflammatory response accompanying bacterial infection such as otorrhea in pediatric patients with AOMT.

CIPRODEX® Otic is indicated in patients 6 months and older for acute otitis externa due to *Staphylococcus aureus* and *Pseudomonas aeruginosa* and for acute otitis media with tympanostomy tubes due to *S. aureus*, *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Moraxella catarrhalis*, and *P. aeruginosa*. CIPRODEX® Otic is contraindicated in patients with a history of hypersensitivity to ciprofloxacin, to other quinolones, or to any of the components in this medication. Use of this product is contraindicated in viral infections of the external canal including herpes simplex infections. CIPRODEX® Otic should be discontinued at the first appearance of a skin rash or any other sign of hypersensitivity. Serious and occasionally fatal hypersensitivity (anaphylactic) reactions, some following the first dose, have been reported in patients receiving systemic quinolones. Serious acute hypersensitivity reactions may require immediate emergency treatment. If the infection is not improved after one week of treatment, cultures should be obtained to guide further treatment. Most commonly reported adverse reactions in clinical trials in AOE patients: pruritus (1.5%), ear debris (0.6%), superimposed ear infection (0.6%), ear congestion (0.4%), ear pain (0.4%) and erythema (0.4%). In AOM patients with tympanostomy tubes: ear discomfort (3.0%), ear pain (2.3%), ear residue (0.5%), irritability (0.5%) and taste perversion (0.5%).

Why trust the realm to anything less than the #1 otic drop among otolaryngologists?

CIPRODEX® Otic is indicated in patients 6 months and older for acute otitis externa due to *Staphylococcus aureus* and *Pseudomonas aeruginosa* and for acute otitis media with tympanostomy tubes due to *S. aureus*, *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Moraxella catarrhalis*, and *P. aeruginosa*. CIPRODEX® Otic is contraindicated in patients with a history of hypersensitivity to ciprofloxacin, to other quinolones, or to any of the components in this medication. Use of this product is contraindicated in viral infections of the external canal including herpes simplex infections. CIPRODEX® Otic should be discontinued at the first appearance of a skin rash or any other sign of hypersensitivity. Serious and occasionally fatal hypersensitivity (anaphylactic) reactions, some following the first dose, have been reported in patients receiving systemic quinolones. Serious acute hypersensitivity reactions may require immediate emergency treatment. If the infection is not improved after one week of treatment, cultures should be obtained to guide further treatment. Most commonly reported adverse reactions in clinical trials in AOE patients: pruritus (1.5%), ear debris (0.6%), superimposed ear infection (0.6%), ear congestion (0.4%), ear pain (0.4%) and erythema (0.4%). In AOM patients with tympanostomy tubes: ear discomfort (3.0%), ear pain (2.3%), ear residue (0.5%), irritability (0.5%) and taste perversion (0.5%).

†Clinical cures: CIPRODEX® Otic vs CORTISPORIN® Otic (87%, 94% vs 84%, 89%) per protocol and (86%, 92% vs 84%, 89%) culture positive.

‡Clinical cures: CIPRODEX® Otic vs ofloxacin (86% vs 79%) per protocol and (90% vs 79%) culture positive.
CIPRODEX® (ciprofloxacin 0.3% and dexamethasone 0.1%) STERILE Otic SUSPENSION

DESCRIPTION
CIPRODEX® (ciprofloxacin 0.3% and dexamethasone 0.1%) Sterile Otic Suspension contains the synthetic broad-spectrum antibiotic, ciprofloxacin hydrochloride, combined with the anti-inflammatory corticosteroid, dexamethasone, in a sterile, preserved suspension for otic use. Each mL of CIPRODEX® Otic contains 90 μg ciprofloxacin hydrochloride (1 mg ciprofloxacin base), 1.5 mg dexamethasone (0.625 mg dexamethasone base) and 0.1 mg benzalkonium chloride as a preservative. The inactive ingredients are boric acid, sodium chloride, water and sorbic acid. Sodium hydroxide or hydrochloric acid may be added for adjustment of pH.

CIPRODEX® is available as the monohydrate monohydrochloride salt of 1-cyclopropyl-6-fluoro-1,4-dihydro-4-oxo-7-(1-piperazinyl)-3-quinolinecarboxylic acid. The empirical formula is C17H18FN3O3·HCl·H2O. Dexamethasone, 9-fluoro-11(beta),17,21-trihydroxy-16(alpha)-methylpregna-1,4-diene-3,20-dione, is an anti-inflammatory corticosteroid. The empirical formula is C22H29FO5.

CLINICAL PHARMACOLOGY
Pharmacokinetics: CIPRODEX® Otic contains a single bilateral 4-drop (total dose = 0.52 mL, 0.04 mg ciprofloxacin, 0.28 mg dexamethasone) topical otic dose of CIPRODEX® Otic to pediatric patients after tympanostomy tube insertion in the ossicles. CIPRODEX® Otic, 3 mg/mL ciprofloxacin (0.3% w/v) and 1 mg/mL dexamethasone were observed in concentrations following administration in 2 of 8 patients and 9 of 8 patients, respectively.

Mean ± SD peak plasma concentrations of ciprofloxacin were 1.38 ± 0.891 mg/L (n=9). Peak plasma concentrations ranged from 0.50 to 3.45 mg/L and were on average approximately 0.1% of peak plasma concentrations achieved with an oral dose of 250 mg. Peak plasma concentrations of ciprofloxacin were observed within 15 minutes to 2 hours post dose application. Mean ± SD peak plasma concentrations of dexamethasone were 1.14 ± 1.143 mg/L (n=6). Peak plasma concentrations ranged from 0.156 to 5.15 mg/L, and were on average approximately 1.4% of peak concentrations reported in the literature following an oral 1.5 mg tablet dose. Peak plasma concentrations of dexamethasone were observed within 15 minutes to 6 hours post dose application. Dexamethasone has been added to aid in the resolution of the inflammatory response accompanying bacterial infection (such as otitis media in pediatric patients with AOM with tympanostomy tubes).

Microbiology: Ciprofloxacin has in vitro activity against a wide range of gram positive and gram-negative microorganisms. Ciprofloxacin is active against a variety of bacteria which is needed for the synthesis of bacterial DNA. Cross-resistance has been observed between ciprofloxacin and other fluoroquinolones. There is generally no cross-resistance between ciprofloxacin and other beta-lactams or aminoglycosides. Ciprofloxacin has been shown to have activity against many of the following microorganisms, both in vitro and in clinically otitis as described in the INDICATIONS AND USAGE section.

Aerobic and facultative gram-positive microorganisms: Staphylococcus aureus, Strep. pneumoniae, Streptococcus pyogenes, Mycobacterium tuberculosis, Pseudomonas aeruginosa.

INDICATIONS AND USES: CIPRODEX® Otic is indicated for the treatment of infections caused by susceptible isolates of the designated microorganisms in the specific conditions listed below:

Acute Otitis Media in pediatric patients with tympanostomy tubes due to S. pneumoniae, S. pyogenes, S. aureus, Strep. pneumoniae, Haemophilus influenzae, Moraxella catarrhalis, and Pseudomonas aeruginosa.

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

WARNINGS FOR OTIC USE ONLY (This product is not approved for ophthalmic use) NOT FOR INJECTION
CIPRODEX® Otic contains 3 mg/mL (3000 μg/mL) ciprofloxacin and 1 mg/mL (1000 μg/mL) dexamethasone. No adverse reactions were observed in animals given intravenous doses of ciprofloxacin greater than 50 fold the maximum human therapeutic dose or budesonide greater than 5 fold the maximum human therapeutic dose. CIPRODEX® Otic was administered in doses up to 100 fold the maximum human therapeutic dose in animals and no adverse reactions were observed.

PRECAUTIONS
General: As with other antibacterial preparations, use of this product may result in overgrowth of nonsusceptible or polymicrobial organisms, including yeast and fungi. If the infection is not improved after one week of treatment, cultures should be obtained to guide further treatment. Otitis perforata after a full course of therapy, if two or more episodes of otitis occur within six months, further evaluation is recommended to exclude an underlying problem such as cholesteatoma, living bone, or a tumor. The systemic administration of quinolones, including ciprofloxacin at doses much higher than given or absorbed by the otic route, has resulted in neutropenia or of the granulocytopenia associated with certain quinolones and in rare cases of agranulocytosis in immature animals of various species. Guinea pigs dosed in the middle ear with CIPRODEX® Otic for one month (60 mg/kg/day) developed granulocytopenia. Cytolytic effects of the ciliary hair cells were observed in the microsomal mitochondria of the guinea pigs treated with CIPRODEX® Otic. This was also shown to lack dermal sensitizing potential in the guinea pig skin prick test and the Guinea Pig Skin Window Test. CIPRODEX® Otic was applied typically in the rabbit eye. Information for Patients: For use once only. This product is not approved for use in the eye. Wash the bottle in your hand for one to two minutes prior to use and shake well before usage. Do not refill the container from the bottle. The outer surface of the dropper and the dropper tip should be cleaned before reinsertion of the dropper assembly into the medication container. Protect from light. If a rash or allergic reaction occurs, discontinue use immediately and contact your doctor. While taking CIPRODEX® Otic as directed by the doctor for treatment of an infection, patients have reported an unusual and allergic reaction with a disulfiram type (DISulfiram) reaction. In rare instances, this may be severe and even life-threatening. Such reactions have included: nausea, vomiting, flushing, headache, hypotension, chest pain, dizziness, dyspnea, respiratory distress, stiffness of the neck, pain, and others. In one case, the patient's blood pressure dropped to life-threatening levels. If you experience any of these symptoms, stop taking CIPRODEX® Otic and call your doctor immediately. Ya should not take CIPRODEX® Otic if you have shown an allergic reaction in the past or are sensitive to the drug. Specific active ingredients (ciprofloxacin and dexamethasone) may cause an allergic reaction in a small percentage of patients. In clinical trials, CIPRODEX® Otic was shown to lack dermal sensitizing potential in the guinea pig skin prick test and the Guinea Pig Skin Window Test. CIPRODEX® Otic was applied typically in the rabbit eye.

Information for Patients: For use once only. This product is not approved for use in the eye. Wash the bottle in your hand for one to two minutes prior to use and shake well before usage. Do not refill the container from the bottle. The outer surface of the dropper and the dropper tip should be cleaned before reinsertion of the dropper assembly into the medication container. Protect from light.

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erence labs must have a tracking system that is reliable for all providers and clinical employees to follow. A paper-based system should include a log of each patient, with the name of the test ordered, when the results were received, when notification was given to the patient, and what follow-up was arranged.

The ABMS recommends that patients be notified of all test results—even normal results—within a 24–48 hour timeframe, and that the communication be documented in the medical record.

Table 3 offers an example of a test tracking log. Some EMRs allow the provider to track test results within the “To Do List” of the software. A separate log can be created for imaging tests and for referrals to specialists.

Regardless of the system chosen, the key component is the follow-up. Every test should be tracked all the way through the work-flow to the point of follow-up. Designated employees should be tasked with checking the log on a weekly basis to make certain that all tests that were ordered were, in fact, performed. They can also be charged with investigating any missing tests. Not only will this system improve patient safety, but it will also reduce an important source of malpractice liability for urgent care centers.

Physicians should avoid telling patients that “no news is good news” when it comes to test results. It is preferable to instruct patients to contact the practice if they have not received the results, normal or abnormal, within a specific time frame. This approach will decrease the risk that a critical result will be missed or delayed and makes patients active partners in their care, which may prevent unnecessary delay.

Critical test results
In addition to tracking routine tests, the clinic should have a process to identify and track critical test results. According to the ABMS, failure to communicate critical test results is responsible for the majority of adverse events that lead to disability; 85% of these failures are due to a delay in receiving the results.

A critical range should be identified for lab tests so personnel can recognize results that fall outside of the range. As soon as a critical result is received by the lab or clinical personnel, they need to notify one of the providers for guidance.

It is recommended that providers take responsibility themselves for notifying patients of critical test or imaging results. Only a provider can answer the important questions a patient will have in these circumstances, and direct the follow-up or referral of the case. Leaving these conversations to others allows more uncertainty to enter the process. The patient might not understand the diagnosis or the urgency of the matter. The follow-up should be arranged by the urgent care center and tracked to ensure that it has occurred in a timely fashion.

Part 2 of this article, which will be published next month in JUCM, will discuss:

- healthcare-associated infection
- radiation
- transitioning care from one provider to another
- emergency preparedness
- personnel qualifications
- patient rights
- discharge considerations.

Resources
- Jenkins RH, Vaida AJ. Simple strategies to avoid medication errors. Fam Pract Manage. 2007;14:41-47.
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.

The patient is a 16-year-old male who fell from his motorcycle and received a blow to his right ankle. The motorcycle was moving at a “good pace.”

On exam, he is able to weight bear, but with significant pain. You note swelling and tenderness over the medical malleolus.

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.

**FIGURE 1**

The patient is a 16-year-old male who fell from his motorcycle and received a blow to his right ankle. The motorcycle was moving at a “good pace.”

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There is a suspicious line (circled) indicative of a non-displaced, intra-articular pilon fracture in the distal tibia. Further views are recommended.

Typically, such injuries are the result of axial compression forces, such as those that might occur in ski accidents and car crashes, with the distal tibia compressing against the talus.

This patient was casted in the urgent care center and referred for orthopedic follow-up.

Acknowledgment: Case presented by Nahum Kovalski, BSc, MDCM, Terem Emergency Medical Centers, Jerusalem, Israel.
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Occult Bacteremia or RSV Infection in Young Children, and Orthopedic Injuries in Child Abuse

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.

Occult Bacteremia is Rare in Young Children with Unexplained Fever

Key point: Since introduction of the pneumococcal vaccine, urinary tract infection has become the most common bacterial infection in children who have fever without localizing signs.


Occult bacteremia and invasive disease are important concerns in children with unexplained high fever. Investigators retrospectively compared the risk for serious infection in children 3 months to 36 months in age who presented to a U.K. pediatric emergency department with fever (>39°C) without localizing signs after pneumococcal conjugate vaccine (1997–1999 and 2001–2004, respectively).

During the pre-PCV7 period, 17 of 148 children had positive blood cultures, with pathogens identified in 10 cases (Streptococcus pneumoniae in six, Moraxella catarrhalis in two, Staphylococcus aureus in one, and Streptococcus pyogenes in one).

In the post-PCV7 period, 13 of 275 children had positive blood cultures, and a pathogen was identified in only one case (Enterococcus sp). The rate of occult bacteremia among children with unexplained fever decreased from 6.8% to 0.4% in the pre- and post-vaccine periods, respectively. Rates of positive urine cultures did not change during the pre- and post-PCV7 periods (6.8% and 7.6%, respectively). About 60% of the children in each period received antibiotics; most (>90%) received antibiotics during the initial ED visit.

Successful immunization programs remove important health risks in children. Children aged 3 to 36 months who have completed H influenzae type B and PCV7 immunizations and who present with fever without localizing signs should be evaluated for urinary tract infections. Other cultures (including blood cultures) and treatment should be based on clinical condition and local epidemiology of non-vaccine serotypes.

[Published in J Watch Ped Adolesc Med, February 4, 2009—F. Bruder Stapleton, MD.]

Burden of RSV Infection in Young Children

Key point: The authors estimate that, in young children, RSV infection is associated with 1 of 334 hospitalizations, 1 of 38 ED visits, and 1 of 13 primary care outpatient visits annually in the U.S.


Respiratory syncytial virus (RSV) is associated with hospitalization in children, but the total burden of disease among young children in the U.S. is poorly understood. The CDC conducted a prospective population-based surveillance study of children younger than 5 years with diagnoses of acute respiratory disease who were hospitalized or presented to emergency departments or outpatient clinics in three U.S. cities during the RSV seasons between 2000 and 2004.

Nahum Kovalski is an urgent care practitioner and assistant medical director/CIO at Terem Emergency Medical Centers in Jerusalem, Israel.
Nasal and throat swabs were obtained from 5,067 children; 919 (18%) had confirmed RSV infection. Co-infecting viruses were identified in only 6% of samples. RSV was associated with 20% of hospitalizations, 18% of ED visits, and 15% of office visits for acute respiratory infections from November through April. Average annual rates of hospitalization for RSV-associated illness were 3 per 1,000 in children younger than 5 years and 17 per 1,000 in children younger than 6 months.

[Published in J Watch Gen Med, February 10, 2009—Howard Bauchner, MD.]

**Age Affects Orthopedic Injuries Seen with Child Abuse**

**Key point:** In children under 18 months, humerus, femur, and tibia/fibula fractures were more likely to stem from abuse than from accidental trauma.

**Citation:** Brown AJ. Age affects orthopedic injuries seen with child abuse. Reuters Health Information. Published by Medscape, February 27, 2009. Available at www.medscape.com/viewarticle/588883.

Whether an orthopedic injury in a child who presents to the ED is predictive of abuse largely depends on the age of the child, according to study findings presented at the American Academy of Orthopedic Surgeons meeting in Las Vegas. The exception is rib fractures, which almost always indicate abuse.

“When examining a child in the emergency room, the clinician should pay careful attention to the age/walking status of the child, and the presence of long bone and rib fractures,” lead investigator Dr. Nirav Pandya, from the University of Pennsylvania, Philadelphia, told Reuters Health.

“If clinicians can more readily identify potential cases of child abuse based on the fractures they treat, the morbidity and mortality that a child can experience from returning to an abusive household can hopefully be minimized,” he added.

Although other studies have examined this topic in the past, the present investigation is one of the largest, Dr. Pandya said.

Included in the study were 500 cases of child abuse (birth to 48 months) entered in the University of Pennsylvania’s Suspected Child Abuse and Neglect (SCAN) database from 1998 to 2007. The orthopedic injuries in these cases were compared with those seen in 985 accidental trauma controls.

In children under 18 months, humerus, femur, and tibia/fibula fractures were more likely to stem from abuse than from accidental trauma. The odds ratios ranged from 12.8 for tibia/fibula fractures to 1.8 for femur fractures.

By contrast, over 18 months of age, humerus and femur fractures were actually predictive of accidental trauma. Moreover, in this age group, tibia/fibula fractures can no longer differentiate abuse from accidental trauma.

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**ABSTRACTS IN URGENT CARE**

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<thead>
<tr>
<th>Test Panel</th>
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<tr>
<td>Comprehensive Metabolic Panel</td>
<td>ALB, ALP, ALT, AST, BUN, Ca, Cl−, CRE, GLU, K+, Na+, TBIL, tCO2, TP</td>
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<td>Basic Metabolic Panel</td>
<td>BUN, Ca, Cl−, CRE, GLU, K+, Na+, tCO2</td>
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<tr>
<td>Lipid Panel</td>
<td>CHOL, CHOL/HDL*, HDL, LDL*, TRIG, VLDL*</td>
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<td>Lipid Panel Plus</td>
<td>ALT, AST, CHOL, CHOL/HDL*, GLU, HDL, LDL*, TRIG, VLDL*</td>
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<tr>
<td>Liver Panel Plus</td>
<td>ALB, ALP, ALT, AMY, AST, GGT, TBIL, TP</td>
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<td>General Chemistry 6</td>
<td>ALT, AST, BUN, CRE, GGT, GLU</td>
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<td>General Chemistry 13</td>
<td>ALB, ALP, ALT, AMY, AST, BUN, Ca, CRE, GGT, GLU, TBIL, TP, UA</td>
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<td>Electrolyte Panel</td>
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<td>Renal Function Panel</td>
<td>ALB, BUN, Ca, Cl−, CRE, GLU, K+, Na+, PHOS, tCO2</td>
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<td>MetLyte 8 Panel</td>
<td>BUN, CK, Cl−, CRE, GLU, K+, Na+, tCO2, Mg, Lactate Dehydrogenase</td>
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<td>Hepatic Function Panel</td>
<td>ALB, ALP, ALT, AST, DBIL, TBIL, TP</td>
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<td>Basic Metabolic Panel Plus</td>
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Putting Patients First: Redefining Quality in the Patient Experience

Urgent message: Patients are the ultimate judges of the quality of care you provide, and their opinions are likely to be swayed by factors that have little to do with your clinical expertise or skill.

Alan A. Ayers, MBA, MAcc

Service industries—from retail stores to restaurants, hotels, and even banks—have embraced the customer’s point of view by meshing contemporary design, cutting-edge technology, and process engineering to develop services that are increasingly affordable and convenient.

But what about healthcare? Healthcare expenditures topped 17% of U.S. gross domestic product in 2008, according to the National Coalition for Health Care, and healthcare is one of the nation’s largest service industries. But despite its prominence in the economy, healthcare is plagued with rising costs, decreased accessibility, and increased hassle for patients.

Fortunately, an urgent care center isn’t any ordinary doctor’s office—it’s a delivery model that provides care on patients’ terms. Locations in high-traffic retail or residential areas, the ability to walk in without an appointment, extended evening/weekend hours, services for the entire family, and affordable pricing make urgent care more comparable to other service industries than to conventional medical providers. Because of this, patients are likely to compare the service at an urgent care center with what they have experienced at retail stores, restaurants, and other retail establishments that have invested significantly in the customer experience.

Thus, the opportunity for urgent care operators is to reframe quality along retail standards by answering the most pressing question: Is the patient pleased? Pleasing patients depends on delivering an experience consistent with patient expectations; how well urgent care centers embrace quality from the patient’s perspective will determine their future growth and profitability.
PUTTING PATIENTS FIRST

Redefining Quality in Urgent Care

There are many ways to define quality in healthcare. Historically, standards have focused on the structure of the medical establishment (e.g., adequacy of facilities and equipment, qualification of providers, and degree of administrative oversight), clinical processes and decision making, and medical outcomes. While all of these criteria are relevant to professional practice, the recipients of care—patients—are usually unqualified to attach meaning to such measures.

By contrast, leading service companies have long understood that if consumers don’t like the experience provided, they won’t return and they’ll tell others to do the same. That’s why it’s patients—not academics, accreditation agencies, or statisticians—who ultimately define “quality.” And whether an urgent care center delivers “quality” depends on how closely the actual delivery of the service (i.e., the patient experience) compares with what the patient expected.

Clearly, to attain satisfaction, a patient must believe the medical reason for the visit was met—but sour employees, bumpy processes, and dowdy facilities can still undermine the best medical outcomes, resulting in patient perceptions of a very poor quality experience.

(Table 1 illustrates how medical practice is only one of five dimensions of service quality.)

If an urgent care center wants to convey quality, it must understand patient expectations of quality and manage service delivery to ensure an experience consistent with those expectations.

Understanding Patient Expectations

Given the relationship between patient expectations and experiences in defining quality, urgent care operators should consider first and foremost the implications of any business decision on patient perceptions—including people (i.e., hiring and training of providers and

### Table 1. Categories of Patient Expectations

<table>
<thead>
<tr>
<th>Patient expectations of service quality are categorized across five dimensions:</th>
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<tbody>
<tr>
<td><strong>Reliability:</strong> Ability to perform promised services dependably and accurately.</td>
</tr>
<tr>
<td><strong>Tangibles:</strong> Appearance of physical facilities, equipment, personnel, and communication materials.</td>
</tr>
<tr>
<td><strong>Responsiveness:</strong> Willingness to help customers and provide prompt service.</td>
</tr>
<tr>
<td><strong>Assurance:</strong> Knowledge and courtesy of employees and their ability to convey trust and confidence.</td>
</tr>
<tr>
<td><strong>Empathy:</strong> Caring, individualized attention provided to the customer.</td>
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It’s important to note that only one attribute—reliability—concerns the service outcome. The remainder of the patient’s quality evaluation focuses on the process of service delivery and factors such as the physical environment and the friendliness, competence, and caring attitude of the provider and staff.
PUTTING PATIENTS FIRST

staff), processes (i.e., registration, billing, and collections), and physical evidence (i.e., layout and design of the physical facility and other tangibles).

Before a patient ever crosses the threshold of an urgent care center, she has some basic expectations as to what the experience will entail. Patient expectations may be:

Explicit: What the urgent care center, through its advertising and service model, promises to deliver.

Implicit: Not directly stated, but inferred by patients from attributes such as price, location, or appearance of the facility.

Based on word of mouth: What friends, family members, and virtual communities say about their experiences frame expectations for future patients.

Based on past experience: Past experiences not only determine whether patients will return or recommend to others, but they also shape future encounters.

Once in the center, patient expectations continue to be shaped—and experiences delivered—through the interaction of people, processes, and physical evidence. For each, the urgent care operator must understand—and deliver an experience consistent with—patient expectations.

People: Putting the Patient First
Successful urgent care centers seek to hire people with a positive attitude who understand the importance of not just doing their job tasks, but anything else that will contribute to a positive patient experience. Provider and staff attitudes have a direct impact on patient attitudes towards the experience.

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PUTTING PATIENTS FIRST: REDEFINING QUALITY IN THE PATIENT EXPERIENCE

Mobilizing people to deliver a quality experience starts with understanding that patients want to be treated as individuals versus impersonally being "processed" through a system. A quality experience, therefore, entails greeting patients as they walk through the door, calling them “Mr.” or “Mrs.,” assisting them in filling out forms, respecting their privacy, asking if they understand the doctor’s orders, and thanking them for their patronage.

Understanding patient expectations can help providers and staff anticipate patient needs before they’re expressed while demonstrating the required skill to solve patient problems and showing genuine concern for the patient’s well-being.

Process: Mapping the Patient Experience

While many urgent care centers conduct patient surveys that evaluate services after the fact, planning good patient experiences also involves directly observing patient behavior in the clinic environment and organizing focus groups to capture patient ideas.

As illustrated by Figure 1, developing a service map is similar to developing a process flow diagram in that both evaluate all activities taking place—the difference being that a service map does so only from the patient’s point of view. Using observed or simulated patient experiences, the service map illustrates exactly how it all comes together.
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what a patient sees, hears, feels, touches, tastes, and even smells in the center.

Direct observation validates a service map by demonstrating instances where patients act outside of the process—for example, interrupting registration to request a change of the television channel. When developing a service map, particular attention should be paid to patient interactions with providers, staff, and the physical environment.

In addition to improving operational processes, the data in service maps can be used to increase effectiveness of providers and staff (e.g., in writing job descriptions or developing training) and to identify enhancements to the physical facility.

**Physical Evidence: The Servicescape**

Service delivery is intricately coupled with the physical environment—which in marketing is referred to as the “servicescape.” Urgent care operators should make perfecting the servicescape a priority because it:

- influences the patient’s initial reaction to the urgent care center and affects the patient's ongoing mood during the visit; what are the patient's initial cues to quality coming through the door, and is the overall environment welcoming or intimidating, calming or stressful?
- differentiates from competitors; could a patient distinguish your urgent care facility from a competitor if all signage were removed?
- facilitates a transaction; is signage visible and worded in such a way that patients readily understand, and is the facility layout intuitive such that patients move in a logical, orderly fashion and that staff can treat patients with minimal number of steps and obstacles?
- creates a social environment; does the space facilitate or hinder communication between and among patients, staff, and providers?

Physical evidence encompasses the servicescape and all other tangible aspects of the experience, as detailed in Table 2. The goal of creating a service environment conducive to good patient experiences, and that also differentiates an urgent care center from competitors, is why many urgent care operators invest in retail-facing locations with comfortable furnishings and a polished fit and finish.

**Exceeding Patient Expectations**

A frequent cliché when speaking about the patient experience is the goal of “exceeding patient expectations.”

The problem with this is that it sets the bar higher for future experiences. The goal shouldn’t be to exceed patient expectations, but to meet them consistently.

For example, the first time I worked on assignment in San Francisco, the hotel upgraded my stay to a corner room with floor-to-ceiling windows providing a magnificent view of the city and bay. The room far exceeded my expectations for the corporate rate paid. On my next trip I booked the same hotel, only to be disappointed when I ended up on the fifth floor overlooking a rooftop air conditioning unit.

The hotel delivered the product it promised—the downtown location, comfortable bed, and exercise facilities—but my expectations on the total experience had been artificially raised so much on my first visit that I was disappointed when I returned.

Similar experiences occur when a new urgent care center—without an established patient base—is able to offer quick service and personalized attention. But once volume ramps up, wait times may begin to extend and the staff soon scrambles to quickly process patients. Repeat patients are likely to comment “service has really gone downhill” when in reality, the experience simply normalized after expectations had been set.

**Measuring Service Quality**

Because service quality is the difference between patient expectations and experiences, the only effective way to evaluate service quality is to ask patients to describe their visits to the center. Such can be accomplished by quantitative and qualitative methods.

Transactional surveys assess patient experiences immediately after their visits and utilize touch-screen kiosks, comment cards, and mail, e-mail, or telephone questionnaires. When asked to score various elements on a scale of 1 to 10, impressions can be quantified and tracked—both across centers and over time—while also providing performance-based data for employee incentives and management rewards.

While quantitative data may be directionally accurate, one shortcoming is that they don’t distinguish among differing patient expectations. In addition, aggregated data cannot be used to remedy specific instances of poor service. Written patient comments provide more detail as to patient expectations and experiences.

Qualitative feedback is particularly useful in responding to specific patient issues. But in order for qualitative feedback to effect organizational change, a classification scheme must be developed to identify the most frequent types of patient feedback and trends over time. In most
cases, patient comments are used to provide anecdotal evidence for data contained in qualitative measures.

The disadvantage of all patient surveys is that they don’t measure the experiences of non-patients, such as referral sources or patients who balked before being served.

In addition, dissatisfied patients often don’t respond to surveys but rather, “vote with their feet.”

**Return on Service Quality Investment**

Providing a quality patient experience does require investment—in people, processes, physical assets, and measurement systems. The link between these investments and profits is not direct, although intuition and experience indicate that it does exist.

Consider the lifetime value of a patient who returns twice a year, every year, for the next 30 years. Not only is such a patient a reliable source of revenue, but if satisfied, will pay a price premium for future services while recommending the center to others.

By contrast, when a dissatisfied patient leaves, marketing costs must be incurred to attract a new patient and to counterbalance any negative word of mouth.

Investments made to improve the patient experience contribute to top-line revenue through increased volume and prices while also reducing overhead through improved operations efficiency.

**Conclusion**

Urgent care is distinct from other healthcare providers—and similar to retail and other service industries—in its orientation around patient affordability, convenience, and ease of use. Therefore, patients measure the service provided against retail-oriented businesses that have invested significantly in the patient experience.

Building a quality urgent care operation involves observation and data analysis to understand patient expectations and then developing people, processes, and physical environments that will deliver an experience consistent with those expectations. ■

**References**

Coding for Observation, and More on Established vs. New Patients

DAVID STERN, MD, CPC

Q. Is it possible for observation status codes (99217-99220) to be billed in an urgent care facility?
   – Question submitted by Andrea Manfredi-Rivera, CCS-P, Staten Island Physician Practice

A. Observation codes will require the point of service (POS) to be a hospital. If your urgent care is operated by a hospital and you can legitimately use a hospital POS, then you may be able to use these codes. If you use the physician office (POS -11) or urgent care (POS -20) place-of-service codes, then you could not use these codes compliantly.

With these types of issues, however, there is always one caveat. If, for some reason, you find that your center is positioned such that you frequently provide (or would be able to provide) observation status for patients that would otherwise receive hospital admission or hospital observation, then using observation services in your urgent care (instead of the hospital) could significantly reduce costs to payors. If this is the case, you may want to consider going directly to the payors, educating them as to the value to them for patient satisfaction and cost reduction. If they are convinced, then they may be willing to sign a contract addendum that allows you to bill for observation from POS -11 or POS -20.

Q. Is there another way (in addition to the E/M code) to code for prolonged observation or treatment of a patient in the urgent care setting?

A. Yes. Prolonged observation in the urgent care setting can be coded with the following codes:
   - 99354: Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (e.g., prolonged care and treatment of an acute asthmatic patient in an outpatient setting); first hour (list separately, in addition to the code for office or other outpatient Evaluation and Management service)
   - 99355: Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (e.g., prolonged care and treatment of an acute asthmatic patient in an outpatient setting); each additional 30 minutes (list separately in addition to code for prolonged physician service)

It is important to note that these codes require the provider to be “face-to-face” for the entire time that is used for calculating the proper code.

For example, code 99354 can be used if the physician spends 45 minutes in the room caring for a very ill patient. Do not, however, use these codes simply to code for time that the patient ties up a room while getting nebulizer treatments or hydration therapy.

In the urgent care setting, it is very rare for the physician to spend this amount of time in “face-to-face” contact with the patient. Thus, it is very rare that these codes would be appropriate in the urgent care setting.

Q. Can an urgent care facility do away with the established patient codes and just use new patient codes all the time, since the patient will more than likely not see the same provider at the urgent care?
   – Question submitted anonymously by e-mail

A. You make an interesting suggestion, but this would not be a compliant method for coding. Instead, you would have to make sure that any physician(s) who saw the patient in the last three years in your practice was actually of a different specialty than the specific physician who is seeing the patient for today’s visit. If the patient had not received services from a physician of that specific specialty, then it would be compliant to code a new patient E/M code.

David E. Stern, MD, CPC is a certified professional coder. He is a partner in Physicians Immediate Care, operating 12 urgent care centers in Oklahoma and Illinois. Stern serves on the Board of Directors of the Urgent Care Association of America and speaks frequently at urgent care conferences. He is CEO of Practice Velocity (www.practicevelocity.com), providing urgent care software solutions to more than 500 urgent care centers. He welcomes your questions about coding in urgent care.
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Since tracking the actual specialties of physicians performing the services for each and every visit involves so much work, most practices simply look to see if a patient has been treated by a physician (without regard to specialty) in the urgent care in the past three years. If so, then the visit is coded with an established patient E/M code.

Q. Can 99211 be used for a new patient visit that has been referred to urgent care from the emergency room only for antibiotic injections? In this situation, the patient presents with a prescription for doctor’s orders and the injections are given by the nurse.

A. CPT code 99211 should not be used for a new patient visit to the urgent care. One possible exception to this rule would be if the emergency department was operated by the same hospital and billed under the same TIN. In that case, the patient would already be an established patient in the hospital. If this is not the case, however, then the patient should be seen by the physician on the first visit to establish the patient in the practice.

On follow-up visits, or visits by patients who are already established in the urgent care, you may use 99211 to code for the visit. A physician should be on site during the visit. The medical record should include more documentation than simple vital signs and “injection given.”

In order to qualify for a 99211, the nurse should document pertinent history, physical, and instructions, i.e., there needs to be evidence of true “evaluation and management” by the non-physician staff member. Here is an example chart note:

S: Patient states pain from abscess is decreasing. Denies fevers and chills.
O: Abscess in right calf with 5x5cm of redness with minimal discharge.
A: Abscess, right calf
P: 1. Rocephin, 500 mg. IM, right gluteus maximus, lot number...
2. Recheck 6/5/09
3. Patient instructed to return or go to ED if pain increases, fever >101 or any other concerns.

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HEALTH LAW

Pull Up! Pull Up!

JOHN SHUFELDT, MD, JD, MBA, FACEP

I am often asked what inspired my love of flying. Although this is the first time I have admitted it in public, I am proud to say that it all began with the movie Airplane!

Dr. Rumack: You’d better tell the captain we’ve got to land as soon as we can. This woman has to be gotten to a hospital.

Elaine Dickinson: A hospital? What is it?

Dr. Rumack: It’s a big building with patients, but that’s not important right now.

As it happens, this was just the first of the movie’s many take-home messages. The deeper meaning, along with my love of flying, grew steadily over the ensuing years. One thing I have learned is that there is always more to learn.

My most recent aviation education experience took place at Flight Safety International. It was an intensive program designed to offer students a “type-rating” in a particular aircraft.

When I first arrived, I thought, “How hard can this be?” The answer came in short order; it turned out it could be, and was, hard! Typical days were 12 hours long, consisting of intense classroom sessions, self study and flying realistic, full-motion simulators.

Once, when my flying partner crashed on takeoff during a simulated engine failure, the instructor offered, “Don’t worry, you’re fine. You are so far behind the plane that you are still in the terminal.”

Looking back, I can’t imagine how I learned so much in such a short period. Along with the necessary skills and knowledge related to flight, I gained some insight that is readily applicable to the business of urgent care:

1. It is possible to make large course changes in a short amount of time with incomplete data. The newer, glass cockpit airplanes often have an instrument called the Traffic Alert and Collision Avoidance System, or TCAS, to identify other airplanes in close proximity. Once a conflict is identified, the pilot may be required to take immediate evasive action by abruptly changing course or altitude. The pilot must be quick and decisive. “Analysis paralysis” can prove fatal.

Dr. Rumack: Can you fly this plane, and land it?

Ted Striker: Surely you can’t be serious.

Dr. Rumack: I am serious...and don’t call me Shirley.

Analysis paralysis is the condition caused by repeated and often unnecessary data collection and dissection down to the minutia.

In the urgent care business, this commonly manifests as an indecisive manager stalling interminably to “analyze data” in an attempt to avoid appearing ineffective. As is the case for the pilot, you must learn to analyze, decide, and take action efficiently. Too often, businesses will languish while the data are collected.

2. When you are off course, you have a very short, finite amount of time to correct the heading before you and your passengers meet with a terrible outcome. When a plane is on an “instrument approach” (managing the flight path based on data from instrumentation), the margin for error is minuscule, and the pilot must monitor closely to keep the plane on the glide slope. Failure to do so could be catastrophic.

Rumack: Elaine, you’re a member of this crew. Can you face some unpleasant facts?

Elaine Dickinson: No.

When things are not going as planned in the urgent care center, waiting until the metrics are far off before initiating course corrections can be equally catastrophic. If, for example, visits are down—thereby impacting revenue—you must take action immediately. Start by

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.
changing staffing levels, and focus your energies on finding other opportunities to reduce expenses. If you wait until the end of the month to preserve the bottom line, it may well be too little too late. Multiple, constant, small course corrections not only provide a more direct route to your goal than large, intermittent changes, but they are also significantly less disruptive to the organization.

**The time to be aggressive is when you are behind the curve.**

3. When you are low and slow, add power to increase your airspeed and climb. On an approach, the worst thing a pilot can do is get slow below the glide slope. If the landing must be unexpectedly aborted, being low and slow is akin to running in waist-deep water.

Steve McCroskey: I need the best man on this. Someone who knows that plane inside and out, and won’t crack under pressure.

Johnny: How about Mr. Rogers?

One of my pet peeves is the oft stated, “You know how things slow down around the holidays.” It is not as if Thanksgiving, Christmas, Hanukah, Festivus, and New Year’s crash down upon us out of the blue. Every year around the same time, there will be a certain amount of scheduled time off. That in mind, plan ahead to forestall avoidable delays. When the organization reaches a low and/or slow point, add power; work longer, harder, and smarter.

The time to be aggressive is when you are behind the curve. Never mind how you got there, power up and fly out while you still can.

4. In an emergency, having too much data is a bad thing. One cool thing about the plane I am “typed in” is that when things are going badly, the plane limits the amount of data it feeds the pilot so as not to overwhelm him or her. The last thing a pilot needs in an emergency is a cacophony of bells and alarms distracting from a rapid review of the vital check list.

Captain Oveur: You ever been in a cockpit before?
Joey: No sir, I’ve never been in a plane before.
Captain Oveur: You ever seen a grown man naked?
Captain Oveur: Joey, have you ever been in a...in a Turkish prison?

Much like Captain Oveur, the urgent care operator must limit communication during an emergency to necessary data points. Do not join the “I ‘cc’ everyone on everything to cover my gluteus” club. No one has unlimited capacity, so determine what your team members actually need to know, and avoid sending them everything that they “might find interesting” in a calmer and more perfect world.

5. You can keep very busy in an airplane accomplishing nothing that will save you. Do you know people who seem really busy (and tell you they are really busy) but who, for whatever reason, don’t actually accomplish anything?

Rumack: The last thing he said to me, Doc, he said, “Sometime when the crew is up against it, the breaks are beating the boys, tell them to get out there and give it all they got and win just one for the Zipper. I don’t know where I’ll be then doc, he said, but I won’t smell too good, that’s for sure.

Ted Striker: Excuse me doc, I got a plane to land.

I occasionally see this exhibited in the emergency department. Some physicians manage to look like they are moving a mile a minute, yet no patients are moving through the department.

As the old adage states, “If you are not fired with enthusiasm, you will be fired with enthusiasm.” If your team is not moving, light a fire under them. If they refuse to move in the face of fire, fire them. One positive aspect of the market today is a plethora of great talent eager to work in the healthcare service industry.

At flight safety, I heard (and used) every excuse imaginable: the autopilot is F***ed up, the sun was in my eyes, the engine quit, the flight instructor went out, a flock of seagulls (not the 80s band, but the Captain Sully version) hit the plane, thunderstorms, hail, syphilis, you name it!

In running an urgent care center, you may encounter a similar spectrum of “justifications.” As the leader, you must refuse to either settle or accept excuses.

This is our time. The urgent care industry is changing the face of healthcare in the United States. Losing the initiative as the result of trepidation in execution is unacceptable.

Personally, I would rather crash into a mountain at Mach 1 than stall and spin to the ground for lack of power and altitude (attitude). We must not fail during this critical juncture. If somehow we do...it appears that “I picked the wrong week to quit sniffing glue.”
The ability to recognize, understand, evaluate, and articulate your clinic’s competitive strengths is central to a superior sales and marketing performance. Yet even the most polished sales efforts tend to fall short in one or more of these areas. An urgent care clinic is likely to either neglect its competitive strengths or offer a wooden recital of them. Clinics are rarely proactive in:

- assessing their strengths vis-à-vis their competition
- matching competitive strengths with sales prospect values as appropriate
- expressing their competitive strengths in a persuasive manner.

I believe that seven principles are essential if you wish to take advantage of your competitive strengths.

1. Keep “competitive” in your definition of “competitive strength.”
   A competitive strength is not necessarily an attribute in a pure sense (e.g., 24-hour service, multiple delivery points, certified staff). Rather, a competitive strength is simply something you do better than your competition.

   For example, in one market having a board-certified occupational medicine physician on staff may not be a competitive strength because competitors also have board-certified physicians. In another market, a program may use an experienced, but non-certified, physician but still maintain a competitive edge because the competition’s medical director is neither certified nor experienced.

   We are talking about relative—not absolute—attributes in virtually every instance.

2. Let your market define what is important.
   Assume that you cannot wait to tell your clients and prospects about a new board-certified occupational medicine physician who has joined your team. Think first before you rush out to share the good news. If your market is mired in recession, or the majority of injuries seen in the clinic are minor, some employers may perceive your board-certified occupational medicine physician as too expensive or over-qualified for their needs. Accordingly, it is imperative to match your clinic’s distinguishing characteristics with at-the-moment marketplace value before anointing the characteristic as a “competitive strength.”

   “If a clinic doesn’t have a genuine competitive strength, it must develop one.”

3. Your competitive strength is directly correlated to the difference in perceived value of that advantage between your program and your competitors.
   The value of your potential competitive strengths are directly related to the strength of that advantage among your competitors.

   Assume that research indicates that employers desire 24-hour access and that you are the only clinic in town with such coverage. This strength is not very strong if a competitor’s clinic is open 20 hours per day or the competitor has an arrangement with a prestigious local hospital emergency department for after-hours care.

   It is necessary not only to note what competitive strengths your clinic maintains but also to subjectively estimate the gap between that advantage and the status of the next best option.

   To genuinely assess the power of your clinic’s competitive strength portfolio, you need to answer three questions:
Are we the best option based on these criteria?
How much better are we than the next best competitor?
Just how important is this attribute to our market?

4. Cite your competitive strengths selectively and only when appropriate.
What is important at the collective market level does not necessarily carry over to the individual prospect level. In a market in which employers collectively do not find the availability of a multiple clinic network to be a compelling advantage, many other employers are still likely to find that attribute important.

A sales professional should interview prospects to identify how much value they place on an array of potential competitive strengths. The salesperson can then refer to the clinic’s competitive strengths without mentioning the “competition” directly.

5. Articulate your competitive strengths in simple, concise and persuasive terms.
The impact of your competitive strength is too important to be lost in a quagmire of information and verbiage. Competitive strength messages should be simple and easy to understand. Articulation of a competitive strength must focus on what is important to the prospect.

6. Summarize relevant competitive strengths at the conclusion of sales calls, phone calls, or written proposals.
Each sales call, important telephone call to a prospect, or written proposal should conclude with a strong summary statement. Beyond the obligatory summary of key points and action steps, a custom-crafted competitive strength summary can be quite helpful. Table 1 presents a prototype competitive strength statement.

7. Develop competitive strengths when none seem to exist.
For every urgent care market leader, there are likely to be several market challengers. Often, market challengers are new or immature programs, or programs hampered by constraints such as poor location, fewer financial resources, or a less respected corporate name. In many instances, market challengers have fewer competitive strengths than the market leader.

If a clinic does not have a genuine competitive strength, it must develop one. This process invariably begins with the marketplace itself by identifying the primary voids that seem to exist among the market’s occupational health providers. Once such voids are identified, steps can be taken to enhance your clinic’s capabilities to fill the gaps.

Table 1. Competitive Strength Worksheet
This sample worksheet demonstrates how you can evaluate your clinic’s most powerful competitive strengths. Columns 1 through 4 measure your program against the competition. Columns 5 and 6 factor in the perceived value placed on the attribute by your market. Your clinic’s net score is the product of the net (dis)advantage times the market’s value of that strength (your strength – competitor’s strength x market value = net score).

<table>
<thead>
<tr>
<th>Strength</th>
<th>1 Your program</th>
<th>2 Competitor #1</th>
<th>3 Competitor #2</th>
<th>4 Net (dis)advantage</th>
<th>5 Market value</th>
<th>6 Net score</th>
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<tr>
<td>Physician(s)</td>
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<td>5</td>
<td>4</td>
<td>3</td>
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<tr>
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<td>7</td>
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<td>(2)</td>
<td>1</td>
<td>(2)</td>
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<tr>
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<td>4</td>
<td>(1)</td>
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<td>8</td>
<td>9</td>
<td>(2)</td>
<td>2</td>
<td>(4)</td>
</tr>
</tbody>
</table>

*Your subjective opinion, on a scale of 1 to 10. †Can be based on your subjective opinion or on market research data; 3 indicates the highest score and 1 the lowest.
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In early 2008, UCAOA revamped its annual survey in conjunction with researchers at Massachusetts General Hospital and Harvard University with the goal of assuring that the UCAOA Benchmarking Committee’s efforts produced a scientifically valid report.

Here we present some of the findings from this landmark survey, to which 436 urgent care centers responded.

In this issue: What percentage of physicians working in urgent care are board certified—and how does that compare with primary care?

The survey also revealed that 85% of urgent care centers have at least one physician on site whenever the site is open.

Acknowledgment: Data submitted by Robin M. Weinick, PhD, at the time, assistant professor, Harvard Medical School and senior scientist, Institute for Health Policy, Massachusetts General Hospital and currently senior social scientist, RAND. Dr. Weinick is also a member of the JUCM Advisory Board. Financial support for this study was provided by UCAOA.

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