Management of the Patient Presenting with Epistaxis
IMPORTANT SAFETY INFORMATION

VIGAMOX® solution is indicated for the treatment of bacterial conjunctivitis caused by susceptible strains of the following organisms:
Corynebacterium species‡, Micrococcus luteus ‡, Staphylococcus aureus, S. epidermidis, S. haemolyticus, S. hominis, S. warneri‡,
Streptococcus pneumoniae, Streptococcus viridans group, Acinetobacter lwoffii ‡, Haemophilus influenzae, Haemophilus parainfluenzae‡,
Chlamydia trachomatis (‡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.

*The dosing of VIGAMOX® solution is one drop in the affected eye(s) 3 times daily for 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‡, Micrococcus luteus ‡, Staphylococcus aureus, S. epidermidis, S. haemolyticus, S. hominis, S. warneri‡,
Streptococcus pneumoniae, Streptococcus viridans group, Acinetobacter lwoffii ‡, Haemophilus influenzae, Haemophilus parainfluenzae‡,
Chlamydia trachomatis (‡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.

*The dosing of VIGAMOX® solution is one drop in the affected eye(s) 3 times daily for 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‡, Micrococcus luteus ‡, Staphylococcus aureus, S. epidermidis, S. haemolyticus, S. hominis, S. warneri‡,
Streptococcus pneumoniae, Streptococcus viridans group, Acinetobacter lwoffii ‡, Haemophilus influenzae, Haemophilus parainfluenzae‡,
Chlamydia trachomatis (‡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.

*The dosing of VIGAMOX® solution is one drop in the affected eye(s) 3 times daily for 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‡, Micrococcus luteus ‡, Staphylococcus aureus, S. epidermidis, S. haemolyticus, S. hominis, S. warneri‡,
Streptococcus pneumoniae, Streptococcus viridans group, Acinetobacter lwoffii ‡, Haemophilus influenzae, Haemophilus parainfluenzae‡,
Chlamydia trachomatis (‡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.
Controlled clinical trials in which patients were treated with VIGAMOX® solution in 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 in vitro susceptibility breakpoints and in vivo therapeutic 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 activity against the following: GABABacteria:
- Mycoplasma pneumoniae
- Mycobacterium marinum
- Legionella pneumophila
- Chlamydia pneumoniae

Anaerobic microorganisms:
- Clostridium tetani
- Clostridium perfringens
- Enterobacter aerogenes
- Enterobacter cloacae
- Escherichia coli
- Bacteroides species

The following organisms are considered susceptible against most systemic infections. Moxifloxacin exhibits in vitro activity against the following: GABABacteria:
- Staphylococcus aureus
- Staphylococcus epidermidis
- Streptococcus agalactiae
- Klebsiella pneumoniae
- Enterobacter aerogenes
- Acinetobacter calcoaceticus
- Staphylococcus saprophyticus

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

VIGAMOX® solution should not be injected subconjunctivally, nor should it be introduced into the conjunctival sac or onto the eye. VIGAMOX® solution is not for injection. Please note that microbiologic eradication of the baseline pathogens ranged from 84% to 94%. Please note that microbiologic evaluation 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:

- Staphylococcus aureus
- Streptococcus pneumoniae
- Moraxella catarrhalis
- Haemophilus influenzae

Other microorganisms:
- Legionella pneumophila
- Mycobacterium avium
- Mycobacterium intracellulare
- Mycoplasma pneumoniae

Clinical Studies: In two randomized, double-masked, multicenter, controlled clinical trials in which patients were dosed 5 times a day for 4 days, VIGAMOX® solution was successful in resolving conjunctival infections in 94% 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 evaluation does not always correlate with clinical outcome in anti-infective trials.

REFERENCES:

The Official Publication of the Urgent Care Association of America, is looking for good few authors.

Submissions on clinical or practice management topics, ranging in length from 2,500 to 3,500 words are welcome. The key requirement is that the article address a topic relevant to the real-world practice of medicine in the urgent care setting.

Please e-mail your idea to JUCM Editor-in-Chief Lee Resnick, MD at editor@jucm.com.

He will be happy to discuss it with you.
Provide your patients with convenience and peace of mind with in-office CBC testing

9 Parameter CBC From A Finger-stick and Only 4 Drops Of Blood:

- lymphocyte/monocyte percentage
- lymphocyte/monocyte count
- granulocyte percentage
- granulocyte count
- hematocrit
- hemoglobin
- MCHC
- platelet count
- white blood cell count

QBC Diagnostics
The World’s Only DRY Hematology System!

For more information contact QBC Diagnostics at 814-342-6210x224 • urgentcare@qbcdiag.com or visit www.QBCDiagnostics.com
LETTER FROM THE EDITOR-IN-CHIEF

Is Urgent Care “Real” Family Medicine?

I am acutely aware that urgent care medicine is practiced by a variety of specialties. However, family physicians make up the majority of those who practice in urgent care settings, and represent the most likely contingent of practitioners to fill the increasing demand for qualified practitioners in the future.

As an organization, UCAOA has made several steps toward improving the competency of family physicians entering the field, from formal training programs to continuing educational opportunities.

Through my work on the fellowship program, I have had many opportunities to interface with family medicine leaders and educators throughout the country. I have also had the opportunity to hear from residents about their perceptions of urgent care as a career, and, in turn, to hear about the feedback they get from their program faculty members and program directors.

Two things are abundantly clear:
1. Most family medicine educators and leaders do not consider urgent care to be “real” family medicine.
2. They are actively discouraging their residents from pursuing careers in urgent care.

The reasons for this are fairly easy to understand:
■ Family medicine, more than any other specialty, is committed to serving the primary care needs of communities nationwide. A key component of primary care by all definitions is continuity of care.
■ It is generally accepted that an urgent care clinic is not the best place for continuity of care.
■ The percentage of all residents entering primary care fields is declining, putting pressure on educators to fill the widening primary care gap.
■ The establishment of the medical “home” as a key component in the effective delivery of healthcare services further casts urgent care as an outsider.
■ The usual dose of specialty protectionism.

At the core of family medicine as a discipline is the concept of a patient viewed in “context.” This is what makes family medicine distinct from other specialties. This “context,” whether it be social, economic, cultural, psychological, educational, or familial dramatically impacts the approach a physician takes with a patient, and, arguably, improves patient outcomes as a result.

No one will argue against the idea that an ongoing relationship with a patient improves evaluation of a patient in context, but primary care has proven unable to manage the volume and scope of acute care problems, driving patients to seek alternative sources for their acute care needs. The options: the emergency department or the urgent care.

Beyond the obvious efficiencies and lower cost of urgent care services, family physicians in urgent care settings offer two real advantages over their emergency medicine colleagues:
1. We are less distracted by the critical patient, allowing for greater attention to be paid to the majority of patients with acute, undifferentiated problems.
2. We have a greater ability to evaluate a patient within context, understanding agendas more quickly, addressing psychosocial and cultural needs more accurately.

All of this, in my opinion, leads to more accurate diagnoses, better compliance, and better outcomes.

I practice family medicine every day, applying the principles of my specialty to better care for my patients. I am proud to be a family physician in urgent care practice. No apologies necessary.

I am interested in hearing from others. Tell your story as a family physician in urgent care practice. You should be encouraged to celebrate your choice of practice without abandoning your pride as a family physician.

Lee A. Resnick, MD
Editor-in-Chief
JUCM, The Journal of Urgent Care Medicine
President, UCAOA
DOCTORS WHO USE EHRs SAY THEY HELP IMPROVE THE QUALITY AND TIMELINESS OF CARE*

STIX®

INTEGRITAS, INC.

Here’s what doctors who use our STIX EHR say:

“We looked at a number of products, and we liked the STIX EHR best of all. It fits our practice and the mix of patients we see. The people at Integritas have been more than supportive in helping us with the transition to electronic records.”

Deeraj Taranath, MD
Premier Immediate Care,
Pennsylvania

“We treat urgent care, occ med and primary care patients, and without a doubt, the STIX EHR makes this mix completely workable for us. Everything I need is right there in the electronic chart, and STIX has increased our ability to code much better.”

Peter Urda, MD
River City
Health Services,
Kentucky

STIX EHR is now certified by CCHIT, a designation which exemplifies leadership in the EHR market. For information on CCHIT, visit www.cchit.org

Call 800-458-2486 or email stixsales@integritas.com for your FREE product demonstration.

www.integritas.com

* New England Journal of Medicine online June 18, 2008.
Whether the precipitating act is the slam of a door or unsafe use of a table saw, the proper initial care of injuries to the nailbed is vital to long-term positive outcomes.

In the next issue of JUCM: Whether the precipitating act is the slam of a door or unsafe use of a table saw, the proper initial care of injuries to the nailbed is vital to long-term positive outcomes.

Management of the Patient Presenting with Epistaxis

Differentiating between the majority of patients whose epistaxis can be managed in the urgent care setting and those few who require admission or specialty consultation is the first step toward successful management.

By Nathaniel Arnone, MD, Samuel M. Keim, MD, and Peter Rosen, MD

BOUNCEBACKS

The Case of a 37-Year-Old Man with Headaches

Could a case of “diagnostic momentum” impede you from recognizing key clues regarding a patient’s condition?

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

PRACTICE MANAGEMENT

Keeping Workers Well and Your Practice Profitable

Corporate wellness may well be “where the rubber meets the road” in the field of urgent care occupational medicine. A look at your options when building a successful program.

By Donna Lee Gardner, RN, MS, MBA

Letters to the Editor

From the UCAOA Executive Director

DEPARTMENTS

Insights in Images: Clinical Challenge

Abstracts in Urgent Care

Health Law

Coding Q&A

Occupational Medicine

Developing Data

CLASSIFIEDS

Career Opportunities
JUCM The Journal of Urgent Care Medicine (www.jucm.com) is published through a partnership between Braveheart Publishing (www.bravehearth-group.com) and the Urgent Care Association of America (www.ucaoa.org).

UCAOA BOARD OF DIRECTORS

Lee A. Resnick, MD, President
Cindi Lang, RN, MS, Secretary
Jeff Collins, MD, MA, Director
Don Dillahunty, DO, MPH, Director
J. Dale Key, Director
John J. Koehler, MD, Director
Peter Lamelas, MD, MBA, Director
Marc R. Salzberg, MD, FACEP, Director
David Stern, MD, CPC, Director
Laurel Stoimenoff, Director
Amy Tecosky, Director
Lou Ellen Horwitz, MA, Executive Director

EDITOR-IN-CHIEF
Lee A. Resnick, MD
editor@jucm.com

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

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

ART DIRECTOR
Tom DePrenda
tdeprenda@jucm.com

2 Split Rock Road, Mahwah NJ 07430

PUBLISHERS
Peter Murphy
pmurphy@bravehearth-group.com
(201) 847-1934
Stuart Williams
stwilliams@bravehearth-group.com
(201) 529-4004

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

JUCM The Journal of Urgent Care Medicine (JUCM) makes every effort to select authors who are knowledgeable in their fields. However, JUCM does not warrant the expertise of any author in a particular field, nor is it responsible for any statements by such authors. The opinions expressed in the articles and columns are those of the authors, do not imply endorsement of the recommendations of Braveheart Publishing or the editors and staff of JUCM. Any procedures, medications, or other courses of diagnosis or treatment discussed or suggested by authors should not be used by clinicians without evaluation of their patients’ conditions and possible contraindications or dangers in use, review of any applicable manufacturer’s product information, and comparison with the recommendations of other authorities.

JUCM (ISSN 1938-002X) printed edition is published monthly except for August for $50.00 by Braveheart Group LLC, at 2 Split Rock Road, Mahwah, NJ 07430. JUCM is pending periodical status at Mahwah Postal Annex, 46 Industrial Drive, Mahwah, NJ 07430. Attn: William Rinesh 201-760-0892 and additional mailing offices.
DocuTAP works closely with you to understand how your practice operates and to identify opportunities to increase physician productivity and staff efficiency. Our experienced, knowledgeable staff is committed to supporting you in the delivery of high-quality healthcare. At DocuTAP, we’re here for the life of your EMR and Practice Management solution.

Paperless is possible and it won’t hurt a bit.

DocuTAP EMR and Practice Management Solution 2.8.2

CCHIT® is a registered trademark of the Certification Commission for Healthcare Information Technology.

Establishing Meaningful Relationships™
1.877.697.4696 • www.docutap.com/JUCM • sales@docutap.com
If you stop to think about it, what you do in urgent care is absolutely astonishing.

You sit in a building all day (and sometimes into the night) and wait for complete strangers to walk in, voluntarily, and offer their bodies to you for healing. On the face of it, it seems like a crazy idea to think that this would work, that anyone would show up.

And yet they do it—on the order of about a million times per year.*

The level of trust that this requires is similarly astonishing. Your patients walk in, never having met you or your staff before, and share their hurts, plagues, and accidents of life, then ask you to fix them. Most of the time, you can do just that.

Some people talk about how hard it must be to work in urgent care, where you don’t ever get to know your patients, but the truth is that you just get to know them faster. Granted, everyone has repeat patients that you do get to know well, but many of the people who walk in the door present you with only one hour (or less) to make the connection needed to help them.

This takes serious skills—people skills, diagnostic skills, time-management skills, good teamwork, and ongoing training—culminating in a well-oiled treatment machine that practically runs itself so you can focus on the reason you are there in the first place (i.e., to provide medical treatment to people who need it).

It isn’t quite that smooth in real life, but it’s closer than would seem possible given all of the complex elements required to make it work.

So the next day you walk into your center, take a moment to appreciate what you are doing, and how unique you truly are.

Five Reasons Working in Urgent Care is Cool

The medicine. It’s interesting, challenging, and different every day.

The people. Urgent care attracts some of the most forward-thinking and entrepreneurial individuals around.

The patients. They need you, and they need you now.

The satisfaction. Much of the time, whatever it is, you can fix it.

The money. Oh wait, that’s not right…

The opportunities. Although urgent care has been around for a couple of decades, it is still in its early stages, and you have the opportunity to shape the futures of an industry and a specialty.

The future is really yours, so come on out and get it.

---

*Projected; proprietary data, 2008.

Lou Ellen Horwitz is executive director of the Urgent Care Association of America. She may be contacted at lhorwitz@ucoa.org.
Nothing gets a person’s attention faster than the sight of blood. Fortunately, episodes of epistaxis can most often be managed right in the urgent care center, without having to refer patients to the ED or consult a specialist. The keys are to quickly identify who does need emergent referral or consultation, and to have a plan of action for the rest.

Dr. Arnone is an emergency physician in the Department of Emergency Medicine at the University of Arizona. Dr. Keim is associate head and residency director of the Department of Emergency Medicine and Dr. Rosen is a clinical professor. In addition, Dr. Rosen is a member of the JUCM Advisory Board.

Certainly even more common than patients with nosebleeds is the patient complaining of headaches. Combine the routine nature of such a presentation with what is “known” about a patient from recent visits to other clinicians and it’s easy to fall victim to an acute case of “diagnostic momentum.” And therein lies the risk of delaying appropriate treatment.

In this month’s Bouncebacks feature (The Case of a 37-Year-Old Man with Headaches, page 23), Ryan Longstreth, MD, FACEP and Michael B. Weinstock, MD review the dangers of altering one’s perception of the history and physical exam to fit previous diagnoses.

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

We’re also pleased to bring you the latest in a series of articles on establishing an occupational medicine component of your urgent care practice by Donna Lee Gardner, RN, MS, MBA. In Keeping Workers Well and Your Practice Profitable (page 34), Ms. Gardner explains the must-have components of a corporate wellness program, as well as various options for customizing your program to suit your clients’ needs.

Also in this issue:

Nahum Kovalski, BSc, MDCM reviews abstracts of new articles on nebulized epinephrine and dexamethasone in bronchiolitis, the predictive value of T-wave abnormalities, and other issues relevant to the practice of urgent care medicine.

John Shufeldt, MD, JD, MBA, FACEP offers advice on how to approach working with medical search firms, such as the relative merits of different types of agreements with those firms.

David Stern, MD, CPC addresses questions about proper coding for nebulizer treatments, as well as payors who attempt to take back reimbursements already paid on code 99051, regarding “normal business hours”.

Frank Leone, MBA, MPH encourages readers to look at the marketing of your occupational health services as a team sport.

If you would also like to contribute—as an author or peer reviewer, or with a Letter to the Editor—we would love to hear from you. Send an e-mail to our editor-in-chief, Lee A. Resnick, MD, at editor@jucm.com.

To Submit an Article to JUCM

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

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

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

Before submitting, we recommend reading “Instructions for Authors,” available at www.jucm.com.

To Subscribe to JUCM

JUCM is distributed on a complimentary basis to medical practitioners—physicians, physician assistants, and nurse practitioners—working in urgent care practice settings in the United States. If you would like to subscribe, please log on to www.jucm.com and click on “Free Subscription.”

To Find Urgent Care Job Listings

If you would like to find out about job openings in the field of urgent care, or would like to place a job listing, log on to www.jucm.com and click on “Urgent Care Job Search.”
In Appreciation of Our Peer Reviewers

Each month, JUCM publishes original articles by urgent care practitioners, for urgent care practitioners. The authors’ names are, deservedly, given top billing in each issue and we’re very appreciative of the time and effort that goes into researching and writing each article.

As a peer-reviewed journal, however, JUCM also enlists the help of other clinicians and academics to comment on and raise queries about each article before it goes to press, and to evaluate the relevance of a given topic in the urgent care arena. Some reviewers are members of the JUCM Editorial Board or Advisory Board, some are authors themselves, and some are readers who want to help us achieve our mission of providing the best content in the urgent care marketplace in a unique, urgent care “voice.”

To encourage our peer reviewers to speak freely, we do not reveal the identities of each article’s authors until the article appears in the pages of the journal. Similarly, we believe the peer-review process works best if the reviewer’s identity is confidential.

Nonetheless, we would like to acknowledge their invaluable contributions to ensuring that JUCM continues to present articles that will resonate with our readers, and be relevant and specific to the way clinicians practice in the urgent care environment.

We are grateful to the following individuals for sharing their time and expertise in reviewing articles that appeared in Volume 2 (October 2007 through September 2008) of JUCM:

Joseph Baumstarck Jr., MD
Jon Brodie, MD, FAAFP
Jeffrey P. Collins, MD, MA
Tanise I. Edwards, MD, FAAEM
Ronald J. Ellis, DO, FACOEP
William Gluckman, DO, MBA, FACEP
Kenneth V. Iserson, MD, MBA, FACEP, FAAEM
Peter Lamelas, MD, MBA
David Landy, MD
Melvin Lee, MD
Brian McCambley, MD
Kevin McKee, DO, MS
Michael McMunn, APRN, FNP-C
Genevieve M. Messick, MD
Charles A. Preston, MD, FAAEM
Marc R. Salzberg, MD, FACEP
Erik Stumpf, MD
Robin M. Weinick, PhD
Adam Wineinger, MD
Mark D. Wright, MD

If you would like to join our panel of peer reviewers, please e-mail Harris Fleming, editor of JUCM, at hfleming@jucm.com.
Comprehensive results without restrictions

The wait is over! Now you can run CLIA waived CMPs on the Piccolo xpress™

On-the-spot lab results without the lab
Reference grade chemistry analysis in minutes
3 easy steps, no special skills required
Improve patient care and increase productivity
Diagnose with confidence

Piccolo xpress CLIA waived chemistry menu:
- Comprehensive Metabolic Panel
- Basic Metabolic Panel
- General Chemistry 13
- General Chemistry 6
- Electrolyte Panel
- Lipid Panel
- Lipid Panel Plus
- Liver Panel Plus
- Kidney Check

For more information call 1.800.822.2947
or log on to: www.abaxis.com/piccolouc
Physician dispensing with InstyMeds...
A way to make your patients better quicker.

A real solution.

The revolutionary InstyMeds system safely delivers acute prescriptions directly to patients. Gain a **competitive advantage**, enhance **patient satisfaction** and increase **compliance** without extra work for you — **InstyMeds does it all!**

Patients follow on-screen instructions to receive full prescription.

System processes payments and adjudicates insurance for patients, automatically.

Triple barcode check system verifies medication, then labels and dispenses.

The InstyMeds team, including pharmacists, are available 24/7 to assist patients.

Learn how safe, effective, affordable, and even profitable the InstyMeds system can be for your practice. Visit www.InstyMeds.com for a demonstration video or call 1-866-467-8963 for more information.
Introduction

Epistaxis is a common presenting complaint, with 15 per 10,000 people requiring medical attention each year.\(^1\) While the presence of blood in the pharynx can cause concern for both patients and the medical personnel treating them, the vast majority of epistaxis episodes can be successfully managed during the presenting episode, and will not require admission or specialty consultation.

Anterior vs. Posterior Origin

It is useful to classify epistaxis as either anterior or posterior in origin.

Ninety percent of all epistaxis episodes are anterior, and can usually be managed successfully with a combination of direct pressure, topical vasoconstrictors, cautery, and packing.\(^2\) Most commonly, anterior epistaxis involves Kiesselbach’s plexus, the area of vascular anastomoses of branches from the superior labial artery, the greater palatine artery, the anterior ethmoid artery, and the sphenopalatine artery (Figure 1.)

Posterior epistaxis usually arises from the sphenopalatine artery. Even if the bleeding appears controlled with a posterior pack, these patients require hospital admission. They have a high rate of recurrent bleeding, as well as the potential for the major complications of the posterior pack, e.g., apnea, purulent sinusitis, and superior sagittal venous plexus thrombosis. Children rarely have a posterior bleed. Their epistaxis
is almost always from a too-dry mucus membrane. Management is almost always simple and easily obtained with direct pressure. Both nares should be filled with petroleum jelly, and the parents instructed to reapply morning and evening for several days. Excessive use of this may cause risk for lipoid pneumonia.

Traumatic epistaxis from a direct blow is common but usually self limited, even when the nose is fractured.

If the septum is deviated, the patient should be seen by an otorhinolaryngologist soon because it is often easier to replace the septum acutely. The nasal mucosa must be examined to be sure there is no septal hematoma that needs to be drained, because this can increase pressure which can lead to septal necrosis.

A laceration over the bridge of the nose must be assumed to indicate an open fracture, and the patient treated with antibiotics.

**History**

Patients should be asked about the onset, timing, and frequency of the bleeding. They should also be queried about any trauma or other contributing factors, such as hypertension, rhinitis, nasal polyps, nasal foreign bodies, anticoagulation and antiplatelet therapies, liver disease, thrombocytopenia, or a history of bleeding diatheses (Table 1).

While there is an association between hypertension and epistaxis, no cause-and-effect relationship has been proven, to date. In one study, there was no difference in the frequency of hypertension in patients with and without epistaxis.3

The fact that the blood pressure is elevated when the patient is having an episode of epistaxis does not necessarily mean that the patient has hypertension.

The treatment of a nosebleed in a hypertensive patient is the same as in a normotensive patient. Often, the elevated blood pressure will return to normal with control of the bleeding. Moreover, there are no data indicating that patients who do have hypertension have higher incidence of epistaxis than do patients with no history of hypertension.

![Identification of anterior vs. posterior origin may be aided by familiarity with key arteries.](image)

**Figure 1.**

**Table 1. Etiologies of Epistaxis**

<table>
<thead>
<tr>
<th>Local</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma (including nose picking and nasal foreign bodies)</td>
<td></td>
</tr>
<tr>
<td>Upper respiratory infections</td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
</tr>
<tr>
<td>Nasal polyps</td>
<td></td>
</tr>
<tr>
<td>Low environmental humidity</td>
<td></td>
</tr>
<tr>
<td>Postoperative</td>
<td></td>
</tr>
<tr>
<td>Tumors</td>
<td></td>
</tr>
</tbody>
</table>

| Systemic                      |               |
| Hypertension (associated with epistaxis, never shown to be causal) |               |
| Hemophilia                    |               |
| Leukemia                      |               |
| Lymphoma                      |               |
| Polycythemia vera             |               |
| Thrombocytopenia              |               |
| von Willebrand’s disease      |               |
| Acquired platelet dysfunction (e.g., related to use of aspirin, NSAIDs, clopidogril, dipyridamole, etc.) |               |
| Hepatic disease               |               |
| Vitamin K deficiency         |               |
| Chemotherapy                  |               |
| Anticoagulation therapy (e.g., warfarin, enoxaparin, etc.) |               |
| Osler-Weber-Rendu syndrome    |               |
We are Committed to Urgent Care

- Unparalleled customer service
- Full line of prepackaged pharmaceuticals
- No fee, web based dispensing system
- Expert EMR integrators
- Guaranteed Work Comp and Occupational Health billing services

Contact us at:
800.333.9800
uc@physicianpartner.com  |  www.physicianpartner.com

Our commitment is your success
The patient will usually be able to describe which naris is bleeding. However, often patients do not know whether direct pressure will control the bleeding because many home remedies are used for epistaxis, a favorite one being to apply ice to the nape of the neck.

Physical Examination
Appropriate management of epistaxis is dependent upon localizing the source of bleeding, which requires a good light source and good exposure.

Patients should be placed in a chair that has the ability to recline, but should sit upright if possible to minimize swallowed blood. A bright external direct light source and a nasal retractor should be used to visualize the anterior nasopharynx. Most physicians will not be adept or comfortable with a reflecting mirror, and forehead lamps are readily available (Figure 2). Clots may be removed manually or with good suction.

Once the naris is cleared, it is worthwhile to take the time to anesthetize the nasal mucosa topically. In the past, cocaine was used, but this is rarely readily available today. A solution of 4% lidocaine can be used, and is more effective when combined with a vasoconstricting agent such as neosynephrine or ephedrine.

To achieve the best visibility, soak small cotton balls in a topical vasoconstrictor such as oxymetazalone, phenylephrine, lidocaine-epinephrine, or 4% cocaine (if available), and place them in the affected naris for 10 to 20 minutes. The Frazier suction catheter (Figure 3) should be used to clear the view of remaining or fresh blood while the patient is being examined. A nasal speculum is placed in the affected naris, and the anterior nasopharynx is inspected for sources of bleeding. If a nasal speculum cannot be obtained, transfer the patient to the ED, where they will have appropriate equipment.

There is simply no point in trying to manage epistaxis without appropriate equipment and lighting. If the bleeding is very diffuse or rapid, congenital or acquired coagulopathies should be considered, and appropriate laboratory studies can then be performed.

Direct pressure should be held manually by medical personnel using fingers, a commercially available nasal clamp, or by taping two tongue depressors together to create a make-shift nasal clamp (sometimes referred to as the Parkland clamp). It is not helpful to ask the patient to hold the pressure, since the discomfort they experience is likely to discourage them from applying enough force to stop the bleeding.

Since bleeding lasts two to five minutes even in normal patients, don’t expect bleeding control in less than five minutes. Direct pressure is also not effective so long as there are clots in the naris.

Treatment
While a simple anterior bleed is easy to control, not every anterior bleed will be simple, and some will require transfer to the emergency department. Likelihood of transfer is determined by:

- bilateral bleeds
- age of the patient (<2 years or >60 years)
- history of prior recent episodes
- presence of tumor
- presence of vigorous bleeds
- early recurrence of bleeding
MANAGEMENT OF THE PATIENT PRESENTING WITH EPISTAXIS

- Suggestion of posterior or combined anterior and posterior bleeding
- Underlying coagulopathy.

Infrequently, some cases of severe epistaxis will require endotracheal intubation and surgical control.

Blood transfusion is rarely necessary for anterior bleeds, but may be needed to control a posterior bleed.

Reversal of anticoagulation is rarely necessary, although its presence does complicate management. Any patient who is anticoagulated—those taking heparin, enoxaparin, warfarin, and the platelet inhibitors—should be transferred to the ED for management. One study finds that only three of 1,065 patients seen at an anticoagulation clinic over a two-year period have epistaxis requiring reversal for supratherapeutic anticoagulation.4

Patients should not blow their nose, nor pick out the clots (though they may be tempted due to significant irritation). Clots should be removed by suction, or manually with a nasal forceps.

Chemical Cauterization

If an anterior source of bleeding has been identified, chemical cauterization can be attained by using silver nitrate sticks.

First, the area should be anesthetized with a topical application of 4% lidocaine. The bleeding source should be suctioned and the area made as dry and free of blood as possible.

The end of the silver nitrate stick is placed in contact with the nasal mucosa and rolled over the target for approximately five to 10 seconds. The nitric acid formed by the reaction of silver nitrate with water causes cauterization. The mucosa under the silver nitrate will immediately turn silver-gray.

Placement for longer periods of time and cauterizing both sides of the nasal septum carry an increased risk of nasal septal perforation.5 After cauterization, a topical antibiotic ointment should be generously applied to the area. Petroleum jelly can be substituted. This keeps the mucosa moist, and prevents scabbing and harsh blood clots that may irritate patients and give them the urge to pick the clots out.

Electrocautery can be attempted if the silver nitrate doesn’t work, but requires some special technique. The metal suction tip cannot be used since it will transmit the electric current, and lead to necrosis of the nasal septum. Suction can be achieved by using a glass dropper, since glass does not transmit the electric current. The coagulation current should be used on the cauter, and should be held for only a few seconds.

Absorbent Gelatin Foams, Oxidized Cellulose, and Nasal Tampons

If there is bleeding from multiple small anterior sites, or if bleeding recurs after cauterization, an absorbent gelatin foam product such as Gelfoam (Pfizer) or oxidized cellulose such as Surgicel (Johnson & Johnson; Figure 4) may be used.

If cauter or absorbent sponges are ineffective, the anterior septum should be packed to provide hemostasis. Packing is uncomfortable for the patient, and analgesia and anxiolytics will be necessary. Remove
any clots that have formed, and reapply a topical anesthetic and vasoconstricting agent.

Several commercial nasal tampon products are available, and may be easier to use than traditional nasal petroleum jelly-impregnated gauze packing strips. If these are used, they must be layered into the entire naris, starting at the base of the naris and continuing until the superior naris is full. The initial and the tail ends of the packing should be left outside of the naris, where they can be taped to the face to prevent the patient from inhaling and suffocating on the packing while sleeping.

Merocel (Medtronic Solon) is an absorbent nasal tampon made of polyvinyl acetate that will expand when wet to become much larger than its packaged diameter (Figures 5a and 5b). The tampon is first lubricated with surgical lubricant or viscous lidocaine, and gentle pressure is applied in an anterior-to-posterior direction along the floor of the nasopharynx. The tampon should be inserted fully; however, it should not be forced if resistance is met.

Rapid Rhino (ArthroCare) is an absorbent nasal tampon that surrounds a small inflatable cuff (Figure 6). It is inserted in a fashion similar to Merocel tampon, and the cuff is inflated with air. Care should be taken not to

---

**Figures 4 - 10.**

Figure 4. Surgicel.
Figure 5a and 5b. Merocel nasal tampon, before and after expansion.
Figure 6. Rapid Rhino nasal tampon.
Figure 7. Bacitracin-laden gauze packing strips.
Figure 8. Xeroform gauze.
Figure 9. Bayonet forceps.
Figure 10. Dual balloon nasal catheter for posterior epistaxis.

*Photos by Nathaniel Arnone, MD.*
Pfizer Helpful Answers can help your patients without prescription coverage get the medicines they need.

No matter their age or income, your patients without prescription coverage can count on us for help. We offer over 100 Pfizer medicines for free or at a savings, and connect patients with the Partnership for Prescription Assistance (PPA) to get help paying for medicines not made by Pfizer. Eligible patients can receive medicines soon after applying, get continuous refills, and easily re-enroll each year. Talk to your Pfizer representative about Pfizer Helpful Answers.

Call 1-866-706-2400
or visit www.PfizerHelpfulAnswers.com

Pfizer Helpful Answers is a joint program of Pfizer Inc and the Pfizer Patient Assistance Foundation™.
over-inflate the cuff, so as to avoid pressure necrosis.

If no commercial products are available, the nasopharynx may be packed with bacitracin-laden gauze packing strips (Figure 7), or with Xeroform (Kendall Healthcare; Figure 8).

Using bayonet forceps (Figure 9), the first layer of packing is laid on the nasopharyngeal floor and advanced to the posterior wall. The next layer is then laid on top, returning in an anterior direction. The layers are stacked in an accordion fashion until the nasopharynx is completely filled. One study finds that Nu Gauze (Johnson & Johnson) packing that is pretreated with topical bacitracin grows significantly more Staphylococcus aureus than the Merocel tampon.6

It is a common—but unproven—practice to prescribe prophylactic oral antibiotics to patients who have been packed to prevent obstructive sinusitis or the toxic shock syndrome. Common choices would include amoxicillin or cephalexin. Packing is typically left in place for 48 hours. If bleeding continues despite adequate packing placement, the contralateral side should be packed, as well.

These patients should be admitted to the hospital. Not only is there a great risk of further rebleeding, but bilateral packing can induce apnea in some patients, and has a much higher risk of being complicated by bacterial sinusitis.

Posterior epistaxis often presents with bleeding that drains down the back of the patient’s throat, with a source of bleeding posterior to the middle turbinate or in the superior posterior nasopharynx.7 If anterior packing is successfully placed for a suspected anterior bleed, and the patient continues to have significant bleeding, posterior packing should be placed.

Rapid Rhino also markets an anterior/posterior inflatable commercial tampon. This product is longer than the anterior tampon, but is placed in the same manner.

Additionally, a dual balloon nasal catheter can be used (Figure 10). First, the nasopharynx is anesthetized and surgical lubricant or viscous lidocaine applied to the dual balloon. The catheter is inserted into the affected naris with gentle pressure until the distal balloon is visible in the patient’s mouth. The distal balloon is then inflated with 5 mL to 10 mL of sterile saline and the proximal catheter is gently pulled back through the nose until the balloon seats itself into the posterior nasopharynx.

Next, the larger proximal cuff is inflated with 15 mL to 30 mL of sterile saline to prevent caudal migration of the catheter. Care should be taken to avoid overinflation of the catheters to prevent pressure necrosis. Additionally, the catheter should be padded with gauze where it exits the naris.

If a commercial device is not available, a Foley catheter can be used in a similar manner.

The Foley is inserted into the nasopharynx and advanced until the distal end is visible in the patient’s mouth. The balloon is inflated with 15 mL to 30 mL of saline and the catheter is pulled back through the nose until the balloon is seated in the posterior nasopharynx. An umbilical clamp can be placed on the proximal end of the Foley to prevent it from slipping caudally. The umbilical clip should be padded with gauze to prevent skin breakdown.

Posterior Packing

Patients with posterior packing should be admitted to the hospital for observation and definitive treatment by an otolaryngologist. Typically, packing is left in place for 48 to 72 hours.5 Complications from posterior packing can include airway obstruction, pressure necrosis, aspiration, infection, toxic shock syndrome, and the controversial “nasopulmonary reflex,” which was thought by some to account for a decrease of PO₂ and an increase in PCO₂.

At least two studies find no clinical evidence of a nasopulmonary reflex in patients with posterior packing.8,9 Nevertheless, there have been cases of patients found dead with posterior packing in place, with the death thought to be secondary to apnea.

Summary

Epistaxis is a common presenting complaint that can often be managed successfully upon the first presentation. Bleeding is usually from anterior sources and is usually amenable to direct pressure, cautery, or nasal packing.

References and Suggested Reading

TUSSIONEX® is indicated for the relief of cough and upper respiratory symptoms associated with allergy or a cold in adults and children 6 years of age and older. Each 5 mL of TUSSIONEX® contains hydrocodone polistirex equivalent to 10 mg hydrocodone bitartrate and chlorpheniramine polistirex equivalent to 8 mg chlorpheniramine maleate.

TUSSIONEX® is contraindicated in children less than 6 years of age due to the risk of fatal respiratory depression, and in the presence of known allergy or sensitivity to hydrocodone or chlorpheniramine. The most common adverse reactions associated with TUSSIONEX® are sedation, drowsiness, and mental clouding, which may impair the mental and/or physical abilities required for potentially hazardous tasks such as driving or operating machinery. TUSSIONEX® should not be taken with alcohol or other CNS depressants. TUSSIONEX® is dosed at 5 mL every 12 hours in patients 12 years of age and older, and at 2.5 mL every 12 hours in patients 6-11 years of age. Overdose with TUSSIONEX® has been associated with fatal respiratory depression. Patients should be advised to measure TUSSIONEX® with an accurate measuring device. A household teaspoon is not an accurate measuring device. As with any other drugs in this class, the possibility of tolerance and/or dependence, particularly in patients with a history of drug dependence, should be considered.


Indication and Important Safety Information

TUSSIONEX® is indicated for the relief of cough and upper respiratory symptoms associated with allergy or a cold in adults and children 6 years of age and older. Each 5 mL of TUSSIONEX® contains hydrocodone polistirex equivalent to 10 mg hydrocodone bitartrate and chlorpheniramine polistirex equivalent to 8 mg chlorpheniramine maleate.

TUSSIONEX® is contraindicated in children less than 6 years of age due to the risk of fatal respiratory depression, and in the presence of known allergy or sensitivity to hydrocodone or chlorpheniramine. The most common adverse reactions associated with TUSSIONEX® are sedation, drowsiness, and mental clouding, which may impair the mental and/or physical abilities required for potentially hazardous tasks such as driving or operating machinery. TUSSIONEX® should not be taken with alcohol or other CNS depressants. TUSSIONEX® is dosed at 5 mL every 12 hours in patients 12 years of age and older, and at 2.5 mL every 12 hours in patients 6-11 years of age. Overdose with TUSSIONEX® has been associated with fatal respiratory depression. Patients should be advised to measure TUSSIONEX® with an accurate measuring device. A household teaspoon is not an accurate measuring device. As with any other drugs in this class, the possibility of tolerance and/or dependence, particularly in patients with a history of drug dependence, should be considered.

Please see full Prescribing Information on reverse.
The Case of a 37-Year-Old Man with Headaches

In Bouncebacks, which appears semimonthly in JUCM, we provide the documentation of an actual patient encounter, discuss patient safety and risk management principles, and then reveal the patient’s “bounceback” diagnosis.

The cases are adapted from the book Bouncebacks! Emergency Department Cases: ED Returns (2006, Anadem Publishing, www.anadem.com; also available at amazon.com and www.acep.org), which includes 30 case presentations with risk management commentary by Gregory L. Henry, past president of The American College of Emergency Physicians, and discussions by other nationally recognized experts.

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

The Case of a 37-Year-Old Man with Headaches

It is common knowledge that each patient needs to have a symptom-specific evaluation with each visit, but it is easy to be misled by “frequent fliers” who have presented many times with the same complaint. Take this month’s case, for example: a 37-year-old man with a headache who had four emergency department and two primary care visits before finally receiving the correct diagnosis.

Accuracy and vigilance must be the goal of each patient encounter, no matter how seemingly benign the chief complaint or previous diagnoses.

Initial Visit
(Note: The following, as well as subsequent visit summaries, is the actual documentation of the providers, including punctuation and spelling errors.)

CHIEF COMPLAINT (at 11:22): Headache

<table>
<thead>
<tr>
<th>Temp</th>
<th>Pulse</th>
<th>Resp</th>
<th>Syst</th>
<th>Diast</th>
</tr>
</thead>
<tbody>
<tr>
<td>98.9</td>
<td>104</td>
<td>18</td>
<td>112</td>
<td>68</td>
</tr>
</tbody>
</table>

HISTORY OF PRESENT ILLNESS (at 11:54):
Pt. is a 37 year old male who presented with complaint of 20-year history of headaches which occur about once per month. The patient was returning from church the day previously and had a constant pain in the frontal region associated with nausea and one episode of vomiting and was similar to past headaches, but lasted longer. No complaints of rhinorrhea, cough, sore throat, earache, dizziness, neck pain, rash, numbness, slurred speech or facial droop, chest pain, SOB, or abdominal pain.

PAST MEDICAL HISTORY/TRIAGE:
PMH: Negative
PSH: Negative
Medications: None
SH: Works for Buckeye steel

Physical exam (at 12:00):
General: Alert and oriented X3, well-nourished, in no apparent distress
THE CASE OF A 37-YEAR-OLD MAN WITH HEADACHES

**Head:** Normocephalic; atraumatic.
**Eyes:** PERRL, EOMI
**Nose:** The nose is normal in appearance without rhinorrhea
**Respir.:** Breath sounds clear and equal bilaterally; no wheezes, rhonchi, or rales
**Cardiac:** Regular tachycardic rhythm, without murmurs, rub or gallop
**Abd.:** Non-distended; non-tender, soft, without rigidity, rebound or guarding
**Skin:** Normal for age and race; warm and dry; no apparent lesions
**Neck:** No jugular venous distention, no lymphadenopathy, supple without nuchal rigidity.

**Neuro:** Patient is alert and oriented times three. Cranial nerves III-XII are intact. Sensory and motor functions are intact. Strength is 5/5 for flexion and extension in all 4 extremities. Patellar DTRs are equal and intact. Finger to nose testing is equal and normal bilaterally.

**Diagnosis (at 13:11):**
Acute cephalgia, recurrent

**Plan:**
Rx for vicodin and phenergan, work excuse, instructions for HA, follow up family practice clinic

**Discussion of Documentation and Risk Management Issues at Initial Visit**

**Error #1:** Inadequate history.
**Discussion:** The chief complaint should be approached both forward and backward—forward as a detailed exploration of the chief complaint (the HPI) and backward by excluding serious illness from the differential diagnosis (review of symptoms).

Though most headaches will be from migraine or tension, life-threatening illnesses such as meningitis, cancer, subarachnoid hemorrhage (SAH), and carbon monoxide (CO) toxicity must be part of every evaluation, usually explored during the ROS.

This is not to say that headache patients need diagnostic testing with each visit, as most serious illnesses can be excluded with a good history and physical exam, but only if done. Our patient was not questioned for onset of headache (sudden onset/less than one minute concerning for subarachnoid hemorrhage), history of fever (meningitis/encephalitis), weight loss (cancer), or if contacts have had headaches (CO toxicity).

**Teaching point:** No matter how benign seeming a chief complaint, maintain vigilance for life-threatening diagnosis with each visit.

**Error #2:** Funduscopic exam not documented.
**Discussion:** The funduscopic exam is quick, painless, and has the potential to reveal a large amount of information, including blurring of the disc margins (increased intracerebral pressure due to tumor or benign intracranial hypertension/pseudotumor cerebri), changes of hypertensive retinopathy, diabetic retinopathy, or AIDS retinopathy (toxoplasmosis or cytomegalovirus).

**Teaching point:** Document a funduscopic exam with all headache patients.

**Error #3:** Tachycardia not addressed or repeated.
**Discussion:** In a previous installment of Bouncebacks, we discussed a study of a retrospective cohort of ED patients.1 A 10-year data review of 387,334 ED visits identified 117 patients who died within seven days of being discharged from the ED, equating to a death rate of 30/100,000. Surprisingly, tachycardia occurred in 25 of the 35 “possible error” cases.

**Teaching point:** Tachycardia is an oft-unrecognized warning sign of a more serious problem. A finding of tachycardia should be discussed in a progress note, the pulse should be rechecked, and evaluation revisited to ensure exploration of potentially serious illnesses.

**Error #4:** Inadequate aftercare instructions.
**Discussion:** Aftercare instructions need to be time- and action-specific. The patient should have a defined time to follow up and know specifically why to return. A patient with diagnostic uncertainty should understand this fact and a notation made that this was discussed with the patient.

**Teaching point:** Patients need to know when to return and why to return.

**SUMMARY OF ED VISIT 2**
- Returned 3 days later with frontal headache
- History notes he had seen PCP 2 days previous and was diagnosed with sinusitis and prescribed Zithromax. Now complains of emesis and decreased appetite. Pain worse when bending forward. No fever, no help with vidodin
- **Exam:** No change from initial exam, except nasal mucosa edematous and erythematous with tenderness to palpation over the frontal and maxillary sinuses
- **Brain CT – Radiology reading:** Right maxillary antrum air fluid level – Sinusitis?
- **Dx:** Cephalgia and sinusitis
**Plan:** Entex. Continue vicodin and zithromax

**SUMMARY OF ED VISIT 3**
- Returned two days later at 6 AM. History included extensive synopsis of past visits and treatments including that pt. had seen PCP again yesterday (the 5th health care visit in 6 days) but the only description of current HA was “facial pressure on the right side”
- **ED course:** Demerol and phenergan IM
- **Dx:** Cephalgia secondary to sinusitis
- **Plan:** Change ATB to augmentin, continue vicodin and phenergan

**SUMMARY OF ED VISIT 4**
- Return same day at 4 PM (10 hours later). History now documents demographics: “37 year male from Guinea who has been in the US for 6 years”. Now complains of “fevers at home”. This is the worst HA of his life.
- **PE:** Normal except tenderness over frontal sinuses. Temperature is 99.0 degrees
- **ED course:** LP performed to look for atypical infection
- **LP results:**
  - RBC: Tube 1 = 250, tube 3 = 11
  - WBC = 5 (1 poly and 4 lymph)
  - Gram stain negative
- **Dx:** Complicated sinusitis
- **Plan:** Change vicodin to per cocet. Will add cryptococcal antigen to CSF. D/C to home

**SUMMARY OF ED VISIT 5**
- Pt. called to return to ED a few hours later with positive india ink stain for cryptococcus.
- **Additional history:** 35 lbs. weight loss in 8 mo.
- **Exam:** No thrush, OHL, adenopathy
- **Dx:** Cryptococcal meningitis
- **Plan:** Started on amphotericin B and admitted to Infectious Diseases. Subsequent HIV test and CD4 count confirms diagnosis of AIDS

**Discussion of Documentation, Diagnosis, and Patient Safety Issues**

**Why did the doctor miss the diagnosis?**
- Our patient had a case of cryptococcal meningitis from undiagnosed AIDS. His doctors had a case of “diagnosis momentum” from placing too much credence in previous physicians’ evaluations.
- In 2002, Pat Croskerry, an ED physician from Canada, described specific features present in the evaluation of patients which may lead the physician astray. Diagnosis momentum occurs when a diagnosis becomes established without adequate supporting evidence, and then gathers momentum with each subsequent provider.
- Our patient had a CT suggesting sinusitis, a sensitive but not specific finding. He was started on antibiotics and when he did not improve, the azithromycin was changed to augmentin.
- If the initial antibiotic does not work for sinusitis, another antibiotic may be tried, but caution should be applied due to the minimal efficacy of antibiotics for sinusitis. The number needed to treat (NNT) with antibiotics is five to 14 and number needed to harm is 17. If in other words, antibiotics will only help 6% to 20% of patients and will harm 6%. If the first antibiotic does not work, the chance of the second helping is even less and the initial diagnosis should be revisited to ensure there is nothing else occurring.

**New Guidelines from ACEP**

**Two key questions**
- In June 2008, The American College of Emergency Physicians (ACEP) released new headache guidelines which answer several questions related to evaluation of patients with acute headache. The two points with the most relevance for urgent care are:
  - Which patients with headache require neuroimaging?
    - Patients with older age (over 50-60 years old) with new headache
    - Occipital location of pain
    - Worsening headache with valsalva
    - Headache waking patient from sleep
    - Headache associated with syncope, nausea, or sensory distortion
    - Sudden onset severe headache (reaching maximum intensity over seconds to a minute
    - HIV/AIDS patients with new or different headache
    - Pregnant patients
    - Abnormal finding on neurologic examination
  - Does a lumbar puncture need to be performed in patients being evaluated for subarachnoid hemorrhage after a normal brain CT?
    - Limitations of brain CT include inability to identify small hemorrhages in areas obscured by artifact or bone, inability to diagnose other conditions such as idiopathic intracranial hypertension, meningitis, carotid or vertebral artery dissection and some cases of cerebral venous sinus thrombosis or pituitary apoplexy, and decay in sensitivity with time (sensitivity 92% day of rupture and 58% five days later).
THE CASE OF A 37-YEAR-OLD MAN WITH HEADACHES

- Of all cases of subarachnoid hemorrhage with normal CT, between 2% and 10% will be identified by positive lumbar puncture
- Conclusion (from ACEP guidelines): “The totality of the evidence suggests that lumbar puncture must still be performed after a negative CT scan result in patients being evaluated for subarachnoid hemorrhage.”

Tricks for Initial Diagnosis of HIV in Asymptomatic Patients

In an undiagnosed patient, the first clue that a patient may have HIV/AIDS is assessment of risk factors, including HIV-positive sexual contacts, injection drug use, hemophilia, multiple unknown sex partners, or travel to/from areas where HIV is endemic. White, gay men no longer represent the majority of new HIV infections in the U.S.; over a third of recently infected individuals acquired HIV via heterosexual contact and 46% by homosexual contact. Over half of new infections are diagnosed in African-Americans, and 27% are in women.

History may provide clues; AIDS patients presenting with major opportunistic infections typically give a history of repeated minor mucocutaneous infections, such as thrush, recurrent herpes simplex, candida vaginitis, or shingles. Weight loss, night sweats and anorexia are commonly present in late stage HIV.

Physical exam clues to HIV diagnosis depend on the CD4 count. Skin exam may show seborrheic dermatitis, especially over the malar eminences, zoster scars, genital or perianal herpes simplex virus, and tinea. Oral lesions include thrush, oral hairy leukoplakia (pathognomonic for HIV) and linear gingivitis. Generalized lymphadenopathy, with strings of 1 cm to 2 cm nodes

And search www.jucm.com for original clinical and practice management content in an urgent care voice.

Our website has a comprehensive search function. Simply log onto www.jucm.com and type a subject in the Search JUCM.com box in the upper right-hand corner of the screen.

“Search others for their virtues, thyself for thy vices.”
Benjamin Franklin (1706-1790), American author, diplomat, inventor, printer, scientist, and Founding Father
in the posterior cervical chain, are typically found. A funduscopic exam may reveal cotton wool spots. Papilledema can be seen with cryptococcus, toxoplasmosis, or CNS lymphoma.

In November 2002, reliable, rapid testing for HIV antibodies became available, making the diagnosis of HIV quick and simple. Even more recently, the Centers for Disease Control and Prevention initiated a campaign to encourage physicians to obtain HIV testing of all persons deemed at risk for HIV infection.

Routine laboratory studies commonly show abnormalities and can support suspicions of undiagnosed HIV infection. Leukopenia with lymphopenia is the rule; its absence argues against HIV. A normochromic, normocytic anemia is common but not universal. Thrombocytopenia is seen in 10% of patients. Patients are commonly co-infected with hepatitis, resulting in abnormal LFTs.

Opportunistic infections (OI) such as cryptococcus or toxoplasmosis typically occur in the later stages of HIV infection when the CD4 count is under 200. Since the CD4 cell count falls 60 to 100 cells per year of HIV infection, it may take years after the initial viral infection for patients to present with an OI.

**Evaluation of Headaches in Patients with HIV/AIDS**

In patients with AIDS, the differential diagnosis includes CNS mass lesions, and a spinal tap should be withheld until a head CT scan is performed, confirming there is not a midline shift. While cryptococcus would be the most common cause of subacute meningitis in an AIDS patient in the U.S., other OIs of the central nervous system include cytomegalovirus (CMV), herpes simplex virus (HSV), herpes zoster (VZV), progressive multifocal leukoencephalopathy (PML), tuberculosis (TB), Mycobacterium avium complex (MAC), B-cell lymphoma, toxoplasmosis, syphilis, listeria, histoplasmosis, and coccidioides. A cerebrospinal fluid (CSF) examination and cultures of the CSF are needed to help sort out these possibilities.

**Symptoms and Diagnosis of Cryptococcal Meningitis**

Cryptococcus is a ubiquitous organism with a portal of entry via the lungs. It spreads to the CNS hematogenously. The most common symptoms of cryptococcal meningitis in HIV patients are chronic headache, fever, and malaise. Our patient’s lack of nuchal rigidity is typical in cryptococcal disease; less than half of patients have a stiff neck. Temperatures normally do not exceed 39° C, and are absent in a quarter of patients.

In AIDS patients with cryptococcal meningitis, the CT scan is normal in most patients, but hydrocephalus and gyral enhancement can be found in some. Cortical atrophy is seen in a third of patients.

An LP was performed on our patient but no opening pressure was noted. This would have been helpful and may have suggested the diagnosis, as opening pressures are elevated (>200 mm of water) in three-fourths of patients with cryptococcal meningitis and AIDS. In fact, the increased intracranial pressure not infrequently causes cranial nerve palsies and visual impairment and is the main determinant of outcome.

An easy diagnostic trick is to check a serum cryptococcal antigen test, positive in about 95% of cases. This can be used to screen patients for cryptococcal disease without having to do a lumbar puncture.

**Summary of Case**

During the repeated visits, it seems that the history and physical exam were changing to fit his previous diagnosis of sinusitis without concerted efforts to look for other causes of headache. Pain worse when bending over (mentioned on the second visit) suggested the possibility of increased intracranial pressure, though this can also occur with sinusitis. Red flags included fever and the fact that he was of African descent (first mentioned by his doctor on his fourth ED visit).

The onset of this patient’s cryptococcal meningitis was insidious, as was his AIDS. It was only through repeat visits and good thinking that the diagnosis was found. There are some clues on history and physical exam such as fatigue, fevers, lymphadenopathy, oral thrush, and seborrheic dermatitis, which may be suggestive of immunosuppression due to HIV/AIDS, but from examining our patients charts, it is difficult to say if these processes were occurring. The correct diagnosis was eventually made and the patient was appropriately treated, but his outcome could have been far different.

**REFERENCES**

URGENT CARE ASSOCIATION OF AMERICA

2009 National Convention

April 20: PreConvention • April 21-23: Main Convention

Over 600 urgent care leaders joined us in New Orleans, so don’t miss 2009!
In each issue, JUCM will challenge your diagnostic acumen with a glimpse of x-rays, electrocardiograms, and photographs of dermatologic conditions that real urgent care patients have presented with.

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

The patient is an 82-year-old man who slipped on the street, experiencing a blow to his right shoulder. He has significant local swelling in the injured shoulder—specifically, over the acromioclavicular joint—as well as significantly limited range of motion. His distal pulses are normal.

View the x-ray taken (Figure 1) and consider what your diagnosis and next steps would be. Resolution of the case is described on the next page.
The x-ray indicates that this patient suffered a type III acromioclavicular joint separation with disruption of the acromioclavicular and coracoclavicular ligaments—a complete tear of the AC joint. Coracoclavicular ligament disruption is noted by the elevation of the distal clavicle. AC disruption is represented by a widening of the AC joint space.

An axillary view of the shoulder is necessary in all type III injuries to rule out a type IV (unstable) injury. This would show posterior displacement of the clavicle and requires immediate referral to an orthopedist.

Type III joint injuries are most often managed non-operatively with rest, ice, sling, and analgesics, as was the case with this patient.

Acknowledgment: Case presented by Nahum Kovalski, BSc, MD, CM
ABSTRACTS IN URGENT CARE

On Patient Satisfaction, Epinephrine and Dexamethasone in Bronchiolitis, the Predictive Value of T-Waves, Acute Otitis Media, Acute Rhinosinusitis, Papaverine for Renal Colic, and Simple Febrile Seizures in Children

NAHUM KOWALSKI, 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.

A Short Video About What to Expect in the ED Increases Patient Satisfaction

Key point: Showing the video to patients in the ED waiting room increased their satisfaction with the ED experience.


Assessment of patient satisfaction has become a component of physician and emergency department evaluation.

Investigators at an academic hospital developed a six-minute video that explained what patients could expect during an ED visit, from registration to discharge, and presented information about an outpatient referral line. A single research assistant administered a validated patient satisfaction survey just before discharge to a convenience sample of 551 patients during the two months before the video was introduced, and 581 patients during the two months after. Eligible participants were adult patients or parents of pediatric patients (mean age, 38; 61% were women) who were triaged to the waiting room and were not admitted to the hospital.

Overall patient satisfaction scores (on a five-point Likert scale, ranging from “poor” to “excellent”) were significantly higher after the video was introduced than before; 65% vs. 58%

A Multicenter Randomized Controlled Trial of Nebulized Epinephrine and Dexamethasone in Outpatients with Bronchiolitis

Key point: Combined therapy with epinephrine and dexamethasone reduced hospital admissions by 30%.


Bronchiolitis is the most common disease of the lower respiratory tract in the first year of life. Hospital admissions have al-
ABSTRACTS IN URGENT CARE

most doubled over the last 10 to 15 years in North America. The objective of this study was to determine if the treatment of infants with bronchiolitis presenting to the emergency depart-
ment with nebulized epinephrine (epi), oral dexamethasone (dex), or both results in a reduction in hospital admissions. Infants 6 weeks to 12 month old presenting with bronchioli-
tis to eight Canadian pediatric EDs were enrolled in a double-blind, placebo-controlled two-factor randomized controlled trial. Infants were randomized to treatment with one of four courses:
- epi and dex
- epi plus placebo
- nebulized placebo plus dex
- nebulized placebo plus oral placebo

The primary outcome measure was hospital admission up to seven days after enrollment. Eight hundred subjects were enrolled. Study groups were similar in age, sex, RSV status, baseline clinical score, length of symptoms, and atopy history.

The epi/dex groups were significantly less likely to be admitted by day 7 than the placebo group, but neither the dex nor epi alone groups showed any significant reduction in admission compared with placebo.

The number needed to treat with epi/dex to prevent one admission within seven days of the initial visit is 11.4. The epi and epi/dex group showed a significant improvement in clinical score and heart rate over the first hour of the study when compared with placebo, while the dex group did not.

In this largest RCT of bronchiolitis treatment, neither dex nor epi alone lowered hospitalization rates, but combined therapy with epinephrine and dexamethasone reduced hospital admissions by 30%. Eleven infants would need to be treated with this combination to prevent one hospitalization.

T-Wave Abnormalities Predict Cardiovascular Events in Patients with Chest Pain

Key point: Risk for cardiovascular events at 30 days increased in patients with T-wave abnormalities who did and did not have known coronary artery disease.

Citation: Lin KB, Shofer FS, McCusker C. Predictive value of T-wave abnormalities at the time of emergency department presentation in patients with potential acute coronary syn-

In patients who present with chest pain, ST-segment changes are strongly associated with acute coronary syndromes (ACS) and risk for cardiovascular events. These authors evaluated the association between T-wave changes and risk for adverse cardio-
vascular events at 30 days in 5,582 patients (age >30) who presented to a single emergency department with a chief complaint of chest pain and had an electrocardiogram or-
dered in the ED. Investigators reviewed patients’ hospital courses and followed up with patients by telephone 30 days after presentation.

Overall, 25% of patients had T-wave abnormalities (flatten-
ing or any degree of inversion) on the initial ECG. T-wave changes were associated with increased risk for the composite endpoint of death, myocardial infarction, reperfusion, or di-
agnostic test results consistent with coronary artery disease (CAD).

The relative risk for the composite endpoint was 1.41 for T-wave flattening, 2.37 for inversions 1 mm to 5 mm, and 3.36 for inversions >5 mm. Risk was increased in patients both with and without known histories of CAD.

Only about 8% of patients with ACS present with normal ECGs, but many others are labeled initially as having only “nonspecific” T-wave changes.

This study’s findings suggest that we consider T-wave abnor-
malities as markers of ischemic heart disease and that the deeper the inversion, the higher the risk

[Published in J Watch Emerg Med, July 11, 2008—Diane M. Birnbaumer, MD, FACEP.]

Trends in Acute Otitis Media

Key point: The incidences of otitis media, treatment failure,
and relapse have declined during the past decade.

Citation: Sox CM, Finkelstein JA, Yin R, et al. Trends in otitis me-

To assess changes in the incidence of acute otitis media (AOM), investigators retrospectively reviewed nine years of visits for AOM in children ranging in age from 2 months to 12 years old in a multispecialty provider group that served 275,000 pediatric patients.

From 1996 through 2004, incidence of AOM declined signifi-
cantly, from 385 to 189 visits per 1,000 person-years. Use of high-dose amoxicillin (>70 mg/kg daily) rose significantly, from 2% of AOM visits in 1996 to 42% in 2004, whereas use of regular-dose amoxicillin and trimethoprim-sulfamethoxazole declined significantly.

Both treatment failure (defined as a second AOM visit associ-
ated with a different antibiotic prescription before comple-
tion of the first prescription) and relapse rate (a second AOM visit associated with a different prescription within 30 days of the first visit) declined slightly, from 3.9% to 2.6% and from 9.2% to 8.9%, respectively.

Receipt of high-dose amoxicillin did not protect against treatment failure or relapse.

The authors acknowledge that the 50% decline in the inci-
dence of AOM during the past decade likely results from many factors, including new vaccines.

[Published in J Watch General Med, April 10, 2008—Howard Bauchner, MD.]
Antibiotics in Acute Rhinosinusitis: Often Prescribed, but Rarely Indicated

Key point: No clinical signs or symptoms identified a subgroup of patients who derived benefit from antibiotics.


About a third of patients who present with upper respiratory infections are diagnosed with acute rhinosinusitis, and 80% of patients with this diagnosis receive antibiotics, even though no known criteria distinguish between viral and bacterial etiologies.

To determine whether a subgroup of patients that might derive benefit from antibiotics could be identified, researchers combined and reanalyzed individual patient data from nine clinical trials that involved 2,547 adults with clinical signs and symptoms of rhinosinusitis who were randomized to receive antibiotics or placebo. No patient had undergone imaging or culture before randomization. Cure was assessed after eight to 15 days in all trials.

The odds ratio for cure in the antibiotic group was 1.37. The estimated number needed to treat with antibiotics to achieve one additional cure was 15; the NNT was similar in all trials.

Symptom severity, symptom duration, and age did not predict increased benefit from antibiotic treatment. Patients with purulent pharyngeal discharge derived somewhat greater benefit from antibiotics than did other patients, but the NNT for patients in this group was still 8.

The authors conclude that adults with acute rhinosinusitis generally should not receive antibiotics, regardless of presenting signs and symptoms, and that guidelines that suggest antibiotic therapy after seven days of symptoms are not supported by evidence.

Some clinicians might argue that an NNT of 8 or 15 is sufficient to warrant antibiotic therapy, but any benefits must be weighed against risks for adverse effects and increased antimicrobial resistance. Of course, patients with unusual signs or symptoms (e.g., high fever, periorbital edema) suggesting a septic process should be treated promptly with antibiotics.

[Published in *J Watch General Med*, April 15, 2008—Bruce Soloway, MD.] ■

Papaverine Hydrochloride, Alone or in Combination, for Short-term Relief of Renal Colic

Key point: Diclofenac provides longer effective analgesia and fewer side effects.


The authors assessed the efficacy of papaverine hydrochloride, a commonly used smooth muscle relaxant, for the treatment of renal colic as a single agent and in combination with sodium diclofenac.

A prospective, single-blind clinical study was performed at two centers. A total of 86 patients with acute renal colic were randomized to three treatment groups of 120 mg intravenous papaverine hydrochloride (29), 75 mg intramuscular sodium diclofenac (n=30), and papaverine hydrochloride plus sodium diclofenac (n=27). Pain intensity was assessed with the visual analog scale at 0 minutes, 20 minutes, and 40 minutes after treatment. Further analgesia was given at patient request and consisted of 1 mg/kg intramuscular meperidine.

Pain intensity decreased significantly (p<0.01) after 20 minutes and after 40 minutes in all groups. Papaverine hydrochloride was as effective as sodium diclofenac in alleviating pain, and the combined treatment group showed a slight trend of more rapid relief. Significantly more patients in the papaverine group required further analgesia, and four patients (14.8%) reported minor adverse effects (dizziness in three, sleepiness in one).

Papaverine hydrochloride is as effective as sodium diclofenac for the short-term relief of acute renal colic pain and may be advantageous in patients with contraindications for nonsteroidal anti-inflammatory drugs. However, sodium diclofenac appears to provide a longer effective analgesia. ■

Simple Febrile Seizures Don’t Raise Death Risk in Children

Key point: Children suffering simple febrile seizures are at no greater mortality risk than other children.


Using national databases, the authors identified some 55,000 children who experienced febrile seizures between 3 months and 5 years of age from a cohort born between 1977 and 2004. The researchers then compared mortality among the seizure group with all other children in the cohort.

Children with simple seizures (i.e., those lasting 15 minutes or less and not recurring within 24 hours) had death rates similar to the unaffected population.

However, children with complex seizures (lasting longer than 15 minutes or recurring within 24 hours) showed increased mortality in the first and second years after seizure. Then their mortality rates returned to background levels.

The authors suggest their findings should reassure parents. One commentator observes that children with complex seizures and underlying neurologic abnormalities “might warrant closer attention and follow-up.” ■
Corporate wellness is one of the five basic service lines an urgent care occupational medicine (UCOM) clinic is advised to offer in order to position itself as a truly comprehensive resource for employers and their employees.

Other primary occupational medicine product lines—health surveillance, injury/loss management, rehabilitation and on-site services—complement the corporate wellness product line. Health surveillance and injury/loss management were discussed previously in JUCM (April and June 2008, respectively; also available at www.jucm.com), and the remaining two product lines will be addressed in forthcoming articles.

Background
The implementation of corporate wellness services in a UCOM practice improves overall access to healthcare for a large segment of the population. The focus is on the effective management of employers’ medical and indemnity costs through injury prevention, health promotion, and disease management initiatives.

The prevalence of obesity, hypertension, diabetes, asthma, depression and other debilitating conditions, combined with the aging workforce, are among issues forcing U.S. employers to develop a more effective way to manage worker absence and productivity loss. Consequently, employers are turning to local medical providers for assistance.

UCOM physicians and allied professionals have an

Urgent message: Adding a corporate wellness component to a UCOM initiative fosters better relationships with clients and good care for their employees—as well as more business for the practice.

Donna Lee Gardner, RN, MS, MBA

Practice Management

Keeping Workers Well and Your Practice Profitable
opportunity to position themselves as primary providers of wellness programs by leveraging their established relationships with employers in their markets. However, they need to be exceptionally well prepared in order to be successful.

**Corporate Wellness Defined**

The corporate wellness service line provides a variety of health programs and screening options to client companies. These range from activities as basic as flu shots and individual blood pressure checks to an array of training programs and health interventions designed to address identified health risks in a given workforce.

A UCOM practice preparing to introduce a corporate wellness line should first ensure the feasibility of providing adequate clinical support for activities such as a high volume of flu vaccinations, health-risk assessments, health fairs, smoking cessation programs, weight loss and nutrition counseling, stress reduction, and other programs that promote healthy lifestyles.

Proposals to client companies for these programs should identify the rationale for need, screening procedures, and proposed post-screening activities, including appropriate referrals for at-risk employees.

When explaining the value of the product line to employers, UCOM practitioners may point out that many potentially costly health conditions can be easily treated if they are detected early through screening. Meanwhile, people with chronic conditions periodically need education and help to manage their condition so they can stay on the job safely.

**Program Components**

Training and screening components of a corporate wellness service line that should be feasible for a UCOM practice or clinic network to offer include:

- **OSHA and Your Company**—A two-hour program looking at the role of the Occupational Safety and Health Administration and how workplace regulations affect business. An overview of OSHA standards is an integral part of the program. Contact your OSHA regional office for a speaker, and hold this program annually. (An interactive map with OSHA regional offices is available at www.osha.gov/html/RAmap.html.)

- **Blood-borne Pathogens**—This specialized one-hour course covers OSHA’s blood-borne pathogens standards, epidemiology, pathogen-related symptoms, modes of transmission, and universal precautions. Typically, the curriculum includes an overview of the components of a control plan. This program can be offered in the worksite. The trainer must be familiar with the regulations, transmittable diseases, and universal precautions.

- **Health Risk Assessments (HRAs)**—An HRA is an assessment tool used to evaluate a person’s health. The assessment usually takes the form of an extended questionnaire about lifestyle issues, personal health, and family medical history. The assessment may also include a physical examination, laboratory tests (e.g., cholesterol level), blood pressure, and physical fitness levels. The outcome is a profile identifying specific risks (e.g., hypertensive, heavy smoking, and sedentary lifestyle) with strategies and targets for reducing the risks.

- **CPR and First Aid Training**—CPR training requires a minimum of six, but not more than 10, participants. CPR training can be combined with a first aid course and offered at the worksite. The trainer must be a CPR-certified instructor. The clinic may want to consider partnering with the American Red Cross or another local resource to provide this service.

- **Flexibility Training**—This program provides guidelines and demonstrations to supervisors to help them implement a 10-minute exercise and stretching program at the worksite.

- **Alcohol and Controlled Substance Abuse Training**—This program is designed to help supervisors manage employees who perform safety-sensitive functions as defined under Department of Transportation (DOT) regulations. The training includes education on DOT screening requirements, the effects and consequences of alcohol and controlled substance abuse, the manifestations and behavioral causes that may indicate alcohol and/or drug use, and recommended resources.
KEEPING WORKERS WELL AND YOUR PRACTICE PROFITABLE

The trainer should be a health professional with a social service and substance abuse background. Typically, the training includes an overview of the DOT regulations; education on the effects and consequences of alcohol and substance abuse on personal health and safety, and the manifestations and behavioral causes that may indicate alcohol and/or drug use or abuse.

Healthy Back—Back injuries are a common, costly, and often preventable complaint. Employers and employees who are educated about the anatomy and functions of the back, as well as the care and protection of the back, including proper body mechanics, are better prepared to avoid back-related complaints.

Instruction may be provided by a physical therapist or other rehabilitation professional through a didactic presentation and demonstration of posture, body mechanics and lifting techniques, and a practice session on recommended back-strengthening exercises.

Workstation Design—This program is geared for upper- and middle-management personnel. The goals of the program are to introduce basic principles and concepts of worksite design through didactic presentation of theory and application of ergonomics and worksite design, discussion of poor worksite design, and managerial workbooks with emphasis on the use of desktop computers.

The trainer must be knowledgeable of ergonomics in both office and industrial settings.

Physical Fitness—This component can be provided via a contract with a credible fitness facility. The

U.S. Healthcare Costs vs. Other Developed Countries

The Commonwealth Fund, a private foundation that focuses on “creating high-performance health systems” (www.commonwealth.org), reports the following per capita healthcare costs for select developed countries:

- New Zealand $2,083
- Britain $2,546
- Australia $2,876
- Germany $3,005
- Canada $3,165
- United States $6,102

How can it be that U.S. healthcare costs are 50% to 70% more than these other countries? Is it due to socialized medicine in other countries? Is it because the American healthcare system is that much better, or the American lifestyle that much worse? Is the healthcare system overused in the U.S.?

Regardless, conservative estimates indicate the per capita healthcare costs in the U.S. will be about $12,000 by 2016. This provides an extraordinary opportunity for UCOM to become the method of choice for reducing modifiable health risks—and thereby moderate healthcare cost increases.

According to the Blue Cross and Blue Shield Association 2007 Medical Cost Reference Guide, healthcare expenditures in the U.S. represent a greater percentage of gross domestic product (GDP) than in any other country. At $2.2 trillion, or 16.5% of GDP, 2006 U.S. national health expenditures dwarf other major sectors of the economy—and they are projected to represent as much as 20% of GDP by 2015.

The majority of the U.S. population (68.6%) is covered by private health insurance; 59.5% by employer-based private insurance and 9.1% by direct-purchase private insurance.

Growth of Severe vs. Moderate Obesity

A study conducted by the Rand Corporation and published in the journal Public Health indicates severe obesity is increasing significantly faster than moderate obesity.

The study identified a severely obese person as having a body mass index (BMI) of 40 or more, with a severely obese male weighing about 300 pounds and a severely obese female weighing about 250 pounds.

According to the study, the number of Americans with a BMI of 30 or more increased 24% from 2000 to 2005, while the number with a BMI of 40 or more increased by 50%. The average healthcare cost for a middle-aged person with a BMI of 40 is double the cost of a similar age person with a normal BMI (18.5-24.9).

The Cost of Diabetes and Heart Disease

Diabetes is the fifth-leading cause of death by disease in the U.S. Since 1987, the death rate due to diabetes has increased by 45%, while the death rates due to heart disease, stroke, and cancer have declined. Total cost of diabetes in 2007 was $174 billion, including $116 billion in excess medical expenditures, and $58 billion in reduced national productivity.

Heart disease remains the number-one killer of women in the U.S. African-American women have a higher death rate than any other population, according to the American Heart Association. Estimated annual cost of heart disease among women alone $74 billion.

The Cost of Severe vs. Moderate Obesity

A study conducted by the Rand Corporation and published in the journal Public Health indicates severe obesity is increasing significantly faster than moderate obesity.

The study identified a severely obese person as having a body mass index (BMI) of 40 or more, with a severely obese male weighing about 300 pounds and a severely obese female weighing about 250 pounds.

According to the study, the number of Americans with a BMI of 30 or more increased 24% from 2000 to 2005, while the number with a BMI of 40 or more increased by 50%. The average healthcare cost for a middle-aged person with a BMI of 40 is double the cost of a similar age person with a normal BMI (18.5-24.9).

The Cost of Diabetes and Heart Disease

Diabetes is the fifth-leading cause of death by disease in the U.S. Since 1987, the death rate due to diabetes has increased by 45%, while the death rates due to heart disease, stroke, and cancer have declined. Total cost of diabetes in 2007 was $174 billion, including $116 billion in excess medical expenditures, and $58 billion in reduced national productivity.

Heart disease remains the number-one killer of women in the U.S. African-American women have a higher death rate than any other population, according to the American Heart Association. Estimated annual cost of heart disease among women alone $74 billion.

Data Validate the Need for Corporate Wellness Services

The majority of the U.S. population (68.6%) is covered by private health insurance; 59.5% by employer-based private insurance and 9.1% by direct-purchase private insurance.

Growth of Severe vs. Moderate Obesity

A study conducted by the Rand Corporation and published in the journal Public Health indicates severe obesity is increasing significantly faster than moderate obesity.

The study identified a severely obese person as having a body mass index (BMI) of 40 or more, with a severely obese male weighing about 300 pounds and a severely obese female weighing about 250 pounds.

According to the study, the number of Americans with a BMI of 30 or more increased 24% from 2000 to 2005, while the number with a BMI of 40 or more increased by 50%. The average healthcare cost for a middle-aged person with a BMI of 40 is double the cost of a similar age person with a normal BMI (18.5-24.9).

The Cost of Diabetes and Heart Disease

Diabetes is the fifth-leading cause of death by disease in the U.S. Since 1987, the death rate due to diabetes has increased by 45%, while the death rates due to heart disease, stroke, and cancer have declined. Total cost of diabetes in 2007 was $174 billion, including $116 billion in excess medical expenditures, and $58 billion in reduced national productivity.

Heart disease remains the number-one killer of women in the U.S. African-American women have a higher death rate than any other population, according to the American Heart Association. Estimated annual cost of heart disease among women alone $74 billion.

The Cost of Severe vs. Moderate Obesity

A study conducted by the Rand Corporation and published in the journal Public Health indicates severe obesity is increasing significantly faster than moderate obesity.

The study identified a severely obese person as having a body mass index (BMI) of 40 or more, with a severely obese male weighing about 300 pounds and a severely obese female weighing about 250 pounds.

According to the study, the number of Americans with a BMI of 30 or more increased 24% from 2000 to 2005, while the number with a BMI of 40 or more increased by 50%. The average healthcare cost for a middle-aged person with a BMI of 40 is double the cost of a similar age person with a normal BMI (18.5-24.9).

The Cost of Diabetes and Heart Disease

Diabetes is the fifth-leading cause of death by disease in the U.S. Since 1987, the death rate due to diabetes has increased by 45%, while the death rates due to heart disease, stroke, and cancer have declined. Total cost of diabetes in 2007 was $174 billion, including $116 billion in excess medical expenditures, and $58 billion in reduced national productivity.

Heart disease remains the number-one killer of women in the U.S. African-American women have a higher death rate than any other population, according to the American Heart Association. Estimated annual cost of heart disease among women alone $74 billion.

The Cost of Severe vs. Moderate Obesity

A study conducted by the Rand Corporation and published in the journal Public Health indicates severe obesity is increasing significantly faster than moderate obesity.

The study identified a severely obese person as having a body mass index (BMI) of 40 or more, with a severely obese male weighing about 300 pounds and a severely obese female weighing about 250 pounds.

According to the study, the number of Americans with a BMI of 30 or more increased 24% from 2000 to 2005, while the number with a BMI of 40 or more increased by 50%. The average healthcare cost for a middle-aged person with a BMI of 40 is double the cost of a similar age person with a normal BMI (18.5-24.9).

The Cost of Diabetes and Heart Disease

Diabetes is the fifth-leading cause of death by disease in the U.S. Since 1987, the death rate due to diabetes has increased by 45%, while the death rates due to heart disease, stroke, and cancer have declined. Total cost of diabetes in 2007 was $174 billion, including $116 billion in excess medical expenditures, and $58 billion in reduced national productivity.

Heart disease remains the number-one killer of women in the U.S. African-American women have a higher death rate than any other population, according to the American Heart Association. Estimated annual cost of heart disease among women alone $74 billion.
program provides an overview of fitness, explains how to start a personal training program, do’s and don’t of exercise, and nutritional guidelines. A two-hour presentation can be provided with options for the company to enroll in a discounted health club membership plan.

The goal for the UCOM facility is to receive a finder’s fee for all companies or individuals who join the club. To ensure continued financial gain, the clinic may also seek a percentage of client company membership renewals.

Wellness Programs—A variety of wellness services may be packaged and sold to meet all of an employer’s wellness and health promotion needs. The UCOM clinic partners with qualified vendors to provide the services.

Examples of services include health-risk assessments, biometric screening, health coaching, stress management, smoking cessation, nutrition, and weight control. The clinic bills the clients for all the services and pays the subcontractor according to their contractual agreement.

Women’s Health—A variety of approaches can be used to present women’s health issues to employers and their employees. Many facilities offer discounted screening during Women’s National Health Week (May 11–17) or National Breast Cancer Awareness Month (October).

Health Fairs—A health fair gives organizations an opportunity to disseminate health information to the public at booths and/or to provide health screenings. Health fairs are usually cosponsored by groups, including hospitals, churches, sororities, and community organizations. They may last anywhere from a few hours to a few days. Representation at a health fair can be excellent exposure for a UCOM practice.

Health Seminars—A health seminar is typically a half-hour to two-hour event at which one or more speakers present information on a particular health issue.

One example is a “lunch and learn” seminar, at which people bring their lunches and listen to the speakers during a lunch break.

Seminars may be large or small, or formal or informal. If your practice has a dynamic physician (or other staff member) who enjoys public speaking, by all means consider this as an outreach option. Consider having the presentation recorded by a professional videographer and make the material available to other employers via a DVD or on your website.

The development of the corporate wellness service line is an opportunity for the UCOM to demonstrate its commitment to local business and industry. Addressing the total health needs of employers helps establish the UCOM as the healthcare provider of choice for the employers and their employees.
HEALTH LAW

Medical Search Firms: Match Making Comes to Medicine

JOHN SHUFELDT, MD, JD, MBA, FACEP

Recently, a friend called to tell me he was going to the airport to meet a woman he met online. He described her as tall, blonde, athletic and, based upon her e-mails and witty repartee, very smart. He brought the photo she e-mailed so he would recognize her when she walked through the gate.

Oddly, he never did see her walk off the plane; however, he felt a tug on the bottom of his coat and looked down to find a small person with a big smile looking up at him. She said, “I’m who you are waiting for, I switched pictures with my friend!” He called back and asked for my advice. The only thing I could think to say was, “Do you drink beer?”

Lesson 1: Don’t underestimate the importance of truth in advertising.

And who can forget the scene in Ghostbusters when Dr. Peter Venkman (played by Bill Murray) says, “Janine, someone with your qualifications would have no trouble finding a top-flight job in either the food service or housekeeping industries.”

Lesson 2: When searching for a new job, aim for a level commensurate with your abilities and experience.

Well-qualified residents often ask me if they should engage a search firm to help them find a new position. The short answer is, “It depends on your circumstances.”

Search firms have traditionally been engaged by hospitals and practices to identify potential candidates to fill a vacancy. In addition, a provider may engage a firm to seek out alternative job opportunities and thereby request that a recruitment firm confidentially identify potential employment opportunities.

For hard-to-fill vacancies (Barrow, Alaska in the winter) or hard-to-hire providers (just out of prison for their third sex offense), the cost-benefit analysis of the search firm inures favorably to their benefit.

Alternatively, when an institution simply does not have the resources to devote to a large-scale search, it may be cost effective to utilize a search firm.

Types of Agreements

Generally speaking, most search firms are engaged by the practice or institution needing a provider. Search firms usually contract in one of two ways: retained agreement or contingency agreement.

Retained Agreements

Under the retained method, the search firms are paid a percentage of the service fee to begin the search. Using this methodology, the search firm often demands an exclusive commitment from the group or institution.

Under such a retained exclusive search, all candidates are contacted and screened by the search firm. In this scenario, the physician does not make the decision to use a search firm but rather receives the inherent recruitment services as engaged by the institution or practice at no cost.

The retainer monthly fee typically ranges from $4,000 to $6,000, or in some cases is simply a percentage of the total search fee. The remaining balance of the search service fee is paid upon contracting with a provider. Depending on the recruitment company and the services rendered, the total search fee ranges from $20,000 to $30,000.

Contingency Agreements

Alternatively, under a contingency arrangement, the total fee is paid to the recruitment company upon completion of the recruitment process and the firm carries the entire cost of the search until the candidate is hired. Total fee amount is similar to the retained arrangement.

Under a contingency recruitment agreement, very few, if any, performance guarantees are provided by the search firm. Essentially, it is a full-risk expense contract for the search firm in the event a successful candidate is not hired.

John Shufeldt is the founder of the Shufeldt Law Firm, as well as the chief executive officer of NextCare, Inc., and sits on the Editorial Board of JUCM. He may be contacted at jjs@shufeldtlaw.com.
Generally, these arrangements are not exclusive.

Provider-driven
When a provider contacts a search firm for help securing employment, they or their future employer are responsible for the fee. This fee is negotiated prospectively with the provider or prior to contracting with an institution or practice.

Search firms vary in size (everything from locally based firms to large national practices) and scope (certain specialties or locations to contracting across the entire spectrum of providers).

Pros and Cons
Like everything, there are pros and cons to working with search firms.

Pros
The firm will:
- Start a database for you based upon your personal and professional parameters and conduct a confidential networking effort to identify potential job openings.
- Assist you in defining your own personal and professional goals, using career planning outlines and other resources.
- Provide information to you about the job and competitive landscape.
- Research markets and opportunities, identify key decision makers and establish contact with the potential employers.
- Send your curriculum vitae to facilitate initial contact and provide a value-added, personal introduction.
- Ensure that the initial contact, due diligence, and interview process proceed in a timely and organized manner.
- Arrange the interview and provide valuable information regarding the internal process and players.
- Help negotiate contract terms.
- Assist in relocating to the new practice and location.

Cons
There are also a number of potential disadvantages to working with a search firm. To avoid them, do your research in advance; speak to peers about their own experiences, interview different firms, research the firm’s history, look to see if the firm has been a party to any provider suits—either as the plaintiff or as a defendant.

Some of the more common concerns include the following:
- Search firms may not be experienced in the area of medicine or area of the country that you want to practice in.
- Many practices and institutions refuse to evaluate a candidate who is represented by a search firm, essentially limiting your marketability.

“One caveat: Be honest in your disclosures; if you have a past, disclose it.”

- Most practices will choose a candidate who is not working with a search firm over one who is in order to avoid paying a search firm fees.
- Some organizations will alter the provider’s compensation plan if they are represented by a search firm. At the very least, the practice will expect the physician to “guarantee” that they will practice for a specific number of months or the provider will be charged pro-rata for the fee paid to the search firm.
- Some practices view the use of a search firm as a “red flag” and will not even consider a provider represented by a firm.

Here is the take home: if you are a qualified applicant—meaning you are board certified or eligible, or have equivalent experience, no significant adverse events, a positive attitude, and a good work ethic—you do not need a search firm. All things being equal, if two equivalent applicants are applying, and one used a search firm, odds are the employer will pick the unrepresented applicant to avoid paying a search firm. Who can blame them, with a $25,000 fee associated with the applicant?

If you have a challenging past, search firms can add value, helping you uncover leads.

One caveat, whether you use a search firm or are representing yourself: be honest in your disclosures; if you have a “past” disclose it. Odds are, it will be uncovered and if you do not preemptively disclose it, you will not be hired. As the saying goes—and as confirmed by further analysis of Ghostbusters—“forewarned is forearmed.”

Spengler: There’s something very important I forgot to tell you.
Venkman: What?
Spengler: Don’t cross the streams.
Venkman: Why?
Spengler: It would be bad.
Venkman: I’m fuzzy on the whole good/bad thing. What do you mean, “bad”?
Spengler: Try to imagine all life as you know it stopping instantaneously and every molecule in your body exploding at the speed of light.
Stantz: Total protonic reversal.
Venkman: Right. That’s bad. OK. All right. Important safety tip. Thanks, Egon.
Nebulizer Treatment Coding and Take-backs on 99051

David Stern, MD, CPC

Q. Payors do not seem to want to pay on the code E0572 (aerosol compressor, adjustable pressure, light duty for intermittent use). What can we do to get payment?
A. This code is not for simple use of the aerosol compressor, but is actually used to code for sale of the actual nebulizer machine. Thus, this code would rarely be appropriate for use in the urgent care setting.

Q. How do we get payors to reimburse for albuterol medications? They do not seem to pay on codes J7603 and J7609.
A. Medicare listings for the albuterol codes have been in a state of constant flux for the past few years. You should not use J7603 and J7609, as these have been removed from the Medicare fee schedule in 2008.

The appropriate codes are:
- J7611: concentrated albuterol (per 1 mg)
- J7612: concentrated levalbuterol (per 0.5 mg)
- J7613: unit dose albuterol (per 1 mg)
- J7614: unit dose levalbuterol (per 0.5 mg)

Use each code once for each milligram that is administered. For example, if you administer 2 mg of concentrated albuterol (usually diluted with saline), then you would code J7611x2.

Q. What is the proper coding for the administration of nebulizer treatment procedures?
A. Typical coding for nebulizer therapy for asthma in an urgent care setting would be:
- 94640: first nebulizer treatment
- 94640: each subsequent nebulizer treatment on each day
- A7003: administration set, with small volume non-filtered pneumatic nebulizer, disposable
- Use J7611, J7612, J7613, J7614 per the answer to the previous question.

Q. A national payor is clamping down on the 99051 code, claiming urgent care centers may not use this code because it is customary for urgent care centers to provide these hours of service and urgent care centers are already paid more than other physician practices (which is not necessarily the case).
A. The payor is mistaken that the code 99051 is only for hours outside of your “customary hours of service,” as the AMA defines this code as being for use during “regularly scheduled office hours.” Thus, this code should never be used for services rendered other than regularly scheduled clinic hours.

In fact, there is a specific code (99050) for services rendered “at times other than regularly scheduled office hours.” Thus, not only is that payor mistaken, but there is another code that is appropriate to the circumstances they describe. You were coding correctly.

As a general rule, payors can do what they want when reimbursing for these codes. As for take-backs, you may want to look at your contract to see if they have the right to require you to refund these claims.

Continued on page 42
A thinly veiled secret in most urgent care clinics is the marginal role that sales and marketing plays in the mores of these organizations. Indeed, healthcare sales professionals tend to be like your Uncle Fred: it's always nice to see him, but he's not really woven into the inner fabric of your family.

Why?
To a large extent, urgent care owners have a hard time merging the healthcare side of their clinic(s) with the business side. And nothing seems to embody the "business side" of healthcare more than sales and marketing, which even in traditional businesses is often viewed as the non-serious, expense account, triple martini side of the business.

Your first step in addressing this problem is to redefine what sales and marketing really is—and what it is not. Forget the "let's make a deal" image often associated with sales; define sales as the vehicle that educates prospective consumers on the virtues of your clinic.

Rule #1: Keep things in perspective. Your clinic staff need not be actively involved in day-to-day sales and marketing in order to contribute. Dedicated sales and marketing staff should be responsible for 95% to 98% of all such activity. It is within this other 2% to 5% that involves team members that a clinic can catapult itself from just another clinic to one that is firing on all cylinders.

Rule #2: Define real responsibilities. A bit of cheerleading in a staff meeting ("Let's all get involved in sales and marketing this year! Rah, rah!") won't get the job done. Rather, each team member should have specific responsibilities defined within the context of his or her skills, personality, and the particular needs of the team as a whole.

Rule #3: Be realistic about team members' strengths. Another way to put it might be, don't ask somebody to do something they either don't want to do or simply are unlikely to do well.

I often hear the phrase "I need to get one of our physicians out to the workplace more often." Realize, however, that some docs wow and woo employers, others are just okay, and others exhibit interpersonal skills that may prove to be counterproductive to the sales and marketing effort.

Using a Physician for Sales and Marketing
Invariably, employers love to meet, talk on the phone with, and have physicians visit with them at their workplace. What can an urgent care clinic do to ensure that the physician makes the most of their time?

1. Be prepared to ask certain questions and show genuine interest in an employer's workplace.
2. Know what employers really want to hear and be certain to get these points across during every encounter.

Carefully crafted questions indicate that the physician has a genuine interest in the nuances of the employer's workplace. On a sales call, the physician should ask questions such as:

"What seems to be your biggest health and safety challenge at this company?"
"How have you addressed these challenges in the recent past?"
"In a perfect world, what kind of relationship would your company like to have with a clinic such as ours?"

Physicians should position themselves as company-oriented caregivers (assuming full clinical integrity, of course) by learning to look prospects and clients in the eye and say something along the lines of the following:

"I practice occupational medicine because I enjoy working with others to address the big picture: getting workers back to work quickly and safely, addressing environmental concerns as..."
they may exist, and working closely with companies to develop a plan for optimal workplace health and safety. Toward this end, I try to ensure that we are always on the same page regarding what is best for your company and your employees, both individually and collectively.”

Get Everyone in the Game
A clinic’s marketing staff and physician(s) are only a part of the larger team. Everyone on the team, from senior management through the receptionist(s), should understand that they have a vital contribution to make. The best way to communicate these roles is by listing them as part of a clinic’s marketing plan.

Teamwork in Action: Sales/Marketing Responsibilities
As noted previously, it is important that each team member understand his or her role in the clinic’s sales and marketing efforts. Expectations should vary based on each individual’s respective strengths and weaknesses, but the following may be a good starting point:

**Owner**
- Articulate the true value and purpose of the clinic’s occupational health program.
- Make at least one phone call per quarter on behalf of the program.

**Physician**
- Participate in one sales call per week.
- Articulate your personal philosophy as an occupational health physician.
- Succinctly articulate the value of your program’s interventions.
- Participate in clinic tours by asking the “right questions” when meeting visiting employers.

**Clinic Coordinator**
- Participate in periodic sales calls.
- Succinctly articulate the value of your clinic’s interventions.
- Develop and execute a carefully plan clinic tour.

**Receptionist**
- Ask the right questions, take clinic tour visitors through a prototype registration process, and routinely point out patient flow attributes as important.

Help is closer than you might think and many, if not all, of your coworkers and employees have something to offer—if only you would ask.

Be certain to make occupational sales and marketing a true team sport. It’s the best way to assure a winning record.

---

**CODING Q&A**

do a take-back in this way. It sounds as though they have changed their rules for coding and are now trying to retroactively apply the new rules. You may need to contact a lawyer to see if you have a legal case to prevent the payor from applying new rules to old claims.

Usually, we try to use this type of a move by a payor as an opportunity to get a face-to-face meeting to explain:

- The benefits that the payor receives from after-hours care:
  - Marketing to employers (i.e., we include quality urgent care providers).
  - Making their most profitable members (i.e., the walking well that utilize very few healthcare resources) happy with their coverage.
  - Reduced emergency department visits.

- The additional costs that your urgent care incurs by providing after-hours care:
  - Wages; we must pay more than typical primary care where hours are 9–5, Monday through Friday.
  - Down time occurs when you are open—and paying staff—even when no patients come through the door, which can occur for hours at a time. When primary care practices have no scheduled visits, they can simply close up shop.
  - Staffing to rush: Due to non-scheduled visits, an urgent care center needs to slightly overstaff so that unacceptable delays do not occur during unexpected rushes of patients.

Then we tell the payor that there are many different ways for the payor to reimburse urgent care centers for these added expenses. Payors sometimes use 99088, 99051, problem-based coding (PBC), a fee schedule at about 120% of primary care fee schedule, or some other method.

The key issue is that we need a mutually beneficial way to continue the relationship. They want urgent care centers to serve their clients, and urgent care centers need adequate reimbursement to pay the electric bill.

**Note:** CPT codes, descriptions, and other data only are copyright 2007 American Medical Association. All Rights Reserved (or such other date of publication of CPT). CPT is a trademark of the American Medical Association (AMA).

**Disclaimer:** JUCM and the author provide this information for educational purposes only. The reader should not make any application of this information without consulting with the particular payors in question and/or obtaining appropriate legal advice.
Career Opportunities

SACRAMENTO, CALIFORNIA URGENT CARE
established 1981. Four physician group seeking full-time physician BC/BE in FM/MMEM. Competitive compensation with possibility of future partnership. EMR (eCW) since 2006. Fax resume to (916) 966-2541.

URGENT CARE IN LAKELAND, FLORIDA SEEKS

LAWRENCE, KANSAS - PHYSICIAN OPPORTUNITY
available in established, free standing, physician owned urgent care and occupational health clinic with onsite physical therapy. Lawrence is home of the University of Kansas and is less than one hour from Kansas City. Excellent housing and schools. Send CV to: Mike Geist M.D., PromptCare, 3511 Clinton Place, Lawrence, KS 66047; or call (785) 838-1500; or email: promptcare@sunflower.com.

Work and Play in the Blue Ridge Mountains of Virginia
Carilion Clinic is searching for an Urgent Care Physician to work at Carilion Roanoke Community Hospital in Roanoke where the ED has been converted to an Urgent Care due to the consolidation of 2 Carilion hospitals located in Roanoke, Virginia. Candidates must be BE/BC in Family Practice, Internal Medicine, or Emergency Medicine with Urgent Care experience preferred. Hours of operation are Sunday - Saturday, from 8 AM to 10 PM, anticipating 36,000 visits annually. Flagship ED located within 1 mile for transfers of acute care. Physician Assistants and nursing support 7 days a week. Enjoy working a 36 or 40 hour work week and every other weekend or 5 out of 10 weekends with days off during the week. Practice with cutting edge technology such as Electronic Medical Records, PACS Imaging and Web-based scheduling.

Roanoke, Virginia, a “five-time “All American City”, population over 280,000, and one of the top rated small cities in the US. Nestled in the gorgeous Blue Ridge Mountains and close to 500 mile shoreline Smith Mountain Lake.

Carilion Clinic is the largest, not-for-profit integrated health system in southwest Virginia with 7 hospitals, 82 multispecialty clinics, 7 residency and 2 fellowship programs, affiliated with the University of Virginia and VCOM, serving 1.5 million throughout the region. The Virginia Tech Carilion School of Medicine is slated to open Fall 2010.

This opportunity offers a salary plus incentive, 10% shift differential, 3p-3a, comprehensive benefits package, paid relocation, 30 days paid vacation, paid malpractice, CME days and allowances, and more.

Visit Carilion at www.carilionclinic.com

For more information or to submit your CV for consideration, please contact Andrea Henson, Physician Recruiter at (540) 224-5241 or ahenson@carilion.com

Visit www.rja-ads.com/jucm for classified rates

GEORGIA - URGENT CARE MEDICAL DIRECTOR
needed, Atlanta Vicinity. Get in on the ground floor! Seeking an experienced, business minded family physician to help start, hire staff and build hospital-affiliated urgent care center. Mix of clinical and administrative duties, urgent care experience preferred. Located across from hospital, center will receive huge number of patients from the ED. Salary starting at $170K, incentives, all benefits. Contact Roberta Margolis, 800-365-8900, ext. 211; roberta.margolis@comphealth.com. Ref. #6510827.

SANTA CLARITA, CALIFORNIA
Beautiful and safe
Employee, partnership track, BC EM/FM or IM
• 56 hour workweek
• 2 year old digital facility UC/FM hybrid
• $180-$200k first year depending on your productivity.
• Malpractice, Blue Shield PPO, IRA included, and 3 weeks paid vacation.

Fax CV to (661) 294-0931 or email CV to: mpin@ca.rr.com; www.scadvmed.com.

South Central Michigan
Seeking BE/BC Urgent Care/FP or Emed Physicians minutes from Ann Arbor
Average 5.5 patients/hour. Typical schedule is 2 on 3 off and 3 day weekend. Two weeks a month. Second schedule is 4-12am with flexibility-equals to 10-8 hour shifts/pay period.

Support staff includes: 3-5 LPN’s, Radiologist, Pediatrician, and Registration staff. Procedures: simple sutures, fractures, casts, and those typical of office practice.

For more information contact: Michelle Spiegelberg at (800) 547-1451
Email: mspielberg@sourceesi.com

Occupational Medicine – Urgent Care
Los Angeles, California
Exciting opportunity for an experienced, outgoing, and motivated urgent care/occupational physician to join our rapidly growing practice. Located near Los Angeles International Airport, you will see patients from around the world. A truly unique opportunity.

For more information, contact: mlebow@laxclinic.net • Fax: (310) 546-1641

Urgent Care - Bloomington, IL
A Family Medicine Physician is needed for our fast paced Urgent Care at OSF St. Joseph Medical Center in Bloomington, Illinois. Come to the fastest growing area offering culture, entertainment, education, community, and stability. Treat walk-in patients using quick diagnostic skills on-site with procedure room, lab, and x-ray. This full-time position includes 8 shifts every 2 weeks and the option to work additional hours.

Please contact: Marie Nootel
OSF Physician Recruitment
Call: (309) 677-8351 or (800) 232-3129 press 8
Fax: (309) 677-8338
marie.k.nootel@osfhealthcare.org
www.osfhealthcare.org
McLeod Health. located in Florence, South Carolina is seeking a BC/BE FM, IM, or EM physicians to work in our new urgent care facility. The facility’s hours of operation are Monday-Friday, 8:00am-8:00pm and weekends 9:00am-4:00pm. The physicians will work together to develop the work schedule. We offer a competitive salary, comprehensive benefits package, retirement package, 30 days paid time off, malpractice insurance, CME allowance, and a relocation allowance. The urgent care center has cutting-edge technology with a digital x-ray and CT scanner on site. Made up of 10 rooms and 2 procedure rooms we provide our patients with quality service.

Florence, South Carolina offers a wonderful family-oriented lifestyle with great schools, civic events, and sporting events. We are located at the intersection of I-20 and I-95 with a regional airport that is operated by US Air and Delta airlines, making our location easy for travel. In addition, we are 1 hour from the beach, and within 2 hours of Charlotte, North Carolina and Charleston, South Carolina.

McLeod is dedicated to patient-centered, evidence-based, and physician-lead healthcare. This is an opportunity where not only can you practice medicine, but also live a balanced and fulfilled lifestyle.

For more information, please contact me at jmclaurin@mcleodhealth.org or (843) 777-5169

Thank you and look forward to hearing from you.
Janisyn McLaurin, Physician Recruiter, McLeod Health

Northern California
 Urgent Care Opportunities

Sutter Health, Sacramento Sierra Region providing services to Greater Sacramento area currently has Urgent Care opportunities in a variety of locations. Full-time and per-diem or supplemental positions are available.

The region offers something for everyone. The central location provides easy access to many of the best attractions Northern CA has to offer: San Francisco, Napa Valley, and Lake Tahoe are all within the immediate area. Enjoy activities such as skiing, camping, and biking or just sit back and relax under the warm California sunshine.

Contact us to learn more about practice opportunities Sutter Health has to offer.

The Medical Opportunity Of A Lifetime On Florida’s West Coast

Life’s too short to practice medicine just anywhere. An inviting career opportunity awaits you with Morton Plant Mease Health Care, a dynamic, multi-hospital Florida health care organization with an exciting future.

Room to Grow for Quality Physicians
(Board-eligible/board-certified only) J1-Visa not eligible.

Morton Plant Mease is offering exciting opportunities in family medicine, internal medicine and urgent care for practicing physicians out-of-area and graduating residents. Start living the medical career of your dreams in the Tampa Bay area. FAX your CV to Kathy Sadler, Manager of Physician Relations, (727) 535-7412; or E-Mail to: Kathy.Sadler@baycare.org.

To learn more about rewarding physician opportunities, Call: (800) 875-8254

www.mpmhealth.com • www.mpmprimarycare.com

Urgent Care Physician
Phoenix, Arizona

Seeking board-certified/board eligible physician in either family medicine or emergency medicine for an urgent care facility located in downtown Phoenix. Join a stimulating practice with a broad variety of patients, and a knowledgeable and supportive staff. Maricopa Integrated Health System (“MIHS”) provides care to the underserved population of metro Phoenix and includes Maricopa Medical Center, a 450-bed hospital with a Level 1 Trauma and Burn Center which is a major affiliate of the University of Arizona, College of Medicine. The position would include employment through Medical Professional Associates of Arizona, P.C., a 250+ physician multispecialty group exclusively contracted to provide patient care and teaching.

Candidates must have an M.D. or D.O. degree and a valid Arizona license. MedPro offers an outstanding work environment, competitive compensation plan/benefits package including relocation assistance, paid time off, CME allowance with paid time off and paid malpractice insurance.

For consideration please forward CV to:
MedPro, Attn: Provider Recruiting
2929 E. Thomas Road, Phoenix, AZ 85016
Fax (602) 470-5067
E-Mail: practice@medprodoctors.com
EOE
**Career Opportunities**

**Richmond, Indiana**

**URGENT CARE**

Long standing Emergency Medicine group of 12 - recruiting primary care BC urgent care physician to staff Fast Track at Reid Hospital in Richmond, Indiana. Work 120 hours per month - very flexible schedule! Patient flow averages 2.5 per hour. Patients are triaged from Level II Emergency Department. Work alongside two RNs. Draw area of 150K. Outstanding earning potential with quarterly productivity bonuses, low cost of living. New 233-bed replacement hospital opened September 2008. Three major metro cities within one hour - Indianapolis, Dayton and Cincinnati. Family oriented community with relaxed lifestyle and excellent schools, including private. Outdoor Recreational activities abound including golf, boating, hunting and fishing to name a few. Great place to live and practice medicine.

Email your CV to Amy Koons, Recruiter Medical Staff Development
koonsa@reidhosp.com
800-765-3104

---

**Isn’t it time for something better?**

**Find Your Passion Here**

**Urgent Care Opportunities-Washington**

Group Health Permanent, the Pacific Northwest’s premier multi-specialty group, is currently seeking a BC/BE Emergency Medicine Physician to join our team. Group Health is dedicated to providing innovative and patient-centered care to communities throughout WA.

- Candidates should have a full range of urgent care skills & an interest in working with innovative group
- Affordable housing, highly rates schools & pleasant neighborhoods, an unparalleled place to raise a family
- A flexible schedule, generous benefits and competitive salaries make this an opportunity worth exploring

For additional information or to submit your CV, please contact:

Cayley Crotty – crotty.c@ghc.org
206-448-6519

www.ghc.org/greatjob

---

**Norton Healthcare has full-time career opportunities in an urgent care network in Louisville, Ky & Southern Indiana.**

Facilities have been in operation for over 20 years.
The hours of operation are from 9am-9pm, seven days a week.
The position includes an excellent compensation package, company benefits, bonus opportunities, and no call.

The consistent growth of Louisville’s medical market is one of the key reasons the city continues to thrive economically. In fact, Norton Healthcare – the region’s largest healthcare provider – will open its 5th full-service hospital in 2009, along with 10 additional immediate care centers, soon to be 11. As a city, Louisville provides an ideal balance for both business and personal growth. Boasting a cost of living lower than cities of its size, Louisville offers suburban and downtown living within close proximity of all its hospitals, along with a thriving arts and culinary community, nationally recognized public and private schools, Division I college sports, host to PGA golf tournaments to include the 2008 Ryder Cup, and, of course, Churchill Downs, the home of the Kentucky Derby.

Visit Greaterlouisville.com for more information on Louisville, KY.

Please contact Amanda Bailey, Manager,
Norton Physician Recruitment at
(502) 961-6897 or
Email: amanda.bailey@nortonhealthcare.org.
Visit Beanortondoctor.com for more information about Norton Healthcare.
NEW JERSEY

EMO Medical Care, a Physician-owned and operated multispecialty group, currently has the following opportunities available for dynamic, fast paced BC/BE physicians:

Regional Medical Director • Medical Director • Urgent/Primary Care Attending

Our locations in Monmouth and Union Counties offer flexible schedules, competitive compensation and excellent benefits.

If you are interested in learning more, please submit your CV to:

Soti Lluberess, Physician Recruiter
(877) 692-4665 Ext. 1134
Fax: (973) 740-9895
Email: lluberess@emomedicalcare.com

Urgent Care - Layton, Utah

Layton, Utah: Intermountain Healthcare needs BC/BE family physicians to do urgent care work in our InstaCare clinics. Full-time and part-time shifts available.

Shifts are very flexible:
• Weekdays 5 hour or 9 hour shifts.
• Evenings 4 hours (5:00 – 9:00 PM) or 8 hours (5:00 – 9:00 PM).
• Weekend shifts are 6 hours.

11 or 12 hour shifts can also be accommodated. Days per week can be variable too.

InstaCare hours:
• 9:00 AM – 9:00 PM on weekdays and
• 9:00 AM – 5:00 PM on weekends.

Physicians will have the ability to make $180k to well over $200k. Employment positions with the Intermountain Medical Group. Intermountain benefits and relocation provided for full-time positions. EOE.

Send/email/fax CV to:
Intermountain Healthcare
Attn:  Wilf Rudert, Physician Recruiting
36 S. State Street, 21st Floor,
Salt Lake City, UT 84111
(800) 888-3134,
Fax:  (801) 442-2999
Email: PhysicianRecruit@imail.org
http://intermountain.net/docjobs

Urgent Care - Peoria, IL

Seeking physicians for employment in modern urgent care facilities operated by OSF Saint Francis Medical Center. Broad based diagnostic skills and experience are essential for practice at our facilities. On-site radiographic imaging and CLIA waived diagnostics available. Full-time position offered with opportunity to work extra shifts if desired.

Please Contact: Stacey Doolittle
OSF Medical Group Physician Recruitment
Call: 309-683-8354
or 800-232-3129 press 8
Fax: 309-683-8353
stacey.e.doolittle@osfhealthcare.org
www.osfhealthcare.org

NEW JERSEY

Career Opportunities

Don’t delay... for classified advertising information, contact us today.

Contact: Trish O’Brien
(800) 237-9851 • Fax (727) 445-9380
Email: jucm@rja-ads.com
Web: www.rja-ads.com/jucm

Urgent Care - Layton, Utah

Attention Providers!

NextCare URGENT CARE

As a member of our urgent care team, you will
• Receive a comprehensive compensation package that includes great benefits, fantastic compensation plan PLUS robust financial incentives
• Work regular hours in an efficient, state-of-the-art practice designed from the ground up by urgent care professionals
• Use a state-of-the-art electronic health record which allows you to focus on the patient not the paper
• Practice episodic, efficient patient care that ranges from routine to moderately high level
• Remember again why you wanted to practice medicine

Opportunities abound in Arizona, Colorado, Georgia, Texas, North Carolina, and Virginia!

Call or visit us online at: 1-888-782-8916 • www.nextcare.com/recruit
Beautiful Western North Carolina
Hospital-owned, freestanding urgent care center in Hendersonville, NC, is seeking a Medical Director for full-service program providing occupational health and hospital employee health services. OM experienced with BC in EM, IM or FP. MRO certification preferred.
Competitive salary/benefits.
Contact Lilly Bonetti, 828-694-7728 or lilly.bonetti@pardeehospital.org

New Mexico (Santa Fe) – Urgent Care
Opportunity. Prefer EM or FP experience. Private clinics in downtown Santa Fe and northern Albuquerque. Seasonal clinics in the Taos ski resort areas. Administrative stipend available. Paid malpractice and moving stipend. Easy access to world class skiing, hiking, biking and climbing, as well as many cultural activities. Full- or part-time.
Fax CV to (505) 989-3536
Email: info@ultimed.net; call (575) 770-1873.

SHARP REES – STEALY MEDICAL GROUP
a 375 plus physician multispecialty group in San Diego, is seeking full-time BC/BE family medicine or emergency medicine physicians to join our urgent care staff. We offer a competitive compensation package, excellent benefits, and shareholder opportunity after two years. Please send CV to SRSMG, Physician Services 2001 Fourth Ave., San Diego, CA 92101
Fax: (619) 233-4730
Email: Lori.Miller@sharp.com

URGENT CARE - SOUTH CAROLINA
From the mountains to the sea and the capital in between, UCI Medical offers opportunity and security in a professional setting. With 26 years of successful history, our group comprises over 40 locations throughout South Carolina, half with on-site Physical Therapy. Competitive compensation includes malpractice, 401(k), productivity bonus, deferred comp plan, etc.
Inquiries and CV to: kmitchell@UCImedinc.com

With a circulation of 13,000 urgent care subscribers, there are plenty of reasons why your company should be a part of The Journal of Urgent Care Medicine’s 11 monthly issues.
Visit our website
www.rja-ads.com/jucm
for classified advertising information or contact us for a quote.
Next available issue is December, with a closing date of October 28th

BUSINESS BROKER SERVICES – Own a busy, clinically excellent urgent care practice? Call for a free consultation from experienced urgent care business brokers. Contact Tony Lynch or Steve Mountain at MT Consulting, (610) 527-8400; or tony@mtbizbrokers.com; www.mtbizbrokers.com.

Email your ad today!
JUCM@rja-ads.com
As an emerging distinct practice environment, urgent care is in the early stages of building a data set specific to its norms and practices. In Developing Data, *JUCM* will offer results not only from UCAOA’s annual benchmarking surveys, but also from research conducted elsewhere to present an expansive view of the healthcare marketplace in which urgent care seeks to strengthen its presence.

*In this issue:* How did patients in a national study of visits to emergency departments in the United States rate their experience according to select key indicators of satisfaction?

### Satisfaction with the ED, by Aspect of Care

<table>
<thead>
<tr>
<th>Aspect of Care</th>
<th>Overall Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrival</td>
<td>79.6</td>
</tr>
<tr>
<td>Nurses</td>
<td>85.1</td>
</tr>
<tr>
<td>Doctors</td>
<td>84.2</td>
</tr>
<tr>
<td>Tests</td>
<td>86.1</td>
</tr>
<tr>
<td>Personal issues</td>
<td>77.9</td>
</tr>
<tr>
<td>Overall assessment</td>
<td>81.3</td>
</tr>
</tbody>
</table>


One can surmise from the data that participants in the study tended to be most satisfied with the more clinical aspects of their visit to the ED, giving nurses, doctors, and “tests” scores of over 84. (In a question not included in this excerpt, “Personal/Insurance Information” also received a high score—86.6.)

However, it may be enlightening to consider that patients were least satisfied with their arrival experience and “personal issues” (defined for purposes of the study as receiving information about delays, pain control, and “other items that demonstrate the value of the patient as a person”) when visiting the ED.

To date, no such study has been done in the urgent care setting. However, thinking as objectively as possible, how would you expect patients to score a visit to your practice?

If you are aware of new data that you’ve found useful in your practice, let us know via e-mail to editor@jucm.com. We’ll share your discovery with your colleagues in an upcoming issue of JUCM.
What Do You Want From Your Urgent Care Association?

I Want “to have access 24/7 to talk to other urgent care providers – to compare ideas, get answers to problems and questions, or references for vendors and resources.”

I Want “to get the latest information from experts – both national speakers and fellow colleagues – and at a nice location!”

I Want “to avoid spending time reinventing the wheel. I need samples of job descriptions, policies, billing and coding templates and tips – everything!”

I Want “an association I can call ‘home’ – where I’ll see familiar faces at every meeting and make connections I can use all year long.”

UCAOA Online Forums

UCAOA Fall Conference and National Urgent Care Convention

UCAOA Members Only Articles and Resources

Join UCAOA!

“I want an association who will listen to me and what my needs are…”

The Urgent Care Association of America provides all of this and more.

Benchmarking Surveys, the Journal of Urgent Care Medicine, Job Bank, Online Forums, Conferences – visit www.ucaoa.org to see what we are working on for you.

Join us! Complete the membership application and fax or mail it back to us – we can’t wait to meet you!

Urgent Care Association of America
Offices in Chicago and Tampa Bay
4320 Winfield Rd., Suite 200, Warrenville, IL 60555
877-698-2262  www.ucaoa.org