

# JUCM™

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## Ears, Nose, and Throat Urgencies in Children

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## LETTER FROM THE EDITOR-IN-CHIEF

# Hospital-owned Urgent Care Networks: Coming Soon to a Community Near You



**T**he whitecoats are coming, the whitecoats are coming!" If Paul Revere were running an independent urgent care network, this would be his call to arms.

After years of denial and arrogance, health systems are *finally* waking up to the system integration benefits of urgent care.

Hospitals stumbled in their response, hampered by bureaucracies, turf wars, and a stifling status quo. Well, the fog has finally lifted and urgent care is on the radar.

Due, in large part, to the work of the Urgent Care Association of America (UCAOA), the industry is now better defined and better quantified, and the discipline is more evolved. Hospitals are finally paying attention, and are trying vigorously to get in the game. They now recognize urgent care as a "front door" to their health systems—with a beautiful foyer and a welcoming staff.

The hospital emergency department, the traditional front door, is proving to be a costly point of access, burdened by regulation, inadequate reimbursement, and infrastructure challenges.

In addition, the past 20 years have trended towards decentralized health systems, as the demand for services in the suburbs has forced hospitals to rethink the tertiary model of care dominated by the urban medical center. Some of the important strategic challenges faced by hospitals include:

- "How do we create cost effective points of access in the suburban communities we serve?"
- "How do we prevent leakage of patients out of the system?"
- "How do we gain market share in these strategically important communities?"
- "How do we capture high-margin services like orthopedics, general surgery, and cardiology?"
- "How do we grow our primary care network, a critical hospital feeder, with new patients?"

With these strategic considerations in mind, it is no surprise that health systems have identified urgent care as an important opportunity for growth.

So, how might this impact the competitive landscape? There are several key considerations:

- Most hospitals are well capitalized. They are capable of creating a network of urgent care centers very quickly.
- Hospitals often consider primary care, inclusive of urgent

care, as a loss leader. While financial pressures are high on struggling health systems, investments in primary care and urgent care are intended more to drive downstream revenue than to be profit centers. Their tolerance of lower margins gives hospitals a competitive advantage.

- Hospitals, through their network of ambulatory medical centers, often have a wholly owned infrastructure that can easily accommodate an urgent care network at marginal expense.

Combined, these key characteristics allow health systems to infiltrate a market without a significant investment. The market quickly becomes saturated and diluted, making it very difficult for an independent, for-profit center to survive.

So, what to do? You have two options to choose from:

1. "In it to win it." Urgent care was built on the following principles: Service, Value, Access, Innovation and Scope. It will be difficult to compete with a hospital urgent care network on access and scope, and differentiating yourself on value may prove equally challenging. Service and innovation are the key competitive strengths of the independent urgent care. If you are in it to win it, then play to your strengths.
2. "If you can't beat 'em, join 'em." Now that you know what hospitals are looking for out of an urgent care network, consider establishing relationships that serve mutual interests. If you have an established network or a strong presence in a strategically important community, there may be no need for the hospital to enter the market if you can effectively integrate your services.

Market changes are inevitable in every growth industry. Anticipating trends and modifying strategy accordingly will keep you well positioned. Understanding your strengths and adapting them to market realities will keep you ahead of the pack. ■

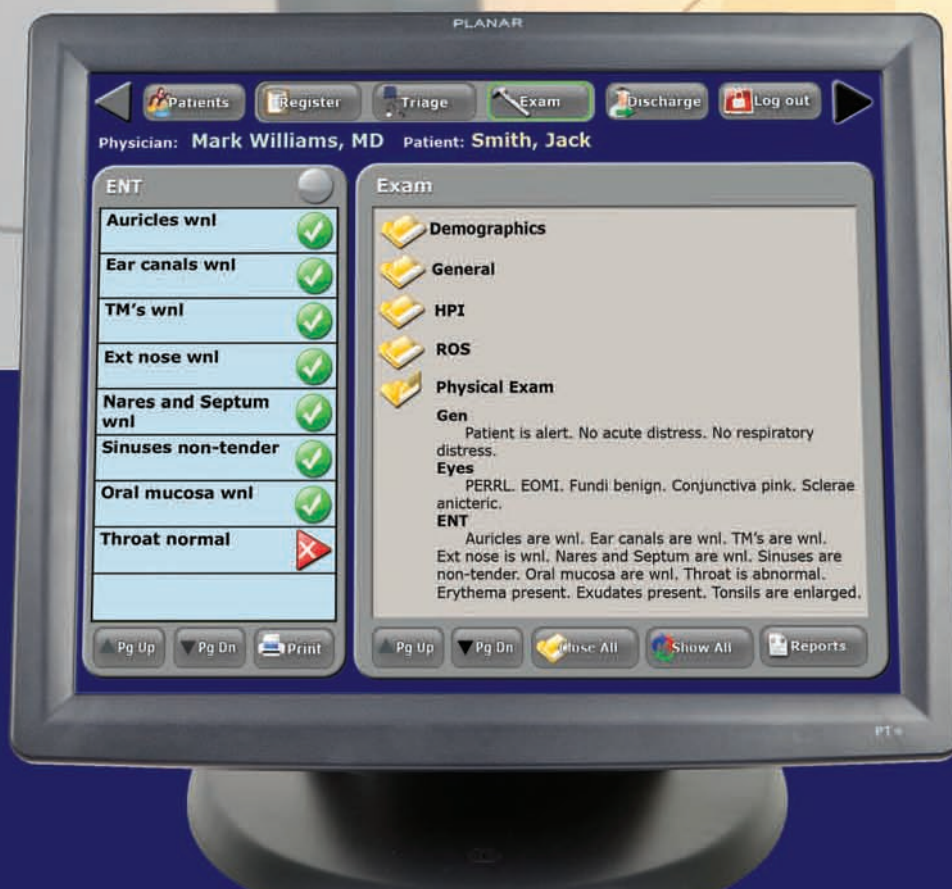
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### CLINICAL

## 11 Ear, Nose, and Throat Urgencies in Children

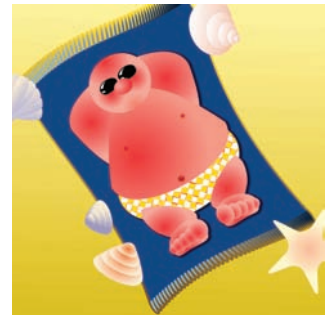
Many infections and injuries of the ear, nose, or throat are unique to the pediatric population. Parents view many of these processes as urgent, leading them to seek immediate medical attention.

*By Ann Mary Bacevice, MD*

## 22 Here Comes the Sunburn: An Update

The advent of warmer weather and spring break season is a reminder that many otherwise sensible Americans fail to heed warnings to use adequate protection from the sun. The urgent care clinician can expect an increase in patients presenting with varying degrees of sunburn.

*By Deepthi Samindla, MB, BS, Beth Braig, BA, Mikayla L. Spangler, PharmD, Shailendra K. Saxena, MD, PhD*



### PRACTICE MANAGEMENT

## 34 Beyond Vital Signs: Managing by Metrics for Optimal Health of Your Practice

Establishing a system of metrics and 'dashboards' allows the urgent care operator to quantify key success factors and company values that may otherwise be impossible to measure.

*By Laurel Stoimenoff*

## 42 The Case for Relationship-based Care

Taking a more relationship-based approach to contact between patients and non-clinical urgent care staff has been shown to improve both copay collection and scheduling of follow-up appointments.

*By Noel Clinton*

### IN THE NEXT ISSUE OF JUCM

*Asthma is a leading cause of pediatric hospitalization and can quickly become a medical emergency. Recognizing the signs of an acute exacerbation in the urgent care center can mean the difference between life and death.*

### WEB EXCLUSIVE

#### Evaluating Febrile Patients with Rash

The broad differential diagnoses in patients presenting with rash and fever range from minor conditions to life-threatening illnesses, requiring the urgent care provider to make prompt but valid assessments with minimal diagnostic tools. Available only at [www.jucm.com](http://www.jucm.com).

*By Kosta G. Skandamis, MD*

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## Mission Statement

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

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Parents will tell you that it seems a child is most likely to require immediate medical care five minutes after the pediatrician's office has closed (assuming they could even get an appointment if it's a "well-baby day"). And so it is that the urgent care center is becoming a destination of choice when younger patients have acute ear, nose, and throat symptoms.

This can be a particular challenge if the practitioner has had little formal training in pediatrics; children are less able to articulate pain, tolerate discomfort, and comply with instructions during an examination.

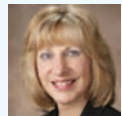
In Ear, Nose, and Throat Urgencies in Children (page 11), **Ann Mary Bacevice, MD** provides an expansive review of common etiologies, recommendations for the work-up, and treatment options.



Dr. Bacevice is assistant professor of pediatric emergency medicine at Rainbow Babies and Children's Hospital, part of University Hospitals Case Medical Center, in Cleveland, OH. Her particular areas of interest within pediatric emergency medicine include resident education and trauma.

Younger patients are also more likely to suffer sunburn than adults—though many Americans old enough to know better nonetheless find themselves with blistering shoulders after too much time unprotected (or under-protected) in the sun. However, there really is something new under the sun when it comes to treatment and prevention, as detailed in Here Comes the Sunburn: An Update (page 22), by a team of authors from Creighton University in Omaha, NE. **Deepthi Samindla, MBBS** is a third-year resident in the Department of Family Medicine; **Beth Braig, BA** is a student in the Department of Pharmacy Practice; **Mikayla L. Spangler, PharmD** is assistant professor in the Department of Pharmacy Practice; and **Shailendra K. Saxena, MD, PhD** is assistant professor in the Department of Family Medicine.

Somewhat less straightforward than identifying and treating sunburn is adopting practices that allow an urgent care operator to measure intangible principles—key success factors, company values, etc.



That's not to say that this is an impossible task, however. In fact, **Laurel Stoimenoff** might argue that creating methods to measure such concepts is paramount to long-term success. She spells out an approach in Beyond Vital Signs: Managing by Metrics for Optimal Health of Your Practice (page 34).

Ms. Stoimenoff has more than 25 years of healthcare management experience and is president and chief operating officer of NextCare. She is also immediate past-chair of the Board of Directors of the Arizona Foundation for Women,

which addresses poverty, caregiving, access to healthcare, and domestic violence. She is a summa cum laude graduate of The Ohio State University, holding a Bachelor's degree in Allied Health Professions with a major in Physical Therapy.

What can be done on the front lines to increase the likelihood of a smooth visit—from check-in to follow-up—for the typical patient encounter, though? **Noel Clinton**, network manager for the Bassett Healthcare Network's Emergency and Trauma Services Department, recommends embedding a clerical component within a relationship-based care approach. And she's got a success story to back up her perspective. The Case for Relationship-based Clerical Care starts on page 42.



In addition to her success with Bassett, Ms. Clinton counts winning the Susquehanna Bass Association's largest bass contest of 2009 among her accomplishments. Her approach to landing a winner is notably similar to her strategy in business: select the location (i.e., where do you need to be?), guide the bait (how are you going to get there?), and wait patiently for the trophy (enjoy the success).



And, exclusively at [www.jucm.com](http://www.jucm.com), **Kosta Skandamis, MD** offers a glimpse into Evaluating Febrile Patients with Rash. And we mean that literally, as he has provided photographic examples to aid in identifying common characteristics of various rash types.

Dr. Skandamis authored our December 2009 cover article, Identifying and Treating Superficial Fungal Infections in the Urgent Care Setting (available in our Archive at [www.jucm.com](http://www.jucm.com)). He began practicing urgent care medicine five years ago after starting his career as an OB/GYN.

## Also in this issue:

**Nahum Kovalski, BSc, MDCM** reviews new abstracts on treating anaphylactic reactions, sexually transmitted infections in adolescent patients, the best approach to rectal impaction, and other topics.

**John Shufeldt, MD, JD, MBA, FACEP** reminds us that ill-advised comments, whether spoken or entered on a patient's chart, can come back to haunt a provider in court.

**Frank Leone, MBA, MPH** advocates for building strong relationships that include a personal touch with clients—and prospective clients—of your occupational medicine business.

**David Stern, MD, CPC** responds to readers' questions about writing off patient responsibility, modifier-51, and new vs. established E/M codes.

We're proud to work with so many leaders in the urgent care industry. In fact, a number of this month's contribu-

tors—Noel Clinton, Frank Leone, John Shufeldt, David Stern, and Laurel Stoimenoff—as well as previous authors and several of our Editorial Board members will be speaking and participating in panel discussions at the Urgent Care of Association's National Convention in Lake Buena Vista, FL May 25-28. An agenda for the conference is available on the UCAOA website ([www.ucaoa.org](http://www.ucaoa.org)).

If you'd like to contribute to *JUCM*, as well, e-mail Editor-in-Chief **Lee A. Resnick, MD**, at [editor@jucm.com](mailto: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](mailto: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](http://www.jucm.com).

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## FROM THE EXECUTIVE DIRECTOR

# The Two Most Powerful Words

■ LOU ELLEN HORWITZ, MA

**L**ike all of you, I've been reading the commentary and praise and doom and predictions about what the Patient Protection and Affordable Care Act will be bringing to all of us as patients, employers, providers, suppliers, and citizen taxpayers.

It's an interesting time, to say the least.

One thing that struck me as I was reading one of these news stories talking about the concerns many states have about the impact this will have on their budgets is the common use of the phrase "will be paid for by the Federal government."

I realize that this is a somewhat naïve point of view, but my first thought was that all of this is not paid for by the Federal government; it's paid for by you and me. It's paid for by employers, pharmaceutical companies, physicians—individuals with certain incomes.

Many of us will start to pay more in taxes of various sorts (or see reductions in payments) so that this Act can be implemented. It is paid for by specific people and groups—not a magical money tree called "the Federal government."

Here's where the naïve part comes in.

Wouldn't it be something—shocking, really—if someone were to say "thank you" to the people who, voluntarily or not, will be giving up funds to make this happen?

If physicians and pharmaceutical companies and employers and high-end taxpayers got praise and acknowledgment for what we are giving back to our fellow man?

For the sacrifices and changes we are going to have to make to our business models or individual plans for the greater good?

Naïve or not, I am sorry to see that there is no new Agency of Funding Appreciation being formed.

When I was growing up, my parents taught me the value of "thank you." It's a simple phrase. Short, easy to say,

*"Your support of existing programs makes the next new ones possible."*

absolutely free, with a great rate of return. Nobody hates to hear "thank you."

The translation of all of this to what we do at UCAOA was almost instantaneous to me.

While it seems that we do what a normal association does—provide member benefits, educational programs, research, resources, recognition programs, etc., which seem like normal business activities—something amazing is taking place virtually every single day. Hundreds of you—members, non-members, vendors, and other interested parties—make regular decisions to call, e-mail, or fax us to give us your money.

We provide something in return, of course, but it is still an active choice you are consciously making that is very humbling for us. This is also a "normal" business activity, but, to us, it is still a wonderful and beautiful thing.

In the four years that I have been in this role, I have watched the UCAOA board, staff, and volunteers work extremely hard to continue to evolve to meet your needs by creating new programs and pushing the envelope on existing ones. Your continued support of those activities is, of course, what makes the next new ones possible. It's a great cycle to be a part of.

Later this month, I will again have the privilege of gathering with many of you at our National Convention. The continued success of this meeting is a thrill to us every year, and we hope you have found that it gets better and better and better.

Whether I get to tell you in person, or this column is my only communication with you, accept my sincerest appreciation for all that each of you has done and continues to do to make UCAOA the organization that it is.

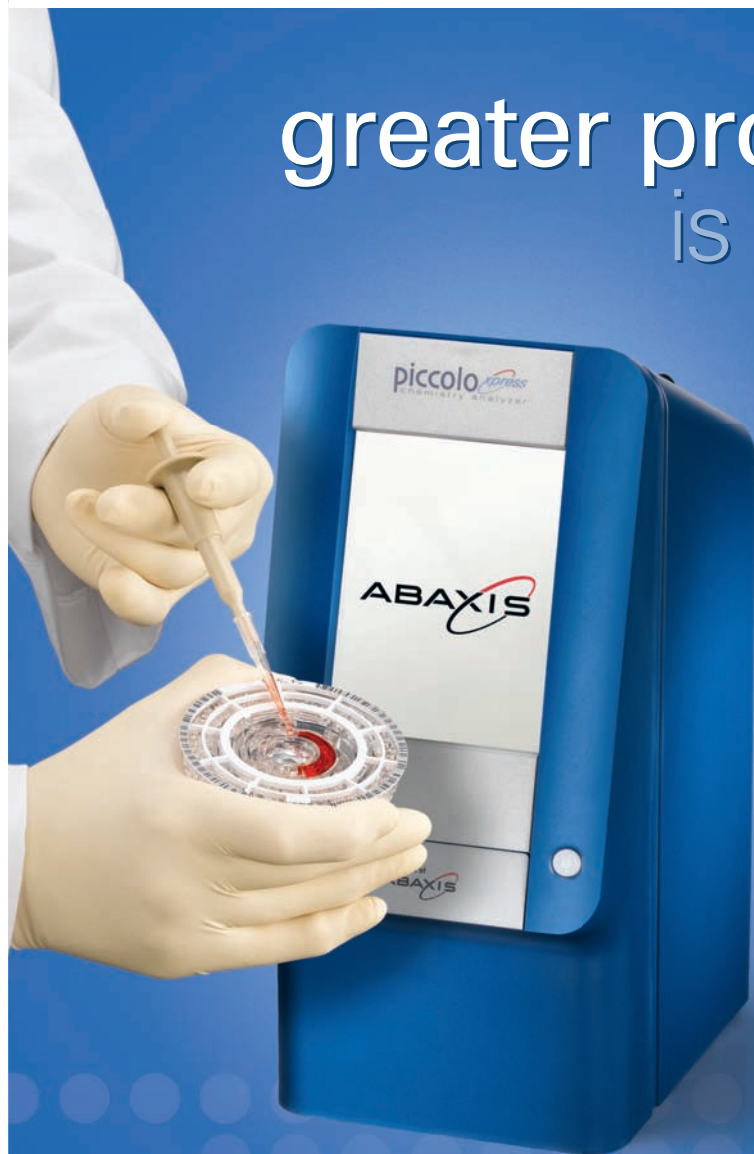
Thank you. ■



**Lou Ellen Horwitz** is executive director of the Urgent Care Association of America. She may be contacted at [lhorwitz@ucaoa.org](mailto:lhorwitz@ucaoa.org).



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## Ear, Nose, and Throat Urgencies in Children

**Urgent message:** Many infections and injuries of the ear, nose, or throat are unique to the pediatric population. Parents view many of these processes as urgent, leading them to seek immediate medical attention.

Ann Mary Bacevice, MD

### Introduction

Children tend to be especially susceptible to a wide range of infectious illnesses, as well as vulnerable to a host of minor traumas to or affecting the ear, nose, or throat. This, added to the fact that they typically are less able to clearly articulate pain or other symptoms than adults, leaves it to the clinician to fill in the “blanks” when taking a history or formulating a diagnosis.

This article will help the urgent care practitioner to understand the diagnosis and treatment of some of the common infections and injuries that affect the pediatric ear, nose or throat.

### Acute Otitis Media

Acute otitis media (AOM) is the most common infection for which antibiotics are prescribed to children in the United States; in 2000, there were 16 million office visits for AOM alone.

The American Academy of Pediatrics (AAP) and the



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American Academy of Family Physicians (AAFP) issued a clinical practice guideline on the diagnosis and management of AOM in 2004 to streamline the care of this common pediatric infection. It specifies that the diagnosis of AOM requires:

- a history of acute onset of symptomatology
- the presence of middle-ear effusion
- and signs and symptoms of middle-ear inflammation.

The presence of a middle-ear effusion can be determined by a bulging

tympanic membrane (TM), limited mobility of the TM, the presence of an air-fluid level behind the TM, or frank otorrhea.

Signs and symptoms of middle-ear inflammation include erythema of the TM and/or otalgia.

With the diagnosis in hand, the first issue to address in a child with AOM is pain. Pain control can be achieved by oral analgesics, including acetaminophen or ibuprofen. The use of topical agents is also ac-



**Table 1. Common Pharmacotherapy for AOM**

|   | Antibiotic                            | Dosing  |
|---|---------------------------------------|---|
| First-line                                      | Amoxicillin                           | 80-90 mg/kg/day divided BID   |
| Treatment failure/severe illness                | Amoxicillin-clavulanate               | 90 mg/kg/day (amoxicillin component with 6.4 mg/kg/day clavulanate) divided BID |
| Penicillin allergy (not urticarial anaphylaxis) | Cefdinir<br>Cefpodoxime<br>Cefuroxime | 14 mg/kg/day QD or BID<br>10 mg/kg/day QD<br>30 mg/kg/day divided BID           |
| Penicillin allergy (urticaria/anaphylaxis)      | Azithromycin<br>Clarithromycin        | 10 mg/kg/day 1, 5 mg/kg/days 2-5<br>15 mg/kg/day divided BID                    |

ceptable in the urgent care center; our standard practice is to not prescribe for home use, however. It should also be noted that topical analgesics cannot be used through a perforated TM.

Observation without the use of antibiotics is an option in certain patients, especially if the diagnosis is uncertain, the child is older, the symptoms are less severe, and the family has reliable follow-up.

#### Treatment

Several treatments are recommended for AOM, including contingencies for children who are allergic to penicillin (**Table 1**).

Amoxicillin remains the first-line agent for treating AOM. The current dosing recommendation is 80 mg/kg/day to 90 mg/kg/day divided in two doses. This dosing will treat both susceptible and intermediate-resistant pneumococci. Treatment is usually 10 days but may be shortened to five to seven days in the older child.

Amoxicillin-clavulanate is used when high-dose amoxicillin treatment has failed. This is usually defined as persistence of symptoms without improvement after 48 to 72 hours of therapy. Amoxicillin-clavulanate is also recommended as first-line therapy for severe illness or when *Haemophilus influenzae* or *Moraxella catarrhalis* is likely. Dosing is 90 mg/kg/day based on the amoxicillin component (with 6.4 mg/kg/day clavulanate component) divided twice daily.

In penicillin-allergic patients where the allergy is not anaphylaxis, cephalosporins such as cefdinir, cefuroxime, or cefpodoxime may be used.

If the penicillin allergy is anaphylaxis, then a macrolide such as azithromycin or clarithromycin may be used.

#### Otitis Externa

Otitis externa (swimmer's ear) is usually seen in the summer months. Risk factors include:

- high humidity
- warmer temperatures
- local trauma
- maceration of the skin
- exposure to water with high bacterial counts
- swimming.

The antimicrobial properties of cerumen are thought to play a protective role in the development of otitis ex-

terna. Children present most commonly with pain that is exacerbated by manipulating the pinna of the ear. On exam, the practitioner will likely see erythema and edema of the ear canal with thick clumpy otorrhea.

#### Treatment

Treatment of otitis externa is with topical antibiotics. Neomycin-polymixin B-hydrocortisone preparations are very effective, although contact hypersensitivity can occur and there is a rare risk of ototoxicity with the aminoglycoside component.

Fluoroquinolones are very effective options for treatment without the issues of contact hypersensitivity or ototoxicity. If the secretions are thick, suctioning or swabbing prior to administration of therapy may be of benefit. The use of an ear wick is also an option in the edematous ear canal.

#### Mastoiditis

Mastoiditis is a suppurative complication of AOM. It is most common in children <10 years of age, with peak occurrence in children younger than 2 years.

Clinically, mastoiditis can be separated into acute and chronic categories. Acute mastoiditis can be further subdivided depending on the involvement of the mastoid bone.

Acute mastoiditis with periosteitis occurs when there is an undrained collection of pus extending to the periosteum but not involving the bone. This can usually be treated with myringotomy and IV antibiotics.

Acute coalescent mastoiditis has necrosis and demineralization of the mastoid air cells and extension into the mastoid bone. This entity requires surgical drainage.



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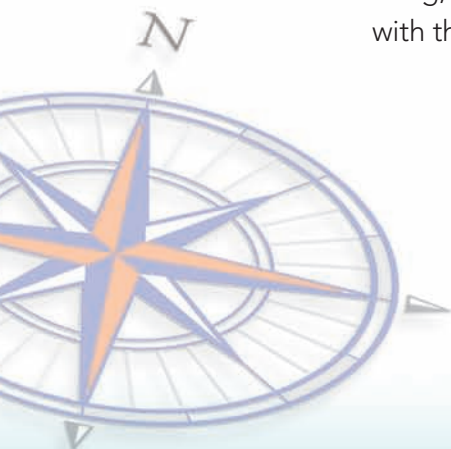
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Children with mastoiditis will present with postauricular pain and erythema with outward displacement of the pinna on the affected side. These children may also have fever, otorrhea, headache, rhinorrhea, and hearing loss. A history or evidence of AOM is usually present, but the absence of these does not exclude the potential diagnosis of mastoiditis.

CT of the mastoids with IV contrast is the imaging modality of choice. If the diagnosis is made, prompt involvement of the otolaryngologist (ENT) is essential, as these children usually require IV antibiotic therapy and, often, some surgical intervention.

### **Cerumen Impaction**

As noted previously, cerumen has beneficial antimicrobial properties. However, its presence is often frustrating for the practitioner examining a child's ear.

#### *Treatment*

There are three general categories of options for removal: irrigation, ceruminolytics, or manual removal.

- *Irrigation* is effective, but can cause pain and/or trauma to the ear canal. Tympanic membrane perforation, the development of vertigo, and otitis externa are noted complications.
- *Ceruminolytics* are easy to apply but are no more effective than saline or water for removal. Allergic reactions to the product and pain with application are noted complications.
- *Manual removal* with a fiberoptic curette or other instrument is effective in removing cerumen but requires more skill on the practitioner's part and more cooperation on the child's part. Pain and laceration of the skin lining the ear canal are complications of this procedure.

In addition, we and other providers have had success using docusate as a softener.

### **Traumatic Tympanic Membrane Perforation**

Children will most commonly obtain a traumatic tympanic membrane perforation due to poking an object in the ear canal. It can also occur after a slap to the side of the head.

Symptoms include pain and bloody drainage.

*“Imaging the sinuses  
is not necessary in children  
<6 years of age and remains  
controversial in children  
>6 years of age.”*

#### *Treatment*

Any perforation that is accompanied by hearing loss, vertigo, or facial nerve paralysis needs urgent ENT consultation.

Clean perforations should heal in two to three weeks. During that time, the ear should be kept clean and

dry. Topical antimicrobials should be prescribed for 10 days.

This child needs close follow-up to reevaluate the ear to ensure proper healing of the TM.

### **Sinusitis**

Knowledge of sinus development in children can aid the practitioner in considering the diagnosis of sinusitis in children.

The ethmoid and maxillary sinuses are present at birth.

The sphenoid sinuses are present by age 5 years.

Frontal sinuses appear around age 7 to 8 years, but are not fully developed until late adolescence.

As paranasal sinuses are a common site of infection in children and adolescents, in 2001 the AAP issued a clinical practice guideline on the management of sinusitis.

Sinusitis in children is a clinical diagnosis that can be divided into the subgroups acute, subacute, and recurrent acute.

*Acute sinusitis* can be defined as upper respiratory symptoms that are persistent or severe. Symptoms are considered “persistent” if they are present for 10 to 14 days but less than 30 days and include a nasal or post-nasal discharge of any quality or the presence of a daytime cough. Severe symptoms include the presence of a fever greater than 39° Celsius or the presence of purulent discharge for at least three to four consecutive days. These children often appear ill.

In *subacute sinusitis*, the symptoms are present for 30 to 90 days.

In *recurrent acute sinusitis*, the child has three episodes of acute sinusitis in six months or four episodes in 12 months with resolution of symptoms between each episode.

Imaging the sinuses is not necessary in children <6 years of age and remains controversial in children >6 years of age. CT scans should be reserved for those patients where surgery may be indicated.



A woman and a young girl are walking barefoot on a path made of white-outlined pill containers. The woman is on the left, wearing a green shirt and jeans, and the girl is on the right, wearing a white shirt and green pants. They are both smiling and looking down at the path. The background is a blue sky with clouds.

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### Treatment

Treatment of acute sinusitis is the same as for AOM (**Table 1**), with high-dose amoxicillin being the first-line treatment.

Amoxicillin-clavulanate can be used for children not improving on amoxicillin, those with moderate to severe illness, those in daycare or those who have been recently treated with antimicrobials.

In penicillin-allergic patients, the alternatives are the same as in AOM. The duration of therapy is controversial, with authors recommending 10, 14, 21, or even 28 days of treatment.

Complications of acute sinusitis can result from delay of treatment, incomplete treatment, or antibiotic-resistant organisms and are caused by direct spread in infection to adjacent structures including the orbit, brain, and subgalea.

Orbital cellulitis can be preseptal, postseptal, or have the presence of an abscess. Affected children present with erythema and edema of the periorbital tissues. Proptosis and limited extra-ocular muscle movements suggest a deeper site of infection.

Cavernous sinus thrombosis can occur by any tissue infection of the midface, orbit, or sinus.

The presence of a cranial nerve palsy with an orbit or sinus infection should raise suspicion for the practitioner. Intracranial spread most commonly occurs from the frontal sinuses and is, therefore, more frequently seen in adolescents. These complications include empyema, cerebritis, or brain abscess.

If considering any of these complications of acute sinusitis, CT scan with intravenous contrast is the recommended diagnostic modality. The presence of any of these complications requires prompt referral to the appropriate surgical sub-specialist and initiation of intravenous antibiotic therapy.

### Epistaxis

In children, the most common causes of epistaxis are upper respiratory infections and nose picking. Other causes include sinusitis, facial trauma, or foreign bodies.

When obtaining the history of a child presenting with acute epistaxis, the presence of easy bruising, bleeding from other sources, weight loss, constitutional symptoms, or family history of a bleeding disorder should prompt further investigation.

Blood work, if indicated, should include a complete

*“Some providers find that using a rolling motion when applying cautery is most effective.”*

blood count and coagulation studies. An x-ray or CT scan can be obtained if there is suspicion of a foreign body that is not readily visualized or a mass is suspected.

The classification of epistaxis is based on the

location of bleeding. Anterior bleeding represents 90% of episodes of epistaxis. Kiesselbach's plexus is a venous plexus located on the anterior nasal septum. It is fragile and prone to trauma. Bleeding from this site tends to be a slow, persistent oozing. Posterior bleeding involves the sphenopalatine artery. The arterial bleed is more profuse and is more likely to cause severe hemorrhage, aspiration, and even airway compromise.

### Treatment

If the child presents with no active bleeding, treatment is limited to nasal hydration and ways to minimize recurrence.

If mild bleeding is present, the head can be kept mildly elevated, but not hyperextended, and the nostrils can be pinched for five to 30 minutes. The bleeding will likely resolve in five to 10 minutes.

If more significant or persistent bleeding is present, there are several options for therapy. Gauze soaked with a nasal decongestant spray, 1:10,000 epinephrine or phenylephrine, can be applied to the affected nostril to induce vasoconstriction.

If a bleeding point is visible, chemical cautery with silver nitrate is an option. The stick can be applied to the bleeding point with firm pressure for up to five seconds; longer contact is not advisable. Some providers find that using a rolling motion when applying cautery is most effective.

If packing is indicated for anterior bleed, petroleum jelly gauze can be used. There are also commercial nasal tampons available for use. Packing a posterior bleed is more difficult and should be done in conjunction with an ENT specialist. Gauze or a balloon can be used.

A more detailed, though not child-specific, discussion of epistaxis was featured in the October 2008 issue of *JUCM*.

### Nasal Fractures

Nasal fractures account for most facial injuries in children. Epistaxis usually occurs with the original injury. Significant edema can limit the initial examination of

the child and prevent recognition of deformity or deviation for several days. X-rays are notoriously unreliable in assisting with the diagnosis.

When examining a child with a suspected nasal fracture, be aware that the nasal septum should be evaluated for the presence of deviation or hematoma. A septal hematoma needs to be drained as soon as possible. Attention should be paid to the presence or absence of cerebral spinal fluid (CSF) rhinorrhea. If CSF rhinorrhea is present, a CT scan should be obtained to evaluate the extent of the nasal fracture. Both septal involvement and CSF rhinorrhea require prompt ENT evaluation.

In the absence of these, the child can follow up with the primary care provider in three to four days, after the swelling decreases, to determine the need for referral to ENT for reduction.

### **Gingivostomatitis**

Gingivostomatitis is the most likely presentation of a primary herpes simplex virus 1 infection commonly affecting children between 1 and 4 years of age. Often,

these children will have fever for several days prior to any oral findings, which include erythematous marginal gingiva with yellowish fluid-filled vesicles on the mucosa, palate, and tongue which rupture and ulcerate. The ulcers are ultimately covered by a gray-yellow membrane.

This illness is self-limited, usually lasting seven to 14 days.

The most common complication is dehydration due to pain.

### *Treatment*

Pain control can usually be achieved with acetaminophen or ibuprofen. Topical therapy is an option but can be challenging in the patient who cannot swish the medication and then spit it out. The practitioner must be cautious about excessive dosing of some topical therapies (i.e., diphenhydramine, lidocaine).

There is insufficient evidence that acyclovir plays any role in the treatment of gingivostomatitis.



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**Table 2. Common Viruses Causing Pharyngitis**

|                     |                             |
|---------------------|-----------------------------|
| Influenza virus     | Coronavirus                 |
| Parainfluenza virus | Adenovirus                  |
| Rhinovirus          | Respiratory syncytial virus |

Parental reassurance is important. Practitioners should provide parents with creative ways of hydrating their child, including using popsicles and other cold foods, as well as using straws if the child is coordinated enough.

Acetaminophen suppositories provide an analgesic option for the child who refuses any oral medication.

### Hand, Foot, and Mouth Disease

Hand, foot, and mouth disease is caused by enteroviruses, typically coxsackievirus, and usually presents in the spring and summer.

The children are often febrile and fussy.

Painful ulcerations are seen most commonly on the soft palate but can occur elsewhere in the mouth. Erythematous papulovesicular lesions can be seen on the hands and feet.

As in gingivostomatitis, dehydration due to pain is the biggest concern.

### Treatment

This illness is self-limited and supporting the child with adequate analgesia and hydration is key.

### Pharyngitis

Viruses are the most common etiology of pharyngitis in children (**Table 2**). These often present in the winter months.

Epstein-Barr virus (EBV) is another viral etiology of acute pharyngitis.

Group A beta-hemolytic streptococcus (GAS) accounts for 15% to 30% of cases of pharyngitis in children.

Certain findings in the history and physical exam of a child with pharyngitis may assist the practitioner in determining the cause of the illness, whether it is viral or bacterial.

Findings suggestive of a viral etiology include: conjunctivitis, coryza, cough, diarrhea and/or viral exanthema.

Findings suggestive of GAS as the etiology include: sudden onset of symptoms, fever, headache, nausea, vomiting, abdominal pain, tender and enlarged cervical lymphadenopathy, scarlatiniform rash, patchy tonsillar exudates and a history of exposure.

GAS can be diagnosed with a rapid antigen test or throat culture.

### Treatment

Treatment is indicated for those children in whom positive diagnosis is made. Oral antibiotics are recommended for 10 days, although there is some literature supporting a five-day course in adolescents.

As GAS has not developed any resistance, standard-dose penicillin or amoxicillin is the treatment of choice. A first-generation cephalosporin or macrolide can be used in patients with a penicillin allergy.

### Infectious Mononucleosis

Infectious mononucleosis is caused by EBV. Affected children present with severe pharyngitis, as well as generalized lymphadenopathy and splenomegaly.

Laboratory findings can include a presence of atypical lymphocytes on a complete blood count with differential, a positive heterophile antibody or specific antibodies to EBV. Treatment is supportive.

### Peritonsillar Abscess

Abscesses can form in the potential space bounded by the tonsillar pillars, piriform fossa, and hard palate. Infection usually begins superficially and extends into deeper tissues. The exact mechanism of initial abscess formation is unknown. Peritonsillar abscesses are polymicrobial, with a combination of GAS and anaerobes seen.

The child with a peritonsillar abscess will present with a gradually increasing sore throat accompanied by ipsilateral ear pain, trismus, dysphagia, and a "hot potato voice."

These children are often febrile. The diagnosis can be made clinically. On exam, the uvula deviates away from the affected side due to peritonsillar mass effect. Erythema and fluctuance are present, along with ipsilateral cervical lymphadenopathy. Radiography can be used to identify other causes if uncertain.

### Treatment

Treatment includes tonsillar aspiration or surgical drainage accompanied by intravenous or oral antibiotics. Children with peritonsillar abscesses are often hospitalized for observation to prevent toxicity, airway compromise, sepsis, or other complications.

### Retropharyngeal Abscess

The retropharyngeal space is bounded by the buccopharyngeal fascia, prevertebral fascia, and the carotid sheaths. Retropharyngeal infections can be





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**\*Remember to use the full course of therapy—7 days.**

#### IMPORTANT SAFETY INFORMATION

VIGAMOX® solution is indicated for the treatment of bacterial conjunctivitis caused by susceptible strains of the following organisms: *Corynebacterium* species<sup>†</sup>, *Micrococcus luteus*<sup>†</sup>, *Staphylococcus aureus*, *S. epidermidis*, *S. haemolyticus*, *S. hominis*, *S. warneri*<sup>†</sup>, *Streptococcus pneumoniae*, *Streptococcus viridans* group, *Acinetobacter lwoffii*<sup>†</sup>, *Haemophilus influenzae*, *Haemophilus parainfluenzae*<sup>†</sup>, *Chlamydia trachomatis* (<sup>†</sup>efficacy for this organism was studied in fewer than 10 infections). VIGAMOX® solution is contraindicated in patients with a history of hypersensitivity to moxifloxacin, to other fluoroquinolones, or to any of the components in this medication. NOT FOR INJECTION. VIGAMOX® solution should not be injected subconjunctivally, nor should it be introduced directly into the anterior chamber of the eye. In patients receiving systemically administered quinolones, including moxifloxacin, serious and occasionally fatal hypersensitivity (anaphylactic) reactions have been reported, some following the first dose. As with other anti-infectives, prolonged use of VIGAMOX® solution may result in overgrowth of non-susceptible organisms, including fungi. The safety and effectiveness of VIGAMOX® solution in infants below 1 year of age have not been established. The most frequently reported ocular adverse events were conjunctivitis, decreased visual acuity, dry eye, keratitis, ocular discomfort, ocular hyperemia, ocular pain, ocular pruritus, subconjunctival hemorrhage, and tearing. These events occurred in approximately 1%–6% of patients.

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**DESCRIPTION:** VIGAMOX® (moxifloxacin HCl ophthalmic solution) 0.5% is a sterile ophthalmic solution. It is an 8-methoxy fluoroquinolone anti-infective for topical ophthalmic use.

### CLINICAL PHARMACOLOGY:

#### Microbiology:

The following *in vitro* data are also available, but their clinical significance in ophthalmic infections is unknown. The safety and effectiveness of VIGAMOX® solution in treating ophthalmological infections due to these microorganisms have not been established in adequate and well-controlled trials.

The following organisms are considered susceptible when evaluated using systemic breakpoints. However, a correlation between the *in vitro* systemic breakpoint and ophthalmological efficacy has not been established. The list of organisms is provided as guidance only in assessing the potential treatment of conjunctival infections. Moxifloxacin exhibits *in vitro* minimal inhibitory concentrations (MICs) of 2 µg/ml or less (systemic susceptible breakpoint) against most (> 90%) strains of the following ocular pathogens.

#### Aerobic Gram-positive microorganisms:

*Listeria monocytogenes*  
*Staphylococcus saprophyticus*  
*Streptococcus agalactiae*  
*Streptococcus mitis*  
*Streptococcus pyogenes*  
*Streptococcus Group C, G and F*

#### Aerobic Gram-negative microorganisms:

*Acinetobacter baumannii*  
*Acinetobacter calcoaceticus*  
*Citrobacter freundii*  
*Citrobacter koseri*  
*Enterobacter aerogenes*  
*Enterobacter cloacae*  
*Escherichia coli*  
*Klebsiella oxytoca*  
*Klebsiella pneumoniae*  
*Moraxella catarrhalis*  
*Morganella morganii*  
*Neisseria gonorrhoeae*  
*Proteus mirabilis*  
*Proteus vulgaris*  
*Pseudomonas stutzeri*

#### Anaerobic microorganisms:

*Clostridium perfringens*  
*Fusobacterium species*  
*Prevotella species*  
*Propionibacterium acnes*

#### Other microorganisms:

*Chlamydia pneumoniae*  
*Legionella pneumophila*  
*Mycobacterium avium*  
*Mycobacterium marinum*  
*Mycoplasma pneumoniae*

#### Clinical Studies:

In two randomized, double-masked, multicenter, controlled clinical trials in which patients were dosed 3 times a day for 4 days, VIGAMOX® solution produced clinical cures on day 5-6 in 66% to 69% of patients treated for bacterial conjunctivitis. Microbiological success rates for the eradication of the baseline pathogens ranged from 84% to 94%. Please note that microbiologic eradication does not always correlate with clinical outcome in anti-infective trials.

**INDICATIONS AND USAGE:** VIGAMOX® solution is indicated for the treatment of bacterial conjunctivitis caused by susceptible strains of the following organisms:

#### Aerobic Gram-positive microorganisms:

*Corynebacterium species\**  
*Micrococcus luteus\**  
*Staphylococcus aureus*  
*Staphylococcus epidermidis*  
*Staphylococcus haemolyticus*  
*Staphylococcus hominis*  
*Staphylococcus warneri\**  
*Streptococcus pneumoniae*  
*Streptococcus viridans group*

#### Aerobic Gram-negative microorganisms:

*Acinetobacter lwoffii\**  
*Haemophilus influenzae*  
*Haemophilus parainfluenzae\**

#### Other microorganisms:

*Chlamydia trachomatis*

\*Efficacy for this organism was studied in fewer than 10 patients.

**CONTRAINDICATIONS:** VIGAMOX® solution is contraindicated in patients with a history of hypersensitivity to moxifloxacin, to other quinolones, or to any of the components in this medication.

#### WARNINGS:

NOT FOR INJECTION.

VIGAMOX® solution should not be injected subconjunctivally, nor should it be introduced directly into the anterior chamber of the eye.

In patients receiving systemically administered quinolones, including moxifloxacin, serious and occasionally fatal hypersensitivity (anaphylactic) reactions have been reported, some following the first dose. Some reactions were accompanied by cardiovascular collapse, loss of consciousness, angioedema (including laryngeal, pharyngeal, or facial edema), airway obstruction, dyspnea, urticaria, and itching. If an allergic reaction to moxifloxacin occurs, discontinue use of the drug. Serious acute hypersensitivity reactions may require immediate emergency treatment. Oxygen and airway management should be administered as clinically indicated.

#### PRECAUTIONS:

**General:** As with other anti-infectives, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. If superinfection occurs, discontinue use and institute alternative therapy. Whenever clinical judgment dictates, the patient should be examined with the aid of magnification, such as slit-lamp biomicroscopy,

and, where appropriate, fluorescein staining. Patients should be advised not to wear contact lenses if they have signs and symptoms of bacterial conjunctivitis.

**Information for Patients:** Avoid contaminating the applicator tip with material from the eye, fingers or other source.

Systemically administered quinolones including moxifloxacin have been associated with hypersensitivity reactions, even following a single dose. Discontinue use immediately and contact your physician at the first sign of a rash or allergic reaction.

**Drug Interactions:** Drug-drug interaction studies have not been conducted with VIGAMOX® solution. *In vitro* studies indicate that moxifloxacin does not inhibit CYP3A4, CYP2D6, CYP2C9, CYP2C19, or CYP1A2 indicating that moxifloxacin is unlikely to alter the pharmacokinetics of drugs metabolized by these cytochrome P450 isozymes.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Long term studies in animals to determine the carcinogenic potential of moxifloxacin have not been performed. However, in an accelerated study with initiators and promoters, moxifloxacin was not carcinogenic in rats following up to 38 weeks of oral dosing at 500 mg/kg/day (approximately 21,700 times the highest recommended total daily human ophthalmic dose for a 50 kg person, on a mg/kg basis).

Moxifloxacin was not mutagenic in four bacterial strains used in the Ames *Salmonella* reversion assay. As with other quinolones, the positive response observed with moxifloxacin in strain TA 102 using the same assay may be due to the inhibition of DNA gyrase. Moxifloxacin was not mutagenic in the CHO/HGPRT mammalian cell gene mutation assay. An equivocal result was obtained in the same assay when V79 cells were used. Moxifloxacin was clastogenic in the V79 chromosome aberrations assay, but it did not induce unscheduled DNA synthesis in cultured rat hepatocytes. There was no evidence of genotoxicity *in vivo* in a micronucleus test or a dominant lethal test in mice.

Moxifloxacin had no effect on fertility in male and female rats at oral doses as high as 500 mg/kg/day, approximately 21,700 times the highest recommended total daily human ophthalmic dose. At 500 mg/kg orally there were slight effects on sperm morphology (head-tail separation) in male rats and on the estrous cycle in female rats.

#### Pregnancy: Teratogenic Effects.

**Pregnancy Category C:** Moxifloxacin was not teratogenic when administered to pregnant rats during organogenesis at oral doses as high as 500 mg/kg/day (approximately 21,700 times the highest recommended total daily human ophthalmic dose); however, decreased fetal body weights and slightly delayed fetal skeletal development were observed. There was no evidence of teratogenicity when pregnant cynomolgus monkeys were given oral doses as high as 100 mg/kg/day (approximately 4,300 times the highest recommended total daily human ophthalmic dose). An increased incidence of smaller fetuses was observed at 100 mg/kg/day. Since there are no adequate and well-controlled studies in pregnant women, VIGAMOX® solution should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers:** Moxifloxacin has not been measured in human milk, although it can be presumed to be excreted in human milk. Caution should be exercised when VIGAMOX® solution is administered to a nursing mother.

**Pediatric Use:** The safety and effectiveness of VIGAMOX® solution in infants below 1 year of age have not been established.

There is no evidence that the ophthalmic administration of VIGAMOX® solution has any effect on weight bearing joints, even though oral administration of some quinolones has been shown to cause arthropathy in immature animals.

**Geriatric Use:** No overall differences in safety and effectiveness have been observed between elderly and younger patients.

#### ADVERSE REACTIONS:

The most frequently reported ocular adverse events were conjunctivitis, decreased visual acuity, dry eye, keratitis, ocular discomfort, ocular hyperemia, ocular pain, ocular pruritus, subconjunctival hemorrhage, and tearing. These events occurred in approximately 1-6% of patients. Nonocular adverse events reported at a rate of 1-4% were fever, increased cough, infection, otitis media, pharyngitis, rash, and rhinitis.

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## EAR, NOSE, AND THROAT URGENCIES

medical, traumatic, or idiopathic in origin. Retropharyngeal abscesses occur most commonly in children <6 years of age.

Signs and symptoms include a prodromal nasopharyngitis with an abrupt onset of fever and dysphagia. These children will exhibit trismus and drooling, as well as limitation of neck movement with extension. Respiratory distress and stridor are late signs.

Retropharyngeal abscesses are most commonly caused by streptococcus viridans, streptococcus pyogenes, staphylococcus epidermidis, or staphylococcus aureus. *Haemophilus influenza*, *Klebsiella*, and anaerobes are other important causes.

Widening of the retropharyngeal space and bulging soft tissue of the posterior pharynx can be seen on lateral neck radiograph. CT scan with intravenous contrast can help distinguish between a true abscess and cellulitis. A chest radiograph can be useful in evaluating for the potential complications of aspiration pneumonia or mediastinitis.

### Treatment

Treatment includes the initiation of intravenous antibiotics and admission to the hospital. Early involvement with an ENT specialist to evaluate the need for surgical intervention is paramount.

### Postoperative Tonsillectomy Bleeding

Tonsillectomy is one of the most common surgical procedures performed in children. As the procedure is commonly performed in the outpatient setting, postoperative bleeding can present to the urgent care practitioner.

Primary hemorrhage occurs within the first 24 hours and most commonly in the postanesthesia care unit. Secondary or delayed hemorrhage can occur up to 21 days postoperatively, but most commonly between days 5 to 10. Approximately 3% of children will have a delayed hemorrhage.

In evaluating the child with a postoperative bleed, first and foremost, keep the child calm. Consult with the ENT provider and alert him or her to the presence of an adenoidectomy, operative complication, and/or prior hemorrhage.

On exam, vital signs, presence of frank bleeding, oozing or clot, and the presence of eschar are all important to relay, as well. Often, complete blood count and coagulation studies are indicated, along with intravenous hydration.



### Treatment

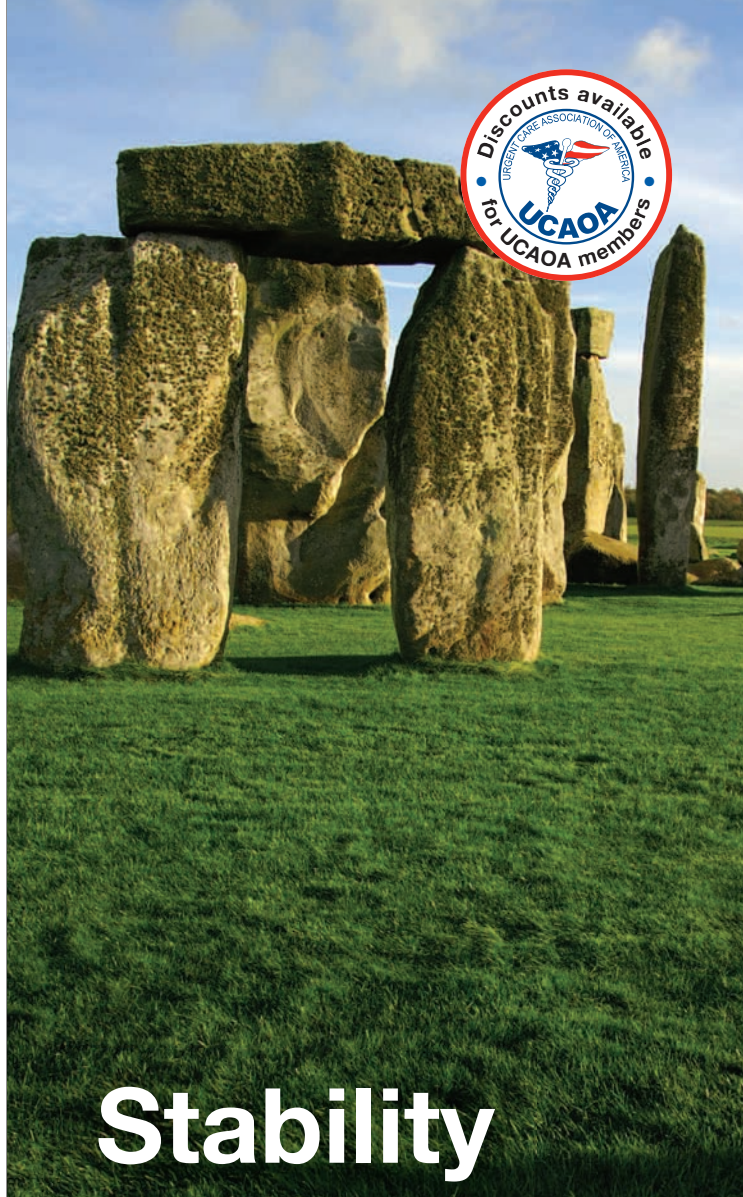
If a clot is present, do not remove it. If there is severe, active bleeding, use gauze and apply digital pressure. Often, these children will need intervention in the emergency department or operating room by their ENT provider.

### Summary

Many infections and injuries to the pediatric ear, nose, or throat can be evaluated and treated in the urgent care setting. An understanding of the more severe infections and injuries is important for the practitioner. Recognizing these entities—and prompt referral to the ENT specialist or emergency department—will ensure appropriate care for the patient. ■

### Resources

- Subcommittee on Management of Sinusitis and Committee on Quality Improvement. Clinical practice guideline: Management of sinusitis. *Pediatrics*. 2001;108(3):798-808.
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## Here Comes the Sunburn: An Update

**Urgent message:** The advent of warmer weather is a reminder that many otherwise sensible Americans fail to heed warnings to use adequate protection from the sun. The urgent care clinician can expect to see more patients presenting with varying degrees of sunburn.

Deepthi Samindla, MBBS, Beth Braig, BA, Mikayla L. Spangler, PharmD, Shailendra K. Saxena, MD, PhD

### Introduction

Sunburn is an acute cutaneous inflammation secondary to excessive exposure to solar ultraviolet (UV) radiation. About 30% to 40% of adults and 70% to 85% of children and adolescents in the United States experience an episode of sunburn every year.<sup>1</sup> It is estimated that 80% of a person's sun exposure occurs before the age of 21.<sup>2</sup>

Hence, lifestyle modifications early in life play a crucial role in the prevention of sunburn and other, long-term, harmful effects of solar radiation.

In this article we provide updated information about sunburn's symptoms, pathogenesis, treatment, and prevention.

### Pathogenesis

Solar UV rays can be classified into UV-A (340 nm to 400 nm) and UV-B (290 nm to 320 nm).

UV-B light is 1,000 times more erythemogenic than UV-A and can induce DNA mutagenesis; therefore, it is more

damaging to the skin.

DNA damage, induction of p53, and generation of reactive oxygen species seem to be the major mechanisms of UV-B related skin damage.

Histologically, sunburn affects the stratum spinosum of skin epithelium. Dyskeratotic cells, also known as sunburn cells, are usually seen in this layer within 24 hours of exposure to UV light.

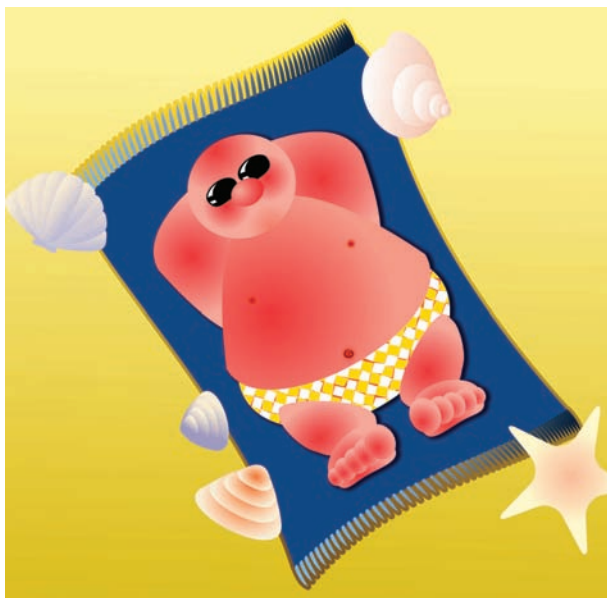
The pathogenesis of UV radiation related skin damage is summarized in **Figure 1**.

### Risk Factors

The two major factors determining the development of sunburn are the amount and duration of exposure to sunlight and patient susceptibility.

Numerous environmental and biologic factors increase susceptibility to sunburn (**Table 1**). A history of sunburn, especially following low-intensity sunlight exposure, is a strong predictor of recurrent sunburn.

Contrary to popular belief, cloudy days are not associated with decreased risk of sunburn, as 80% of the UV

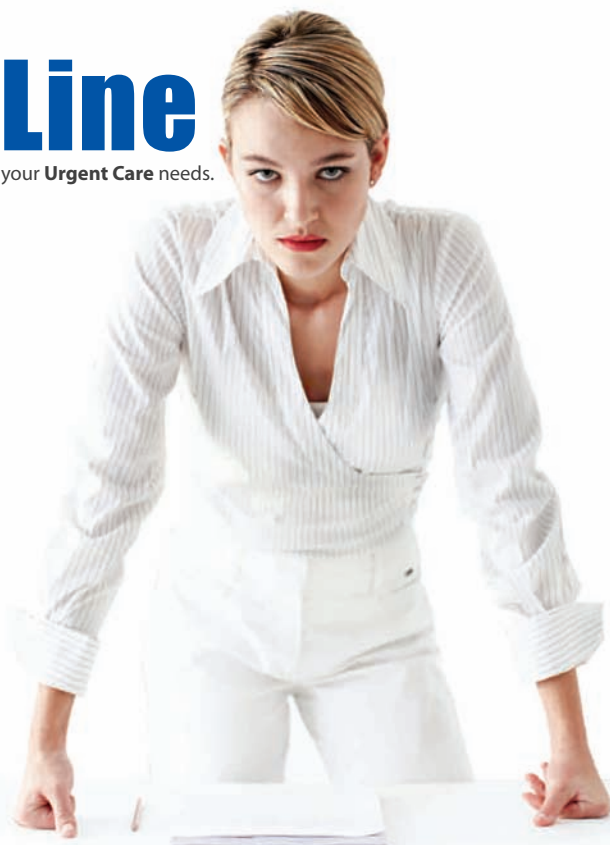


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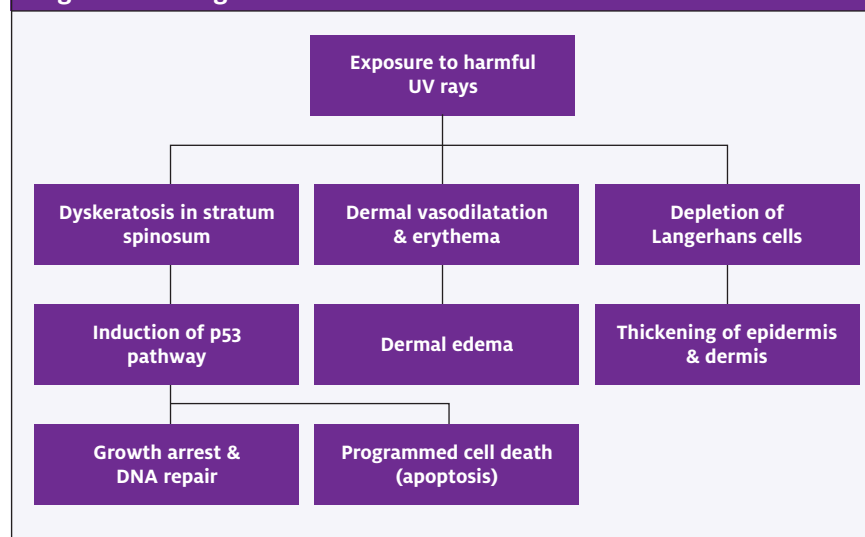


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**Figure 1. Pathogenesis of sunburn.**



**Table 1. Factors Increasing Susceptibility to Sunburn**

| <i>Environmental</i>  | <i>Biologic</i>  |
|---|--|
| <ul style="list-style-type: none"> <li>• Proximity to equator or residence in sunbelts</li> <li>• High altitude</li> <li>• Amount of outdoor activity (occupational/recreational)</li> <li>• Use of photosensitizing medications                             <ul style="list-style-type: none"> <li>– Retin A</li> <li>– Psoralens</li> <li>– Antihistamines</li> <li>– Oral contraceptives</li> <li>– Sulfas</li> <li>– Tetracyclines</li> <li>– NSAIDs</li> <li>– Anticonvulsants</li> <li>– Furosemide</li> <li>– Thiazides</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>• Caucasian ethnicity</li> <li>• Light hair and eyes</li> </ul> |

rays can penetrate the clouds. In addition, for every 100 feet above sea level, radiation increases 4% to 5%.<sup>2</sup>

A simple classification of skin phototypes based on response to initial sun exposure proposed by Fitzpatrick is depicted in Table 2.<sup>3</sup>

### Clinical Manifestations and Diagnosis

Clinical manifestations of sunburn can range from painless erythema to blistering and second-degree burns (Fig-

ure 2 and Figure 3).

Common complaints include pain, redness, burning, blistering, and swelling. Physical signs include erythema, warmth, tenderness, edema, and blistering. Erythema develops three to four hours after exposure and peaks around 12 to 24 hours. Scaling and desquamation are late signs and are often noted four to seven days after exposure. Diagnosis is usually based on history of exposure to sunlight, typical symptoms, and the characteristic appearance of sun-exposed skin.<sup>4</sup>

### Prevention

The following measures may help prevent sunburn and other unde-

sirable effects of sunlight (i.e., photoaging, actinic keratosis, and dermatologic malignancies such as melanoma and basal cell carcinoma).<sup>2</sup>

1. Avoidance. Avoiding direct exposure to sunlight, especially during summer between 10 a.m. and 4 p.m. Patients should be educated that cloudy days offer no protection against harmful UV radiation.
2. Sun-protective clothing. Clothing filters out the sun's rays. Covering up with a wide brimmed hat, sunglasses with appropriate sun blockade, and wearing loose-fitting clothing with long sleeves provide sun protection.

Summer clothing usually provides limited protection because of the looseness of the weave, typically ranging from 2 to 6.5 Sun Protection Factor (SPF); SPF estimates the protection offered by clothing or sunscreen or sunblock against sunburn. Synthetic materials used in sun-protective garments have tighter-woven fabric and provide greater protection. These specialized garments demonstrate high solar protection in studies despite color or moisture content.<sup>2,5</sup>

3. Sunscreens. The current gold standard for photo protection is sunscreen.<sup>2</sup> If an individual develops erythema after 10 minutes of direct sun exposure, the use of SPF 15 sunscreen would prevent erythema from a similar intensity exposure of about 150 minutes. Sunscreens are classified as either physical/inorganic or chemical/organic sunscreens.

*Physical sunscreens* contain inert minerals such as titanium dioxide, zinc oxide, or talc and work by reflecting UV-A and UV-B rays away from the skin. Aestheti-

**Table 2. Skin Phototypes**

| <i>Skin type</i> | <i>Description</i>                  | <i>Skin color</i> | <i>Recommended SPF for outdoor activity</i> |
|------------------|-------------------------------------|-------------------|---|
| I                | Always burns, never tans            | White             | 25-30                                       |
| II               | Always burns, tans minimally        | White             | 25-30                                       |
| III              | Burns minimally, tans slowly        | White             | 15  |
| IV               | Burns minimally, tans well          | Olive             | 15  |
| V                | Rarely burns, tans profusely/darkly | Brown             | 15  |
| VI               | Rarely burns, always tans           | Black             | 15  |

cally unappealing qualities limit their use.

*Chemical sunscreens* are sub-classified based on their ability to absorb UV-A, UV-B, or both. **Table 3** lists the various chemicals used in sunscreens, as well as their spectrum of protection.<sup>6</sup> Most sunscreens available today have a combination of UV-A and UV-B protective chemicals.

Choosing an appropriate sunscreen from the wide array of products is challenging. Certain products have received a Seal of Recommendation from the Skin Cancer Foundation, awarded to products that have proven to safely and sufficiently "aid in the prevention of sun-induced damage to the skin."<sup>7</sup> A minimum SPF of 15 for adults and 25 for children is recommended.

Use of sunscreens in children <6 months of age is not recommended.<sup>8</sup>

Products with an SPF above 30 offer little additional benefit and may expose the individual to potentially harmful levels of chemicals.<sup>2,6,8</sup>

Uniform and proper application of an appropriate sunscreen is essential to achieve full benefits and is outlined in **Table 4**.<sup>8</sup>

### **Treatment**

Symptomatic therapy is the mainstay of management of acute sunburns. A number of treatments aimed at altering the course of sunburn have been explored, but no conclusive evidence supporting their use exists at present.<sup>9</sup>

#### *NSAIDs*

The use of NSAIDs has been studied in the treatment of sunburn. Both topical (e.g., diclofenac 0.1% gel) and oral NSAIDs have been shown to decrease erythema and pain. However, the beneficial effects, especially of topical preparations, decrease after the initial 24 hours.

#### *Corticosteroids*

Although corticosteroids have anti-inflammatory effects, neither topical nor systemic use has been shown to effect clinical improvement compared with placebo.<sup>9</sup> Similarly, prednisone 80 mg given 24 hours before exposure has not been shown to improve symptoms when compared with placebo.

Combining topical corticosteroids with oral NSAIDs has been shown to be more efficacious than either agent alone.

*Continued on page 30*

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## ABSTRACTS IN URGENT CARE

# On Anaphylaxis, STIs in Adolescents, Rectal Impaction, Hip and Pelvic Fractures, Saying 'No' to Patients, Wait Time and Visit Length, and Cardiac Death in Athletes

■ 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.

### Emergency Treatment of Anaphylactic Reactions

**Key point:** *Early treatment with intramuscular adrenaline is the treatment of choice for patients having an anaphylactic reaction.*  
Citation: Pumphrey R, Cant A, Clarke S, et al. Emergency treatment of anaphylactic reactions—Guidelines for health-care providers. *Resuscitation*. 2008;77(2):157-169.

Patients experiencing an anaphylactic reaction have life-threatening airway and/or breathing and/or circulation problems usually associated with skin or mucosal changes. Such patients should be treated using the ABCDE approach: airway, breathing, circulation, disability, exposure.

Exact treatment will depend on the patient's location, the equipment and drugs available, and the skills of those treating the anaphylactic reaction, but the treatment of choice is intramuscular adrenaline.

- Despite previous guidelines, there is still confusion about the indications, dose, and route of adrenaline.
- Intravenous adrenaline must only be used in certain specialist settings and only by those skilled and experienced in its use.
- All those who are suspected of having had an anaphylactic reaction should be referred to an allergy specialist.



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

- Individuals who are at high risk of an anaphylactic reaction should carry an adrenaline auto-injector and receive training and support in its use. ■

### STIs in Adolescents

**Key point:** *The estimated prevalence of STIs in adolescent girls ranged from 14% at age 14–15 to 34% at age 18–19.*

Citation: Forhan SE, Gottlieb SL, Sternberg MR, et al. Prevalence of sexually transmitted infections among female adolescents aged 14 to 19 in the United States. *Pediatrics*. 2009;124:1505-1512.

Sexually transmitted infections (STIs) often accompany initiation of sexual activity. Researchers tested a random sample of 838 female adolescents (14- to 19-years-old) who participated in the National Health and Nutrition Survey 2003–2004 for *Chlamydia trachomatis*, *Neisseria gonorrhoeae*, *Trichomonas vaginalis*, herpes simplex virus type 2 (HSV-2), and human papillomavirus HPV; 23 oncogenic types or type 6 or 11.

The prevalence of infection with any STI was 24% and varied by age from 14% at age 14–15 to 34% at age 18–19. Half the adolescents reported sexual experience; STI prevalence ranged from 20% among those who reported one partner to 53% among those who reported three or more partners.

According to the authors, this is the first published, nationally representative survey of the prevalence of common STIs among U.S. female adolescents.

[Published in *J Watch Pediatr Adolesc Med*, January 6, 2010—Howard Bauchner, MD.] ■



## Treating Rectal Impaction: From Above or Below?

**Key point:** Enemas and high-dose PEG are equally effective for treating impaction.

**Citation:** Bekkali N-L-H, van den Berg M-M, Dijkgraaf MGW, et al. Rectal fecal impaction treatment in childhood constipation: Enemas versus high doses oral PEG. *Pediatrics*. 2009;124(6):e1108-e1115.

Functional constipation in children can lead to rectal fecal impaction (RFI), which can cause pain and encopresis. Both oral and rectal treatments for RFI are effective, but they have not been compared prospectively.

Investigators in the Netherlands randomized 90 children (age range, 4–16 years) with functional constipation and RFI to receive oral polyethylene glycol (PEG; 1.5 g/kg/day) for six days or dioctyl sodium sulfosuccinate (docusate) enemas once daily for six days.

After six days, all children received maintenance therapy with PEG (0.5 g/kg/day).

Successful disimpaction after six days occurred in 80% of

children in the enema group and in 68% of children in the PEG group.

After the six-day disimpaction regimen, the mean frequency of fecal incontinence improved from 16 to three episodes per week in the enema group but remained at 13 episodes per week in the PEG group.

Two weeks after disimpaction, each group had a mean of five incontinence episodes per week. Watery stools were more common in the PEG group after disimpaction and at two-week follow-up. Colonic transit time improved equally in the two groups. Behavior scores indicated equal levels of anxiety in both groups during disimpaction.

More children in the enema group than in the PEG group experienced abdominal pain after treatment (82% vs. 52%).

This study suggests that a week of either daily enemas or high-dose oral PEG can successfully disimpact most children with rectal fecal impaction.

[Published in *J Watch Pediatr Adolesc Med*, January 27, 2010—Cornelius W. Van Niel, MD.] ■

*Continued on page 32*

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### Important Risk and Safety Information

- Published clinical trials support the use in children three years of age and older
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- Over spraying may cause frostbite
- Freezing may alter skin pigmentation
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## INSIGHTS IN IMAGES

# CLINICAL CHALLENGE

In each issue, *JUCM* will challenge your diagnostic acumen with a glimpse of x-rays, electrocardiograms, and photographs of dermatologic conditions that real urgent care patients have presented with.

If you would like to submit a case for consideration, please e-mail the relevant materials and presenting information to [editor@jucm.com](mailto:editor@jucm.com).



The patient is a 50-year-old female who presents with pain in her right thumb after taking a fall.

On examination, you note local swelling at the base of the thumb. The patient confirms this is the site of her pain, as well.

View the image taken (**Figure 1**) and consider what your diagnosis and next steps would be.

Resolution of the case is described on the next page.

## THE RESOLUTION



The x-ray shows a Bennett's fracture dislocation.

As noted in *Wheeless' Textbook of Orthopaedics* ([www.wheelessonline.com](http://www.wheelessonline.com)), this fracture dislocation is an intra-articular fracture occurring at the base of the carpometacarpal joint of the thumb.

Patients who experience this most common of all thumb fractures should be referred to hospital for reduction and management by orthopedist.

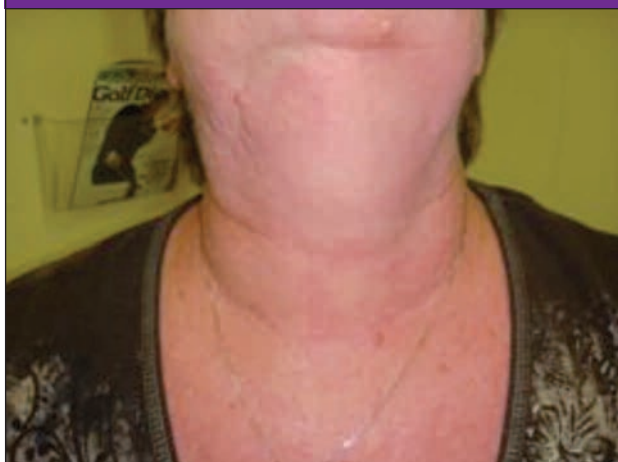
*Acknowledgment: Case presented by Nahum Kovalski, BSc, MDCM, Terem Emergency Medical Centers, Jerusalem, Israel.*

*This case is one of hundreds that can be found in Terem's online X-ray Teaching File, with more being added daily. Free access to the file is available at <https://www2.teremi.com/xrayteach/>. A no-cost, brief registration is required.*

**Figure 2. 10-year-old boy with sunburn.**



**Figure 3. 60-year-old female with sunburn on exposed areas only.**



#### Emollients

Limited data exist on the use of emollients after sunburn.

#### Antioxidants

The role of antioxidants in prevention and treatment of sunburn remains questionable. No definitive evidence exists to justify the widespread use of substances such as vitamins, melatonin, or thiamazole for erythema due to sun exposure.<sup>9</sup>

#### Summary of Recommendations

The following constitutes a basic guide for patients (and providers) wishing to avoid excessive exposure to solar UV radiation.

- Avoid the sun, especially between 10 a.m. and 4 p.m.
- Wear protective clothing, including a hat, long-

**Table 3. Active Ingredients in Sunscreens**

| UV-A absorbers    | UV-B absorbers   | UV-A & UV-B absorbers  |
|-------------------|--|--|
| Dibenzoylmethanes | <ul style="list-style-type: none"> <li>• Cinnamates</li> <li>• Camphor derivatives</li> <li>• Para-amino benzoate (PABA) derivatives</li> <li>• Salicylates</li> </ul> | <ul style="list-style-type: none"> <li>• Benzophenones</li> <li>• Triazoles</li> </ul> |

**Table 4. Appropriate Use of Sunscreens**

| Correct use  | Incorrect use   |
|--|---|
| <ul style="list-style-type: none"> <li>• Liberal uniform film of sunscreen</li> <li>• Apply 15 minutes before sun exposure</li> <li>• Apply adequate amount (30 ml or 1 oz./body application)</li> <li>• Reapply twice hourly and after swimming/heavy sweating</li> </ul> | <ul style="list-style-type: none"> <li>• Applied too thinly or rubbed too vigorously</li> <li>• Using sunscreen to prolong time in sun</li> <li>• Inadequate SPF</li> </ul> |

sleeved shirt, and long pants made of closely woven fabrics.

- Use a sunscreen with an SPF of 15 to 30 for children over 6 months of age and for adults.
- Wear sunglasses that protect from UV-A and UV-B light.
- Beware of reflected light from sand, cement, water, and snow.
- Be more careful at high altitudes.
- Avoid the sun if you are taking certain medications or have a condition that makes you photosensitive.
- The only treatment currently recommended is symptomatic. ■

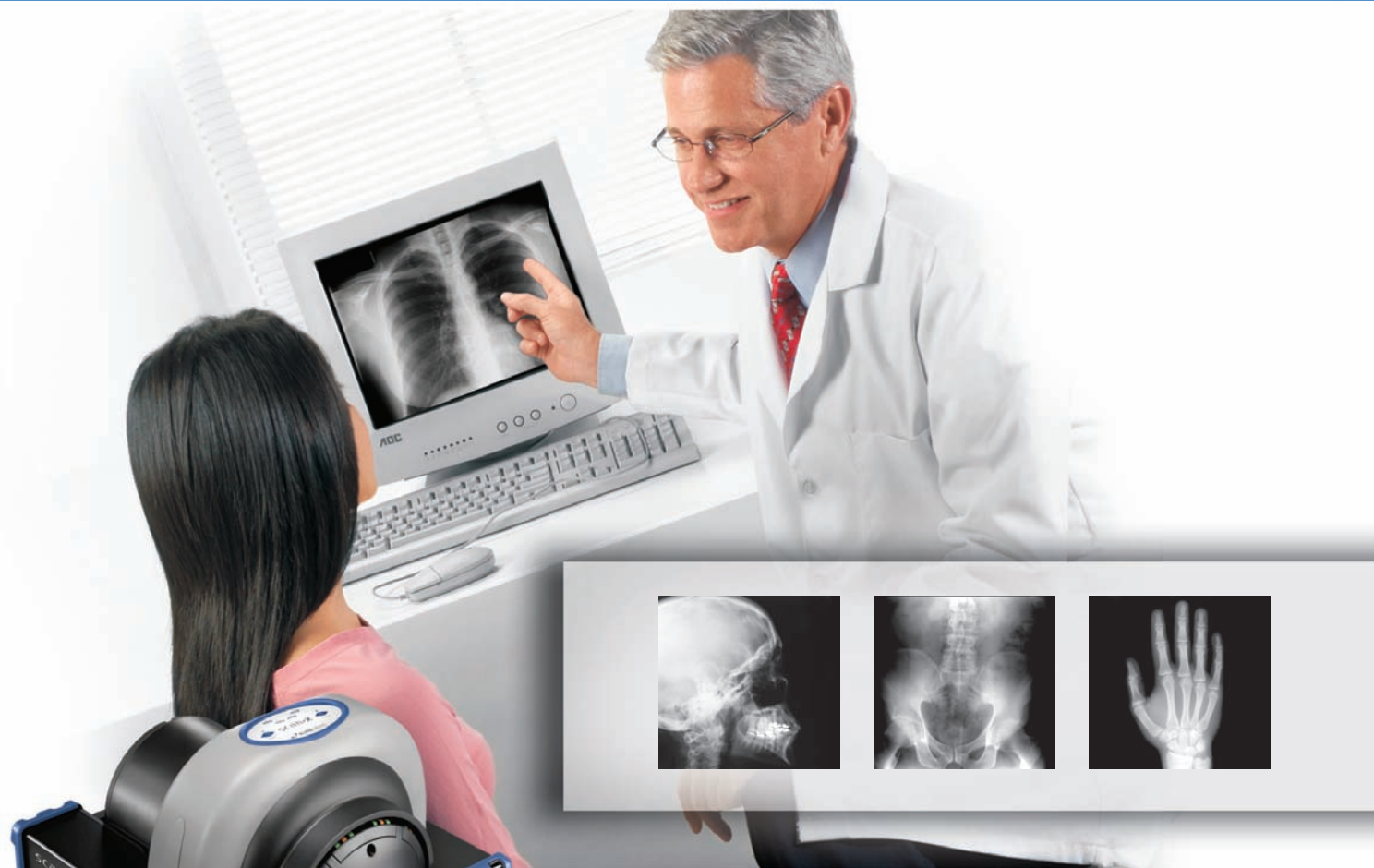
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## **Radiographic Detection of Hip and Pelvic Fractures in the Emergency Department**

**Key point:** A new study has found that standard x-rays are often inconclusive in detecting hip and pelvic fractures in the emergency room.

**Citation:** Kirby MW, Spritzer C. Radiographic detection of hip and pelvic fractures in the emergency department. *AJR*. 2010;194:1054-1060.

Researchers studied 92 patients who underwent x-rays followed by MRI to evaluate hip and pelvic pain. The patient sample included 77 women and 15 men, with an average age of 70.8 years; 65 of these patients had a history of trauma.

The x-ray exams of all patients were reviewed retrospectively by one experienced musculoskeletal radiologist who was blinded to the results of each radiographic and MRI exam. Those obtained within one calendar day prior to the MRI were reviewed first, and MR images were assessed for fractures, bursitis, tendinopathy, muscle injury, and other causes of pain.

Radiographs were considered to be either positive or suggestive of a fracture in 26 patients. In 11 of those patients, MRI showed no fracture. In the other 15 patients, MRI detected 12 additional pelvic fractures not identified on x-rays. Thirteen patients with normal radiograph findings were found to have a total of 23 fractures by MRI. ■

## **Strategies for Saying ‘No’ to Patients**

**Key point:** Outright rejection resulted in the lowest patient satisfaction.

**Citation:** Paterniti DA, Fancher TL, Cipri CS, et al. Getting to ‘no’: Strategies primary care physicians use to deny patient requests. *Arch Intern Med* 2010. 170(4):381-388.

Patients ask for specific medications in 10% of office visits, according to some studies. To evaluate physician strategies for saying “no” to such requests, U.S. researchers assigned 18 trained and scripted standardized patients to visit physicians and to request antidepressants.

The patients were insured middle-aged white women who presented with histories consistent with depression or adjustment disorder and with low back pain or wrist pain.

Patients requested antidepressants during 199 of the visits; prescriptions were denied in 36% of visits in which patient histories were consistent with depression and in 53% consistent with adjustment disorder. Strategies used for denying requests included:

- patient-perspective-based approach (focus on patient history and circumstances and offer alternative diagnosis), 63%
- biomedical-based approach (prescribe sleep aid, order diagnostic tests), 31%
- outright rejection, 6%.

Many physicians who used patient-perspective-based strate-

gies left the door open to prescribing an antidepressant at a later date and often referred the patient for further evaluation.

Some physicians who used the biomedical-based approach prescribed a different agent (e.g., trazodone for insomnia symptoms) or ordered further testing (e.g., thyroid-stimulating hormone level) as an alternative to prescribing the requested agent.

In a few instances, physicians rejected the request outright and quickly moved the discussion to the back or wrist pain.

Standardized patients who were offered an alternative diagnosis reported greater visit satisfaction than those who were referred for additional diagnostic testing or were rejected outright.

[Published in *J Watch Gen Med*, March 18, 2010—Jamaluddin Moloo, MD, MPH.] ■

## **Emergency Department Wait Time and Visit Length: Up, Up, and Away**

**Key point:** Wait times and visit length vary widely among EDs.

**Citation:** Horwitz LI, Green J, Bradley EH, et al. U.S. emergency department performance on wait time and length of visit. *Ann Emerg Med*. 55(2):133-141.

The National Quality Forum has endorsed a set of consensus standards for emergency care quality that include measures of ED wait time and visit length for admitted and discharged patients.

In a retrospective cross-sectional study, these authors used data from the 2006 National Hospital Ambulatory Medical Care Survey to examine wait time and visit length for a random sample of 35,849 patient visits to 364 U.S. EDs.

Mean and median wait times were 52.4 and 34.0 minutes, respectively. Mean and median visit length were 4.9 and 4.3 hours, respectively, for admitted patients and 3.0 and 2.3 hours, respectively, for discharged patients.

As we continue to grapple with increasing patient volumes and illness acuity, we need to be prepared for the fact that hospital-specific ED quality metrics, including wait time and visit length, will be publicly reported. Although bringing this information into the public domain may help emergency physicians press their case for more resources, meaningful change will require significant process redesign.

[Published in *J Watch Emerg Med*, March 12, 2010—Richard D. Zane, MD, FAAEM.] ■

## **Preventing Sudden Cardiac Death in Athletes**

**Key point:** Screening, theoretically, is cost-effective, but many practical barriers remain.

**Citations:** Wheeler MT, Heidenreich PA, Froelicher VF, et al. Cost-effectiveness of preparticipation screening for prevention of sudden cardiac death in young athletes. *Ann Intern Med* 2010;152(5):276-286.

Baggish AL, Hutter AM, Wang F, et al. Cardiovascular screening in college athletes with and without electrocardiography:

A cross-sectional study. *Ann Intern Med.* 2010;152(5):269-275.  
Maron BJ. National electrocardiography screening for competitive athletes: Feasible in the United States? *Ann Intern Med.* 2010;152(5):324-326.

About 90 young U.S. athletes suffer sudden cardiac death (SCD) annually. The International Olympic Committee and other organizations recommend electrocardiography (ECG) screening for athletes. In two studies, researchers explored this proposal for U.S. high school and college athletes.

In a decision analysis, investigators modeled the efficacy and costs for one-time screening of student athletes for known SCD risk factors (e.g., prolonged QT interval, left ventricular hypertrophy), considering published estimates of prevalence, screening accuracy, SCD risk, screening and follow-up costs, and treatment effectiveness.

History and physical examination (H&P) alone saved 0.56 life-years per 1,000 athletes screened at a cost of \$199,000 per life-year saved compared with no screening. Adding ECG to H&P saved an additional 2.1 life-years per 1,000 athletes screened at a total cost of about \$76,000 per life-year saved. ECG alone was more cost-effective than H&P alone.

In the second study, 510 Harvard University athletes were screened with H&P, ECG, and transthoracic echocardiography (TTE; the gold standard). Clinicians who performed ECG and TTE were blinded to H&P results and vice versa. Of 11 TTE findings considered to be significant, five were identified by H&P alone, and five were detected by ECG alone; of three TTE findings that resulted in restriction from sports participation, one was identified by H&P alone, and two were detected by ECG alone. However, 78 athletes (15%) exhibited abnormalities on ECG that were false-positives and did not result in restriction from sports; many of these "abnormalities" (e.g., increased QRS voltage) represented physiologic remodeling.

The authors of the first study note that actual ECG interpretations are highly variable and that a high threshold for suspicion was used in the theoretical model. An editorialist notes that most SCD occurs in non-athletes, that a widespread U.S. program would cost about \$2 billion initially (and that cost would recur if screening was performed annually), and that substantial legal liability could accrue to physicians who must enforce disqualification decisions.

[Published in *J Watch Gen Med*, March 11, 2010—Thomas L. Schwenk, MD.] ■

## Afraid you missed something?



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# Practice Management

## Beyond Vital Signs: Managing by Metrics for Optimal Health of Your Practice

**Urgent message:** Establishing a system of metrics and ‘dashboards’ allows the urgent care operator to quantify key success factors and company values that may otherwise be impossible to measure.

Laurel Stoimenoff

**Metric**—Function: noun \‘me-trik\ Def: A standard of measurement — *Merriam Webster Online Dictionary*.

“What gets measured gets managed.” This pearl applies not only to the behemoths like General Electric, but also to a single-site urgent care center.

A 2008 survey by the Urgent Care Association of America revealed that the average net revenue for an urgent care clinic was in excess of \$1.4 million. In my capacity as president and chief operating officer of NextCare, I often remind our clinic managers that while they perceive themselves as being in the business of healthcare, they are also running a million dollar *business*.

To facilitate their ability do that, it is my responsibility to give them the tools that they need to succeed. It is also the charge of the organization’s leadership to as-



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sure that the company’s goals are aligned, and that all clinic and department managers are collectively focused on the short- and long-term strategies and objectives of the organization.

Establishing the right “dashboard” and relentlessly benchmarking and communicating results is an essential strategy. The information age facilitates and almost obligates us to do so as responsible managers.

An entire *business intelligence* industry has emerged, with software programs prepared to crawl through data points and create a

multitude of pie charts, bar graphs, Pareto diagrams, trends, and variances. But you need not be a technologically advanced or a multi-site urgent care company to create your own dashboard on a spreadsheet and utilize the data to produce meaningful improvement in processes and outcomes. The data may simply require



# In the Realm of the Ear, the mighty always go forth with CIPRODEX® Otic.



## The powerful combination of an antibiotic and an anti-inflammatory to defeat acute otitis externa (AOE) or acute otitis media with tympanostomy tubes (AOMT)<sup>1</sup>

- ✱ In well-controlled clinical trials, CIPRODEX® Otic cured more patients with AOE than CORTISPORIN® Otic<sup>†</sup> and more patients with AOMT than ofloxacin<sup>1‡</sup>
- ✱ 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<sup>1</sup>



Why trust the realm to anything less  
than the #1 otic drop among otolaryngologists?<sup>2</sup>

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%).

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

<sup>‡</sup>Clinical cures: CIPRODEX® Otic vs ofloxacin (86% vs 79%) per protocol and (90% vs 79%) culture positive.

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Please see adjacent page for prescribing information.



# **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 antibacterial agent, ciprofloxacin hydrochloride, combined with the anti-inflammatory corticosteroid, dexamethasone, in a sterile, preserved suspension for otic use. Each mL of CIPRODEX® Otic contains ciprofloxacin hydrochloride (equivalent to 3 mg ciprofloxacin base), 1 mg dexamethasone, and 0.1 mg benzalkonium chloride as a preservative. The inactive ingredients are boric acid, sodium chloride, hydroxyethyl cellulose, tyloxapol, acetic acid, sodium acetate, edetate disodium, and purified water. Sodium hydroxide or hydrochloric acid may be added for adjustment of pH.

Ciprofloxacin, a fluoroquinolone is available as the monohydrochloride monohydrate salt of 1-cyclopropyl-6-fluoro-1,4-dihydro-4-oxo-7-(1-piperazinyl)-3-quinolonecarboxylic acid. The empirical formula is C<sub>17</sub>H<sub>18</sub>FN<sub>3</sub>O<sub>3</sub>·HCl·H<sub>2</sub>O. Dexamethasone, 9-fluoro-11(beta),17,21-trihydroxy-16(alpha)-methylpregna-1,4-diene-3,20-dione, is an anti-inflammatory corticosteroid. The empirical formula is C<sub>22</sub>H<sub>29</sub>F<sub>05</sub>.

## CLINICAL PHARMACOLOGY

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

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

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

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

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

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

## CONTRAINDICATIONS

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

## WARNINGS

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

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

## PRECAUTIONS

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

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

## Pregnancy

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

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

## ADVERSE REACTIONS

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

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

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

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

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

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

## DOSE AND ADMINISTRATION

**CIPRODEX® OTIC SHOULD BE SHAKEN WELL IMMEDIATELY BEFORE USE**

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

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

## HOW SUPPLIED

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

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

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U.S. Patent Nos. 4,844,902; 6,284,804; 6,359,016

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Rx Only

Revision date: 17 July 2003

a greater investment of time and resources to gather and populate than if you had a business intelligence solution, but it is no less available and just as valuable.

### Overview

The process utilized internally by our company begins with an annual strategic planning session as the precursor to the budget process. We reevaluate our direction and, typically, tweak the plan that has been established based on internal and external forces.

Following that meeting, sales and marketing plans are established and the clinic-level budget process begins. A dashboard is subsequently developed for the coming year, highlighting our fundamental strategies and objectives, extending well beyond the financial metrics. Each individual business unit may also have some unique categories the manager may want to measure and monitor, but they cannot ever be allowed to trump the overall company goal.

In the song, “Sittin’ on the Dock of the Bay”, Otis Redding laments, “I can’t do what 10 people tell me to do, so I guess I’ll remain the same.” In our turbulent and evolving medical climate, we simply cannot afford to *remain the same*, and our dashboard serves as the constant that tells every executive, every manager, and every provider and employee what is important to us.

Conversely, we limit those metrics circulated among our associates so we don’t end up like Otis Redding—stuck in the status quo by virtue of being overburdened. This signifies one overarching business strategy and one consistent message. Innovation is encouraged, but not if it conflicts with our organizational direction.

### Fundamental Metrics and Beyond

Organizational “vital signs” are the obvious things that we must consider every day to keep our doors open and pay our employees and our bills. These fundamental metrics are those that allow your clinic to remain viable.

Understanding your patient volume break-even numbers, good billing practices, and cash controls are the “vitals.” We look at dashboarding as going well *beyond* managing the vital signs, while clarifying to all employees what is important to the organization.

Recently, I listened to a presentation on establishing your organization’s “wildly important goals,” or “WIGs.” The WIGs are subsequently achieved through the identification and communication of lead and lag indicators. In the lecture, the presenter emphasized the importance of creating a “player’s scorecard” for the employees vs. generating what is typically a more complex

**Table 1.**

| Balanced Scorecard          | Company Value |
|-----------------------------|---------------|
| Financial                   | Results       |
| Customer                    | Caring        |
| Internal Business Processes | Integrity     |
| Learning & Growth           | Excellence    |

and potentially confusing “coach’s scorecard.”

The player’s scorecard is one that can be easily understood within five seconds by any employee in the company. Our 2010 Clinic Scorecard was culled down from the one we utilized in 2009 to achieve that objective. We limited the number of metrics by which they would be measured against one another and our internal goals, but also simplified the metrics themselves. “Players” want to know the score and if they are winning. While a senior executive or board member may want to know the return on invested capital (ROIC), this is not a relevant metric to a front office clinic employee.

Our historical dashboard had what senior management deemed a very meaningful metric. It was computed using the number of full-time equivalent employees (FTEs) by the number of total patient visits by the average acuity level of the patient, based on E&M coding. This allowed us to give credit to those clinics that had to utilize more staff due to greater overall patient complexity.

This metric was a failure because it was entirely too complex and was, therefore, disregarded by all. Lesson learned.

An excellent reference for establishing your metric management tool is the well-known book by Robert Kaplan and David Norton, *The Balanced Scorecard*. Kaplan and Norton strongly recommend that a business’s metrics fall into four basic categories:

- Financial
- Internal Business Processes
- The Customer
- Learning & Growth.

In our quest to not only convey the importance of our internal metrics with our strategy, we also wanted to stress the importance of how those metrics aligned with our company’s stated values—Caring, Excellence, Integrity, and Results.

Taking Kaplan and Norton’s recommendations, we modified, compartmentalized, and ultimately communicated our 2010 clinic dashboard into the following the “headlines” listed in **Table 1**, each bearing its own set of key metrics.

Each organization and each business unit must determine what is important to it by category. For example, a “customer” metric in a billing office might be “all calls





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**Figure 1. The knowledge pyramid.**



returned within 24 hours;" a clinic customer metric is more likely to relate to patient satisfaction scores and likelihood to return or refer others.

We consider employees to be our "internal customers," so Employee Retention is a metric that we measure across all business units. With a stated goal to be the "employer of choice for the employees of choice," we stress hiring the right people and then coaching, communicating, and rewarding them so they stay. Our people are our greatest asset, and the metric demonstrates that to managers as well as the individual associate. The chosen metrics allow us to look at norms and outliers and intervene when the evidence suggests there may be a problem, and to evaluate those clinics that seem to be excelling.

Since negative and positive variances are often explained and not necessarily a harbinger of doom nor an assurance of success, we have recently elected to label these tables as "dashboards" versus "scorecards."

A negative measurement on a gauge on your automobile's dashboard may simply be the product of a faulty gauge, but it is a red flag that bears looking into until the variance is understood. The numbers are never a replacement for the Tom Peters 1980s acronym, MBWA (Management by Walking Around), but they sure make the walk more targeted and time well spent.

### **Dashboards**

Our dashboards are simple, aligned, and focused. This is not to say that we may not implement another



**Table 2. The Dos & Don'ts of Developing a Strategic Metric Plan**

| DO   | DON'T   |
|--|---|
| <ul style="list-style-type: none"> <li>■ Tie the metrics to the strategic planning process.</li> <li>■ Make sure everyone in the organization, from senior management to individual employees, understands what is being measured and why.</li> <li>■ Limit the number of measures to optimize understanding and usefulness. Focus on the truly crucial strategic variables.</li> <li>■ Use graphic format to display results to ease recognition and interrelationships, trends, and outliers.</li> <li>■ Link metrics to reward systems, where and when appropriate</li> <li>■ Accept uncertainty of the future, and anticipate some failures.</li> <li>■ Secure the commitment of senior management in the development and selection of measure and targets.</li> </ul> | <ul style="list-style-type: none"> <li>■ Limit metric development responsibilities to senior executives. Everyone in the organization should understand the process and contribute to it.</li> <li>■ Treat metric development as a one-time event.</li> <li>■ Wait for perfection of every detail.</li> <li>■ Introduce metrics only for compensation.</li> <li>■ Underestimate the cause and effect relationship between your metric and the desired outcome.</li> </ul> |

Adapted from: Staying on course with strategic metrics: Are you using strategic metrics? If not, you might be straying off course and not know it by Suzanne Krentz, Aaron DeBoer, and Sasha Preble, *Healthcare Financial Management*.

measurement throughout the year as we identify or update a wildly important goal, but the fundamental dashboard remains consistent and drives the clinic employee bonus plan.

Achieving budgeted earnings is not enough to attain a clinic bonus. Instead, the clinic must excel beyond the financial targets by also achieving those related to the customer, internal business processes, and learning and growth. The dashboards provide relevant information that allows each clinic to measure itself against not only the ultimate goal, but against each other.

A clinic manager can pick up the phone and call a



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colleague to determine why that particular clinic is excelling in a certain area. It fosters strategic and tactical discussions on continuous improvement, identifies our champions, and galvanizes the organization.

We also weight metrics differently by importance, which influences the aggregate sum.

Overall patient satisfaction may be weighted more in your practice than door-to-vitals time or relative value units/hour. It is up to you to consider what you most want to influence.

As you begin to analyze the data, you may find that door-to-vitals time is a leading indicator, statistically correlating with the overall patient satisfaction score.

Urgent care's on-demand approach to patient care is practiced by emergency departments and many outpatient laboratories, but it is certainly not the norm—hence, commanding a unique set of measurements such as wait time and door-to-vitals.

Our representations of these dashboards show the scores, aggregate scores, and weighting. Color-coding provides an additional visual illustration of whether or

not the team has exceeded the benchmark while also ranking each and every site in order of success.

Every manager has monthly review meetings with his or her supervisor. They are challenged to interpret the data and progress through the knowledge pyramid (**Figure 1**), wherein *data* becomes *information*, *information* becomes *knowledge*, and *knowledge* becomes *wisdom*. The expectation is that the *wisdom* gained then translates into *action*.

John Nash was the real-life troubled but brilliant mathematician portrayed by Russell Crowe, depicted in Ron Howard's movie, *A Beautiful Mind*. He saw numbers and equations in everything, ultimately being awarded the Nobel Prize for his gift and theories.

The leap from paper to information technology has accelerated our entry into the world of John Nash. Collecting the data is the first step. Identifying actions for improvement and executing them is essential. Information really is power—the power to improve clinical and operational performance and create a better place to work and to receive care.

And that is, indeed, a beautiful thing. ■

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# Practice Management

## The Case for Relationship-based Clerical Care

**Urgent message:** Embedding a clerical component within a relationship-based care approach has been shown to improve both financial outcomes and patient satisfaction.

Noel Clinton, BS

### Introduction

When we hear the term “relationship-based care,” we tend to think first about the relationship between the clinical staff and the patient. However, a prospective program at Bassett Healthcare in Cooperstown, NY has shown that positive patient care and improved financial outcomes are also a result of developing a “bedside” business relationship.

Bassett Healthcare Network is a system of physicians, providers, and hospital community health centers covering 5,000 square miles in eight New York counties. Around the region, the network provides primary, preventive, and outpatient care at 28 health centers—including urgent care at facilities in Herkimer and Oneonta, NY—and operates 13 school-based health centers.

The Emergency and Trauma Services Department for Bassett is responsible for providing the professional staff for this entire network, and implemented a process in which clerical staff initiate contact with patients at specific points during a visit.



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### Background

Significant growth within the network led to the addition of a management position whose mandate was to carry the department's patient care approach to the operational level. The primary focus for this individual, initially, was to deal directly with patient complaints. The ability to listen to patients in a non-judgmental manner and “getting to ‘yes’” was the building block for learning about patient expectations.

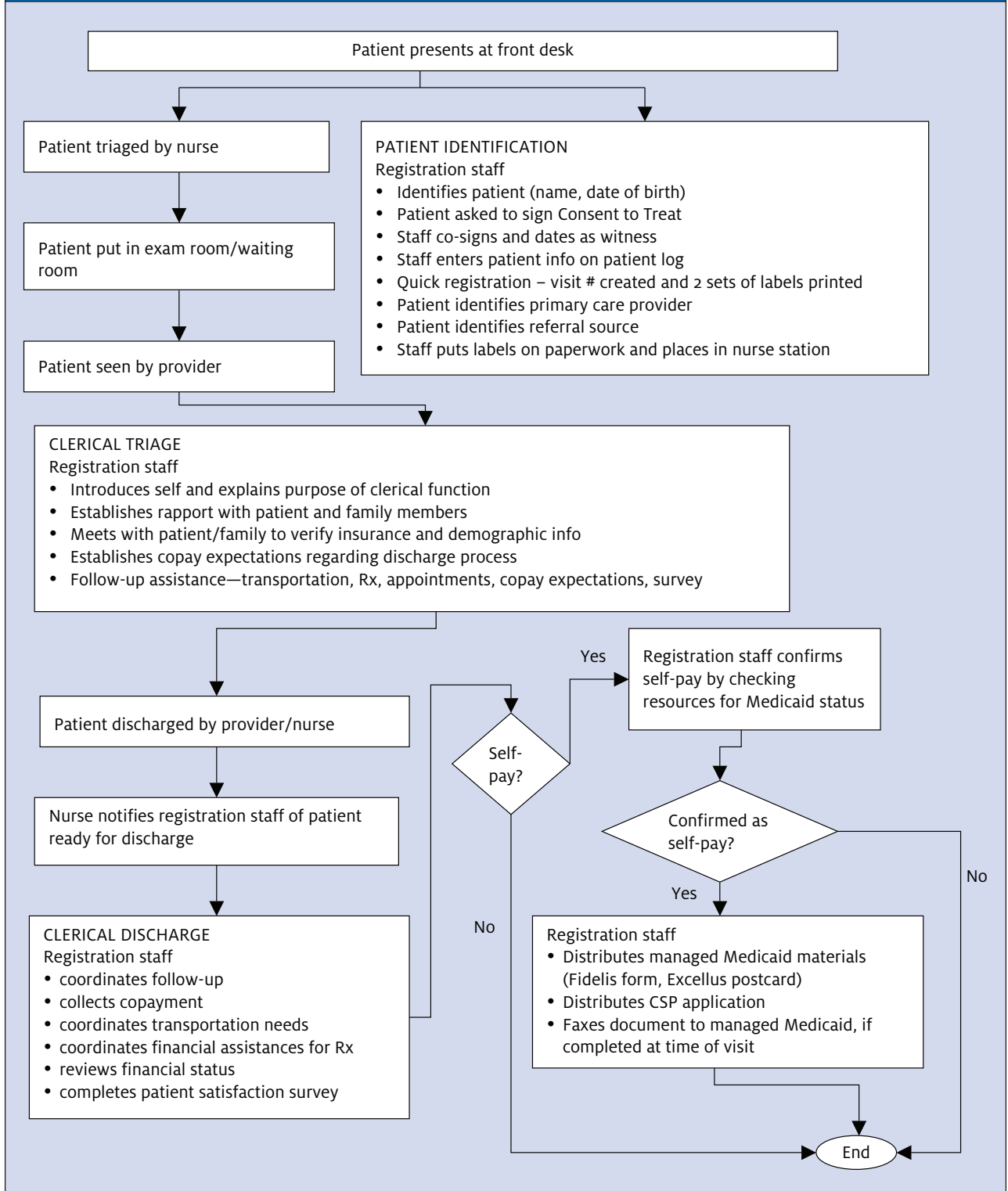
Consistent and visible support helped establish trust and respect with the

individual affiliates' leadership teams, paving the way for processes to be standardized.

Historic and internal data from a callback program and patient complaints illuminated inroads to improving the patient experience. The network manager assembled a multi-location team to review that data and investigate opportunities to improve processes within patient flow.

A nursing and business representative was asked to participate in a series of meetings that resulted in the “Fantasy Flow Workgroup.”



**Figure 1. Relationship-based clerical care: Aligning clerical and clinical care workers for positive patient outcomes.**

**Table 1.**

|   | <i>Reference point</i>   | <i>Data to be collected</i>  | <i>Method/source/<br/>who collects</i>   | <i>Tracking/trending results</i>   |
|---|--|--|--|--|
| <i>Program growth &amp; opportunity</i><br>Expand primary care across network   | Market share development: Identify patients within the ED requiring a follow-up appointment who do not have an established primary care provider   | Number of appointments made for patients without a primary care provider   | <ul style="list-style-type: none"> <li>• At each patient encounter, rep indicates follow-up information in access database</li> <li>• Information reported to network manager monthly</li> </ul> | Data reviewed and additional work plans generated; e.g., request for direct access to primary care at main campus  |
| <i>Service delivery</i> <ul style="list-style-type: none"> <li>• Focus on patient access for all services</li> <li>• Implementation of relationship-based care</li> </ul> | Access, access, access <ul style="list-style-type: none"> <li>• Keep all referrals in the system</li> <li>• Develop enterprise scheduling <ul style="list-style-type: none"> <li>– Develop process and system to schedule all follow-up required for ED/UC patients at the time of services</li> </ul> </li> </ul> | Number of appointments made for patients at the time of discharge  | <ul style="list-style-type: none"> <li>• At each patient encounter, rep indicates follow-up information in access database</li> <li>• Information reported to network manager monthly</li> </ul> | Develop e-messaging between locations as it relates to “clerical communication”  |
| <i>Finance</i><br>Attain long-term financial strength   | <ul style="list-style-type: none"> <li>• Reach copayment collections rates</li> <li>• Downstream revenue generated by scheduled appointments</li> <li>• Conversion of self-pay patients into an insurance program</li> </ul>   | <ul style="list-style-type: none"> <li>• Number of copayments collected at the time of service</li> <li>• Funds obtained through follow-up appointments</li> <li>• Conversion rates</li> </ul> | <ul style="list-style-type: none"> <li>• At each patient encounter, rep indicates follow-up information in access database</li> <li>• Information reported to network manager monthly</li> </ul> | <ul style="list-style-type: none"> <li>• Implementation of self-pay financial options analysis</li> <li>• Appointment referral at time of service for Managed Medicaid services</li> </ul> |

### Care Delivery

Planning began with defining individual and unique needs and responsibilities for each unit, while mapping out the overall common themes needed for the patients.

The “deep dive” on the data showed the following:

- Patients felt staff was not spending adequate time with them.
- Arrival rates, patient volumes, and increased acuity were having significant impact on length of service time and nursing ratios.
- The urgent care location faced increased demand—up to 17% new growth each year.
- Less than 48% of patients followed discharge instructions.
- Patients were choosing to not fill their prescriptions or schedule the recommended follow-up appointment at an unacceptable rate.

This information was highly relevant to quality of care, and raised several important questions:

- If there was more time to be spent with a patient, where would it be best spent?
- How do we instill in our patients the value of following our instructions?
- How can we assist the patient in being compliant?

Billing and cost of care were the primary themes of complaints that we heard. However, once we really listened, we learned that in addition to the fear of inability to pay, patients were uncertain how to navigate the healthcare system for follow-ups (e.g., appointments, prescriptions, insurance referrals).

### Resources

Once the Fantasy Flow Group began mapping out the patients’ experiences, it became evident quickly that the missing link in our patient’s experience was with our clerical staff.

*Continued on page 46*



## A Slip of the Lip Can Sink a Practice

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

When I was 11, attending Our Lady of the Wayside, I was on the wrong side of this exchange during a Marriage and the Catholic Family class, taught by a “largess nun” named Sister Marie Magdalena, whom the entire seventh grade called “MooMoo.”

MooMoo: “Sexual relations are a very beautiful thing and can only occur between a husband and a wife.”

JS after being called upon: “How would you know how beautiful it is?”

Now, I spent most of my formative years boxing competitively, studying tae kwon do, and full-contact sparring, and I can honestly say I was never hit as hard as MooMoo hit me. I am sure, to date, I have at least a mild cognitive impairment. I am sure, to date, I have at least a mild cognitive impairment.

Anyway, despite my one-time, off-color but honestly sincere question, I am blessed with the ability to not say or, save for this column, write the wrong thing at the wrong time. For reasons I don’t quite understand (maybe because of my impairment) not everyone is blessed with this gift.

What follows are actual statements which were written in charts or comments which were directed at what I suspect were incredulous patients in front of dumbstruck staff.

### Written in Charts

- “But for the patient’s profound stupidity, he would be here today.”
- “He shows up yet again today, foul-smelling, demanding narcotics, and being generally obnoxious.”
- “Child is lethargic.” (This necessitates a work-up and further documentation if you are planning to send the child home



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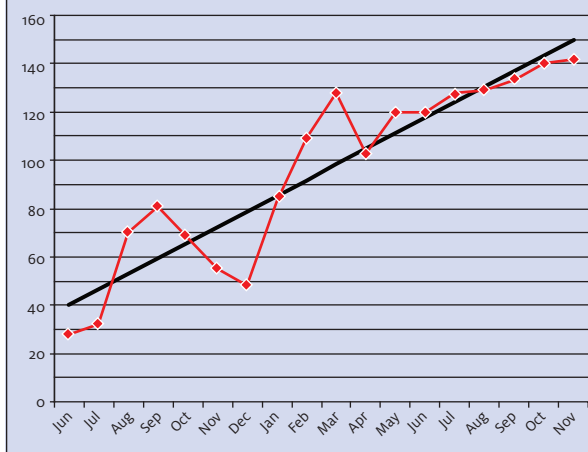
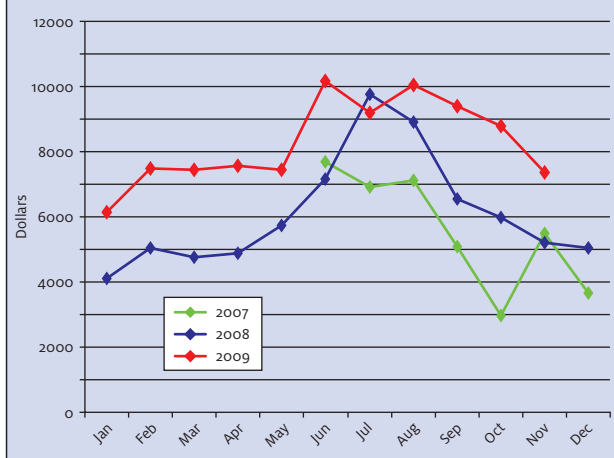
without intervention.)

- “Patient reports that their neck is stiff and that they have a headache and has been running a temp.” (This necessitates a lumbar puncture and possibly a CT of the patient’s brain.)
- “Patient remains confused.” (This was written by the RN on her note just before the patient was discharged to drive himself home).
- “But for the nurse’s incompetence, the patient would have lived.”
- “The patient is responding only to gravity.” (Written in the chart of an unresponsive patient).
- “I repeatedly told the Dr. X not to send the child home.” (Written by a nurse on the chart of a child who ultimately died from an intracerebral bleed).
- “ROS positive for SOB and blood tinged sputum.” (Patient was *not* worked up for a PE and ultimately died).
- “The patient is OK for D/C, they have no plan.” (Written by a crisis worker while seeing a patient whose pistol jammed and misfired while attempting suicide.)

### Said to Patients

- “This would not hurt so much if you would just quit whining.”
- “If you get up one more time, I’ll sew your f\*\*\*\*\*n ears to the bed.” (The physician ultimately did sew the patient’s ear lobes to the mattress and was subsequently kicked out of their residency.)
- “I don’t have a crystal ball, how do I know what’s wrong with you?”
- “Why should I habla?”
- “You again?”
- “Fat, drunk and stupid is no way to go through life, son.” (OK, you caught me. That one was from *Animal House*.)
- “‘What’s wrong’ with you? How much time do you have?”
- “Who’s your daddy now?”
- “Seriously, who could possibly be ‘endowed enough’ to get

*Continued on page 47*

**Figure 2. Follow-up appointments scheduled.****Figure 3. Copayments collected.**

Historically, the “regular” check-in process was public, rushed, and impersonal. The checkout process at some of our locations was nonexistent.

Rather than simply instructing clerical staff members to interact with patients during a visit, the nursing representatives coached them on how to relate to a patient at bedside. This was a new approach to our interactions with patients—and a cultural change for both staff and patients. This truly was our department’s first experience with the relationship-based care model in action.

Our locations all fall under Emergency Medical Treatment and Active Labor Act (EMTALA), so we targeted the “clerical triage” to occur after the medical screening examination.

The initial interaction between the patient and the urgent care representative focused on introduction and

setting expectations. Confirming demographics and insurance were weaved into the process. The patient was given a verbal outline of what assistance would be provided to them at the end of the visit and a commitment to be there with them, either literally or symbolically, throughout the process.

It is in the discharge process that full customer service and attention is placed in the hands of the representative. That process included scheduling follow-up appointments, making transportation arrangements, offering financial programs for prescription, collection of copayments, review of financial insurance status, and completion of a patient satisfaction survey.

The entire process is outlined in **Figure 1**.

The network manager tested the mapped process by filling the role a staff member would play over a three-month period, cycling through different days and times of the week. Time studies were conducted on all aspects of the expectations for this role, and then tasks were prioritized. A job description was written, graded, and approved through the human resources department. Senior leadership approved a temporary position and recruitment began. A successful candidate was hired and trained by the network manager.

### Outcomes

Key indicators—outcome measures, to use a clinical research term—that would reflect a positive impact on the patient’s experience needed to be determined for this newly created bedside business relationship. These indicators needed to have the ability to motivate senior leadership to grant the position full-time status.

The best way to report results to administration is to use the tool they created, the Annual Operating Plan. The reference points outlined for the bedside clerical relationship were designed to fit into the corresponding matrix (**Table 1**).

The implementation of this new bedside process brought the patient relationship full circle. The concentrated focus on the clerical triage and clerical discharge process resulted in decreased billing complaint rates and high satisfaction scores (defined as meeting/exceeding expectations), and facilitated service excellence.

It also produced the desired results in two key outcome measures: follow-up appointment scheduled (**Figure 2**) and copays collected (**Figure 3**).

Finally, changing the culture to include clerical staff in the delivery of care has changed our relationship with the patient. In addition to the positive financial outcomes, patients are more compliant with instructions. ■



you pregnant?"

- "Darwin obviously did not know you." (Said to a smooshed, drunken patient after he was "compacted" while sleeping one off in one of those large trash containers).
- "Are we on *Candid Camera*?" (Said to a patient who was huffing paint and fell off a bridge into freeway traffic, where he was struck by a truck.)
- "You are going to feel a little prick between your legs." (Said by a sleep-deprived, resident—yours truly—to a patient just before giving a local anesthetic before an episiotomy. To which the patient responded, "I wish someone would have told me that nine months ago.")

As funny as many of these statements are, it is sobering to remember that they were uttered or written in the context of provider-to-patient communications during a visit for medical care.

The take-home point is this: The patient "owns" the medical record inasmuch as it is theirs if they request it. Do not document something that you would not be comfortable seeing enlarged and projected on the wall of a court room.

In addition, if you or a staff member writes something on

a chart that, if true, necessitates some sort of intervention, ensure that the intervention is completed (after informed consent) or, if not completed, that a narrative about why you did not believe it was necessary is included on the chart.

Most cases of malpractice hinge on what was or wasn't documented in the medical record. Moreover, many cases of malpractice are initiated because the patient did not feel like they were treated with respect by the provider or staff. So, comments like, "you again?" do not help your cause when trying to prevent a malpractice suit after a questionable outcome.

Patients and their families sue providers, oftentimes, simply because they are angry.

Case in point: I just took a call from a disgruntled patient who was inquiring about my firm representing him. After I told him that I don't do any plaintiff work, he said, "I just want to teach that son-of-a-b\*\*\*\* a lesson!"

At the end of the day, it boils down to this: If you simply treat people with respect, give and document informed consent, and practice within the standard of care, chances are you will go through your professional life unscathed.

Simply put, don't allow yourself to be one of the "sons-of-a-b\*\*\*\*" who requires a lesson. ■

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# Writing Off Patient Responsibility, Modifier-51, and More on New vs. Established E/M Codes

■ DAVID STERN, MD, CPC

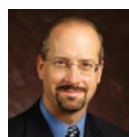
**Q.** I listened to your UCAOA coding webinar, and it raised a question. You mentioned that if we bill insurance for a 99051 and the payor denies payment as “patient responsibility,” then we should bill the patient and not write it off. Does that hold true to the S9088, as well? I often see this code either denied or applied to the patient’s coinsurance/deductible.

– Question submitted by Megan Fontenot, Integrity Urgent Care, Colorado Springs, CO

**A.** If the code is denied, then it is appropriate to write it off. If it is applied to patient responsibility or to patient deductible, then you need to invoice the patient for any balance that the payor makes patient responsibility.

It is not compliant to bill a payor for a service that you will write off if the payor applies it to patient deductible or patient responsibility. Otherwise, you are merely using the old BIO (bill-insurance-only) method for that line item. This is not compliant, as the patient is either 1) getting credit for payment toward a deductible that the patient never paid or 2) you are billing for a service for which you don’t really expect payment. In addition, if you are contracted with the payor, writing off these balances would not only be non-compliant, it would likely be an illegal violation of your contract with that payor. ■

**Q.** I have been using the -51 modifier, but never knew that you were supposed to put it on specific procedure codes (based on their reimbursement). I



**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](http://www.practicevelocity.com)), providing urgent care software solutions to more than 500 urgent care centers. He welcomes your questions about coding in urgent care.

**didn’t know insurance companies would reimburse differently. Will you explain that to me again?**

– Question submitted by Amanda Strickland

**A.** Reimbursement is reduced on codes with modifier -51 attached. Putting the modifier on codes with lower reimbursement will allow you to get full reimbursement on the code with the highest reimbursement. Codes with lower reimbursement will be reduced in payment, but these reimbursement reductions will be less than if they were taken on the code with the highest reimbursement rate. Thus, by putting modifier -51 on codes with lower reimbursement rates, you will maximize reimbursement on the whole claim. ■

**Q.** Why do the payors reduce reimbursement on a code if performed on the same day as other procedures? The doctor does the same work on the procedure, whether it is combined with other procedures or not.

**A.** The rationale that the payors use is that much of the work pre-procedure and post-procedure for a given procedure is not repeated when two or more procedures are performed. The work of the actual procedure is repeated, but the work before and after the procedure is supposedly similar whether one or two procedures are performed on a given visit. ■

**Q.** The doctor performed a 2.0 cm simple laceration repair on the index finger and a 1.2 cm simple laceration repair on the middle finger. I coded 12001 (Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities [including hands and feet]; 2.5 cm or less) for the first laceration and 12001-51 for the second laceration. The payor denied

*Continued on page 50*



# Exceptional Relationships Lead to Exceptional Sales

■ FRANK H. LEONE, MBA, MPH

**R**elationships play an integral part in occupational health sales. In many types of sales, actual relationships mean less—if they have any value at all. The more one's product is a commodity that can be purchased online, to cite an example, the less relationships matter.

On the other hand, the more complex a product and the more education required to make the buyer understand the product's worth, the more a buyer-seller relationship comes into play.

### Why Do Relationships Matter?

As the inherent return on investment of core clinical services such as injury management decreases, clinics are expanding their portfolio to offer more services to their relatively static client base.

Most add-on products (e.g., wellness services) tend to be part of a larger whole that contributes to the health and safety of the workforce. Hence, they are not commodities, but rather another piece of an increasingly complex puzzle. Occupational health sales professionals—a term that includes clinicians who are pressed into service for the good of making a sale—are becoming far more educators than they are commodities dealers.

But there is a catch. The greater the need to educate, the harder it is to get the “I don't have a second to spare” prospect to sit down to actually be educated. Uneducated prospects are likely to revert to being commodities buyers, and your clinic's chance of an in-depth relationship with the company is diminished.

The best way to get a prospect's attention is to establish

credibility with that prospect at the outset. This usually requires patience, foresight, and innovation.

Other reasons for honing exceptional relationships with your prospects include:

- **Word of mouth.** Never underestimate the reach and power of word of mouth. Develop merely a *good* relationship with a prospect and they are unlikely to be singing your praises.

Develop an *extraordinary* relationship and word is likely to spread quickly; remember, everyone you meet along the way has the potential to be a de facto subcontractor to your sales effort.

- **Follow the bouncing ball.** Up to one third of your contacts are likely to be employed elsewhere a year from now.

Over the years, numerous healthcare CEOs at RYAN Associates' client companies have left their organization for another, only to hire us again to replicate what we did for their former organization.

These “out of nowhere” leads would not have developed had we not walked out of the door with an exceptional relationship.

### Build the Relationship

Exactly how does one build exceptional relationships, though? It varies somewhat based on the sales professional's persona, but there are some general rules:

1. **Be yourself.** Often, a sales professional wears their professional hat from 8:00-5:00 and their personal hat the rest of the time. In many cases, such a dual personality is correct and even commendable; in sales, it usually is not.

That is to say, it is important to allow your “personal self” (not just your “professional self”) to shine through when establishing a relationship with a prospective client.

*Continued on page 50*



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

**2. Learn—and remember—what is really important.**

Learn what is really important to a prospect/client—both professionally and personally—and go back to these issues time and again. Remember, sales are always about “them.”

**3. Check in frequently, and with balance.** Most salespeople establish contact with clients or prospects only when there is a professional objective. However, it is important to balance sales-oriented contacts with no-obligation “social calls.”**4. Do little favors.** In the e-mail era, it does not take much effort to send a short note, or forward a relevant attachment or a timely link. Yet, sales professionals rarely take the time to do this.

Once you know what is important to one or more of your prospects/clients, you can scour for relevant material and send it on (or, at times, on to more than one client/prospect interested in the same topic).

Do this frequently for contacts and you are likely to grow quickly from “just another salesperson,” to an “exceptional salesperson.”

**5. Note critical dates.** Gather birthdates and acknowledge them (a personal e-mail will do). Also, pay attention to any hints you may pick up, such as “I’m getting married August 19.”**6. Be selective.** You cannot cultivate exceptional relationships with every prospect/client; you need to be selective. “Red hot” prospects that offer great professional opportunity for your clinic’s program warrant a seat in the front of the bus.

But what about chemistry? There are certain people that you are unlikely to cultivate an exceptional relationship with: you are from Mars and they are from Pluto. In such circumstances, you should avoid trying to fit the proverbial square peg into a round hole and consider even a “fair relationship” to be a victory.

Sales professionals should be “people-people.” As such, building strong relationships with others should be inherent in their fabric and a vital part of their professional day.

As occupational health becomes more complex, extraordinary relationships are essential. ■

**the second code. How can I get them to reimburse for the second laceration? After all, the doctor really did perform two procedures.**

**A.** Wound repair codes are a little different than many other codes. If the laceration repair was of the same complexity and the code for the repair includes repairs on the same body areas, then you should add the lengths of the repaired wounds and select the CPT code based on the sum of the lengths of the wound repair. Thus, to code these procedures, you should add the lengths of the two lacerations (2.0 cm + 1.2 cm = 3.2 cm) to select the proper code, which for this claim would be 12002 (Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities [including hands and feet]; 2.6–7.5 cm). ■

**Q. I code for emergency room physicians. Our physicians also work for our urgent care center. If a patient is seen in the ER by one of our physicians, then a week later seen at our urgent care center, on the second visit is that patient considered a new or established patient?**

— Question submitted by Cathy Stover, Richmond Hill, GA

**A.** Choosing a new or established code depends on the specific scenario:

- If the patient is seen by the same physician in both locations, then the second visit is coded with an established E/M code, no matter how each of the businesses is incorporated.
- Assuming that the physicians are employed by a different group in each location and assuming that the patient is seen by a different physician on each visit, then the second visit is coded with a new E/M code.
- If the physicians are employed by the same group in both locations, then the second visit (if seen by a physician of the same specialty) is coded with an established E/M code.
- If the physicians are employed by the same group in both locations and the two different physicians practice different specialties, then the second visit is coded with a new E/M code. ■

*Note: CPT codes, descriptions, and other data only are copyright 2010, American Medical Association. All Rights Reserved (or such other date of publication of CPT). CPT is a trademark of the American Medical Association (AMA).*

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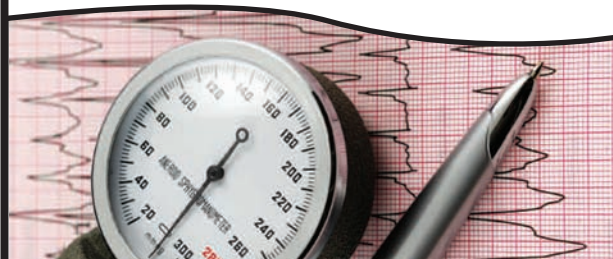
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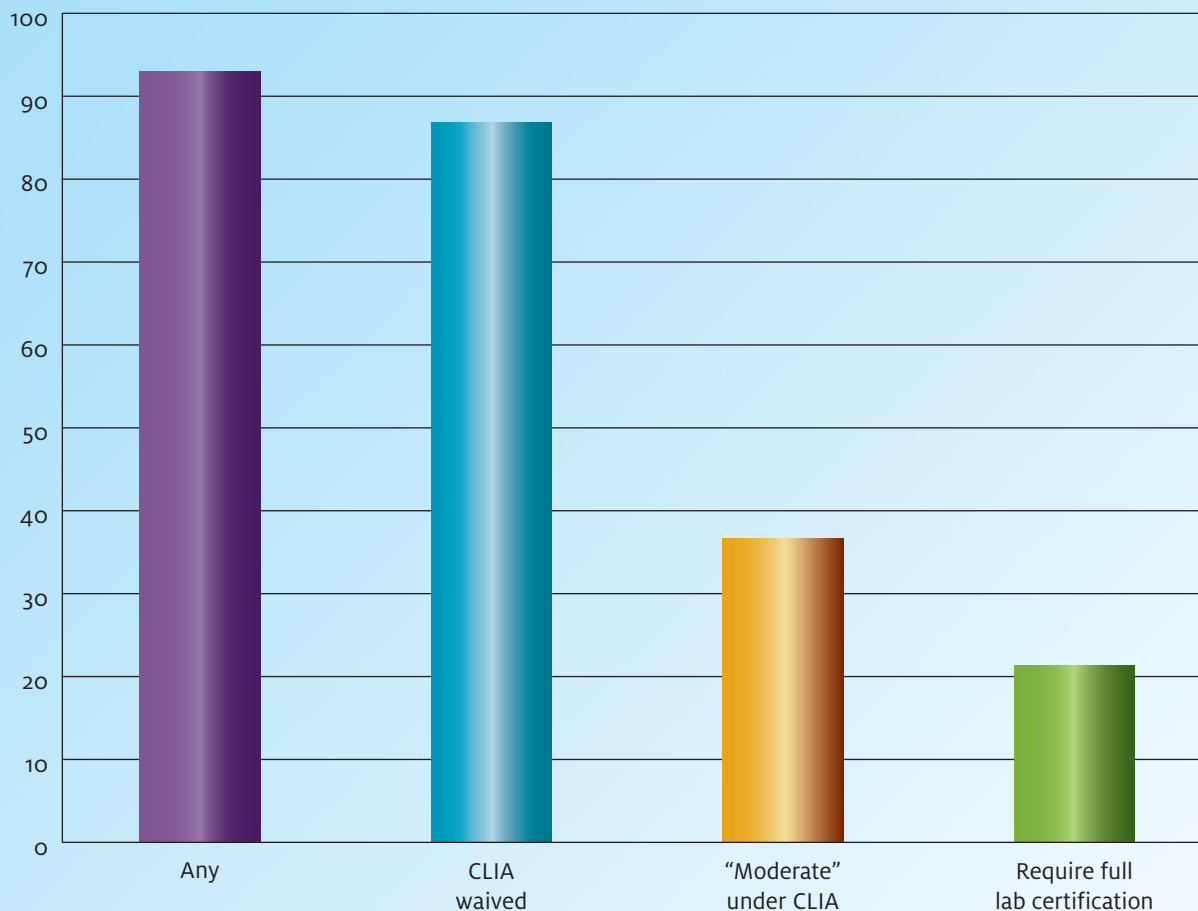
## DEVELOPING DATA

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 data from this landmark survey.

*In this issue: How common is it for urgent care centers to process lab tests onsite—and what tests are they, typically?*

### LAB TESTS PROCESSED ONSITE



The question regarding lab tests was just one segment of a section of questions on services offered in urgent care centers. In the June issue of *JUCM*, Developing Data will report on services such as administration of intravenous fluids, sports and school physicals, and travel medicine.

Acknowledgment: Data submitted by Robin M. Weinick, PhD, at the time of the survey assistant professor, Harvard Medical School and senior scientist, Institute for Health Policy, Massachusetts General Hospital. 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](mailto:editor@jucm.com). We'll share your discovery with your colleagues in an upcoming issue of *JUCM*.



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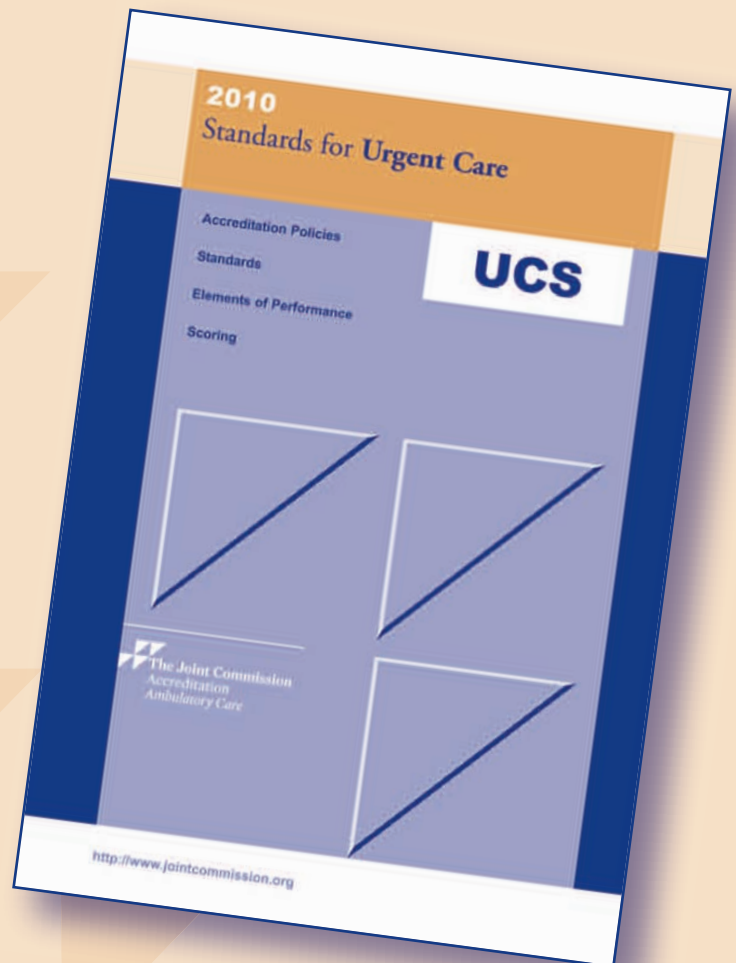
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