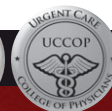


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LETTER FROM THE EDITOR-IN-CHIEF

Notes From the Convention



As I write this, the annual convention of the Urgent Care Association of America (UCAOA) is in full swing in Las Vegas. This year's assembly is the largest gathering of urgent care professionals in the world...ever. With well over 700 attendees, the energy is palpable.

The excitement surrounding the discipline and the industry has never been greater as more and more physicians, entrepreneurs, health systems and others clamor for a sample of this exciting wave in healthcare. My observations from the convention can be summed up into a few salient take-home messages:

The field of urgent care has become more specialized and its representation has followed. We now have separate organizations to represent the many interests and facets of the specialty. The Urgent Care College of Physicians (UCCOP), launched last year with the support of UCAOA, is making significant strides developing a unified voice for physicians who practice in this setting. Once managed by committees within UCAOA, the specialty development, education, and academic initiatives each has its own home.

The distinction between clinical and industry functions is now clear. Each has a separate organizational representation and both groups are committed to working together. Their shared goal is to build a discipline with greater definition, legitimacy, and strength so that urgent care professionals have a more relevant and representative voice within the "house of medicine" and about our health care delivery system as a whole. For more information about these organizations, visit www.ucaoa.org and www.uccop.org.

The formal launch of the Urgent Care Foundation at the convention generated a great deal of interest and excitement. For the first time ever, a foundation has emerged that is solely dedicated to funding education and research projects within the discipline of urgent care. The critical nature of the foundation's mission cannot be overstated. As with any other health care field, the strength and legitimacy of urgent care as a discipline is the most critical factor for the specialty's future growth and sustainability. No clinical field before us has survived without a dedicated effort to support this mission. This fact is underappreciated by most urgent care professionals, but we must learn the valuable lessons of history.

Programs funded by it will not show a direct or tangible return on investment, and therefore, will not generate the short-term excitement that surrounds other initiatives. Industry stakeholders will ask, "What does this do for my business? I don't have a 'marketing' budget for that." Clinicians will ask, "How does this impact ME?" The cold hard truth is we are a house of cards without the Foundation. And urgent care has no future in any sustainable form that we can be proud of if we ignore it. Formal training programs like the clinical fellowships in urgent care are paramount for the development of what is termed the "Core Competency Document" for the entire discipline. It literally "defines" what we do, how we do it, and why urgent care is unique in content and delivery. Without a Core Competency Document, urgent care will not exist in the modern "house of medicine" and the specialty will not evolve to represent the highest level of care and quality possible.

Fellowships are not about creating a pipeline of adequately trained physicians. They are, instead, the formative laboratories for developing the specialty. Educational outreach, clinical and health services research are similarly positioned to weave urgent care firmly into the fabric of health care delivery, once and for all.

Everyone I spoke with at the UCAOA convention wants urgent care to have a prominent role in healthcare. Supporting the foundation and its programs is our most critical step in that direction. UCAOA has taken the unprecedented step of providing a seed grant of \$25,000 in support of the Urgent Care Foundation effort. UCAOA also has offered a challenge grant of up to \$75,000 to help generate momentum for the Foundation's fundraising. We cannot let this opportunity to advance our field slip by. The time has come for industry and clinicians alike to support this effort to solidify our future. For more information about the Urgent Care Foundation, go to: www.urgentcarefoundation.org. ■

Lee A. Resnick, MD
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Patients with tooth-related complaints increasingly are presenting to urgent care centers. Managing these cases can be a challenge because physicians often receive limited training in this area.

Katherine Hurst MSc, MD, and Richard E. Walton DMD, MS

CASE REPORT



20 High-Risk Conditions Presenting as Back Pain (Part 3)

Fever plus back pain should alert a provider to a potentially serious condition that warrants further workup.

*Erica Marshburn, BS, BA, and
John Shufeldt, MD, JD, MBA, FACEP*

PRACTICE MANAGEMENT

25 Public Relations in Urgent Care: A Step-by-Step Plan for Success

Getting local media attention can drive patients to an urgent care center's doors. Applying best PR practices can produce results and conserve marketing dollars.

Marcia Horn Noyes



IN THE NEXT ISSUE OF JUCM

Lymphadenopathy is a common presentation in urgent care and usually benign and self-limiting. In a small minority of patients, however, it is caused by malignancy. Our cover story next month looks at how to determine the etiology of lymphadenopathy, which requires a complete history and physical examination. Included are tips on "red flags" for diagnosis, categories of diseases that present with lymphadenopathy, appropriate tests in the urgent care setting, and recommendations for management.

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With the aging of the population and given limited availability of dental services in the evenings and on weekends, more and more patients with dental complaints are presenting to urgent care centers. Urgent care providers, therefore, need to be familiar with tooth and tooth-related problems and be able to design treatment protocols to manage a patient's injury, relieve his or her pain, and prevent the spread of infection.



Our cover story this month aims to help meet the challenge of diagnosing and managing dental problems likely to be seen in an urgent care setting. Authors Katherine Hurst, MSc, MD, and Richard E. Walton, DMD, MS, describe common and less-common, treatable dental emergencies and conditions that a patient may interpret as an emergency but that do not require immediate treatment.

Dr. Hurst is an emergency room physician at Trinity Muscatine, Muscatine, Iowa. Dr. Walton is professor emeritus at the University of Iowa College of Dentistry, Iowa City, Iowa.

Our case report this month is the third in the series by Erica Marshburn, BS, BA, and John Shufeldt, MD, JD, MBA, FACEP on high-risk conditions presenting as back pain. In this installment, read about a 36-year-old employed mother of two with back pain radiating around her side to her chest and learn why this complaint, coupled with fever, should raise your index of suspicion for a serious condition.



Ms. Marshburn is an independent business consultant and the principal of Medical Business Technologies in Scottsdale, Arizona. Dr. Shufeldt is principal of Shufeldt Consulting and a member of the JUCM Editorial Board.



Our practice management article this month offers an inside view of what you need to do to effectively communicate story ideas to reporters and harness the power of public relations to boost your practice's bottom line. As author Marcia Horn Noyes notes, urgent care medicine is fertile ground for quick and compelling stories that reports look for every day. The key for providers is to apply best PR practices, which can also conserve marketing dollars.

Ms. Noyes is a former television news reporter, newspaper journalist and writer.

Also in this issue:

John Shufeldt, MD, JD, MBA, FACEP, explores the concept of coaching, 360-degree feedback that can be a real game-changer and of benefit to anyone who is interested in personal development. Dr. Shufeldt suggests that urgent care providers enlist the help of a coach to help both their careers and their businesses flourish.

Nahum Kovalski, BSc, MDCM, reviews new abstracts on use of CT by ED physicians and treatment of pediatric fracture pain in the ED.

In Coding Q&A, **David Stern, MD, CPC**, discusses coding of multiple wound repairs, coding an E/M, use of codes for infusion, and why not to unbundle individual items in the Comprehensive Metabolic Panel.

Our Developing Data end piece this month looks at use of computer sys-

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tems for clinical processes. Most urgent care centers that responded to the survey use computers for clinical processes, and the remainder have plans to implement such systems soon. ■

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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.

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to editor@jucm.com. The first page should include the title of the article, author names in the order they are to appear, and the name, address, and contact information (mailing address, phone, fax, e-mail) for each author.

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FROM THE EXECUTIVE DIRECTOR

Convention Closes, Industry Awareness Campaign Website Opens

■ LOU ELLEN HORWITZ, MA

As I write this, we leave for the Convention in Las Vegas in about 24 hours! Participation has passed our all-time record (for both attendees and exhibitors) and we couldn't be more excited to see everyone and get that show on the road. But, by the time you read this, all that will be behind us and it will be time to move on to what's next.

If you were unable to come to the Convention this year, we hope you enjoyed some of the special communications we sent out while we were there to give you a small glimpse of what you missed. Remember, we record almost all of the sessions during the meetings, so while it's not nearly the same as being there, you can still get access to the lecture content via our Online Education in a few weeks. We'll make an announcement when the recordings are ready. *If you did attend the Main Convention, remember that you, too, get access to the recordings for free as part of your tuition!*

So...what IS next? The Industry Awareness Campaign!

The buzz about our industry awareness campaign has already started—and spread beyond the confines of just urgent care centers. We've heard from commercial payors, state health departments, and others who want to use the campaign materials to educate their patients on using urgent care centers—and we haven't even launched it yet.

That's great news on many fronts. First, we have distribution points for our awareness messages that we have never had access to or interest from before. Second, we know we are not alone in wanting to educate patients about using urgent care. Third, we'll be able to leverage all these different distribution points and do even more than



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

The buzz about our industry awareness campaign has already started—and spread beyond the confines of just urgent care centers.

we thought we could with every center in the country participating...the possibilities are really quite huge!

So—it's time to get ready. In the past couple of weeks, you've seen UCAOA doing the "See One" we talked about in last month's column, so the rhyme idea should be familiar to you already. Now, it's your turn.

The campaign resources website—ucaoa.org/rhyme—goes up May 15th for you to explore and you can forward the URL to anyone you know who may want to help spread the word about urgent care. On that site, you'll find all the pieces for the summer campaign that starts in June (next month) that you can download and use:

- Art files for use electronically and in print (websites, posters, giveaways—anything!)
- Email templates for your patient e-messages
- Ideas for marketing and PR strategies, techniques & targets for June/July/August
- Plus a guide to PR terminology and technical details for using the artwork files

NOTE: All of these resources are CUSTOMIZABLE for your center—your name, your address, your logo. That said, remember that a high tide raises all boats...so all of you will be helping each other, too.

On June 1st, there will be a press release from UCAOA announcing the campaign, and that's your starting gun to begin using the materials publicly as much as you are able. On your mark... ■



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An Urgent Care Provider's Guide to Managing Dental Emergencies

Urgent message: Patients with tooth-related complaints increasingly are presenting to urgent care centers. Managing these cases can be a challenge because physicians often receive limited training in this area.

KATHERINE HURST MSC, MD, and RICHARD E. WALTON DMD, MS

Tooth or tooth-related complaints are common presenting issues in patients seen at urgent care centers because of the limited availability of dental services in the evenings and on weekends. More patients also are seeking emergency dental treatment in hospitals or similar facilities as the U.S. population continues to age and the number of individuals who are uninsured (or underinsured) increases.¹

Urgent care providers, therefore, need to have some working knowledge of the management of common dental emergencies but they may not because physicians typically receive limited training about these problems. To meet the challenge of diagnosing and managing dental problems likely to be seen in an urgent care setting, providers should understand the disease process, be familiar with the presentation and diagnosis, and be able to design a treatment protocol to manage a patient's injury, relieve his or her pain, and prevent the spread of the infection.

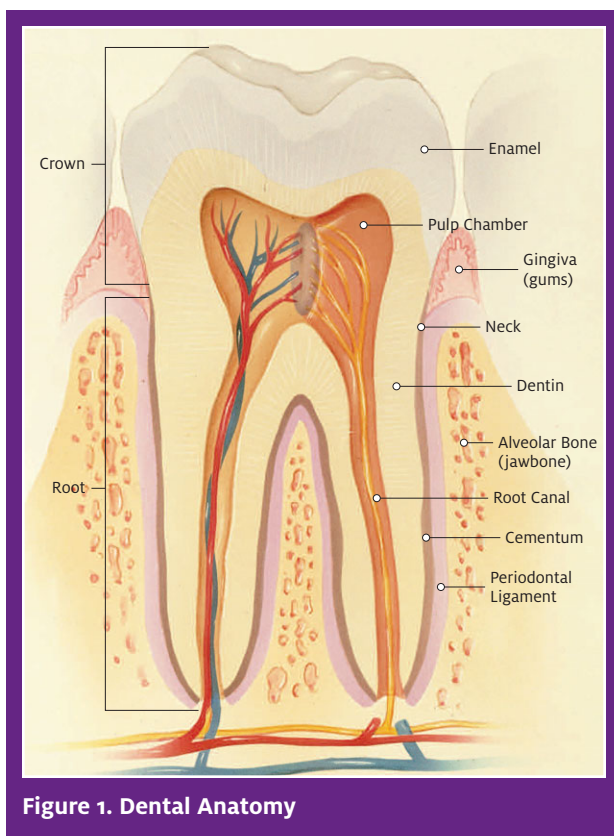
Oral-related issues often are caused by hard- and soft-tissue injuries, pain, or infection.² Most dental emergencies are localized, but some may spread to



involve fascial spaces (cellulitis), possibly requiring hospitalization and more extensive and expensive systemic treatment.²

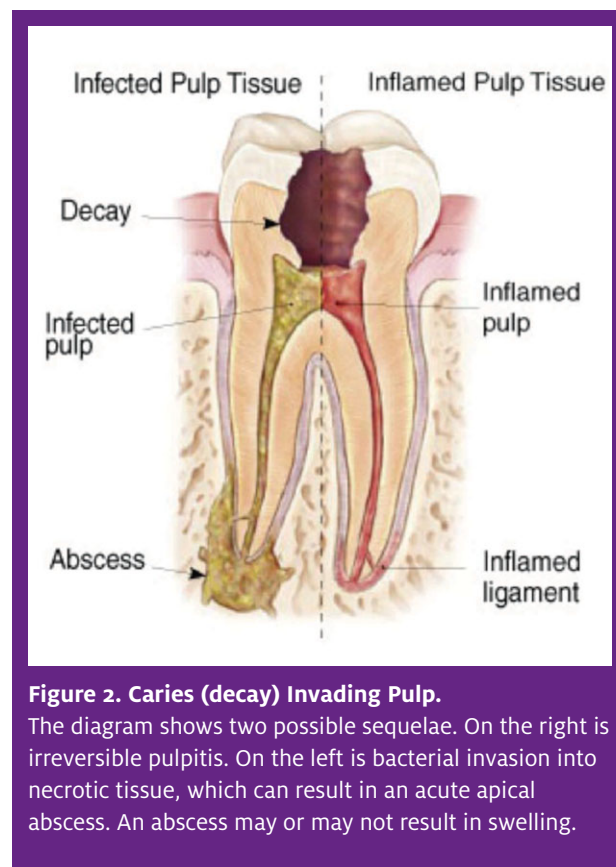
Severe dental infections tend to occur in individuals

Katherine Hurst is an Emergency Room Physician at Trinity Muscatine, Muscatine, Iowa. **Richard E. Walton** is Professor Emeritus at the University of Iowa College of Dentistry, Iowa City, Iowa.



from lower socioeconomic groups who have limited access to dental care. Therefore, they are more commonly seen in an emergency or urgent care setting than in the average dental practice. Such presentations may also be further complicated because patients with dental emergencies often have other medical issues related to existing dental and systemic diseases or chemical addictions, or they suffer from poor nutrition.

Although comprehensive dental procedures are not within the scope of practice of most urgent care providers, therapies are available in the clinic to provide patients with some degree of relief from acute pain and to minimize adverse reactions to infection and tooth injuries. This article briefly describes common and less-common, treatable dental emergencies. Background information as to pathosis, clinical findings, basic diagnostic procedures and a treatment plan for each diagnosis is included. Also described are conditions that may be interpreted as an emergency by the patient, but that do not require immediate treatment. Another consideration is non-dental conditions that can mimic toothache because of referral from other structures. In this category are sinusitis, temporomandibular dysfunction,



The diagram shows two possible sequelae. On the right is irreversible pulpitis. On the left is bacterial invasion into necrotic tissue, which can result in an acute apical abscess. An abscess may or may not result in swelling.

(muscles of mastication pain), herpetic lesions, migraine or cluster headaches, and neuralgias. These conditions must be differentiated from odontogenic problems and treated (or not treated) accordingly.

Pulpal and Periapical Pathoses

The most common causes of emergency visits for dental complaints are pulpal and periapical pathoses.³ These presentations represent progression of disease from the crown of the tooth to the pulp (if untreated) and then eventually to the periapex, which is the medullary bone in the region of the root tip. Because the root is surrounded by alveolar bone, disease in this region has the potential to involve the overlying soft tissues. (**Figure 1**)

Pulp injury has many etiologies, but the most common initiator of pulp disease is dental caries, commonly known as a "cavity." Caries is a disease of hard tissues that involves bacterial invasion from surface plaques (bacterial masses). The bacteria, in combination with a carbohydrate substrate (primarily sugars), form acids that demineralize and invade the enamel, then the dentin. If the decay process is not corrected



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by the dentist with removal and restoration, bacteria will continue to demineralize tooth structure and eventually reach the vital tissues of the pulp (**Figure 2**). Caries confined to hard tissues results in reversible pulpitis, which is a localized immune response in the pulp. This inflammatory process is usually asymptomatic, but can cause sharp, brief pain, particularly in response to cold. This condition is not a significant pathosis or an emergency and does not require immediate treatment.

Most emergency room or urgent care visits for dental issues are for either irreversible pulpitis or acute apical abscess

Irreversible Pulpitis

Pathosis. When dental caries, with their attendant bacteria, invade the pulp, the result is a localized tiny area of liquefaction necrosis (microabscess), confined to the coronal pulp, and colonization of bacteria. Other injuries, such as extensive restorations or fractures, also can cause severe pulp injury, or irreversible pulpitis (**Figure 2**). By definition, this condition cannot resolve by itself; either root canal treatment or extraction is required. If neither is performed, the microabscess will progress, either rapidly or slowly, to involve the entire pulp. Again, the resultant inflammation is primarily an immune response to bacterial byproducts and to leukocytic enzymes and chemical mediators. It is not a true infection.

Clinical presentation and diagnosis. Irreversible pulpitis typically is asymptomatic, although it can be extremely painful. For unknown reasons, occasionally the inflammation becomes very active, producing an excess of fluid transudates and exudates and mediators. Because the pulp space is non-compliant (cannot swell), fluid pressures increase and stimulate C-fibers. The pulp is richly innervated with sensory nerves with an abundance of receptors. The pain tends to be exaggerated by thermal stimuli and is often referred and poorly localized; that is, the patient cannot identify the offending tooth. Significant pain on biting or pressing on the tooth or overlying tissues is unlikely. Intraoral examination usually (but not always) enables identification of the problem and the offender, that is, a tooth with deep decay or with a large restoration or fracture.

Treatment plan. The preferred treatment is either immediate removal of the inflamed pulp by root canal treatment and preparation of the tooth for restoration,



Figure 3. Localized Intraoral Swelling From an Apical Abscess.

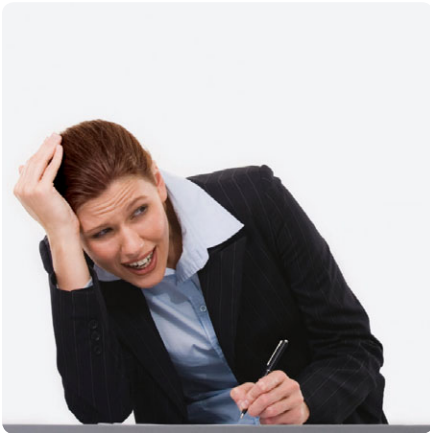
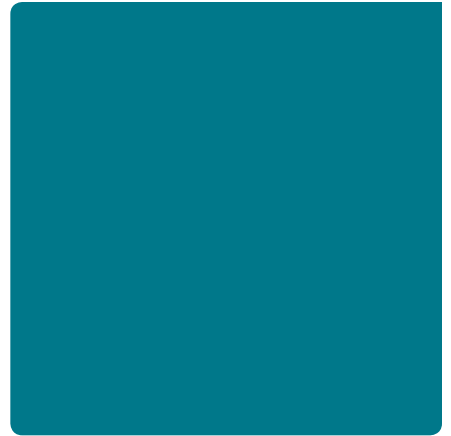
or extraction, if the tooth cannot be saved. In an urgent care setting, it may not be feasible to implement either of these treatment options. Therefore, the best temporary measures are local anesthesia and analgesics to maintain the patient until he or she can visit a dentist.

Pain control. The preferred anesthetic agent is articaine, which penetrates bone best. Infiltration of the maxilla over the tooth apex will provide 1 to 2 hours of relief, enough time for oral analgesics to take effect and ease the pain. (Total relief is unlikely.) Infiltration on the mandible is less successful, but will give some relief. On the mandible, the preferred injection is an inferior alveolar block. Video tutorials on the inferior alveolar nerve block (IANB) are available at <http://www.youtube.com/watch?v=sZgLtbNe6ek> and <http://www.youtube.com/watch?v=Yhu4ROEP4ZA>.

The best analgesic approach is a combination of narcotics (oxycodone or hydrocodone) with nonsteroidal anti-inflammatory drugs (NSAIDs) or acetaminophen. Antibiotics are of no benefit and are contraindicated, because irreversible pulpitis is not an infection and does not have systemic effects.⁴ Hospitalization is not required, and while the condition can be very painful, it is not serious.

Follow-up. Instruct the patient to visit a dentist for definitive care, which will be either root canal treatment or extraction.

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Figure 4. Patient With Cellulitis

In this case, the rapid spread of swelling and markedly distorted facial features dictate more aggressive treatment.

Acute Apical Abscess

Pathosis. In this situation, as a result of complete necrosis of the pulp, inflammation reaches the alveolar bone at the root tip and an abscess often develops in the bone. The abscess may be confined to noncompliant bone (very painful), or spread to the soft tissues on the lateral (facial) or lingual (medial) sides, with resultant swelling (less painful). Infrequently, the abscess may move into fascial spaces, which is potentially more serious, and in rare cases, life-threatening.

The acute apical abscess (AAA) seldom has systemic manifestations. A localized AAA, with or without swelling, does not result in elevated temperature, malaise, altered pulse rate or blood pressure changes because it has effectively been localized by the body's defenses.⁵ Cellulitis also does not usually produce major systemic complications. Swelling and distortion of the face and/or neck may be diffuse and extensive, but elevated temperature or malaise may not occur. No reports exist of sepsis or other consequences of cellulitis on other systems.

Clinical presentation and diagnosis. As previously stated, if an abscess is confined to bone, there will be no swelling. The pain tends to be intense and localized to the offending tooth, which is very tender to biting and pressure. The discomfort is a result of fluid accumulation



Figure 5. Intraoral Incision and Drainage of a Localized Abscess

and pressure related to the abscess per se and because of inflammatory mediators stimulating receptors.

Swelling often is present but usually confined to overlying mucosa, either buccal (commonly) or lingual (occasional) (**Figure 3**). Localized swelling often is accompanied by facial edema that is noticeable extra-orally. Again, the localized swelling does not have systemic manifestations or complications because it has been effectively controlled by the body's defenses. After a time, it may develop into cellulitis (seldom) or may regress spontaneously if untreated with drainage and/or debridement. After regression, the swelling eventually will recur because the underlying cause—the necrotic pulp—has not been removed. The patient will report that the “swelling comes and goes.”

Cellulitis is uncommon, but can occur, particularly in compromised individuals. It is a rapidly spreading, facially distorting swelling, suggesting (though undemonstrated) that bacteria are no longer confined to the abscess and have invaded regional tissues (**Figure 4**). Cellulitis can result in such systemic signs as elevated temperature, lymphadenopathy, and malaise. Patients with the condition will be understandably distressed.

Cellulitis seldom leads to dangerous systemic events. If sepsis does occur (there are no reported, well-documented cases), it is very rare. The major danger is airway closure from swelling of pharyngeal spaces or in sublingual spaces (Ludwig's angina). The source is mandibular molars. Patients who are experiencing such airway

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closure events will have severe swelling in the lower face and may report difficulty in breathing or swallowing. Oral examination likely will show drooping of the soft palate, displacement of the uvula, and possibly trismus ("lockjaw"). Closure of the airway requires immediate and aggressive treatment, usually hospitalization to establish an airway (intubation or tracheostomy) and intravenous administration of antibiotics.

Treatment plan. For resolution, two modalities are critical: 1) removal (debridement) of the necrotic tissue and bacteria from the pulp space; and 2) drainage of the abscess. Without both, the abscess will resolve poorly, or not at all. Removal of the source of the problem can be accomplished by initiating root canal treatment or extracting the tooth. Debridement of the pulp space usually is not an option in an urgent care setting, unless managed by a dentist with appropriate instrumentation. However, when indicated, drainage alone will help relieve symptoms and result in some resolution. Drainage is implemented via either intraoral or extraoral incision. Intraoral incision of a swelling can be performed by a dentist or physician with the patient under local anesthesia in a clinical setting (**Figure 5**); extraoral incision usually is done on an inpatient basis and under general anesthesia. Hospitalization often is considered for patients with cellulitis who have systemic signs and symptoms.⁶ Management of such cases requires more aggressive treatment, usually under the care of an oral surgeon.

Pain control. This is primarily accomplished with local anesthesia, and if convenient, by incision for drainage to relieve pressure, supplemented by analgesics. Local anesthesia and oral analgesia are the same as for irreversible pulpitis.

Antimicrobial control. Antibiotics have very limited application, depending on whether the abscess is localized or involves cellulitis. Clinical studies^{7,8} and specialty organization guidelines suggest that antibiotics are not useful and are not indicated for the localized abscess. Although there are no data as to benefit, an antibiotic is recommended for cellulitis.⁹ The pathogenic organisms responsible for the rapid spread through soft tissue are most likely to be gram-negative anaerobic streptococci. Empirically, the preferred antibiotic is potassium penicillin, 1000 mg stat and 500 mg qid for 7 days. For penicillin-allergic patients, clindamycin, 300 mg qid is the next choice.⁹



Figure 6. Pericoronitis

A partially erupted (one cusp is visible) third molar (wisdom) tooth is evident on the distal. The surrounding tissues are severely inflamed, particularly on the lingual (tongue side).

Follow-up. The patient should be instructed to seek dental care as soon as possible. Root canal treatment is required if the tooth is to be saved, otherwise, extraction is necessary.

Pericoronitis

Pathosis. Pericoronitis is a localized abscess associated with a partially erupted tooth; nearly all occurrences involve mandibular third molars (wisdom teeth) that have insufficient space for complete eruption. A remnant of gingival tissue (operculum) partially overlays the tooth surface and becomes traumatized by the maxillary molars during chewing or closing. Bacterial plaque and other debris invade this space and cause further injury.¹⁰

Clinical presentation and diagnosis. Pericoronitis is a painful, localized, angry, fluctuant swelling surrounding the third molar (**Figure 6**). Edema of the adjacent cheek often occurs. (Note: Because of the region of the extraoral swelling and pain, this condition is often mistaken for parotitis). The patient may exhibit trismus and lymphadenopathy of the submandibular and cervical nodes. Pressing on the swollen tissues often produces purulence from under the flap. Systemic signs, such as elevated temperature or malaise, seldom are present. Rarely will this condition progress to more serious manifestations such as peritonsillar abscess or cellulitis.

Treatment. In an urgent care setting, at a minimum, after infiltration with local anesthetic, the space under



Figure 7. Acute Necrotizing Ulcerative Gingivitis

The gingival margins are swollen and inflamed. The interdental papillae are necrotic. (Courtesy of Dr. Lewis Humbert)

the flap should be irrigated with normal saline to reduce plaque and debris. The patient should be instructed to rinse with hot salt water (1 tsp in a cup of water as hot as can be tolerated).

Pain control. Local anesthetics and over-the-counter (OTC) analgesics should be administered.

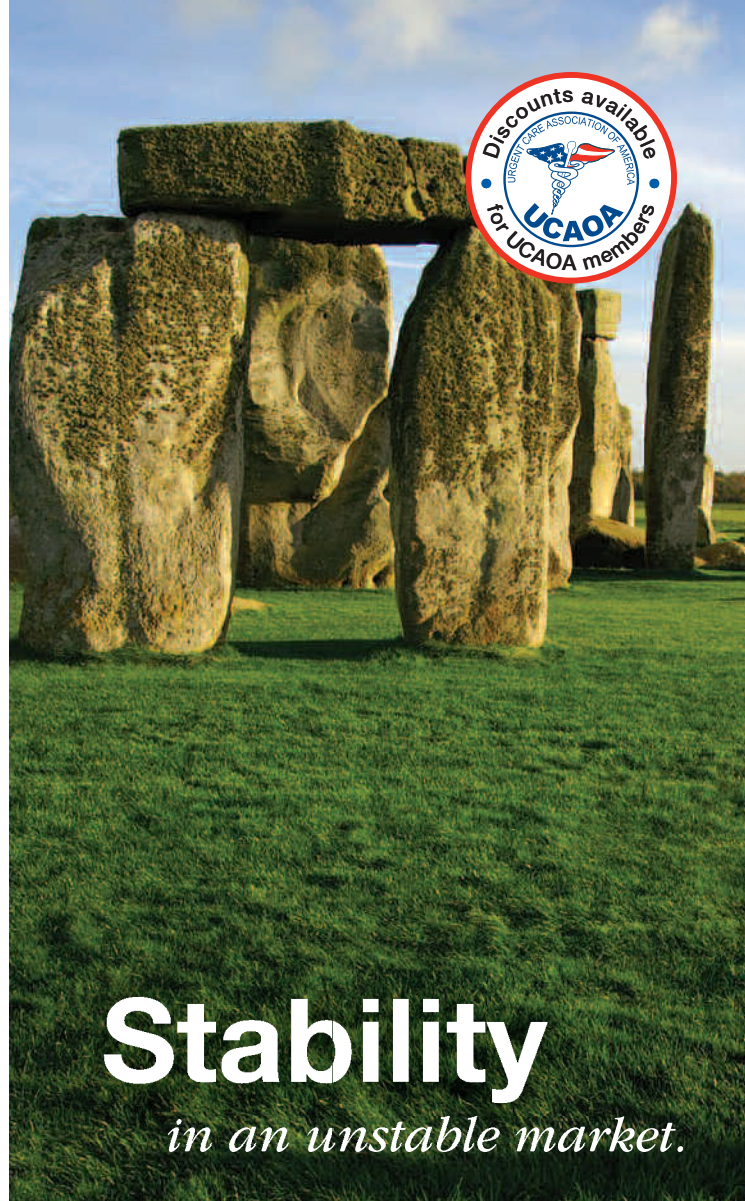
Antimicrobials. Antibiotics are not indicated unless there are significant systemic signs and/or cellulitis. If so, penicillin would be the medication of choice, as previously recommended for cellulitis.

Follow-up. The only definitive treatment is extraction, which should be performed as soon as is feasible for the patient and the dentist. If the offending tooth is not removed, the abscess will continue to form repeatedly.

Acute Necrotizing Ulcerative Gingivitis

Patients occasionally present to emergency departments with various periodontal diseases.¹¹ The most dramatic of these is acute necrotizing ulcerative gingivitis (ANUG). Most emergency periodontal problems can be managed as described below for ANUG, that is, with debridement and lavage.

Pathosis. During World War I, ANUG was known as “trenchmouth” because it was common in soldiers who spent long, stressful periods in battlefield trenches



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and often had poor nutrition and no oral hygiene. ANUG results from impaired host response. Causative factors can include inadequate sleep, poor nutrition, tobacco use, AIDS, and psychological stress. The overriding etiology is poor oral hygiene, resulting in gross plaque accumulation. Spirochetes and other bacteria abound in the necrotic gingival tissue.¹²

The most common causes of emergency visits for dental complaints are pulpal and periapical pathoses.

icillin, 1000 mg stat, then 500 mg every 6 hours for 7 days.⁹

Follow-up. Patients with ANUG should be encouraged to follow up with a dentist as soon as possible. The dentist will completely remove the local irritants and perform prophylaxis (thorough cleaning) and instruct the patient in appropriate oral hygiene measures.

Clinical presentation and diagnosis. The most obvious and immediate finding is a strong, fetid malodor, which may be detectable from across the room. Intraoral findings are readily apparent and include gingival inflammation, with beet-red, swollen tissues at the margins of the teeth and a gray, pseudomembranous slough of gingiva, particularly of the interdental papillae (**Figure 7**). A patient with ANUG will report constant radiating, gnawing pain with a foul taste. Systemic complications are infrequent.

Treatment. Systemic signs, such as elevated temperature, malaise, and lymphadenopathy, should be evaluated. Although ANUG is unpleasant, these patients do not necessarily require immediate treatment in an urgent care setting. Treatment can be delayed until a patient can see a dentist, preferably as soon as is convenient. If the decision is made to render treatment, topical anesthetic can be applied to the inflamed tissues. After several minutes, gently swab the gray pseudomembrane and remove it with moistened cotton swabs or pellets to reduce irritants and the microbial load. Hemorrhage will be copious. Use each pellet in a limited area and then discard it. Then rinse with warm water or saline.

Instruct the patient to avoid alcohol and tobacco and to rinse with 3% hydrogen peroxide every 2 hours. Rest is required. Brushing can be done gently with an ultrasoft brush and also flossing, if it is not too painful. The patient must be informed that the tissues will bleed readily.

Pain medication. Conventional OTC analgesics, usually NSAIDs or acetaminophen, are appropriate for pain management. Narcotics usually are not needed.

Antimicrobials. Antibiotics are of no benefit for ANUG, unless systemic signs and symptoms are significant, which is unlikely. With systemic signs, the choice is amox-

Conclusion

Dental emergencies are an emerging chief complaint for patients presenting in an urgent care setting. A systematic approach that includes a good physical exam of the gums, teeth, and throat; a correct diagnosis; and proper treatment plan can provide pain relief and avoid further complications. The treatment protocol for such emergencies usually ends in a dental referral, which is often not feasible on weekends and evenings. The goals of treatment in the urgent care setting are to relieve pain, and occasionally, swelling, and to educate the patient on home management and the importance of seeking dental care as soon as possible. Some urgent care providers may want to consider seeking further training in dental emergency procedures to meet the increasing need for after-hours dental care. ■

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Case Report

High-Risk Conditions Presenting as Back Pain (Part 3)

Urgent message: Fever plus back pain should alert a provider to a potentially serious condition that warrants further workup.

ERICA MARSHBURN, BS, BA, and JOHN SHUFELDT, MD, JD, MBA, FACEP

Overview

Many high-risk conditions can present as back pain and back pain is a very frequent presenting complaint in urgent care medicine. When the back pain is associated with fever of unknown etiology or if it occurs in someone with a history of receiving intravenous (IV) medicine or in an IV drug abuser, consider epidural abscess as a high-risk rule out.

Case Presentation

A 36-year-old employed mother of two presents with a complaint of back pain radiating around her side to her chest and a low-grade fever over the last 2 days. She was recently discharged from the hospital after a stay in the intensive care unit for a closed head injury resulting from a motor vehicle accident.

Pertinent Physical Exam

The patient's pulse is 115, blood pressure 160/94, respiratory rate 18, and temperature 39.5°C. On exam, she has some mild tenderness over the lower thoracic spine. Extensor plantar responses are positive and lower extremity strength is RLE (right lower extremity) 4/5, LLE (left lower extremity) 4+/5. Deep tendon reflex is +4 or hyperactive with clonus. The rest of the patient's exam, other than her vital signs and deep tendon reflexes, is completely normal.

Labs/Imaging

Laboratory:

CBC: WBC 17,500 with a left shift

I-stat: Lytes, BUN and creatinine are normal.

Erica Marshburn is an independent business consultant and the principal of Medical Business Technologies in Scottsdale, Arizona. She plans on entering medical school in the fall. John Shufeldt is principal of Shufeldt Consulting and sits on the Editorial Board of JUCM. He may be contacted at jshufeldt@shufeldtconsulting.com.



Figure 1. Sagittal T1 Weighted MRI

Urine: Normal

Blood Cultures: Sent to lab, pending

ESR: 36

C-reactive protein: Elevated



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Figure 2. Sagittal MRI



Figure 3. Epidural Abscess - Sagittal MRI

The complete blood count reveals leukocytosis, which is present in about two-thirds of patients with spinal epidural abscess. Blood cultures are positive in 60% of cases and erythrocyte sedimentation rate (ESR) may be highly elevated in cases of spinal epidural abscess. Leukocytosis and ESR elevation are nonspecific laboratory findings and are not invariably present. Neither the presence of these findings nor the degree of laboratory abnormality is specific for spinal epidural abscess.

Lumbar puncture is relatively contraindicated if spinal epidural abscess is suspected because of the risk of introducing purulent material into the subarachnoid space. However, lumbar puncture (LP) done under fluoroscopy may be essential to exclude meningitis from the differential diagnosis.

Imaging:

Immediate imaging of the spine and spinal cord is imperative when a diagnosis of spinal epidural abscess is suspected based on clinical findings. Such patients should be transferred to the emergency department for further imaging and admission. Magnetic resonance imaging (MRI) with and without gadolinium is the modality of choice because it has the greatest diagnostic accuracy and affords much more better differentiation of soft tissue densities than does computed tomography (CT) imaging.

If MRI is unavailable, CT myelography can reveal a spinal epidural abscess. CT scan is inadequate, however, for showing soft tissue structures adequately. Conventional myelography also can be used, but may underestimate the size of the abscess and like

LP, risks contaminating the entire spinal cord.

The only possible value of plain films would be if osteomyelitis were suspected initially or with any injury to the lumbar spine. Plain radiographs are never sufficient to establish a diagnosis of spinal epidural abscess.

This patient's epidural abscess is causing a transverse myelopathy, requiring surgical decompression (**Figure 1**). The spinal cord is also vulnerable to encroachment by benign/malignant tumors, infectious diseases of the bony vertebra and disk spaces, stenosis of the neural foramen, vascular malformations with and without bleeding, and posterior herniation of disc material.

Depending on the type of images generated (T1 or T2 weighted), spinal fluid may be seen as a bright or dark signal. In **Figure 2**, starting at the lower levels, we can follow the spinal cord upward. The spinal fluid appears white. At the level of the pathology the dura, spinal cord, and epidural abscess are all clearly seen.

The sagittal view in **Figure 3**, of the same disease process, shows fluid collection and the cord as two separate densities. Looking at the sagittal MRI at the level of the pathology, we can clearly see a density difference between the abscess and the spinal cord.

An axial rather than sagittal reconstruction above the level of the abscess shows a normal spinal cord, vertebral body, and posterior elements (**Figure 4**). A large epidural abscess is impinging upon the spinal cord, which is diagnostic for an epidural empyema. With an axial scan sequence, we can see the difference between the cord and the fluid collection compressing the cord and jeopardizing spinal cord function.

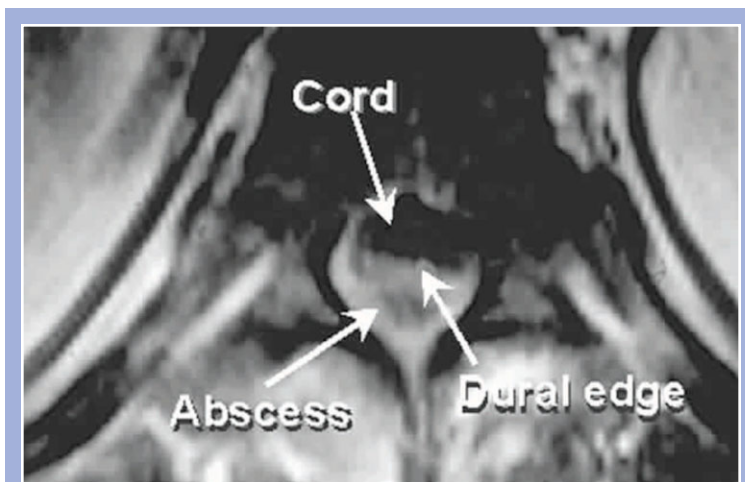


Figure 4. T₁ Weighted MRI

Diagnosis

A spinal epidural abscess is a rare, but potentially fatal, condition that requires early detection and proper management to optimize neurological outcomes. Spinal epidural abscess is an infectious process usually confined to the adipose tissue of the posterior epidural space, where there is a rich venous plexus. Major risk factors include diabetes, intravenous (IV) drug abuse, chronic renal failure, alcoholism, and immunosuppression. Presentation begins with backache that progresses to localized back pain associated with tenderness to percussion. Fever, sweats, and rigors are common (30%-75% of cases), and marrow edema in facet articular processes and adjacent laminae are often seen. **Table 1** lists differential diagnoses that should be considered.

Course and Treatment

Treatment most often consists of both medical and surgical therapy. Emergent surgical consultation should be sought for decompression and drainage of purulent material. Blood and abscess culture results guide definitive medical therapy. Antibiotic treatment with CT-guided aspiration of the epidural space is increasingly used in patients who are at prohibitively high risk of surgery or who have a presumably irreversible fixed paralysis. Successful treatment with a combination of abscess aspiration and antibiotic treatment has been reported and its use seems to be increasing. Resolution of the abscess with antibiotics alone has been reported in patients who are not candidates for surgery because of spine instability or coexisting medical problems. Deterioration of clinical and functional status while undergoing antibiotic therapy alone has been observed and may dictate emergent surgical decompression.

Empiric antibiotic coverage should include antistaphylococcal antibiotics. With the increasing incidence of methicillin-resistant staphylococcus (MRSA) infections, coverage that includes antibiotics effective against MRSA is recommended. If a patient remains neurologically stable and has a mechanically stable spine, some clinicians recommend that antibiotic treatment be delayed until material is obtained for a culture. Coverage should be tailored if culture data are available or if a suspected precursor to the infection is established.

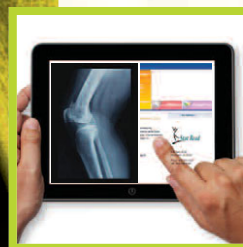
If a patient's infection follows a neurosurgical procedure, an antistaphylococ-

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Table 1. Differential Diagnosis of Spinal Epidural Abscess

Arteriovenous malformations	Metastatic disease of the spine and related structures
Brain abscess	Multiple sclerosis
Cervical spondylosis	Psoas abscess
Diskitis	Spinal cord hemorrhage
Endocarditis	Spinal cord infarction
Epidural hematoma	Tropical myeloneuropathies
Herniated nucleus pulposus	Vertebral osteomyelitis
HIV-1-associated vacuolar myelopathy	Vitamin B ₁₂ -associated neurological diseases

Table 2. Common Sources of Spine or Paraspinal Tissue Infection

Hematogenous infection of skin and soft tissue

- Infected catheter
- Bacterial endocarditis
- Respiratory tract infection
- Urinary tract infection
- Dental abscess

Contiguous spread

- Vertebral osteomyelitis
- Retropharyngeal abscess
- Dermal sinus tract
- Psoas abscess
- Penetrating injury
- Epidural injections

cal penicillin, a third-generation cephalosporin, and an aminoglycoside should be prescribed in combination. Patients with spinal epidural abscess may be clinically unstable because of concomitant systemic infection, shock, complications of diabetes mellitus, or other complications. As a result, the increased surgical risk often must be weighed against the risk of using antibiotic therapy alone.

Discussion

Most symptoms of spinal epidural abscess are a result of enlargement of the abscess and inflammation in the surrounding area, which leads to tissue compression and ischemia of the spinal cord. Most cases of spinal epidural abscess are caused by *Staphylococcus aureus*, but a range of other bacteria can also bring about infection.

Clinical presentation can be quite variable. The clinical triad of fever, back pain, and neurologic deficit is not present in most patients, and should not be relied upon for diagnosis. Early presentations may be subtle, and atypical presentations are not unusual. Reflexes may vary from absent to hyperreflexia with

clonus and extensor plantar (Babinski) responses. Areflexia may indicate spinal shock with transient inhibition of spinal reflexes. Nuchal stiffness or rigidity may be present, most notable with cervical epidural abscesses. Ten percent of patients with spinal epidural abscess present with encephalopathy.

A four-phase sequential evolution has been described in the literature: 1. Localized spinal pain, tenderness, and possibly fever; 2. Radicular pain and reflex abnormalities; 3. Muscular weakness, sensory loss, and sphincter dysfunction; and 4. Paralysis.

The virulence of the infecting organism and the mode of infection contribute to the tempo of this progression. Hematogenous abscesses tend to progress rapidly, whereas abscesses from osteomyelitis or discitis may evolve over weeks or months with a slower progression of symptoms. Localized back pain often is the first symptom and patients frequently give a history of back strain or mild injury. A source of infection in skin or soft tissue also may be found, and radiculopathy with radiating or lancinating pain, including chest or abdominal pain, is a common symptom.

IV drug users are a high-risk group for spinal epidural abscess, and even patients with a remote history of IV drug abuse are at risk. Cases are frequently reported in patients with spinal trauma, alcoholism, conditions involving chronic immunosuppression, and diabetes mellitus, a risk factor in 50% of reported patients. Hematogenous seeding of the epidural space with abscess formation may stem from IV lines, urinary catheters, or implantable devices.

Epidural abscesses at the level of the cauda equina cause symptoms consistent with cauda equina syndrome rather than a spinal cord syndrome, and can involve paraparesis with prospective progression to paraplegia as well as sphincter dysfunction, including incontinence or increased residual urine volumes. Central cord syndrome from epidural abscess also has been reported and is marked by disproportionate impairment of motor function in the upper extremities compared with the lower ones.

Physical findings vary with the degree of spinal cord compression or dysfunction. In the most advanced cases, a transverse cord syndrome is seen with motor and sensory levels found with neurologic examination. Localized tenderness to percussion or palpation at the site of the abscess may be noted. Paraspinal muscle spasm also may be present.

Most cases of spinal epidural abscess arise from hematogenous seeding of the epidural space from a distant source of infection, but a few cases are the result of direct extension of infection from the spine or paraspinal tissues. Common sources of infection are listed in **Table 2.**

Practice Management

Public Relations in Urgent Care: A Step-by-Step Plan for Success

Urgent message: Getting local media attention can drive patients to an urgent care center's doors. Applying best PR practices can produce results and conserve marketing dollars.

MARCIA HORN NOYES

Despite the meteoric rise in urgent care center openings over the past decade, media outlets indicate that story pitches received from urgent care providers pale in comparison to those submitted by hospitals and pharmaceutical companies. Yet urgent care medicine remains fertile ground for quick and compelling medical stories sought by reporters each day. Harnessing those needs by submitting story ideas based on the services an urgent care center offers is one way that providers can propel their businesses forward in their own communities.

To do so, an urgent care provider must understand best practices for public relations initiatives and media outreach so that urgent care practices can be taken to the next level and avoid falling short of goals while wasting valuable marketing dollars. This article offers an inside view of what it takes to effectively communicate story ideas to reporters and the difference an ongoing public relations initiative has made to one group of urgent care clinics in Texas.

Introduction

Public relations (PR) is often viewed by business owners as “just another aspect” of marketing. Although

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the two disciplines often work hand-in-hand, they remain vastly different in approach and investment. Marketing's immediate goal is business profit, whereas the goal of PR is long-term relationship-building that can affect positive community perception and business positioning as well as solidify the expertise of business owner(s) in the community.

This article examines the effects of establishing a PR outreach program through one case study and identifies ways in which urgent care centers can best accomplish the often overwhelming task of media outreach, either internally or with an outside agency.

Case Study

Over the past 30 years, Texas MedClinic has expanded to support the San Antonio and Austin communities with 14 clinics strategically located throughout the two cities. In an effort to increase community visibility through media outreach, the previous marketing director decided to divert some of the clinic's marketing dollars to PR. Initially, the marketing director attempted PR efforts along with her ongoing marketing responsibilities. Quickly, she recognized that her skill-set did not include knowledge or previous work experience with local reporters and all the multi-tasking hampered her efforts.

She then hired outside PR professional Kay Floyd of Kay Floyd PR in San Antonio, who made it her personal goal to have Texas MedClinic visible in some media publication or broadcast at least once a month. "I recognized that the mention might be some small announcement published about a physician hired, but the size really didn't matter," explained PR firm owner Kay Floyd. "The fact that it may not be a major story every month was of little consequence; my goal remained to have people from the community say to the owner that they see his name and business everywhere."

Six years later, local reporters now regularly use Texas MedClinic as a go-to source for particular types of medical stories, and the clinics frequently receive widespread media coverage about medical conditions they treat, as well as publicity surrounding new openings and product launches.

PR Considerations

Developing a PR campaign and continual media outreach can often be more effective than advertising. However, defining goals and knowing the approximate lead time for success is critical in these efforts. Before initiating a PR campaign, hiring an outside agency or approaching media, an urgent care provider must have the following:

- Upper management buy-in;
- A decision about handling PR internally versus external execution; and
- Full understanding about the success lead time

PR professional Kay Floyd states that buy-in must be both philosophical, as well as financial. "Often, the financial side is the easiest," explains Floyd. "Cutting a check is simple, but the commitment to meeting the time constraints of reporters, being mindful of HIPAA laws and regulations as they relate to broadcast footage and having a medical professional readily available to explain complex medical terms in com-

mon language is the difficult part."

Also, urgent care centers must initially decide whether internal or external efforts make more sense. Marketing Director Gwynn Deaver of Texas MedClinic says that for a single urgent care center, handling PR internally isn't realistic. "I wear a multitude of hats, so it's not logical for me as the marketing director to handle PR, nor do I have the expertise needed." Deaver also cautions that if an urgent care center does decide to execute PR initiatives internally, hiring the right person is imperative. "Someone fresh out of college with a PR degree is not the best option, because deep media relationships are formed over time and those just entering the workforce don't have those longstanding relationships."

Even with hiring an outside PR agency, urgent care businesses must also recognize that PR success doesn't happen overnight. It took Texas MedClinic 3 to 4 years before reporters began calling for its medical expertise without outbound prompting or pitching.

For Texas MedClinic, a commitment to meeting reporter deadlines is one strategy that has helped achieve this success. "We conduct interviews within 30 minutes to 1 hour after each reporter call, making that commitment an important part of what we do," explains Deaver.

Tips for Hiring the Right PR Agency

While the cost of an outside firm may be first and foremost in mind, an urgent care provider should not select a firm based solely on price. Kay Floyd recommends that if plans include hiring an outside agency, the following considerations should be made:

- Look for an experienced PR practitioner – experience is well worth the money.
- Find a practitioner who belongs to the Public Relations Society of America (PRSA). Members of the Society, whether individuals or agencies, are involved in ongoing PR education and know best practices in the field.
- Locate someone who has healthcare experience or has other healthcare clients. Knowing the reporters who cover the types of stories you want placed is invaluable.
- Determine if the potential agency or individual has longstanding media relationships in your community. If a particular media personality covering healthcare has never heard of the agency or individual, be wary.

Press Outreach: Getting Off on the Right Foot

Hiring the right individual or PR agency is important



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The Urgent Care College of Physicians (UCCOP) is a young, independently governed organization committed to clinical urgent care medicine and the physicians who practice it. With the support of the Urgent Care Association of America (UCAOA), The Journal of Urgent Care Medicine (JUCM) and others, UCCOP has been able to begin it's work and move onto critical growth tasks.

Specialty development and advocacy efforts, initially supported by UCAOA, have now become a primary part of the UCCOP mission. Some of these efforts include authoring and reviewing clinical articles for JUCM, developing, performing, and publishing clinical research, furthering fellowship training in urgent care and developing and providing clinical education programs specifically for the urgent care practitioner. Please consider joining us as a member and help improve our strength by participating.

Visit us at **www.uccop.org** and find out what we can do together to help UCCOP continue inspiring excellence and advancing the future of urgent care. We have several committees we encourage members to work on, and only together can we be successful.

Look for future information on our website, via email, and at the Spring UCAOA/UCCOP conference in Las Vegas at Caesar's Palace April 16-19, 2012.

Sincerely,

William Gluckman, DO, MBA, FACEP
President, UCCOP

because understanding the story needs of local press is the first step in effective media outreach. Around the country, newsrooms are shrinking and are often a shadow of what they were two decades ago. In this news climate, knowing what *not* to do may be even more important than knowing best practices.

Neal Barton, news director for KETK-TV in Tyler, Texas, says “Calling in or writing to say that ‘you need to or better cover this or that story’ is one sure way to create animosity with overworked assignment editors, reporters and news directors. “The story must have value to the audience and meet the station’s brand,” explains Barton.

Even in knowing what not to do, developing a story idea that can break through the barrage of pitches and story leads that can easily reach 50 emails an hour is a difficult task for most PR professionals. However, KCNC-TV Assignment Editor Doug Hoffacker from Denver, Colorado, lists several ways to rise above the PR-crowded landscape with reporters:

- Know the media outlets in your area. Not every story fits every news station or publication’s audience; some stations are focused heavily on hard news, while others make feature stories a major part of their broadcast.
- Determine which reporters cover the types of stories you will pitch. If you don’t know, call the assignment desk and ask. Assignment editors have short attention spans, as their tasks often include handling details around breaking news stories; it’s often more advantageous to reach out directly to reporters.
- Develop a rapport with medical reporters or producers. Call reporters and mention a particular story upon which they’ve recently reported, then ask about other stories in which they might have an interest.
- Be respectful of time constraints. Reporters, assignment editors and producers are wearing multiple hats in newsrooms across the country and have little time to chitchat about stories. Craft pitches as succinctly as possible and provide the necessary details about time, place, possible interviews, as well as offering ideas about the type of visuals that can be provided.

Tips for Getting Television Coverage

In the past, television news consisted of noon, 5 p.m.

Even with hiring an outside PR agency, PR success doesn’t happen overnight.

and 10 p.m. broadcasts; now, news is required throughout the day. “It’s equally important for us to obtain news for the morning shows, Facebook and Twitter pages, as well as for all newscasts,” explains Hoffacker. “We need updates continuously to keep the

news flow going and to satisfy our audiences.”

Keeping the story pitches coming from businesses and PR professionals is important to KCNC-TV, so Hoffacker often speaks to PR professionals about the right way to pitch a story idea. He has developed the following pitch tips based on his station’s needs and offers the best way to have stories hit the air. Those include:

- Keep it short. Broadcast stations typically decide the day of an event about news coverage, not before.
- Communicate efficiently. Email the media outlet, then place a phone call within a half hour later to follow up.
- Be timely. If you can, tie your story pitches to a major trend or into current news.
- Realize the audience and ask the question. Will your entire state care about this story, or is the story of interest only within your particular neighborhood?
- Cast a wide net. If one station doesn’t bite on the story idea, try others, as well as large and small newspapers alike.
- Avoid calling at bad times. Monday mornings, Friday afternoons, 9:30 a.m. to 10:15 a.m. and 4:30 p.m. to 6:00 p.m. are heavy planning times for television news departments and are some of the worst times to call.
- Schedule news conferences at 10:00 a.m. or 11:00 a.m. Reporters can get to news conferences easier at those times than at 3:00 p.m. when it is closer to the busy afternoon news block.

Next Steps for Handling PR Internally

At the end of 2011, PR Manager Suzy Buglewicz, who handles all client-related press releases for iTriage product launches throughout the country, took note of the hospitals, physician practices and urgent care centers that had stellar media success. In all cases, Buglewicz found that those medical providers who had engaged an outside PR firm or had developed local media contacts with an internal PR initiative had the greatest number of media hits after launching iTriage in their respective communities.

With the help of Buglewicz, iTriage offers press release

writing and distribution services to help its clients that haven't yet embraced the nuances of media outreach, but for those urgent cares that want to "dip toe" into PR, she offers these steps for press release distribution:

- Always include a press release in the body of an email, never as an attachment. Some reporters automatically delete all emails with attachments for fear of virtual viruses.
- Offer to send a high-resolution photo or video clip somewhere in the pitch or press release. Print publications and online media sources like visuals and this will help the overall pickup of press releases.
- Keep press releases to no more than 2 pages; 1 page is ideal for reporters inundated with story ideas and press releases.
- Include contact information (email and phone number). Reporters will quickly hit the "delete" button if you neglect the most important details.

Conclusion: PR Sources and Facts to Know

With urgent care mergers and acquisitions, as well as expansions across state lines, coordinating and hiring multiple PR agencies can become necessary. In those instances, one source to consider is the PRConsultants Group — a collaborative of senior-level PR experts located in every major market in the United States. When PR is required for multiple media markets, urgent care providers can access this collaborative to meet PR needs anywhere in the country.

Determining agency costs and quantifying success is difficult, as numbers often vary. However, here are some figures and information upon which to base your proposed PR initiatives:

- Average cost to hire an outside agency — \$750 to \$2,000 per month
- Expected time for outside agency success — 3 to 4 years
- Expected time for internal PR success — 4 to 6 years
- Types of stories easiest to place: Hard news, such as information on H1N1, methicillin-resistant *staphylococcus aureus* and changes in state law relative to vaccinations

For urgent care providers contemplating PR, the most important question remains: What is the potential return on investment? The impact of PR may be difficult to gauge in the early stages, but the efforts can make a significant impact on business expansion, community visibility, and the bottom line without adding additional marketing dollars.

To illustrate, in 2005 Texas MedClinic had 8 clinics. "Today, we have 14 and are opening one to two clinics each year," explained Deaver. "Without PR efforts, we would not be enjoying the expansion we have today. An uptick in patient volume can typically be tracked to every new story." ■

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ABSTRACTS IN URGENT CARE

■ Use of Head CT by ED Physicians

■ NAHUM KOVALSKI, BSc, MDCM

■ Treatment of Pediatric Fracture Pain in the ED

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.

ED Physicians Vary Widely in Use of Head CT

Key point: *ED physicians vary widely, by as much as 300% for patients who presented with atraumatic headache, in their ordering patterns for head CTs.*

Citation: Prevedello LM, Raja AS, Zane RD, et al. Variation in use of head computed tomography by emergency physicians. *Am J Med.* 2012;125(4):356-364.

A research team led by Dr. Luciano Prevedello, a fellow at the Center for Evidence-Based Imaging at Brigham and Women's Hospital, conducted a study of variation in head CT exam ordering by emergency physicians. The researchers' primary objective was to quantify the extent of variation among individual emergency physicians, including a subanalysis of ordering brain CT exams for patients with atraumatic headaches. They also wanted to determine if any variation remained after controlling for factors believed to be associated with differences in ordering head CT exams.

The researchers identified 55,281 patient visits to the hospital's emergency department in 2009. Of these, head CT exams were ordered for 4,919 patients, or 8.9% of the total patient population. The researchers determined that the rate of ordering head CT exams ranged from 4.4% to 16.9%. After controlling for pertinent variables, a twofold variation existed, with a range of 6.5% to 13.5%.

There was a threefold variation in the number of CT scans ordered by emergency physicians to diagnose patients with atraumatic headaches. After adjusting for factors such as patient mix and degree of trauma, head CT ordering rates for patients presenting with atraumatic headaches ranged from 21.2% to 60.1%.

No correlation in head CT ordering frequency could be es-

tablished based on physician age, gender, or experience. Time of day and the location within the hospital where the patients received emergency treatment also were unrelated.

The study confirms earlier peer-review published findings of wide variation in imaging use, the authors concluded. They attributed the variation to issues such as physician knowledge gaps and practice style variations. ■

Pediatric Pain from Fractures Is Undertreated in the ED

Key point: *Only 70% of children with isolated long bone fractures received pain medication during their emergency department stays.*

Citation: Dong L, Donaldson A, Metzger R, Keenan H. Analgesic administration in the emergency department for children requiring hospitalization for long-bone fracture. *Pediatr Emerg Care* 2012;28(2):109-114.

To evaluate the frequency and predictors of analgesic use for pediatric pain, investigators reviewed charts for 773 children <15 years (mean, 6.4 years) with isolated long bone fractures who presented within 12 hours of injury to a single level I pediatric trauma center during 2 years.

During the first hour after arrival in the emergency department (ED), 10% of patients received adequate pain medication (standard doses of opioids, nonsteroidal anti-inflammatory agents, or acetaminophen), 31% received inadequate pain medication, and 59% received no pain medication. Overall, 71% of patients received pain medication during their ED stays. In multivariate analysis, children aged 10 to 15 years were more likely to receive adequate pain medication within the first hour than those <2 years (adjusted odds ratio, 2.5). Longer time from injury to ED arrival, closed fractures, and upper-extremity fractures were associated with lower likelihood of receiving adequate analgesia.

Published in *J Watch Emerg Med.* March 2, 2012 — Katherine Bakes, MD. ■



Nahum Kovalski is an urgent care practitioner and Assistant Medical Director/CIO at Terem Emergency Medical Centers in Jerusalem, Israel. He also sits on the *JUCM* Editorial Board.



It's You

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

Maybe you read my columns in the two previous issues of *JUCM* and had a brief moment of self-awareness. Maybe one of your co-workers put them in your mailbox. Did you actually ask your co-workers and subordinates if you were the “cancer” I was talking about? They are not going to be honest. They care little about you and fear for their jobs, and so, are hardly going to be candid. You may have even told your significant other, but she already knows the real you and has come to the same conclusion. Maybe you even took a shot at the messenger, but no matter what, there’s no hiding from the facts. Unlike Arnold, “It’s not a tumor” Schwarzenegger, it is a tumor and it’s you.

What do you do? You could continue to blame others for your lot in life, but where will that take you? By the way, your employer has not told you yet, but you are on the way out, so you better get your act together fast because another job change at your age does not look good on the old resume and you have abused too many vendors and past employees to find meaningful work, even in a city as big as yours. So now what?

The How and Why of Coaching

Personal development involves a sometimes painful examination of your opportunities for improvement. The process entails 360-degree feedback from all the people you interact with, both inside and outside of the organization. The feedback should be direct, honest and unbiased. This sort of assessment is best performed by a professional coach. Typically, such coaches are psychologists, organizational behavior experts, successful retired executives, or educators. Historically, coaching was reserved for the underperformers. Today, however, leaders in all fields are using professional coaches to ensure that they reach their full potential.

The concept of coaching goes back to the Yale v. Harvard Football days of the late 1800s, when Yale hired the great Walter Camp and beat Harvard 26 out of 30 times in American-rules

football. Since then, coaching has become an integral component of athletics. Professional athletes, singers, and performers employ coaches for the entire duration of their careers. Coaching has also proved useful in the classroom. The students of teachers who are coached have better classroom test scores than their counterparts. The typical pedagogy of collegiate coaching, wherein at some point, the student no longer needs a coach, does not necessarily apply, however, in the professional world.

In some careers, people simply peak early. For example, my pop music career was over well before my 30s. People in other careers, such as mathematics, baseball, and pole dancing, also peak before age 30. Compare these jobs to ones that require complex interpersonal skills or an understanding of science or nature. The average age of a Fortune 500 CEO is 52. One study found the maximal productivity for a geologist occurs in the mid-50s.

Benefits of Coaching

Who can benefit from a coach? We all can! Studies reveal, however, that very few of us will actively seek out professional assistance to help us stretch. Some of us hate the idea of being observed, others fear that having a coach means you are not competent or are convinced that the coach was hired to report back to his or her superiors. Remember, everyone can benefit from being coached. Sometimes, it may be the most seemingly trivial thing in the world, but the trickle-down effect from this inconsequential behavior can be a game changer.

Take famed UCLA basketball coach John Wooden. At the start of every season, he had the entire team sit down while he taught them to put on their sweat socks. Back in the Wooden era, UCLA was a powerhouse. Many on the team went on to careers in the NBA. Imagine their chagrin when they were being taught how to put on socks. Wooden was teaching two points: Putting on socks correctly prevents blisters. He taught them how to roll the socks up their feet and ankles and then smooth out the creases. Preventing blisters helps athletes stay in the game and may be the difference between a win and a loss. He was also demonstrating that seemingly small details separate winners from losers. “Details create success” was the credo of the UCLA men’s basketball program.



John Shufeldt is principal of Shufeldt Consulting and sits on the Editorial Board of *JUCM*. He may be contacted at jshufeldt@shufeldtconsulting.com.

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HEALTH LAW

If your ego can accept the fact that you may not be perfect, then enlist the help of a coach.

Good coaches drill into the details, reviewing the nuances of whatever role they are evaluating. What was your body language during that discussion? How did you open the meeting? Did you communicate the message so that everyone was clear on your intent? Were the results effectively communicated? How did you coach that employee? Did you communicate in a way that the employees understood the message? Was your communication style belittling?

Highly successful individuals are intentional. They engage in very deliberate practice to develop the full range of behaviors and traits required for sustained performance at an elite level. First, they identify areas of deficiencies. This is a tough, ego-bruising exercise. A good coach can gently help you through the exercise of self-reflection. Expertise requires transitioning from unconscious incompetence (I am incompetent and unaware), to conscious incompetence (I know my weaknesses), to conscious competence (I have to consciously work at it), to unconscious competence (It has become an ingrained habit). This evolution can only begin with the transition from incompetence to consciousness and that can only happen with either introspection or coaching.

With only a diploma in hand, few of us can muster the level of introspection necessary for sustained, elite performance. However, with a good coach, many of us could. During budgetary crises, coaching, mentoring, and training are the first things to get cut. However, doing so is akin to cutting marketing dollars when more patients are needed to improve the top line.

Training and the 'Tumor'

As providers and operators, we always want the best, newest equipment and supplies, no matter the cost. We quote statistics about patient safety and reduced complication rates. We argue about search engine optimization, a larger media buy, bigger signage—the list goes on and on. Yet, are we willing to turn the lens toward ourselves? Are there techniques and strategies you could employ to produce amazing results? Are there things you can do to motivate your employees that would enable them to carry your business further?

If your ego can accept the fact that you may not be perfect, then enlist the help of a coach and move from unconscious incompetence to unconscious competence and watch your career and business flourish. As for my friend, "The Tumor," one way or another, I suspect the outcome is predestined. ■



Coding of Multiple Wound Repairs, Coding an E/M, IV Infusion, Coding of the Comprehensive Metabolic Panel

■ DAVID STERN, MD, CPC

Q. We have a patient with several lacerations to both of his hands. On his left hand, we sutured a total of three lacerations that have a grand total of 3.5 cm and on his right hand, we sutured one laceration with a total of 3.0 cm. What is the best way to code this?

A. Assuming that all the procedures were simple wound repairs, you would simply add the lengths of each repaired wound together then code for a simple wound repair of the hand of the resulting length summation:

- 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.
- 12002 Simple repair... ; 2.6 cm to 7.5 cm
- 12004 Simple repair... ; 7.6 cm to 12.5 cm
- 12005 Simple repair... ; 12.6 cm to 20.0 cm
- 12006 Simple repair... ; 20.1 cm to 30.0 cm
- 12007 Simple repair... ; over 30.0 cm

You would sum wound repair lengths if all wound repairs were in the specified anatomic locations for the same code range and of the same complexity.

You would sum the wound lengths only for the wounds that are in any of the specified anatomical locations: that is, "scalp, neck, axillae, external genitalia, trunk, or extremities (including the hands and feet)." Wounds outside of these anatomic areas would be coded separately.

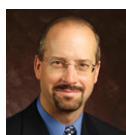
In addition, you should never sum the length of wound repairs for wound repairs of different complexities, even if

the repair is in the same anatomic location. For example, for a patient with a 2-cm simple repair of a laceration on the back and a 6-cm complex repair of a laceration on the back, you should code each separately as 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) and 12042 (Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm). You would not sum the lengths of the repairs because the repairs were not of the same complexity. ■

Q. I work in a hospital-owned urgent care center and would like to know what is correct when coding an E/M with 96370. I've been told to simply add Mod-25 to E/M and bill the medicine. It also depends on who the payors are. Some insurance companies will pay for the injection and some will not. Can you please clarify the correct coding?

A. The code (93670) you mention is for subcutaneous (SQ) (not intravenous [IV]) infusion. Thus, it would very rarely be used in urgent care. It should never be used:

- if the infusion was actually performed IV;
- if the infusion was not at least for 91 minutes. Note: For therapeutic infusions of 15 minutes or less, you should simply code for a SQ injection, i.e., 96372, Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular. For infusions of 16 – 90 minutes, you should code with 96369 alone.
- if the infusion was for hydration (most common reason in urgent care for infusions); or
- if 96369 is not coded for the first hour. The code 96370 is an add-on code to code for hours subsequent to the first hour. Code with 96369 for the first hour, then add code 96370 for each subsequent hour. ■



David E. Stern is a certified professional coder. He is a partner in Physicians Immediate Care, operating 18 clinics in Illinois, Oklahoma, and Nebraska. Dr. Stern was a Director on the founding Board of UCAOA and has received the Lifetime Membership Award of UCAOA. He serves as CEO of Practice Velocity (www.practicevelocity.com), providing software solutions to over 750 urgent care centers in 48 states. He welcomes your questions about urgent care in general and about coding issues in particular.



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Contact JUCM's editor, at editor@jucm.com.

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CODING Q & A

Q. What codes can our urgent care center use for infusions?

A. The codes below can be used for different infusions in urgent care. Specifically note that the codes for infusion fall into two basic categories. Hydration is separated from the codes for therapeutic, prophylactic, and diagnostic.

Hydration Administration Codes

- 96360 Intravenous infusion, hydration; initial, 31 minutes to 1 hour. If the total infusion time is 30 minutes or less, then you should not use this code.
- 96361 Each additional hour. Only use this code as an add-on code to 96360. It is added once, if the total infusion time is 91 to 120 minutes. It (96361) would be added a second time if the total infusion time is 121 to 180 minutes.

Therapeutic, Prophylactic, and Diagnostic Administration Codes

- 96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
- 96366 Each additional hour
- 96367 Additional sequential infusion, up to 1 hour
- 96368 Concurrent infusion
- 96369 Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour, including pump set-up and establishment of subcutaneous infusion site(s)
- 96370 Each additional hour

Q. We want to build a panel in our EMR, so that we can code the correct CPT code for each individual component of the Comprehensive Metabolic Panel (CMP). This will increase the revenue for performing a CMP by approximately ten-fold. However, a biller in our company does not believe that this is compliant. Is he correct?

A. Your biller is correct. Billing for each individual item in the CMP separately would be an example of unbundling. Unbundling refers to the practice of billing separately for individual codes in a situation when a single code exists that could include all of the individual codes. The Centers for Medicare & Medicaid Services has found this practice to be non-compliant and would consider billing this way to be fraudulent. ■

Note: CPT codes, descriptions, and other data only are copyright 2011, 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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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 email the relevant materials and presenting information to editor@jucm.com.

FIGURE 1



The patient, a 40-year-old woman, presented with trauma to the left wrist.

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

Resolution of the case is described on the next page.

THE RESOLUTION

FIGURE 2



Diagnosis: The x-ray reveals fracture of the scaphoid. A spica cast and follow-up with an orthopaedist are appropriate for this patient.

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

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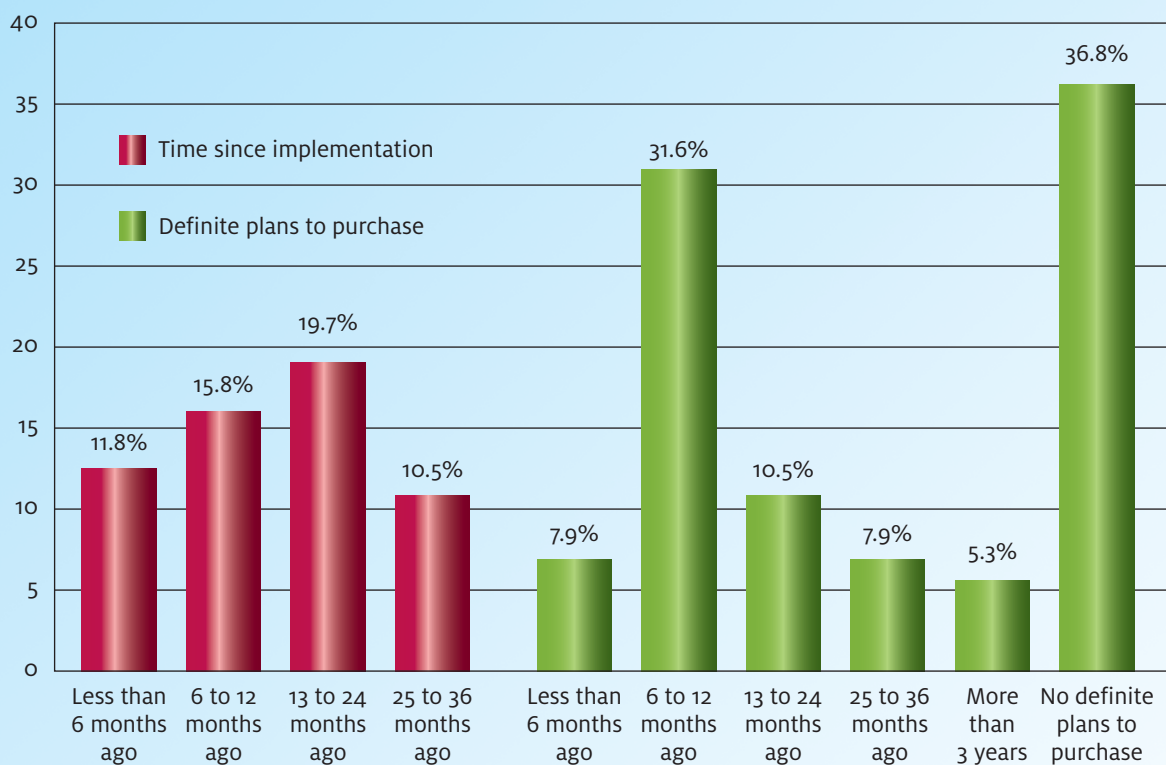
DEVELOPING DATA

These data from the 2010 Urgent Care Benchmarking Survey are based on responses of 1,691 US urgent care centers; 32% were UCAOA members. The survey was limited to “full-fledged urgent care centers” accepting walk-ins during all hours of operation; having a licensed provider and x-ray and lab equipment onsite; the ability to administer IV fluids and perform minor procedures; and having minimal business hours of seven days per week, four hours per day.

In this issue: Is your center using computerized systems for clinical processes?

USE OF COMPUTER SYSTEMS FOR CLINICAL PROCESSES

The 2008 survey revealed that utilization of computerized systems was fairly heavy for certain aspects of operations, such as billing and claims management, and less so for other aspects, such as prescription ordering. The 2010 survey looked at this data a little differently, examining also time in use. Where computerized systems were not in use, respondents were asked about plans for the center’s future use.



Of the urgent care centers that responded to the survey, 66.7% use computerized systems for clinical processes, but this is a much newer adoption than for practice management. Of the 33.3% who do not, there are more plans to implement soon.

Acknowledgement: The 2010 Urgent Care Benchmarking Study was funded by the Urgent Care Association of America and administered by Professional Research Associates, based in Omaha, NE. The full 40-page report can be purchased at www.ucaoa.org/benchmarking.



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